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**EMPOWERING WOMEN'S SELF-CARE: A
PARTICIPATORY APPROACH TO PREVENT
HIV/AIDS FOR WOMEN AND CHILDREN IN
NORTHEAST THAILAND**

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Ph.D

2005

**Empowering Women's Self-Care: A Participatory Approach to
Prevent HIV/AIDS for Women and Children in
Northeast Thailand**

Siriporn Donkaewbua

**A thesis submitted in partial fulfilment of the
requirements of The Robert Gordon University
for the degree of Doctor of Philosophy**

**Centre for Nurse Practice Research and Development
School of Nursing and Midwifery
Faculty of Health and Social Care
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Aberdeen
Scotland**

September 2005



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A handwritten signature in black ink, appearing to read 'S. Donkaewbua', with a stylized, flowing script.

Siriporn Donkaewbua

8/ 12/2005

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Empowering Women's Self-Care: A participatory approach to prevent HIV/AIDS for women and children in Northeast Thailand

Abstract

Across Thailand there has been a general reduction in the incidence rate of HIV infection in all but one special population group: married women and their offspring whilst the incidence rate is relatively low (1.2%) it has remained steady for a number of years.

This participatory approach aims to understand the married women's points of view and to facilitate their self-care to prevent HIV/AIDS for themselves and their next child. The research utilised a three phase design: exploratory, explanatory and intervention phases. The findings from the first two phases have substantively informed the construction of the intervention phase.

The overall findings of the research indicated that women have general knowledge about HIV/AIDS and carried out general self-care practices. Specific self-care practices however were lacking. Through the participatory intervention phase the research has been able to illuminate a number of important factors pertaining to women's self-care most-noticeably: the importance of support; the strategies women adopt to balance health and social risk; the importance of consciousness raising; and the need for culturally sensitive health care programmes.

The research concludes by presenting an analytical model of women's self-care for the prevention of HIV/AIDS and makes a series of recommendations with regard to the development of existing Thai health care services, the enhancement of the current educational curricula, and the incorporation of participatory approaches in health promotion and health care provision for families

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Translation and transcription

The following transcription system will be utilized throughout the thesis for both Thai and Isaan terms.

The system used below is based upon the application by the Royal Institute (1999)

Consonants

Thai	First consonants	Last consonants
ก	k-	-k
ข ค ฆ	kh-	-k
ง	ng-	-ng
จ	-ch-/j-	-t
ฉ ฌ	Ch-	-t
ญ	y-	-n
ด ฎ ฒ (เสียง ด)	d-	-t
ต ฏ	t-	-t
ถ ฐ ท ฑ (เสียง ท)	th-	-t
ณ ฒ		
น ฌ	n-	-n
บ	b-	-p
ป	p-	-p
ผ ฝ ภ	ph-	-p
ฝ ฝ	f-	-p
ม	m-	-m
ย	y-	-
ร	r-	-n
ล ฬ	l-	-n
ว	w-	-
ศ ษ ฬ ฌ	s-	-t
ห ฮ	h-	-
อ	-	-

Vowels

Thai	Roman
อะ อັ-	a
อา-	
อา	an
อำ	am
อิ, อึ	i
อี, อึ	ue
อุ, อู	u
เอะ, เ-, เอ	e
แอะ, แอ	ae
โอะ, -(โอะลดรูป)	o
โอ, เอะ, ออ	
เออะ, เอ (เอลดรูป)	oe
เออ	
เอียะ, เอีย	ia
เอือะ, เอือ	uea
อัวะ, อัว	ua
-ว- (อ้งลดรูป)	
ไอะ, ไอ, อัย, ไอย, ขาย	ai
เอา, อาว	ao
อุย	ui
โอย, ออย	oi
เอย	oei
เอือย	ueai
อวย	uai
อิว	io
เऔ, เऔ	eo
แऔ, แऔ	aeo
เอียว	iao
ฤ (เสียงวี), ฤา	rue
ฤ (เสียงวิ)	ri
ฤ (เสียงเวอ)	roe
ฦ, ฦา	lue

Thai saying

The following Thai saying were used in text of some chapters of the thesis. Terms are listed in English alphabetical order.

Phonetic transcription	English translation
<i>Ajarn</i>	Lecturer in the university or school which means that this is a respected person
<i>Ajarn pa ya bal</i>	Nurse lecturer who generally takes responsibility as clinical instructor as well
<i>Chang thao laung</i>	A hind leg of an elephant which means that woman is a follower to her husband which is symbolized by an elephant foreleg or the leader in Thai society
<i>Chang thao na</i>	A foreleg of an elephant
<i>Choak cha ta</i>	A fate, lot or a destiny which is believed to be the consequences of the previous life
<i>Dam</i>	A skin turned black
<i>Dek Mai</i>	Literally a ‘New girl’ and represents a young girl who just engaged in sex-service business and is believed that she is virgin and free from HIV/AIDS.
<i>Fan</i>	Boy friend, girlfriend, or temporary or permanent sexual partner. It is also used as a pronoun to call husband or wife of one’s own
<i>Hang</i>	A condition of weakness and skinny
<i>Hao Hao</i>	Isaan word means very vigorous or lively
<i>I.M.F.</i>	This term is used to imply an economic crisis in Thailand by 2000
<i>Isaan women</i>	Woman who is born, grown up and lives in Northeast Thailand
<i>Jai on</i>	A soft-hearted or kind characteristic that likely to compliance with other requests or demands
<i>Kilate Tanha</i>	A desire, greed, or a lust
<i>Kong mai pen rai</i>	It’s doesn’t matter
<i>Kreng jai</i>	A consideration for the feeling of others is a social interaction to avoid conflict and maintain good relationship in Thai society
<i>Liang do po suea</i>	The way of hospitality among men for his special guests or friends which includes providing of food, drink, service, and prostitute

Phonetic transcription	English translation
<i>Mai mua khem</i>	Do not share syringes for injection of addictive drugs with others
<i>Mai sam son</i>	Do not being sexually promiscuous
<i>Mak maak</i>	Avid to have lust for sex or sexually insatiable
<i>Mang- da</i>	A pimp
<i>Mara pa or mara noi</i>	Wild or little balsam pear believed that they can cure some disease such as AIDS
<i>Mia noi</i>	An illegal wife or a man's mistress
<i>Moa</i>	Doctor or physician. It is commonly used by people to call health professionals
<i>Nai hoi</i>	A pronoun used by a villager to call a rich man in their communities
<i>Pai teiw</i>	Going around for getting fun. It is also used as implying of visiting CSWs
<i>Plog</i>	An idiom of a condom
<i>Plong</i>	A coping style which means that people are resigned to their own fate or to make up one mind
<i>Pron ni bat samee</i>	The expected role and responsibility of the wife which would minister to the needs, comfort and happiness of husband
<i>Puah deiw mia deiw</i>	A monogamous marriage for the rest of one's life
<i>Sia tua hai chai</i>	Literally 'lose body to a man'. Generally this phrase was used to signify the value of women's virginity. Thus once a woman lose her virginity to any man it means that she lose her body to him.
<i>So-pae-nee</i>	A prostitute
<i>Thamjai</i>	To be calm or to be dispassionate
<i>Thung Yang</i>	A condom
<i>Tua AIDS</i>	The symbolized AIDS person
<i>Tum</i>	Skin lesions such as blister or rash

Definitions

Women's self-care: encompasses decisions and actions taken by a woman in order to prevent herself and her next child from contracting HIV/AIDS. Self-care also includes actions that are undertaken with the support of lay people, networks, and health care professionals. Self-care actions are voluntary, adequate and continuous in order to achieve the goals of HIV/AIDS prevention.

Social support: A support which women received, both in terms of help or suggestions in regard to promoting self-care to prevent HIV/AIDS for themselves and their next child. This support is composed of: 1) social- care - a supportive care received from their social network such as family, relatives and friends, and 2) professional- care - a supportive care received from health professionals or health services.

Empowerment: a participative and interactive process between women, HIV/AIDS nurses counsellors and the researcher aimed at promoting women's strength and self-development. The consequences of the empowerment process are ones of adaptation by: making it possible to avoid HIV/AIDS risk and undertake socio-culturally self-care activities to prevent HIV/AIDS for themselves and their next child.

Participation: Engaging in groups as a partnership with regard to knowledge construction and utilization aimed at improving women's self-care to prevent HIV/AIDS

Vertical transmission of HIV/AIDS: Mother to child HIV/AIDS transmission during pregnancy

Well child clinic: A clinic which provides routine health check up and care to a child aged under five years. This includes immunization.

Ante-natal care clinic: A health care unit where pregnant women received routine health care

Abbreviations

VCT: Voluntary counselling and testing (for HIV).

STDs: Sexually transmitted diseases

STIs: Sexually transmitted infections

ICSWs: In-direct commercial sex workers means non-brothel commercial sex workers

CSWs: Direct commercial sex workers represent brothel commercial sex workers

IE& C: Information, education and counselling

CHAPTER I

INTRODUCTION TO THE THESIS AND FOCUS OF INVESTIGATION

This chapter provides an introduction to the thesis, and makes explicit the focus of the investigation. The chapter is structured in 6 sections.

Section 1: Significance of the problem

Section 2: Gender issues and HIV/AIDS

Section 3: Researcher's assumptions

Section 4: Importance of women's perspective

Section 5: Purpose of the study

Section 6: Synopsis of thesis

SECTION 1: SIGNIFICANCE OF THE PROBLEM

The epidemic of acquired immune deficiency syndrome (AIDS) in Thailand appears to be driven primarily by patterns of heterosexual behaviour (Muecke 1990; UNAIDS 1998; Ministry of Public Health Thailand 2004a). Sexual transmission accounts for 83.70% of all cases (Ministry of Public Health Thailand 2004a). Surveys of sexual behaviour have shown that many Thai men have often visited commercial sex workers [CSWs] (Anusornteerakul et al 1996). Consequently, unprotected sexual intercourse with CSWs was widespread (Sittitrai et al. 1991; Pradubmook 1996).

Human immunodeficiency virus (HIV) infections among women in Thailand have usually occurred through heterosexual transmission (Plipat 1996; Ministry of Public Health Thailand 2004a). The evidence suggests that married women have been infected with HIV mostly from husbands (Mangclaviraj 1994; Dilookwatana et al. 1996; Brown 2001; The Thai Working Groups on HIV/AIDS Projection 2001; Rhucharoenpornpanich et al. 2003).

In Thailand pregnant women are one of the fastest growing risk groups for the human immunodeficiency virus (HIV) infection (Photharamich and Thainhua 1996; Plipat 1996). A retrospective study on pregnant women attending ante natal care clinics (ANC) at various hospitals was conducted throughout Thailand. It was found that the new cases of HIV infected women increased from zero percent in 1990 to the highest peak of 2.3 % in 1995 (Ministry of Public Health Thailand 2004ab). The prevalence rate remained stable for several years. The percentage of women infected with HIV, declined from 1.5% in 1998 to 1.2% in 2003 (Ministry of Public Health Thailand 2004ab). In particular, the prevalence rate is higher than the goal (1.0 %) of the 9th National Economic and Social Development Plan. This has resulted in a high proportion of mother to child transmission (Division of AIDS and STD Control 1996; Photharamich & Thainhua 1996; Plipat 1996; The Thai Working Groups on HIV/AIDS Projection 2001).

Until 1995, paediatric cumulative HIV infections throughout Thailand were 12,172, paediatric cumulative AIDS cases were 3,413, and paediatric cumulative AIDS deaths were 3,354 (The Thai Working Groups on HIV/AIDS Projection 2001).

These children were born from HIV sero-positive mothers who acquired the disease from their husbands (Plipat 2000: Epidemiology Section Khon Kaen 2002).

It has been estimated that, in each year a large number of newborn infants from HIV infected mothers will be passively infected with HIV. By the end of 2004, it was estimated that 24,800 children aged 0-14 years would be HIV infected (Ministry of Public Health Thailand 2004ab), and many of them would die in their early life while the remaining would be orphaned (The Global Orphan Project, MOPH cited in Ministry of Public Health Thailand 2004a). From 1984 to 2004 vertical transmission has accounted for 4.31% of the total number of those infected, and children have accounted for 3.95% of AIDS cases reported (Ministry of Public Health Thailand 2004ab).

So far, the prevalence rates among women and children have been steady. If such a trend continues, this will have a largely negative impact on the medical, psycho-social and economic situations and will lead to a great social burden (Pradubmook 1994; Plipat, 1996; The Thai working groups on HIV/AIDS projection 2001; Ministry of Public Health Thailand 2004ab).

The epidemic varies between regions and groups within the population. However, the prevalence rate of HIV/AIDS is high in large cities (UNAIDS 2002; Ministry of Public Health Thailand 2004ab). Khon Kaen is a large city and has prerequisite conditions for an HIV/AIDS epidemic among pregnant women and children.

FOCUS OF INVESTIGATION

Khon Kaen is one of the top ten provinces which have had the highest cumulative AIDS cases in Thailand. By June 2004 Khon Kaen had 4,757 AIDS cases and 2,169 symptomatic HIV infections. The number of deaths from AIDS was 854 whilst deaths from symptomatic HIV were 83 (Epidemiology Section, Khon Kaen 2004). In 2004 there were 2,170 HIV infections, and the highest number of HIV infections (n=527) was concentrated in Muang district, the city centre (Epidemiology section, Khon Kaen PHO 2004). Khon Kaen is also one of the provinces which has had high prevalence rates of HIV infection in Northeast Thailand, and can be considered as representative of the national incidence pattern.

Heterosexual intercourse was the most frequent mode of transmission, from the beginning of the epidemic until 2004, in Khon Kaen. It accounted for 81.5% and 79.5 % in AIDS cases reported and symptomatic HIV patients respectively. Housewives accounted for 2.6 % and 3% of AIDS cases reported and symptomatic HIV patients respectively (Bunyong 2003; Epidemiology Section, Khon Kaen 2004).

Mother to child transmission accounted for 5.4 % and 6.2 % of AIDS cases reported and symptomatic HIV patients respectively. Consequently, the proportion of preschool children with AIDS and symptomatic HIV patients was 4.9 % and 5.3 % respectively. By June 2004, there were 543 children (1-14 years old) who were AIDS and HIV infected patients (Epidemiology Section, Khon Kaen 2004).

From 2000 to June 2004, the percentage of preschool children who were AIDS patients was 4.6% and the percentage of symptomatic HIV infections was 6%. It was also found that Muang district (city centre) had the highest prevalence of HIV/AIDS in Khon Kaen province (Epidemiology Section, Khon Kaen 2004).

The prevalence rate of HIV/AIDS among pregnant women and infants in Khon Kaen remains steady compared to the other specific groups of sentinel surveillance. In other words the proportions of preschool children, housewives, and mother to child transmissions have not changed (Bunyong 2003, Epidemiology Section, Khon Kaen 2004).

Since HIV infections among women are mostly through heterosexual transmission, in order to make sense of and understand this phenomenon, ideas about gender responsibility need to be understood.

SECTION 2: GENDER ISSUES AND HIV/AIDS

I was born and grew up in the Northeast of Thailand where I learned about gender roles, responsibility, and relationships between men and women from my direct experience, observing others, discussions with relatives and friends, and from literature. These learned experiences have convinced me that gender responsibility might be a contributing factor to the spread of HIV/AIDS among Thai people, particularly Thai women.

THAI MEN'S PLEASURES

In Thai society, women and men are expected to have clearly defined gender oriented roles and responsibilities, particularly in terms of sexuality. Across Thai society, Thai manhood is closely linked with sexual adventure. They also view this as a normal sexual activity due to natural drives in the male persona and are advantageous to men's lives (Kaewteph et al 1999). Instead of sanction against, Thai society accept men's promiscuity and polygamy (Whittaker 1994; UNAIDS 1998; Kaewteph et al 1999). Sexual abstinence would only be viewed as 'normal' behaviour while men are ordained as monks. It is during this period that men achieve their highest social and spiritual status (Keyes 1986).

Men's pleasures focus on enjoying themselves by drinking, gambling and having sex; referred to as **pai thiew**, which literally means to go out and have fun (Kaewteph et al 1999; UNAIDS 1998). These pursuits are almost exclusively in the male domain and are important for peer perception. Seeking sexual pleasure with CSWs or several partners forms another dimension of their freedom and solidarity (Bamber n.d). "Visitation of CSWs is a much common and traditional practice among Thai males, and has been considered as a male rite of passage" (The Joint United Nation Programme on HIV/AIDS in Thailand, 2004 p. 15). Although some men have morally unwilling to visit CSWs, many of men will still visit them. In addition there is little sanction from public to those who frequent CSWs (Lyttleton 1994; UNAIDS 1998). Men like to boast, and often joke about their sexual adventures and prowess among friends. (Whittaker 1994).

With regard to HIV transmission, the important question is whether these sexual contacts involve the use of condoms and 'safer sex' practices. Studies in Thailand suggest that condoms usage is closely linked to commercial sexual encounters but they are rarely used in casual and longer-term non-commercial sex relationships (Ministry of Public Health Thailand 2004a, Havanon, Bennett and Knodel 1993; Rhucharoenpornpanich et al. 2003; Sirinak et al. 2003; UNAIDS 2002).

Men who frequent CSWs have reported non use of condoms because of reduction of the sensitivity and feeling too tight and uncomfortable. Many of men belief it is possible to select safe commercial sex workers (Kaewthep et al 1999; Boonmongkol 1999). Long sexual relationship with CSWs and alcohol induced careless or incapability are also other reasons for low condom use among men (Thaweesit et al. 2003).

Among CSWs, studies suggested that even if they use condoms with clients, they are unlikely to do so with their non-commercial sexual partners (Techawongkam 1995). A study in the North part of Thailand showed that the percentage of condom usage is low amongst men when having sex with non-brothel sex workers, who men perceived as less risk, and with whom a more personal relationship has been developed (Havanon, Knodel, and Bennett 1993). Inconsistent use of condoms among CSWs resulted from not having a condom to hand, having sex with regular customers, and pleasing clients at the time of 'business is low' (Thaweesit et al. 2003)

In addition, several studies in Thailand show that married men have a high rate of extramarital sex, with girlfriends or colleagues, and casual sex partners where it was also found that the percentage of consistent use of condoms was low (Rhucharoenpornpanich et al. 2003; Ministry of Public Health Thailand 2004a).

THAI WOMEN'S SEXUALITY

Thai society traditionally has a double standard for women's sexuality. This factor, coupled with women's beliefs, attitudes, and expectations by society may be the important risk factors for HIV infection in Thai women. Whilst women's sexuality is seen as a risk and has a need therefore to control it, positive values are placed on fertility, childbearing and motherhood by Thai society (Ogena and Kittsuksathit 1996; Sparkes 1996; Boonmongkol 1999). Only through the mechanisms of marriage, consummation of marriage and motherhood can women's sexuality be positively expressed. Men being naturally polygamous means that good women are expected not to provoke sexual arousal in men other than their husbands (Siriyuwasak 1983; Muecke 1992; Kaewteph et al 1999).

The power inequity between men and women, which is supported by social and cultural systems, makes it difficult for women to take preventive safer sex measures (Fongkaew 1996; Ogena and Kittsuksathit 1996; Boonmongkol 1999). In addition, male resistance to the use of condoms and women's inability to negotiate safer sex put women at greater risk of HIV infection (Beesey 1996; Limanonda 1996; Kaewteph et al 1999).

In the past, it was acceptable for Thai men to have several wives at the same time while women were never expected to have more than one husband in their lives. Even though a woman became a widow because of her husband's death, it was difficult for her to be accepted if she remarried. Weakness and the lack of leadership are perceived characteristic of women (Kaewteph et al 1999; Stam 1999).

Women dislike their husbands having a mistress more than them visiting CSWs. Although husbands are expected to be monogamous, but many women accept that it is normal behaviour of men to visit CSWs occasionally (Sukuntawanish 1988; Whittaker 1994; Kaewteph et al 1999). Thai women also believe that it is in men's nature to enjoy 'variety'. This may lead them to be at risk of HIV infection (Boonmonkul 1999; Kaewteph et al 1999).

The risk for married women is primarily due to inaccurate of obtaining the information about their husbands' extramarital sex coupled with their limited ability to protect themselves (Stam 1999). A study in the North part of Thailand indicated that if some Thai men contracted sexually transmitted diseases (STDs), they immorally concealed this from their wives. Some men refrained from sexual intercourse for days and sought treatment. If their wives become infected with this disease some men would expect them to find treatment for themselves (Beesey 1996).

The adoption of Western values that emphasise sexual equality has resulted in changing attitudes and practices towards women. Thai women are promoted in terms of higher education and position of work. They can also enjoy social benefits like

men. As a result more women go out to work instead of waiting for their husbands' earnings. A husband is expected to have one wife at any given time however, women are expected not to have more than one husband in their lifetime (Boonsuae, n.d. in Indharatat 1995; Stam 1999). In addition there is the Thai saying which teaches the young that a woman with three husbands in her lifetime is to be avoided and should not be associated with. In other words having many husbands is a social stigma. This proverb reinforces the double standard in Thai society.

After their marriage, women maintain responsibility for housework as well as the needs of husbands. Having sexual relations means that a woman "loses her body to the man" and this is expressed in the Thai saying as "**sia tua hai chai**". These beliefs and attitudes strongly influence Thai society. As a result, although some people's attitudes have changed, many still believe that once married, women will become the property of their husbands and men retain a dominant position (Boonsuae, n.d. in Indharatat 1995). Women are expected to show respect to their husbands through their obedience and acceptance of husbands' decisions (Siriyuwasak 1983; Sakrobanack 1984; Boonsuae n.d in Indharatat 1995; Coyle and Kwong 2000). As a result many women have little power over their lives and bodies and rarely to negotiate for equality in sexual relations. Women's silence puts them at risk of HIV/AIDS (Sakrobanack 1984; Whittaker 1994; Kaewteph 1999).

A study by Whittaker (1994 p.186) suggests that "Women are also at an increased risk of HIV due to their reproductive status, and limited means of avoiding infection with STDs. Condoms and non-penetrative sex are incompatible with conception, and their promotion ignores the importance placed on women's reproductive roles.

Therefore, majority of newly married women will not use any form of contraception until the birth of two children". Condoms are available free at all levels of health facilities. However they are strongly associated with CSWs and casual sex and perceived as interfering with men's pleasure and are unlikely to be used within marriage (Fongkaew 1996; Boonmongkol 1999; Kaewthep et al 1999).

Studies in other countries also suggested that women were at risk for the same reasons as Thai women were. There are several barriers that may prevent women from learning of their risk to HIV infection. One barrier is a belief that AIDS is not a disease of heterosexual women who are not intravenous drugs users [IDUs](Flaskerud and Calvillo 1991; Mays and Cochran 1988). Another reason for failure to recognize of the risk is results from their belief that people who are healthy are rarely to become infected, even if exposed, because they can fight off the virus (Flaskerud and Calvillo 1991).

Even though women perceive the HIV risk, some of them may face formidable obstacles in practising self-protective behaviour (Boonmongkol 1995; The Joint United Nations Programme on HIV/AIDS in Thailand 2004).

Several strategies for solving this crisis have been identified and efforts have been made by government and non-government sectors through propaganda campaigns to urge people to adopt safer sex behaviour such as "100% condom use", "do not practice promiscuity", and "do not share needles for injection". However, these measures have not much affected the number of women and newborn children, who are HIV positive because the prevalence rate among them has been steady for years.

These issues are of concern to the present study and will be described further in the next section.

SECTION 3: RESEARCHER'S ASSUMPTIONS

The steady state of the HIV/AIDS prevalence rate among women and children in Thailand may come from many factors. The following aspects have been noted and drawn from my experiences as a nurse and educator working in maternal and child health for a number of years.

The majority of HIV prevention strategies were developed from concepts based only on professional perspectives, and very often the strategies did not meet the needs of the people (Emmel and O'Keefe 1996). It was found in several studies that professionals' and laypersons' points of view differ (Tversky and Kahnemann 1974; Corbin 1987; McGeary 1994; Emmel and O'Keefe 1996). For instance, McIntosh (1993) argued, from her study, that while health professionals expected mothers to feel happy after delivery, most women in the study had post-partum depression and they did not receive any attention or effective intervention relating to their needs from health professionals. Even though this study was not concerned with people with HIV/AIDS, it reflects the different points of view held by lay people and health professionals. This difference was also found in studies, which showed no relationship between women's self perception of risk and the biomedical risk scores utilized by health professions (Heaman et al. 1992; McGeary 1994).

Gender responsibilities were not taken into account in the strategies used to reduce HIV/AIDS. It was noted that women have difficulty in securing guidelines or adherence to safer sex and this may be even more difficult for married women. This may relate to inequalities in male-female sexual situations (Almond 1996; UNFPA 2002). Indeed it has been shown in several studies that females have less power to negotiate as they have traditionally taken an inferior role in Thai society (Achawakul and Boonmongkol 1996; Fongkaew 1996; Boonmongkol 1999; Kaewteph et al 1999). In addition, Pradubmook (1996) and Najaitruek and Pinichvek (2001) argued that Thai men have more power in terms of negotiation to use condoms than women. A study among married women in rural communities in North part of Thailand showed gender inequity in terms of sexuality as well (Boonmongkol 1999). It is important that gender responsibilities should be taken into account.

The intervention programmes have emphasised individual knowledge and have been less concerned about socio-cultural and economic factors which may also contribute to HIV transmission. The findings from one study implied the significance of the need to appreciate the influence of personal values, beliefs and norms when implementing any intervention to promote people's health (Heaman, Gupton and Gregory 2004).

Health behaviour approaches, with regard to prevention of disease, generally assume an individual choice. However, many scholars address the association of health behaviours and the perception of susceptibility to the disease (Rosenstock 1966, 1974; Heaman, Gupton, and Gregory 2004). In respect to married women or women who have only one permanent sexual partner, they may not perceive their

own susceptibility to HIV/AIDS. As a result, self-care behaviours may not occur. All of these issues should be taken into consideration by health professionals and other disciplines working with women and children at risk of HIV/AIDS, and have been included in this research.

RESEARCHER'S PERSONAL REFLECTION

I have several years of experience both as a nurse and nursing instructor in the area of mother and child health. My experiences have led me to understand many aspects of the lives and health of women and their children, and have enabled me to provide support to help them attain their ultimate goal of optimal health. However, it became apparent to me that my existing expertise was not supportive enough to some particular groups of mothers and infants.

From 1993 to 1996, while instructing nursing students in the area of "Well Child Clinic", the clinic for child health in Khon Kaen a province of Thailand, I noticed that there were a large number of infants who were infected with HIV. These children were born from HIV sero-positive mothers, who acquired the disease from their husbands (Mother and Child Hospital 1997, 2001; Plipat, 2001: Epidemiology Section Khon Kaen 2004).

In addition, I was a researcher in a control trial (Sakondhavat et al 1999) which focused on the prevention of HIV transmission from mother to child and was also a nurse counsellor for HIV sero- positive pregnant women from 1997 to 1999. I noticed and understood how women suffered by getting HIV/AIDS from their husbands and how difficult it was for them to seek help for themselves and their

children. It seems to me that preventing women and children from being infected with this virus should be an urgent priority, but this has been ignored.

Many questions arose in my mind and these are: 1) Do women carry out “self-care” to protect themselves from HIV/AIDS which might be transmitted by their husbands including performing “dependent-care” to protect their child? If so to what extent is it effective?; 2) What factors are related to their “self-care” and “dependent-care” for HIV/AIDS prevention for themselves and their next child; 3) Do they have any kind of support or help from human and institutional resources, in terms of HIV/AIDS prevention, and what is the function and quality of any support; and 4) How can health care professionals, particularly the nurse, contribute to the promotion of women’s choice with regard to HIV/AIDS prevention?

While looking into health care services, I realized that there was limited knowledge to guide health professionals, particularly nurses to deal with these problems. Therefore, this research was designed.

SECTION 4: IMPORTANCE OF WOMEN’S PERSPECTIVES

Equipping people physically, mentally, and emotionally to deal adequately with their health is a central task for health professionals (Rodmell and Watt 1992). In addition, promoting and enhancing clients’ potential to perform self-care effectively are the important roles and responsibility of nursing professionals (Orem 1991; Lipson and Steiger 1996; Reed, Shearer, and Nicoll 2004). Through this research I intend to identify, from the women’s perspective, a culturally sensitive programme to enhance women’s self-care to prevent HIV/AIDS for themselves and their next child.

Nursing process, which is congruent with scientific method of solving problems, refers to a systematic way of organizing and providing nursing care. It comprises four components. These are assessment, planning, implementation, and evaluation (Lipson, and Steiger 1996). Therefore, before any nursing intervention, the assessment stage should be performed. This approach to nursing is also congruent with the practice of health education and health promotion.

Scholars and theorists' recommendations for professions, who work in the field of health care, are similar. All emphasise the significance of making sense of and understanding individual life styles as well as, socio-cultural and environmental factors influencing health before implementing any programme to enhance the health of people (Beesey 1996; Cottrell et al. 2002; Tones and Green 2004).

In addition, "health is a social product" (Rodmell and Watt 1992 p.19), therefore adopting an ideology of individualism and freedom of choice might lead to the term known as "victim-blaming" (Rodmell and Watt 1992 p. 23; Tones and Green 2004 p.14). This implies that "any failure can be viewed as the fault of the client, not the health educator" (Rodmell and Watt 1992 p. 23). In relation to this issue, Gray (2003 p.viii) emphasises that "in order to understand health, one must consider systems and structures that govern social and economic as well as the physical environment, and take cognisance of how these factors impinge on health both at a social and personal level". Because structural constraints affect choice the collective solutions of such constraints should not be ignored. Realizing how the above ideology could influence the provision of health care. I have deemed it is important

to emphasize the relationship between an individual's self-care, self responsibility and socio cultural factors.

Because I intend to identify a socio-culturally sensitive programme to promote women's self-care to prevent HIV/AIDS for themselves and their next child therefore, a method or approach that effectively promotes the self-care capability of women is needed. Empowerment has been addressed repeatedly and used widely in reference to women and other groups whose basic rights have been denied (Jones and Meleis 1993; Kaewthep et al 1999; UNAIDS 2002, 2004). Empowerment has also been emphasized as being the best process for promoting women's health and HIV/AIDS prevention (Ruangjiratain and Kendall 1998; UNAIDS 2002).

The concept of empowerment has been defined by a number of scholars including psychologists, social workers, educationists and nurses. It is viewed as both process and outcome (Gibson 1991). Rappaport, Swift, and Hess (1984) view empowerment as a process by which people, organisations, and communities assume power to control over their own lives. In reference to Simmons (1989) Jones et al. (2000) describe empowerment process as "helping individuals develop a critical awareness of their situation and enabling them to master their environment to achieve self-determination" (p.1). Empowerment is also defined as a process of progressive self-development (Keiffer 1984).

Gibson's definition (1991) gives more detail and direction that can be applied thus:

"Empowerment is a social process of recognizing, promoting, and enhancing people's abilities to meet their own needs, solve their own problems, and mobilize the necessary resources in order to feel in control of their own lives. Even more

simply defined, empowerment is a process of helping people to assert control over the factors which affect their health” (p. 359).

In terms of viewing empowerment as consequences or outcome, Gibson (1991) describes it as: self efficacy, sense of control, sense of mastery, growth, a sense of connectedness, and improved health and well being.

In my opinion, nursing professionals are in suitable positions to promote women’s empowerment due to their knowledge, skills, and expertise. Therefore, in the context of the present study, empowerment seems to be an appropriate intervention to promote women’s self-care to prevent HIV/AIDS. Guiding by Gibson’s definitions (1991 p. 359) and according to the purpose of the present study empowerment is therefore, *a social process of recognizing, promoting, and enhancing women’s strengths, potential or abilities to perform self-care, and to mobilize essential resources in order to prevent HIV infection for themselves and their next child.*

From reviewing the literature, I have noted that two ideologies, the feminist perspective and participatory action research (PAR) are useful to understand and empower women. The feminist perspective is an approach which views women through a “female prism” (Cook and Fonow 1986 cited in King 1994 p.20), is valuable for studying a problem relevant to women, involves with the female participants, and focuses on women’s life experience in a local context (Wilson and Hutchinson 1991). The feminist research is interactive and non-hierarchical approach which facilitates the women’s voice to be heard (Keddy 1992). It is suggested by several authors that feminist inquiry can truly contribute to women’s ways of knowing and facilitate the emancipation of women.

Participatory Action Research (PAR) is a dynamic interactive process and has essential strengths, which can be used in a diverse context to explore knowledge and perceptions of lay people. It also gets concerned people involved as active contributors and gives an authority to people within the research process. Therefore, participants are empowered and respected as capable agents to analyse and solve their own problems (Cornwall and Jewkers 1995), and determine the outcomes of their own inquiry (O'Brien 1998). According to characteristics and principles, feminist theory was used as the ideology and participatory action research was used as an approach underpinning this study.

The present research aims to obtain a deeper understanding of women's experiences in terms of self-care and social support to prevent HIV/AIDS for themselves and their next child and to make sense of the relationship between women's self-care and the socio-cultural context influencing their performances of self-care. In addition, it is important for health professionals to get an insight into patterns, functions and quality of the existing supportive care and health care given to women from their own perspectives.

By involving women themselves the research aims to work with explorations and understandings derived from women's life experiences to construct a socio-culturally sensitive programme for HIV/AIDS prevention among women and children. These issues have not been studied in detail previously, particularly from the perspective of the women themselves, who live in a Thai town where there is a limited supportive-care network.

So far there has been very limited knowledge about the issues mentioned above. There have been studies among married women in Khon Kaen but these have focused on HIV sero-positive women or female AIDS victim. A few studies have related to HIV sero-negative married women but these mostly took place in rural rather than urban areas (Sakondhavat and Sittiri 1996; Lyttleton 1996; Rujakornkarn et al. 1996).

Married women in urban areas such as those who live in the city centre of Khon Kaen have their own life style, values, norms, and practices. Due to their life style, they are unlikely to have the same social support network as village or rural women have. Therefore women's self-care, socio cultural, and environmental factors need to be understood particularly from the women's perspectives. Then these findings can be used to empower women's self-care and identify a socio-culturally sensitive programme to prevent HIV/AIDS for women and children in Northeast Thailand. These findings contribute to guidelines on practice for health professionals, and in particular nursing professions.

The findings of the study can be used as a source of information and to create a guide for nursing practice with regard to promoting women's self-care for HIV/AIDS prevention for themselves and their child. It is anticipated that the findings will contribute to service reform in the area of maternal and child health. Finally since AIDS is a world wide health concern (Barbour 1993; Sherr 1996; UNFPA 2002 UNAIDS 2002) the findings of the present study may be relevant for more general usage.

SECTION 5: PURPOSE OF THE STUDY

The nursing goal behind this study was to empower women's self-care to prevent HIV/AIDS for themselves and their next child and to identify a socio culturally sensitive program to prevent HIV/AIDS for women and their children. To do so requires several steps and methods of study. Therefore, the study has been divided into three distinct phases with specific aims as follows.

PHASE 1: THE EXPLORATION PHASE

The purpose of this phase was to explore women's self-care and supportive care to prevent HIV/AIDS for themselves and their next child.

The specific aims of this phase were to:

- 1) Determine the nature of women's self-care with regard to protecting themselves and their next child from HIV/AIDS.
- 2) Identify factors related to women's self-care with regard to protecting themselves and their next child from HIV/AIDS.
- 3) Assess the perceived function and quality of supportive care related to women's self-care in order to protect themselves and their next child from HIV/AIDS.

PHASE 2: THE EXPLANATION PHASE

This phase provided detailed insights into the nature and pattern of women's self-care and social support to protect themselves and their next child from HIV/AIDS.

The specific aims were to:

- 1) Gain an in-depth understanding of characteristics, patterns and functions of women's self-care in order to protect themselves and their next child from HIV/AIDS.
- 2) Gain an in-depth understanding of the relationship between socio-cultural and environmental factors and women's self-care in order to protect themselves and their next child from HIV/AIDS.
- 3) Gain an in-depth understanding of the nature of support provided by social and professional networks with regard to promoting women's self-care in order to protect themselves and their next child from HIV/AIDS.

PHASE 3: THE INTERVENTION PHASE

This final phase engaged women in the research process in order to inform self-care practices with regard to the prevention of HIV/AIDS.

The specific aims were to:

- 1) Empower women to perform effective self-care in order to protect themselves and their next child from HIV/AIDS.
- 2) Collaborate with women to identify a socio-culturally sensitive programme to prevent HIV/AIDS for women and children.

SECTION 6: A SYNOPSIS OF THESIS STRUCTURE

The thesis comprises 9 chapters.

Chapter One: Introduction to the Thesis and Focus of Investigation. This introduction to the research examines the significance of the HIV/AIDS problem among women and infants as well as socio-cultural conditions, which may be related to the problem. The focus of the study has been clarified and its purpose defined and declared.

Chapter Two: Thai Background and Context of the Research. This chapter provides the background and context of the study, in order to make sense of and gain insight into, the analytical findings in subsequent chapters. It begins with a country profile of Thailand, an introduction to the Northeast and Khon Kaen province, its health care and educational system. The National Plan strategies are given to provide a historic and current picture of the HIV/AIDS epidemic in Thailand. The issues concerned and challenges faced with regard to the evolution of the HIV/AIDS epidemic, and its particular impact on women and infants, are discussed in detail.

Chapter Three: Background Literature. This chapter considers background theoretical and research literature. The main themes covered are: self-care, social support, health belief, self-efficacy, and empowerment. The lessons learned so far, from studies related to HIV/AIDS, are reviewed and analysed. The chapter finishes by highlighting the need for a study to identify new ways of preventing HIV/AIDS among women and children.

Chapter Four: Research Design. Combined research methods, which are to be used, are presented for each of the three phases of the research. The exploratory phase presents methods for data collection and analysis, and suggests the need for additional inquiry methods in the explanation phase in order to get a more detailed insight into women's self-care practices which are most important for the practice of nursing and nursing education in Thailand. The methods and processes of data collection in the explanation and intervention phases are presented in terms of recruitment, in-depth interview techniques and the PAR spirals. Ways of defining units of analysis and verifying the themes that emerged from the three phases are outlined. Ways of obtaining ethical clearance and the importance of protecting respondent's rights are highlighted.

Chapter Five: Women's Concept of HIV/AIDS and Self-care to Prevent HIV/AIDS. This chapter explains the nature and pattern of women's self-care and social support in order to prevent HIV/AIDS for themselves and their next child. It also highlights catalysts and barriers to self-care and the need for a deep understanding of women's life experiences related to HIV/AIDS prevention.

Chapter Six: Women's Self-care: Unbalancing the Health Risk and Social risk in the women's world. The substantive themes generated from the study are presented to explain women's life experiences pertaining to self-care to prevent HIV/AIDS for themselves and their next child. Women's self-care deficit and the inadequacy of social support for HIV/AIDS prevention is identified and shapes the intervention approach used in the next phase.

Chapter Seven: Women's transformation and initiation into HIV/AIDS Prevention. The use of participatory action research, to promote women's self-care to prevent HIV/AIDS for themselves and their next child, is presented in terms of process and outcome. Details of each PAR cycle are delineated in terms of planning, action, observation, reflection, and re-planning. The substantive themes of women's transformation are addressed and women's empowerment is outlined with regard to antecedent, attributes and consequences. The proposal of a new service for HIV/AIDS prevention generated from women's perspective is provided.

Chapter Eight: Discussion and conclusion. This chapter discusses four themes of the cognitive process and practical problems with regard to women's self-care to prevent HIV/AIDS. The women's participation and empowerment inside of the groups as immediate transformation are evaluated. The possibility of the further and wider implications of women's strategies with regard to HIV/AIDS prevention is also discussed. The analytical model for promoting social health and empower women's self-care to prevent HIV/AIDS is generated and proposed.

Chapter Nine: Implication and recommendations. The lessons learned from the three phases of the study in relation to the research aims are outlined. The strengths and the limitations of the study are described. The implications are drawn out and recommendations for nursing practice, nursing education, health education and promotion, and further research are proposed. Recommendations are also presented with regard to the need for policy reforms within health care services in Thailand.

CHAPTER 2

THAI BACKGROUND AND CONTEXT OF THE STUDY

This study was conducted in Khon Kaen province in the northeast of Thailand. To assist in making sense and understanding of the findings in the following chapters therefore, this chapter provides an overview of the context of the study. The themes here in cover these sections:

Section 1: Country profile

Section 2: Thailand's healthcare system

Section 3: The HIV/AIDS epidemic in Thailand

Section 4: National response and its impact on HIV/AIDS

Section 5: Introduction to the northeast and Khon Kaen

Section 6: Khon Kaen HIV/AIDS situation

SECTION 1: COUNTRY PROFILE

The Kingdom of Thailand is known as *the land of smiles*, located in the heart of continental Southeast Asia. It shares borders with Myanmar in the west, Laos and Cambodia in the east and Malaysia in the south (Appendix I). Thailand has a surface area of 513,115 square kilometres. The total length of the country is approximately 4500 kilometres and its coastline measures 2,614 kilometres. It has a hot tropical climate and is rich in natural resources. The country is divided into 4 regions: the Central, North, South, and Northeast with a total of 76 provinces (The Joint United Nations Programme on HIV/AIDs in Thailand 2004).

The current population of Thailand is 63.52 million (The Joint United Nations Programme on HIV/AIDs in Thailand, 2004). The majority (95 %) of the citizens are Thais and the rest are Chinese or Indian with a few other ethnic minorities. The Thai language is officially and commonly used, and the adult literacy rate is 96%. Most Thai people (92.56 %) are Buddhist with a few Muslims, Christians and others religions. Infant mortality rate is 20 per 1,000 live births, and children under 15 years number 14.6 million (The Joint United Nation Programme on HIV/AIDs in Thailand 2004).

Thailand has been a constitutional monarchy since 1932, and the local government system in Thailand has four hierarchical units. A province consists of several districts: a district consists of several sub-districts and a sub-district is made up of several villages. A provincial governor heads each province.

“The current educational system consists of four levels: one to two years of pre-school, nine years of compulsory primary education grades 1-6 (Prathom) and grades 7-9 (Matahayom 1-3), three years of non-compulsory secondary (high school) education (Matahayom-4-6), and then 4-6 years of tertiary (higher) education” (The Joint United Nation Programme on HIV/AIDs in Thailand 2004 p. 12).

SECTION 2: HEALTH CARE SYSTEM

ORGANISATION

Health resources are distributed amongst various agencies responsible for implementing health programmes in the public and private sectors. The Ministry of Public Health (MOPH) is the principal agency responsible for public health nationwide (The Ministry of Public Health Thailand 1998ab).

HEALTH SERVICES

Health services in Thailand are classified into five levels according to the level of care (The Ministry of Public Health Thailand 1998ab, 2004ab) as follows:

Self-Care Level: Services at this level include the enhancement of people's capacity to provide self-care and make decisions about their own health.

Primary Health Care Level: The services, organized by village health volunteers (VHVs), include health promotion, disease prevention, curative care and rehabilitative care.

Primary Care Level: This level of care involves health promotion, disease prevention and simple curative care. Health facilities at this level are: 1) Community

health posts, 2) Sub-district health centres, 3) Out patient department (O.P.D) in hospital, and 4) Drugstores.

Secondary Care Level: Doctors, nurses, and health personnel provide health care at this level with various degrees of specialisation. General and specialized facilities include: community hospitals, general or regional hospitals, other large public hospitals, and private hospitals.

Tertiary Care level: Doctors, nurses and health professionals provide health services at this level, mostly with specializing expertise. Health facilities include: regional hospitals; general hospitals; university hospitals and large public hospitals and large private hospitals which all have fields of medical specialists.

HEALTH INSURANCE

Thailand has several health insurance schemes; however about 19.7 % of people are not in any scheme (The Joint United Nation Programme on HIV/AIDs in Thailand 2004). The “30 Baht-Health Scheme” was introduced in April 2001 for people who were not in any scheme (Office of the Prime Minister 2002 p.94). This health insurance scheme enables a large number of Thais to access a basic health care with a medical treatment cost of 30 Baht per visit (74-75 Baht= 1 Pound Sterling). Medication used, in health promotion, disease prevention and control, must be on the national basic medicine list (National Health Security Office 2001).

MATERNAL AND CHILD HEALTH:

Mothers and children receive health care mostly at the primary level of all health facilities in terms of health check ups and health promotion. This includes services during pregnancy at ante natal care clinics (A.N.C.), giving birth, family planning, and child health promotion at well child clinics.

As regards to HIV/AIDS, voluntary counselling and testing (VCT) for HIV is provided for pregnant women attending A.N.C. at some health facilities. These include community hospitals, provincial or regional hospitals, hospitals attached to universities, and private medical clinics or private hospitals. This service is not provided in health facilities lower than hospitals such as health centres, health posts, etc. There are a few hospitals that provide special services for volunteer counselling and testing (VCT) for HIV before marriage, however this has not been well known and only a small number of men and women have utilized these services. For instance, a survey in Khon Kaen province by Thaewnoongnuew and Matphuthorn (2003), reported that only 21.9% of single people went for VCT before marriage.

The provision of anti-retro virus (ARV) drugs is allowed only to prevent vertical transmission, such as mother to child transmission. Mothers and infants will be supported in terms of counselling, supportive treatment for opportunistic infection, and the infant's formula (The Joint United Nations Programme on HIV/AIDS in Thailand 2004).

SECTION 3: HIV/AIDS EPIDEMIC IN THAILAND

Since the first case of AIDS was reported, the epidemiological progression is best understood through three time frames: HIV/AIDS waves; national response; and manifestation after implementing of national plan strategies.

INITIAL HIV/AIDS EPIDEMIC WAVES

The earliest cases of AIDS were recorded in 1984 in homosexual or bisexual men. Three years later the transmission of HIV among homosexuals, the first wave of HIV/AIDS epidemic in Thailand, was overshadowed by a rapid increase in infection amongst intravenous drug users (The Ministry of Public Health Thailand 1998b).

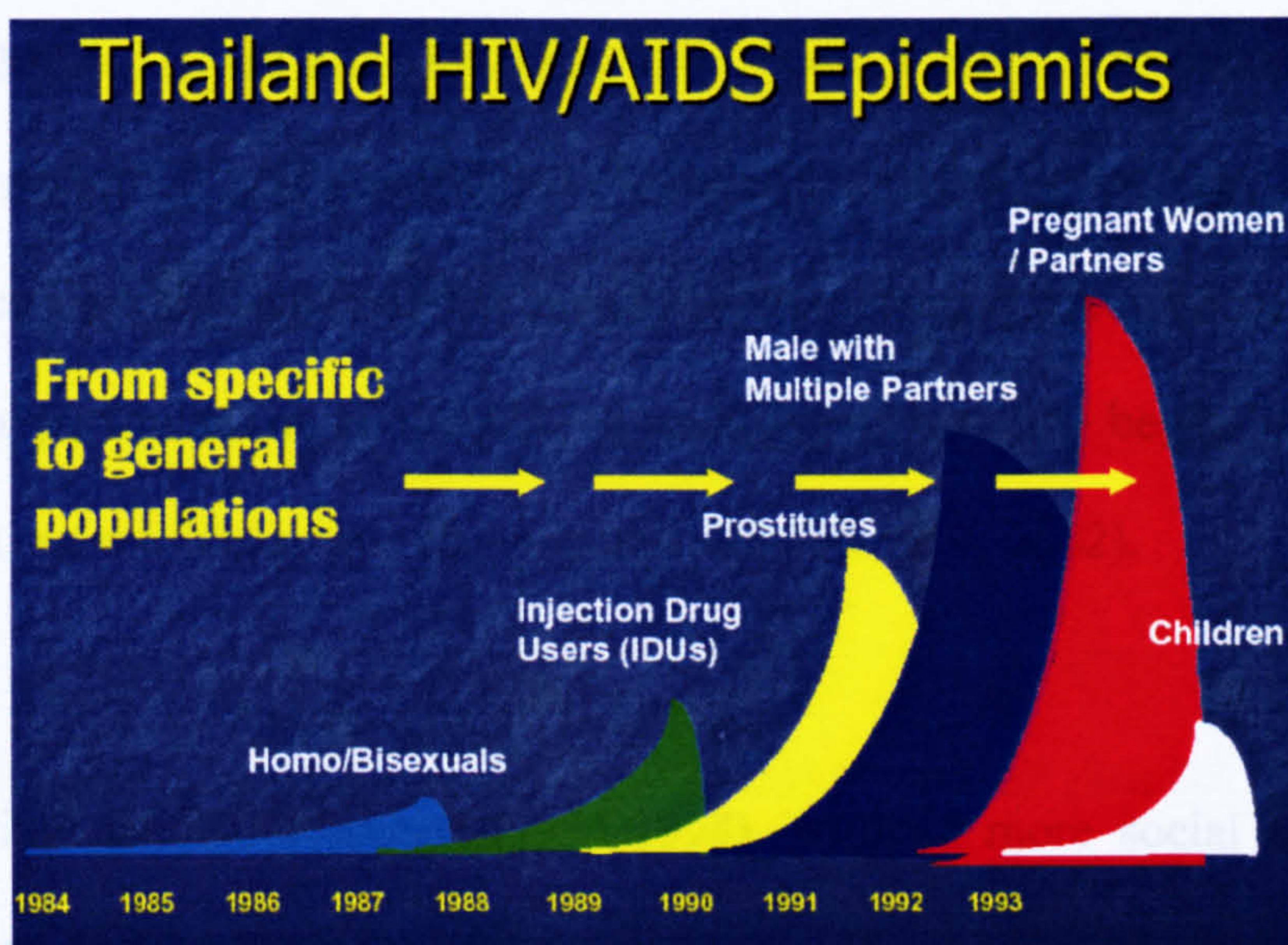
In 1994, infection among CSWs reached 31% nationwide. One in ten clients and one in three CSWs were infected with HIV (AIDS Division 1997; UNAIDS 1998, 2002). Most of the male clients were either single men or married men. The major outbreak of HIV/AIDS amongst CSWs was the third wave and their clients were the fourth wave of the HIV/AIDS epidemic in Thailand (UNAIDS 1998, 2002; The Ministry of Public Health Thailand 2004).

The wives and girlfriends of men who visited CSWs constitute a fifth wave of the epidemic. Among pregnant women attending antenatal care clinic in Bangkok, HIV prevalence increased from 0.2% in 1990 to 2% in 1994 (AIDS Division, 1997). HIV prevalence among this group has reached as high as 10% in provinces in the north. The median HIV prevalence among pregnant women nationwide, however, remained around 2% in 1997.

SECTION 4: NATIONAL RESPONSE AND ITS IMPACT

In 1991, mother to child transmission (vertical transmission) cases started to be reported. After women got infected, the final wave of the epidemic in children born from HIV infected mothers quickly followed. Based on this information it is suggested that HIV/AIDS spreads from high risk groups to the general non high risk population (Figure 2.2).

Figure 2.2 Thailand HIV/AIDS waves of epidemic



Source: The Ministry of Public Health Thailand 2004

SECTION 4: NATIONAL RESPONSE AND ITS IMPACT

NATIONAL RESPONSE:

The first national response to HIV/AIDS (1984-1990) was a health approach plan implemented by the Ministry of Public Health. Before 1989, HIV infection was reported only through the medical system. This system, coupled with the fact that HIV infection was asymptomatic for many years, failed to detect the rapid pandemic (UNAIDS 2002). It was after 1989 that HIV sentinel surveillance was introduced. Sexually Transmitted Diseases (STDs) clinics and counselling services within these STDs-clinics were subsequently expanded and strengthened. A national program to train health personnel in HIV/AIDS counselling eventually began. Outreach to commercial sex establishments also began (UNAIDS 1998, 2002).

The following national response (1991-1994) involved more social interventions with various high-risk groups of populations. The high risk groups included intravenous drug users (IDUs), homosexual groups, commercial sex workers, truck drivers, and the migrant populations. This was later expanded to include the general adult male population who frequently visited CSWs (UNAIDS 1998). Furthermore the National AIDS Prevention and Control Committee (NAPCC) was established in 1991 (UNAIDS, 2002).

Soon after 1991 it became evident that the HIV/AIDS epidemic was affecting mainstream populations and the national program began to include a wider range of activities that integrated health, medical and social programs. One of the activities

introduced was the 100% condom promotion program. This resulted in a dramatic decrease in STDs nationally and later in HIV sero-prevalence, shown in the survey among male military conscript (UNAIDS 2000). However, this success has less effect on the slow but steady transmission of HIV from infected male clients of CSWs or from male IDUs to their wives and regular sex partners (Plipat 2001; The Ministry of Public Health Thailand 2004b).

As more members of the general populations became infected, stigma and discrimination became obvious evidence. HIV/AIDS also posed a social challenge because of the violation of the rights of the infected persons. This violation occurred in the family, community and workplaces. These conditions led to the realization that a more integrated plan involving a multi-sector approach was needed (AIDS Division 1997; UNAIDS 1998).

HIV/AIDS MANIFESTATION AS THE CONSEQUENCE OF THE NATIONAL PLAN

The manifestation of the epidemic after implementing the National Strategic Plan (1997-2001) can be illustrated as follows.

From 1984 to 2004 the total number of AIDS cases and symptomatic HIV were 326,651, the ratio of disease in men and women was 3:1 (The Ministry of Public Health Thailand 2004b).

With regard to occupation, the AIDS cases reported from September 1984 to January 31 2004 showed that the highest prevalence rate was among labourers

accounting for 46.63%, followed by agricultural workers at 20.89%. The unemployed accounted for 5.55% followed by shop-keepers, 4.34%. Prevalence among children was 3.95%, and the remainder classified as others was 18.64% (The Ministry of Public Health Thailand 2004b).

Regarding the routes of transmission, heterosexual transmission accounted for 83.70% of reported AIDS cases whilst among intravenous drug users it was 4.72%, and transmission from mother to child accounted for 4.13% (The Ministry of Public Health Thailand 2004b).

HIV/AIDS prevalence among other specific groups, except among pregnant women, declined dramatically. However prevalence rates have remained high particularly among IDUs (Table 2.1). The national strategic plan seemingly has less impact on this group. It should not be forgotten that this group not only transmits HIV to other IDUs but also to their sexual partners and their wives as well.

Table 2.1 National HIV sero-prevalence rate (%) among specific groups of populations

Year	IDUs	Direct CSWs	Indirect CSWs	Male STD	Pregnant women	Blood Donor**
1997	40.00	26.14	8.26	6.79	1.68	-
1998	47.46	21.05	6.67	8.50	1.53	-
1999	50.77	16.00	6.55	9.09	1.74	-
2000	47.17	18.46	5.51	5.92	1.46	-
2001	48.81	16.20	5.43	5.93	1.49	0.37
2003*	33.33	10.87	3.67	4.00	1.18	0.27

Source: Plipat, 2000; The Ministry of Public Health Thailand 2004b).

*HIV/AIDS Division 2004, ** Surveillance among blood donor was begun in 2001

It should be noted here is that whenever any group has a high prevalence rate, this leads to a negative impact on women and children. In addition the prevalence rate among women and children has slowly decreased, increased for one year and then remained relatively steady.

HIV/AIDS ISSUES, CONCERNS AND CHALLENGES:

After implementing the second plan, Thailand has had substantial success in HIV/AIDS prevention. However, the prevalence rates are still high and unacceptable, and there are several important issues which need to be carefully considered as follows:

Huge sources of HIV/AIDS transmission: The prevalence rates among specific groups remain high, in particular among IDUs (50.80%). Limited activity has been done to prevent transmission among them. The prevalence rate is also high both among CSWs (13.53%) and indirect CSWs (4.93%) which are noted to be the major sources of HIV/AIDS transmission in Thailand (Epidemiology Division 2003). The projections of AIDS cases and new cases of HIV infection in each year are high and have remained steady during the last two years.

Potential for epidemic resurgence is high: This is because people have been taking HIV/AIDS risks in several ways. These are: 1) rising trend of males having sex with CSWs during in the period 2001-2003. This pattern also applies, but with a higher percentage, to men having sex with indirect CSWs and non regular sex partners, 2) high percentage of extramarital sex and casual sex among men combined with a low percentage of consistent condom use, 3) declining percentage of condom use among men both for first sex and consistent use with CSWs and non regular sexual partners, and 4) increasing trend of sexual experience at an early age of both sexes with low percentage of condom use.

Routes of transmission have changed over time: Modelling of HIV transmission developed by UNAIDS in collaboration with the Thai Red Cross Society (Brown 2001) shows that, in the beginning, major modes of transmissions were through CSWs. However, recent studies have shown increasing transmission trends among men who have sex with men, injecting drug use, and husband to wife. Furthermore extramarital sex with non commercial sex workers has been indicated in the dynamics of the epidemic of HIV transmission and these suggest that the epidemic is

evolving. As a result the response to this change needs to be adapted in order to remain maximally effective.

Declining trend of concern: Thailand has mobilised various sectors of society at all levels to respond to the epidemic. However, should the previous sense of urgency be lost and efforts become weakened or men no longer perceive significant risk in visiting CSWs then the trends will not continue to decline. These conditions might lead to inconsistent use of condom and the wide spread of HIV/AIDS epidemic could begin again. The increasing trend of sero-prevalence among pregnant women in the Northeast region (Saploon et al. 2001), and nationwide during 2000-2001 together with male conscripts may be the effect of such a “relapse”. Failure to sustain preventive measures by men has been observed in some other countries (Saploon et al. 2001). This might be expected to happen among some Thai men if there is no continued effort.

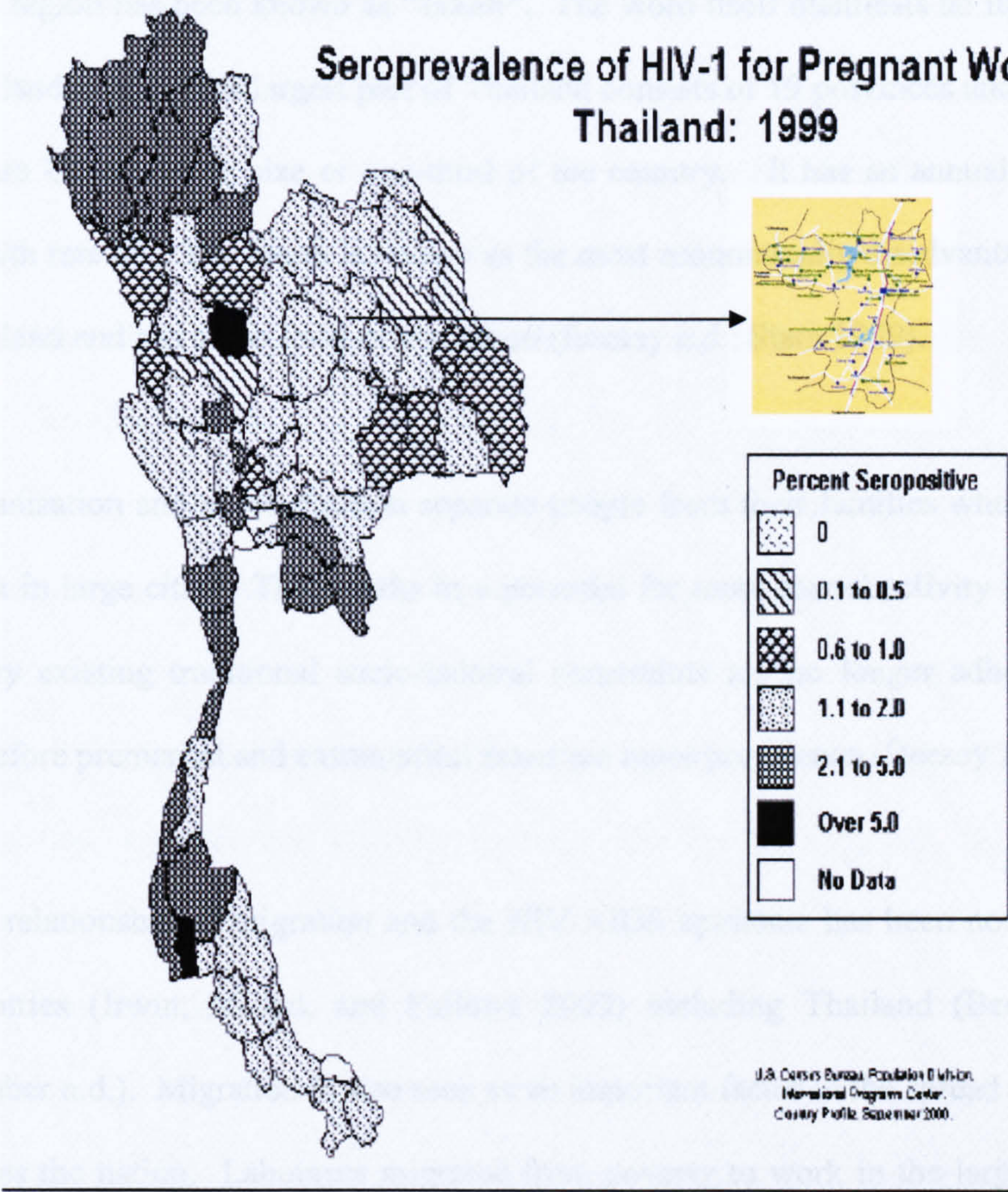
Serious and continuing efforts still required: To sustain the success of HIV/AIDS prevention and control of the epidemic requires serious and continuing efforts to ensure that there are specific programmes which deal with all groups. In particular socio-culturally sensitive programmes specific to the needs of some groups should be established. Married women is one particular group which needs specific new programmes to protect them from HIV/AIDS since the existing measures have not much affected the prevalence rate among them and their infants.

Women and children are a group which gives rise to concern in several ways. These are: 1) No matter how high the prevalence rate of HIV/AIDS is or the high

risk behaviour of any group, it finally contributes to HIV/AIDS among women and consequently HIV/AIDS in children, 2) STDs prevalence rate among housewives accounts for a high proportion and shows a high correlation to extramarital sexual activity in men, 3) The vertical transmission rate is still high, and it cannot be completely prevented by existing anti retrovirus drugs, 4) This prevalence trend has been steady for several years, and it is over the target goal of 1% as specified in Thailand's National Plan. It is noted that existent strategies seem to have less impact on this group, 5) Two-fifths of all new infections in the year 2000 occurred through husband-to-wife transmission, and mother-to-child infections have now become a significant portion of new infections in Thailand (The Thai Working Group Projection on HIV/AIDS 2001). During 1994-1997, there were 800,000-900,000 pregnant mothers giving birth annually (Saploon et.al. 2001). Considering that each year there are around 9 millions married women of reproductive age it follows that this may lead to large numbers of HIV infections among children.

Despite the Northeast of Thailand not having the highest incidence of HIV/AIDS in the country, it does however contribute in a major way to the epidemic. Among the specific population groups, women are one group of particular concern. The prevalence rate among pregnant women in the Northeast in 2000 rose again, after an earlier decline (Sapool et al. 2001). Another significant factor is that the prevalence rate of HIV infection in pregnant women is still higher than the goal (1%) of the 9th National Economic and Social Development Plan (UNAIDS 2004). The manifestation of the epidemic can be illustrated in the figure 2.3 below:

Figure 2. 3 HIV Sero-prevalence in pregnant women in Thailand and Khon Kaen



Source: Modified from U.S. Census Bureau, International Programs Center,
Country Profile, September 2000

SECTION 5: INTRODUCTION TO THE NORTHEAST AND KHON KAEN

This region has been known as “**Isaan**”. The word itself manifests an image of “an arid land area”. This largest part of Thailand consists of 19 provinces and is 170,000 square kilometres in size or one-third of the country. It has an annual population growth rate of 2.3%. **Isaan** is known as the most economically disadvantaged part of Thailand and has a low level of education (Beesey n.d.; Stam 1999).

Urbanisation and modernisation separate people from their families when they seek work in large cities. This results in a potential for more sexual activity with CSWs. Many existing traditional socio-cultural constraints are no longer adhered to and therefore premarital and extramarital sexes are more prevalence (Beesey 1996).

The relationship of migration and the HIV/AIDS epidemic has been noted in many countries (Irwin, Millen, and Fallows 2003) including Thailand (Beesey 1996.; Bamber n.d.). Migration is also seen as an important factor in the spread of HIV/IDS across the nation. Labourers migrated from poverty to work in the large cities and this turns their lives from being at less risk into a higher vulnerability to HIV/AIDS (Beesey n.d.; UNAIDS 1998). This has held true in several provinces of the Northeast including Khon Kaen.

KHON KAEN: CENTRE OF BUSINESS, EDUCATION, AND HEALTH CARE

Khon Kaen has been selected for the present study because it has all the prerequisite factors contributing to the HIV/AIDS epidemic. These are similar to those of any other large city which have been known to have high prevalence rates in Thailand.

Khon Kaen is a large city located in the heart of Isaan. The province covers an area of 13,404 square kilometres and is about 450 kilometres from Bangkok, the capital city of Thailand. The population is approximately 1,756,995 contained in 19 Amphoes (districts), 5 sub-districts. The city's population is approximately 381,268.

The high level of literacy in the province is attributed to a well-developed network of educational institutions, with many institutes of higher education available, including Khon Kaen University.

Manufacturing and industry are attracted to Khon Kaen because of a well developed transportation network. Khon Kaen is one of four cities selected for accelerated growth in Northeast Thailand through infrastructure improvements. These include the planned upgrading of a new highway to the Eastern Seaboard, and the use of container transportation. As a result Khon Kaen's potential as an export entry to Indo-China has increased. Currently many industries such as fishnet factories, liquor distilleries, sugar, pulp and paper mills are located in Khon Kaen province. Consequently, Khon Kaen has been rapidly transformed from an agricultural city to the business, health service, financial, and educational centre of the Northeast region without the allied growth in support to alleviate social problems associated with rapid industrialisation.

SECTION 6: KHON KAEN HIV/AIDS SITUATION

The rapid development of Khon Kaen, as mentioned above, occurred concurrently with the rapid spread of the HIV/AIDS epidemic. The prevalence rate reached a

highest peak from 1996 to 1998 ranking 32.63-37.37 of AIDS cases per 100,000 populations before declining slowly. Heterosexual activity accounts for the largest proportion of HIV transmission, (85.1% of AIDS cases reported, and 79% for symptomatic HIV patients), followed by vertical transmission (5.4%), and IDU (2.5 %) respectively (Epidemiology Section, Khon Kaen 2004).

In respect to occupation, labourers (41.9%) and agriculture workers (32.6%) account for the largest proportion of reported AIDS cases. The other groups which have significant proportions are traders (4.4%), government officers (3.5%), and the 2.9% unemployed (2.9%) (Epidemiology Section, Khon Kaen 2004).

The numbers of AIDS cases and symptomatic HIV among women and children in Khon Kaen conforms to the prevalence rates of the national levels and have remained stable. The number of cases among pre-school children was 5 in 2002 to 4.6 in 2004 whilst among housewives it was 2 in 2002 increased to 2.8 in 2004. AIDS cases and symptomatic HIV (from vertical transmission) were 5.7 in 2002 and increased to 6.2 in 2004 (Epidemiology Section, Khon Kaen 2002, 2003, 2004).

According to surveillance among specific population groups (Table 2.2), it has been found that prevalence rate of HIV/AIDS are at unsatisfactory levels. Among IDUs, the HIV sero-positive results are two in every nine tests; 13 in 100 for direct CSWs and 10 in 151 among indirect CSWs. The prevalence rates amongst these two groups are higher than that of the region. The prevalence rates among STDs patients and pregnant women attending antenatal care (ANC) are over 1%. In addition, Khon Kaen has many conditions contributing to HIV/AIDS epidemic. Therefore the need

for continue effort to sustain the low prevalence rate is necessary or the widespread growth of the epidemic will return.

Table 2.2 HIV surveillance among specific population groups in
Northeast region and in Khon Kaen until June 2001

Group	Khon Kaen			Northeast Region		
	test	+ve	%	test	+ve	%
Blood Donor	1573	0	0.19	21162	62	0.29
STD patient	96	1	1.04	746	25	3.35
Pregnant women	2984	32	1.07	18630	207	1.11
IDUs	9	2	22.22	24	6	25.00
Directed CSWs	100	13	13.00	701	86	12.27
In directed CSWs	151	10	6.62	2762	118	4.27

Source: Division of epidemiology, MOPH 2001

Muang district has the highest prevalence within Khon Kaen province. The numbers of AIDS patients and symptomatic HIV infections in Muang district are 25.75 per 100,000 populations (Khon Kaen PHO 2004). With huge number of population in the municipality (381,267.92); therefore Muang district has the highest cumulative AIDS cases compared to other districts. Until June 2004 it had 1229 AIDS case with 218 deaths and 527 symptomatic HIV with 18 deaths (Khon Kaen PHO 2004).

SUMMARY

In summary it has been noted that HIV/AIDS in Thailand, particularly among women and children, still should be a critical concern because sources of transmission are large and the potential of risk behaviour relapse is high. Failure to sustain preventive measures by some men has been observed in other parts of the world or it might be expected among some men in Thailand, especially in light of the shift to indirect sex work, which many men may perceive as lower risk.

Women and children are of concern owing to the fact that most sero-positive women have acquired the disease through heterosexual contact most commonly from their husbands. That being the case, the high HIV/AIDS prevalence rate among any of the specific population groups finally contributes to HIV infection among women. Consequently mother to child transmission is difficult to avoid. In addition the existing measures seem to have little impact on this group. Their incidence rate has declined very slowly and seems to have remained steady for several years. Furthermore, within Khon Kaen the current rate is higher than the target goal of the National Plan.

Women and children in Khon Kaen are key groups that need to be helped, particularly women who live in the town where contributory socio cultural and environmental factors prevail. These problems coupled with limited social support networks enhance women's risks and raise special concerns for nurses working in maternal and child health.

CHAPTER 3

BACKGROUND LITERATURE

This chapter provides the conceptual framework which underpins the study, and starts with general concepts and theories. Then applied and focal theories related to women's self-care to prevent HIV/AIDS for themselves and their next child are delineated. The chapter is constructed around the following 3 sections.

Section 1: Self-care considerations

Section 2: Empowerment process and outcome

Section 3: Thai research into women and HIV/AIDS

SECTION 1: SELF-CARE CONSIDERATIONS

BACKGROUND AND VISION

Throughout history, a great deal of evidence suggests that self-care was performed as an integral part of the lifestyles of people. Before modern medicine became the major approach to health care delivery, individuals and families took responsibility for their own health both during periods of wellbeing and illness (DeFries et al. 1989). In the contemporary context self-care has become a supplementary to a professional healthcare system (Dean 1986).

The major influences on the movement to promote self-care were from: 1) the realisation and the acceptance that involving the individual is key and most important for responsible health care, and 2) the recognition that the individual has the right to preserve his/her health either when they are well or ill (Mullin, 1980).

SELF-CARE IN THAILAND

Self-care has been fixed in the lifestyle of Thai people as an action to prevent their own disease and to preserve their own survival. Ordinary people performed various forms of self-care and relied on their own beliefs, friends, family, neighbours and lay healers to maximise their health and well being.

Self-care is emphasised and promoted as a strategy of primary health care in Thailand (Rakpoa 1990a). The evolution of the health service system in Thailand was from self-reliance, which used local wisdom for treatment of diseases and health promotion (The Ministry of Public Health Thailand 1998a). Until 1988, the Thai government provided health care service for its people. Subsequently influences from modern medicine in western countries have played a major role in the development of health care systems in Thailand. Meanwhile, many people still rely on the traditional methods of self treat and self-care (MOPH 1998-2000) and traditional healing practices.

SELF-CARE DEFINITION

Self-care has been defined in various ways and there is no commonly agreed-upon term and scope of self-care. The following are some selected definitions which provide rich explanations to understand the concept of self-care and are useful in the context of the present study.

Levin et al.(1976) suggested that “self-care is a process whereby a layperson functions on his/her own behalf in health promotion and prevention and in disease

detection and treatment at the level of the primary health resource in health care system” (p.11). Although Levin and Idler (1983) stated that people generally perform self-care without help from health professionals, they maintained that “individuals are informed by technical knowledge and skills derived from the pool of both professional and lay experience” (p.181).

According to Orem (1991 p.73) “self-care means care that is performed by oneself for oneself when one has reached a state of maturity that is enabling for consistent, controlled, effective, and purposeful action”. She also states that individuals who have developed self-care capabilities can take care of themselves in their environmental context to maintain life, health and well being. Going further than other nursing scholars, Orem (1991, 1995, and 2001) extended her focus on caring for other dependents in an adult social network as well. Caring for those dependents, both incapable adults and children, whose self-care abilities have not been developed, was defined as dependent care.

According to the definition described above, self-care places emphasis on the responsibility of the individual or family to make decisions and actions to promote or restore their own health. However, self-care is not free from socio-cultural influences as some authors describe below.

According to WHO’s definition (1986) of self-care quoted by Kickbusch (1989):

“Self-care refers to unorganized health activities and health related decision making by individuals, families, neighbours, friends, and colleagues at work etc.; it encompasses self-medication, self treatment, social support in illness, first aid in a

‘natural setting’, i.e. the normal context of peoples’ everyday lives. Self-care is definitely the primary health resource in the health care” (p. 126).

Backman and Hentinen (1999 p. 3) in reference to Dean (1989), describes that “in order to understand self-care behaviour, it is necessary to understand the interactions between the components of caring for self and their interplay with socio-cultural influence. Not all activities of self-care are rational solutions: unrecognized, socially learned meanings also contribute to self-care”.

It is also suggested that self-care is a value-laden concept. This is because self-care behaviours and strategies promoted in health education are created from the perspectives of professionals, who develop the programmes. Thus the beliefs and practice of an individual’s self-care are judged, by society and the professionals, as appropriate or inappropriate (Berman and Irish 1998).

Dean’s definition (1986 p.62) captures all aspects of self-care as:

“Self-care involves the range of activities individual undertake to enhance health, prevent disease, evaluate symptoms and restore health. These activities are undertaken by laypeople on their own behalf, either separately or in participation with professionals. Self-care includes decisions to do nothing, self-determined actions to promote health or treat illness, and decision to seek advice in lay, professional and alternative care networks, as well as evaluation of and decisions regarding action based on that advice”.

It should be noted here that although self-care is individual or family responsibility, it is shaped and influenced by many factors as discussed above. Understanding the client’s perspective is necessary before planning individual self-care (Berman and Irish 1998). Thus for this study of HIV/AIDS prevention amongst women it is necessary to understand the nature of their self-care practices alongside other contributing factors.

For present purposes, self-care in this study is defined as:

The process encompasses decisions and actions taken by a woman in order to prevent herself and her next child from contracting HIV/AIDS. Self-care also includes actions that are undertaken with the support of lay people, social networks, and health care professionals. Self-care actions are voluntary, adequate and continuous in order to achieve the goals of HIV/AIDS prevention.

SELF-CARE PATTERNS

Patterns of self-care can be explained and understood in terms of preconditions, mediators, and outcomes (key concepts are given in italics).

Preconditions: These conditions usually occur before individuals perform self-care. For instance: *attention to health* (Leenerts and Magilvy 2000), *life experience*, *personality* (Backman and Hentinen 1999), *self-values* (Moore 1990), *coping strategies* (Burke and Flaherty 1993), and *social support* (Muhlenkam and Sayles. 1986; Tungulboriboon 2002).

Mediators: The key factors which promote and sustain the process of self-care. Such as: *risk awareness* (Becker, Drachman, and Kerscht 1972), *cognitive or perceptual ability and health beliefs* (Tungulboriboon 2002), *important turning points* (Leenerts and Magilvy 2000), and *health care or professional care* (Backman and Hentinen 1999).

Outcomes of self-care: The terms which have been employed to describe the consequences of self-care are: *quality of life*, *health status growth*, and *illness control* (Tungulboriboon 2002), *being active about self-care* (Backman and Hentinen 1999),

discovering creativity in living (Leenerts and Magilvy 2000), and *making autonomous decisions about life* (Charmaz 1991).

Each of these has consequences for the present study especially the connection between cultural expectations and self-care.

SOCIAL SUPPORT

As addressed previously many scholars give credence to the importance of the interaction between the components of self-care and their interplay with socio-cultural influences (Dean 1989; Backman and Hentinen 1999). These interactions can either support or be a barrier to self-care.

Social support provides an important role which impacts on the health outcomes of an individual both directly and indirectly. As a resource, it provides encouragement to the recipient. As a result social support may promote health behaviour, a sense of belonging, and feelings of personal efficacy (Muhlenkamp and Sayles 1986).

The roles of social support on self-care can be addressed through a person-centred health promotion model. The relationship between self-care and supportive care are clearly illustrated in the Health Care Pyramid developed by Romeder et al. (1990). Self-care is placed on top, and is considered to be the primary source for an individual who faces health problems. Family/voluntary care and professional/institutional care, as social supports, are other resources for the individual to choose to consult with. The physiological and economic environment which influences all forms of health is denoted by the circle which encompasses the pyramid (Figure 3.1).



Figure 3.1. The Health Care Pyramid (Romed et al 1990)

Social support was also emphasized in The Ottawa Charter in 1986 (WHO 1986) which called for health promotion action, organised into 5 categories. These are: 1) building a health policy, 2) creating supportive environments, 3) strengthening community action, 4) developing personal skills, and 5) reorienting health services (Laverack 2004).

By modifying the concepts discussed above social support in this study will be composed of: 1) social- care; supportive care received from their social network such as family, relatives and friends, and 2) professional- care; supportive care received from health professionals with regard to promoting women's self-care to prevent HIV/AIDS for themselves and their next child.

In addition, by considering the professional role to be one of support it is planned to facilitate an approach to self-care which may enable the 5 categories of the Ottawa Charter to be considered.

NURSE'S ROLE IN SELF-CARE

The primary focus of nursing is the client's health. The goals of nursing practice are "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible" (Henderson 1966 p. 15). The nurse's role is to support the client's adaptive coping mechanisms responding to alteration in health. Several scholars also state clearly that self-care is fundamental in individual health promotion and disease prevention (Lipson and Steiger 1996; Berman and Irish 1998). The present research supports the idea that the nurse has a supportive role in enabling self-care.

SELF-CARE DEFICIT THEORY

Among nursing theories, Orem (1995) is the pioneer in introducing the self-care theory. Her self-care deficit theory is well known, and has been applied in nursing education, research and practice. It explicitly defines the nurse's role as enhancing the client's capability to perform self-care. The theory of self-care includes the three major concepts: 1) the therapeutic self-care demand- a set of self-care activities determined through universal self-care, developmental self-care, and health deviation self-care requisites, 2) Self-care agency- an individual's ability or power to engage in self-care and composes of foundational capabilities and ten power components, and 3) nursing system- the type of nurse-client relationship is based on needs and self-care agency of the client.

In respect to the present study which aims to promote women's self-care to prevent HIV/AIDS it is necessary to understand women's self-care demands and self-care agency with regard to HIV/AIDS prevention. Thus the creation of nursing approach which utilises social support or supportive systems relevant to women's needs and capabilities is considered essential.

HEALTH BELIEF

The development of the health belief understanding resulted from the widespread failure of individuals to engage in preventive health measures (Glanz, Rimer and Lewis 2002).

The core components of the model are: 1) *individual perceptions*- encompasses perceived susceptibility, and perceived severity, 2) *modifying factors*- involves demographic variables, perceived threat, and cues to action, and 3) *the likelihood of action*- difference between perceived benefits and perceived barriers (Lipson and Steiger 1996; Brown 1999; Glanz, Rimer, and Lewis 2002).

Once an individual perceives a threat to his/her health and is simultaneously cued to action, and can perceive the benefits of such, then that individual is most likely to undertake the recommended preventive health action. However, there may be some factors (demographic, socio-psychological, and structural) that can influence an individual's decision.

Action may not take place, even though an individual may believe that the benefits to taking action are effective. This may be due to barriers related to the characteristics

of a treatment or preventive measure which may be considered to be inconvenient, expensive, unpleasant, painful or upsetting or culturally inappropriate. These characteristics may prevent an individual from taking appropriate health behaviours (Lipson and Steiger 1996; Brown 1999; Glanz, Rimer and Lewis 2002).

The key components in health belief are useful for understanding individual health behaviours. These concepts will be explored in terms of the connection with women's self-care to prevent HIV/AIDS in this study. This exploration may be useful for intervention phase of the present study.

SELF-EFFICACY

Bandura (2001) and Vickery and Iverson (1994) understood self-efficacy in terms of an individual's own judgement about his/her own capability to carry out actions with desired effects.

The important role of self-efficacy has been noted to play a major influence in individual self-care and not only in terms of having information and skills but also in terms of sustaining change (Vickery and Iverson 1994). Increasing self-efficacy not only promotes behavioural changes but also maintains those changed behaviours (Nicki, Remington and MacDonald 1985).

Self-care to prevent HIV/AIDS amongst women requires lifelong behaviours. Enhancing self-efficacy will be taken into account for promoting and sustaining women's self-care in the present study.

SECTION 2: EMPOWERMENT PROCESS AND OUTCOMES

LEVELS OF EMPOWERMENT

The operation of empowerment can be both at individual and community level.

Based on Tones and Green (2004):

“Individual or self empowerment is a state in which people possess a relatively high degree of actual power- that is, a genuine potential for making choices. Self-empowerment is associated with a number of beliefs about causality and the nature of control that are health promoting. It is also associated with relatively high level of realistically based self-esteem together with a repertoire of life skills that contribute to the exercise of power over the individual’s life and health” (p. 35).

According to the purposes of this study, individual empowerment will be considered as a part of the study. The key factors indicating that an individual is empowered described above may be useful for evaluating the outcomes of the intervention phase of this study.

NURSING CONSIDERATIONS

The nurses’ role in an empowerment process can vary widely. Nurses are not only personal resources but can also mobilise other resources in the client’s social network. Nursing encompasses facilitating client access to all essential resources that enhance their sense of control and self-efficacy, and as a result promotes their health (Jones and Meleis 1993).

In the empowerment process, nurses need to abandon their own power and help the client to gain power instead (Gibson 1991). In addition, “Nurses need to develop the

new skills and specializations in enabling and empowering people for self-care, self-help, and environmental improvement and in promoting positive health behaviours and appropriate coping abilities of people to maintain health” (Maglacas 1988 p. 71).

THE EMPOWERMENT PROCESS

The empowerment process has been described by scholars variously according to the context (Gibson 1995; Ellis-Stoll and Popkess-Vawter 1998; Sawatphanich, Ross, and Suwansujarid 2002). The components which are commonly used to explain the process cover the three stages of: *preconditions*, *attributes*, and *consequences*.

Preconditions: Preconditions are the necessary circumstances that must happen before the empowerment process begins (Ellis-Stoll and Popkess-Vawter 1998). Some selected preconditions relevant to the present study are: *personal significance*, *autonomous choice* (Elles-Stoll and Popkess-Vawter 1998), *mutual trust and respect* (Rodwell 1996), *commitment* (Gibson 1995), and *responsibility* (Sawatphanich, Ross, and Suwansujarid 2002).

Attributes; Defining attributes are the conditions that enable the process of empowerment to continue. For instance, *mutual participation*, *active learning*, and *individualized knowledge acquisition* (Ellis-Stoll and Popkess-Vawter 1998), *values*, *beliefs*, *experience*, *determination*, *social support* (Gibson 1995), and *cognitive or reasoning*, *decision-making skills* (Sawatphanich, Ross, and Suwansujarid 2002) are all attributes which may have a bearing on this research..

Consequences: The consequences of the empowerment process are: *mastery or sense of control* (Rodwell 1996), *self-efficacy* (Ryles 1999), *self-development or growth* (Gibson 1995), *self-esteem* (Rodwell, 1996), *self-determination* (Elles-Stoll and Popkess-Vawter 1998).

In relation to nursing, empowerment as a participative and interactive process between clients and nurses aims to promote adaptation by making it possible for clients to avoid or reduce unhealthy behaviours and adopt independent health behaviours (McWhirter 1991). Therefore, the positive consequences of the empowerment process are self-determined, independent health-promoting behaviours.

Methods and strategies: There are several methods and strategies that have been addressed in the empowerment literature. Wallerstein quoted by Gandelman and Freedman (2002 p.2) states that the empowering process encompasses: “engaging groups to identify and discuss problems. Once the issue is fully understood by community members, solutions are jointly proposed, agreed and acted upon”. Health promotion then can be obtained by increasing people's feelings of power and control over their lives. This is important for the third phase of the present study as it has been planned to be participatory.

According to Kobkul (1996) cited in Sawatphanich, Ross and Suwansujarid (2002) techniques of empowerment include: 1) acceptance of the client's situation, 2) identifying and enhancing the client's potential, 3) collaboration on analysis of

powerlessness and methods to obtain power, 4) equipping with essential skills such as problem solving, interaction, protection, and motivation.

Empowering women's self-care to prevent HIV/AIDS is a main concern of the present study. The concepts and definitions described are advantageous for guiding the process of empowerment and for evaluating the outcomes and consequences of the intervention phase of the present study.

SECTION 3: THAI RESEARCH INTO HIV/AIDS

A review of literature from source materials over the period from 1995 through 2005 has been carried out and synthesized to provide a review scope of studies, to identify the lessons learned so far, and to indicate the direction for further study. Several studies have been carried out among specific groups under national surveillance systems within Thailand. Therefore, in this section, only studies which have been conducted outside of those systems and are related to the focus of the present study will be reviewed.

WOMEN HIV/AIDS KNOWLEDGE, RISK, AND PREVENTION

HIV/AIDS knowledge

In Pinyo's study (1998), data collection was by structured questionnaire. The results showed much confusion about HIV/AIDS among pregnant women from low socio-economic background (n=300) in "Chiang Mai" northern Thailand. Although the majority of women obtained a high to moderate score of knowledge and perception about HIV/AIDS, analysis of each item showed their misunderstandings. Women

from this study believed that: 1) they are not at risk if their husbands have had unprotected sex with CSWs who had a negative HIV test result (42.7%), 2) ejaculation outside the vagina could prevent HIV infection (36.3%), 3) screening for HIV was not necessary because the disease could not be cured (13.3%), and 4) prevention of mother to child transmission might not be possible (27.6%). 4.7% of women in this study also reported that they had been infected with at least one sexually transmitted disease from their husbands. Their misunderstandings can lead to their being at risk of HIV/AIDS. In particular, if their beliefs in relation to number 1 and 2 described above are brought into practice.

A study among married women (n=223), in Samutprakarn province central Thailand, by Phichitpongpaio (1995) draws the conclusion that knowledge about safer sex had no association with practice. For instance the majority of women would consider themselves as low risk even though they realized that their husbands had engaged in risk-related behaviour, such as having had sex with commercial sex workers. In addition, a study by Muangsom et al (1994) among married women, (n=240) who sought cure at a STD clinic in KhonKaen, revealed that although the women (82.1%) knew and realized that the condom was a means of preventing HIV/AIDS, only 32.6% of them knew the correct way to use it and only 11.5 % had ever used a condom during sexual relations with their husband.

In respect to acquiring information, housewives (n=201) who lived in a municipal area had many more sources of information, but had less knowledge and had less discussion with others about issues surrounding AIDS than housewives (n=223) living in rural areas (Suchaya, Sooknirand, and Sookcharoen 1996). A study by

Nishino (1994) among men and women (n=1800) confirmed that the mass media played important roles in women's perception of and communication about HIV/AIDS. However, women had much more difficulty communicating about means of prevention of AIDS in comparison with men because they lacked negotiation skills and were influenced by cultural constraints surrounding sexual issues.

It has been noted that inadequate knowledge is not the only single factor related to prevention of HIV/AIDS infection among women, but there are many other risk factors illustrated in several studies which will be described next.

Risk factors

A comparative study between housewives (n=200) and CSWs (n=316) seeking treatment at an STD clinic in central Bangkok reveals that the housewives' risk factors were: 1) husband's HIV sero-positive status, 2) low education, 3) domiciled in north or northeast of Thailand, 4) husband's occupation (driver in particular), 5) drinking alcohol, and unprotected extramarital sex of their husbands, and 6) husband's history of STDs. It was also found that the percentage of HIV sero-positive housewives (27.5%) was higher than CSWs (13.9%) in this study (Vechakit 1997).

Dumronggitigule (1993) concluded from her study that cultural factors and under-perception of the husband's risk behaviours may lead to women themselves being at risk. This study was carried among married couples in northern Thailand (n=178), data was collected by structured questionnaire. The findings showed that half of all

informants reported it was common for married men to patronage prostitutes. Sixty one percent of men and women endorsed the belief that when a wife cannot satisfy her husbands' sexually, men would have rights to have extramarital sex. In addition higher numbers of men (82%) and women (87%) felt that it was socially acceptable for men to visit prostitutes if HIV protective measures were taken. 20% of husbands reported having had an STD during the past 3 years with only 11% of wives recognizing this. While 33% of husbands reported that they continued to visit prostitutes, only 15% of wives believed that their husbands visited a prostitute. 80% of wives requested their husbands not to visit prostitutes, and 70% trusted their husband's promise.

A further two qualitative studies have been conducted to make sense of influencing factors of HIV/AIDS risk among women as follow.

Boonmongkol (1999) employed anthropological method to study rural married women (36) and married men (n=13) in the north part of Thailand. The study showed 5 major risk factors prohibiting women from practising HIV prevention. These included: 1) low level of perception of their husband's extra marital sex, 2) "perceived social risk", 3) lack of knowledge of early detection and seeking treatment of STDs, 4) unfamiliarity with the use of a condom within marriage, and 5) unsafe sex practices of women outside marriage.

Whittaker (1994 p. 19) employed "genderised anthropology" to carry out a study at a village to understand ethnicity, gender, and health of the "Isaan woman". This study illustrated three socio-cultural factors leading women to be at risk of HIV/AIDS.

Firstly traditional social constructions of gender, sexual relations, and desires conceal “good” women from perception of HIV/AIDS vulnerability. Secondly influence by educational campaigns of “high risk groups” led to misunderstanding that only CSWs, and promiscuous women were at risk. Thirdly migration, separation of spouses, and the pervasiveness of the commercial sex industry were associated HIV/AIDS risk factors (Whittaker 1994).

These socio-cultural associated risk factors were found during the early period of HIV/AIDS in Thailand. After several HIV/AIDS prevention programmes have been implemented these factors should be re-explored and understood through the present study. These understandings may be fruitful to implementation of the intervention phase. For it is suggested that there may still be scope for change and enhancement of women’s perspective.

Preventive behaviours

In an area of high prevalence rate of HIV/AIDS, Sonthirat (1993) studied low socio economic married women (n=400) by collecting data through structured questionnaires. Her study indicated 63% of married women performed HIV preventive behaviours properly. Meanwhile, a higher percentage (78.4 %) of preventive behaviours was found among higher educated women (bachelor degree 41.2%) in Poouen’s study (1994) with 102 married women in suburban Bangkok. In the latter study preventive behaviours undertaken by pregnant women who found their husbands infected with STDs were: 1) abstinence from sexual relations or using a condom (25.4%), 2) using a condom and avoiding having sex which led to a high risk of HIV such as oral sex or anal sex (19.6%), 3) avoid having sex which led to

high risk of HIV only (18.6%), 4) abstinence from sexual relations or avoid having sex which led to high risk of HIV (10.8%), 5) abstinence from sexual relation. only (2%), and 6) using condom during sexual relations only (2%). It also found that sharing information about HIV/AIDS between the couple predicted preventive behaviour of married women in this study.

Pinyo (1998) carried out study with low socio economic pregnant women (n=300) in northern Thailand. According to data collection by questionnaires, majority of pregnant women (n=206) obtained moderated score of HIV preventive behaviours follow by low score (n=81) and high score (n=13) respectively. Common HIV preventive behaviours which were undertaken by women in this study were: 1) abstinence from sexual relations or using a condom if they found the husband was infected with STDs, 2) asking husband not to visit CSWs , 3) talking about AIDS with husband, 4) going to see a doctor if they noticed an ulcer or pus on the husband's genital organ, 5) not having oral sex or anal sex with husband, and 6) getting tested for HIV during pregnancy.

Although the studies described were carried out several years ago a high percentage of HIV preventive behaviours of women were revealed. These beliefs and practices among women about HIV/AIDS prevention will be explored and compared in the present study.

A study of housewives (n=210), attending antenatal care clinics at one hospital in southern Thailand, showed that family activities related to prevention of AIDS among them, commonly focused on discussing and warning about the danger of

AIDS within the family (54.48%), followed by not having extra marital sex (49.52 %), and the use of a condom during sex (5.42%). However, 45.52% of them said they preferred to “do nothing”. Within communities the patterns were similar. There was a large number (68.57%) who said everyone should take responsibility in caring for themselves (Osotsatian 1998). This finding may imply that women felt that they could “do nothing” as well.

Dumronggitigule’s study (1994) among married women (n=139) and married men (n=119) showed that both men and women, (67%) believed that if a husband becomes HIV infected he would be unlikely to discuss it with his wife. The suggestions which respondents proposed to reduce HIV risk among couples included: 1) improve sexual relationships which emphasizes much more on self improvement among women, 2) asking husbands not to visit prostitutes as a means of HIV/AIDS risk reduction. However, women believed that these practices were hard to apply because of the women’s workload of house-hold chores and child rearing. In addition there was significant difference in expectation, 74% of men and 53% of women, like the wife to initiate sexual relations. However, only 38% of both men and women actually believed that this practice could be possible.

The relationship of sexual dissatisfaction within marriage and husbands’ extramarital sex was found in some studies and could be HIV risk factor for women. Thus this association will be researched further in the present study.

Studies reveal the influencing factors for HIV prevention among married women include: occupation, social factors, individual characteristics, perception of AIDS,

and psycho-social factors (Sonthirat 1993), women's education, perception of risk, and self locus of control (Nichapanich et al 1997).

Drawing from the evidence in the studies described, factors related to HIV/AIDS prevention among women seem to derive from traditional values and norms of both men and women according to their gender roles and sexuality expectations within Thai culture. All of these socio-cultural factors are not only useful in making sense of women's self-care to prevent HIV/AIDS in the present study but also provide foundational information to guide the intervention phase of the present study.

HIV/AIDS PREVENTION PROGRAMME

HIV/AIDS preventive programmes, which relate to women, have been developed through three main types of studies: 1) community based interventions, 2) participatory action research, and 3) randomized control trials or quasi-experimental studies. These studies will be described in brief into two categories as: 1) projects conducted in Khon Kaen and Northeast, and 2) projects carried in other parts of Thailand.

The community based intervention is mostly socio-culturally sensitive in nature, and likely to involve community participation in order to develop methods or strategies to prevent HIV/AIDS in communities. Researchers in Khon Kaen and the Northeast such as Espey (1993), Matika-Tyndale (1996), Sakondhavat and Sittitri (1996), and Elkins et al. (1996) have investigated these issues. These studies suggest that empowerment plays important role in programmes aiming at reducing risk behaviours and sustaining such changed behaviour in communities. In addition, an

intervention should be congruent with the lifestyle of the target group. Thus lessons learned from these studies will be brought into consideration in the intervention phase of the present study.

Action research applications have also been carried out. One was the Project of the Bangkok Metropolitan Authority (Ard-am and Nakhalajarn 1997) within the “AIDS care network” in which dissemination of information about AIDS and AIDS prevention initially by 20 peer leaders finally reached more than 40, 000 people. A second project was the 3-year community based intervention study of Sombatmai et al. (1999) who employed a “Friends Helping Friends” approach with 70 couples. Both of these studies indicate the important role of social support and peer group influence in reducing HIV/AIDS sexual risk behaviours. Thus lessons learned from these studies with regard to the importance of social support for HIV/AIDS prevention will be incorporated into the present study.

Participatory action research (PAR) was used as a methodology in one study carried out in the South of Thailand. The first phase was designed to study general information relating to the project. The second phase was participatory action research which started with establishing relationships with participants. An implementation phase was conducted. Data collection was through in-depth interviews, focus group discussion, participants observation, field notes, and audio tape and video tape recording. Three programmes were developed as an outcome of the study and these included a health education programme to promote preventive behaviours, a self-care program on AIDS for the community, and a training program for community nurses. In addition a pattern of community participation in the

research project was also created (Chuerprapaisilp et al. 1996). This study provides an example of methodology for conducting PAR in rural area. Thus the present study which has carried out PAR with married women living in a city centre may contribute to a more comprehensive understanding for promoting women's self-care with regard to HIV/AIDS prevention.

Studies, which apply *quasi-experimental* techniques include: Anusorntheerakul et al (1996) study of female school students (n=812) in Khon Kaen. The project aimed to enhance HIV/AIDS knowledge, perception of HIV/AIDS risk, and promote female student's role and the potential for an AIDS campaign in school. A pre and post test design was used. A significant difference in all aspects mentioned was found for the experimental group. Studies in other parts of Thailand were those of Cash, Anasuchatkul and Busayawong (1995) who investigated 240 single female factory workers in northern Thailand. This study aimed to identify the method which most influenced subjects' beliefs and behavioural intentions with regard to HIV/AIDS prevention. Quantitative and qualitative data collection were utilised and the results showed that of the three interventions tested, the most effective was the use of peer leaders.

These studies emphasise the importance of peer leaders as a means for HIV/AIDS prevention among women. The influence of the peer group will be studied in the current research.

Xu et al (2002) studied married women in Northern, Thailand to determine the effectiveness of individual counselling on HIV preventive behaviours. All enrolled

women (n=779) were tested for HIV antibodies at 6 and 12 months as base line data. Two sessions of individual counselling covered: partner communication; partner HIV testing; and condom use by steady partners. After the intervention, women reported an increase in communication with their husbands in terms of safer sex and HIV testing. Women also reported a slightly increase in HIV testing and consistent condom use by husbands.

Jiraphongsa et al (2002) studied unmarried young adults (n=398) in Northern, Thailand. The project aimed to evaluate a technique of active group intervention by promoting HIV testing and counselling (HIV-TC) services. At baseline, only 23% of respondents were tested for HIV at least once and most respondents believed that they had no vulnerability for contracting HIV. After one day of group counselling women in the experimental group (95.77%) were more likely to receive HIV-TC and return for the results, compared to the control group. However, factors associated with acceptance of HIV-TC were: previous STD; ever been married; intended getting the test; and had ever participated in AIDS activities. Although this intervention was acceptable it had less effect on promoting the utilization of HIV-TC service among the unmarried population.

These two studies suggest that both a short period of group intervention and individual counselling are not effective methods for promoting HIV/AIDS preventive behaviours among women. The effectiveness of these interventions will be compared to that of the intervention in the present study in which group participation for a longer period of time was carried out.

Only one study aimed to *empower* married women in Northern Thailand and this was carried by Tripiboon and Srisupan (1999). The study aimed to enable rural women (n=607) to improve in the “positive factors” of self efficacy, self esteem, and hope and to increase behaviour skills in relation to safer sex with husbands. The intervention was implemented through trained village health volunteers and change agents in the communities. An evaluation, through pre and post test method revealed a significant increase in all positive factors among married women. It was also found that the number of women demonstrating an ability to negotiate safer sex, and the number of couples using a condom more frequently increased in the experimental group

This study illustrates the significant role of social support or change agents for HIV/AIDS prevention. Other types and functions of social supports will be further explored in the present study.

PREVENTION OF MOTHER TO CHILD TRANSMISSION

Agpachaya, Pinprateep, and Vainate (1995) reported in a study of mothers (n=252) that the key influencing factors for getting an HIV test were: 1) recognition of the high prevalence rate of HIV in their own province, 2) intention to terminate their pregnancy if they were HIV sero-positive. Another study by Trujillo and Rhucharoenpornpanich (2003) revealed reasons for not testing among women, was a suspicion of already being HIV infected. The reported reasons for not returning to get test results were being afraid of the test results and not caring about one's own or the baby's health.

A study on prevention of HIV transmission from mother to child, in which I was one of investigators, was conducted in Khon Kaen. Ante-retroviral drugs as a peri-natal

prophylaxis were given to HIV sero-positive pregnant women and their newborns. Oral Zidovudine (ZDV) was also given every 3 hours for women during delivery coupled with ZDV syrup orally every 6 hours for 7 days for their newborns. Newborn HIV antibody and polymerase chain reaction (PCR) were done at 6 weeks and 6 months after birth. It was found that the overall transmission rate was 5.2%, with 3/58 children confirmed infected with HIV by at least two positive PCR test results (Sakondhavat et al 1999). Thus recommending that all pregnant women are tested for HIV and prescribing peri-natal prophylaxis drugs for HIV sero-positive women is important and will be one aspect of promoting women's self-care in the present study.

ALTERNATIVE PREVENTION METHODS FOR WOMEN

In Thongkrajai's clinical trial study (1996) it was found that among vaginal preparation products containing nonoxynol-9, films was the most preferred barrier method among married women (n=38), followed by either a gel or microbicide pessary. Although women had a positive attitude toward these methods, 5.4% (25/38) reported irritations such as a burning sensation and itching or painful urination.

Using a microbicide is still controversial. A study by Tharawan et al (2001) explored negative attitudes to the use of microbicides amongst married women (n=370) in the north of Thailand. In a later clinical trial study (Bentley et al 2004) carried out in 4 countries including Thailand (N=98), it was found that the use of a microbicide was approved by the majority of women (73%). However, both women and their partners

in this study reported that if used and kept secret from an permanent partner it might “break the trust” of the relationship

Unfortunately, a meta-analysis from 10 identified randomized control trials shows that microbicide containing nonoxynol-9 did not protect against sexually transmitted infections. In addition it also indicated the possibility of harm by increasing the rate of genital ulceration. However, this study did not cover HIV prevention (Wilkinson et al. 2004). Because the effectiveness is unsure and seems to have several side effect therefore, this method of prevention will not be promoted for use in the present study.

Comparisons from other countries led to the conclusion that the female condom seems to be the women’s choice for HIV prevention. Artz and Brill (2000) studied the effectiveness of a training programme to promote barrier use with 1159 women. Use of the female condom increased significantly after the intervention, and high use was maintained during a 6-month follow-up. The researcher concluded that if female STD clinic patients received appropriate promotion and were trained to use them correctly, the female condom can be applied into their practice.

Studies relevant to HIV/AIDS prevention among men, women, and infants are summarised by Table 3.1 as follow.

Table 3. 1 Summary of studies among women and men in relation to HIV/AIDS prevention from 1995-2005

Important variable	Rural	Urban	VCT**	Mother to child	Empowering	Volunteer network	Programme development	HIV/AIDS Information	Female method	Male method	Married		Single	
											M	W	M	W
Matika-Tyndale, 1996	✓	✓						✓		✓	✓		✓	
Sakondhavat and Sittiri, 1996	✓				✓		✓		✓	✓	✓			
Anusorntheerakul et al, 1996		✓				✓	✓	✓	✓				✓	✓
Thongkrajai, 1996	✓								✓			✓		
Sakondhavat et al, 1999	✓	✓	✓	✓				✓				✓***		
Elkins et al, 2003	✓				✓		✓	✓	✓	✓	✓	✓	✓	✓
Cash, et al., 1995*		✓				✓	✓	✓	✓					✓
Chuerprapaisilp et al., 1996*	✓				✓		✓	✓	✓			✓		✓
Ard-am and Nachalajarn 1997*	✓					✓		✓			✓	✓	✓	
Sombatmai et al., 1999*	✓				✓	✓	✓	✓			✓	✓		
Tripiboon and Srisuphan, 1999*	✓				✓	✓	✓	✓	✓			✓		
Jiraphongsa et al, 2000*		✓	✓	✓				✓	✓					✓
Xu et al 2002		✓	✓	✓				✓	✓					

Note: * Studies outside Northeast Thailand, ** VCT = Voluntary Counselling and Testing for HIV, *** HIV positive pregnant women

As can be seen from table 3.1 previous studies have considered various factors associated with HIV/AIDS prevention. All of these are relevant to the present study, and through these review pertinent issues have been incorporated into the design in general and the intervention phase in particular.

CONCLUSION

In conclusion people in general perform “self-care” to promote their health including prevention of disease. Individuals perform self-care on their own behalf, even though they consult many times with lay people or professionals, during health or sickness. In addition mature adults perform “dependent care” on young children. Self-care then is considered to be the self-responsibility of every individual. However, there are several factors which may inhibit or prohibit individual self-care. In such circumstances health care professionals play an important role in terms of helping clients to develop a self-care agency appropriate to their need and their culture.

In respect of HIV prevention, while there is not yet any vaccine to prevent the disease, the most effective means for prevention is to minimise if not avoid risk taking risk behaviours. In the case of married women and their infants risk taking behaviours have a special meaning related to gender roles, cultural norms and condition of living.

Nurses are in the position to play an important role in relation to helping clients to assess their own needs for self-care. Gender inequality seems to be a barrier for Thai

women in relation to HIV/AIDS prevention. Empowerment of women's self-care may be an appropriate strategy for HIV/AIDS prevention among them. There are several concepts and theories to guide us in making sense of HIV prevention among women. These include the self-care deficit theory, the health belief model, self efficacy theory, and social support.

Emancipatory inquiries such as feminist theory and participatory action research may help to fill the gap both in regard to gender issues and professional versus lay perspectives. Identifying a culturally sensitive programme for prevention of HIV/AIDS among women and infants can be achieved from the women's point of view.

From the literature reviewed most studies related to women's knowledge and attitudes toward HIV/AIDS, HIV prevalence rate, risk behaviours and risk factors. There are several studies aimed at enhancing single or young women's preventive behaviour but not married women. However, socio-cultural factors were not brought into account in most of the studies. Socio-cultural based studies, in northern and north-eastern, Thailand, have been carried out but only on sample of rural women. However, most of these aim to understand the socio-cultural factors related to HIV/AIDS infection among women. Only a few studies have carried out an intervention strategy. One interesting participatory action research study was carried out to develop the HIV prevention programme for women living in the rural south Thailand. Only one study was conducted to increase women's self-efficacy and was carried out in north Thailand. This present research builds on previous knowledge and aims to empower women's self-care to prevent HIV/AIDS for themselves and

their next child, and to identify a culturally sensitive programme for HIV/AIDS prevention among women and children in the north-east of Thailand from the women's perspective. In particular, women who live in urban areas such as the Muang district of Khon Kaen province.

CHAPTER 4

RESEARCH DESIGN

This chapter provides details of research methodologies and research procedures which were used in the three phases of the study and comprises four sections.

Section 1: An overview of the research design

Section 2: The exploration phase

Section 3: The explanation phase

Section 4: The intervention phase

SECTION 1: OVERVIEW OF THE RESEARCH DESIGN

THE RESEARCH QUESTION

Based on the background and rationale from previous chapters, the research question was established and is as follow:

Can and how does women's participation contribute to a socio-culturally sensitive approach to HIV/AIDS prevention for women and children in urban Northeast Thailand?

THE PURPOSE OF THE STUDY

Based on the research question the purpose of this study is declared as below:

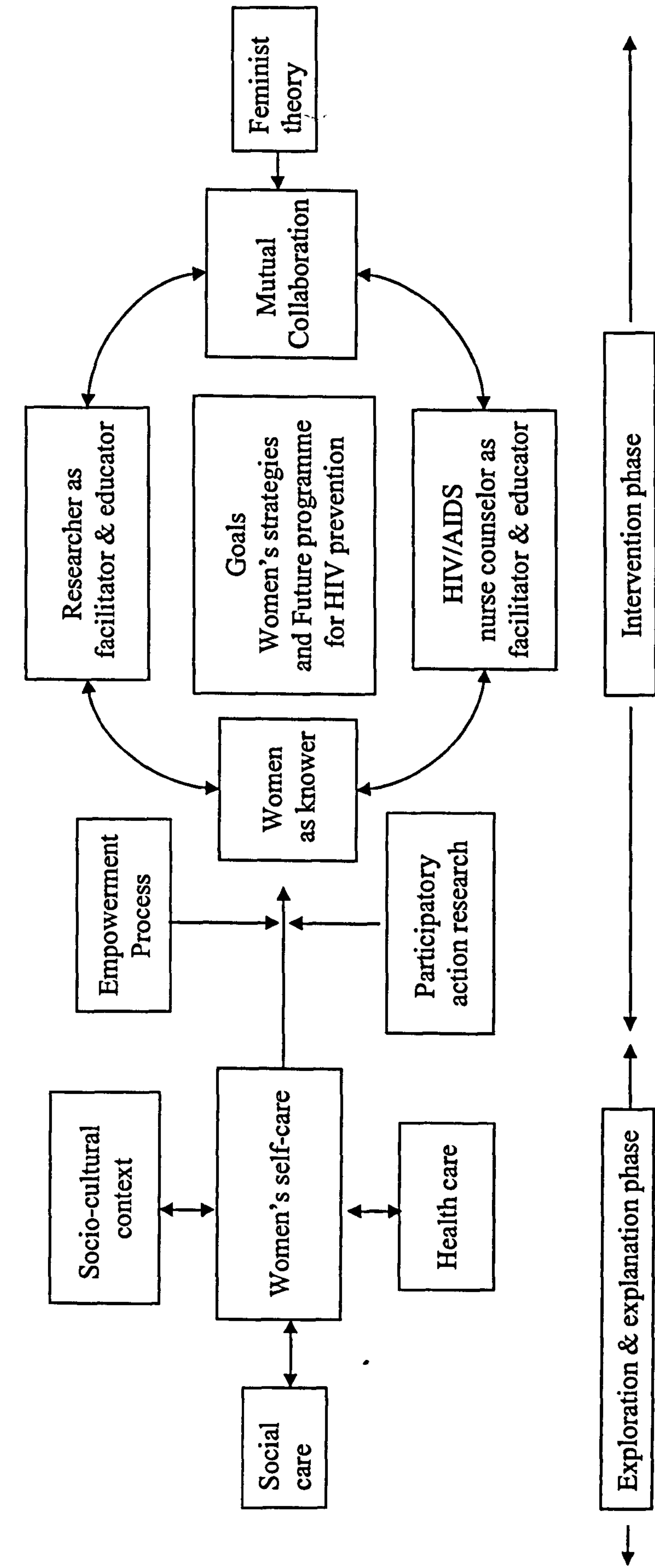
The purpose of this study is to pursue a socio-culturally sensitive approach to prevent HIV/AIDS in women and children in urban Northeast Thailand.

In order to clarify the purpose of the study and give more focus for the investigation, five subsidiary questions were established as follows:

- 1) What is/are women's self-care behaviours to prevent HIV/AIDS for themselves and their next child?
- 2) What is/are factors associated with women's self-care to prevent HIV/AIDS for themselves and their next child?
- 3) Does the self-care, to prevent HIV/AIDS for themselves and their next child, of HIV sero-negative women differ from the self-care of HIV sero-positive women? Can this difference contribute to the promotion of women's self-care to prevent HIV/AIDS for themselves and their next child?
- 4) Is there any substantive theme that captures women's self-care to prevent HIV/AIDS for themselves and their next child?
- 5) Can and how does a participatory approach empower women's self-care to prevent HIV/AIDS for themselves and their next child?
- 6) Can and how does a participatory approach contribute to an initiation of a construction programme to prevent HIV/AIDS for women and children?

A conceptual framework governing the study design was developed and is illustrated in figure 4.1.

Figure 4.1 The conceptual frame work of the study design



According to figure 4.1, in the exploration and explanation phases of the study it is planned to understand women's self-care, through their interplay with significant others, institutions, and organisations in the socio-cultural context. The substantive theory of women's self-care and social supports generated from these phases will provide foundational knowledge for the empowerment process in the intervention phase. Within the intervention phase participatory action research as an approach for empowering women's self-care is represented by PAR cycles. Through mutual collaboration of women, HIV/AIDS nurse counsellors, and researcher, and through interaction process by which women's self-care strategies and future programme for HIV prevention will be created.

Two roles of participatory action research in the intervention phase were determined. These were: 1) bridging gaps between women and health professionals, nursing professionals in particular, in respect to knowledge creation, and 2) contributing the transforming of theory generated, with regard to HIV/AIDS prevention into self-care of women under study.

Feminist theory is applied to the present study for understanding and illuminating the influencing of socio-cultural factors, in particular gender and sexuality, on women's vulnerability for contracting HIV/AIDS. Feminist theory also helps in making sense of women's self-care strategies with regard to HIV/AIDS prevention for themselves and their next child.

As suggested previously HIV/AIDS issues involve gender inequity therefore, feminist inquiry will be theory underpinning this study. The ideology and philosophy will be discussed next.

FEMINIST THEORY AND NURSING RESEARCH

The necessity of the feminist approach in nursing research has been addressed by academicians. Scott (1997) suggested that we need a theory that will break the conceptual hold, at least of those long traditions of philosophy that “have systematically and repeatedly construed the world hierarchically in terms of masculine universals and feminine specificities.” (p.758)

I do agree with feminist scholars who insist that research methods and findings that are exclusively based on men should not be applied to women. In addition feminist research has focused on an exploration of the ‘reason’ for and the ‘remedying’ of the inequity which traditionally affects women’s health (Sigsworth 1995). It has been suggested (chapter 1-3) that male methods, which have been promoted in Thailand for HIV/AIDS prevention cannot be applied into women’s practice effectively. Therefore, a more feminist approach more appropriate and will be applied in the present study.

Feminist theory will be used to aid interpretation of data in the explanation and intervention phases so that I may obtain a better understanding of cultures.

ETHICAL CONSIDERATIONS

“Ethical issues related to professional nursing practice arise daily in the constant struggle to do good for the patients and avoid harm” (Streubert Speziale and Carpenter 2003 p.311). Occurrences of these ethical dilemmas are attached to the facts that direct relationships with human beings are crucial in nursing practice. In addition the profession of nursing has a code of ethics that guides nursing practice. I do agree with Streubert Speziale and Carpenter’s statement (2003 p.311) that, their understanding of ethical principles in theory and experience in nursing practice, prepares nurses to make sound ethical and moral decisions on a daily basis. This knowledge and experience can be transferred to comprehend ethical issues with regard to research procedures.

It is important to state here that ethical issues must be critically considered when carrying out any research study particularly, qualitative research in which the researcher is a tool for study. The mainstream ongoing discussion devoted to ethical issues addressed by Streubert Speziale and Carpenter (2003 p.311) can be defined in four categories. These are: informed consent, confidentiality, participant-researcher relationships, and anonymity.

To ensure that respondents and participants in this study should be treated as autonomous individuals, their well-being is protected, and their rights must be strictly preserved, I adopted principles mentioned above as a framework for considering ethical issues in this study as described below.

The ethical clearance of the study was obtained from The Ethical Clearance Research Committee of The Faculty of Medicine, KhonKaen University, Thailand. This is the local Ethics Committee unit assigned by KhonKaen University to be responsible for considering and giving approval to all human subject research under KhonKaen University (Appendix II). Approval and consent to conduct the study was obtained from each of the three research site hospitals. After getting permission the study was clearly described and discussed with physician, nurses, AIDS/HIV counsellors and, social workers at each hospital.

Informed consent was obtained before data collection began because I recognise that the participant's autonomy was important and to be respected. In the study situation all women were given brief information about the research project and asked by staff nurse whether or not they were willing to participate in the study. Only women who intended to participate in this study were introduced to the researcher. At this point full information on the research project was given by the researcher. Women were also informed clearly that their decisions were respected and if they decided not to consent it would not affect any services given to them.

Confidentiality of women's personal information was strictly adhered to. Anonymity of participants was crucial. Interviewing sessions were conducted in comfort and in a private room. All information gathered from and relating to participants was always kept confidential and stored in a secure place. Participants' names and addresses were not stored with the data collected and women's pseudonyms were used when reference was needed. All reported data has used pseudonyms. Permission from participants was obtained before audio tape recording was operated.

The relationship between the researcher and the women in this study was the relationship between researcher and research participants. However, the researcher was also known as “Ajarn pa-ya-bal” (Clinical instructor for nursing students) because she instructed students at “well child clinics” twice a week. In order to facilitate relationships which the researcher believed would help women to relax and allow open discussion she referred to herself as “Pi”. This is a pronoun used in Thai society to refer to elder sisters and therefore, this implied a relationship as of a relative, rather than client and provider or researcher and researched.

The right not to be harmed was conducted by placing the needs of participants before the research protocol. Potential risk of any harm to participants was outweighed by the benefit of research procedures.

Further ethical issues: reflections from the researcher

The multiple roles I held during my research namely those of nurse, educator, and researcher could effect any phase of the study. Realising that as nurse and educator and given my knowledge background I might like to influence women’s choices with regard to their health. As researcher I am obliged to not interfere with participants’ point of view and choice of practice. To fulfill these roles during the PAR process was very difficult. However, I tried to reduce my influence as much as possible by doing constant self reflection and getting reflections from my supervisors and the nurse counselors at various stages of my study. By doing these I ensured that my personal biases had less effect on my study and the findings from my study truly derived from data rather than from my perspective.

SETTING OF THE STUDY

Well child clinics of three hospitals, where the researcher noticed a number of mothers and infants who had been infected with HIV were clients, were selected as the setting for this study.

The study was divided into three phases as summarised in Table 4.1 below.

Table 4.1 The study plan

Study phase	Research procedures	Purpose
Chapter 5: Exploration phase a) Qualitative research with: -15 HIV sero negative women - 9 HIV sero positive women b) Supportive data from pilot with: -18 HIV sero negative women - 3 HIV sero positive Women	- In-depth interviews - Interviewing by open-ended and close-ended questionnaires	- Examine women's life experience with regard to self-care to prevent HIV/AIDS - Preliminary survey on HIV/AIDS knowledge & attitude, self care & social support for HIV prevention among women
Chapter 6: Explanation phase a) Qualitative research with: -38 HIV sero negative women support with data from 3 husbands b) Qualitative research with: -5 Brothel's owners -1 CSWs c) Informed data with descriptive survey with: -134 HIV sero negative women -10 HIV sero negative Couples	- In-depth interviews (two sessions each) - Focus group - In-depth interviews - HIV risk assessment questionnaires	- Theory generated on women's self-care to prevent HIV/AIDS - Prepare women to participate in intervention phase - Triangulation of data on men's sexual behaviours - Recruitment participants to participate in this explanation phase - Determine married women at risk - Verify women's risk with their husbands
Chapter 7: Intervention phase Participatory action research with: -6 groups of HIV se-ro negative women, 4-5 persons each (N=29)	- Implementation of participatory action research 5 cycles through focus group discussion, 30 sessions all.	- Empowerment women's self-care to prevent HIV/AIDS - Initiation of HIV prevention programme for women and children

SECTION 2: THE EXPLORATION PHASE

Apart from pursuing answers to some parts of this study this exploratory phase acted as a pilot study. The researcher aimed to familiarise herself with the Isaan women's context in relation to HIV/AIDS prevention. Theoretical sampling was carried out for further data collection in the explanation phase. Combined quantitative and qualitative methods were employed.

STAGE 1: QUANTITATIVE RESEARCH

The objectives of this stage were to examine HIV/AIDS knowledge, women's self-care, and social support to prevent HIV/AIDS for themselves and their next child. Comparison of these concepts and practices between HIV sero-negative and HIV sero-positive women was another objective of this phase.

The recruitment process was very challenging because HIV sero-negative women thought that this was not in their interest whilst HIV sero-positive people did not wish to reveal themselves. The criterion for sample selection was married women, who sought health care for their child at "well child clinics" of three hospitals located in the city centre of KhonKaen in Northeast Thailand. 18 HIV sero-negative and 3 HIV sero-positive women, across the three hospitals, participated.

The limitation of the non-probability or purposive sampling is that it may prohibits us from knowing precisely the degree to which the sample represent to the whole population (Gibson 1995). However, the three hospitals which were selected as the field study setting have different policies and protocols for giving services. As a

result women had some different reasons for seeking care from these three hospitals which may arise from their personal characteristics. Respondent recruiting from three hospitals was justified as appropriate for this study by their life experiences pertaining to self-care for HIV/AIDS prevention.

Instruments to obtain data at this stage were both open-ended and close-ended questionnaires. The close-ended questionnaire was developed by employing concepts derived from reviewed literatures and discussion with colleagues. Valid construction was obtained by six experts in the HIV/AIDS area, three were physicians and the other three were HIV/AIDS nurses from the three hospitals which were selected as research sites. The questionnaires were tried out with 21 HIV sero-negative women, seven from each hospital and six HIV sero-positive women, two from each hospital. Provisional reliability was obtained with Cronbach coefficients at 0.67 and deemed acceptable at this exploratory phase. The final draft of questionnaires comprised of three parts (Appendix III).

Data collection was carried by interviewing which was conducted either before or after the clinic visit as participants desired. The open-ended questionnaire was administered prior to the close-ended questionnaire in order to avoid data contamination by leading questions from close-ended questionnaires.

Data analysis was through statistical analysis regarding frequency of occurrence, percentage and mean scores. Comparison between HIV sero-positive and HIV sero-negative women could not be carried out with statistical analysis rigour. This was

because of the relatively small number of HIV sero-positive women who could participate in this stage (See table 5. 1).

The small number of respondents limited generalization. In this study qualitative data due to its nature is the main source for generating substantive themes to understand women's self-care to prevent HIV/AIDS. Crude quantitative data derived from this stage was employed for data triangulation.

STAGE 2: QUALITATIVE RESEARCH

Recruitment process in this stage was similar to first stage. There were 15 HIV sero-negative women and 9 HIV sero-positive women who participated.

An interview Guide was developed by the researcher to be used to ensure that the given set of topics was covered in interviews with participants (Appendix IV). The interview guide contained open-ended questions and the researcher used it as a broad guide to encourage participants to talk freely about their knowledge and experience relating to HIV/AIDS. New topics were either created from the response of previous participants or emerged during the interview.

Data Collection methods at this stage included in-depth interviews, general observations during interviews, reviewing medical records and discussions with staff who provided service to children at "well child clinics". All in-depth interviews were conducted by the researcher and took place in a private and comfortable room located in the hospital context.

Even though there was a topic guide for the interview; the answers from participants guided the direction and content of the interview. When appropriate, the participant was asked to verify or refute content, which was raised by previous participants. The interview was considered complete when the participant had nothing more to add and the researcher felt she had no more avenues of information to pursue. Each in-depth interview session lasted for approximately 120-150 minutes.

After each interview session, the researcher made field notes. The concept of “saturation” means that the repetition of discovered data and confirmation of previously collected data is emerged (Morse 1994). After twenty four in-depth interviews the researcher was able to recognize repletion and determine that additional information confirmed the previous findings rather than added new information thus data saturation was achieved.

Data analysis process was carried by adopting “content analysis” recommended by Polit and Beck (2004 pp. 572-578).

Transcribing: As each interview was completed, it was transcribed verbatim in both Thai and “Isaan” dialects by the researcher, who speaks both dialects fluently. Checking the accuracy of all transcriptions was carried out by the researcher.

Developing a categorization scheme: The preliminary data analysis was performed by using Thai transcripts and with the help of a Thai supervisor, who is experienced in the area of qualitative research. To allow for the possibility of collecting new data to fill in the gaps, data analysis was done after completion of the first interview.

Questions were raised and discussed with a Thai supervisor regarding unclear or missing data therefore the researcher could explore such information as early as possible with the next participants. The entire set of transcriptions was read carefully to capture a sense of the whole. The underlying concepts were identified and clustered to form a category scheme.

Coding the data: After a categorization scheme was developed the data was reviewed and coded for exemplification into identified categories. The researcher wrote relevant codes in the margins of each segment or paragraph of data (Appendix V). Each significant statement and paragraph from the interviews was cut and placed into files according to category area.

Data analysis: This task began with a search for themes. To accomplish this task the researcher searched for relationships in identified categories and then synthesised these into themes. The nature and pattern of women's self-care were identified and validated to the themes using an iterative approach. Weaving the thematic pieces together into an integrated whole and formulating an exhaustive description to explain women's self-care was the final step. To avoid threat to the data, the literature review and the personal bias of the researcher were fenced off during these analyses as much as possible.

Trustworthiness: According to Guba (1981) the rigour in qualitative research relies on and is manifested through the researcher's attention to and confirmation of discourses information. "The goal of rigour in qualitative research is to accurately represent the experience of the participant being studied" (Streubert Speziale and

Carpenter 2003 p.38). Operational techniques which contribute to the rigour in qualitative research include: credibility; dependability; confirmability; and transferability (Guba, 1981; Guba and Lincoln, 1994). These techniques were applied in the process of data collection and analysis to obtain trustworthiness of this study as describe below.

Credibility includes “the activities which strengthen the probability that credible findings will be created” (Lincoln and Guba, 1985 cited in Streubert Speziale and Carpenter 2003 p.38). Through the process of data collection mentioned above credibility and dependability of the finding were ensured.

Coding scheme and theme categories were drafted by the researcher. Although “member check” was not carried out in this stage of the study, the researcher adopted Van Kaam’s method (1966) for validation of results that inter-subjective agreement can be obtained from expert judges. This preliminary draft including all interview transcripts was brought to discuss with one Thai supervisor, who had extensive experience in qualitative research. Similar categories were amalgamated and some categories were discarded if they were not substantiated without further study. To make the emerged themes and holistic view as rigorous as possible, pertaining to women’s self-care, the revised draft was brought for further scrutiny by a second Thai supervisor. Agreement among the three led to articulation of the final draft and was used in reporting the findings.

Through relationship building the respondents could talk freely about their life experience. The researcher performed “data triangulation” as much as possible, to

ensure that the findings in this study have credibility. The dependability was ensured as it has criteria, which were met through obtaining credibility of the research results (Guba 1981 cited in Streubert Speziale and Carpenter 1995 p.38).

Confirmability is a “process criterion” (Streubert Speziale and Carpenter 2003 p. 38).

The objective of this process “is to leave an ‘audit trail’, which is a recording of activities over time that other individuals can follow” (Streubert Speziale and Carpenter 2003 p. 38). Recognition of this importance, the researcher provides a rich description of research methods and processes for data collecting, analysis and interpretation. The examples of how to formulate meaning from data including generating substantive themes in this study was also given.

Since the researcher realized that her feminist ideology and literature review may result in a biased conclusion of the findings, the data collection procedures were followed strictly. The literature review and the analytical framework that formed the basis of this study were bracketed and kept alongside during data collection and analysis (Powers and Knapp 1995 p. 15; Streubert Speziale and Carpenter 2003 p.22, 23). The personal bias of the researcher was also verified and excluded both by herself and Thai supervisor during discussion sessions. Therefore, the conclusions of the findings are truly derived from the respondents and are not from the researcher” (Guba and Lincoln 1981 cited in Miles and Huberman 1994).

Transferability refers to “the probability that the study findings have meaning to others in similar situations” (Streubert Speziale and Carpenter 2003 P. 39). The findings from this study is context oriented therefore, they may have some limitation.

Applying these findings to other women should be considered carefully. Rich descriptions of the limitation and implications with other similar characteristic groups of women are provided in chapter 9.

Combining of findings from stage one and stage two of this exploratory phase was carried out. The substantive themes emerging from the data answers the initial research objectives and revealed that women's self-care was composed of two major types. These were: 1) *general self-care* and 2) *specific self-care*. However, most of women in this phase of the study had *inadequate self-care*. As a result there was a need to move into the next phase.

SECTION 3: THE EXPLANATION PHASE

Promoting women's self-care to prevent HIV/AIDS was the goal of this study. Through theoretical sampling, HIV sero-negative women were the focus of this phase. Combined methods of quantitative and qualitative research were employed for data collection in this phase.

STAGE 1: QUANTITATIVE APPROACH

Objective: This stage aimed to obtain empirical data that can elicit a concrete picture of HIV/AIDS vulnerability among women who participated in this phase of study. This concept was obtained by utilizing the HIV/AIDS risk assessment tool, which the researcher developed herself (Appendix VI). Construction of this tool was guided by information from three sources. These included: 1) the findings from the first

phase, 2 reviewing pertinent literature, and 3) interviewing three HIV sero-positive women and six HIV sero-negative women from three research settings. Valid construction was obtained from three HIV/AIDS nurse counsellors, one from each of the research settings. The final draft of the HIV/AIDS risk assessment tool included 20 items with three levels of answers.

Recruitment and data collection process: The protocol employed in the first phase was applied again in this phase. There were 144 HIV sero-negative women were asked to complete the HIV/AIDS risk assessment tool including answering an open-ended question about their self assessment of their HIV/AIDS risk. Data triangulation was carried out by using this tool with 10 HIV sero-negative husbands of women participating in this stage of the study.

Data analysis: Statistical analysis relating to frequency of occurrence and percentage occurrence were carried out. Congruence between the level of risk assessed by the HIV/AIDS risk assessment tool and the level of risk self-assessment by women were quantified. Congruence between level of HIV/AIDS risk from self-identification by women and their husbands were also carried among ten couples.

STAGE 2: QUALITATIVE RESEARCH

Objectives: This stage aimed to generate substantive themes of women's self-care to prevent HIV/AIDS for themselves and their next child. This substantive theme will then be used as a guideline for the intervention phase. This stage was also carried out to acclimatize women to the investigative procedures of the intervention phase.

Recruitment process: Qualitative research uses the purposive sampling method rather than the probability sampling method. Selection of typical individuals relating to the phenomenon under study is crucial (Burns and Grove 2003 p.374). In this phase of the study, women who were vulnerable to HIV/AIDS, as assessed by HIV risk assessment (whatever level of risk) and agreeing to participate in the intervention phase were invited to be respondents (Appendix VII). The researcher also used the “snowballing” technique to attain diverse perspectives from women who were different from others respondents. Applying this technique the researcher asked respondents to suggest women or other individuals known to them, who could provide information useful to the study (Burns and Grove 2003 p. 374).

In-depth interview guide: The broad guidelines were designed to embrace various aspects in the interview. The broad questions set the stage for in-depth interviews with the recruited respondents and were used to gain insight into the life experiences of women pertaining to self-care to prevent HIV/AIDS for themselves and their next child (Appendix VIII).

The main information needed related to matters that covered all aspects of answers to these questions:

- What are women’s conceptions and understanding of HIV/AIDS?
- How and to what extent do women’s self-evaluation of HIV/AIDS vulnerability and women’s self-care relate to their response to this evaluation?
- What are significant women’s cultural influences which affect women’s self-care to prevent HIV/AIDS for themselves and their next child?

- Are there significant social supports, both within their social network and health care services, which can enhance women's self-care?

Data collection: As mentioned previously, a second interview not only gave the researcher the opportunity to expand, verify, and add descriptions of the phenomenon under study but also helped respondents to clarify and expound inadequate information (Streubert Speziale and Carpenter 2003). In addition, "the more comfortable each participant is, the more likely he or she will be to reveal the information sought" (Streubert Speziale and Carpenter 2003 p.28). In addition where women found it difficult to comprehend the meaning behind some questions I used core vignettes to ask them about what they would do in such a situation. For example:

One day when you take your husband's clothes for washing and you find a condom in his trouser pocket. How do you think you would respond to this situation?

You are so exhausted by looking after your 6 month old baby and you do not enjoy sexual relations with your husband. One day you found out that your husband had asexual affair with one woman. What do you think you would do?

Two sessions of in-depth interview were carried out with 38 HIV sero-negative women and these took place at women's home.

This process has advantages not only for prolonged engagement with the subject matter but also for a "member check" of the coding scheme. Participants'

observations, in their context, were also done as much as possible. The interactions of some respondents, with their social networks, were also noted. Field notes were recorded in each case and verified against each other for individual respondents. Theoretical sampling and constant comparisons were carried out and suggested collecting data from other sources (Table 4.1).

On appointment, the respondents and their children were greeted for 2-3 minutes to relax and acclimatize them before the interview session proper began. After the participants had no more information to volunteer, the investigator began to put questions to help gather any other information that may be pertinent to help to understand the nature and pattern of women's self-care. The issues under discussion were flexible in order to keep a gentle pace and a natural atmosphere during the conversation. Each interview session took around 2-3 hours. After finishing each in-depth interview session the researcher repeatedly listened to and reviewed the tape recording. This reiteration searched for any questions or issues that should be repeated or added to the next meeting. In addition, an interpretation of the findings in each event was attempted and noted down.

Arguments by some scholars that "member check" by respondents may be inappropriate because respondents may have a tendency to compliance with researchers, even with themes which they have not recognized as their own story (Polit and Beck 2004). The researcher employed an alternative technique by posing opposite questions to validate the emergent themes with respondents during the second round of in-depth interviews. Two sessions of in-depth interviews were taken with thirty eight mothers who were selected from three hospitals.

Data Management: The research assistant, who speaks fluently both Thai and Isaan dialects, transcribed all of the tape recordings verbatim. The verbatim transcriptions in both of these dialects were carried out without translation. All verbatim transcriptions were then rechecked for accuracy and completeness with the original tape recording made by the researcher.

Data analysis process: Procedures which were used in the qualitative research of the first phase were applied for data analysis in this stage of study (See section 1 and appendix V, IX and X). The cognitive process as described by Morse and Field (1995) was also used to guide analysis of the data of this stage. Four steps of the analytical process include: comprehension, synthesis, theorizing, and re-contextualizing.

Substantive themes generated from the explanation phase were constants compared with concepts that emerged from the first phase and concepts from literature. At this point the vision of the nature and pattern of women's self-care was refined and consisted of broader abstracted conceptual themes. New substantive themes to explain women's self-care to prevent HIV/AIDS for themselves and their next child were generated. Women's self-care was captured by the metaphor as "*Unbalanced sea-saw of risk between HIV/AIDS and social mores*". Thus, promoting women's self-care is to empower women to balance this sea-saw. The researcher then applied these new substantive themes to the intervention phase.

SECTION 4: THE INTERVENTION PHASE

The substantive themes generated from the exploratory and explanation phases captured the picture that women were not empowered to reduce risks by performing self-care effectively. Considering the preconditions and attributes for women's self-care it was found that *women's cultures, health belief, self-esteem and cognition proficiency* play important roles. These conditions prohibit women from exerting fully their potential strength and capability pertaining to prevention of HIV/AIDS for themselves and their next child. In addition, the findings also suggest that women did not have adequate *social support* to assist them in performing effective self-care. The *existing health service and preventive measures* do not conform to the women's culture and their needs. *Social-care* in the women's social network also did not provide adequate supports. As a result women could not apply technological know-how to their practices.

The researcher believes that women's participation to identify socio-culturally sensitive preventive measures in order to prevent HIV/AIDS for themselves and their next child is an option. From the researcher's experience she has recognized the gap in understanding between health-care professionals and clients. I do agree that "valuing others' expertise, particularly in situations characterized by cultural and linguistic diversity, requires researchers to acknowledge the limitations of their own perspectives and to be open to diverse points of view" (Turnbull, Friesen and Ramirez 1998 p. 184).

Reviewing literature, participatory action research was identified as an approach, which promoted all involved persons to participate in problem solving. The researcher also believed that any effective services need to have the input concurring with constructive opinion from involving clients in developing the service system. In addition, the ultimate goal of this study is to place a greater value on research that directly improves nursing practice, rather than on theory development only. Therefore, the researcher decided to adopt participatory action research as the approach for the intervention phase.

PARTICIPATORY ACTION RESEARCH

In order to apply this approach effectively, the researcher reviewed literature to understand the essence of definition, history, philosophy and methodology for conducting participatory action research.

Definition: Participatory action research (PAR) has been defined in many ways. According to McTaggart's definition (1991) cited by Turnbull, Friesen, and Ramirez (1998 P.178) "participatory action research is one means of addressing the gap between researchers and the intended beneficiaries of research". PAR is defined by Kemmis and McTaggart (1988 p.5) as "collective, self-reflective enquiry undertaken by participants in a social situation in order to improve the rationality and justice of their own social...practices". The ultimate goal of participatory action research is taking action to solve the problems of its participants or group (Whitney-Thomas 1997).

PAR is closely related to social constructionist approaches because they view knowledge as socially constructed by both researcher and researched. They also believe that there are pluralistic realities which are socio-culturally specific in nature (Guba & Lincoln 1994). The strong emancipatory aspect of PAR is also linked to critical and feminist theory in terms of viewing that knowledge is socially constructed by and it is mediated through the perspectives of dominant groups in society (Polit and Beck 2004; Williams and Cervin 2004).

I do agree with Turnbull, Friesen and Ramirez (1998) saying that there is “no cookbook” approach for PAR implementation. The important factors therefore, are researcher comfort and experience. In addition, if the research design is developed from the previous study with the participants being studied, engaging in decision-making at the stage of identifying the relevant problems in practice and determining creative ways for solving these problems may be sufficient and adequately prioritised. In this study the researcher initiated the PAR project, based on two phase of the previous research findings.

PAR process: Kemmis and McTaggart (1988) constructed the process of action research as a series of “action research spirals”. These research cycles indicate planning, acting, observing, reflecting and revising of the plan (Figure 4.2). This useful tool is widely used thereafter in several types of action research, including participatory action research. The research spirals are interdependent and follow each other.

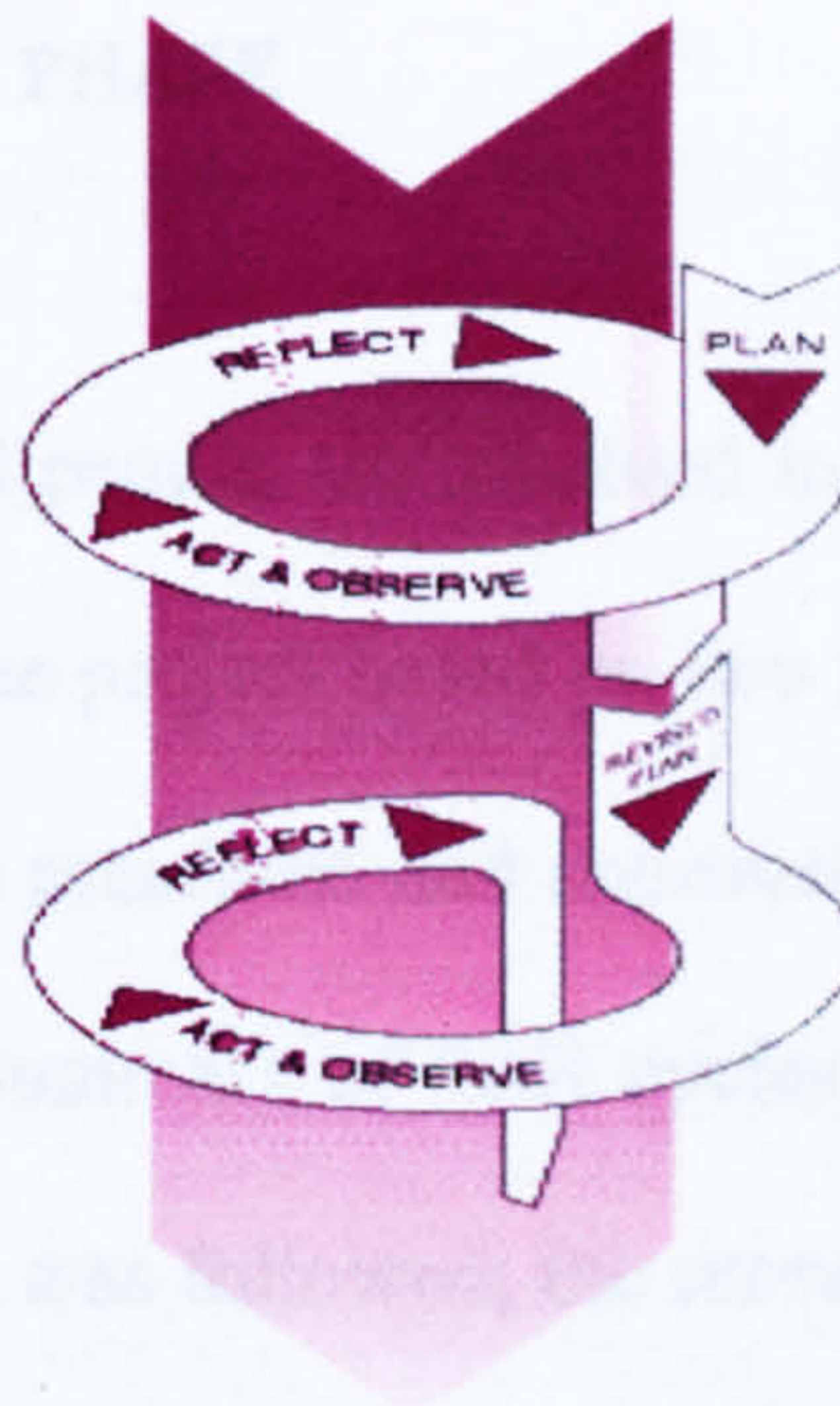


Figure 4.2 Action research spiral (Source: Kemmis and McTaggart 1988 p.11)

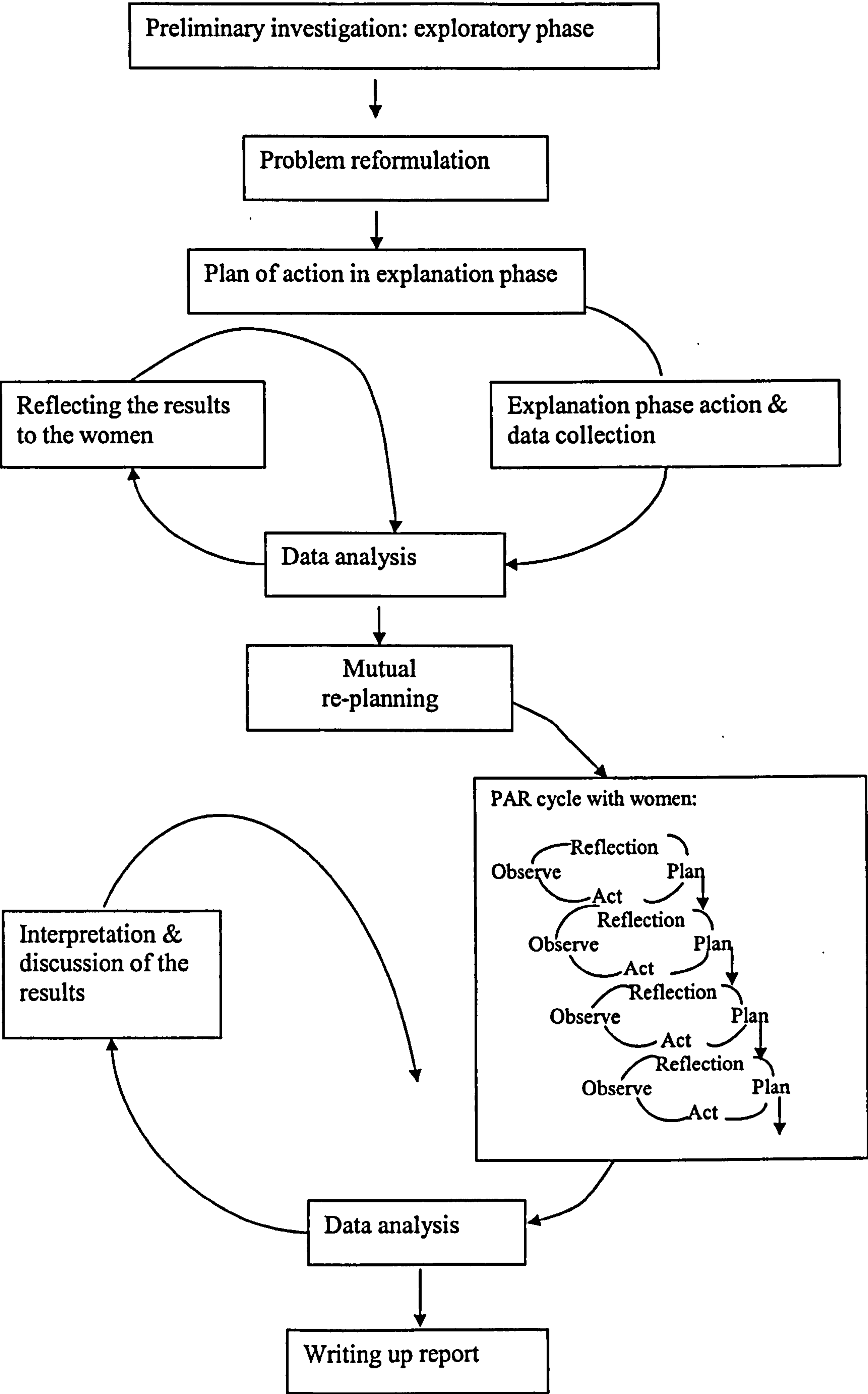
Women are generally the primary consumers and providers of health care however, engaging in defining health care goals and priorities for themselves has been limited in many developing countries including Thailand. The international declaration of primary health care signed in Alma Ata since 1978 emphasised the promotion of the rights of individual and community to participate in planning and implementing their health care (Koch, Selim and Kralik 2002).

The idea as mentioned above coupled with the philosophy and principles of PAR which emphasised greater participation of the group under study with regard to knowledge construction and utilization aimed to improve their health and lives. Participatory action research was therefore the approach selected and feminist theory underpins this study, which aimed to empower women's self-care to prevent HIV/AIDS for themselves and their next child.

DESIGN OF INTERVENTION PHASE

Ideally, in PAR, the concerned people are involved in all steps of the study. In this study the researcher initiated the project based on two phases of her previous studies. However, this initial draft was presented and approved by all group members in the study in the first PAR cycle (Summary of PAR cycles protocol). In order to ensure that rigorous scientific method was followed; the researcher developed a protocol for implementing PAR with women. Street's (1995) participatory action research process described following a corkscrew shape to give more detail and illuminate the open-ended yet ongoing nature of the structure of a PAR project where the evaluation stage leads to a reformulation of the action plan. Because of the salient characteristics of the model, the researcher adopted Street's PAR process to show the overall plan of this study. This meant that all phases of this study could be captured. Kurt Lewin's action research spiral (1946) is the best fit for the PAR process in the intervention phase and therefore; it will be used in this phase. The research designs of this study are displayed in figure 4. 3.

Figure 4.3 The participatory action research process design



The protocol of intervention was developed in sequential steps to make concepts and activities clear to all involved participants in this study. The protocol comprised 5 cycles where various objectives and activities are described in each cycle. The drafted protocol for PAR implementation was reviewed, adjusted to be approved by the major advisor and by the Thai advisor to be the final protocol.

PAR cycle protocol

Recruitment process: Women who had two sessions of in-depth interviews in the explanation phase and agreed to attend the 5 cycles of PAR were invited to be participants in this phase. Based on agreement among participants during interview sessions, PAR cycles would be conducted at the hospital where each group of women utilised the services. Based on the researcher's experiences in conducting focus group with lay people, 5-10 participants is the number most effective for a group process. This group size is congruent with several researchers such as Morse and Field (1995) and Burns and Grove (2003). There were 29 women contained in six groups, ranging from 4-5 in each group, who participated in this phase of study.

Management of facilities: The comfort and convenience of the rooms was arranged at each hospital. Audio-visual aids and kits necessary to encourage full participation and reflection among group members and facilitate data analysis were included in the design of the rooms. Snacks and soft drinks were provided for participants during all PAR cycles.

Roles and responsibility of participants: The role of the researcher, HIV/AIDS nurse counsellor and women participating in this study were broadly defined by the researcher. This initial draft was brought into the discussion and approved by all group members in the first PAR cycle.

Roles and responsibility of the researcher described by O' Brien (1998) include planner leader, catalyser facilitator, teacher designer, listener observer, and synthesizer reporter. However, in many action researches the role as facilitator is the most salient. In this study the researcher identified her role as a facilitator to encourage dialogue and foster reflective analysis among the participants. Providing participants with periodic reports and writing a final report, at the research end, was another crucial responsibility. The role of the researcher as a facilitator is very socially and politically important.

The researcher role in this study is congruent with Soltis-Jarrett's (1997 p.3) identified philosophy grounded steps to consider for carried out in group meetings in the PAR process cycle. These include:

- “Creating a transformative milieu in the group to provide a structure, authority, and rigour;
- Promoting reality to open the discourses in the group, in nursing, and in society;
- Promoting resistance and accepting rejection because all action (behaviour) has meaning;
- Reclaiming reality to maximize reciprocity, theory building, and validity”

(p. 3)

HIV/AIDS nurse counsellors' roles were health educators and information providers, group participants, and research assistants. Because HIV/AIDS nurse counsellors had provided counselling for HIV infected person and AIDS affected persons at each hospital they could therefore give more detailed information relating to the HIV/AIDS services of their own hospitals. These included preventive measures or any type of community outreach services, related to HIV/AIDS prevention and control, existing in each hospital, such as distribution of free condoms, voluntary counselling and testing for HIV (VCT), etc. By using models and pictures they also explained and demonstrated how to use male and female condoms correctly. These included methods for women to help their husband to use a male condom.

Because of their gender, the HIV/AIDS nurses also took roles as group participants. Therefore, they shared their life experiences, both in terms of personal experience and professional experience, related to the issues being discussed in the group.

Taking roles as research assistants, the HIV/AIDS nurse counsellors helped the researcher in terms of defining the conclusions of each session of the focus groups. They helped the researcher to reflect the consensus derived from each session of the PAR cycle. This was valuable in obtaining confirmation of the data gathered from groups.

Women took roles as knower and as research participants in the present study. However, in order to get as much involvement of the women as possible, the objectives of the overall PAR programme and that of each cycle of the focus group were reviewed and agreed by all participants in the first PAR cycle. Women

participated both in the empowering stage and initiation stage of programme initiation. Therefore, they were participants from the outset, made a situational analysis of their own circumstances, shared with each other to identify the problems related to self-care, determined self-care action and tried this out with their husbands, then evaluated the result for modifying to a more effective self-care action appropriately to each of the participants. Another role of women was to collaborate with other group members to initiate the HIV/AIDS prevention programme for women and infants.

Basic rules for focus group participants based on Berg's (1998 p.115) suggestion was brought into the discussion and approved by each groups in the first PAR cycle. These included: "1) only one person should talk at a time, 2) no sub-group discussion, 3) allow others to speak, 4) respect others' rights to express views that are not your own, and 5) keep other group members' information confidentially"

Data generation and collection

Qualitative data were collected through focus groups; each session lasting for 3 hours. Various methods were used to facilitate participants in finding creative ways to explore their lives, tell their stories, and recognize their own strengths (Park 1993; Polit and Beck 2004). In this study methods employed were dialogue, game playing, storytelling, vignettes, medical models and kits, video, pictures, and flip charts. Understanding women's lives through the metaphors was used as well. Issues raised in one group were often taken for inclusion in another group discussion to further data generation and collection. Discussion of sexual imbalance and the demonstration of condom use were carried out in the subsequent groups because they

were shown and requested in the first group. The focus group discussions were audio recorded and transcribed verbatim.

Reflection is an important part of action because it assists in gaining insights into change and its impact on those who are part of it. In this study the researcher applied questions recommended by Street (1995 p.113) to facilitate the reflection process. For instance: “What happened when you put your plan into action?”, “What problems did you encounter and how did you solve them?”, and “What have you learnt as a result of this participation?”

“Member checking occurs *in situ*” was a technique for enhancing data quality and analytical rigour by Polit and Beck (2004 p. 589). In this study before the end of each focus group session a summary of major themes or view points was presented by flip chart to participants for their feedback. This step aimed to validate the interactive and critical knowledge produced through this process, and was also used to formulate the plan for action in the next PAR cycle as well. Field notes were carried out by the researcher after each step of the PAR cycle. The detail of each activity including place, environment, atmosphere, sequence of events, persons who were involved in each event, concepts or important information that popped-up in the study were written down.

The details of plan, act & observation, reflection and revised plan are summarised in Table 4. 2).

Table 4.2 Summary of data collection in PAR implementation

Plan	Act & observe	Reflection	Revised plan
Cycle 1: -Building relationship -Refining substantive themes of self-care	-Introduction of oneself -Ice-breaking by a game -Introduction to PAR - Presentation of findings from previous phase	-Reflection on substantive themes of women's self-care generated from previous phases	-Mutual collaboration on defining PAR process: goals, roles rules, and activities for the group process
Cycle 2: Consciousness raising about HIV/AIDS risk	-Comparing the facts about HIV/AIDS from stories in video and substantive themes of women's self-care	-Critical thinking on HIV/AIDS problem and methods for solving problems in general	-Identify the needs and methods for re-defining self HIV/AIDS risk
Cycle 3: -Self-reflection -Re-defining self HIV/AIDS risk	-Comparing one's own situation with the stories from video and the HIV risk assessment tool - Determining and bringing into practice self care in relation to relevant problems	- Reflection from peers for accurate risk assessment and self care -Reflection on roles of oneself in HIV/AIDS prevention	-Mutual determination of the need for improving self-care to prevent HIV/AIDS and methods to achieve this task
Cycle 4: Self-care in action and evaluation	-Reporting self-care practice and results -Analyze the obstacle and suggest alternative measures of self care for each other	-Reflection from peer group on practicing self care -Discussion on self with regard to interaction with others	-Mutually determining the need for social support for the prevention of HIV/AIDS
Cycle 5: Possible ideas for the HIV prevention programme	- Analysis of national plan for HIV/AIDS prevention as an impact on oneself - Mutual initiation of HIV prevention programme	Reflection of pros & cons of the programme related to cost effective means	Implications for future services for HIV/AIDS prevention

Data analysis

As data were collected it was also analysed. In order to assure cross validation of information, three sources of data were used for data analysis. These included verbatim transcriptions of focus group discussions, post session reflections, and field notes. Data management employed in the previous two phases was also applied to this phase. Units of analysis were both at the group and the individual level.

Reflexive and dialectical critiques suggested by Jenks (1999) were used as methods for data analysis. Reflexive critique is based on an ideology that all statements made during data generation are subject to reflexivity. As a result the language individuals use to describe an experience reflects not only the particular experience but also all other experience in each individual's life. Knowing that observations and interpretations are reflexive creates two important assumptions for action researchers. These are: "1) a rejection of the idea of a single or ultimate explanation for an event, and 2) the belief that offering various explanations for an experience explicitly increase understanding of the experiences" (p. 260). Dialectical critiques were used to "probe data to make explicit of their internal contradictions rather than complementary explanations" (p.261).

Grounded theory suggested by Glaser and Strauss (1967) was also employed for theory generation. A procedure referred to as constant comparison was used. Three levels of coding; open, selective, and theoretical were employed. Nine criteria for identifying core categories and 18 families of theoretical codes and memos were applied for substantive theory generation.

Based on a personal intention to get maximum involvement of participants coupled with a recognition that “interpretations and explanations can not be offered unless the context is fully understood” (Streubert Speziale and Carpenter 2003 p. 263). I also believed that only participants in the study will be individuals, who can most accurately reflect the context. In addition, the PAR analytical process is a joint activity and should include all stakeholders. The entire research team can bring its perspectives to the discussion. This process facilitated the opportunity for dialogue and debate about the findings and their respective meaning.

In this study the analytical process began with post session reflection. By examining a summary of the concepts and issues emerging from group discussions presented through flipcharts, participants were encouraged to reflect critically. Participants brought their value system and norm into more focus. Their explanation and interpretations led to greater insights into their lives and experiences in relation to self-care. Through dialectical critique of the data the women’s assumptions and contradictions were explicated and it enhanced their understanding of their own situation. Core categories emerged from each verbatim transcription, analysed by the researcher, which were consistent when compared with concepts generated from field notes and those that emerged from post session reflection. The coding schemes from these sources were present at the beginning of subsequent PAR cycles. Participants ascribed meaning to what they had said; including a plan of action defined previously, further discussion and action in this cycle. Through this process data collection and analysis were ongoing activities. Congruence between what was said and what was recorded was ensured and created validity. This process of analysis was applied to all PAR cycles and to all groups in this study. “Concurrent

data analysis enabled participants to identify their problems and helped in planning and revising strategies for action” (Choudhry et al. 2002 p. 6).

Constant comparison in this study involved the process that categories elicited from each focus group or each participant (when an individual level was required) were constantly compared with other sets of data analysed previously. Through this technique “the commonalities and variations could be determined” (Polit and Beck 2004 p.255). The process continued until the categories were compared with all sets of data and all data derived from other sources. Through selective sampling, saturation of categories was obtained. After substantive codes were accomplished, the researcher began theoretical coding to modify and integrate concepts into substantive theory. Constant comparisons were also carried out with pre-existing research and literatures. Some concepts were redefined and an emerged fit was obtained. A broader abstraction of the substantive theory to explain women’s self-care was achieved. Although pre-existing values and belief were protected as much as possible the researcher is mindful that through these processes, that her perspective may in part influence the substantive theory generated in this study.

QUALITY CONTROL PROCEDURES AND TRANSLATION PROCESSES

This brief section provides an overview of the quality control processes adopted throughout the collection and interpretation of evidence.

- The open-ended questionnaire was used before the constructed questionnaire for data collection in quantitative research stage.

- A common standardised topic guide for in-depth interviews was used for data collection with all respondents involving in the particular phase of the research. This procedure was carried out to ensure that all questions were asked with all respondents. However, new concepts which were raised during interviews were brought into discussion with the next respondent. Furthermore care was taken to avoid using leading questions throughout data collection process.
- All interviews were transcribed verbatim by keeping both “Isaan” and Thai dialects. All sets of transcribed verbatim interviews were verified thoroughly with audiotape records and the notes made by the researcher. Thai transcriptions were utilised for data analysis and interpretation to ensure that all meanings from data were kept accurate.
- In order to reduce my own influence on the data my personal experiences, knowledge gained from the literature review and analytical framework were bracketed during data collection and analysis. This was a very difficult process which involved self-reflection and constant comparison between my own values and beliefs and the concepts that emerged from the data. This was carried out during all steps of data analysis.
- Member check by my respondents during the second round of in-depth interviews, and reflections of all participants in summarising the concepts that emerged during our focus group discussions also took place. Critical reflections from my Thai were used to help exclude the researcher’s point of view during interpretation.
- The first draft of the report was written-up in the Thai language under the supervision of a Thai supervisor. The Thai version was then translated into

English by the researcher and was edited by a Thai supervisor who is excellent in English. Using Thai concepts kept the translation from Thai to English in a vernacular and enabled us to use idiom. The revised draft of the thesis was developed in the U.K. with the close supervision of my British supervisor. Through reflection and discussion with my British supervisor the procedures to eliminate the researcher's personal bias was applied again in the U.K. Care was taken to avoid losing meaning in the translation processes. So when no suitable English concept could be identified I chose to use the Thai saying to preserve meaning. The English draft was edited into a final draft by a native English speaker in U.K. Through these processes, quality control for data collection and interpretation were obtained and the substantive theory which has emerged from the data explains women's life experience pertaining to self-care for HIV/AIDS prevention among women and children in Northeast Thailand.

- Quotations from participants which have been cited in the chapters 5,6,and 7 have been chosen because they provide the best examples of the concept or phenomenon.

SUMMARY

This chapter presents the conceptual framework of the study which is based on feminist theory, and participatory action research. The present study was divided into three phases; the exploration phase, the explanation phase, and the intervention phase. Combined methods were utilized appropriately according to research question in each phase. Research procedures were designed with concern for the protection of human rights. The data collection and analysis process were guided

and carried out with recommendations from leading scholars who are experts in each research approach. The study was carried out in three periods. The research proposal was developed in The United Kingdom. The field work and writing up of the first draft of thesis were conducted in Thailand. The final version of the thesis was written up in the U.K.

CHAPTER 5

WOMEN'S CONCEPT OF HIV/AIDS & WOMEN'S SELF-CARE

This chapter mainly presents the findings from substantive stage of the first phase of this study. However, the data gathered from the first stage (Appendix XI) was used to support the understanding from the more in-depth interviews. The chapter covers four sections as below:

Section 1: Respondent's characteristics

Section 2: Women's concept of HIV/AIDS

Section 3: Self evaluation of HIV/AIDS risk

Section 4: Women's self-care and social support for prevention of HIV/AIDS

SECTION 1: RESPONDENTS' CHARACTERISTICS

As seen in table 5.1 this sample (n=24) represents women in the city centre of Khon Kaen province. Both groups of women had similarities in terms of average age, the majority had graduated from primary school level, and most of them were housewives and wage earners. However, women in the HIV negative group had a higher average level of education (two diploma and three bachelor), and independent financial status than the HIV positive group. Although most women knew they were infected with HIV when they attended ante natal care for their first pregnancy, two of the nine women knew about this during their second pregnancy.

Table 5.1 Characteristics of respondents and their husbands

Hospital		Wife							Husband				
	Case	HIV status	AGE	Education	Occupation	No. of children	Blood test before pregnancy	HIV status	AGE	Education	Occupation	Living together	
I	1	+ve	32	Grade 9	H.W.	2	No	NR.	34	Grade 9	Trader	No	
	2	+ve	20	Grade 9	Trader	1	No	NR.	24	Grade 9	Labour	No	
	3	+ve	34	Diploma	Labour	1	No	+ve	35	Grade 9	Driver	No	
II	4	+ve	26	Grade 4	Farmer	1	No	NR.	29	Grade 6	Farmer	No	
	5	+ve	23	Grade 6	Trader	1	No	NR.	25	Diploma	Engineer	No	
	6	+ve	29	Grade 4	Labour	0	No	+ve	29	Grade 6	Dead	No	
III	7	+ve	26	Grade 9	Trader	2	No	+ve	28	Diploma	Trader	Yes	
	8	+ve	24	Grade 6	Labour	1	No	+ve	33	Diploma	Labour	No	
	9	+ve	26	Grade 4	Labour	1	No	+ve	29	Grade 4	Labour	Yes	
I	10	-ve	24	Diploma	Trader	2	No	NR.	30	Grade 9	Trader	Yes	
	11	-ve	22	Grade 6	H.W.	3	No	NR.	25	Grade 6	Labour	Yes	
	12	-ve	36	Grade 6	H.W.	3	No	-ve	34	Grade 6	Labour	No	
	13	-ve	26	Grade 9	H.W.	1	No	NR.	29	Grade 6	Business	Yes	
	14	-ve	28	Grade 6	H.W.	2	No	NR.	29	Grade 6	Driver	Yes	
	15	-ve	24	Grade 6	H.W.	1	No	NR.	25	Grade 9	Farmer	Yes	
II	16	-ve	25	Grade 6	Trader	2	No	NR.	24	Grade 9	Trader	Yes	
	17	-ve	18	Grade 6	H.W.	1	No	NR.	21	Grade 9	Labour	Yes	
	18	-ve	34	Diploma	Labour	3	No	-ve	36	Grade 4	Labour	Yes	
	19	-ve	27	Grade 6	Labour	2	No	NR.	28	Grade 9	Driver	Yes	
	20	-ve	37	Bachelor	Teacher	2	Yes	-ve	38	Bachelor	Business	Yes	
	21	-ve	24	Bachelor	Unemployed	1	Yes	-ve	24	Bachelor	Teacher	Yes	
	22	-ve	29	Bachelor.	Teacher	2	Yes	-ve	35	Bachelor.	Teacher	Yes	
	23	-ve	24	Grade 6	H.W.	1	No	-ve	30	Grade 6	Labour	Yes	
	24	-ve	32	Grade 6	H.W.	2	No	NR.	34	Grade 9	Labour	Yes	

Note: N.R.=No report, H.W.= House wife, +ve= HIV sero-positive, -ve= HIV sero-negative

SECTION 2: WOMEN'S CONCEPTS OF HIV/AIDS

Women's concept about HIV/AIDS can be understood through categories of transmission, risk behaviours, risk groups, symptoms, treatment, prevention, and examination methods along with diagnosis.

TRANSMISSION OF HIV/AIDS

Women cited four main means of transmission, i.e., through sexual relations, blood transmission, through body fluid, and through sharing sharp utensils. Vertical transmission from a mother to her foetus was rarely mentioned. The following were some examples of the evidence. (Quotes have been selected on the basis of the best illustration of the concepts).

"It is transmitted through blood, sexual intercourse, and through using the same syringe. Also when we are wounded, if someone's blood (HIV infected person) came into contact, we would also be infected. I'm not sure if swimming in a public swimming pool would be a cause of infection. Kissing should be a cause of transmission because their saliva can enter our body. However, I know we can eat safely with an HIV patient" (1.1 HIV negative).

"If a pregnant woman is infected, then her child will be infected. Or it could be from syringes, such as when we get contraceptive injections from private clinics, they might not be as clean as at hospitals" (2.2 HIV positive).

"My 'fan' used to be a soldier and he said his friends sometime borrowed his razor blade. I don't know whether this may make him get AIDS from them or not?" (1.3 HIV positive).

Researcher reflection: It seemed to me that the last two respondents (2.2 HIV positive and 1.3 HIV positive) tried to convince themselves that their infections was not their husbands' fault.

RISK GROUPS

Women's perception of HIV risk groups is quite similar between the two groups.

Their opinions were addressed below:

"Those working night shifts, masseurs, prostitutes, men visiting brothels or prostitutes, labourers and construction men are risk groups. These construction men could do anything; drinking, going to prostitutes, visiting brothels. Then there are drivers and tricycle riders. These men love visiting brothels." I guess that's all, I mean they are promiscuous" (1.2 HIV positive).

"Women whose boyfriends are drug addicted and share syringes with others. In our neighbourhood we had a case of a truck driver who worked in Bangkok...This man died. His wife got pregnant her child was born with AIDS" (3.3 HIV negative).

Comparing between single and married women, the majority believed that married women were more prone to HIV infection than unmarried women. However, some believed the opposite. Women who believed that married women are more highly susceptible to infection than single women gave the following reasons.

"Those who are not married wouldn't get involved with sex. Unmarried women have their own choice. For married women it's up to their husbands, not to themselves alone" (3.3 HIV positive)

"I think a risk group is housewives. They think they don't sleep with any body only their husbands. They are so confident. They don't really know. So how can they be so sure? That's why I think they are more likely to be infected" (3.2 HIV negative).

Women who believed unmarried women have an equal or greater chance to become infected compared to married women indicated that:

"Girls working in factories think that because of the nature of their jobs they are not a risk group. But some girls sleep with men, trusting that they will not be infected. They don't realise that the men transmit the disease to them. These men use syringes, for they are drug addicts. Surveying in our community, a doctor told me that 20 out of 100 factory workers are HIV infected" (2.3 HIV negative).

“Generally it is the students who go out at night. Teenagers now are sexually indiscriminate. I don’t think they protect themselves. People often solve a problem after it happens, and it is often too late” (2.2 HIV positive).

Two women mentioned homosexuals, which used to be the high-risk group in the past and related that:

“Whenever I see gays I would say they are ‘Tua AIDS’ (symbolize of AIDS). I think they are men, but why should they sleep with men? I always blame them ‘Tua AIDS’ (1.2 HIV positive)

Researcher reflection: Believing that married women had less chance to be infected with HIV might help some women feel comfort. However, this might make them ignore their own risk as well. Women’s concept in relation to routes of transmission and risk group might lead them to believe that HIV/AIDS is only confined to some groups of people who have risk behaviours. Women who practiced monogamy might not think they could be infected through hetero sexual transmission. This concept influenced their perception of HIV/AIDS risk and their self-care, which will be described in section 3.

AIDS’ SYMPTOMS

Most women (14 in the HIV negative group and 8 in the HIV positive group) did not distinguish an HIV infected person from an AIDS victim. They believed all HIV infected people must be AIDS victims. The following are portions of descriptions about AIDS symptoms given by two women.

“I’ve seen pictures on television. They looked thin, having awful blisters along their bodies. Looked dark and have sunken eyes. They also had white patches in their

mouth and on their tongue. Someone said they also had herpes or were sick very often” (2.5 HIV negative).

“He seemed to be sleepy all the time, as if he didn’t want to wake up. Then he had a sore mouth and he couldn’t eat. He felt stiff. He had blisters on his legs and they were itchy. He also excreted frequently. Then he had tuberculosis. We still had not got the result of his final blood test when he died.” (2.3 HIV positive)

DIAGNOSIS

All women know that diagnosis is via blood examination, and that it takes a period of time to know the result. One woman explained:

“When I went for my pregnancy care appointments I had my blood checked for AIDS. It was negative. My husband checked also. His was negative too. ...The Moa (The pronoun which women sometimes use with health professionals) told me to take him to check. If you want to know you must get checked but you don’t know the result immediately. It takes months” (3.2 in HIV negative).

However, the majority (n=21) believed that their negative results of blood test proved their husbands’ sero-status. One woman explained that:

“When I was pregnant I had my blood checked for AIDS and liver virus. But my husband has not done that. ...I think one’s enough, for my blood is negative. We’ve been together for 3 years. If one has it the other must have it too. If he does, then I do too” (2.2 HIV negative).

Women in the HIV positive group knew how to diagnose HIV sero-status of a newborn baby from an HIV positive woman. However, six women could not accept this and would not take the baby to be re-checked. Apart from this, some women (n=17) used their own experience to judge if the other was HIV infected.

“Will my baby be infected, Moa? .When he was born they checked him but haven’t told me the result. The Moa said when he’s one and a half years old he should be checked again to be certain. But I don’t want him to be checked. I’m afraid. My heart is not in it. I guess I’ll ask my husband or someone to take him.No, I think finally

it'll be me, for I don't want the others to know. I haven't told anyone." (1.2 HIV positive)

Researcher reflection: It is noted the important roles of health professional in evidence described above. Firstly by giving advice to women to persuade their husbands to get test for HIV may be more advantageous rather than let women believed that this is not necessary. Evaluation of the husbands' HIV-sero status from women's negative test result may not be enough because it was found that at least two women were infected with HIV during their second pregnancy (Table 5.1). Secondly the reluctance to bring their babies to be rechecked to confirm HIV sero-status indicated that women may not be informed adequately to deal with their situations in relation to become HIV victims. This may lead to improper self-care of themselves and their babies too.

In addition, women seemed to have their own methods for assessing others infections with HIV. One woman reported that:

"I knew the woman on the opposite bed was infected. ...I noticed she didn't breast feed her baby either. ... Myself also, when I came back for the instant milk I believed people knew I was infected"(2.2 HIV positive).

Researcher reflection: Based on evidence described above, it is highly possible that women assessed who were AIDS victims by *considering their general appearance and behaviours*. By not distinguishing between HIV infected persons from AIDS victims might conceal women from doing accurate assessment of HIV infected persons. Although women knew the methods to be used for diagnosis of HIV infection but the awful image of AIDS victims may influence their evaluation of this issue. For instance they would assume that people were AIDS victims if they had

skin lesions, weakness, a thin body, a severe cough and/or severe diarrhoea. They also related herpes simplex and tuberculosis with AIDS victims. This belief might lead to the misunderstanding that if people looked clean and healthy, they were free from HIV/AIDS. These concepts might influence the women's determination of their own risk and their self-care to prevent HIV/AIDS properly, which will be discussed later.

TREATMENT

Based on what the women in this study said, their understanding about the cure of the AIDS disease can be summarized as below:

Women from both groups were well aware that there was still no possible means to cure AIDS patients. The only thing to do was to help lessen the severity of the symptoms as they appear, and to help nourish the patients. Women in the HIV positive group had been searching promising drugs both through modern medicine and through traditional medicine. Some of them did self-treat by herbs, certain vegetables, and relied on vegetarian food. The vegetable that received greatest attention was “mara pa” (wild balsam pear) or “mara noi” (little balsam pear). Leaves of a certain type of gourd, tiny balsam pear and certain mushrooms had also been of interest.

Researcher reflection: Perceiving that AIDS is unable to be cured may influence some people's judgement whether or not to get test for HIV. This may be the obstacle for women to persuade their husbands' to get test as well.

ATTITUDE TOWARDS HIV/AIDS

The terms women used to express their feeling about HIV/AIDS reflected their attitude of this disease. These such as: fatal disease, fear to be infected with, a disease of promiscuous persons, and carrying social stigma.

“This disease can’t be treated, like cancer. I’m afraid it’d happen to me. When a person has blisters and loses weight, he looks disgusting. It’s a disease disliked socially. If it’s virulent, it’s dreadful. But if a person takes good care of his health and is mentally OK then he’s just like a normal person, and looks healthy. It depends” (3.2 HIV negative).

“I don’t want to see those who are AIDS victims. Everybody says it’s a sexually promiscuous disease, a disgusting disease” (1.2 HIV negative).

However, there was one woman in the HIV positive group saying she was quite neutral about the disease and could accept it. The disease did not make her worry.

She said that:

“Someone committed suicide knowing he had it. I believe this disease is nothing to worry about. I just keep it to myself. You must be firm and not think too much about it. You could just think a person was born to die. ..Just think simply. There are many diseases. So that’s how I accept it. ...They said to me I have it. The doctor asked me if I could sleep, eat, and if I were distressed. I told the doctor I wasn’t distressed. I’m just neutral, no worries” (2.1 HIV positive).

Researcher reflection - This woman knew she was infected since she was 15 years old when she had her first pregnancy care. During interview she was 26 years old. Although her blood examination result is positive, she has never had any symptoms. This may help this woman cope with her infection very well. Her coping style may be influenced by the Buddhist religion and this is a good way to accept something that happens which we really cannot change it. However, this coping style was found

in many women who, faced with some difficulty in relation to performing self-care to protect themselves from HIV/AIDS. Believing that they couldn't do anything may lead some women to give up trying to find an alternative way to solve the problem and may lead them into risky HIV/AIDS behaviours and will be detailed in the next section.

PREVENTION

All women from both groups said AIDS prevention was by avoiding all risk behaviours. The most popular method addressed by women was a slogan from the government campaign for fighting AIDS in Thailand. Their understanding about prevention of HIV/AIDS can be summarized into three groups as below:

- **'Mai sam son'** (mean not being sexually promiscuous)
- **'Mai mua khem'** (not sharing syringes with other)
- Avoiding contacting the blood or body fluid of infected persons or AIDS victims especially when you have a wound.

There was a controversial belief related to AIDS prevention of children whose women are infected. Thirteen from fifteen women in the HIV negative group believed that there was no way to prevent this disease. Only two from nine women of the HIV positive group were not certain if there was any preventive means. Two HIV positive women received AZT, from one research project, for prevention of mother to child transmission.

"If a woman is pregnant and is infected, then the baby will be infected. No way has been found yet to prevent transmission from a woman to her baby. As far as I know, you shouldn't breast feed your baby" (3.4 HIV negative).

"I'm afraid I will die soon. I'm also afraid my baby will get it. If only I went to see the Moa at that time, to hear my blood test result when I was pregnant um...but I doubt there is a preventing injection, ... one that will prevent transmission of the virus to the baby, ... is there any, Moa ?" (1.1 HIV positive)

Researcher reflection: Influenced by their understanding about HIV/AIDS as described the women developed their own concept. They believed that AIDS is fatal, incurable, and a social stigma disease. The major routes of transmission were unprotected indiscriminate sexual relations, sharing needles for injections, sharing sharp utensils, and using public toilets or the swimming pool. By such perceptions women believe that this disease is *confined to risk groups only* these such as CSWs, IDUs, homosexuals, promiscuous people, and immigrants.

SOURCES OF KNOWLEDGE

Based on women's description essential sources of knowledge perceived by both groups of women were varied according to their satisfaction.

The most satisfactory type of media that the majority reported was television, because they provided both pictures and sound. Some like to get information from books since they can come back to read them at anytime, or radio if they are not able to watch television. Some women liked to listen to health education about AIDS from health professionals. Some have obtained information from being trained and seeing exhibitions on AIDS. Some women in the HIV negative group reported that information from posters on buses and placards were useful and made them afraid of

catching the AIDS virus. However, similar posters and placards standing at intersections and along the streets, on the contrary, had negative impact on the feelings of some HIV infected women.

Researcher reflection: These suggest that a variety of sources of HIV/AIDS information of relevance to women is necessary. Preparation of HIV positive women to cope with their situation may be also needed.

HOW DO WOMEN GET HIV/AIDS

Based on women's perception HIV infection among ordinary women can be described in two ways: 1) who transmit HIV to women and 2) how those people get HIV. According to their perception almost all of women from both groups agreed that women in general were infected because of their boyfriends or husbands who were infected with HIV from CSWs. One said:

"Decent women do not get themselves involved with many men. If they were faithful to their husbands they wouldn't be infected. Good women can be infected only from their husbands if they enjoy going to nightclubs and bars. When they sleep with their wives, their wives become infected. I don't think they get it from taking drugs, it must be from their husbands" (3.4 HIV negative).

However, one woman from the HIV negative group related from her experience that women, especially teenagers may become infected from taking drugs.

"If they are not married, perhaps they get it from taking drugs. Back home I see teenagers hanging around in groups and taking a lot of amphetamines. Young kids when they become high would go on doing just anything, like sleeping together or injecting drugs" (3.3 HIV negative).

Women from the HIV positive group related what really happened to them. They mainly contracted the virus from their husbands although there were two women who were not quite certain from where and from whom they became infected. The following were examples from their stories.

"I guess I got it from my husband because he used to go out to drink and to prostitutes. When I knew I was infected I tried to think where I got it from. Then I was sure that it must be from my 'fan,' for I only slept with him. He must have brought it to me" (1.2 HIV positive).

One woman was not sure where she contracted the virus. She said:

"I don't know where I got it. My father and mother had it (AIDS). They both died. I don't blame them. I didn't ask them. I took care of them so I might have got it from them because sometimes I had a wound and it was bleeding. But my husband goes to prostitutes. He might have transmitted it to me. He could have transmitted it to me or I could have transmitted it to him. ...This I didn't ask" (1.1 HIV positive).

In respect to how husbands get HIV and transmit it to their wives and according to their perceptions, the majority of women of both groups believed that most men contracted the HIV infection before marriage rather than after marriage. Below was explanation from one woman from the HIV sero negative group.

"I think they might be infected before marriage. Single men tend to go to prostitutes, but married men might not go often. Mostly they have sex with their wives so getting AIDS after marriage may not be common" (1.4 HIV negative)

This belief was confirmed by explanations by women from the HIV positive group based on their direct experiences. One of them said:

"When he was young, my husband loved visiting prostitutes. People back home said he used to have wives, not real wives but he stayed with one girl and another. After we got married I went down to live with him. I don't see him going out. He is

punctual. After work he buys food and arrives home on time. I don't think he visits prostitutes. I think he got it before marriage" (1.3 HIV positive).

However, two women had certain clues that their husbands might be infected with HIV after marriage.

"I think he didn't get it then since the first baby was not infected. I went for my pregnancy care they (the health officers) didn't say anything, so I thought we weren't infected. After I thought about it, I don't blame anyone, not my husband either. I should blame myself for not letting him sleep with me before my last pregnancy. Because I had a problem with my womb and I felt very painful when having sex with him" (3.1 HIV positive)

"I got married when I was 19 years old. My elder daughter is 13 years old already. She was born here. I just know I am infected. This is my second child. I think I got it from my husband for he had many partners and liked going to prostitutes. Most men drink and go there. I think he got it because he didn't protect himself" (1.1 HIV positive).

Researcher reflection: Although the evidence from this phase of study suggested that men were infected with HIV before marriage two from nine women had reliable clues that their husbands were infected after marriage.

SECTION 3: SELF EVALUATION OF HIV/AIDS RISK

Women's evaluation of their HIV/AIDS vulnerability can be described in two ways: the perceived level of risk and the criteria for assessing that risk. Women's priorities indicated their practices and lifestyle as following those of their husbands in assessing their risk.

HAVING NO RISK

Nearly all of the women in both groups (N=20/24) evaluated themselves as at no risk. They believed they had no chance of becoming infected with the AIDS virus for the following reasons:

- Never being promiscuous, not enjoying night life, not taking drugs, never sharing syringes, and being careful when using public facilities.
- For their husbands' lifestyles, women reported that they trusted their own husbands because their husbands were; never promiscuous, never went to prostitutes, stayed at home all the time, were afraid of AIDS, never stayed out overnight somewhere else, and regularly check their blood.

Some explanations from women were:

"I've never thought I'd have a chance of being AIDS infected. I've never done that sort of thing (sexual relations) with others. My 'fan' doesn't like going out. I can rely on him. We live together all the time" (1.4 HIV negative).

"My 'fan' said he is AIDS proof. He said he has never been to prostitutes. He's afraid to be infected. I think married women have no chance to be infected if they are not promiscuous" (1.1 HIV negative).

"I don't think I have a chance to be infected except from my husband. But he has his blood checked regularly as his company requests him to do. He also hasn't got venereal diseases" (3.5 HIV negative).

"Before I was infected I'd never thought I would get an AIDS infection. To tell you the truth, I have never gone out with boys. After we got married, my 'fan' has never gone to prostitutes. I think he must have visited prostitutes when he was young. That's how he got it" (1.3 HIV positive).

Although some women from the HIV positive group had some clues (when they thought back), which might indicate their risk, but they did not think they had a chance of being infected with HIV/AIDS at a time.

Other women said:

"My husband is a ladies man I think. Before marriage he might often use prostitutes. After marriage I just believed he didn't go again. I never thought I will be infected with AIDS. How do we know? It may be because I didn't pay attention about his behaviours so why I got it" (3.2 HIV positive).

"Teenagers are thinking only about love and trust. My 'fan' was flirtatious before we live together. But I thought he went out with teenagers, not to prostitutes. When we lived together he never went out. If his friends came to take him he would say, 'No, my wife is home.' I've never thought I would become infected ... because I've never slept with others. I used to have a boyfriend before but I've never had sexual relations with anyone except my husband." (1.2 HIV positive)

SUSPECTING THEIR OWN RISK

Only two women from the HIV negative group revealed that they were not sure about their risk. Apart from their own revealed lifestyle, as described above, women who thought they had a chance to be infected, though not very high risk, pointed to their husband's lifestyle as a risk factor. One of them expressed her worry that:

"My husband is not flirtatious. He's never stayed overnight elsewhere. Sometimes he goes out to drink with his friends. I am afraid he would become infected. If he drinks and then goes to a place with his friends, what should I do? When I ask him he says he hasn't been there. But if he does, how can I know. I try to observe but it's hard to tell. My 'fan' says he doesn't have that much money to go to prostitutes. ...I don't believe him. I think I can rely on him about 70%." (3.4 HIV negative)

"I cannot guarantee it by myself for we don't live together. My husband goes to work abroad. He said he used to go to prostitutes in the past. I am afraid now that he will go to a girl (here meaning prostitutes). If he's home he won't go. When he's away I don't trust him for he flirts with girls. When he calls he tells me not to worry about girls. He says he wouldn't spend money on this" (1.3 HIV negative).

Researcher reflection: The evidence suggested that most of women were likely to be confident that because they were not promiscuous therefore, they had no chance to be infected. They also always used concrete evidence such as seeing or not seeing husband visiting CWSs as major criteria for assessing their HIV/AIDS risk. As one woman said it is hard to know.

SECTION 4: WOMEN'S SELF-CARE AND SOCIAL SUPPORT FOR PREVENTION OF HIV/AIDS

Apart from three women in the HIV negative group who convinced their husbands to get a test for HIV, self-care among other women in this study did not differ between the groups. Based on the data, the nature of women's self-care fell into two categories as general self care and specific self-care.

NATURE OF GENERAL SELF-CARE

Objective

Women's self-care in this category was to prevent contracting HIV/AIDS from other people, who had HIV/AIDS outside their family.

"I am not promiscuous and my husband has never gone anywhere. I don't think he would bring AIDS to me. What I do is only to get a shot from the 'Moa' and I am careful not to let other people's blood get into my body" (3.4 HIV negative).

Self-care activities

Women practiced avoiding risk behaviours by adopting general precautions for HIV/AIDS prevention into their practices. One women's explanation was:

"I have never had sex with anybody except my husband. I have never used drugs. Because I am afraid that I would get AIDS from a toilet, when I travel by bus I never use the toilet in the bus. I have visited my friend who is an AIDS patient in hospital. I felt so much pity for her but I could not touch her, just sat beside her. I saw other AIDS patients there. I did not stay close to them" (2.4 HIV negative).

Antecedents

The conditions which occurred before women's self-care in this category were a fear of being infected with HIV/AIDS from others and recognition of AIDS victims in their community. As one woman said:

"Many people died by this disease. AIDS people look awful with skin lesions. I am so scared to be infected with this disease. I have to be careful. When I went to the beauty salon I bring all of my own scissors or razorblade" (3.3 HIV negative).

Attributes

One attribute of women's general self-care was their HIV/AIDS knowledge that was influenced by health education campaigns through various media. One woman explained:

"I listen to the 'Moa' when I had an appointment for pregnancy care at hospital. They always said that you should not share needles for injections, don't be a promiscuous person. I also get this information from T.V. I haven't done that anyway but I am careful not to contact anybody's blood. I know it can get into your body through blood" (2.5 HIV negative).

Consequence

The outcome from practising general self-care is best perceived in the fact that most of the women felt comfortable and confident that they would not get HIV/AIDS from anyone else. One woman related that:

"I think if we do not let other's blood get into our body or use sharp utensils with others we would not get AIDS. Good women who are monogamous are not at risk. I am confident that I have no chance of contracting AIDS. So that's it. Eating or drinking with the same glass can not transmit AIDS. However, I feel comfort not to do this" (1.2 HIV negative).

However, there were some women, who did general self-care and who used to have confidence to remain uninfected with HIV/AIDS, who became HIV/AIDS victims.

One woman told her story:

"I am not a person who enjoys nightlife or is interested in sexual relations. I take good care of my health. I haven't drunk alcohol or used any drugs. I am very careful when going somewhere else and never use toilets in other places. I get shots only from a hospital that I think is clean. I never thought I would be infected with AIDS by my husband" (1.3 HIV positive).

Researcher reflection: The confidence as a consequence of performing general self-care may be real for some women if their husbands have never taken risk. However, it is difficult to know the husband's risk. It seems inadequate for many women as found in this study.

SPECIFIC SELF-CARE PRACTICES

Objectives

Women performed self-care in this category in order to prevent them from getting HIV/AIDS from their husbands and to prevent mother to child HIV/AIDS transmission. In the other words, specific self-care is the prevention of HIV/AIDS through heterosexual transmission and vertical transmission.

Only a minority of women, (n=9) in this phase of the study, deliberately performed specific self-care. There were some key differences in specific self-care between HIV positive (before being infected) and HIV negative women in this study. The antecedent, attributes, activities and consequences will be described. The nature of the specific self-care is also summarised in table 5.2

Antecedent

It was found that according to the women's opinions that, the husband's lifestyle, personal characteristics, husband's sexual risk behaviours, social support, self responsibility, recognition of AIDS victims in the community, were the preconditions for specific self-care of women in this study.

"I thought I should protect myself. People back home got AIDS, and one after another died. I thought these people must have been promiscuous. So I said to my husband if he were like them I wouldn't let him sleep with me, he just laughed. ... Before marriage we didn't check our blood. But when we were free we went together and our blood was normal" (3.1 HIV negative).

Social support as an antecedent which illustrates the health professional's role in women's self-care to prevent HIV can be noted in an explanation from one respondent.

"When I came for my pregnancy appointments I had my blood checked. I have never though to ask my husband to get test. My husband was checked because the 'Moa' told me to take him to be checked. The results were negative" (3.2 HIV negative).

Attributes

The most often found attribute of specific self-care among women in this study was perceived susceptibility to and the severity of AIDS. This was followed by cognition

capability, power relation with the husband, self-responsibility, knowledge, and capability to access health services respectively. Some attributes were illustrated in this interview by one woman, who was also a teacher, she said:

“This disease cannot be cured so we have to protect ourselves and those around us. I have to be strict with my husband. I don’t do it myself, but I have to protect my husband. If he wants to have sex, I won’t reject him. If he’s satisfied he won’t go outside the home for it. If he does, he’ll transmit the virus to me. I won’t let him get drunk outside. He must have sex with me only. If he goes out to drink, it is possible that he could go far beyond that...” (3.3 HIV negative)

Self-care activities

Nine specifics issues associated to the women’s self-care activities.

- 1) Discussion about AIDS with the husband (n=9)
- 2) Preventing their husbands from visiting prostitutes (n=6)
- 3) Persuading their husbands to be tested for HIV after marriage (n=2)
- 4) Convincing her husband to be tested for HIV during pregnancy (n=1)
- 5) Asking the husband to use condoms with CSWs (n=1)
- 6) Asking the husband to be tested after discovering the husband had sexual relations with another girl (n=1)
- 7) Responding to the husband’s sexual desires (n=1)
- 8) Monitoring the husband’s sexual behaviour (n=1)
- 9) Searching their husbands’ sexual background before marrying them (n=1)

Researcher reflection: Only 7 women performed specific self-care and many of self-care activities were performed by the same women, in particular relatively high protection self-care activities.

The following were some excerpts from women's conversations about their specific self-care.

"He left me to live with another woman. When he came back I didn't trust him 100%. So I didn't let him sleep with me. I asked him to check his blood first. When he said he was OK I didn't believe him. He had to show me his medical report" (2.4 HIV negative).

"In the past I didn't know the AIDS disease. I didn't think it would happen to me. When the disease spread a lot in our province, I asked my husband to move away. We saw people with AIDS all around us. ... I was afraid that he would go to prostitutes. So I asked him not to go to those girls but it is too late" (3.3 HIV positive).

Among the HIV positive women, specific self-care was only carried out by one woman as described above. The importance of specific self-care among most of them was found only in relation to preventing mother to child transmission. All of them did not give breast-feeding to their children. Only three of the women in this group sought AZT from one research project for prevention of vertical transmission.

Table 5.2 Summary of specific self-care of both groups of women

Antecedents	Attributes	Activities	Consequences
Concern over her own & child's health -Personal characteristic, higher education (3.1 HIV +ve)	-Perception of threat & susceptibility & severity -Self-responsibility -Cognitive capability -Equal power relation with husband	-Searching husband's background -Responding to husband's sexual desires -Prohibiting husband to go drinking outside home -Persuading husband to be tested for HIV	-Husband being tested for HIV -Free from worrying -Confident of not being infected with HIV
-Recognition of AIDS victims -Social support from elder sister -Concern over her own & child's health - Personal characteristic, higher education (3.2 HIV - ve)	- Perception of threat -Self-responsibility -Cognitive capability -Equal power relation with husband	-Talking about AIDS with husband -Prohibiting husband from going to CSWs - Persuade husband to be tested for HIV	- Husband being tested for HIV - Free from worrying -Confident of not being infected with HIV
-Social support from health professional -Personal characteristic, higher education (3.3 HIV -ve)	- Perception of susceptibility& severity -Cognitive capability -Equal power relation with husband	-Talking about AIDS with husband -Prohibiting husband from going to CSWs -Persuading husband to be tested for HIV during pregnancy -Monitoring husband's sexual behaviours Always accompanying husband going out -Asking friend to monitor husband's sexual behaviours	- Husband being tested for HIV -Free from worrying -Confident of not being infected with HIV
-Discover husband's extramarital sex -Personal strength (2.2 HIV -ve)	-Cognitive capability	-Modifying safer sex practice -Asking husband to be tested and show the result before reconciling to have sex	-Husband being tested for HIV -Free from worrying
-Recognition of AIDS victims in community -Husband's history of STDs -Husband's HIV/AIDS risk behaviours and gets drunk (2.3 HIV +ve)	-Perceiving severity & susceptibility	-Asking husband to move from epidemic area	-Being infected with HIV before moving
-Husband's occupation -Husband's history of HIV/AIDS risk before marriage (1.3 HIV-ve)	Perceiving severity & susceptibility	-Prohibiting husband to go to CSWs -Often making overseas call to husband -Sending her baby's picture to husband	-Releasing from worrying but unsure of the outcome of her action
- Concerning over her own & child's health -Coping style (1.2 HIV-ve)	-Perceiving severity & susceptibility -Perceived HIV/AIDS knowledge -Cognitive capability	-Talking about HIV/AIDS with husband -Asking husband to use a condom if he goes to CSWs	-Releasing from worrying but unsure of the outcome of her action

Researcher reflection: It was found that social support, social care and health care, act as antecedents of specific self-care among two women who perform relatively high protection of HIV/AIDS. However, only 8/15 in the HIV negative and 1/9 in the HIV positive group performed specific self-care. More than half of the women (15/24) in this study identified themselves as invulnerable to contracting HIV/AIDS from their husbands therefore; they did not undertake specific self-care. In order to explore further the researcher used the questions to probe into specific self-care capability among women who did not perform self-care previously.

SPECIFIC SELF-CARE CAPABILITY

Probing into women's capability for undertaking specific self-care was carried out through two questions. The first question aimed to explore women's capability with regard to evaluating their husbands' risk behaviours. In responding to the first questions such as: 'how do you know your husband is not participating in HIV/AIDS risk behaviours?' the women's answers can be summarized as follows:

- 1) Noticing abnormal behavioural clues from their husbands, for instance: having a girl's photograph, and having telephone number of other girls. (n=9).
- 2) Monitoring the husband's out-of-the-ordinary habits such as coming back home late at night, drinking alcohol, and using much more money without proper reason (n=7).
- 3) Observing husband's sexual desires (n=3)

Following the first question the second question was asked to examine further their capability related to their own specific self-care. The second question was: What would you do if you knew your husband was taking HIV/AIDS risks?

Half of women (n=12) stated that they would use safer sex practices. One woman said:

"If my 'fan' went out to prostitutes and came back to sleep with me I would say, 'since you behave like that you have to wear a condom. If you don't I won't let you.' ...I won't mind if he gets cross. ...I would say, 'If you choose it that way and you still want to sleep with me you have to wear condom. You have to protect your wife and baby first. It's not fair if you enjoy yourself but your wife and your baby are the victims.' That's what I would say" (1.2 HIV negative).

The remainder explained their intention to adopt safer sex practices and ask their husbands to get tested for HIV. However, they expressed their reluctance to perform such specific self-care. One woman described:

"If it were me I would ask him if he used a condom when he went to the prostitute. If he didn't wear it I wouldn't let him sleep with me. But this means I know it. If I don't know it then just let it be. But perhaps I wouldn't let him sleep with me still. I would ask him to have his blood checked. For if my baby and I got it, that's so bad. If he doesn't wear condom, oh! I don't know what I'm going to do. It depends on what sort of person he is. But I keep trying. (She showed a very frustrating look.) Or else he should go to the doctor to check first. But do we know the result right away, after he's been to prostitute? I know it's very long until you know the result. Oh! It's risky. ...Wearing condoms is not always safe. They may break and it's risky still. (She mumbled, and looked distressed.) It could leak. What should I do then? If I don't let him sleep with he wouldn't listen. For it will take months" (2.1 HIV negative).

Researcher reflection: In respect to intention for their own specific self-care only half women had confidence that they could do as they said. It was also noted that women were confused about the window period because they thought the blood test technique, which is usually used in hospital, could screen for HIV infection

immediately after people contracted it. Women in the HIV sero-positive group accepted that it was difficult to recognize their own risk and perform specific self-care. The lessons learned from the HIV positive women may be utilised in helping others.

The following are some reflections from two of the HIV positive women in this study about their real stories.

"I know he used to go to prostitutes. He drank and he went out often. I told him to wear condoms but he said no, he didn't have one. So I said then we shouldn't sleep together. And I didn't take contraceptive pills. He said never mind. I was getting worried we would have a baby. He said it wasn't going to happen after once, and he did it. So that's it. I told him to wear a condom, he wouldn't. And he wouldn't go to buy it. I couldn't resist him. I wanted to part from him many times, but he wouldn't let me. ...But when I was pregnant and told him that I was, he left me" (2.1 HIV positive).

"If he goes to those places, I have to accept that. But how can I know if he does? I never know. However, if I know it I'll have to let him sleep with me anyway. He's my husband. He could have a new wife if I wouldn't let him. Then I'll have another worry. The only thing is to have him wear condoms. It's impossible not to let him sleep with me. Men can't stand it. They'll go out to prostitutes and they'll bring the disease to us. But again, men don't like to use condoms. They say it's not 100%" (3.1 HIV positive).

BARRIERS TO WOMEN'S SELF-CARE

The women identified several barriers to specific self-care. These were categorized into three groups: women's personal factors, the husband's factors, and the unsafe environment.

Women's personal factors

"Women's nature" was commonly raised as personal factor obstacle to specific self-care among women in this study and include the following aspects: 1) Unaware of the HIV/AIDS risk, 2) perceived social risk, 3) Women's submissiveness, 4) Less attention to HIV/AIDS information, and 5) Lack of social support or model.

"How did we know? He looked normal and didn't have anything that caused me to suspect. I didn't ask since I have to trust him. He's my husband" (2.3 HIV positive)

"I'm not the sort that enjoys sex at all. I've never climaxed, not even once. But I have to let him sleep with me. I've never told him. I'm afraid he would get angry and might have another girl. I only hope he's happy and our family is happy" (1.5 HIV negative).

"At present there are many sources of knowledge for housewives. If we just listen to them we'd be able to protect ourselves. But those who don't open their eyes and ears, just doing the housework, can get it" (3.1 HIV negative).

"I didn't know who had blood test before marriage in our community. Nobody told me about this. Yes I have heard from TV that they advise people to be tested for AIDS before they marry. But I didn't think I should do it" (1.2 HIV negative).

Husband's factors

According to the women's perceptions the major obstacle were the husband's factors and there were confined to "men's lifestyle" or "men's habits", factors which in their opinions led men to be involved in unprotected extramarital sexual relations. Women believed that men were influenced by several factors: 1) Men's social values and beliefs, 2) Strong sexual desires, 3) Men's attitudes towards using condoms, and 4) Unsafe environment.

"Some men have friends taking them along. If they didn't go they would lose face" (2.3 HIV negative).

"This happened when I got pregnant for the first time. I wouldn't let him sleep with me just as normal pregnant women wouldn't. I felt moody and didn't want him to

come near me. I think most girls feel like this. I knew what he wanted but I just couldn't. That is men's nature they can not abstinent. So there he went, having another girl" (2.5 HIV negative).

"Men don't like to use condoms. If we ask them to use them, it not only makes them feel we do not trust them but also they get mad. If we did not have obvious clues we could not do anything. If we ask them to use with CSWs how do we know they use it" (1.1 HIV negative).

"They watch pornography videos and some movies. Porno books are available everywhere. Sometimes they go to restaurants having food and sitting with call girls. These are Thai men's habits. It's their happiness. Now there are lots of prostitutes and people enjoy night life, going to bars and call girls" (1.5 HIV negative).

Researcher reflection: By pointing to men's and women's nature or habit the women were prone to think that these matters could not be changed.

IDEAL SELF-CARE

Responding to questions asking about what women should do to prevent heterosexual transmission and vertical transmission of HIV/AIDS, their recommendations can be summarized in the following way.

- 1) Not behaving promiscuously (n=all)
- 2) Not sharing syringes with others especially drug addicts(n=all)
- 3) Convincing her fiancé to be tested for HIV before marrying him (n=all)
- 4) Responding appropriately to the husband's sexual needs (n=20)
- 5) Searching the sexual background of a man whom one is marrying with thoroughness (n=16)
- 6) Persuading her husband to be tested for HIV before deciding to have a child (n=15)

- 7) Observing the husband's sexual risk behaviours, preventing him from having sexual relations with other women, applying safe sex practices if the husband is found to have sex with other women until his blood examination is shown to be safe (n=14)
- 8) Regular acquisition of AIDS knowledge (n=10)
- 9) Husband and wife should always live together (n=10)

Researcher reflection: Looking into their recommendations it was found that women prioritized self-care activities different from preventions generally given in the earlier part of conversation with the researcher. Getting a test before marriage and before deciding to have child, which was not addressed previously, were placed in higher priority.

VOICE FOR SUPPORT

Most women (n=19) believed that information and knowledge provided by the government was fine. However, as the disease become so widespread and can not be reduced the women realized that it was difficult for them to deal with this problem. Therefore they expressed their need for support with regards to HIV/AIDS prevention.

- 1) Promotion actively to change men's social values in respect to sexual relations (n=18)
- 2) Promoting the family institution relationship (n=13)
- 3) Health education should be continued and carried out through various methods and media (n=20)

- 4) Strictly regulation and control of all types of pornography and commercial sex industries (n=22).

However, there were 18 women who believed that this was a personal issue between couple and therefore it was difficult to get health advice outside of the family.

SELF-CARE INADEQUACY

When comparing women’s self-care in their actual practice with ideal self-care it was found that women’s self-care was inadequate to protect themselves and their next child from contracting HIV/AIDS. This phenomenon is illustrated in table 5.3.

Table 5.3 Comparison of women’s self-care practice with ideal self-care

Ideal self-care	Number of Women’s practice self-care
<ul style="list-style-type: none">• General self-care	<ul style="list-style-type: none">• All women (n=24)
<ul style="list-style-type: none">• Specific self-care<ul style="list-style-type: none">• Persuading their fiancés to be tested before marriage• Discussion about HIV/AIDS with their husband• Convincing their husbands to be tested before deciding to have a child• Monitoring husbands’ risk behaviours• Prohibiting husbands from visiting CSWs• Practice safer sexual relations if they suspect the husband is taking HIV risks until he gets a negative result of a blood test for HIV	<ul style="list-style-type: none">• Specific self-care<ul style="list-style-type: none">• N= 0• N=9• N=2• N=1• N=1• N=1

CONCLUSION

Nature and pattern of women's self-care

The findings from this phase show that women's self-care to prevent HIV/AIDS for themselves and their next child is composed of general self-care mainly to prevent contracting HIV/AIDS from other people outside family, and specific self-care to prevent HIV/AIDS through hetero-sexual transmission and vertical transmission. The woman's understanding of HIV/AIDS knowledge is fine and adequate to perform general self-care. Women in both groups, HIV positive and HIV negative, were no different in performing general self-care. With regard to specific self-care it was found that the numbers of women in the HIV negative group, who performed some specific self-care, were more than those in the HIV positive group. In addition, specific self-care activities which have relatively high protection against contracting HIV/AIDS were performed more among women in the HIV negative group than women in the HIV positive group. Inadequate self-care was found from both groups when comparing between the women's self-care practice and the ideal self-care.

Women's concepts about HIV/AIDS, gender roles and responsibility, sexuality, and family life inhibited women from carry out thorough self-care. These concepts led women to believe that AIDS was a disease confined to only high risk group and that monogamous women were not vulnerable. Women also believed that responding to husbands' sexual desires was a wife's duty. Women perceived that men had strong sexual desires which they could not control. If their husbands could not get sexual satisfaction from them, extramarital sex was legitimate or they may even abandon

their wives for other girls. Such perceptions meant these women could not refuse sex with their husbands even though it might be risky.

Limitation of the exploratory phase

The nature and pattern of specific self-care which emerged from the exploratory phase derived from only 9 out of 24 women. This is a major limitation in generalising about women's self-care. Thus there was a need to move into an explanation phase of the research in order to construct substantive theory in this area of self-care to prevent HIV/AIDS among women and their next child.

CHAPTER 6

**WOMEN’S SELF-CARE: BALANCING HEALTH RISK AND SOCIAL RISK
IN THE WOMEN’S WORLD**

This chapter provides inductive substantive theory to explain the nature and pattern of women’s self-care and social support in order to prevent HIV/AIDS for themselves and their next child. The link between findings from the explanation and designing the intervention phase is described. The findings which are presented in this chapter mainly derive from 38 women, out of 144 women, who had some risk factors according to HIV risk assessment tool (Appendix VI) and agreed to participate in two sessions of in-depth interview (Detail in chapter 4). Pseudonyms have been used throughout and once again quotes have been selected for inclusion based on the best examples of the concepts or phenomena. The chapter is divided into 7 sections.

- Section 1: Respondents’ profiles
- Section 2: Women’s views of HIV/AIDS
- Section 3: Perception of HIV/AIDS widespread
- Section 4: Isaan women’s culture in marriage
- Section 5: Perception of vulnerability to HIV/AIDS
- Section 6: Women’s self-care to prevent HIV/AIDS
- Section 7: Role and function of social support

SECTION 1: RESPONDENT PROFILES

38 women completed 2 in-depth interviews across the 3 hospitals. The following table provides a profile of the respondents. .

Table 6.1 Participants profiles

Participants										Husbands			
ID	Age	Education	Occupation	Number of marriage		Year of marriage	Number of child	Age	Education	Occupation	Number of marriage	Number of child	Marriage licence
JITREE	1.1	28	Grade 6	HW	1	5	2	35	Grade 12	GO	1	2	R
PON	1.2	26	Grade 9	Farmer	1	4	1	28	Grade 12	Famer	1	1	R
MALEE	1.3	29	Bachelor	Employee	2	3	1	27	Diploma	Worker	1	1	R
NIDA	1.4	17	Grade 9	HW	1	1	1	18	Diploma	Bachelor	1	1	R
PIM	1.5	27	Grade 6	HW	1	8	2	31	Grade 12	GO	1	2	R
SRIPEN	1.6	27	Diploma	HW	1	3	1	30	Grade 6	Worker	1	1	R
NONG	1.7	27	Grade 6	HW	1	4	2	28	Grade 6	Worker	1	2	R
ARUNOTHAI	2.	30	Grade 9	HW	1	5	2	29	Grade 9	Worker	1	2	R
KAEW	2.2	32	Grade 9	Trader	1	8	1	35	Grade 6	Trader	1	1	R
TIP	2.3	25	Bachelor	HW	1	7	1	42	Diploma	Worker	2	2	NR
KITTY	2.4	20	Diploma	HW	1	2	1	20	Grade 9	Worker	1	1	R
SUNEE	2.5	25	Diploma	Trader	1	5	1	24	Grade 9	GE	1	1	R
YING	2.6	30	Grade 6	Famer	1	5	2	31	Grade 6	Famer	1	2	R
VANISARA	2.7	30	Grade 12	Worker	1	3	1	32	Grade 9	Worker	1	1	R
NOM	3.1	31	Grade 6	Trader	1	5	2	33	Grade 9	Trader	1	2	N.R
JUN	3.2	19	Student	Student	1	1	1	17	Grade 9	Unemploy	1	1	N.R
RABIN	3.3	19	Grade 9	Trader	1	2	1	20	Student	Student	1	1	N.R
NOON	3.4	27	Grade 6	HW	1	5	2	36	Grade 6	Worker	1	2	R
ANN	3.5	30	Grade 6	Trader	1	5	1	30	Grade 6	Trader	1	1	N.R
SUPAP	3.6	30	Grade 6	HW	2	2	3	25	Grade 6	Worker	1	2	N.R
VIYADA	3.7	22	Grade 9	HW	1	1	1	23	Grade 9	Worker	1	1	N.R
PHA	4.1	22	Grade 6	Worker	1	5	2	27	Grade 9	Worker	1	2	N.R
LADA	4.2	25	Grade 12	HW	1	5	1	31	Diploma	Worker	1	1	N.R
MARAYAT	4.3	28	Grade 6	HW	1	2	1	28	Grade 6	Worker	1	1	R
PANWAD	4.4	22	Diploma	HW	1	3	1	22	Grade 12	Bachelor	1	1	N.R
RACHA	4.5	33	Grade 9	HW	1	5	1	35	Diploma	GO	1	1	R
JOY	4.6	24	Grade 9	HW	1	7	2	25	Grade 9	Worker	1	2	R
PRANEE	4.7	22	Grade 6	HW	1	2	1	22	Grade 6	Worker	1	1	R
YOOPAYONG	5.	35	Grade 9	HW	1	10+	2	35	Grade 9	Bachelor	1	2	R
NAMWHAN	5.2	35	Grade 9	HW	1	3	1	36	Bachelor	NGE	1	1	R
PLOY	5.3	19	Diploma	HW	1	3	1	19	Diploma	NGE	1	1	R
LUNTUM	5.4	37	Grade 6	Trader	1	6+	2	38	Grade 6	GE	1	2	R
NAN	5.5	30	Bachelor	Worker	1	3	1	31	Grade 9	NGE	1	1	R
PRAPAPAN	6.1	27	Grade 12	Worker	1	8	1	27	Bachelor	Sale man	1	1	R
SOMSRI	6.2	33	Grade 12	Worker	1	11	1	41	Diploma	GO	1	1	R
TIKHAMPON	6.3	36	Diploma	Worker	1	8	1	45	Diploma	GO	1	1	R
WANVILAI	6.4	30	Grade 12	Worker	1	9	1	35	Diploma	GE	1	1	R
NAMOOI	6.5	28	Grade 12	Worker	1	9	1	29	Grade 9	NGE	1	1	R

Note: HW= house wife, NGE= non government employee, GE= government employee, NGO= non government officer, GO= government officer

LIVING ARRANGEMENTS

27 respondents resided in the city centre with the remaining 11 living in the suburbs 5-10 kilometres away. Those in the suburbs tended to live in extended families (n=9) without definite properly boundaries as neighbours were well known. Respondents in the city centre mostly lived in nuclear families (n=19). Their houses have definite boundaries. The majority of women in this group seldom knew or communicated with their neighbours. Nine of the women had dual residency since their husbands worked in other provinces as policemen and sales/business men.

Most of respondents (n=26) had been married less than 5 years. Most were in their first marriage. Two were in their second marriage whilst only one husband was in a second marriage. The majority were officially registered married (n=28, 73.69%). However, there were a number of couples (n = 10, 26.31%) who were cohabitating, and most of them were in the younger age group. Traditionally in Thai culture, registering for marriage means security of family life in at least three aspects as follows:

- Women will become legitimate wives, and then the women and their children will acquire rights over matrimonial assets.
- Women's social status will be more acceptable.
- The wives' and husbands' security depended on not only their personal relationship but also on the law.

However, women who were not registered for marriage gave several different reasons. Some women did not care about the asset and heritage since their husband

was not a rich person. Others believed in personal relationships rather than law. Only two young married women declared an intention to register for marriage later. The majority of respondents had only one child. In general Thai women get sterilization after having two children. Some respondents, who had two children, and were not sterilized yet was because their second child was young.

In order to get insight into women's perceptions and belief about HIV/AIDS, I used scripted questions to initiate conversation. Such as: "What do you think of when talking about AIDS?", "What do you know about AIDS?", and "Could you tell me about AIDS?" In addition if women did not have direct experience, I also used core vignettes to probe into women's understanding, decision making, and practice relating to prevention of HIV/AIDS. The themes which emerged will be discussed in the subsequent sections.

SECTION 2: WOMEN'S VIEWS ON HIV/AIDS

WOMEN'S VIEWS OF THE DISEASE

What this disease meant to the respondents in this study can be explained and categorized in the following way.

- Fatal incurable disease (n=38)
- Disease of high risk group such as CSWs, IDUs, promiscuous person, and homosexual (n=38)
- Social dilemma disease (n=38)
- Disease coming from over sexual desires (n=24)

- Disease of careless people (n=22)
- Disease coming to eradicate bad people (n=3)

Some women expressed:

“There were several AIDS patients around here. Some men are so promiscuous. The trend is to get drunk and often went to those girls. After become AIDS he had to live alone in a small house near rice farm until died. Some women who are prostitutes came back home after working in Bangkok. Their house so big but after they died nobody live in the house. Some leave their child with grand mom I don’t know they are infected or not. I found one boy he had skin lesion and itch he is so thin and so pity” (Sripen 27 years old).

“Some of them had bad skin lesions on their body, and they could not lie on the mattress. Therefore they had to lie on banana leaves instead. Some of them look thin and have severe diarrhoea. After they die they were wrapped in black plastic bags and were not permitted to be cremated at the temple. Their relative had to arrange the funeral outside the temple. My mother is a village health volunteer; she did not allow me to see those patients. I also did not want to stay close to them as they look awful” (Jun 19 years old)

FEAR OF BEING INFECTED WITH HIV/AIDS

Awareness of HIV/AIDS being widespread coupled with knowing it could be transmitted through blood and body fluid reinforced the perception of the disease as a social dilemma. Perception of the severity of AIDS made respondents afraid of getting it.

“Everybody who contracts the AIDS germ will die soon. At the present time there was no vaccine for prevention of this disease. When I go out I am very careful to use the public toilet. I also do not get nail cut at any beauty salon shop cause I am afraid the instruments are not cleaned properly” (Nong 27 years old).

LAY DIAGNOSIS OF AIDS

It was found that women had their own knowledge and understanding of HIV/AIDS closely related to their understanding of diagnosis. Based on external appearance, women classified AIDS victims into three categories.

- AIDS “Dam:” if they notice that patient’s “skin turned black”.
- AIDS “Tum:” if the patient had “chronic skin lesions”.
- AIDS “Hang:” if the patient became “weak and skinny”.

One woman said:

“There was one guy in our community who came back home after several years of migration to be the wage worker for a housing construction in Bangkok. He looked very ill, thin, black skin, and had sunken eyes. People said he was AIDS Hang. He died soon after that. We just pity for his wife and his son. We did not know if they were infected or not” (Pon 26 years old).

Researcher reflection: Women’s perception about HIV/AIDS as describes above confirms women’s concepts as found in the first phase of study. These mean that:

- They view HIV/AIDS as disease of the others, who have risk behaviours.
- By viewing AIDS as a social dilemma may relate in some part to women’s self-care such as inhibiting the sharing of information with others, and limiting their taking preventative measures such as getting test for HIV. Because in doing so it may lead other people suspect that they are AIDS victims.
- Awful out look of AIDS is salient and may influences women consideration of who the AIDS person was. Women may have difficulty to consider that people who look clean and healthy will be HIV infected persons.

MISUNDERSTANDING ABOUT HIV/AIDS

Based on the responses to questions and vignettes, it was found that women had misunderstandings about HIV/AIDS knowledge in many aspects. These confusions can be listed according to their frequency of occurrence as follows:

- Misunderstanding about the window period (n=38)
- Women sero-negative result proved that their husband was free from AIDS (n=34)
- All infants born from HIV sero-positive mothers would be infected with HIV (n=30)
- No available regimen for prevention of HIV vertical transmission (n=30)
- The soldiers and policemen had routine and regular blood test for HIV. Therefore, wives of these government officers had less chance of being at risk (n=4)
- If their husband had a health check-up, they would automatically have blood test for HIV (n=4)
- If a man ejaculates outside it could help to decrease the risk of HIV transmission (n=3)

Researcher reflection: Misunderstandings described above may make women pay less attention to perform self-care to prevent HIV/AIDS properly.

Under emphasis on the necessity for blood testing for HIV before marriage (n=34), before pregnancy (n=36) and during pregnancy (n=33) may prohibit women from taking preventative measures to prevent vertical transmission, either through ineffective means or far too late in the process. There were some women who

acquired ante natal care (n=7) only during the last trimester, particularly in second pregnancies. Lack of promulgation of the knowledge about regimens for prevention of vertical transmission may facilitate the continuing ignorance about HIV testing amongst the group of women, who had a passive/fatalist coping style.

There are HIV sero-surveillance programmes only among new military conscripts and during some research programs. This misunderstanding may make some women pay less attention to HIV/AIDS issues, and may make some women perceive their HIV/AIDS vulnerability as lower than it actually is.

In general a health check-up does not include HIV sero testing. Those few that do have high costs and people must give informed consent to be tested.

According to epidemiological fact, penetrative sexual intercourse creates abrasion of soft tissue. HIV virus, which is a very small particle, can then penetrate into the body. Women may be in danger if they believe that ejaculation outside the vagina will protect them from HIV.

SECTION: 3 PERCEPTION OF MEN'S RISK BEHAVIOURS

In responding to question as "Why do Thai men take HIV/AIDS risk?", the answers from all women pointed to four contributing factors. These were: 1) Thai men's sexual life style, 2) the huge number of CSWs, 3) the unsafe environment, and 4) unsafe sex practice.

THAI MEN'S SEXUAL LIFE STYLE

Men's perceived nature

All respondents believed that men in general had strong sexual desires, and rarely abstained from having sex. This nature coupled with being free from the risk of getting pregnant and seeking a "new flavour" led them to have casual sex. One respondent explained:

"Is the high sexual desire in the man due to his hormones? Men are Muk Maak (promiscuous for sex) just bored of their girls, and then they go out to look for another exciting sex relationship. It is their nature, they have no discrimination. He can have sexual relationship with no fear of being pregnant. No body knows what they did, they are not worried" (Pon 26 years old).

All respondents perceived that many Thai men fulfilled the stereotype of sexual practice such as drinking alcohol and having indiscriminate sex. These practices are not seen as problems but indicate manhood, and therefore men take pride in it. Some respondents maintained:

"In the factory where my husband works there is a boss who is a ladies man. He plays around and always looks for girls. He is not only doing that himself but also persuades his subordinates to do so. Sometimes as a bonus he treated workers with meals and girls for sex" (Pha 22 years old)

"Men are supposed to believe that feeling of having been anywhere would only be obtained if they had sex with women there. That why they had a culture of Leang-do-po-suae (a welcome and greeting their male guests with meals and women for them to have sex with expressed in the Thai phrase). In my husband's workplace after office hours men gathered in groups talked and drank alcohol. After getting drunk they persuade each other to visit CSWs in town. Some men in the beginning had never done, but after several months they did as their friends did" (Arunothai 30 years old).

Extramarital sex

Half of women (n=19) specified that men were likely to have extramarital sex either with any women or CSWs if they could not get sexual fulfilment from wives. These circumstances could occur in various ways such as: wives were in condition

prohibiting sex, men stayed overnight at other places, and getting bored of having sex with their wives.

“When their wives being pregnant and after giving birth they can not have sex with their wives they might go to prostitutes. Some men just go because they like to have something new”(Ying 30 years old).

“On a sales-tours in other towns both men and women, sometimes stay overnight there, and have sexual relationship on that chance” (Vanisara 30 years old).

These perceptions by women were supported by the findings from another two women, whose husbands migrated to work in other provinces, and they had personal experience of their husbands' extramarital sex. Even though women viewed men as mentioned above, they discerned that not all men had casual sex. The distinguishing factor was their moral attitude or responsibility when having sex, which will be explained next.

Men's morality in sexual relations

Women's moral views of men's sexual life style can be summarized into three types:

Strict morality/responsible sexual life style: Men attributed to this type had sexual practices strictly adhering to ethical or moral principles by following the five commandments of **“The LORD BUDDHA”**. The majority of respondents in this study put their husbands in this type (n=33). One woman said:

“If men who strictly follow the third commandment, which prohibits the committing of adultery. Therefore, they won't have extramarital sex, and irresponsible sex as it is “The sin” and it will be against morality. In addition perceiving the severity of AIDS, coupled with being faithful to their wives, men in this type would not take the risk of HIV/AIDS” (Vanisara 30 years old).

Moderate morality/responsible sexual life style: Men attributed to this type had occasional extramarital sexual relations by consistent use of condom. Some of the respondents (n=5) put their husbands in this type of sexual life style.

"They might have sex with CSWs if they could not have sex with their wives in particular circumstances such as wives were in condition prohibiting them from having sex: physical separation between couples, influencing from peers, or could not get satisfaction through having sex with their wives. However, they were responsible for themselves, their wives, and partners by consistent use of condom" (Supap 30 years old).

Immoral/irresponsible sexual life style: Men in this type usually practice the opposite of the first category. In addition men belonging to this type had negative attitudes to safe sex. Although women viewed that many married men attributed to this type none of them viewed their husbands' sexual life style as such.

"I think it depend on their inborn trait. For some men having sex with several partners are the goals of pleasure and contentment. They are so careless having casual sex. In addition amusing with alcohol they end up with spending on a commercial sex service. If away from home without their wives as company they are Hao- Hao (Isan word means very vigorous or lively). They believed and said that using a condom is only for a tenderfoot. It was like scratching their back whilst still wearing clothes" (Somsri 33 years old).

LARGE NUMBER OF CSWs:

All respondents also pointed out that large numbers, and various types of commercial sex workers were significant factors contributing to Thai men's risk behaviours and HIV/AIDS spread in Khon Kaen. Respondents believed that free availability and easy access facilitated men's casual sex.

Types of commercial sex industries

The majority of women (n=34) described these phenomena in three ways: brothel-commercial sex services, non brothel-commercial sex services (amateur CSWs), and commercial sex service at cow market. They also perceived that amateur-

commercial sex service was becoming men's favourite since the men believed that these girls were free from AIDS. Following are some quotes from respondents about these phenomena:

"There are a vast number of prostitutes in this province. They are available in many places in brothel, massage pallor, ka-ra-o-ke shop, and restaurant. However, my husband said that nowadays some men rarely visit prostitutes since they are afraid of AIDS. If they feel the need they would look for young girls who trade sex for money as a part time job. There are a lot of such girls. I think it is because they don't worry about getting pregnant. They use pills for birth control, and even know about post-coital birth control pills. In the student dorms my friends who work there said that in the bins there were a lot of empty boxes of pills" (Nong 27 years old).

"The cow market is the most popular place and event for selling sex outside the whore house. Because after selling cows Nai Hoi, (a name which villager calls a rich man in their communities), will have a lot of money. Women who trade sex have their own strategies, such as persuading men to drink alcohol or seduce men to have sex with them. Some of those women are food vendors. Men who have money and drunk are easy to convince to have sex with these women. Some of them lose almost all their money, and quarrel with wives when they go back home. The villagers are familiar with these types of prostitute" (Somsri 33 years old).

Common customer of commercial sex workers

In responding to question "Who is the person who frequently uses prostitute?" all women in this study believed that single men were more common to visit CSWs than married men.

"In general single men frequently visit those girls. After married men rarely to go because they have sex with their wives. My husband he accepts that he used to pai teiw before marriage. After we are married I haven't seen he go anymore" (Pranee 22 years old).

Safer sex practice among men

Women had some perceptions of condom use among men by hearing in their community, joking in conversation among men, listening to radio and television, and

reading from newspapers. Based on the beliefs of most of women (n=33) attitude and practice among men in relation to using of condoms can be summarized as follow:

Men were not likely to use condoms during sexual encounters since they felt it decreased sexual pleasure. In terms of casual sex men use of condoms relied on what they believed about their current sexual partner. Since men were afraid of AIDS the trend was to use condom with brothel commercial sex workers. Therefore men did not use a condom in casual sex outside the commercial sex industry. Women also viewed that men who did not use condom during casual sex were persons who lacked responsibility to themselves and their partners or their wives.

VISITING THE BROTHELS: SOME INSIGHTS INTO PRACTICES

Women's views as described above were evaluated from several significant key informants. These include some respondent's husbands, six brothel owners, and one CSW in Khon Kaen. It was also correlated with two sources of data, epidemiological surveillance and HIV/AIDS risk assessment among 10 couples.

Mr. Observer, the pseudonymous name of one respondent's husband, used to work in a job related to the sex-service business for several years and had a lot of first hand experience of the sex industry. He had one close friend who died from AIDS. Because he was afraid of this disease, he had quit having sex with CSWs. At the present time he is a volunteer in the community surveillance of addicted drug users. Now he is married with a two month old daughter.

He took the researcher to observe and question six brothel owners in various brothels. The researcher gathered the information that the high income groups or relatively high income persons or high ranking officers used the sex-service from brothel houses indirectly through the bellboy in the hotel. These people were interested only in girls who they believed to be “Dek Mai” literally “New Girl” (a young girl who just engaged in sex-service business), and believed that these girls were virgin and free from HIV/AIDS.

The following are portions of the conversations from the first key informant, Mr. Observer.:

“Formerly, I worked and was involved in the sex industry. Therefore people in this business were familiar with me. Most of the men who came to visit the whore house were married, though some were older single men. Teen-agers might not have enough money to spend on this sex service or they might have sex with their girl friends or sex partners same as single men. Since Thailand has had the crisis of economy, the number of blue-collar workers, low income group of people who visit CSWs was decreased somewhat. This may be because they were unemployed they also did not have much money to spend on this sex-service. For well-known persons or high-income groups of people, they dislike and don't want to visit the whore houses, yet ask for the newcomer and young girls from these places to sleep with them in their hotel. Most of them emphasized the criterion of Dek Mai since they are afraid of AIDS.”

Actually the “Dek-Mai” was rarely a real virgin girl according to Mr. Observer's explanation. To please the customer, the brothel owners had several ways to build up the new-comer ‘virgin’ girl. These include training the girls how to behave appropriately, and helping the girls to get surgical vaginal repair.

To show the extent of brothels concealed in city centre of Khon Kaen, Mr. Observer accompanied the researcher and the research assistant on a tour around the actual

places at night to observe some events happening there. He also suggested talking with the brothels' owners and CSWs to gather other perspectives. The researcher took this opportunity to make data triangulation to answer the questions which emerged during data collection such as: 1) what kind of men mostly visited CSWs and what were the facts about condom use among men who visited CSWs?, 2) what was the incidence rate of sexual transmitted diseases there?, and 3) Do their girls have routine health check ups?

Mr. Observer arranged the sessions for us by asking permission from the most senior brothel owner who was respected by the other owners. The researcher recognized that this survey was on a very sensitive issue therefore, the interview was carried out in a carefully respectful manner to all key informants involved. Firstly we made an appointment with the most senior brothel owner to introduce ourselves and explain the objectives of the investigation before moving to meet with others. Secondly, in front of five brothel owners we gave the same explanations as with the most senior one. After that the investigation was carried out.

The following is an extract from conversation with the senior brothel owner, a 72 year old woman:

"Men still visit our girls. Even though, after I.M.F. (this term was used to imply an economic crisis in Thailand) the number has decreased and they may have less money than they did. There are all kinds of men coming here, both married and single. Most of them are married adults of middle-age, a smaller number are older single men. The teenagers do not come a lot. We don't know why."

In the focus group interview with five brothel owners, a 43 years old owner commented on the changes to CSWs in Khon Kaen.

"Unlike in the past, when a few of them lived with us, most of them came to our place only when they want to work, and because there are several places, they sometimes went to other place. We can't control them. They are free to move from place to place depending on the money they can earn from any sex-service and rely on the number of customer at each place. Some of them work only when they are short of money. Many of them live with their Fans (Temporally or permanent sexual partner) who do not earn any money. It is very often that their Fans abuse them but they still live together. This is a story which has been happening for a very long time. It is their lives, the pimp and the prostitute (Mang da and So pae nee). They usually have no saved money as in the past when they stayed with us we saved the money for them."(Brothel owner focus group)

With regard to the prevention of HIV/AIDS and health check up for CSWs we were told by a 47 year old brothel owner that:

"Formerly they worked, ate and lived here, and when they were sick we took care of them, and took them to see the physician. In the past our girls were infected with sexual transmitted diseases a lot, some of them couldn't even walk. Now it is not much problem as we teach them ask men to use Thung Yang (Condom). If any man intended not to use it the girl refused to have sex with them. Here we protect our girls from being harmed by men. One time I even heard of a girl being kicked out of bed by an old man who got drunk and refused to use Thung Yang he cried out loud Ha Ha (Laughter). We guarantee that this caution is taken, since we need to keep quality for our customer. Our girls are clean so we don't have any girl who is infected with HIV working here. But those girls who are working independently outside our places may hardly negotiate with customer as they don't have anybody to help them as we do. In addition we advise our girls to take health check-ups routinely every year."

The information from the senior brothel owner, related to consistent use of condom, was supported by one commercial sex worker. As she said:

"I know the risk. I always use Thung-yang with men....Sometimes there were drunken men who did not want to use it, but I refused to sleep with them. It is difficult with some men, who are crazy, and get heavily drunk. Even though they wore it, but if they did not get orgasm or if he felt it delayed orgasm, they would take it off later. I have always refused men who did so...but sometime they play a trick by pretending to wear. Sometimes we could hardly notice. Leakages occasionally happened, but not often...Umm...This also is hard to ask since men come to us for their pleasure. Therefore, they do not like to withdraw whilst it's potent...They paid money you know? They just want to get sexual pleasure as much as possible. "

However, there was some controversy between the brothels owners and the CSW views and Mr. Observer's view of condom use.

Mr. Observer said:

"I assure you that they can not use Thung-yang 100 % of the time.. It still relies on the level of satisfaction of the girl to the customer. Many of my friends who are not afraid about AIDS and many drunken men have never used Plogs (condoms). In addition there are some girls who are greedy for money and they don't care about AIDS. They instead call on men, having sex with them without using condoms."

Mr. Observer also told about the positive role of a nurse who worked in his community related to prevention and surveillance of HIV/AIDS among CSWs. He described that:

"In the past when AIDS came to Thailand about five years ago, there was one nurse who come to visit the girls and teach them be worried about AIDS and distributed Thung yangs (condoms) to use. She took the girls to have blood tests and advised them how to take care of themselves if they get STD infection. She also took them to hospital for treatment. I used to cooperate with her for taking the girls to hospital several times for having blood tests for HIV. After she quit, I have never seen any body come to do it like in those time therefore, the girls hardly go for blood testing. Nobody knows which girls are infected with HIV. However, I know one of them who is infected and still working here."

Surveillance of HIV sero-prevalence rates among specific groups, which was conducted at the same time as the present study, found that consistent use of condom among CSWs in Khon Kaen was 88.1%. Therefore, inconsistent use of condom was 11.9 %, and the prevalence rate of STI among CSWs was 18.9 % (Najaitruek and Pinichluek, 1999).

In 2000, HIV risk behaviour sentinel surveillance among specific groups, such as military conscript men, male workers in industries and factories, and male secondary school students, was carried out. It revealed that among each group of men the

percentages, who had sexual relation with CSWs, during the previous year, were 26.8 %, 29.9 %, and 13.3% respectively. Among those who had sexual relation with CSWs, only 38.5-62% reported consistent use of condom, and 9.2-16.7 % notified having symptoms of sexually transmitted infection (Najaitrek and Pinichluek, 2000).

In addition, from the evidence which was gathered from 10 couples during the HIV risk assessment phase six husbands reported visiting CSWs before marriage. There were at least another two husbands who reported visiting CSWs after marriage. They also reported inconsistent use of condoms during these sex encounters, in particular when they got drunk.

Researcher reflection:

The findings from these encounters with brothel owners and CSW undertake that men, both single and married, still patronise CSWs. Consistent used of condoms is still not high. Brothel-CSWs sometimes comply with customers, who refuse to wear condoms and the brothel owner may not know. Deception takes place at many levels.

Health checkups among CSWs were inefficient because of lack of active support. Even though brothel owners warned their girls to get checked, they may not know if they do or not. The CSWs may hardly be checked for health since it seems that there is no coordination between healthcare services and brothels as there was previously. An active and independent community nurse had a great impact on health checkups and the consistent condom use among CSWs at one time but was no longer.

WOMEN'S VIEWS: UNSAFE ENVIRONMENT

Another obvious phenomenon, which the majority of women referred to as contributing factors in casual sex and widespread of HIV/AIDS in Khon Kaen was the unsafe environment. This included pornography, entertainment and alcohol.

"The men preferred to watch the dirty video together while teasing each other. They complained about their wives for not being sexy and seductive. Then persuade themselves to go to town to get commercial sex, and after that come back home for a quarrel with their wives. The man doesn't want to be alone in this and he tries to persuade the others to have the same bad sex practices" (Ying 30 years old).

"A music concert and a pop/local Isaan-style singer's shows are entertainment events that bring people to have a chance to chat, drink and eat in a happy atmosphere. They do not mind bodily contact during the dance leading to get closer to each other, with out discrimination of proper Thai culture and tradition. After the show, many of them end up with unfaithful sex affairs" (Somsri 33 years old)

"In the seminar, study tour and training events outside the office, particularly if they have to stay overnight there, after the academic time men and women have chances to meet socially and join together in restaurants or entertainment places. They talk and drink alcohol and after getting drunk some of them had sex affairs also. Some of them are single persons and divorcees but some are married persons, yet, they practice this misconduct in secret" (Malee 29 years old).

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Researcher reflection: According to respondents' perceptions HIV/AIDS risk behaviours among men derives from many factors both from men's factors and environment factors. However, by their perception, most of women seem to believe in these facilitating factors and that they are unable to influence their husbands' sexual behaviour.

SECTION 4: ISAAN WOMEN'S CULTURE IN MARRIAGE

According to information from respondents, women's values, beliefs, and norms that might be contribute to self- care practices may be understood through their understanding of marriage and sexuality.

MEANINGS OF MARRIAGE

According to the findings, marriage can be understood through gender roles and responsibility, significance of family, monogamy, and conjugal partnerships.

Roles and responsibilities:

The majority of women in this study (n=25) perceived that the major roles of husband were a family "breadwinner" whilst wife's role is a "care giver".

The husband's work was the major source of family income, which should be used for the expenditure of daily living and child rearing. Women also viewed that husband is a "protector" as well. They expected that the husband should protect them and their children from any harm and danger. Meanwhile women had two roles as "wives" and "mothers". The roles of wife were ministering to the wants of the husband which is expressed in Thai phrase as "**Pron-ni-bat-samee**" Those duties related to household chores, meals, comfort, and sexual pleasure". In respect to mothers' roles women should take the responsibility for "nurturing children".

In spite of viewing the husband as earner there were 15 women who were working. 7 women identified themselves as housewives who were earning money as self-

employed traders and dressmakers, and two of them were working together with husbands as farmers. In addition three housewives had an intention to return to their own career after their babies were one or two years old. The reason, why most women had to have their own occupation, was that the income from the husband's work was not adequate for living expenses and the future education of their children. Therefore, they felt obliged that they should take on this responsibility as well.

Even though more than half of respondents (n=22) had to earn money, they still had to take care of household chores and child rearing. The majority (n=28) had been nurturing young children, and 22 lived in a nuclear family without extended family help.

Researcher reflection: From this female ideology, women in the present study, as a good wife and a good mother in their view, tried to perform these duties perfectly. Believing that these were their responsibilities women rarely asked for help. Instead if they could not carry out their roles and responsibilities they would feel guilty and remiss in their duties. By trying hard to meet these '*ideals*', women had "*over work load*" and "*less time for attention to themselves*".

Conjugal partnership

One important factor which influenced women's self-care was the power relation with the husband. Women's values, beliefs, age, education, economic status, personal characteristics, and husbands' personality determined the nature of the conjugal partnership. Their relationship before marriage also played a role in this

matter. Power relationships of women and their husbands in the present study can be explained within three types of Thai beliefs.

The follower: Women in this group (n=31) believed that husbands were the leader and the head of the family which is expressed in the Thai proverb as the women being the “**Chang thao lang**” literally “elephant’s hind legs”. Their husbands had authority and made decisions, therefore they were the “**Chang tao na**” literally “elephant’s forelegs”. Women in this group mostly relied on husbands’ economically, and were younger than their husbands.

Partnership: Gender equality and mutual responsibility were the belief and practice of some women in this group (n= 6). They compared themselves and their husbands as ‘right and left legs’. This meant that both legs were equal, and should walk in synchrony and in parallel. Such women were always involved in decision making and activities within the family side by side with their husbands. These women tended to be the same age as their husbands, and particularly were friends from the same school, and either had their own occupation or relied on the husbands’ income.

The leader: There was only one woman who determined that she had more authority than her husband, even though she was younger than him. She and her husband were self-employed traders whilst the husband also ran a small shop for fixing motorcycles at their house. Her husband tended to do things at her request. She viewed her husband as timid since he had never gone any place without her. Therefore she viewed that she was an elephant’s forelegs instead.

Significance of the family

It was found that family was of high values to almost all of the women (n=35).

"We engage in marriage because hoping that this will lead us to prosperity and security in our life. We can also get a companionship. If we have some difficulty we can have someone help for solve those problems. Having someone who love and care for us make we feel good and happy. For me I want to be married only once in my life. I believe in monogamy therefore, peaceful and happiness within family are important for my marriage life" (Joy 24 years old).

Hold on monogamy

Based on placing high values on family almost all of women (n=36) valued monogamy.

"Love of and trust in each other is important for me. I have an ideal of monogamy. Therefore, after marriage I do not want to have sex affairs with anybody else, and I do hope my husband is faithful to me too... My husband works hard for our family and sometimes he comes home late, but I have never doubted him. I understand and do not fuss over him. My husband and I will be taking care of each other for a long time and as it is said we share happiness and suffering" (Yoopayong 35 years old)

"I don't intend to remarry. I believe in 'Puah-deiw-mia-diew' (Monogamous marriage as saying in Thai). If we quarrel too often it might lead to unrest in the family. The situation will be bad if it leads to divorce, in which mostly the woman is blamed. Therefore I have to avoid any conflict with my husband. Even though many times I get mad with his behaviour I have to be patient. That's why I behave the way I do" (Nong 27 years old).

Researcher reflection: All women state that they love and were faithful to their husbands and expected that husbands would act in the same manner. This means that the husband would not have extramarital sex. They believed that love, trust, and understanding of each other were significant factors in sustaining married life with peace and happiness. Therefore they would not hurt their husband's feelings by letting them know that they were not trustworthy husbands. Women would do

anything to keep the marriage safe. This may even lead them to take HIV/AIDS risk too.

IDEAS ABOUT SEX AND SEXUALITY

Shame

Almost all of women (n=31) thought that talking and having an interest in sexual relations, particularly sexual intercourse was a shameful and incriminating thing. They believed that paying much interest in, and expression of sexual relations were not the business of 'good' women. In addition they would not share, or seek information about sex. Women who believe in this way had less knowledge about sexual relations.

"I didn't know before marriage that husband and wife would have sexual intercourse. Even though I married with my husband with love, I just thought we would live together. When my husband had sex with me I really felt shameful. I have never been interested in it. I hate people who love to tell dirty jokes...video about sex I have never wanted to see" (Marayat 28 years old).

Advantage

Only seven women believed that interest in and seeking information about sexual relations was advantageous for married life. Women in this group obtained their knowledge by sharing with friends. Moreover women learned from ladies magazines, radio, television programmes, and video. They used this knowledge to understand the sexual desires of their husbands and themselves, and improve sexual relations with their husbands.

Extramarital sex

Extramarital sex of husbands was viewed as “unfaithful behaviour” and all women did not want it to occur. However, acceptance of extramarital sex was different among the women

Accept with some conditions: There were only two women, who could accept husbands’ extramarital sex within two conditions. Firstly they accepted this if they themselves were in a condition that prevent them from having sex with their husband eg some period during pregnancy, 6 weeks after delivery, physical separation such as migration between husband and wife, for a long period of time. Secondly if extramarital sex was performed by using a condom and the husband had no long term relationship with that sexual partner. Under such circumstances, they would accept the husband having extramarital sex with CSWs rather than other women.

“My husband has to live in another province for several days. Because he runs a car hire business, he has to drive a car for customers. Because I am afraid of AIDS, in addition to warn him about this matter. I sometime prepared condoms for him if he has to go for several days” (Luntom 37 years old).

“If he can’t abstain from sex, and really needs to have sexual relations while living in another province. I might accept it if he go to CSWs and uses a condom. I also said don’t bring me a contagious disease. It may be better than he has another woman as a casual sexual partner. That might make him bond with that woman” (Panwad 22 years old).

No acceptance at all: The majority of women (n=34) said that they could not accept extramarital sex by their husband regardless. They all expected that their husbands should abstain from sex or solve this problem in other ways if there was no sex in the marriage.

"I can not accept it since I am faithful to him so I expect that he should do the same thing. It is something like we used the same toothbrush with another woman. I am scared by it. If my husband has extramarital sex I might choose to divorce" (Vanisara 30 years old).

"While I do love him and behave nicely, and take good care of him, work hard in our house including rearing our kid, but he goes out having fun and extra sex. It's not fair. No, I would not be patient. Unfaithfulness in my husband would hurt my feelings since I would think he does not love me" (Viyada 22 years old.)

Sexual imbalance

In respect to sexual relations, some women in this study reported that they could occasionally express their sexual desires by using non-verbal communication with husbands or refused to have sex with them. However, usually most of women did not refuse their husbands' demands. Women's compliance with husbands' sexual desires was for several reasons. These include: 1) they viewed it as a wife's duty, 2) they like to provide sexual pleasure to husband, 3) to avoid conflict between couple, and 4) to prevent husband using this issue as an excuse for having extramarital sex.

There were some conditions which created sexual imbalance between couples.

Perceived sexual imbalance: It was found that at least 5 women complained of serious sexual imbalance whilst more than half (n=24) reported having sex with husbands without the desire for it themselves several times. Based on respondents' perception, sexual imbalance between themselves and their husbands came from five major factors.

- Women's workload made women too exhausted and too tired to have sex (n=4).
- Worry of child observing since they slept in the same bed (n=1)

- Husband had too much sex drive, and demanded sex too often (n=3)
- Effect of morning sickness during pregnancy (n=1)
- Husband drunk (n=1)

One woman said:

“We, as the female, do not need much sexual activity where the man seems to need sex every day. Some times I hurt, got bored and didn’t want to sleep with my husband. During pregnancy my man wanted to make love with me every day, but I worried about the danger of abortion. When he came close to me I just felt sick of him. Even a short time after giving birth he did not abstain from sex and I was so scared of my wound’s stitches being separated” (Marayat 30 years old).

Sexual imbalances had a negative impact on women’s health in both mental and physical ways as illustrated in these extracts:

“Sometime I was so exhausted and sleepy from working all day, both in the work place and at the house since my child was very young but he still insisted on having sex. That time I felt like I was raped, and I cried. After that event my husband promised not to violate me again. Now he is willing to compromise more than in the past” (Wanvilai 30 years old).

“I felt fed up with having sex; several times I got so much pain. I really do not like to have sex with him” (Lada 25 years old)

“I could not work effectively during the day time since I was too exhausted and sleepy” (Wanvilai 30 years old)

“Some days during feeding my baby I fell asleep and sometimes I hadn’t energy to be patient with my boy’s naughty behaviour” (Namwhan 35 years old)

Management: Only 1 in 5 women, who had serious problems of sexual imbalance, perceived that the husband was compliant with her after knowing that she felt as if she had been raped when he forced her to have sex with him. The other three stated that they had unsuccessful negotiations with their husbands, and had some conflict because of this. Another one women (25 years old) did not communicate the

problem to her husband at all. This woman was a housewife, and totally financially dependent on her husband.

Unperceived sexual imbalance and its management: There were some special conditions, when women could not have sex with husbands. For instances during the first and last trimester of pregnancy, throughout pregnancy period if the women had a condition which threatened abortion, during the 6 weeks after giving birth, and during physical separation among couples. Only two women used to help husband to obtain sexual pleasure by using other methods instead of having sexual intercourse. The majority of women (n=34) had never thought they should help husbands in this matter. Few women believed that their husband might masturbate, and only one woman noticed if her husband did. None of them thought that her husband might have extramarital sex, even though they believed that in general other men might do.

Two women said:

"I did not think about his sexual desire while I got pregnant, and did not pay attention on how husbands solved this problem. I had no idea and skills to cooperate with him to release tensions, but I think men would know how to do that more than me" (Ploy 19 years old)

"During pregnancy and after giving birth I have never had sexual relations with him. It is now two months after delivery, but I still do not sleep with him, since I have not had a health check-up after delivery yet. I don't know how my husband dealt with this problem. But I used to see he did masturbation only one time. I just leave this to his responsibility" (Kitty 20 years old).

Researcher reflection: It is noticeable that most women normally paid much attention to and tried to respond to their husbands' sexual desires. In several sexual relations women had no sexual desires. Responding to her husband's demands without sexual desire may not lead to sexual fulfilment, and may also lead to

boredom between couples, which in consequence may lead to extramarital sex of husbands and serious sexual imbalance. The meaning taken from these perceptions is that women seem to be unable to manage these issues properly.

However, when there were some special conditions, which they could not have sex with their husbands they expected that their husbands should solve problems appropriately. This suggests that women “trust” and “have confidence” in their husbands. Their trust may make them ignore the possibility of helping husbands get through this period properly and safely.

SECTION 5: PERCEPTION OF HIV/AIDS VULNERABILITY

Women’s perception of their vulnerability to HIV/AIDS can be understood through the gap between trust and truth, diversity of perception, and the barriers to perception.

GAP BETWEEN TRUST AND TRUTH:

According to the results from the structured HIV risk assessment questionnaire, risk factors among mothers were varied, and ranged from 3-12 items. Their HIV risk status was calculated at three levels:

- Low risk (n=9) - when they had risk factors of less than five items
- Moderate risk (n=28)- when they had 5-10 risk factors
- High risk (n=1)- if their risk factors were more than ten

When comparing this result with women's opinions a "gap" between women's views and the assessed risk could be interpreted as follow:

- **Under-perception** –Majority of women (n=30) viewed themselves as having HIV/AIDS vulnerability less than that derived from the risk assessment.
- **Over perception** - Women in this group (n=5) viewed their vulnerability as more that the derived from the risk assessment.
- **Accurate perception** – Minority of women (n=3) viewed their vulnerability as being the same as that derived from risk assessment.

Considering respondents' beliefs related to their vulnerability, it was found that women had different point of views toward the cue evidence of risk. This diversity will be discussed next.

SELF ASSESSMENT OF HIV/AIDS VULNERABILITY

According to their explanations the difference in women's perceptions of HIV/AIDS vulnerability and their reasons in determining such vulnerability can be categorized in to three groups as follow:

Table 6.2 Women’s perceptions of HIV/AIDS risk based on their own evidence, n=38

<p>Perceived no risk:</p> <ul style="list-style-type: none">• <i>I am confident that he has never visited CSWs (case 1.2, 2.1, 2.4, 2.6, 2.1, 2.6, 5.1, and 6.5).</i>• <i>My husband is a strictly religious man and very moral (case 1.5, 3.1, 6.2).</i>• <i>I have never seen him going to any place after office hours (case 2.1, 2.4, and 2.6).</i>• <i>I trust that he has never visited CSWs. He is a person who loves and gives very good care to his wife and child (case 6.1, and 6.3).</i>• <i>We live together and he has never been any place without me (case 1.2, 2.6, 2.1, 4.6, and 6.3).</i>• <i>He is a policeman therefore I think he was tested for HIV routinely (case 1.1, 1.5)</i>• <i>He used to worked in foreign countries therefore he was tested for HIV (1.6, 4.3)</i>• <i>During pregnancy I was tested for HIV and our kid is fine (all cases).</i>• <i>He sometime went out drinking with friends but didn’t come home late at night (case 1.3, 2.1. 2.4, 2.5, and 6.5)</i>
<p>Perceived less risk:</p> <ul style="list-style-type: none">• <i>He has several friends who like to visit CSWs (case 1.1, 1.3, 1.7, 2.2, 2.3, and 2.5)</i>• <i>He always goes out drinking with friends and comes back late at night (case 1.7, 2.3, 2.5, and 6.4)</i>• <i>He works and lives in other provinces therefore, I am not sure he would not visit CSWs (case 1.1, 2.7, 4.4, 4.5, 6.4, and 6.5)</i>• <i>I got sexual transmitted disease from him, but now he behave nicely (case 2.2, 6.5)</i>• <i>He likes to go to massage pallor after office hour, but he said he did not have sex (case1.3)</i>• <i>I detected his extramarital sex with other women and CSWs (case 2.7, 4.7, 4.3, and 4.5).</i>• <i>He had a history of several partners and visited a lot of CSWs before marriage, but now I have never noticed if he has (case 6.4, 6.5).</i>• <i>I asked and he accepted he just had sex with CSWs currently, but he said he used a condom (case 2.5, and 5.2).</i>
<p>Perceived moderate risk:</p> <ul style="list-style-type: none">• <i>He always gets drunk and has strong sexual desires. I found condoms in his pocket (case 1.1)</i>• <i>He has a history of several partners before marriage and he works a night shift (case2.3)</i>
<p>Perceived high risk:</p> <ul style="list-style-type: none">• <i>I got syphilis from my husband (case 2.2)</i>• <i>My husband works on night shift, and he has a history of casual sex (case 2.3)</i>• <i>My husband works and stays overnight at other places several times (case 6.4)</i>• <i>My husband is a salesman (case 6.5)</i>• <i>My husband had regular sexual relation with CSWs, but he said he wore a condom. (case 6.2)</i>

Researcher reflection: It was noticeable that how women determined their vulnerability to HIV/AIDS, very much relied on concrete evidence of observable behaviour of the husband. In addition some women determined their vulnerability from the same evidence to differing degrees. It seems to me that determination of HIV/AIDS vulnerability among women should be considered very thoroughly. Depending mostly on observable evidence may not be adequate to accurately assess

the vulnerability risk of HIV/AIDS among women. Their perception of risk may influence their self-care. Therefore, factors that are an obstacle to women's perception should be taken into account when shaping self-care programme with clients.

BARRIERS TO PERCEPTION OF RISK

All of the women in this study perceived an unsafe environment and recognized that women had risks of being infected with HIV from their husband, but many of them had never thought it could affect their own case or situation. Under-perception of HIV/AIDS vulnerability among women found in this study can be explained within five areas:

Belief about high risk group:

Women viewed HIV/AIDS as confined to only high risk groups such as IDUs, CSWs, and promiscuous persons (detail in section 2). They believed their husbands were not in those groups of people. Therefore, they had no or very little risk of being infected with this disease.

Reliance on concrete observable evidence:

It was found from table 6.2 that women, who identified themselves as at risk in the last two groups (Feeling less risk and moderate risk), mostly had some cues about extramarital sex of husbands. In addition respondents also stated that if there is no concrete evidence women can hardly be sure about their husbands' extramarital sex. Therefore they relied on what they had noticed.

"I found he had intimate talks with one beautiful woman. When I asked he said he was her regular customer before marrying me. He said he has never visited her again after marriage and I have never noticed he visited CSWs. So I think that he has stopped doing this" Wanvilai 28 years old)

Relying only on observable evidence, women fail to consider their own situation critically. They could not link and use other people's experience to learn and understand the possible nature of their own husband's sexual practice. For instance, women perceived that men commonly had extramarital sex if they could not get sexual pleasure from their wives. Women even knew that husbands who practiced as described would conceal this matter from their wives. However, they could not connect this issue to their own situation. Comparing of risk factors between 10 couples it was found that at least 6 women did not know their husbands' extramarital sex behaviour, both with general women and CSWs. Furthermore 4 from those 6 husbands accepted that they had inconsistent use of condoms in sexual relations.

Women's work load:

Women's work load (Detail in section 4) may play some part in the perception of vulnerability of HIV/AIDS among women. Their duties which took much of their time may not allow women to pay adequate attention to this matter. As a result critical thinking may be prohibited which may curtail women's perception of their own vulnerability as well.

Trust in husband's love:

According to their reports, women trusted their husbands as a consequence of sexual bonding between couples. They had long relationships, love and intimacy with their husbands. In addition they were loyal to their husband, and expected that they would

get honesty from husbands as well. Women trusted the husband as they would themselves since they had the idea that the husband and wife were the same person. Women believed that if their husbands love them, husbands would not bring harmful things to them. These included not bringing any disease to them.

How trust may mask a women's perception of HIV/AIDS vulnerability as illustrated in the two examples below:

"I think he loves me therefore, he will not deceive me. I also love and am very faithful to him. We live our lives for a long time. He is head of our family so I think he would protect us from any harm. We have never have any secret between us. He said he's also afraid of AIDS, and has never visited CSWs. He said he had no desire to have sex with CSWs" (Joy 24 years old).

"My husband work as a salesman. He has to go to several provinces, and many times has to stay over night at other places. However, he said he worked so hard every day so too busy to go find fun. He also said sometimes he worked until late evening. Then after working he often went back to the hotel and fell asleep immediately. He also told me that many times bellboys asked him about girls he just refused. Even though some young girls, whom he met by himself, offered sex for sale to him, he has never accepted. He has never lied so I trust him." (Prapapan 27 years old)

Reconciling:

In many cases, the mothers selected to perceive only information which fitted their own beliefs. Women in the study revealed that they had to trust what their husband said since, if they doubted it, they could not do anything, they just decided to trust them. They also altered some information to make their minds more comfortable.

This phenomenon was found in many places, such as in the following quotations:

"After knowing that he had sex with CSWs I was so angry and regretted it.. I also worried that he might bring disease to me, but he said he wore a condom. I think he did since he should know how to protect himself." (Sunee 25 years old)

"He said he just went with friends to sing along in ka-ra-o-ke club, by the end of this entertainment his friends were accompanied by girls from the club to go some where else, but my husband came back home...He came home by midnight." (Namooi 28 years old).

In responding to my question whether any wife used to accompany, or had seen, the results of the blood examination of their husbands? The answer was no one did. Therefore, their perception on the blood examination of their spouses was only based on the assumption that the blood test for a health check up also included HIV examination. In fact, the HIV test is not scheduled to include in the routine health-care check up. The HIV test is based on the voluntary decision of the owner of the blood sample. They have to indicate this specific test in the request form for the blood examination. Some hospitals have various routine health checks-up programs and some optional programs will include the HIV test in the request form but the cost of the test is rather high.

Women's cognition:

According to information in table 6.4 it was found that women perceived their vulnerability to HIV/AIDS at different levels. For instance, whilst one woman (case 3.5) perceived a high risk level because her husband worked as a salesman, and she performed an ideal self-care, another woman (case 3.6) who was wife of one salesman viewed herself as at no risk, and she applied only general precautions for prevention of HIV/AIDS. Another example is one woman who viewed herself as at no risk even though she knew that her husband had un-protected sexual relations with another woman whilst another woman viewed the same evidence as her high risk. Furthermore, one woman viewed herself as high risk who only perceived that

her husband had a history of casual sex. Therefore, how women perceived their vulnerability may be influenced by their opinions of the evidence.

SECTION 6: WOMEN'S SELF-CARE TO PREVENT HIV/AIDS

In response to the question, "What have you done to protect yourself from AIDS disease?" Nearly all of them (n=36) answered quite similarly, and it reflected their beliefs that they were not vulnerable to the disease. However, responding to various vignettes, self-care among women in this study can be understood once again in terms of general self-care and specific self-care.

NATURE OF GENERAL SELF-CARE

The objective, attributes, activities and consequences of general self-care were not different from the findings from the first phase of this study. All women perform this type of self-care which can be categorized as follows:

- Carefully selecting the place for having hair cut, avoid sharing needles and sharp instruments with others
- Caution not to be exposed to others peoples blood or secretions
- Strictly to be non-sexually promiscuous person

One woman told her story:

"In general I have my hair cut at the beauty shop where I am familiar with the owner for a long time. I know that she cleans all instruments very well. However, I have my own set of nail- cutters. My husband also has never used a razor at a hairdressing shop. He shaves his beard off by himself at home. I don't visit my friends at hospital, I saw an AIDS patient there. He had awful skin lesions. I was so

scared then that I stayed a distance from him. I was afraid to be exposed to his body fluid and blood from his wounds.” (Yoopayong 35 years old)

As discussed previously general precautions are not difficult for women since they have authority to do this without any cooperation from their husbands. However, this self-care may be not able to protect women from getting HIV/AIDS, which might be transmitted by their husbands. Therefore, specific self-care needs to be performed and will be discussed next.

NATURE OF SELF-CARE TO PREVENT HETERO SEXUAL TRANSMISSION

The majority of women (n=35) in this study answered that they had never thought about the prevention of HIV/AIDS from their husbands. They perceived that they did not have any risk of the disease since all of them were not promiscuous persons. However, there were nine women, who performed some activities that could be considered as self-care in order to protect themselves from getting HIV from husbands. Their self-care can be classified as follow:

Applied preventative measure (n=2): One example was:

“I had attended a training course about AIDS and learnt of it when I was a student. My boyfriend is a salesman. He goes around from place to place. Therefore, I am not confident that he might not have casual sex. I recognized the situation which I had already learned about. I thought I should not take the risk, and I am lucky that my friend works at the hospital laboratory. My boyfriend and I went directly to the labs to be tested for HIV, and got the results there” (Nan 30 years old).

Adopted safer sex practice (n=1) by abstinence for sex until confident that husband stops casual sex. The respondent explained:

"I was very angry. I thought why did he not take responsibility and protect himself. I had so much suffering from getting syphilis. Particularly when I had to get several injections it was very painful. I decided not to sleep with him for a year. I even thought about divorce since I felt he did not care about hurting my feelings. After he behaved nicely and were checked and got negative result for this disease we reconcile to have sex as usual" (Kaew 32 yearsold).

Early treatment of sexually transmitted diseases (n=1): Woman described her self treatment as:

"When I got pain in my lower abdomen and was sore at urination I went to drugstore near by my house. After I taken a medicine the pain was over. When my husband came back home and he saidhe said to me about his sore and pain at urination. I said that serve hm right but I went to buy medicine for him" (Namoi 28 years old).

Monitoring husband's HIV/AIDS risk behaviours by visiting husband's work place without appointment, and checking any cue of extra marital sex (n=1).

"He is not a ladies man. However, as I know at his work place that many of his colleagues are so promiscuous. It start from their boss down until workers, they often drinking alcohol and like to go to prostitutes in town" (Pha 22 years old).

Management to stop husband's extramarital sex by negotiation with husband's other girl (n=1). Her story was:

"I began to suspect when she visited him without appointment. I found he had intimate talk with that girl. I start to observe his behaviour and found her telephone number and her mother's home address. I went to see and to talk with her to stop her relationship with my husband or else I will tell her mom about this issue. Since she is a school teacher she afraid that this would be recognized by the school principal and her mom. After he knew this matter he promise me to stop his relationship with her" (Racha 33 years old).

Arrangement to move husband from unsafe environment: One woman convinced her husband to leave the work place where his colleagues were likely to drink and go to CSWs. She said:

“Previously we lived in another province. At my husband’s work place, after work they gathered around and drank alcohol. Many times they persuade each other to go to the prostitutes. My husband, even though he said he didn’t go but sometime he came back home late. My sister lives here and she tell me about this place. So I decided to ask him to work here because they provide house for us to live in side. Even though my husband still has drinks with his friends it is just at our neighbours’ houses. I can go there to ask him to come back home more early” (Arunothai 30 years old).

NATURE OF SELF-CARE TO PREVENT VERTICAL TRANSMISSION

Prevention of HIV/AIDS from mother to child transmission among respondents (Table 6.4) was focused into two periods.

Before pregnancy: There were 2 couples who applied preventative measures for vertical transmission by having VCT for HIV before deciding to have their next child: These were the same couples, who had VCT for HIV before marriage.

“Asking him to be tested before marriage was easier, but before I got pregnant was harder. He said he had tested already so there was no need to be tested again. I perceived that there were several people that had got AIDS. I even know one of the CSWs, who still sell sex. My husband has to drive a car for his customers to several places. He stays overnight in other provinces many times. I thought if he got AIDS my kid would be infected. I felt pity for my child. So I tried to convince him to be checked for his health since he has a problem with his thyroid gland. Then I took this chance to ask him to be checked for AIDS at the same time” (Luntum 30 years old)

During pregnancy: All of respondents had VCT for HIV on the first date of attending ante natal care clinic. However, majority of them (n=30) did not know before that this would be done. In addition none of them had any anxiety about the blood test results, because they never saw themselves in a high risk group for HIV/AIDS. One woman said:

“Not until my aunt told me, I hadn’t known I had to attend ante natal care clinic. Let alone knowing about blood tests for AIDS before marriage or before getting pregnant, I did not recognize the danger. I began to attend the clinic after getting pregnant about 6 months. The doctor admonished me and teased me that if I had come later she might not have given care to me” (Panwad 22 years old).

PATTERN OF WOMEN’S SELF-CARE

Table 6.3 Pattern of women’s self-care

Antecedents	Attributes	Consequences
- Concerning over her own & child’s health -Recognition of AIDS victims -Husband’s occupation (Luntoom)	-Perception of susceptibility & severity -Perception of preventive measure -Cognition proficiency -Hardiness	-Husband being tested for HIV -Free from worrying -Confident of not being infected with HIV
- Perceived knowledge about AIDS - Concerning over her own & child’s health - Social care from friend - Husband’s occupation & lifestyle (Nan)	- Perception of susceptibility and severity - Perception of preventive measure -Cognition proficiency	- Husband being tested for HIV -Free from worrying -Confident of not being infected with HIV
-Social support from health professional - Concerning self and health - Husband’s risk behaviour (Kaew)	- Perception of susceptibility& severity - Perceived benefit of safer sex -Equal power relation with husband	- Husband being tested for sexually transmitted disease - Husband behave more nicely
-Discover husband’s extramarital sex -Personal strength (Racha)	- Perception of susceptibility& severity - Personal hardiness - Cognition proficiency	-Husband behave more nicely -Free from worrying
-Recognition of AIDS victims in community -Unsafe environment of husband -Husband’s gets drunk with friend (Arunothai)	- Perceiving severity & susceptibility of HIV/AIDS - Personal hardiness	-Being infected with HIV before moving - Controlling husband’s situation
- Concerning over her own health (Namoi)	-Perceiving severity of sexually transmitted disease - Self reliance	-Releasing from abnormal symptom
- Social care from Aunt (Panwad)	- Perceive benefit of preventive measure	- Free from worrying
- Recognition of AIDS victims in community - Unsafe environment of husband (Pha)	- Perceiving severity & susceptibility of HIV/AIDS - Cognition proficiency	- Free from worrying but not unsure of the outcome of her action

According to respondents' information and professional knowledge, it seems that women have a self-care deficit, which confirms the findings from the first phase as well. This can be illustrated by table 6. 4 as follow:

Table 6.4 The comparison of women's self-care and ideal self-care , n= 38

Ideal self-care	Perform	Non- perform
General precaution	38	0
Self-care to prevent hetero-sexual transmission	9	29
Self-care to prevent vertical transmission:		
-Before pregnancy	2	36
-After pregnancy	38	0

Since women's self-care seems to be relevant to how they perceived vulnerability therefore tabulation was used to display and cross-reference the relationship between protection risk and aspects of specific self-care for the 11 women who practiced some specific self-care and another 27 women who did not practice.

Table 6.5 Women's self-care and perception of HIV/AIDS among three hospitals, n=38

Risk assessment	Perceived risk level	Specific self-care	Relative protection
Moderate	High* (Luntoom)	<ul style="list-style-type: none"> • Man and woman got VCT before marriage & before deciding to have child • Facilitate her child to make a phone call to her father • Giving condom to husband before leaving to work in other province 	High
Moderate	High * (Nan)	<ul style="list-style-type: none"> • Man and woman got VCT before marriage & before deciding to have child • Calling via phone every time husband leaving for another province 	High
High	High* (Kaew)	<ul style="list-style-type: none"> • Receiving proper treatment from doctor • Couple had blood test for VDRL • Refused to have sex with husband until ensure husband did not patronise CSWs 	High
Moderate	High* (Arunothai)	<ul style="list-style-type: none"> • Arranging husband moving from unsafe environment 	Moderate
Moderate	High (Sunee and Namwhan)	<ul style="list-style-type: none"> • Asked husband not to patronise CSWs 	Low
Moderate	High (Tip)	<ul style="list-style-type: none"> • None 	Low
High	Moderate (Namooi)	<ul style="list-style-type: none"> • Self medication by buying medicine from drug store for treatment of both herself and husband • Asked husband not to patronise CSWs 	Moderate
Moderate	Moderate (Racha)	<ul style="list-style-type: none"> • Asked husband not to have extramarital sex • Negotiating with another girl of husband 	Moderate
Moderate	Moderate (Jitree)	<ul style="list-style-type: none"> • Asked husband not to patronise CSWs or have extramarital sex 	Low
Moderate	Low (Pha)	<ul style="list-style-type: none"> • Monitoring husband's risk behaviour 	Low
Low-Moderate	Low-Moderate (N=27)	<ul style="list-style-type: none"> • None 	Low

Note: * Women's perceptions as high risk occurred before being involved in this study

From table 6.5 it seems that for women to perform two types of self-care for themselves and their next child they not only need to perceive their own vulnerability but also need the cooperation of their husbands. Such a complex inter-relationships involves many issues some of which will be discussed further.

BARRIERS TO WOMEN SELF-CARE

Low self recognition

In Thailand and also in Khon Kaen, the high transmission rate of HIV/AIDS meant that it was well recognized as a sexual transmitted disease. Women who were monogamous therefore, could get the HIV infection only from an HIV infected husband. Almost all of the monogamous wives (n=33) in this study then believed that it was the responsibility of their husbands, not them, to prevent this disease from entering their family. The following come from one woman.

"It does depend on the man. It is his responsibility, not a woman like us to take preventative measures. I have never had a chance of being infected since I sleep with only my man, and even something like nail cutting I have had my own set of clippers. If my man does not visit CSWs, both I and my kid will not be at risk. I can do nothing, in the case where my man is irresponsible, having sex with a commercial sex worker without using the condom, so it can be dangerous. He already knows about this incurable and dreadful AIDS, It depends on him, whether he loves his family, wife and children or not" (Nong 27 years old)

It was found that many respondents (n=21) gave more significance to the satisfaction of their husband and child rather than themselves. These women viewed that well being and pleasure of husband and child was the first priority. One woman said:

"I did not like to complain too much. I do not want to hurt his feelings in thinking that I do not believe him. I just hope he tells the truth. Another thing is I am so busy at my work place. When I come back home I have to do every thing myself, preparing meals for my husband and kid, particularly because my kid is so young. These jobs take almost all of my time" (Malee 29 years old)

Low self-efficacy

Low self efficacy among respondents was from several factors:

- Perception of preventative measure as male method (N=35)
- Lacking of knowledge and skill to adopt preventative measures such as female condoms (n=38) and volunteer counselling and testing for HIV (VCT) (n=35).

- Inferior power relation with husbands (n=31).
- Lacking of essential skills for safer sex practice within marriage such as skills to assess accurately their own vulnerability to HIV/AIDS (n=35).
- Lack of negotiation skills to deal appropriately with husband after knowing of their extramarital sex (n=34).

One woman described:

"After the first interview, I asked my man whether he had ever been involved in a commercial sex service since we had married. He was reluctant to say at first, but confessed later to that activity after I was insistent to know. It really shocked me. He told me that it happened one month ago. He had been out and drunken with friends then ended up in the brothel. Well, I could not do anything since the event was a month in the past and we slept together as usual. He also said he used a condom, but I did not know whether he told the truth or just said it to comfort me. However, I did not do any thing since I only found out after having sex with him several times."
(Sunee 25 years old)

Inadequate self-care capability

Lack of skills to prevent husband's extramarital sex: There were two crucial conditions among women which might lead to husband's extramarital sex. These include sexual imbalance, and sexual relation prohibiting conditions (detail in section 4). However, women seemed not to be aware of these matters. In addition women could not solve these problems. This may be from lacking particular skills to deal with these conditions. If these conditions led the husband to have extramarital sex, it meant that women could not prevent husbands from having sex outside of marriage.

Inadequate skills to solve sexual imbalance: It was found that at least five women had this life experiences. The following expressions illustrated lack of skills to solve sexual imbalance among women.

"After giving birth I did not have any sexual desire. My husband demanded it so much. I got pain and did not enjoy having sex. I could not refuse my husband, and do not know how to." (Lada 25 years old)

"I wonder if there is any drug which can reduce men's sexual desires. I am very boring to have sex with my husband. I have even refused but he got mad, and he said he suspected that I did not love him. Why do men like to have sex very often?" (Namwhan 35 years old)

Lack of skills to help husband's get through sexual relation prohibiting conditions: Majority of women did not think it would be their responsibility, and had no skills to help husband get through this event (detail in section 4). This evidence was illustrated clearly in life experience of one woman as:

"During pregnancy and after giving birth I didn't have sexual relations with him. It is now two months after delivery, but I still do not sleep with him, since I have not had a health check-up after delivery yet. I don't know how my husband deals with this problem. I just leave this to his responsibility. Only men should know how to do this, and I have no idea how to do" (Kitty 20 years old)

Fatalism coping style

The hardiness characteristic was found among women, who performed specific self-care. On the other hand there were respondents who believed they could not change their husband's sexual risk behaviours and had to live their life with them. The majority of women (n= 31) developed a fatalist coping mechanism by "making their minds let it go", as saying in Thai 'Tham jai' (Jongudomkarn 2001). They leave their lives to "fate" literally in Thai "Choak cha ta". This meant that they could not do anything else. They would live their lives with these problems and hope it would be alright after all. One example which reflected this coping style is:

"He went out every night and came back home late at night. Sometimes so drunk that just slept in his car parked right in front of our house. He does not care what I ask him, he will still be the same and that makes me fed up with him. I think it is not a problem since it has been like this for many years. I have to Tum Jai or get stressed. I could not accompany him everywhere as I am so tired after working all day. He

said he just went out drinking with friends and never visited CSWs. Actually I could not know the facts. If I get AIDS it's maybe my Choak cha ta" (Tikumporn 36 years old).

SECTION 7: ROLES AND FUNCTION OF SOCIAL SUPPORT

SOCIAL- CARE AND WOMEN'S SELF-CARE

The range of social support was very limited for these women. Some described a warning system where women received warnings from senior relatives in their family mostly about the dangers of men going out drinking with friends, and having casual sex (n=4). In addition they also warned woman to attend for ante-natal care at the clinic. As a result women could get good healthcare, and get a blood test for HIV. Women did not get any warnings from the family about blood tests before marriage or before pregnancy.

A few women shared information with friends in terms of sexual relations and applied this to their married life. This practice was mostly among the younger women. However, this kind of support was not found among the majority of women in this study.

Ease of getting blood test for HIV. Only one woman and her fiancé received help from a friend and this facilitated them to get a test before marriage. This kind of support is not common and may not available for women in general.

HEALTH- CARE AND WOMEN'S SELF- CARE

Provision of information and health education

It was clear that healthcare services provided information relating to fact about HIV/AIDS, which could help women take general precautions to protect them from getting HIV/AIDS. However, women's culture relating to sexuality seemed to be a barrier to their receiving the disseminated information.

Provision of voluntary counselling and testing for HIV (VCT)

According to most women's (n=30) points of view this service was provided only in hospitals and the campaign to promote such a service had less impact on women. Healthcare services were not seen as helping women to perform ideal self-care. The majority of women had under-evaluated the risk of HIV/AIDS within their family, were under-aware of VCT before marriage or before getting pregnant, and during pregnancy. Consequently very few took up these ideal preventative measures.

Accessibility and feasibility of applying preventative measures

All of respondents stated that applying some preventative measures was difficult for women. Using a condom in their sexual couple was not practical and depended on the men. In addition they never had condoms available in their house if the use was needed. This was also true in respect to VCT for HIV before marriage and before getting pregnant. More than half of the respondents (n=24) viewed that it was difficult to use such services, unlike VCT during pregnancy. Two respondents said:

"Before marriage we did not think about any disease. We just too busy, preparing our wedding ceremony, to think about any other things. Asking my boy to get test was difficult since he might think I did not trust him. Before pregnancy is also difficult because I didn't take any method of birth control after marriage" (Vanisara 22 years old).

"I am tired of waiting in the hospital; it really eats up my time. If I am not seriously ill I will not go to the hospital. Even though I like my husband having blood test for AIDS, he may not like to do since he is very busy working all day. He also doesn't like to go to the hospital, particularly when he looks healthy. The other thing is we don't know how to request it" (Viyada 22 years old).

CONCLUSION

The characteristics of women and their husbands in the present study were diverse in terms of age, years of marriage, education, and occupation. Data combining was carried out and regular comparisons with findings from the first phase of the study were made. The aim of this phase of the study was to gain an in-depth understanding of Isaan women's experience with regard to self-care to prevent HIV/AIDS and this was achieved.

Isaan women's self-care to prevent HIV/AIDS:

It can be concluded that the self-care of Isaan women is composed of two types. General self-care aims to prevent contracting HIV/AIDS from other people outside of the marriage. Specific self-care aims at prevention of heterosexual transmission and vertical transmission within the marriage.

Nature and pattern of general self-care:

Perceiving that AIDS was a fatal incurable disease coupled with being afraid of being infected, women performed some self-care action to protect themselves from getting HIV/AIDS, which might be transmitted to them by other people outside of their family. The majority of Isaan women's self-care in this type was general precautions to inhibit contagion from body fluids. These included avoiding the

sharing of needles and sharp instruments with other people; avoiding contracting other body fluid; and not practising promiscuity.

The characteristics of specific self-care which derived from the explanation phase were: 1) applying preventive measures into practice by persuading male partner to get test for HIV before marriage, and before pregnancy, 2) adopting safer sex practices until getting cues that ensures the husband had stopped risk behaviour, 3) obtaining early treatment of sexually transmitted diseases, 4) arranging for the husband to move from an unsafe environment, 5) managing husband to cease extramarital sex, 6) requesting husband to be tested for HIV before reconciling to have sex again following an episode of extramarital sex, 7) monitoring husband HIV risk behaviours, and 8) asking husband not to patronage CSWs or have extramarital sex.

The antecedents of specific self-care of Isaan women were: 1) concerns about the health of 'self' and children, 2) ideas about HIV/AIDS, 3) social support from both social-care and health-care, 4) women's strengths and hardiness, and 5) husband's lifestyle and risk behaviours.

The attributes of specific self-care were: 1) cognitive capability, 2) self-responsibility, 3) health beliefs, 4) high self-esteem, and 5) self-care capability such as power information and negotiation skills.

However, many women could not or did not perform specific self-care adequately.

The major obstacles to self-care were: 1) under-perception of HIV/AIDS

vulnerability, 2) misconception about HIV/AIDS and preventative measures, 3) low self recognition, 4) low self-efficacy, 5) inadequate self-care knowledge and capability, 6) women's coping style, and 7) inadequate social support.

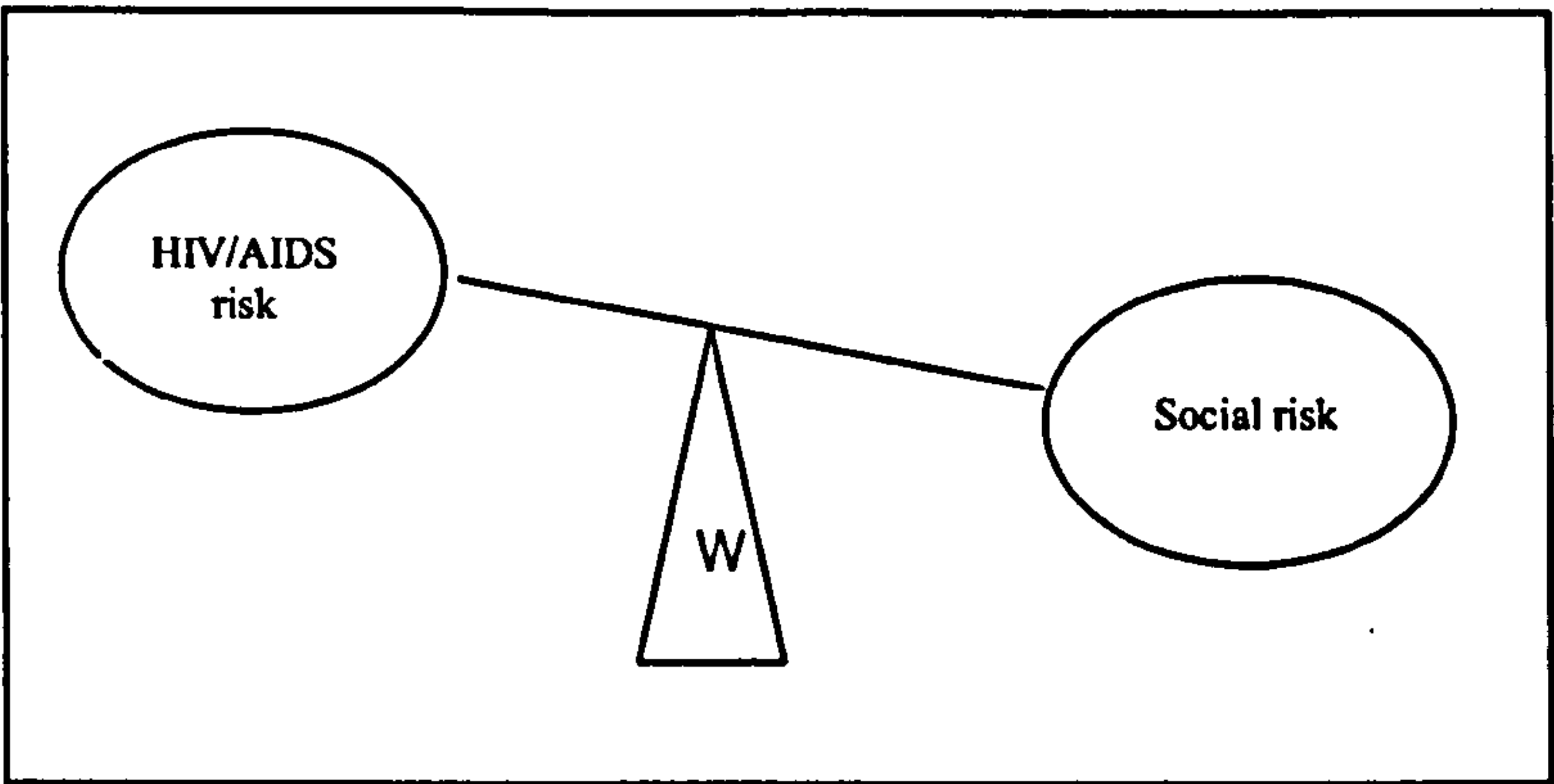
Social support for women's self-care

Two types of social supports seem important. The social-care received from senior relatives which acts as the warning system and the support from friends to acts as facilitators. Such support helps women to perform specific self-care effectively especially that related to pre-marital and pre-pregnancy counselling. The health-care service provides information related to HIV/AIDS facts and existent preventative measures. It also provided service in regards to volunteer counselling and testing for HIV. However, the services provided were not congruent with the women's culture and needs, as they could not prepare women to deal promptly with the complicated problems of HIV/AIDS prevention within marriage in Isaan.

Implication for intervention phase

Performing self-care to prevent HIV/AIDS was found to be difficult due to several factors as mentioned above. To maintain a good relationship with their husbands and avoid social risk, women seem to be prepared to accept an HIV/AIDS risk as illustrated by figure 6. 1 below:

Figure 6.1 Unbalanced risks of HIV/AIDS among Isaan women



Note: 'W' represents women

Therefore, socio-cultural sensitive measures, which can help women, achieve a better balance between HIV/AIDS risk and social risk needs to be established. Since the obstructing factors to women’s self-care relate to low self-recognition, low self-efficacy, inferior-power relationships with their husbands, and fatalist coping style, an empowerment process is needed and was selected for the intervention phase of the study.

CHAPTER 7

WOMEN'S TRANSFORMATION AND INITIATION INTO HIV/AIDS PREVENTION

This chapter presents the findings from the participatory action research phase, which was carried out with six groups of women from three hospitals. Once again pseudonyms have been used for each of the women and quotations have been selected based on the best illustration of the concepts and phenomena. The chapter is composed of five sections as follows:

Section 1: From understanding to acting

Section 2: Personal background of the group members

Section 3: The interaction process of participatory action research (PAR)

Section 4: Transformation process and outcome of the PAR programme

Section 5: Suggestion of future health service

SECTION 1: FROM UNDERSTANDING TO ACTING

The intervention phase was conducted in order to achieve two objectives of the present study:

- 1) Empowerment of women to perform self-care in order to protect themselves and their next child from HIV/AIDS.

- 2) To initiate a socio-culturally sensitive service, from the woman's perspective, to enhance women's self-care in order to protect themselves and their next child from HIV/AIDS.

The findings from the exploration and explanation phases clearly revealed how difficult it was for women to perform ideal self-care to protect themselves and their next child from HIV/AIDS. The majority of women could perform general self-care or precautions. Only a small number of women performed specific self-care. The researcher believes in women's innate wisdom that if they have the opportunity for rethinking their own situation and receive good support, then their potential could be mobilized to benefit them in terms of performing effective self-care. In addition the main purpose of the present study was to create a socio-culturally sensitive programme for HIV/AIDS prevention, which is initiated from the woman's perspective. To do so needed active involvement from women.

The researcher believed that the direct experience of women with regard to performing specific self-care to prevent HIV/AIDS would facilitate effective participation. In addition the PAR process would enable women to gain insight into their own situation in terms of HIV/AIDS vulnerability more accurately. They could then consider and make decisions to perform self-care actions by utilizing existing supportive resources appropriate to their vulnerability. The roles of all research participants were described and agreed upon by all participants before the implementation of PAR (detail in chapter 4).

SECTION 2: PERSONAL BACKGROUND OF THE GROUP MEMBERS

Twenty-nine out of 38 women who were interviewed for two sessions in the explanation phase (detail in chapter 6 and table 6.1), according to their time schedule, could participate in all 5 cycles of PAR. Based on their convenience, women from each hospital determined to participate in any group by themselves. There were six groups of participants in this phase, 4-5 women formed the group. The personal profile of each woman in each group is given.

GROUP I

NUMBER I.1: JITREE was a housewife but she also sold vegetables at the market every day as a supplement to her husband's income. Jitree perceived her husband as a ladies' man, who worked in another province. He also got drunk very often, and she found condoms in his pocket. She accepted that she had moderate vulnerability to be infected with HIV. However, her husband had always told her that he had to have blood tested for HIV routinely and he had negative results. In addition her husband was a quick-tempered man, and had higher rank relationship with Jitree. She therefore had to try not to think too much about this matter

NUMBER I. 2: PON was a housewife. Her husband used to be a teacher at a primary school, but now she and her husband were farmers. They lived together therefore, even though husband had never been tested for HIV, Pon was 100% confident that she was not infected with HIV. Based on Pon's perception the power relationship between the couple was equal.

NUMBER I. 3: MALEE was a teacher at a kindergarten school. She lived together with her husband, who was a driver and ran a small business as a car fixing shop. Her husband often came back home late at night. He told her that after fixing cars he was so exhausted that he went to have traditional massage. She knew that some massage places offered sex services to customers. Despite this Malee wasn't sure that her husband had had extramarital sex but she could not ask since she thought it might create conflict in her family. The power relationship between the couple, based on Malee's perception, husband had higher rank than her.

NUMBER I.4: NIDA was the youngest woman in the group and was a housewife. She and her husband lived together with her extended family. Based on Nida's perception the power relationship between the couple was equal. She was not worried a great deal about being infected with HIV since her husband did not often go out for entertainment or drinking alcohol.

NUMBER I.5: PIM was a housewife, whose husband could only come back home twice a month. Pim perceived that her husband had high moral standards and she believed that all policemen had blood tests for HIV routinely. Therefore, she did not worry much about her vulnerability to HIV/AIDS.

The only man who participated in the group was Nida's husband. He was initially forced by his mother-in-law to accompany Nida to participate in the group. However, he participated in the following four sessions due to his own interest.

GROUP II

NUMBER II.1: ARUNOTHAI was a housewife and lived together with her husband. This couple used condoms to prevent conception only before the action of pills become effective. She also earned money from being a dressmaker. Based on her perceptions she had an equal power relationship with her husband, who drank alcohol quite often with friends. She escaped from home to protest against her husband going out at night with friends. After this event and mutual agreement her husband drinks but with friends who live nearby. Her husband had never been tested for HIV and she was confident that she had no vulnerability of getting HIV from her husband.

NUMER II.2 KAEW a house wife of a retail dealer. Kaew helped her husband run the family business whilst taking care of two children. They lived together all the time. However; she was infected with syphilis by her husband several years ago. Sleeping with CSWs was normal practice among her husband's kinsmen. She refused to have sex with husband for a year after husband promising and behaving more properly with her, she reconciled to have sex with him. Now she believed that if he did patronise CSWs he would probably use condoms. Her husband was often drinking alcohol with friends and relatives and had not been tested for HIV. Based on Kaew's perception she had an equal power relationship with her husband.

Researcher reflection: Arunothai and Kaew's cases were good examples of high self esteem. To protect themselves, they bravely challenged men's power. They determined to take social risk rather than taking AIDS risk. This practice does not often occur in Thai society. Therefore, these examples were brought into and discussed in groups.

NUMBER II.3 TIP a housewife of an office manager of a company. Her husband was a dictator of a man and often drank alcohol with friends when he was out. Even though he had several partners before he married Tip, he said he did not like to visit CSWs. Tip had never been infected with any sexually transmitted diseases, but she was worried by his history of casual sex.

Researcher reflection: Tip believed that it was useless to ask about husband's sexual behaviour as it created family conflict. She therefore, developed a fatalistic coping style, and this result in another unbalance between AIDS risk and social risk among women in this study.

NUMBER II.4 KITTY a housewife of a jockey. This couple lived together. According to Kitty's perceptions her husband was a reliable person, and he did not often ask to go out with friends. Since Kitty had had a previous miscarriage, during her last pregnancy and post delivery she did not have sexual relations with husband. This period covered about thirteen months, and she had not paid attention as to how her husband had released his sexual desires. However, she had seen that her husband had masturbated a few times.

Researcher reflection: Less attention or ignorance of sexual relations during particular conditions of women may lead men to take their own actions and have extramarital sex. This issue was raised for discussion in the group later on.

NUMBER II.5 SUNEI a house wife, who was studying in her last year at vocational school and lived together with her husband. Sunee had one relative who had died from

AIDS. Sunee told the researcher that she had just found out that her husband was having extramarital sex with CSWs. Her husband told her that he used a condom therefore she just asked him not to do it again.

NUMBER III.1: NOM and her husband were traders. The couple lived together, and according to her belief her husband seemed to be in awe of Nom. She believed that her husband was in her sight at all times, and had never visited CSWs. In addition she could not use any other kind of contraceptive method, and did not want to be concerned about safe period, they used condoms every time while having sexual relations. Therefore, she was confident that she had no vulnerability to HIV/AIDS.

Researcher reflection: Using condom while having sexual relation with husband not only prevented Nom from getting pregnant but also from getting HIV/AIDS from husband as well. Her practice was taken into discussion about women self-care in all groups afterwards.

NUMBER III.2: JAN and her husband were studying. Even though they lived in the same community her husband went back and forth between her house and his parent's house. Therefore, she was never sure that he would not have extramarital sexual relations, since he sometimes drank alcohol, and had never been tested for HIV. They never used condoms, so she considered herself to be at moderate risk of HIV infection. However, one thing which made her less worried was that he had no money to visit CSWs. In addition, Jan suspected that one of her aunts might be infected with HIV since after being a widow she had had several friends who were men, and went to see doctors

several times. However, she argued to herself that if her aunt had HIV then why she was so healthy and looked very good.

Researcher reflection: Although having had several sexual partners is not the norm among the majority of Thai women there are some who do. Jan's suspicious about her aunt was raised as an issue, for discussion within the groups. In addition Jan's relationship with her husband seems unstable. This circumstance may make Jan at risk of HIV/AIDS therefore, this problem was also taken into the group discussions.

NUMBER III.3: RABIN lived with her husband who was studying. They had one child without a wedding ceremony and without marriage registration. Rabin earned money by selling barbeques meatballs whilst her husband relied on his parents. Every three to six months he donated blood at one hospital in Khon Kaen, therefore she was confident that she had less vulnerability of being infected with HIV from her husband.

Researcher reflection: Regular blood donation of husband helped Rabin knows her husband's HIV sero-status. In addition it also influenced her husband's sexual behaviour as well. The advantage of blood donation in respect to HIV/AIDS prevention was then brought to the group be considered

NUMBER III.4: NOON was a shy housewife of a contractor for housing construction. Sometimes her husband had to work and stay overnight in other provinces. Even though he had never been tested for HIV and sometimes drank alcohol, she had never thought her husband would transmit HIV to her. This was because she believed that her husband

had never visited CSWs. She had just given birth three months previously. Both Noon and her child had HIV sero-negative results.

Researcher reflection: Because husband was several years older than Noon, and her economy relied on her husband's income, Noon seemed to obediently trust her husband. Although she gave migration as a factor of extramarital sex among men, during in-depth interview, she did not link this factor to her own situation.

NUMBER III.5: ANN and her husband were traders and lived together. Ann perceived that she had a power relationship equal to her husband. One of Ann's friend got HIV from her husband, who died from AIDS. Her friend married another man even though she knew in her heart that she was infected with HIV from her ex-husband. She told this man about it, but he did not believe her and married her friend anyway. Ann tried to persuade her husband to be tested for HIV but he did not comply since she had no strong reason to convince him. But she said before deciding to have their next child she would ask him again since he was often drinking alcohol with friends, and she thought he would agree if he were doing it for their next child.

Researcher reflection: Doing it for the child seems to be a common reason among women for persuading their husbands to be tested for HIV.

GROUP IV

NUMBER IV.1: PHA was married to a man who was a company employee. They lived together and had an equal relationship. Drinking alcohol in a group and visiting CSWs or casual sex were a norm of her husband's colleagues. However, her husband did not often come back home late except occasionally when he did a part-time job. After marriage, her husband gave all his income to her every month. Pha therefore, was not so anxious about his sexual behaviour. She also earned money as a laundress. They sometimes used condoms for birth spacing and not for HIV prevention. In the long term, Pha used the contraceptive coil to prevent pregnancy.

NUMBER IV.2: LADA was a housewife and her husband was a bus driver. This couple lived together and her husband had a higher rank in their relationship. Her husband had an operation after he fractured his leg in an accident; therefore she believed that her husband would have been tested for HIV. Lada and her husband had episode of sexual imbalance in their relationship several times. She did not discuss this with her husband because she believed that it would not help.

Researcher reflection: Since this situation was found among other women (participant number I.1, IV.3, V.2, and VI.5), it was taken into discussion in all of the groups.

NUMBER IV.3: MARAYAT was a housewife. Her husband previously had a secret mistress for a period of time but finally returned completely to his wife. Her husband worked abroad and therefore he was tested for HIV before going there. Marayat knew

that her husband had not used a condom whilst having sex with his mistress. However, she could not convince her husband to have his blood tested for HIV after he came back from having extramarital sex with another woman. Marayat felt there was a sexual imbalance in the relationship with her husband, in particular, during pregnancy and the postpartum period. Although she earned money from selling barbequed meat ball every day her husband's earning was the main source of family income.

Researcher reflection: Marayat had a negative attitude about sexual relations. She seems to believe that a good woman should not be interested in sexual relations, and should not express her sexual desires. Marayat relied on her husband's income and complied with her husband's demand. This situation is one example of low self-efficacy among these women and it may lead them to risk their own health. Marayat had to weight these risks.

NUMBER IV.4: PANWAD was a housewife of a man who ran a small business with friends. Panwad graduated from vocational school but was unemployed. Therefore she looked after her child at home whilst her husband worked and lived in another province. He came back home twice a month. She once secretly added one type of drug into her husband's glass of whisky in the belief he would stop drinking alcohol. After severe vomiting he completely quit from drinking alcohol. Panwad therefore, was very confident that she was not vulnerable to HIV/AIDS from her husband.

Researcher reflection: Panwad had positive attitude about sexual relations. She was interested in information about this and used the information to improve her sexual

relations with her husband. Her attitude and practice were brought into the group discussions.

NUMBER IV.5: RACHA was a housewife and her husband was a teacher. Her husband worked and lived in another province. He came back home only during week-ends. Her husband had had extramarital sexual relations with another woman for a period of time. She solved this problem very wisely by tackling the mistress directly and finally her husband returned to her. Her husband met a good friend who persuaded him to cultivate a money-generating hobby and he could earn more from this hobby and thence behave more properly. Her husband had never been tested for HIV but she was confident that he had given up his old behaviour and she was less vulnerable to HIV/ADS.

Researcher reflection: Experience of this participant was a good example in many aspects such as solving problem of husband's mistress; management after knowing husband had unprotected extramarital sex, and the benefit of hobby. These experiences were taken into discussions in the last three groups.

GROUP FIVE

NUMBER V.1: YOOPAYONG and her husband were of the same age and at the same level of education. Whilst her husband ran a small business Yoopayong did all the household chores and took care of their child. Her husband had to live in other places occasionally and he had never been tested for HIV. Yoopayong, however, had never worried that her husband would transmit HIV to her because she believed that her husband did not like to patronise CSWs. In addition he had attended a training course

for HIV/AIDS prevention, and after that he was sometimes the instructor of the course. Moreover her husband had some collaborative work with Christian organizations. Both of them used to participate in seminars for the promotion of family ties, which this organization conducted. Yoopayong said she was very confident that her husband would not be unfaithful to her since she had never been remiss in a good wife's duties.

Researcher reflection: It was found in this study that many women believed, same as Yooppyong, that if they were good wives and faithful to their husbands the husband would do likewise. This issue was used to encourage critical thinking with women in all groups.

NUMBER V.2: NAMWHAN was a housewife to a man, who worked as an officer of a private company. They lived together and her husband had slightly higher rank in their relationship. Both of them had never seen an AIDS affected person. She discovered that her husband accompanied his uncle to visit CSWs. Her husband had never been tested for HIV. Since he always liked to go out drinking with friends she was worried that he might have more extramarital sex. She had experiences of sexual imbalance with her husband, which she could not solve.

Researcher reflection: Even though discovered husband's extramarital sex with CSWs, she had never requested husband to get test for HIV before having sex with him again. The researcher motivated discussion of this issue with all groups of women in this study.

NUMBER V.3: PLOY was a young housewife. Only her husband earned money from being a private employee; however they had been friends since school and their power relationship was equal. Her husband had never been tested for HIV, but she was not worried since he did not often go out with friends at night. She had heard her husband warn his friend who had had unprotected sex therefore Ploy was confident that her husband would not have unsafe sex outside of marriage. They lived together and she took pills for birth control.

NUMBER V.4 LANTUM was a trader who was married to a man who worked as a government employee. Her husband also ran a small business for car renting. Therefore, very often, he had to go and stay overnight in other provinces. Her husband had one nephew who was HIV positive. Her husband was “a ladies man” before he was married to Lantum. She persuaded him to get tested for HIV before marrying him and before they decided to have their second child.

Researcher reflection: Lantoom was one good example of women’s wisdom. She took the appropriate opportunity to persuade her man to be tested whilst retaining a good relationship with him. Her experience was shared and learned by her peer group and other women in group six since the researcher brought this issue to be discussed by them.

GROUP SIX

NUMBER VI.1: PRAPAPAN was a government employee whilst her husband was a salesman, who had to travel to other places and stay overnight regularly. He could come back home only during weekends. Prapapan believed that her husband had been tested

for HIV a long time ago in a health check up. Since he often lived far away from home she was sometimes worried about husband's risk behaviour, but tried not to think about it. Neither of them had sighted an AIDS affected person. Her husband had a slightly higher rank in their relationship.

Researcher reflection: Prapapan ignored the risk of AIDS. She seemed to believe that by asking her husband about his extramarital sex and asking husband to be tested for HIV would be mistrusting her husband. Trusting in some circumstances may not benefit women and may lead them to be at risk of HIV. Therefore the issue of trust of the Thai wife was discussed in all groups.

NUMBER VI.2: SOMSRI and her husband were government employees in the same organization. The couple lived together and her husband had the higher rank in the relationship with Somsri. Somsri and husband had seen an AIDS affected person. Her husband took excellent care of her and he had his health checked up (which she thought included testing for HIV). In addition her husband paid a great deal of attention to his health. Therefore, she determined that she had no vulnerability to HIV.

NUMBER VI.3: THIKAMPON and her husband were government employees. Her relationship with her husband was strained since her husband was always going out drinking with friends after work, but she liked to stay at home. He often went back home in the early morning. She felt hopeless to solve this problem since he never listened to her. Several times they had quarrels with each other particularly if Thikampon told him to not going out for a drink. She then adopted a coping mechanism

by not thinking too much about this matter. She believed that she could not change her husband's behaviour. She described her coping style as "Plong", which mean that she "was resigned to her own fate".

Researcher reflection: A fatalist coping style was found in some women in this study. This occurred among women who believed that they could not change some situations or solve the problems. To comfort their mind they adopted the saying "What ever will be will be" which implied just do nothing. This passive practice may lead women into trouble of HIV/AIDS risk. I have an optimistic idea that all problems can be solved. I do believe that with good support and sharing problems with other women the problem would be solved or reduced in many ways if the woman understands its cause and learns how to solve it. Such ideas were taken to all the groups.

NUMBER VI.4: WANVILAI was a government employee. Her husband's father had died from AIDS. Before he died her father-in-law often took his son to visited CSWs, and taught his son to use condoms with CSWs. Her father-in-law had never used a condom with CSWs, but as his wife had requested, he used it with his wife. Her husband had not been tested for HIV yet. Experience from his father made Wanvilai believed that her husband would not be infected with HIV. Wanvilai had severe sexual imbalance with her husband several years ago during the time that their first child was very young. At that time she felt as she was raped by her husband. When he saw her cry after sex her husband decreased his demand for sex with her. However, Wanvilai found that he talked closely with a CSW whom he had known before marriage. Wanvilai did not pay attention to this event anymore.

Researcher reflection: Sexual imbalance between a couple mostly occurred during three stages of the peri-partum and child rearing. It seems to me that women believed they have only two choices. They either have to be patient and respond to their husband's sexual desire or risk husband having extramarital sex. This was brought into the discussion of all groups.

NUMBER VI.5: NAMOOI and her husband were government employees. Her husband had to work in other provinces for long periods of time. During these times he came back home once in a while for a short period. He had been infected with a sexually transmitted disease and gave it to her a year ago. However he had not been tested for HIV. Two months before participation in this group her husband moved to work in the same province as her. At the present time they live together. In addition her husband had promised not to visit CSWs again. Therefore, she was not worried about vulnerability to HIV/AIDS or any STDs.

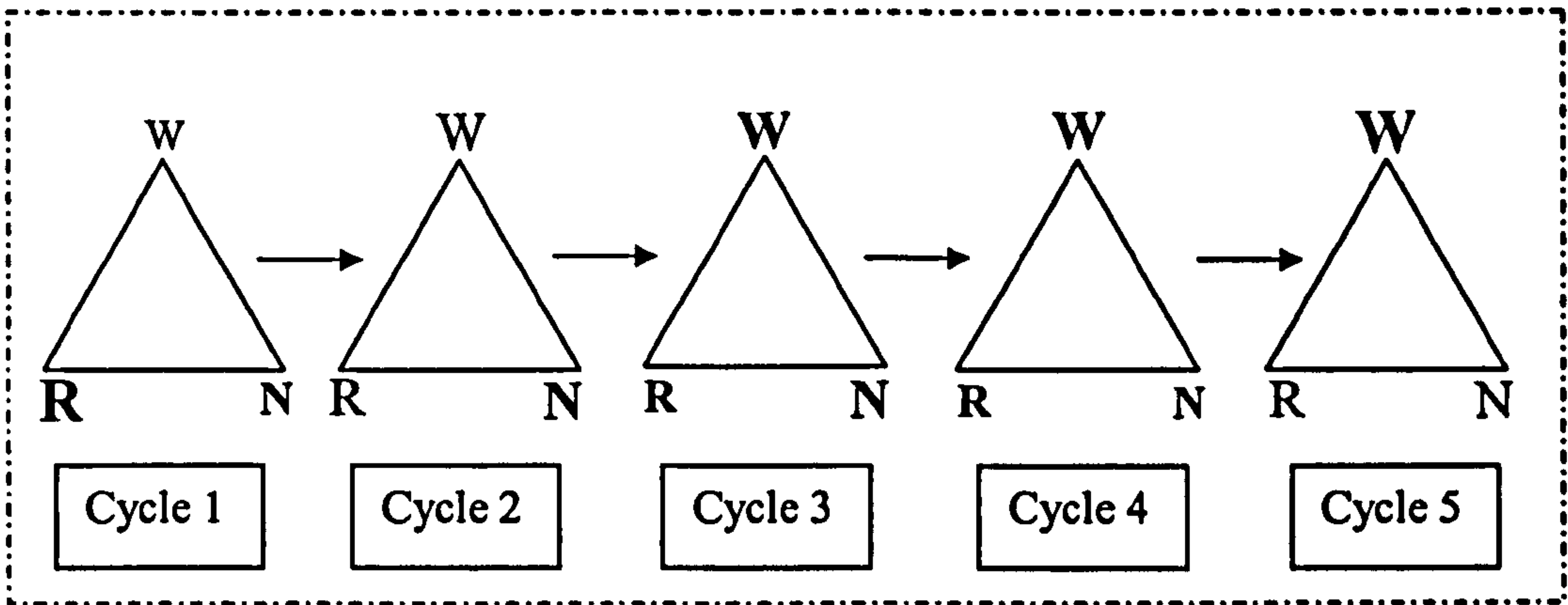
Researcher reflection: Although Namooi got a STD from her husband she did not ask her husband to be tested for HIV. Neither of them went to see a doctor for proper treatment. Namooi's case is one example of being unaware of the fact that she would be at risk of HIV/AIDS. Proper management after knowing about her husband's extramarital sex was one important issue brought to the groups. Namooi might believe that separate residency was the cause of husband having sex with a CSW therefore, if they lived together her husband would quit this behaviour. This issue was raised for rethinking in the group.

To illustrate the whole participatory action research process (PAR process) in this phase of the study I divide presentation into two sections. These are interaction process and transformation process of the PAR programme, which will be explained next.

SECTION 3: THE INTERACTION PROCESS OF PARTICIPATORY ACTION RESEARCH

In order to obtain effective participation from group members, roles of participants and rules for group discussion were addressed and agreed by all participants before session began (detail in chapter 4). However, roles of participants in the groups were varied according to which roles would be the dominant role in relation to discussed issues. The dominant stage of participants' roles during 5 PAR cycles can be illustrated by figure 7.1 as follow

Figure 7.1 Varying stages of dominant roles among participants in the PAR programme



Note: W = women, N= HIV/AIDS nurse counsellor, R= researcher : Big and bold letters indicate dominant role of participants

The interaction process was made up of five cycles. The PAR cycle began with gaining trust, moving to perception of vulnerability to HIV/AIDS then to explanation of self-care and action, then ways of self improvement, and finally to the initiation of the HIV/AIDS prevention programme. The components of each cycle were problems or pre-conditions which were brought into discussion and then followed through. The interaction processes which occurred in each cycle are illustrated in figures 7.2-7.6, and are also described in detail.

1ST CYCLE: GAINING OF TRUST

Trust among participants mostly emerged during cycle 1 and it was increased in cycle 2. This phenomenon was the basic foundation for self-reflection and open discussion among participants in the following cycles (figure 7.2).

Researcher reflection: One factor, which the researcher was worried about, was the barrier in Thai society for open discussion about sexuality, sensitive issues which generally can not be voiced publicly. In particular within Group I where the husband of one woman asked to participate with the group. However, it was found that this was not a real issue. All participants welcomed and accepted him as a group member, and could share with him freely. It can be explained that women generally might like to tell some things to their husbands, but when they have no opportunity to tell them directly, trying out with another trusted man might be a strategy to probe into men's feelings and to get their responses. Therefore this potential inhibiting factor did not become an obstacle but was in fact a facilitating factor in Group I instead.

In the other groups no man participated. The only barrier here was the Thai tradition that women have been taught not to disclose personal matters, particularly family issues, to other people outside the family. However, when all participants understood the purpose and the ethics of the study, this was not an inhibiting factor after all.

2ND CYCLE: PERCEPTION OF HIV/AIDS VULNERABILITY

The emergence of perception or awareness of vulnerability to HIV/AIDS was found in some participants during in-depth interviews, but was not strong enough to encourage them to perform any self-care action by themselves prior to participate in the group. After discussion within the group, and watching videos about other women's experiences of getting HIV/AIDS from husbands it was found that the women's awareness of HIV/AIDS vulnerability increased both by the number realising their vulnerability and their perceived level of vulnerability. This phenomenon mostly

emerged during cycle 1-2; however the perceived level of vulnerability varied among participants.

Catalysts were:

- 1) Learning from HIV/AIDS statistics and video.
- 2) Discussing the HIV/AIDS epidemic situation made women realize that levels HIV were higher than they expected.
- 3) Sharing ideas about the chance of getting HIV/AIDS and reflection from the peer group led women to recognise their vulnerability to HIV/AIDS.

Barriers were:

- 1) Social-desirability bias among women who had the tendency to believe that their husbands had adequate knowledge and high responsibility to protect his wife from HIV/AIDS.
- 2) Woman's belief systems such as 'no problem' or 'never mind', and the idea of "it won't happen to me" leading to ignorance of vulnerability of HIV/AIDS among women.
- 3) Women tend to look outward rather than look inside themselves because they fear seeing or knowing some things they do not like to perceive (figure 7.3).

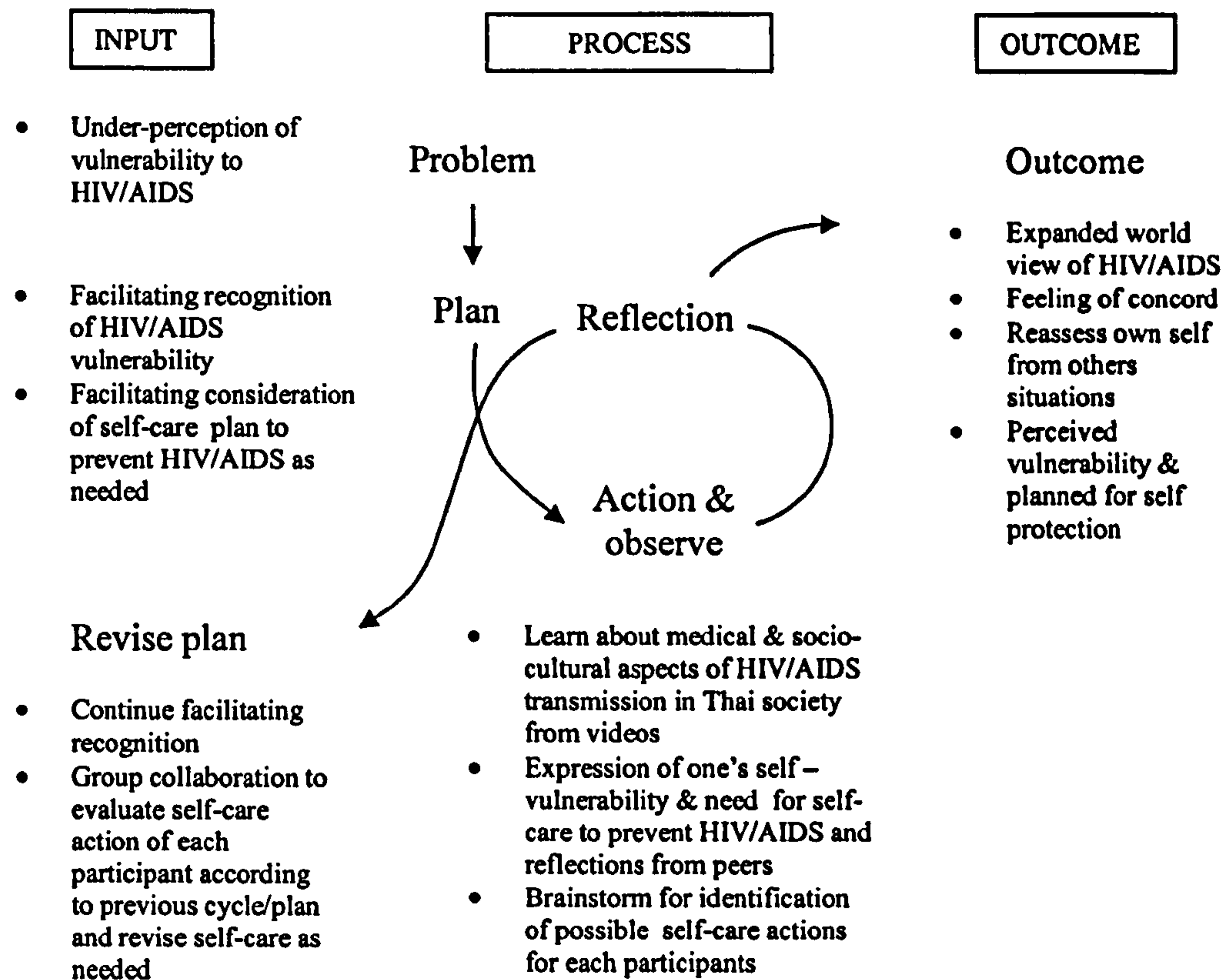


Figure 7.3 2nd Cycle Perception of HIV/AIDS vulnerability

3rd CYCLE: SELF-CARE DETERMINATION & ACTION

After reassessment of each participant's vulnerability, self-care activities were determined appropriate to each women's vulnerability, and were brought into action with their husbands (figure 7.4). This process emerged during cycles 3 and 4.

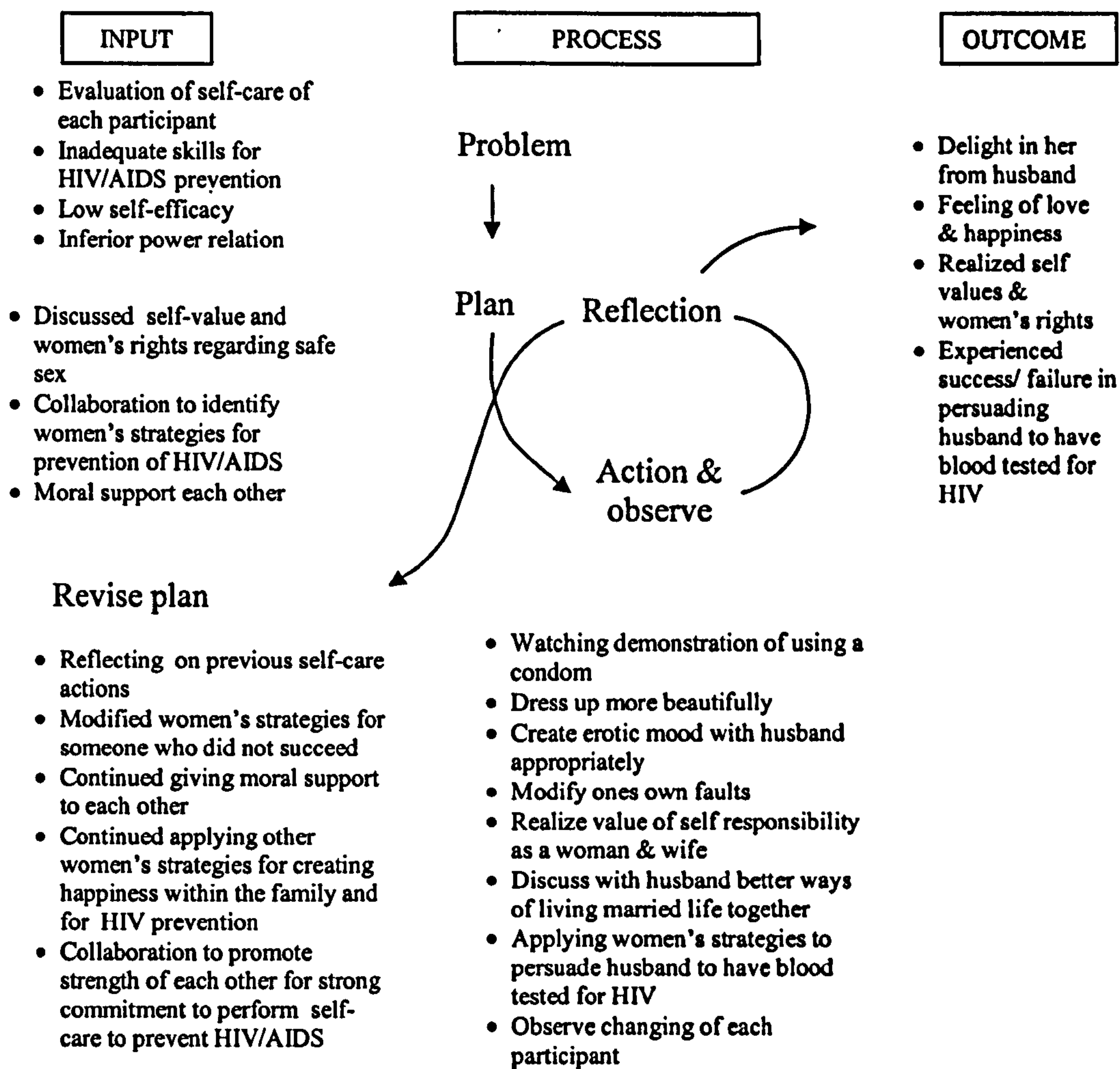


Figure 7.4 3rd Cycle: Self-care determination and actions

Catalysts were:

- 1) Sympathetic mood and feeling of being in the same situation created the willingness to help each other.
- 2) Gaining a better understanding of both medical knowledge and associated socio-culturally issues helped to expand the world view of women about HIV/AIDS problems.

- 3) Discussion and observing a man (one participant of Group I) and/or nurse counsellor demonstrating how to wear a condom with a model motivated woman's ideas for discussion. This also led to attitude change on using a condom among women and creation of applying condom in an erotic mood with her husband.

The only barrier was that in giving suggestions and recommendations, some participants tended to be self-centred; therefore some suggestions could not be applied to other women. This needed skilful handling by the moderator in conducting the focus group discussions.

4th CYCLE: ACTION LEARNING

Feelings of success were beginning to emerge during cycles 3-4 after participants transformed their own beliefs, that they had less chance in getting HIV/AIDS from husbands, to the idea that even though it was a small chance it was still an important risk. In the majority women agreed more or less that they had some HIV/AIDS vulnerability therefore; they needed to take precautions and needed to perform self-care activities which they had never considered significant and could help in some part in the prevention of HIV/AIDS.

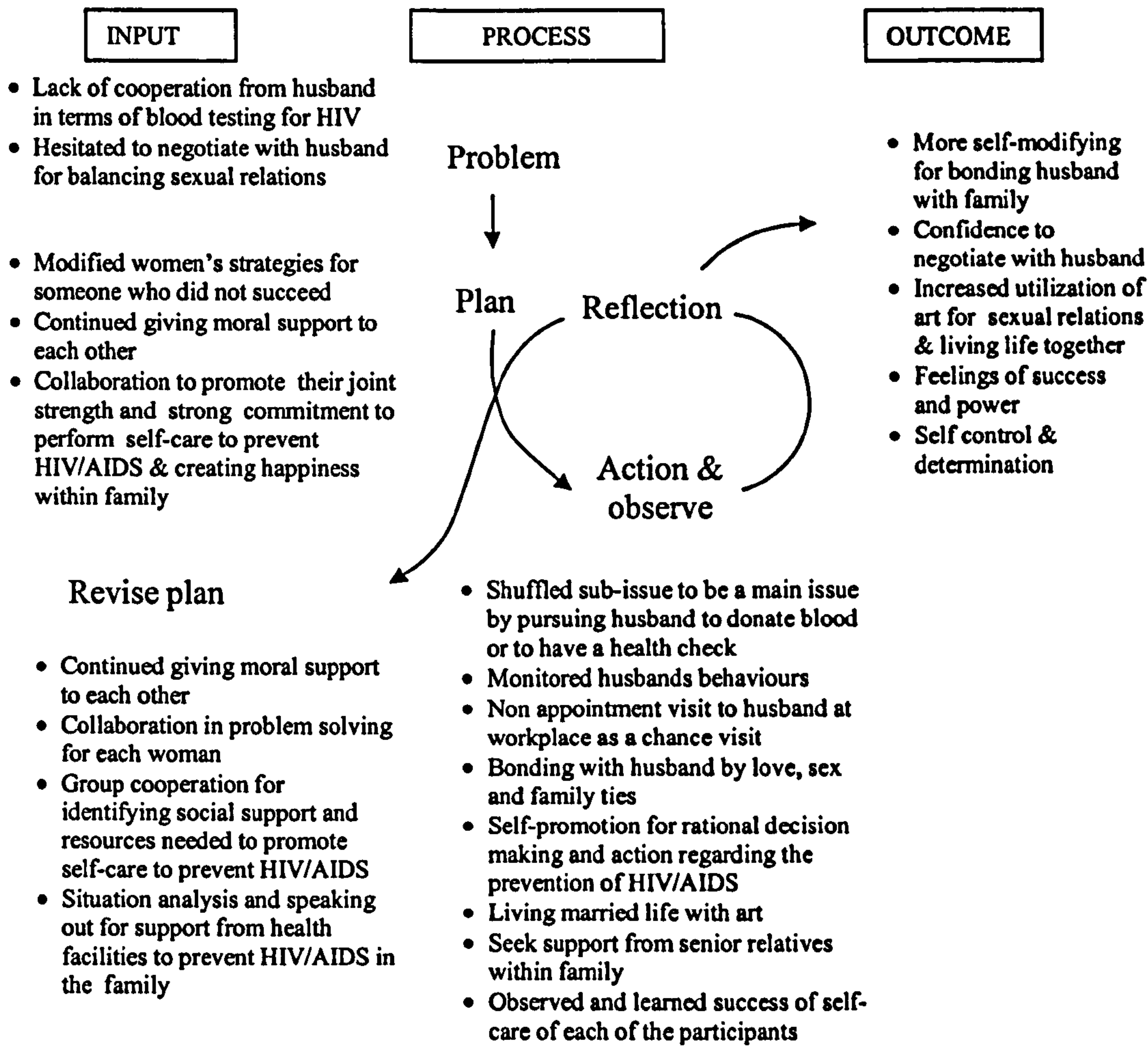


Figure 7.5 4th Cycle: Action learning

Hope of success occurred once they had made the decision and had chosen some selective activities both directly and indirectly related to HIV/AIDS prevention. By getting benefits from doing such activities, husbands' admiration and peer group praising, created the feeling of success among women in this group.

However, failure in doing some selective self-care actions by some participants also occurred. This created feelings of failure not only in those participants but also in other

members of the peer group. This matter led women to realize the need for help and support from health services and other related organizations.

Through the interaction process women gained much more understanding of their own situation, decision making and problem solving skills, and finally action learning emerged.

Catalysts were:

- 1) Sharing with and encouragement from peer group.
- 2) Becoming more aware of HIV/AIDS vulnerability.
- 3) Realization of the benefits and perceiving that self-care activities were not tasks that were too hard to perform.

Barriers were:

- 1) Personal characteristics of husband such as a drunkard, apt to get angry and self-centred persons.
- 2) Soft-hearted nature of the women themselves.
- 3) Low self efficacy of the woman herself.
- 4) Too busy working to earning money, doing housework and taking care of children.

Women's initiation occurred during cycle 3, 4 & 5, in self-care for HIV/AIDS prevention. By feelings of trust and concord, and awareness of vulnerability to HIV/AIDS, group members mixed together to solve problems of each participant. Some

general self-care in prevention of HIV/AIDS for all members were identified and tried out by all of them. They called this initiation “women’s strategies”. Some strategies specific to some participants were identified by all of the group members but operated only by some women who had specific problems (Section 4).

5TH CYCLE: INITIATION OF THE HIV/AIDS PREVENTION PROGRAMME

The initiation of programme development occurred when participants realized that there were some obstacles to prevention of HIV/AIDS for their families by themselves. Furthermore, significantly notable is that their ideas that HIV/AIDS infection within any family was a personal issue were transformed to be a public matter. Because even though their husbands behaved responsibly but living in an unsafe environment including influences from some socio-cultural factors affecting their husbands sexual behaviours in a Thai society context might lead to their husbands engaging in unsafe sex outside marriage. Realizing that most women under-perceived their own vulnerability to HIV/AIDS, had inferior power relationships with their husbands, and lacked essential knowledge and skills needed to solve problems in particular circumstances of high HIV/AIDS risk, led to ineffective self-care among women. These were beyond their capability to change on their own and therefore they realized the need for support from health service systems and voiced this need for help (figure 7.6).

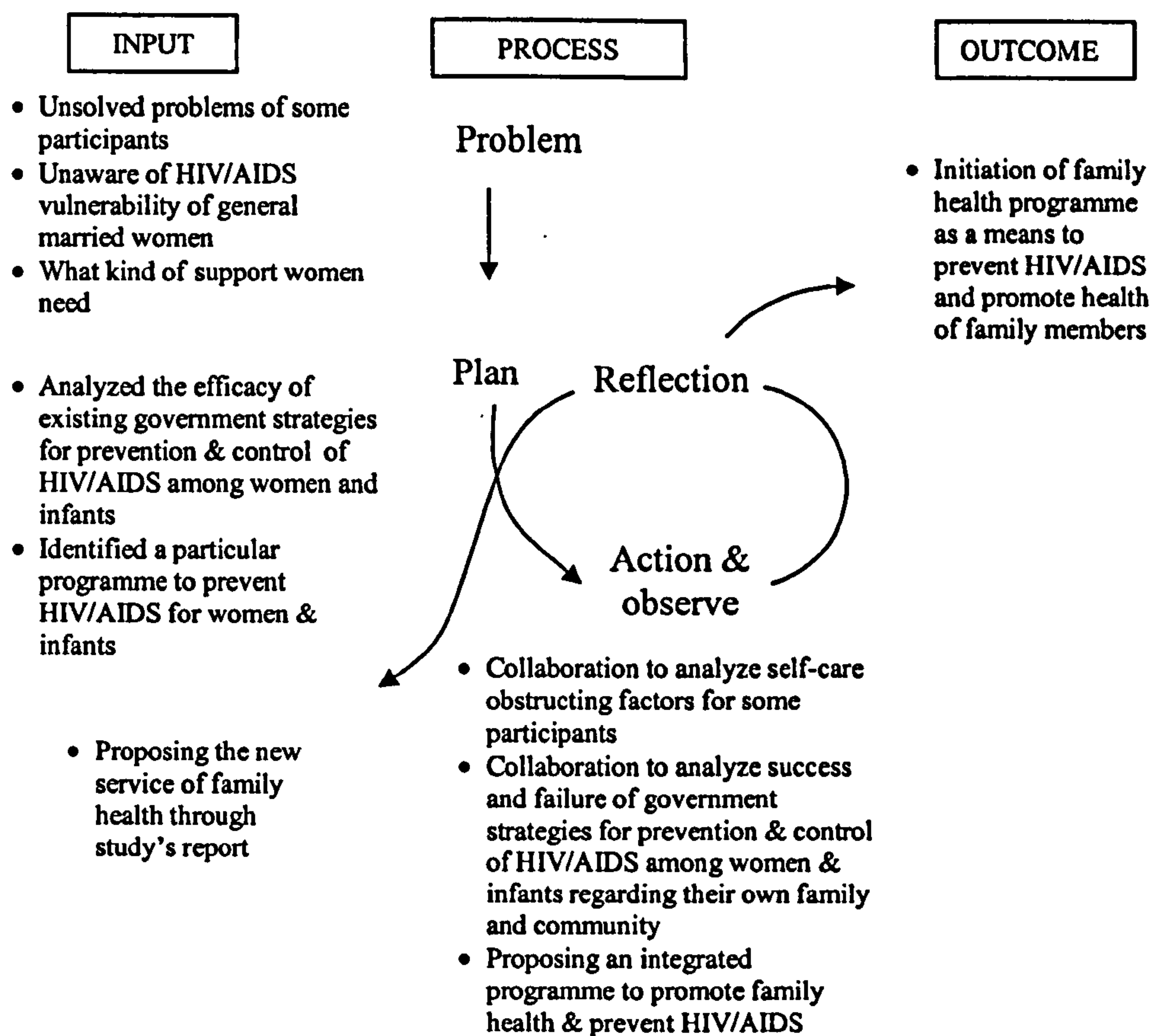


Figure 7.6 5th Cycle: initiation of HIV/AIDS prevention programme

Initiation of the development of a socio-cultural sensitive programme for HIV/AIDS prevention among women and infants was based on the following realisations, discussions, and actions of the participants:

- 1) Analyzing how the previous action plans of HIV/AIDS prevention and control, operated by the Thai government, affected their families.

- 2) Discussion of socio-culturally factors affecting men's sexual behaviours which might lead them to HIV/AIDS risk behaviours.
- 3) Doing a situation analysis of healthcare services, which provided support for HIV/AIDS prevention and control in terms of availability and accessibility.
- 4) Discussion of the HIV/AIDS social stigma and its effect on HIV/AIDS prevention and control among the Thai population. Determining strategies to avoid the effects of HIV/AIDS social stigma on the proposed prevention programme.
- 5) Collaboration in the establishment of a family health programme as a means for prevention of HIV/AIDS for men, women and children: a programme they titled "Family health services".

Catalysts were:

- 1) Transformation of the idea that if the husband behaved well it means that the wife had no chance of being infected with HIV/AIDS.
- 2) Emancipation from their old idea that the prevention of HIV/AIDS entering the family was the husband's responsibility only.
- 3) Realization that to prevent HIV/AIDS entering a family effectively, self-care and a supportive programme were significant components.
- 4) Wishing other women to have good experiences such as they did and wishing women and infants to have a good supportive service for prevention of HIV/AIDS.

SECTION 4: TRANSFORMATION PROCESS AND OUTCOME OF PROGRAMME

By participation in the group, women could think critically about their own situation, share with their peer group, and attend education sessions which opened the women's world view and enhanced the women's strength in various aspects. These phenomena can be explained within the major themes of: discovering the reality, self-care demands, investment of self-care, self development, grasping sense of power, and authorizing new service.

THEME 1: DISCOVERING THE REALITY

Participation in the group provided an opportunity for women to compare their own experiences with given information and stories from videos about HIV/AIDS. They also had chances to share with the researcher and HIV/AIDS nurse counsellor, and reflect with each other within the group. By looking at themselves in a different light the women's world view expanded. Through 'opening eyes and ears', 'thinking back', and 'inspecting things from the women's perspectives they gained a better understanding of their own self in various aspects. Women also perceived their men's difficulties as well. All combined to help women discover their reality in relation to HIV/AIDS risk.

Table 7. 1 The evidence from the women’s reflections

<p>Carelessness:</p> <ul style="list-style-type: none">• Before marriage I was just confident that he wasn’t infected with AIDS (Marayart, Pim).• After marriage I had an idea that prevention of AIDS should be my husband’s responsibility. Since I trust him I did not have any birth control (Kitty, Kaew, Nida).• If I got a positive result of a blood test it was my fault, it would have a bad impact on my child (Sunee, Namwhan, Ann).
<p>Inadequate knowledge of sexuality:</p> <ul style="list-style-type: none">• I felt it is a shameful subject for women (Marayart, Ann).• I had never shown an interest in sexual matters nor talked about sex with others (Lada, Malee).• After marriage I let my husband take the lead in this matter and if he did not request anything then I just thought he was O.K (Kitty, Wanvilai).
<p>Love & affection lack of critical thinking:</p> <ul style="list-style-type: none">• We didn’t think about being blood tested for HIV (Lada, Nom).• We didn’t need to have blood tested any way since we trusted each other (Pha, Pim, Arunothai).• I now understand why people say that love leads you blindly (Nida, Ploy).• I have even seen condoms in his pocket he told me that the condoms belonged to his friends (Jitree)• Even though I did not trust him I just asked him not to bring the trouble to me (Malee, Jun)• I had to forget about this or I might get anxiety I eased my mind with the thought that it did not matter(Tip, Thikampon, Namoi, Sunee)
<p>Making sense of HIV/AIDS risk:</p> <ul style="list-style-type: none">• When I cried from feeling like I was raped by my husband. He did not so demand for sex with me. Now I doubt that he might have sex with CSWs since I saw he talked with one beautiful woman, who he told me he was her customer before married me (Wanvilai).• He might have extramarital sex with other women who are not CSWs or indirect CSWs. I think if I ask about this he might not tell me the truth (Tip)• We have known other husband’s extramarital sex, but never thought it would be our case as well. See in our group there were two husbands having extramarital sex. I doubt that we could not rely on only what we have seen (Kitty)• I realize that there were so many factors surrounding us which can induce my husband to make a mistake. Men might have misconceptions that they were charming enough so that women seduced them first. Having sex with such women men might not use a condom as they go to CSWs. It is a weak point of men because those women might not be virgins and might have AIDS that we would not know about (Ploy)• I realized that husbands love and husbands behaviour as good people may not guarantee that wives will be absolutely safe from HIV/AIDS Like in video we watched last week that in many circumstances men were persuaded by peers, colleagues, and /or subordinates, to take the risk of HIV infection by having extramarital sex with both direct and indirect CSWs (Arunothai)

Discovering the reality that there were several factors which may lead to HIV/AIDS risk was a 'turning point' in the self-care process.

THEME 2: SELF-CARE DEMANDING

There were at least 5 of the 29 women in this study that discovered their husbands had extramarital sex. These women revealed that apart from trusting that their husband was using a condom while having extramarital sex, they lacked the knowledge and skills to deal with their husbands in such critical situations.

As a group they agreed that women should take responsibility as well coupled with the idea that prevention was best. Discussion about: i) protection of women's right, ii) self-responsibility, and iii) need to eliminate HIV/AIDS risk enable the women in collaboration with the researcher and HIV/AIDS nurse counsellor to identify essential knowledge and capabilities to deal with such situations. The consensus of the group focused on four areas: window period and blood testing, erotic way of using a condom, and negotiation skills for safer sex.

Window period and blood testing:

All women in the group learned from HIV/AIDS nurse that after exposure to the AIDS virus, the antibody to the AIDS virus could be detected within two weeks by the laboratory test utilized in general. In addition if the result was negative it needed to be confirmed again within three months. Therefore, before confirmation of the test results condoms needed to be used during sexual intercourse. There are test techniques which

could detect AIDS rapidly, but the cost is still prohibitively expensive and these services are not available in every hospital in KhonKaen.

Erotic way of using condoms:

In addition to negotiation and reasoning, the HIV/AIDS nurse counsellor introduced how the condom could be used as foreplay. This would help get the cooperation of the husband more easily. Women therefore, learned erotic techniques of using a condom. Based on women's reflections from this session women said that they had confidence to use condoms, if necessary, with their husbands. In addition, women also discussed that having a condom in house might make their husbands suspicious of their faithfulness or their distrust of her. The women believed that the best way to tell the husband about the condoms was that they were distributed at the hospital.

Researcher reflection: It was noticeable that not only husbands but women also did not like to use condoms. This may be from their attitude that condoms are associated with CSWs. Usage of the condom as foreplay may be one significant strategy and an alternative way for HIV/AIDS prevention among women. Preparing women to use condoms in an erotic way was helpful to some women. It may change the women's and husband's attitude to it. If women were trained to use it naturally then they can use it effectively when needed.

Negotiation skills to deal with husband

Negotiation for family responsibility: To release women's work load the majority of women agreed that they should ask their husbands to help look after the baby when they return from work. A closer father child relationship would help them. One woman said:

"Asking him to help other house hold chore might not work I think. You should ask him to help in looking after your baby. This can help to create a closer relationship between fathers and baby as well. Once he develop bonding with baby he will come back home sooner after work to play with kid. He then may give up going to message pallor as well" (Pim 27 years old).

Researcher reflection: Recommendations from groups seems to be a very simple task for some people. However, if women and husband have the idea that family care is female responsibility it is not easy for women to ask for help. Comparing their own experiences with others help women feel more confident.

Negotiation for safer sex: Women realized that negotiation skills for safer sex should be done if women suspect or discover their husbands' extramarital sex. In particular if they know that their husbands had unprotected sex. The effective ways of negotiation which women in all groups shared and learned were:

- Communicate with their husband in a polite and reasonable manner, particularly with regard to the safety of their child.
- Reassure the husband that they still love them and do not discriminate against him.
- Determine an appropriate method for postponing sexual intercourse until the husband has had blood test or as long as possible

- Ask husband to collaborate in using a condom, and help the husband to wear a condom as part of foreplay.
- Negotiate with the husband to have a blood test for HIV as soon as possible according to lessons learned, about window period and blood testing.

THEMES 3: INVESTMENT IN SELF-CARE

Discovering the reality, making sense of HIV/AIDS vulnerability and acquiring a self-care capability increased women self-efficacy to prevent HIV/AIDS.

Improving their own lifestyle

Evaluating their normal practice in the past more than half of the women (n=19) realized the need for self improvement.

Tikampon 36 years old told about her husband that, "He went out every night and came home very late and I did not know where he had gone. He also got drunk and that made me worried that he might have gone to visit CSWs. He had never listened to my request for not going out drinking leading to our relationship becoming worse. He said he liked to associate with his friends. Sometimes he did not come back till nearly morning. I didn't pay attention so he slept outside in his car until morning several times. I even rebuked him but he did not pay attention."

Responding to Tikampon's problem the peer group suggested that she had to justify herself first in order to change the unwanted behaviours of husband.

"It seemed to me that you might not express love and care you have on him. Talk nicely with him and show him how you love and care I think it would work better than to rebuke him. Try to dress up more beautifully it can cheer up your mind and he might want to stay home" (Somsri 33 years old).

“Try to arrange party at home, and invite your friends or neighbours to join. I always did and turn around among friends. Each family brought their own meals therefore; we were not tired from these activities” (Wanvilai 30 years old).

This suggestion was found to be effective since Tikampon reported to her group afterwards that:

“I tried to clam down my self and had a lot of smiles whilst I talked with him and said I would arrange a party at home on our daughter’s birthday. At first he just looked at me surprisingly, but during the party we had a lot of fun. We agreed that we will do it again at my friend’s house. Now my husband was very pleased and applauded my change. Our relationship had improved and my husband stayed home more than in the past”.

Researcher reflection: Tikampon chose to begin her change and a new family activity on an important day. It also benefited her daughter and husband’s relationship. In addition she moved a favourite situation outside into the home.

Allocating responsibility to husband

By realizing the association between work load, women’s exhaustion, boredom with sex, sexual imbalance, and husband’s extra marital sex, women began to include other family activities justification of other family activities such as rearing the baby or doing household chores as one part of the husband’s responsibility and therefore as a domain of their own self-care. There were 5 women, who had young babies and they began to negotiate with husbands. The following was the interaction between participants in

Group V

“I got bored having sex with him every night and I did not know why he liked it so much. Because of rearing our baby and doing household chores I felt so tired but for him (her husband) after work he was still in town talking and drinking with friends. He came home very late sometimes at 9-10 p.m. or if he came home early after dinner he went out again and came back nearly at midnight. Although very late he still insisted on having sex while I so sleepy and didn’t want to. Even though my son is two years old he didn’t

like my husband coming close to me and sometime he hit him and did not allow my husband to hold him. Sometime he said he felt touchy” (Numwhan 35 years old).

Responding to her problem one peer group suggested.

“When he came back from working you should persuade him to help look after the baby. Then you can have a time for other cooking. After having dinner together let him play with baby whilst you finish all house work. Trust me this can prohibit your husband from going out drinking with friends. Then arrange baby to sleep. You will see that you have time for relaxing, and have fun from having sex with your husband” (Yoopayong 35 years old).

Researcher reflection: Building a closer relationship with the baby was a way to help this problem.

Strengthening family ties with love and affection

Others strategies that women believed helped in preventing the husband from having extramarital sexual relations were “strengthening family ties” by love and affection.

One recommendation was:

“In our culture we feel embarrassment to express our feeling; I think we need to change this attitude. Doing something sweet to each other would create bonding between couples. Paying attention to their health is another important thing” (Racha 33 years old).

“In my opinion, if men can have a comfort, enjoy favourite meals and sexual gratification they may not go any where else. Finding a leisure time to go for picnic or having some favourite activities together such as gardening is also good. Dress up more sexy sometime will not only make us feel good but our husband may be admired. I think creation of happy home and close relation with each other will be our choice for reducing men taking HIV/AIDS risk” (Panwad 22 years old).

Researcher reflection: It is not a surprise that methods and techniques which women selected to “strengthen family ties” are solely expected roles that they had been taught

since they were young. In general Thai women have good manners, love to take care of their families and their husbands. This has always been the stereotype of Thai women. In Thailand today, even though women go to work like men and many are promoted to be leaders in organizations. Many of them are more self-confident in the working world but at the same time do not neglect their families.

Introducing HIV/AIDS knowledge into husband's environment

Almost all women found out ways to enable the husband to get more information about HIV/AIDS. The following is an example of their investment.

"The video I have seen is not illustrated clearly like this video, could I borrow it to play at home. I like my husband to see it, but we need to borrow video player from our relative since we do not have video player anymore. It might be good if there is DVD about AIDS" (Prapapan 27 years old).

Paying attention to husband's sexual behaviours

"Previously I just trust that he could abstinance for sex or did masturbation during my period of pregnancy and after giving birth. This because I did not have sexual desire during this period, I thought he might did not has as well. Knowing from the group I realized that did not requesting for sex from wives men might go to CSWs instead. Now I have observed his sexual behaviour more than in the past. Sometime I asked him nicely about this" (Kitty 20 years old).

Improve/reform sexual relations with the husband

Realising that dissatisfaction in sexual relations was one major cause of extramarital sex the women placed more significance on sexual relations and the value of improving sexual relations with their husbands as a means to prevent extramarital sex and so preventing HIV/AIDS from entering the family. One woman shared:

"Nowadays there are a lot of videos and movies about this rated X and rated R, moreover we can learn from many magazines so we must perform better sexual relations with our husbands than CSWs do. If we can do this both we and our husbands will be satisfied and our husband will not go out to other women" (Nida 17 years old).

Researcher reflection: This advice was also strongly supported by the man who participated in the group. In addition it was found that women emphasised the sexual satisfaction of couples, rather than sexual gratification of husband only, as a mean for the improvement of sexual relation.

Arranging husband to be tested for HIV

The majority of women (n=21) in this present study would like their husbands to be tested for HIV. 4 women arranged HIV test for their husbands after sharing in group.

The following were reported from two of the women.

"At first I was so frustrated and reluctant to do. This because I like to know is he infected or not. However, I was afraid he might get mad. Since I realized that if I can do this will be benefit to our family I decided to ask him. After talking with him I felt I was released. He also complied easily, I am so surprised. I told him that participating in group, and 'Moa' (Health professional) advice has to do so. Now conflict between us is eliminated" (Namwhan 35 years old).

"Participating in this group remind me about several years which I suffered by syphilis transmitted by my husband. I think I should not find fault with him but knowing that there was a package for health check up, I bought it for my husband. This included blood test for AIDS. He got a negative result for all diseases" (Kaew 32 years old).

However, there were some women (n= 4) raised the reverse that is the problem of knowing husbands HIV status. One woman said:

"If they know that they are infected with AIDS some people worsen. I found one guy lived near by our house at first he look very well. After he knew he was infected he got very ill suddenly. If we persuade our husband to get test, we should think about this" (Racha 33 years old).

Researcher reflection: Women had their own way of persuading their husbands to be tested. In addition it was clever of women to claim participation in the focus group as a starting point for change. They took this opportunity for negotiation and believed that by claiming it in this way they would acquire co-operative from their husbands.

THEME 4: SELF-DEVELOPMENT

Based on reflections from the women and the researcher’s observation there were changes the way women thought about themselves and their health after participation in the group. Their self-improvement can be explained in terms of emancipation. These were noticed from both cognitive and behaviours changed among them.

Changes in Thinking

The evidence which indicates changes in women’s thinking is summarised in the following table.

Table 7.2 The difference in women's thinking before and after intervention

Domain of change	Before participation	After participation
<ul style="list-style-type: none"> • Women's work such as house hold chore and child rearing 	<ul style="list-style-type: none"> • Could allocate to men (n=8) • Significant as paid labour (n=11) 	<ul style="list-style-type: none"> • Can allocate some activities to men (27) • Significant as much as paid work or professional work (n=26) • Replace by others for doing these jobs need to be paid with a high cost (n=17)
<ul style="list-style-type: none"> • Women's income from their own careers or work 	<ul style="list-style-type: none"> • Significant as husband income, even it less than (n=12) 	<ul style="list-style-type: none"> • Significant as family income (25)
<ul style="list-style-type: none"> • HIV/AIDS prevention 	<ul style="list-style-type: none"> • Responsibility of couples (n=1) • Woman could do some things to prevent HIV/AIDS transmitted by her husband (n=2) • Confident to perform self care (n=1) 	<ul style="list-style-type: none"> • Mutual responsibility of couples (29) • There were strategies which women could adopt to prevent HIV/AIDS (29) • Confident to perform self care (n=29)
<ul style="list-style-type: none"> • Sexual relation 	<ul style="list-style-type: none"> • Good women could pay attention to sexual relation issues (n=7) • Women can improve sexual relation with husband (n=4) • Couples should have sexual gratification together rather than just for husband's satisfaction (n=4) 	<ul style="list-style-type: none"> • It should be advantage for women to have knowledge about sexual relation (n=26) • Women could apply this knowledge to their marriage life (n=23) • Sexual gratification for couples not only for husband (n=28)
<ul style="list-style-type: none"> • Self values 	<ul style="list-style-type: none"> • Absolutely attached to husband admiration, and minister to husband's demand (n=17) 	<ul style="list-style-type: none"> • Add value to themselves, paid more attention and significant to their own, concerned more about their own need whilst remain relationship with husband (n=24)
<ul style="list-style-type: none"> • Coping style 	<ul style="list-style-type: none"> • Fatalism: what ever will be will be, do not think too much if can not change situation (n=8) 	<ul style="list-style-type: none"> • Self determination: intention to perform self care to prevent HIV/AIDS for themselves and their next child (n=28)
<ul style="list-style-type: none"> • Women's right 	<ul style="list-style-type: none"> • Have no right to refuse having sex with husband (n=19) • Have right to request husband to get test for HIV if they doubt of husband risk behaviour (n=7) 	<ul style="list-style-type: none"> • Have right to refuse having sex with husband (n=29) • Have right to request husband to get test for HIV if they doubt of husband risk behaviour (n=28)

Changing behaviour:

Most of the women’s strategies did not feature actual health protective measures. However, their approaches did on the prevention of HIV/AIDS. Indications of behaviour change among women are summarized in Table 7.3.

Table 7.3 Indications of behaviours changes following group participation

Domain of behaviour transforming	Changed number
	N=
• Communicate nicely and reasonably with husband	29
• Dress up more attractively	15
• Allocate family activities responsibility	6
• Strengthen family ties and relationships	23
• Monitor husband’s sexual behaviour by nicely asking and observing	21
• Improve sexual relations for sexual gratification of couple	16
• Negotiate with husband to get test for HIV	4
• Persuade husband to get health check up	2
• Persuade husband to donate blood*	-
• HIV/AIDS knowledge intimately	23
• Introduce HIV/AIDS knowledge into husband’s environment	23

Note: * Identified but not carried out

THEME V: GRASPING SENSE OF POWER

After self-care was performed all women reported their successes and failures to the group. The rewards each woman received from successful actions were felt, not only by her, but also by all group members. In other words, the success of each woman was a success of their peer group as well. Successes varied from very simple tasks to very difficult tasks. Some women were satisfied only when their husbands committed fully to do what the women asked. They perceived their own power and were confident that they would deal with their husband more effectively.

"After telling him about my problem he helps me much more for looking after our baby. Now we arrange new bed for our baby beside our bed, and we have a curtain between us and her. I found it really worked, and now I can control the situation. We can enjoy our sexual relations and have a happy life together" Lada 25 years old

"First two days of participating in the group provoked my worrying about my husband's sexual behaviour which I tried to ignore it. Advising and motivation from friends in the group I began to facilitate him to look after our baby. I found he came home sooner and played with baby much more. I did not think I can do. Now I have learned how to deal with him in other circumstance without conflict" Malee 29 years old.

Women also explained that it was not easy to negotiate with their husband, but when they talked and the husbands accepted what they asked them to do they were relieved from all anxiety. They emphasized, sharing with the peer group was a "powerful motivation" that supported them to achieve this success.

THEME VI: AUTHORISING THE NEW PROGRAMME

Women's evaluation

There were some failures as well as successes however. Through discussion and reporting, about investment in self-care among women, they identified weak points.

Twelve participants believed that women's weak points were barriers to self-care.

Tip 25 years old said, *"My husband is self-centred. He is also apt to get angry if I discuss any thing that does not show complete trust in him. This may be because he is much older than I and I do not earn money therefore I have to rely on his money. Even though I have been worried that he might have extramarital sex I could not do any thing"*.

"I asked him on my birthday by saying that I would be so happy if he showed me his love by having his blood tested for the HIV virus. The first time he said he did not have time to go since he had to work every day so I asked him to go to a private hospital. When he saw the needle and syringe he moved back so quickly. I saw his face turn white and he looked dreadful. At that time I felt pity on him and therefore I did not force him to continue the process" (Prapapan 27 years old).

Researcher reflection: These two events indicated that perception of powerlessness was major obstacle which stopped women getting cooperation from their husbands.

There were several aspects which contribute to the risk of HIV/AIDS for men. These included: less opportunity to get direct information and health check-ups, social values and an unsafe environment.

"We, the women, who do not use this information directly, received it a lot, whilst men, who must use this information, received little. I think it would be better if the Moa (health professional) gave health education about AIDS directly to the men while waiting for their wives at the hospital" (Ploy 19 years old).

"It's hard to tell your husband to be tested for HIV since he will get angry and may think we do not trust him. In general husbands are not expected to be obedient to their wives but they will comply with peer groups. They are also trust Moa's advice rather than us. I think the Moa should request all of them to be tested for HIV when they accompany their wives to hospital" (Ann 30 years old).

Researcher reflection: Even though most husbands accompany their wives, particularly the first pregnancy there is no service for husbands. One significant reason is from the preconception that the woman's health is reflected directly in the child's health and therefore, health professionals pay attention to the woman rather than the man. In fact child health is a product of both the man's and the woman's health.

Women's voice for family health

The need for support for women was emphasised by the groups. Even though there were several things which women had done successfully, they strongly agreed that participation in this study was a significant help to them in obtaining those successes.

"I had always known that there was a counselling service, but I did not know how to access that service. I think people in general still don't know about pre-marriage blood tests for HIV this. It was not promoted as it should be" (Numooi 27 years old).

"To provide effective service for the prevention of AIDS, there should be a schedule for men to have a health check-up and receive health education routinely including AIDS in the same way as women and children receive it at present. The booklet for maternal and child health should be changed into man, woman and child health." (Rabin 19 years old)

"For me I like this focus group discussion a lot since it has enabled me to share with both health professionals and a peer group. It has opened out my world view and prepared me to deal with risk situations better than in the past and I also have so much more confidence to perform what I never thought I could do" (Jun 19 years old).

Researcher reflection: By realizing that the couple have a joint responsibility enable changes in thinking and some indications of behavioural change also.

SECTION 5: SUGGESTION FOR FUTURE HEALTH SERVICES

According to situational analysis women in this study get insight into the weak points of men and women deriving from the influences of socio-cultural factors in the Thai context. They also come across the limitation of available health services in relation to HIV/AIDS prevention (detail in section 1). The women assimilate a new knowledge, acquiring it from participation in groups, with their past experience to provide a direction for future health services for HIV/AIDS prevention. Women propose a *'family health programme'* as a replacement for the current maternal and child health (MCH) service. The reasons for their proposition and the detail of the new service will be discussed next.

Reasons for replacement

- 1) Women's recognition of the advantages of female support groups for their sexual health and prevention of HIV/AIDS. This perception coupled with knowing that they can not get these benefits from any other existing services. Women therefore, would like this programme to be continued.
- 2) HIV/AIDS carries a social stigma and providing a service under this name may prohibit women from participating.
- 3) Awareness of their own weak points and the chance of relapsing from their commitment for doing self-care.
- 4) Women perceive the significance and benefits of bringing men into the health service, which they believe would not only promote men's health but would also help in reducing men's sexual risk behaviours. As a result the prevention of HIV/AIDS to family is a more achievable objective.
- 5) Promotion of men's health has previously been limited. In addition many men often accompanied their wives and children to obtain health services but receive no direct benefit or knowledge for themselves. Providing family health to the whole *family*, father, mother and children is both reasonable and carries significant advantages.

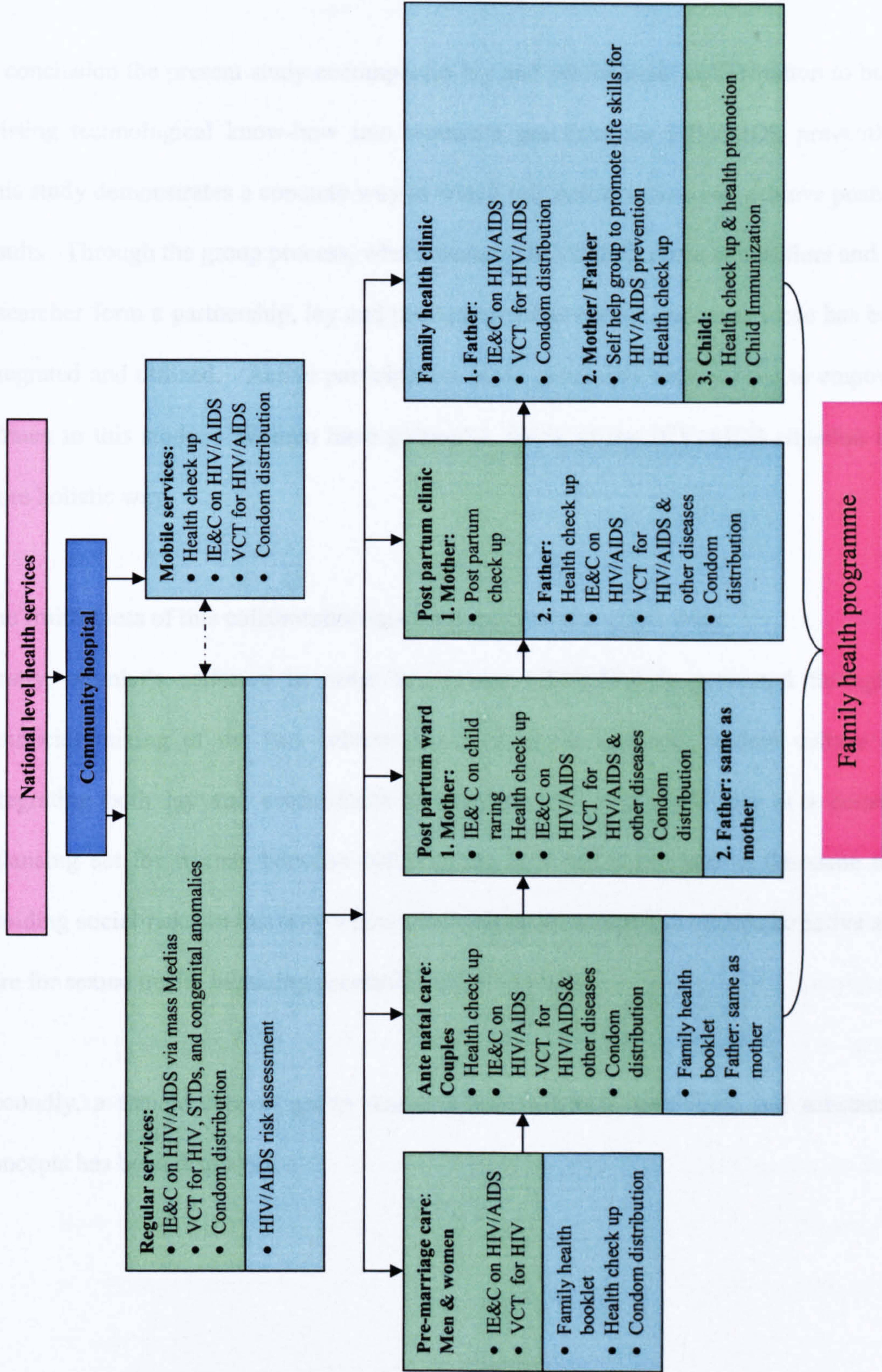
Components of family health service

- 1) The first priority, in which women from all groups reached a consensus, is that the mother and child health booklet urgently needs updating and improving. They suggest that, in order to facilitate men's participation in health actively, this should be changed into a family health booklet.

- 2) The second priority is to schedule health check-ups for men which should be established as a routine procedure.
- 3) The third priority is that sexual health counselling and voluntary testing for HIV should be provided in all front line primary health services.
- 4) Last but not least are female support groups, male support groups, and or couple support groups should be a highly available service for sexual health and HIV/AIDS prevention.

The pattern of family health programmes is illustrated in figure 7.7 as below:

Figure 7.7 Women’s proposal for family health service development



Note: Light blue represents the new ideas from women, Green represents existing services
: H.E represents health education; VCT represents voluntary counseling and testing; IE&C represents information, education, and counseling

CONCLUSION

In conclusion the present study encompasses lay and professional collaboration to bring existing technological know-how into women's practices for HIV/AIDS prevention. This study demonstrates a concrete way in which this collaboration can achieve positive results. Through the group process, where women, HIV/AIDS nurse counsellors and the researcher form a partnership, lay and professional knowledge and experience has been integrated and utilized. Active participation in the group has been proven to empower women in this study. Women have grasped a vision of the HIV/AIDS situation in a more holistic way.

The fruitfulness of this collaboration has been evidenced in three ways.

Firstly, women's self-care in order to prevent HIV/AIDS is generated through a beneficial mixing of the two cultures involved, traditional and modern culture and integrating both lay and professional knowledge. Women's self-care is a constant balancing act for woman between reducing the HIV/AIDS risk and at the same time avoiding social risk. In this way women have been encouraged to undertake active self-care for sexual health including prevention of HIV/AIDS.

Secondly, a female support group model, whose methods, processes and substantive concepts has been displayed.

Thirdly, a family health programme proposal providing concrete guidelines for the implementation of a revised, more holistic approach, involving the integration of new services into the existing system of Thai health care has been proposed.

Strengths and weakness of the research

The study among this group of women may have some limitation to be generalized to other populations. However, knowledge generated from this study can give some guidelines for health professions who work with HIV/AIDS. The strengths and weaknesses of this study are discussed below:

Strengths:

- 1) The study has been carried out mainly with women about women's concerns therefore; knowledge has been derived from an 'emic' point of view.
- 2) Richness and data saturation were obtained from various qualitative methods. Data triangulation has been done from various key informants. Data analysis and interpretation has been carried out thoroughly, step by step, as per plan (detail in chapter 4). Thus accuracy and rigorousness of the information is assured.
- 3) Because HIV/AIDS is a socially constructed disease and greatly influenced by gender inequality, feminist theory has been utilized to illustrate how gender inequality has a negative impact on women and direct the problem solving in this study with more focus. Women's self-care and the family programme generated from this study are socio-culturally sensitive to women's need and the problem as envisaged currently. These two measures are consistent with the lifestyle of

married couples in a Thai context. They also accord with Thai people's habits in utilization of health measures and health facilities.

- 4) This study demonstrates dramatically how collaboration between lay people and the professional can be acquired to great advantage for both.

Weakness

There are some limitations of this study as follows:

- 1) This study involves women's life experiences pertaining to self-care to prevent HIV/AIDS for themselves and their next child. Women's points of view and perspectives as the knower are very crucial since the themes emerged from 'emic' or 'insider' are strength and useful. The substantive themes are derived from discussion rather than discovery. However, the problem of HIV/AIDS is associated with men and women or husband and wife relationships. Data gathering from only the women's perspective has limitations. Women are not able to give accurate information relating to their husbands. Therefore, a study from both men and women's perspectives may fruitful to get a more comprehensive understanding about HIV/AIDS from both points of view.
- 2) The HIV risk assessment utilized in this study can help women to realize their risk of HIV/AIDS. In addition it was used as a guide to solve women's problems in related to HIV/AIDS issues and sexual health as well. However, it may have some limitations with regard to evaluate women's HIV/AIDS vulnerability. This comes from the fact that all items on the risk factors were designed to have the

same value score. However, some risk factors may have higher degree of risk than others. The HIV/AIDS risk assessment used with Thai women is limited. The tool was created to be used for this particular group of women. Further development of a more sensitive HIV risk assessment questionnaire to use with Thai women is needed.

CHAPTER 8

DISCUSSION AND CONCLUSION

This chapter discusses and concludes the findings from the present study. The chapter covers four sections as follows:

Section 1: Cognitive process and practical problems

Section 2: Inside the group: women's participation and empowerment

Section 3: After the group: further, wider implications

Section 4: Health through emancipation

SECTION 1: COGNITIVE PROCESS AND PRACTICAL PROBLEMS

Changes happened to the women who participated in this study by means of the interaction and transforming processes of the group. Participating in the group led women to understand the HIV/AIDS problem at a deeper level. Reflection from their peer group worked as it appeared that the women had many mirrors lighting on them from all aspects. The women used various types of evidence to assess their vulnerability of getting HIV/AIDS from their husbands. By thinking through issues they could link and analyse all the associated evidence which led to a more meaningful evaluation of their vulnerability.

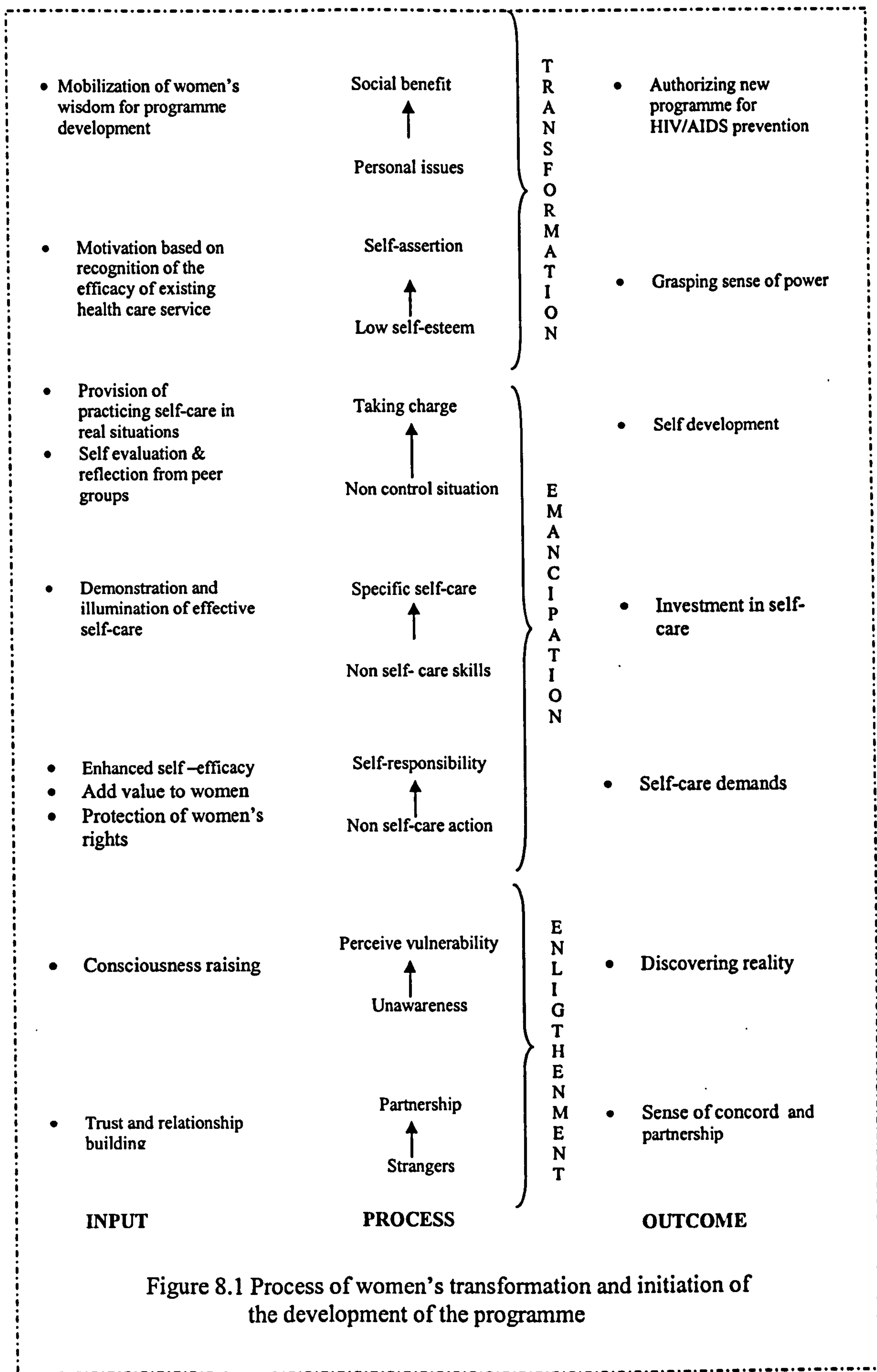
Discovering the reality, awareness was raised of *self responsibility* to protect themselves and their offspring from AIDS. Realising the demands of self-care

encouraged the women to search for essential knowledge and develop the skills needed for their *readiness* to work in collaboration with their husbands

By investing in their own self-care they could 'see improvement in their own life', 'rearrange family activities', 'strengthen family ties', 'introduce information to the husband's environment', 'pay more attention to husbands' sexual behaviours', 'find an opportunity to reform their sexual relations', and 'facilitate their husbands to be tested for HIV'.

The most difficult was arranging for their husbands to be tested for HIV. However, the women found clever ways of persuasion. They referred to the group as a reason for asking their husbands to be tested or they arranged for their husbands to get a health check up which included HIV testing. Although not all women succeeded in this activity, all stated that they were determined to find the opportunity to do so in future.

Finally the women proposed the essential idea for developing the 'Family health programme' as a better means of HIV/AIDS prevention. The interacting and transforming process is summarised in Figure 8.1.

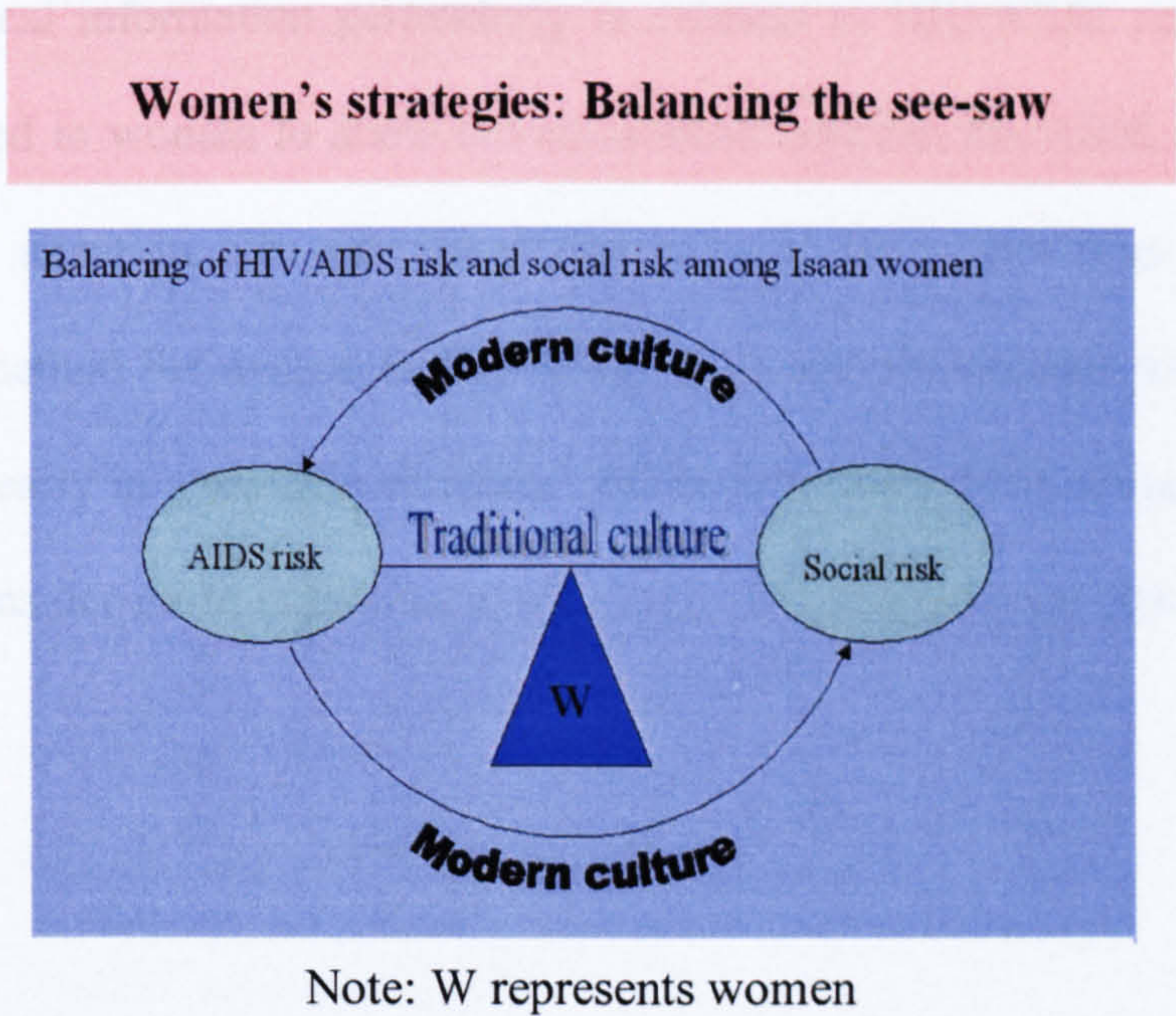


The outcome of the participatory action research can be categorized in terms of its effect on women’s readiness, personal strategies, patterns of female support, and the development of an HIV/AIDS prevention programme.

The PAR programme has produced four advantages.

- 1) Women’s readiness for prevention of HIV/AIDS in changing circumstances.
- 2) Women’s strategies which integrate traditional and modern practices to balance the see-saw between AIDS risk and social risk very wisely (Figure 8.2).
- 3) New patterns of female support group interactions for HIV/AIDS prevention.
- 4) The development of a socio-culturally sensitive programme for HIV/AIDS prevention.

Figure 8.2 Women’s strategies: Balancing the see-saw



SECTION 2: INSIDE THE GROUP: WOMEN'S PARTICIPATION AND EMPOWERMENT

It has been shown in this study that participation in the group empowered women both cognitively and practically to enable them to carry out specific self-care to prevent HIV/AIDS. This outcome is discussed in two ways: firstly the participatory approach and secondly in terms of empowerment processes.

PARTICIPATORY APPROACH

The four stages of introducing, facilitating, promoting, and supporting facilitated different levels of participation amongst the women

Introducing

Epidemiological information particularly in relation to HIV/AIDS risk behaviours was introduced to women to show the association between the AIDS epidemic and the women's situation. It was found that use of video tapes was the preferred educational method for women in this study. This may be because the video could tell a story clearly in a realistic situation. Being moved by these stories allowed the women to consider more deeply an array of the HIV/AIDS issues (detail in chapter 7).

Facilitating

Reflection from the peer group had a great impact on the women's critical thinking of their own situation. Because it encouraged women to associate all relevant evidence about their husbands sexual risk behaviours. As a result women realized

their own vulnerability to HIV/AIDS. Enhancing empowerment, which in turn promoted self-care by helping individuals to develop a critical awareness of their situation and enabling them to master their environment to achieve self-determination has been recommended in many articles (Simmons and Parsons, 1983; Jones and Meleis 1993).

Promoting: Enhancing women's strength was one important point. Promotion of women's self-values, self-efficacy, and life skills potential for safer sex were crucial. Helping women to have a positive attitude towards the use of condoms and promoting their skills in using them in erotic ways with their husbands were essential skills for safer sex. These promotions prepared women to promptly undertake and be ready for specific self-care action. Although there were several recommendations in previous research about how to change women's and men's attitudes towards the use of condoms, there is no study which incorporates the demonstration of an erotic way of using the condom in a marital situation.

Supporting: There were two types of support, which enabled women to undertake specific self-care appropriately in the present study. First was information support about health check up packages, health service resources for VCT, and blood donating. This array of information was given to women for them to consider using. Second was psychological support. Listening to women's problems, helping to identify the cause of problems, and mutual problem solving were effective mental supports for women to perform specific self-care as well. These findings are consistent with those of Natterland and Ahlstrom's study (1999) in Sweden, which

revealed that psychological support by health professionals helped participants in the rehabilitation process.

EMPOWERMENT PROCESS

Drawing together understandings of culture, health beliefs and self-care deficits the main aim of the intervention phase was to enable the women to become more confident of themselves and their actions. Failure to adopt existing and known preventive measures was found among the majority of women in this study. In the intervention phase therefore, the “key point” was how to bring existing “technological know how” into women’s self-care for HIV/AIDS prevention. According to this study this knowledge could be applied to women’s practices through two main processes as below:

Sharing lay and professional knowledge

This process began with promotion of mutual respect and relationship, and mutual decision making and problem solving. Lay persons and professionals became a partnership rather than receivers and providers. Problems were identified from the women’s points of view and knowledge from the women and the professionals alike was shared and integrated. These actions led to an improved mutual understanding across all participants in the group. Problem solving was carried out by all participants as contributory ‘stakeholders’. Women’s empowerment was promoted through participation in the group, and this contributed to the initiation of specific self-care practices.

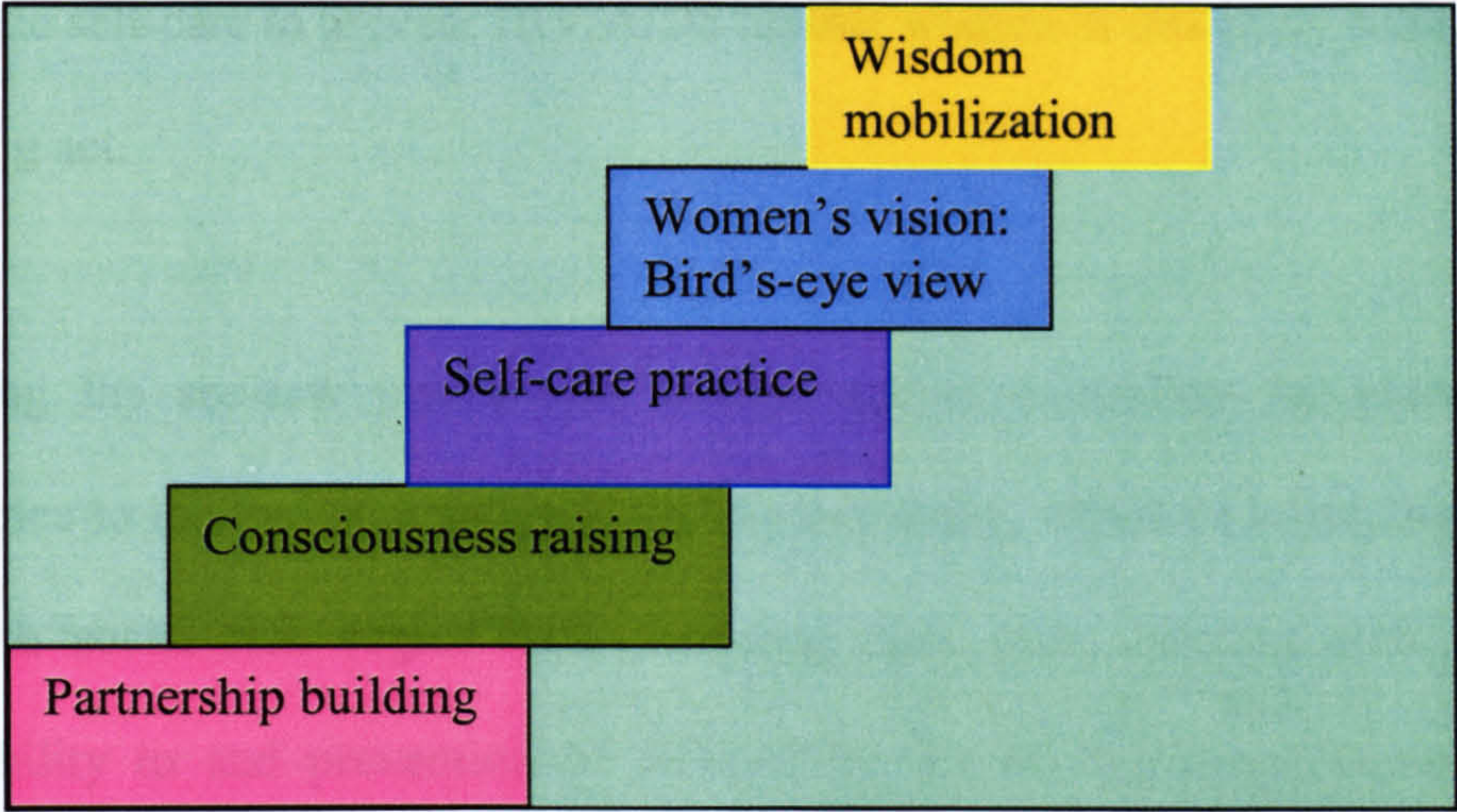
Strengthening self-esteem

Women's self-esteem was increased by participating in the group. Before participating the women placed more significance on their children and husbands rather than on themselves. Through sharing and discussing the effect of this on women's health in general and sexual health in particular the women began to recognize their own values and rights.

Although behavioural change was not directly observed in this study it is suggested that through gaining an increased self awareness direct self-care will develop later on. This is because self-efficacy plays a more important role in self-care than having information and skills. Increasing self-efficacy can produce behavioural change and maintain such change (Nicki, Remington, and MacDonald, 1985).

Learning step by step in the group led women to become emancipated from their own beliefs, integrate some new activities into their usual lives, and exercise some specific self-care related to their own sexual health. Women in the groups felt they had moved to where they now had a bird's-eye view. They had a vision of HIV/AIDS in relation to their own situation in a holistic way. Women obtained insight into men's and women's weak points in terms of HIV/AIDS prevention. As a result women were not only ready to deal with their husbands but also mobilized '*women's wisdom*' to give a new direction for HIV/AIDS prevention as well (Figure 8.3).

Figure 8.3 Women’s transformation and vision



It is noted that through such consciousness raising and increasing of self efficacy women could exert power to control their health and lives and as a result independent health behaviours were obtained.

SECTION 3: AFTER THE GROUP: FURTHER, WIDER IMPLICATIONS

Women’s Strategies: Balancing The See-Saw

The influence of women’s culture and health beliefs forced women into an imbalance between AIDS risk and social risk as mentioned previously (see also chapter 5, 6 and 7). Participation in the group empowered women to become self-determined and self-reliant rather than passive responder or fatalist as previously. Women realized their self-responsibility and their rights to protect themselves from getting HIV/AIDS. They perceived specific self-care demands. This was the “turning point” that “reversed” the direction of the imbalance of the see-saw as was the case before participation in the group. However, women did not want to radically challenge men’s power. They determined the methods which helped to reduce

HIV/AIDS risk whilst keeping acceptable social risk levels. Undertakings in respect to specific self-care to prevent HIV/AIDS among women in this study were a kind of balancing act.

Balancing the see-saw means that women act as controllers by placing equal importance to the two contrasting sides. In this study, women's balancing of AIDS risk with social risk begins with assessing their own situation with regard to vulnerability to and prevention of HIV/AIDS. To do this these women utilized several strategies which will be discussed further:

Incorporation

Instead of abandoning '*traditional cultures*' women integrated these with '*modern culture*'. This practice was also seen in one study among elderly people in an African community, which demonstrated a mixing of traditional culture with Western culture to perform self-care as well (Hildebrandt and Robertson 1995). The existing medical technical know how and feminist perspectives were new cultures, which women incorporated into their traditional culture for specific self-care to prevent HIV/AIDS. For instance, while women recognized their own rights to protect themselves women asked their husbands politely, demonstrating their respect to their husbands, to get tested for HIV instead of ordering it as if it was their right.

Another example was when women realized how husbands were influenced by their male peer group they arranged a party at home instead of prohibiting husbands from going out with friends. In this way the woman reduced the chances of HIV risk whilst the husband did not lose face with his friends. Demonstrating their respect

and modesty women brought their husbands, back from outside, into the home and into a situation which they could control more straightforwardly.

Health action ideas

Although the majority of women in this study would like to know their husbands' HIV sero-status, requesting their husbands to be tested was difficult for most. This also applied to circumstances where women discovered their husbands' extramarital sex. In fact extramarital sex was a crisis situation for the women. However, asking their husbands to get tested for HIV was far too difficult for most women in this study. However, some women took an opportunity, supported by the peer group, to ask their husbands to be tested for HIV. This was one extraordinary example of women's strategies. It was a kind of transformation of a crisis into an advantageous health solution which may influence the husbands' sexual risk behaviours later on. Another benefit was that the women became confident that they had healthy sexual relations with their husbands. This finding contrasted with Boonmongkol's study that women in the North of Thailand would ask husbands to be tested more easily if they discovered that their husbands visit CSWs (Boonmongkol, 1999).

Bargaining for mutual benefit

Bargaining was utilized as a women's strategy in specific self-care for HIV/AIDS prevention as well. Women recognized that men placed high significance on sexual relations and pleasure, and they might therefore seek sexual gratification from others if they could not get it from their husbands. However, there were several factors which constrained women from achieving sexual gratification with their husbands. Women related this sexual imbalance to their work loads (detail in chapter 6 and 7).

Believing that releasing women from some responsibility would allow them to enjoy sexual gratification with their husbands, women bargained with the husband to look after their baby in order to improve their sexual relationship with their husbands. Bargaining for the husband to reduce alcohol consumption and improving sexual relations also took place. This did not only reduce the likelihood of husbands having extramarital sex but also brought mutual sexual gratification to couples as well. There is a paucity of research in relation to this issue for comparisons to be made. Indeed more research is needed.

Conjugal partnership

Whether husbands perceived it or not, women became more of a partner in the conjugal relationship with their husbands. Using a polite and modest manner, women initiated new things into their husbands and families' lives. They acted as subordinate to their husbands as usual but took more control in some situations. Family conflicts associated with sexual relations were brought into conversation and solved with their husbands rather than kept unspoken as previously. These practices were carried out with sweetness and in a kind manner. Women sometimes perceived that their strength was decidedly inferior to their husbands, and they therefore, were '*gradually taking part in*' decision making with their husbands rather than '*using force against force*'. Despite women not requesting equal rights with husbands, their relationship becomes more of a conjugal partnership, and although not yet ideal, it was better than before participation in the group.

PATTERN OF WOMEN'S SELF-CARE

The self-care pattern to prevent HIV/AIDS among women in this study can be considered in terms of antecedents, attributes, catalysts and consequences.

Antecedents for women's self-care:

Recognizing self-value motivated the women to perform self-care in this study.

Women realized their rights to protect themselves from getting HIV/AIDS which might be transmitted to them by their husbands. Self-value has been shown to be a precondition for self-care in other research among the elderly (Moore 1990).

Self-responsibility was another antecedent for women's self-care in the present study.

This was because women perceived that they could not rely on their husbands' responsibility. Protection of their next child from HIV/AIDS was also the women's responsibility as well.

Family stability was very significant to the women. This played an important part in motivating women's self-care to prevent HIV/AIDS. This was because women realized that if their husbands were infected with HIV it would lead to ruin for their family.

Social support was also found to be a precondition for women's self-care. Social support, which women received both from the social-care and the health care services was important to them. Women in this study received suggestions from their relatives and help from friends in relation to getting tested for HIV before marriage and before deciding to have children (detail in chapter 5 and 6). Accessibility to health care services also encouraged women to undertake self-care. This was demonstrated by some women buying health check-ups for their husbands (as a means for their husbands to be tested for HIV) because it was simple to do. It

has been found in several studies that social support is a precondition for self-care (Raatikainen 1992; Tungulboriboon 2002).

Attributes of women's self-care

Women's culture played an important role in whether or not women undertook self-care to prevent HIV/AIDS. Norms and social values which women adhere to determined their self-care. The motivation to women to perform self-care or how they performed it would be influenced by their beliefs, attitudes, and values. For example: women who believe the benefit of information about sex are more likely to be interested in and seek information about sex to improve their sexual relations with their husbands. On the other hand women who had a negative attitude about sex might feel shame in being interested in sexual relations or expressing their sexual desires. As a result it prohibits women from improving their sexual relationship with their husbands, which was believed to be one important factor influencing the extramarital sex activity of their husbands.

According to Pinthupan and Soonthonchai's study (2001) men and women ranked the priority and significance of features which contributed to sexual satisfaction differently. The researchers also concluded that knowing what actions improved their partner's sexual satisfaction and bringing those into improving sexual relations would enhance their sexual relationship and improve sexual exclusivity. This practice can help to promote monogamy, sexual health, and the prevention of HIV/AIDS as well.

Health belief was another contributing factor which influenced women's self-care to prevent HIV/AIDS in this study. When the women perceived their vulnerability to this disease coupled with recognizing it as a fatally incurable disease the women were more likely to protect themselves from HIV/AIDS. They would be likely to perform self-care if the benefit accompanied an acceptable cost. This means that women could consider undertaking self-care which could protect them from getting HIV/AIDS whilst not destroying their relationship with their husbands. However, the likelihood of undertaking self-care actions might not occur if women perceived themselves as having low self efficacy. This may stem from the perception of their subordinate social status to their husbands and lack of essential skills to perform self-care. Bringing together cognitive ability perceptual understanding and health beliefs have been shown to be mediators of self-care amongst adolescents (Tungulboriboon 2002) as well as important in this research.

Social life skills played an important role in specific self-care to prevent HIV/AIDS among women in this study. It was found that their perception of low self-efficacy among women was because they did not know what activities should be brought into action. They also did not know how to perform self-care. Acquiring the social life skills necessary promoted women's self-efficacy and as a result promoted '*goal directed self-care*' actions among women in this study.

Catalysts for women's self-care

Frustration goaded women into performing self-care. Once women perceived their vulnerability to HIV/AIDS they would be more likely to protect themselves from being infected. Performing specific self-care, according to women's beliefs, might

create conflict within the marriage. Unhappiness with this feeling acted as a driving force which pushed women to undertake self-care to eliminate it.

Peer group support was another significant catalyst for women's self-care in this study. Saying in other words that the feeling of support from a peer group enhanced the women's confidence to perform self-care. This was because she perceived that she had someone on her side and perceived that she had done the right thing. This finding has also been brought out in some other studies of self-care (Backman and Hentinen 1999; Leenerts and Magilvy 2000).

Consequences of women's self-care

Positive impact on the family instead of conflict was found to be a consequence of women's self-care in this study. Women's self-care promoted mutual understanding between couples. Fathers, mothers, and children spent more time together in their house whilst some self-care activities enabled a family to have some more social activities as well.

Sexual health improvement was noted in three directions. Firstly, improvement of sexual relations not only reduction in sexual imbalance but sex as gratification to the couple rather than for the husband only. Secondly, reducing the husband's extramarital sex led to a reduction in their husband's sexual risk behaviours as well. Finally, reduction of HIV/AIDS vulnerability for women and their family were noted.

A sense of control over situations was observed after women succeeded in undertaking specific self-care. Managing to get their husbands to have a health

check up, or test for HIV, to look after babies, and enjoy a party at home released women from frustration, gave them experience of self-authority, and an enjoyable feeling of self-determination.

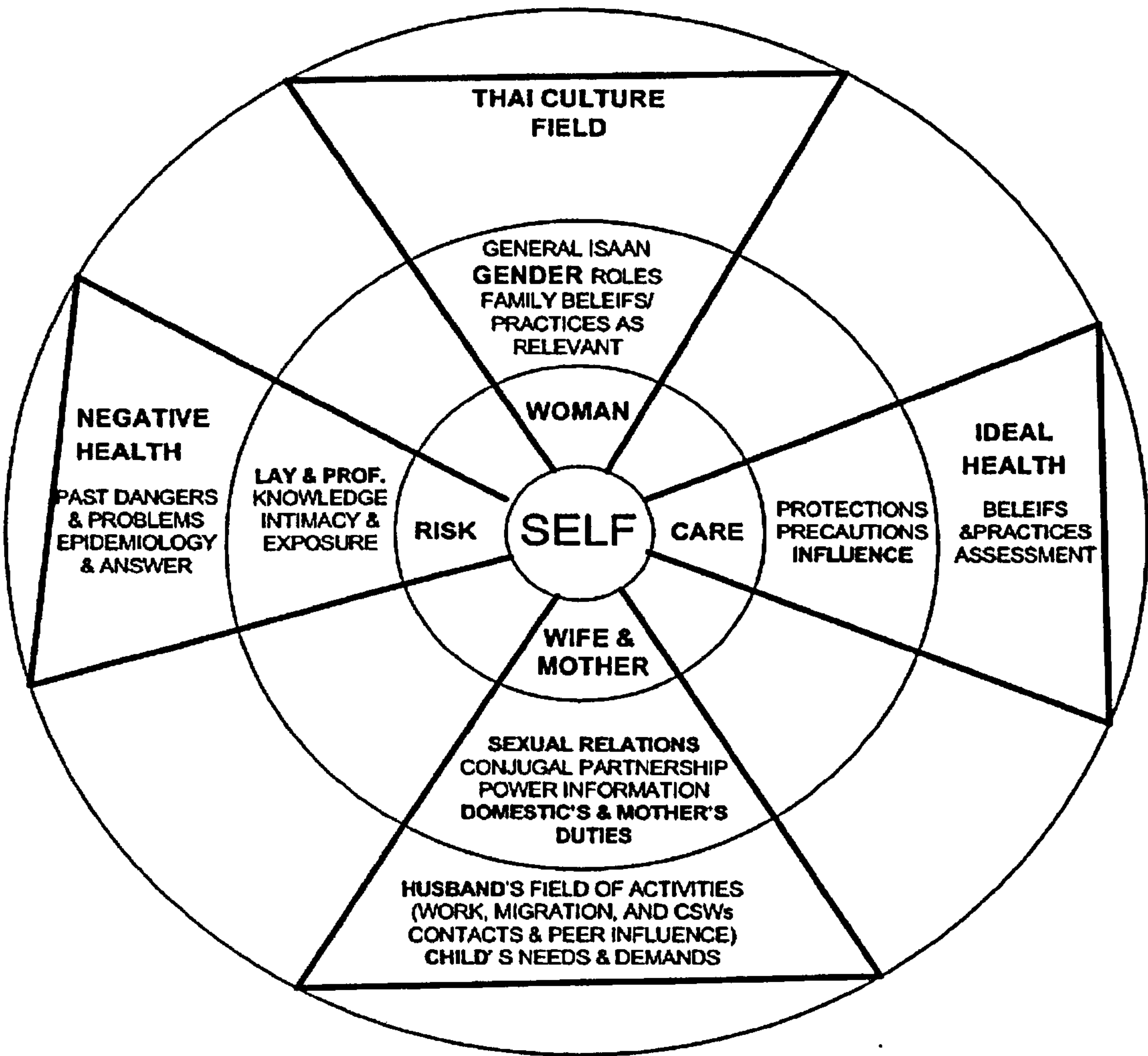
Effectiveness of resource utilization was one important outcome of women's self-care. Women could more properly utilize resources within their social network and health care services. For instance: women sought help from their mother in-laws to prohibit their husbands from going out drinking with friends; managing to get husbands to be tested for HIV from private organization in cooperation with community outreach in the health care services.

SECTION4: HEALTH THROUGH EMANCIPATION

A women's self-care model has been derived from the findings of the present study and consists of five main concepts contained in four vectors. In the centre of figure 8.4, there is a core concept representing '*self*' as a '*woman*', as a *wife & mother*, as a '*risk*' and as a '*care*'. '*Self*' in the social sense is coming from individual interactions with '*significant others*'. How individuals view themselves is a consequence of how he or she interacts with '*significant others*' in their broader context. The vertical line demonstrates how '*self*' as '*woman*' was shaped from general Thai culture and Isaan gender roles. Downwards from the top of the woman's vector to the *wife & mother's* vector where we see '*self*' being influenced by specific cultures of married life, and the mother's roles. The horizontal line displays the relationship of '*self*' with the two vectors of '*self*' as a '*risk*' and '*self*' as a '*care*' where a negative health influence from the left moves to an ideal health influence on the right. Within each

vector there are key concepts relevant to the core concepts of 'self' and the other four main concepts: 'woman', 'wife& mother', 'risk' and 'care'.

Figure 8.4 Self-care model for HIV/AIDS prevention for women



Source: Reconceptualised from Mead G.H. 1934

The *Woman's* vector consists of two keys concepts, 'Thai culture' and Isaan 'gender' roles, which play an important part in stereotyping Isaan women. Considering themselves as an individual 'self' is a consequence of the extent to which women adhere to these cultural norms. Socialisation through family values

and norms, coupled with interaction with others, constructs the individuals 'self' as separate from others. In other words the individual 'self-concept' is socially and culturally constructed and, in relation to other main concepts, will play an important role in the women's self-care for HIV/AIDS prevention.

The *Wife & Mother* vector contains two key concepts. These are 'married life' and the 'mother' role. The individual's sense of 'self' is also determined by married life experiences in terms of sexual elation, conjugal partnership, domestic & mother roles, and power information. The husband's personality and field of activities such as work, migration, communication, interest, extramarital sex, and peers influence plays a part in the self recognition process and can make a difference to a woman's self-care.

The *Risk* vector displays two key concepts of '*negative health*' and '*risk*'. It demonstrates past experience as relevant to HIV/AIDS epidemiology, which leads her to be at risk. Elimination/reduction of the risk of HIV/AIDS vulnerability can be obtained through lay and professional knowledge gained and exposure to the context of mutual participation in it.

The *Care* vector includes the other two key concepts of women's self-care, '*Ideal health*' and '*care*'. In order to prevent HIV/AIDS for herself and her next child women need to undertake two types of self-care. Firstly, general self-care by adopting existing general precautions into her everyday life. Secondly, specific self-care, more complex women's strategies need to be undertaken to protect herself and her next child from HIV/AIDS. Whether or not negative health factors can be

transformed into ideal health ones is influenced by the woman's capability to assess correctly her own vulnerability to HIV/AIDS. This capability coupled with her health beliefs and practices, and her information-based potential for practicing safer sex with her husband. Social support from the social network, such as relatives or friends and the availability of health services also play a part in the promotion of women's self-care for ideal of HIV/AIDS prevention.

Although '*self-care*' is defined as the care which individuals take responsibility for performing, self-care can not be operated only by the individual; it is normally undertaken through interaction with the others in the broader socio-cultural context surrounding them. According to Dean (1989), caring for self and the interplay with socio-cultural influences is importantly linked. It is therefore how the self-care process encompasses interaction between the individual and their environment which might support or obstruct self-care as well.

Based on this belief, in order to prevent herself and her next child from HIV/AIDS, the woman as both 'self' and as 'wife' needs to eliminate/reduce a health risk and improve care of herself to acquire the ideal health objective.

In applying this self-care model for HIV/AIDS prevention for women we should bear in mind that the horizontal axis is the centre of change. Thus changing negative health into ideal health is the goal. In the vertical axis, starting at the top we can not easily change the society and culture of Thailand. However, changing values and norms about gender roles and responsibility, family beliefs and practice as relevant to sexual health and HIV/AIDS prevention can be facilitated. Such changes influence

women's practices in the domain of wife and mother with regard to HIV/AIDS prevention for themselves and their next child.

In order to conduct a female support group effectively and with more focus, making sense of these concepts and their inter-relationships may help health professionals in general and nurses in particular, to plan, operate, and evaluate the outcome of the group process which aims at promoting women's self-care to prevent HIV/AIDS.

CONCLUSIONS

In conclusion the present study, participatory approach has provided a forum for women to share, learn and solve their own problems more effectively. Through this interactive process consciousness was raised, self-esteem and self-care capability were enhanced. Women transformed from a "culture of silence" to a "culture of salience", and put forward personal issues to be public issues. Women not only created self-care strategies, which were culturally appropriate and sustainable but also contributed ideas for health service reforms.

This investigation pertains to Isaan women who have their own socio-cultural background, which may be different from other groups of women in other parts of Thailand and other countries. Their empowerment process and self-care strategies may be different from other groups of women in other cultures. Application of theory generated from the present study to other group of women requires further research.

CHAPTER 9

IMPLICATIONS AND RECOMMENDATIONS

This chapter draws out the implications of and makes recommendations for clinical practice, nursing education, executive administrators, policy makers, health care reform within the health care system in Thailand, and further research.

This study has been carried out with a specific group and specially pertains to self-care to prevent HIV/AIDS of women and children in the Northeast of Thailand. The generalizability of the findings is limited. However, the empirical evidence has been analysed in a broader cultural context. Substantive theories generated from this study therefore, provide significant concepts and guidance and have implications for clinical practice and nurse education in the broader Thai context with regard to sexual health and the prevention of HIV/AIDS.

CLINICAL PRACTICE

Women's culture has been curtailed in Thai society and as such has limited women from preparing themselves to deal with the problems of sexual health properly. Their problems indicate the need for socio-culturally sensitive health care services, which can help them to cope with these issues effectively. There are several clinics which provide services for women but all of them focus on antenatal and postpartum care, treatment of gynaecological diseases and sexual transmitted diseases rather than prevention of diseases and health promotion. In addition, sexual relations are viewed as a personal and private issue. Women rarely talk about their sexual experience in

Thai society and health personnel, who are not well trained in this area might be reluctant to provide such a service. Women's sexual health problems including self-care to prevent HIV/AIDS have largely been ignored.

It should be noted here that how health professionals see their roles and responsibilities in community health care influences their services (Hildebrandt and Robertson, 1995). Health professionals should recognize that the women's problems are real and need to be solved seriously. They need to review their attitude toward these problems and should recognize their important roles and responsibilities to provide socio-culturally sensitive health services that promote women's self-care for sexual health and prevent HIV/AIDS. As a result they can help to promote women's health and enhance the quality of their lives in line with the ultimate goal of health professionals, in particular, nursing professionals (Henderson 1966, Rogers 1980 cited in Maglacas 1988 p.67; Lipson and Steiger 1996).

The analytical model of women's self-care which has been generated from this study can be used as a concrete guideline to enable the provision of socio-culturally sensitive health care for women in relation to HIV/AIDS prevention. It is recommended that application of this analytical model into clinical practice is carried out.

Health education: information for people

Television programme and videotapes were the most favourite way of gaining knowledge about HIV/AIDS among women in this study. However, various media are needed because many women acquired information from different sources such as

leaflets from hospital, or radio programme. In addition, the video tape, which was used in this study, could raise women's consciousness about HIV/AIDS issues. Some women borrowed this video to encourage their husbands to watch it. It is recommended that videos, CVDs, and DVDs are produced which women can borrow and take home to watch at any time as these may help the husbands obtain information about HIV/AIDS too.

Women in this study did not believe that they were a risk group for HIV/AIDS. Thus it is recommended that health education materials should convey information, which helps people realize that HIV/AIDS can be every person's problem. Furthermore campaigning for pre-marital and pre-conception HIV/AIDS testing should be carried out. The campaigns should also convey information that this practice is an important for everybody not only for special risk groups. In addition, information about cost and how to obtain this service should be included in the health education information.

Sexual health counselling

The findings from this study revealed perceptions of sexual imbalance among several couples. This problem was felt to impact on women's health and work and was also perceived as one factor which forced their husbands into extramarital sex. It is recommended that sexual health counselling, which includes HIV/AIDS prevention for women or couples is provided and that the promotion of this service for women and couples needs to be done sensitively to avoid Thai women feeling embarrassed and reluctant to participate.

It is also recommended that the analytical model generated from this study is used to guide health professionals in assessing factors associated with sexual imbalance among couples or to assess husbands' extramarital sex. Women's self-care strategies can be proposed where counselling is given to women only and the same strategies can be modified in counselling given to couples.

The present study has demonstrated the value of facilitating a female support group on women's empowerment and self-care. One salient advantage of female support is the potential of promoting vicarious experiences. It is therefore suggested that the application of this approach to women's sexual health and HIV/AIDS prevention not only provides a socio-culturally sensitive service specific to their needs and problems but also may expand further women's health strategies and should be adopted and evaluated accordingly.

Female support group: utilising the approach in Thai health care

A female support group can be conducted as part of hospital in-service or community outreach services. It is suggested that *community outreach* services are needed initially to help cost problems associated with gaining access to existing services. Waiting for a long time, arranging transportation, and the cost for services are obstacles to women. Community out reach as the first stage of service development may help women to talk openly about issues, perceive the benefit of participating in a group and lead women into *in-service* provision at health care facilities, later on. Such an approach has been used in the expanded programme on immunization in Thailand. Such an approach is recommended for HIV/AIDS prevention amongst women.

To apply the model effectively, health professionals need to make sense of the methods and strategies used for promoting the group process. They need to understand that women's self-care is a social process, and that caring for themselves interplays with others factors in their socio-cultural context. Therefore, staff development is necessary for those health care professionals who will be involved. It is recommended that such a programme should focus on the process of empowerment. Beginning with partnership building, which facilitates open sharing and discussion of women's issues moving on to consciousness raising, and illumination the realities so that women get insight into the issues that influences them. Finally, focusing on strengthening women's self-esteem by enhancing self-recognition, promoting self-efficacy and promoting self-reliance.

NURSE EDUCATION

The recommendations for health education have relevance to the development of educational roles and processes within nurse education in Thailand.

It is recommended that:

Clinical instructors act as role models whereby they adopt women's strategies to provide counselling for women in relation to sexual health and HIV/AIDS prevention. In addition by promoting a female support group pattern and using the model of women's self-care, clinical instructors can demonstrate how to provide socio-culturally sensitive services for sexual health and HIV/AIDS prevention for women.

Furthermore it is suggested that *the nursing curriculum is revised* by placing more emphasis on sexual health care both in undergraduate and graduate curricula. Initiating sexual health care into clinical practice experiences for students is also needed.

Providing short course training aimed at strengthening health professional capability to provide socio-culturally sensitive services for sexual health and HIV/AIDS prevention for their communities.

Producing master's prepared nurse practitioners in the area of sexual health, which includes STDs and HIV/AIDS prevention for women is another crucial contribution for professional development.

Finally under the theme of nurse education, it is recommended that *a research based textbook* in the area of women's sexual health for nursing students and health professionals is produced and used as a guideline manual for clinical practice.

POLICY MAKERS

It is recommended that:

Executive administrators and policy makers need to change their attitude about sexual health and HIV/AIDS prevention, in particular for women. First, they should *realize this problem as real* and should not ignore the issue.

Provision of health education materials as suggested is required and should be carried out through various mass media and should have general content so as to promote people's awareness that HIV/AIDS can be a problem for all. Such initiations require budgets to be allocated and supported by policy-makers.

Policy-makers support and facilitate sexual health services for women at both in-service and out-reach facilities.

Policy-makers support and allocate budgets to facilitate future research in relation to women's sexual health and women's self-care for HIV/AIDS prevention.

Health care reform

The findings from this study suggest two types of health care reform are needed: *sexual health service* and *family health service development*.

Sexual health service: Apart from under-perception of HIV/AIDS vulnerability, the inconvenience of getting a test for HIV has been identified. In addition, testing methods available are invasive and provided in big hospitals only. Furthermore, people have to wait for at least two weeks to obtain test results. Reforming the health care system to ensure access, quality care, and services at affordable costs are crucial. Sexual health services should be established at the frontline of the health service system such as sub district health centre and health promotion section in all hospitals. This frontline service should include service for voluntary counselling and testing for HIV as well. Studies in Thailand have shown that saliva testing could serve the purpose of HIV surveillance and screening (Phakjarearnpol et al. 1993; Meesiri 1994;

Kamolped, Yaisoongnern and Tungsupachai 1995; Frerichs et al. 1994). It therefore, should be an alternative to serum for HIV-antibody testing (Frerichs et al. 1996). This service may promote people to be tested for HIV before marriage and before deciding to have child.

Family health care service should be a replacement of the existing maternal and child health service. This proposed new service (detail in chapter 7) not only promotes men's involvement in HIV/AIDS prevention but also promotes sexual health among couples.

These two services mentioned above should be routine and have a concrete schedule, and should be included in "30 Baht-Health Scheme" of health insurance for Thai people.

FURTHER RESEARCH

It is recommended that:

To generalize the substantive concepts and theories, which have been generated from this study, further research is needed.

Further development of the model of women's self-care need to be carried by constructing assessment instruments, based on the theoretical perspectives generated in this study and applied to a wider group in order to examine women's self-care strategies with regard to sexual health and HIV/AIDS prevention.

A female support group approach as a nursing intervention for women's sexual health and HIV/AIDS prevention should be evaluated with other groups of women.

The proposed family health programme, as an approach for promoting "Holistic health" for mothers, fathers and children, should be set up and investigated as action research. The need to develop tools for evaluating the intervention process and outcome are strongly recommended.

Multi-site research is recommended to investigate women's self-care, female support group, and family health programme. These will give great contributions of the new knowledge pertaining to sexual health and HIV/AIDS prevention for women and children including health sciences knowledge.

The findings from this study reveals that only few women persuade their fiancées to get test for HIV before marriage and before deciding to have child. Qualitative research among single women and men, and married couples to understand factors associate with their practices will shed further light on these phenomena.

Obtaining more information from married men's perspectives is required to fully understand the issue. Qualitative research among married men and couples to understand their cultures in relation to sexual health and HIV/AIDS prevention are also suggested.

Trans-cultural knowledge developments in all aspects mentioned above can be carried out by adopting a theoretical perspective and approach from this study to research in

other countries. This endeavour is also recommended to advance health science knowledge.

Dissemination Strategies

Finally it is proposed to disseminate the findings of this research by:

- Providing a brief executive summary for policy makers
- Publishing articles in nursing and public health journals
- Presenting conference papers at the national seminar on AIDS in Thailand, and at international AIDS conferences.
- Sharing the educational ideas with colleagues in the Faculty of Nursing at Khon Kaen University in order to develop our undergraduate educational programme.
- Providing a summary of the research to practitioners in the three hospitals concerned and outlining ways of developing educational programmes for staff nurses.

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Figure 2.1 Map of Thailand



Source: Available from<http://www.thailandlife.com/map/index.html>

Appendix II

**KHON KAEN UNIVERSITY**

This is to certify that

The Project Entitled: The development of program to prevent AIDS among mother and Infants Muang district, Khon Kaen, Thailand

Principle Investigator: Assistant Professor Siriporn Intarakamhaeng

Address: Faculty of Nursing, Khon Kaen University,
Khon Kaen, Thailand.

Has been reviewed by The Khon Kaen University Ethics Committee for Human Research, based on the declaration of Helsinki

Date of approve: May 26, 1997

Giving on: August 4, 2005

Professor Pyatat Tatsanavivat, M.D.,
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Questionnaires form in exploratory phase

Interviewing questionnaire

This interviewing questionnaire is divided in to three parts. Part one is personal information. Part two concerns about self care of married women in order to prevent AIDS among themselves and prevent vertical transmission during pregnancy. Part three relates to supportive need from government and non-government sector in order to prevent AIDS among mothers and infants. There will be both close ended and open ended questions in this questionnaire.

Part 1 Information about participants

Section 1 Please answer the following question accurately.

		Variables	Col
		ID () () ()	1-3
		V1 ()	4
1. Age at last birth day			
1) 15-20 yr.	2) 21-30 yr.		
3) 31-40 yr.	4) 41-50 yr.		
2. Marital status		V2 ()	5
1) Single	2) Couple		
3) Widow	4) Divorce		
5) Separate			
3. Living arrangement		V3 ()	6
1) Municipality	2) Outside municipality		
4. Within one year do you live in the same house with husband?		V4 ()	7
1) Yes	2) No		
5. Level of education		V5 ()	8
1) Compulsory or lower	2) Secondary school- certificate		
3) Diploma- bachelor degree	4) Master degree or higher		

6. Your occupation is

1) House wife

2) Worker

3) Business

4) Government officer

5) Other -----

V6 () 9
7. The major source of your income

1) Husband

2) Your income per day

3) Your salary

4) Interest from business

5) Other

V7 () 10
8. Please indicate your approximate family income per month (baht)

1) 10000 or less

2) > 10000

V8 () 11
9. Religion preference

1) Buddhism

2) Islam

3) Christian

4) Other -----

V9 () 12
10. This child is ----- from -----

V10 () V11 () 14
11. Hospital attendance

1) Srinagarind hospital

2) Khon Kaen hospital

3) Maternal and child hospital

V12 () 15
12. Self-identified HIV/AIDS risk level is

1) Very high risk

2) High risk

3) Moderate risk

4) Low risk

5) No risk

V13 () 16
13. The reason of self-identified HIV/AIDS risk level is-----

14. Self perceived of HIV sero-testing is

1) Positive

2) Negative

V14 () 17
15. Laboratory report of HIV sero-testing is

1) Positive

2) Negative

V15 () 18
16. Did you receive counselling related to HIV/AIDS before taking blood examination?

1) Yes

2) No

V16 () 19
17. Did you receive counselling after taking blood examination?

1) Yes

2) No

V17 () 20

Section 2 Since information about HIV/AIDS has been disseminated through various media therefore you may have learned about it. Please answer the questions below related to this issues.

1. How knowledgeable do you feel about the way HIV is transmitted?

V18() 21

1) Excellent2) Good3) Fair4) Poor
2. What is/are the important source(s) from which you obtain HIV/AIDS information?

1. -----2. -----3. -----4. -----5. -----
3. What is the cause of AIDS disease?-----
4. Is there any effective treatment to cure the AIDS disease?

V19() 22

1) Yes2) No
5. Do you think that AIDS is a fatal disease?

V20() 23

1) Yes2) No

Why do you think so?-----
6. If you were the AIDS person, is there any negative impact on you and your family? -----

How does it impact?-----
7. Can AIDS virus transmit to a baby in the womb if the mother is AIDS person?

V21() 24

1) Yes2) No
8. The items below are the behaviours which might be risky for AIDS transmission. Please identify your perceived level of risk of those behaviours by putting a mark (/) if most high risk =4, high risk=3, moderate risk=2, low risk=1, or no risk=0.

Risk behaviours	Risk level					
	4	3	2	1	0	
1. Exposure to others blood on skin with scratch or break						V22() 25
2. Vaginal intercourse without condom						V23() 26

Risk behaviours	Risk level						
	4	3	2	1	0		
3. Anal sex perform without condom						V24()	27
4. Oral sex with condom						V26()	29
5. Oral sex without condom						V25()	28
6. Anal sex perform with condom						V27()	30
7. Sharing needles for legal drugs						V28()	31
8. Exposure to blood on skin						V29()	32
9. Vaginal intercourse with condom						V30()	33
10. Kissing person with AIDS						V31()	34
11. Sharing eating utensils						V32()	35
12. Hugging person with AIDS						V33()	36
13. Sitting on public toilet seat						V34()	37
14. Swimming in public swimming pools						V35()	38
15. Blood donation						V36()	39
16. Mosquitoes biting						V37()	40
17. Wet and deep kissing						V38()	41
18. Sharing needles for illegal drugs						V39()	42

Part 2 Self care of married women to prevent AIDS (for HIV infected women , it is self care before infection)

Section A. Every individual has agency and capability to perform self care in different ways to restore and enhance their health, and prevent disease. As a married women you may have some self care different from non married women. Please give the five most important things you have been done in order to prevent AIDS for yourself and your baby.

1-----

2-----

3-----

4-----

5-----

Section B. Below are activities, which some married women might have done when caring for themselves in preventing AIDS among them and their babies. Please put a mark (/) in the column which applies to you.

4= always done, 3 =almost always, 2=sometime, 1=rarely, 0=never done.

Self-care	Application						
	4	3	2	1	0		
Eat sensible						V40()	43
Get enough sleep						V41()	44
Get enough exercise						V42()	45
Have enough time for relaxation						V43()	46
Take vitamins						V44()	47

Self-care	Application						
	4	3	2	1	0		
Intake of substance(s) such as traditional medicine, or herbal						V45()	48
Take good care of personal hygiene						V46()	49
Play or live by the principle of religion						V47()	50
Discuss health with lay friends, neighbours and relatives						V48()	51
Seek information about AIDS						V49()	52
Ask fiancés to get test before marrying him						V50()	53
Discuss AIDS with husband						V52()	54
Warn husband to use condom with other women						V53()	56
Warn husband to use condom with commercial sex workers						V54()	57
Never let husband go working outside province						V55()	58
Use various media to arouse fear of AIDS to husband						V56()	59
Maintain close relationship with husband						V57()	60
Act as a good wife to prevent husband from having sex outside marriage						V58()	61
Get treatment immediately for STD if any						V59()	62
Use germicide during sexual activities						V60()	63
Use female condom						V61()	64
Ask senior relatives to raise awareness of AIDS threat to husband						V62()	65
Never let husband drink outside house						V63()	66
Have blood tested for HIV before deciding to be pregnant						V64()	67
Have blood tested for HIV during pregnancy						V65()	68
Never decide to be pregnant if having diagnosis of HIV sero positive						V66()	69
Terminate pregnancy if having HIV sero positive						V67()	70
Continue pregnancy and get treatment by modern medicine to prevent vertical transmission if HIV positive						V68()	71
Continue pregnancy and get traditional healing if HIV sero positive						V69()	72
Continue pregnancy and hope that your baby will not acquire HIV						V70()	73

Part 3 Supportive need to prevent AIDS

Section A. Even though married women can perform some self care to prevent AIDS among them and infants but there are several factors contributing to this issue of which outside there control. There supportive need should be addressed. Please indicate the five most important thing you would like to be supported from health care agencies both government and non-government.

- 1-----
- 2-----
- 3-----
- 4-----
- 5-----

Part B. The list of activities below be applied to prevent AIDS among mothers and infants. Please identify activities you like to ask government and non-government to do. Using the criteria as the following:
mostly=3, moderately=2, not sure=1, do not want at all=0.

Supportive need	Level of need				
	3	2	1	0	
Counselling and screening for HIV before marriage					V70() 73
Counselling and screening for HIV before pregnant					V71() 74
Counselling and screening for HIV during pregnant					V72() 75
Provide AZT by free of charge to HIV positive pregnant					V73() 76
Allocate a huge grant to develop HIV vaccine					V74() 77
Health education program before marriage					V75() 78
Special program to enhance skill necessary to safer sex negotiation among commercial sex workers					V76() 79
Provide adequate condom to all brothels					V77() 80
Special program enhancing self care to prevent AIDS among married women					
Campaign to promote healthy sexual behaviours every year					V78() 81
Promote family relationship					V80() 83
Increase taxation for alcohol					V81() 84
Strict regulation of the drugs dealers					V82() 85
Legal control of the wide spread availability of pornography					V83() 86
Prohibit advertisement of alcohol though mass medusa					V84() 87
Legal control for condom use in commercial sex services					V85() 88
Prohibit of sponsor for sport by alcohol factories					V86() 89
Strictly regulate on wide availability of commercial sex services					V87() 90
Legal control on alcohol advertisement by using girl nude calendar					V88() 91
Special measures to change male attitude about having sex outside marriage					V89() 92

INTERVIEW TOPIC GUIDE IN EXPLORATORY PHASE

1. Demographic Data:

- Age, Sex, Education, Occupation, Living Arrangements, Marital Status, Number of Child, Date of Marriage, Hospital Visit

2. Attitude and Knowledge of HIV/AIDS:

- Are you familiar with HIV/AIDS? What can you tell me about HIV/AIDS? What are your personal feelings about HIV/AIDS? How do people get the AIDS virus?
- What are the risks and behaviours associate with the AIDS virus? Among these behaviours, which are considered high risk, moderate risk and low risk?
- What precaution should people take to prevent themselves from HIV infection? Can you explain the symptoms of HIV/AIDS? Can AIDS be cured? Currently is there a vaccine available to prevent the AIDS virus? Who are the five most prevalent groups most likely to be infected by AIDS virus?

3. Source of HIV/AIDS knowledge:

- How have you educated yourself about HIV/AIDS? What are the five most important sources of HIV/AIDS information? From these sources do you have adequate knowledge of HIV/AIDS?

4. Awareness of HIV risk status:

- Who are the five most vulnerable groups of HIV infection? Why do you think these groups are most vulnerable? Between married women and single women, who has the most chance of contracting the AIDS virus? Why do you think so? Can you give some characteristics of women who are at high risk, moderate risk and low risk?
- Have you ever discussed about HIV/AIDS with your spouse, family and friends? What would be the benefit of open discussion?
- Have you ever taken a blood test for HIV? What would be the benefit of taking a blood test? What were the results?
- Have you ever been infected with a sexually transmitted disease (STD)? How often were you infected with STD? How did you resolve your STD infection?

- Has your spouse ever taken blood test for HIV? What would be the benefit of your spouse taking a blood test for HIV? Where did your spouse take the blood test? What were the results?
- Has your spouse ever been infected with an STD? How often was your spouse infected with an STD? How did your spouse resolve the STD infection?
- Have you ever thought you were infected with AIDS? Why did you think you were infected? How do you categorize yourself in respect to the high risk, moderate risk, low risk or no risk AIDS groups? How did you base your conclusion?
- How does a married women contract the AIDS virus? What are the reasons for your conclusion?

5. Habits of Married Women To Promote The Prevention of HIV/AIDS:

- Do all women have to take precaution to promote the prevention of HIV/AIDS? What are the reasons for your conclusion? Who should take precautions to promote AIDS prevention? Between married women and single women, who has the most difficulty in taking precaution to promote HIV/AIDS prevention? What are the reasons for your conclusion?
- Have you ever thought that you had to take precaution to promote the prevention of HIV/AIDS? Have you ever taken precaution to prevent yourself from contracting HIV/AIDS? What are the five most important precautions you have taken? Have you ever use a male or female condom or use germicide with spouse while having sexual intercourse in order to prevent HIV/AIDS? How often did you use these preventive methods? Did you have your spouse agreement and cooperation while applying these preventive methods? Did you have any problems applying these preventive methods? How did you resolve these problems?
- Has your spouse ever had sexual relations outside of your marriage? What are the five most important methods you can use to prevent your spouse from having sexual relations outside of your marriage? What were the results of these methods positive? If not, how did you resolve these problems?

6. Prevention of Vertical Transmission of HIV/AIDS:

- During pregnancy, did you ever think that you may transmit AIDS to your foetus? How about if you were infected with HIV/AIDS? Do you know how to prevent HIV/AIDS transmission to your foetus?
- Have you ever taken blood test for HIV/AIDS before pregnancy? What were the results? Where did you have the blood test taken? Did you receive counselling before or after your blood test?

- How did you feel when you first were realised you were HIV positive? What did you do to prevent your foetus from being infected by HIV/AIDS? Have you ever taken AZT? If you could go back in the past, what would you have done to prevent yourself and your foetus from HIV/AIDS infection? (Ask only HIV positive mothers).

7. Facilitating Factors of The Wide Spread of HIV/AIDS:

- Why is the wide spread of infection of HIV/AIDS in Thailand so common, especially among mothers and infants? What are the five most important factors, both with and outside of the family, which facilitate the rapid spread of HIV/AIDS infection?

9. HIV/AIDS Prevention Programme Which Should Be Implemented By The Thai Government:

- Can you explain the HIV/AIDS prevention in Thailand? Are the programmes preventive methods effective enough to prevent the widespread infection of HIV/AIDS in Thailand? If they are not, what other methods could the Thai government implement to reduce the spread of HIV/AIDS?
- Are the methods being used at the present time suitable to eliminate or reduce the spread of HIV/AIDS infection of mothers and infants? What is the reason for your conclusion? Are there any things that Thai government should do to prevent HIV/AIDS infection among mothers and infants?

Coding scheme for concepts about HIV/AIDS

- A. Perceived wide spread of HIV/AIDS

1. Relative died from AIDS

2. Visiting friends who was AIDS victim

3. People talk of AIDS persons around here
- B. HIV/AIDS risk group

1. Disease of promiscuous person

2. Good women had no chance to get AIDS

3. Confining in particular groups
- C. Social stigma disease

1. Do not want any body know

2. Afraid of being suspect as AIDS person

3. No body want to contact the AIDS victim

4. Awful look
- D. Fatal incurable disease

1. AIDS person will die sooner

2. No regiment to treatment

The example of codes according to categories scheme

<p><i>There were several AIDS patients around here. Some of them had bad skin lesions on their body and they could not lie on the mattress. They had to lie on banana leaves instead. Some of them look thin and have severe diarrhoea. After they die they were wrapped in black plastic bags and were not permitted to be cremated at the temple. Their relative had to arrange the funeral outside the temple. My mother is a village health volunteer; she did not allow me to see those patients. I also did not want to stay close to them as they look awful (Jun HIV negative).</i></p> <p><i>“Those working night shifts, masseurs, prostitutes, men visiting brothels or prostitutes, labourers and construction men are risk groups. These construction men could do anything; drinking, going to prostitutes, visiting brothels. Those who are drugs addicted persons. Then there are drivers and tricycle riders. These men love visiting brothels.” I guess that’s all, I mean they are promiscuous” (1.2 HIV positive).</i></p> <p><i>“Decent women do not get themselves involved with many men. If they were faithful to their husbands they wouldn’t be infected (3.4 HIV negative).</i></p> <p><i>“This disease can’t be treated, like cancer. I’m afraid it’d happen to me. When a person has blisters and loses weight, he looks disgusting. It’s a disease disliked socially. If it’s virulent, it’s dreadful. People who got it die very soon” (3.2 HIV negative).</i></p>	A. 3
	C.4
	C.3
	C.3
	B.4
	B.1
	B.2
	D.2
	D.1

Appendix VII
Letter of invitation

Faculty of Nursing
Khon Kaen University
Date.....

Dear Mrs.....

My name is Siriporn Donkaewbua. I am conducting a study as part of the requirements for my Ph.D. This study aims to pursue the suitable methods and services for women to protect themselves and their child from AIDS.

You are invited to participate in this study which composes of two phases as follows.

The first phase will be two sessions of interview, which will be taken placed at your house and scheduled at a time that is convenient to you.

The second phase is five sessions of focus group discussion with other women, which will be held in a comfortable room at this hospital.

This study focuses on women’s life experience therefore; you are the most important person as insider to provide information. It is hoped that the results of the study will be fruitful for knowledge construction and better understanding of women’s need for support in regard to prevention of AIDS. The explicit understanding about your life experience can be advantageous for nurses and health care professionals so that they can deliver the best services for you, your family, and other women and their families as well.

The response and information provided will be confidential. Your name as well as your family name will not be disclosed on any interview forms or attached to audiotapes. I would like to assure that your decision to participate in this study will not affect any aspect of care and services you receive from the hospital. You are free to refuse to answer any questions you do not like to discuss or to stop participation in this study at any time.

Any inquiry about this study is welcome and answer will be provided by me personally.

Sincerely yours,

If you agree to participate in this study please signs your name

.....

Siriporn Donkaewbua, RN
Maternal and Child Health Nursing Department
Faculty of Nursing, Khon Kaen University
Tel (Office): 043-237606
(Home): 043244586

.....

Participants signature

Appendix VIII

The interview guide for in-depth interview in the explanation phase

Code:

Of Interview.....

Date.....

1. Present circumstances

- Woman age
- Educational level
- Occupation
- Marital status
- Number of child
- Husband age
- Husband educational level
- Husband occupation
- Number of family members (Specify)

Probe: Living and financial arrangement

- : Previous marriage of women and husband
- : Social support within family
- : Dual residency
- : Methods of birth control

2. Conjugal partnership

- Roles and responsibilities
- Authority and decision making
- Communication
- Problem solving

Probe: Power relation between couples

- : Husband and wife personality
- : Women's coping style

3. Understanding about HIV/AIDS

- Facts about HIV/AIDS-transmission, risk behaviours, and prevention etc.
- Preventive measures
- Health service related to HIV/AIDS

Probe: Application of knowledge into practice

- : Misconception about HIV/AIDS

4. Perception of HIV/AIDS vulnerability

- HIV/AIDS wide spread- contributing factors
- Awareness- self evaluation and level of risk

Probe: Influencing factors of perceived vulnerability-history of STDs, husband's extramarital sex and STDs, husband sexual life style

- : Responding to this perception

5. Self-care to prevent HIV/AIDS for themselves and their next child

- Self-care activities
- Factors associated with self-care
- Safer sex- understanding, awareness and practice

Probe: Cultural meaning of sexuality, marriage, and family life

- : Self-concept, self-values, and self-efficacy
- : Sexual imbalance and women's work load,
- : Help seeking behaviour

6. Potential help and support pertaining to HIV/AIDS prevention

- Availability and accessibility to support and help in social networks
- Availability and accessibility to health services in relation to sexual health and prevention of HIV/AIDS
- Suggestion to improve health service and information

Probe: Nature and function of social support needed and associate factors-facilitators and barriers.

Appendix IX

The example of collapsing level I code into the level II code for women's cultures pertaining to self-care to prevent HIV/AIDS

Quote	Level I code
<p><i>"I know he used to go to prostitutes. He drank and he went out often. I told him to wear condoms but he said no, he didn't have one. So I said then we shouldn't sleep together. And I didn't take contraceptive pills. He said never mind. I was getting worried we would have a baby. He said it wasn't going to happen after once, and he did it. So that's it. I told him to wear a condom, he wouldn't. And he wouldn't go to buy it. I couldn't resist him. I wanted to part from him many times, but he wouldn't let me. ...But when I was pregnant and told him that I was, he left me" (2.1 HIV positive).</i></p>	<ul style="list-style-type: none">• Inferior power relationship• Low self-esteem
<p><i>"If he goes to those places, I have to accept that. But how can I know if he does? I never know. However, if I know it I'll have to let him sleep with me anyway. He's my husband. He could have a new wife if I wouldn't let him. Then I'll have another worry. The only thing is to have him wear condoms. It's impossible not to let him sleep with me. Men can't stand it. They'll go out to prostitutes and they'll bring the disease to us. But again, men don't like to use condoms. They say it's not 100%" (3.1 HIV positive).</i></p>	<ul style="list-style-type: none">• Concept about marriage life• Believed about men's sexual desires

Appendix X

Example of field note and level I code

Line	Fn 9/07/2000	Coding
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	(9:00 AM): Vanisara was waiting for interviewed at the ground floor of her house. This house did not have fence and there was a house near by. Whilst the researcher was beginning the interview session with this respondent, her neighbour came back from the market. She stopped to talk with Vanisara likely to know about our conversation. Vanisara told her neighbour that I came to interview her about how woman prevented herself from AIDS. Her neighbour turned to me and said, "Why don't you interview prostitutes rather than ask us? I think we are not persons whom will be infected with this disease". Vanisara said to her neighbour that "Moa just like to know about general people. I just like to talk with her and tell her about things I know. If we are not sam son person we are not get it. I am not worried about this. I am not a drug addicted and haven't used needle with any body for injection so I am not afraid to be infected with AIDS." The researcher told Vanisara's neighbour that there were several project had been studying with prostitutes but my project concerned women in general. Then the researcher told her that if she interested to share her opinion about this issue we will talk later. Vanisara's neighbour became another respondent of this study afterward.	Women's concept about HIV/AIDS
24 25 26 27 28 29 30 31 32 33 34 35 36 37	(9:10 AM): Vanisara laughed and told that her neighbour likely to know other's people secret but she did not have anything to be anxious. Because she was not an AIDS person. Her blood test was OK. Her husband hasn't gone for prostitute. She believed that even he like to do he may don't have money. Her husband was a wage worker therefore; he got money from work day by day. So she hasn't thought she needed to do anything. Pointing to her baby (two months old) she said "I had my blood test during pregnancy and I don't have AIDS. My baby is healthy so it proves that my husband free from AIDS too. If I ask him to be tested it west our time and our money. His boss may not allow him to go to hospital for this since they would not have any person for doing work".	Women's health belief
1 2 3 4 5	Fn 10/07/05 (9: 00AM): At Viyada welcomed me at the front door of her house. We walked in to the living room where her baby (four months old) was lying on the mattress placed on the floor. There were noises of conversation from many people in the next room in the house. Viyada was smiling whilst	Women's simple way of life: It would not happen to me

6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26	<p>told me that those people were playing cards with her parents. Viyada's husband worked in another province. He would come home once a month. They were cohabitant without wedding ceremony. This because they had premarital sex and she was pregnant. They still not registered for marriage and did not care so much about this, but she might do it later. Viyada even said she was not trust her husband 100 % for not going to visit CSWs when he stayed in another province, but she seemed not be worried about this. She believed that her husband would ware condom if he went to visit prostitute. However, she hasn't asked her husband. She believed that he would know the way to protect himself therefore; she said it would not a matter. She said she might not unlucky to be infected with AIDS. She felt uncomforted to ask her husband to get test for HIV. Because she thought she did not have a reason to so. Viyada lived with her parents in extended family. However, she did not discuss about her marriage life or about AIDS with her parent. She believed that they may not have time to concern about this issue. She said just wait and see to measure the situation.</p>	<p>Under-perception of vulnerability to HIV/AIDS</p> <p>Trust husband</p> <p>In adequate function of social care</p>
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	<p>Fn 14/09/2001</p> <p>(13:00PM): I arrived to Tip's house in the afternoon and found she was feeding her baby (six months old). Tip lived with her husband. However, her mother and father in-law house located next to her house. Tip's husband was several years older than tip. This was his second marriage, but first marriage for Tip. Tip graduate bachelor degree but her husband want her looked after their baby rather than doing another job. Tip relied on her husband's financial. Because her husband work at nightshift in an entertainment area. This coupled with he had history of sexual indiscriminate before marrying her led Tip a bit worried about AIDS. Because her husband gets angry easily Tip could not ask him about this. Tip asked me to talk about the AIDS issue with her husband. This was the reason why she made appointment in the afternoon.</p> <p>(13.45 pm): Whilst we were talking her husband woke up and came in the living room. Tip introduced her husband to me and re-explained about why I came to see and talk with her (She told him about this appointment before). He started the conversation by complaining about the quality of health service at hospital where Tip gave birth. We discussed this problem for several minutes. Until I found him clamed down and satisfied with the information I provided.</p>	<p>Could not control the situation</p> <p>Seeking help and support</p> <p>Dissatisfaction of health service</p>

25	(14:00PM): We turn our talk to the evidence of AIDS in	Introducing HIV/AIDS information to Tip's husband
26	Khon Kaen province. He listened and discussed with	
27	interested in this issue particularly the prevalence rate of	
28	HIV infection among brothel and non- brothel CSWs. I	
29	also introduced the percentage of condom breakage rate into	
30	our talk and I noticed that he listen cautiously. Tip's	
31	husband talk with us for several minutes. He played with	
32	his lovely son for a while before taking him leaving to see	Perceived benefit of doing something
33	his parent next door. (14:20pm)	
34	After her husband leaved us alone Tip had big smile and	
35	she said to me that she believed that her husband	
36	consciously interested in the issue he talked to me. She also	
37	hoped this would help her husband took much more caution	
38	if he would have extramarital sex. I told her that it was a	
39	good start but need to be continued. When we talk in the	
40	group we will share with others to find out the best way for	
41	women to deal with this problem. I left Tip's house with	
42	the belief that I will see her in our group discussion	
43	afterward (16: 20pm).	

Appendix XI

SUMMARY OF THE FIRST STAGE OF THE EXPLORATORY PHASE

Respondent profiles

There were 21 respondents in the first stage of the exploratory phase of this study, 18 were HIV negative women and three were HIV positive women. There were seven from hospital III, five from hospital II and six from hospital I. There was one HIV positive women from each hospital.

There was a diversity of respondents' characteristics in terms of age, education, occupation, living arrangement, family income, and number of children. However, almost all of them were Buddhism. Most of them educated at secondary school and were housewife (Table 5.1). This represents the figure of Thai women in general. The findings from both open ended and close ended will be discussed as follow.

Women's understanding about HIV/AIDS

In responding to question "How knowledgeable do you feel about HIV/AIDS?", most of the women chose the fair category (66.67 %) followed by good (23.81 %). Only one mother from hospital III chose "excellent" category (4.76 %), this mother graduated at master degree. There was one from hospital I chose "poor" category (4.76 %). The major sources of information about HIV/AIDS were from television, radio, leaflet from hospital, and health professionals. This evidence confirmed by all data obtained in all phase of this study later on.

Nearly all of respondents (95.23 %) indicated that AIDS is a fatal disease and incurable. Only one from hospital III indicated that AIDS can be cured, and one from hospital I indicated that AIDS is not a fatal disease. Women's concept of HIV/AIDS obtained from closed ended confirmed by their concepts obtained from open ended. Women's concept about HIV/AIDS can be drawn from their explanation of causes of AIDS as well. Based on the salient of frequency, women viewed that HIV/AIDS confined within CSWs, IDUs, and promiscuous person. It can be conclude that women viewed HIV/AIDS as a fatal, incurable, and social dilemma disease, and it confines in some particular group. All of women (100 %) knew that HIV virus can be transmitted to the foetus. This evidence has a strong support from evidence from open ended as well.

There were nine test behaviours which more than ten women incorrectly defined the level of risk according to assigned risk. In addition there were several misunderstandings about risk behaviours which can lead women at risk of HIV infection if they apply this understanding into their practice. These were: 1) perception that oral sex with condom, vaginal intercourse with condom, and anal sex with condom were no risk, and 2) perception that having sex without condom was either moderate or low risk.

Women perception of their vulnerable to HIV/AIDS

Most of respondents identified themselves as “no risk” of HIV infection. The percentage of high risk, moderate risk, and low risk were equal. Two women from HIV positive group identified themselves as “no risk” and another one as moderate risk. There was one mother from HIV negative group who identified herself as high risk. Based on data from open ended questionnaires, women judged the degree of risk to HIV/AIDS among married women from their husband’s sexual behaviours.

All of women perceived the result of their HIV testing correctly. This was confirmed by laboratory reports in their health records. The number of women who received counselling before and after having blood testing was equal. A large number of women reported that they did not received counselling (47.62 %) of these women from hospital III had highest proportion number (6 : 8), followed by women from hospital II (2 : 6) and those from hospital I (2 : 7). However, all HIV positive women did. These might be because how women defined the meaning of counselling influenced their answers in these categories. However, this evidence reflects that more effort needs to be put forward in this area.

Comparing the HIV/AIDS knowledge mean score among three hospitals were found that with the maximum score of 4, married women from hospital II obtained the highest mean score (4.00), followed by those from hospital III (3.75), and hospital I (3.71). In the part 2 of this the maximum score was 18, married women from hospital III obtained the highest mean score (0.25), followed by those from hospital I (9.86), and those from hospital II (8.67). One way analysis of variance was used to test the different, and it found that there was no significant different of mean score of HIV / AIDS knowledge in both parts among three hospitals.

Women’s self-care and social support

Self-care among HIV negative and HIV positive were not difference. There were very important self care activity which all respondents never done at all this was asking fiancé to get test before marrying him. Almost all of women also did not get test before deciding to have child. Only one woman did because she use coil device as a birth control. This woman was advised by health professional to get test before having child when she went to hospital for removing her coital device. This is a very good example of health professional role to promote women self-care to prevent vertical transmission of HIV. It also found that several specific self-cares were not performed by many women. Female condom and germicide which are female methods were not applied into self-care of women. This evidence suggests in adequate self-care among women in the first stage of the exploratory phase. The findings from open ended also revealed that women did not undertaken two important self-cares. These are: asking their fiancés to get test before marrying him and getting test for HIV before deciding to have child. In addition women placed being faithful to their husbands and were not being promiscuous person as priority. This believed and practice is one important specific self-care to prevent HIV/AIDS. However, women’s vulnerability to HIV/AIDS relies very much on their husbands’ sexual behaviours. This practice may not adequate to prevent women from getting HIV/AIDS.

It was found some differences of social support required by two groups of women. Meanwhile women in HIV positive group placed significant to counselling and testing for HIV before marriage as first priority women in HIV negative group placed in the third priority. In addition, HIV negative women required social supports, which more focus on activities performing by others rather than social supports, which would be enhance their self-care. This finding was confirmed by data from open ended questions. This may influences by their beliefs that they could not do anything for prevent HIV/AIDS particularly if it transmitted by their husbands.

The comparisons of mean score of self-care and social support needed among married women were carried out. The mean score of women's self-care from hospital II were highest (82.50), followed by those from hospital III (71.13) and those from hospital I (70.42) in ascending order. The mean score of social supportive needed by women among three hospitals were not much different and one way analysis of variance confirmed that there was no significant different of these.

In conclusion, findings from the first stage of exploratory phase show that women had some misunderstanding about HIV/AIDS. Most of women identified themselves as no risk. This may influenced their self-care since it was found that most of women had inadequate self-care. Their requirements of social support indicate their beliefs that they can not do any things for protecting themselves from getting HIV/AIDS. These may lead many women to be at risk to be infected with HIV/AIDS. These findings suggest the need for the development of the appropriate methods to raise women awareness of HIV/AIDS risk and to promote their self-care to prevent HIV/AIDS for themselves and their next child.

The instrument which was used in the present study was interview questionnaire and will be discussed in terms of format, validity and reliability. The format of interview questionnaire allowed respondents the opportunity to answer both open ended questions and close ended questions. The open ended question was followed by the close ended questions of each section: therefore, the data were obtained from open ended questions were not influenced by the close ended questions.

Limitations of study in the first exploratory phase

It is feasible to collect the data from this target population and location. The constructed validity of instrument, which was utilized, was obtained from the panel of four experts. However, the development of instrument was guided mostly by concepts from literature and experts. Although there were some open ended questions but they were a small proportion when compared to close ended questions. In addition, as in a short time frame only a few women completed the answer of each open ended sections. As a result the data collected by the interview questionnaire in the pilot study were from professional perspective rather than women perspective. This may make the findings have some limitation to disclose women's self-care to prevent HIV/AIDS for themselves and their next child. Another pilot study is needed and qualitative research is suggested as methodology for study. This is to ensure that the live experiences of women pertaining to self-care to prevent HIV/AIDS are explored thoroughly.