ORIGINAL ARTICLE

The Meaning of Motherhood: Perception of Mothers Living with HIV in Southern Thailand

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ABSTRACT

Introduction: Women should have their rights to become mothers regardless of their health conditions. The literature suggests that HIV-positive mothers want to become a mother but encounter many difficulties. However, little is known about the meaning of motherhood among southern Thai women living with HIV. This paper explores the perception of motherhood among these mothers. **Methods:** Semi-structured in-depth interviewing and drawing methods were combined to collect data from 30 HIV-positive mothers. Thematic method was employed to analyse the data. **Results:** Three themes were constructed from data analysis: 1) meaning of motherhood and desire to have children, 2) what makes women to be more confidence to have more children, and 3) the importance of children: A social capital value. Motherhood was perceived as an important role in producing children for the future of society and they desired to have children because becoming a mother signified their womanhood. Having a child could fulfill their married life as the child would nourish their relationship as a couple and provide social support for them. They were confident that their children would have high chance of survival rate because of the advanced modern medical care they had access to. Mothers strictly followed the advice and kept appointments to help reduce the chance of HIV transmission to babies. **Conclusion:** Children were seen as social capital to HIV-positive mothers and thus had a special meaning to them. However, the desire and the rights to become a mother among Thai HIV-positive mothers were common and deserved greater attention.
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INTRODUCTION

Thailand has one of the highest HIV adult numbers in Asia and the Pacific region. It accounts for approximately 10 percent of the region's total population of people living with HIV (1, 2). In 2022, 560,000 people are living with HIV and 457,133 are undergoing Antiretroviral (ARV) treatment. HIV caused 11,000 death cases and 9,200 were new diagnosed HIV (2). The prevalence of HIV-positive rates is high among women of the childbearing age group. About 230,000 women of reproductive age (15 and over) are living with HIV (1). Because of their fertility, the number of women who became pregnant and give birth is still high (1, 3). The prevention of mother to child transmission from 2014 to 2022 remains lower than the country expected indicator; 2 per cent (2). Although 98 per cent of pregnant women with infected HIV received antiretroviral treatments to prevent mother-to-child transmission, the prevalence of HIV among pregnant women who attended ANC is relatively high (4).

However, with the successful scaling up of access to antiretroviral therapy (ART) and essential health care programs in recent decades, many persons with HIV can live longer and have a better health status (2). There is evidence that a substantial proportion of women living with HIV continue to have children after being diagnosed with HIV (5, 6). Many mothers desire to have children (6) and antiretroviral treatments can minimise the chance of vertically transmitted infections occurring during pregnancy (5-8). Pregnancy has no sustained effect on the progression of the HIV disease (5-7).

In many societies, women living with HIV want to have children because having children is valued as a source of unconditional love and joy. It also can increase self-worth and a sense of motherhood among these women. This is because this signifies women's sexual and reproductive ability as well as being a source of achievement. Having a child then becomes a woman's desire, although they discover they are HIV-positive (5, 9).

There has been some research exploring the desire for having children in other settings (6, 8, 10) and the dilemma they may face if failing to have children (5, 10). Women, regardless of their health status, have their basic rights to become a mother. However, little is known about these issues among women living with HIV in Thailand especially in southern region, weather they wish to become a mother and what makes them desire to do so. Thus, this paper explores the desire for motherhood among HIV-positive mothers in the rural communities of southern Thailand.

The desire of couples to have children following HIV infection is common in most societies. It is believed that having a child can promote higher social status for such women and men through the admiration and respect of society. This desire is considered a mutual way of strengthening the bonds between parent and child (6). Fortes (11) (p. 125) argues that parenthood ensured "attainment of the full development of the complete person to which all aspire". Thus, having children is a fundamental feature of parenthood and enhances social status (6). Saleem et al. (6) point out that having children is a common means to fulfill the individual's destiny by providing children for a community. The study conducted by Beyeza-Kashesya et al. in Uganda (12), revealed that there are many reasons for HIV-positive mothers why they want to have children: making sure family future generations, supportive relationships of childbearing, pressure from family members and relatives to produce offspring, tightening couple relationship and accessibility for antiretroviral treatment. The consequence of HIV positive creates conflict and separation among couples. They seek new relationship expecting to have children because children are recognised as a bond of a couple.

Marriage and fertility are usually assessed by outcomes. Fertility is recognised as the capacity of individuals to produce children. It is a highly valued aspect compared with other human endowments. Children are expected by parents to pass on crucial factors such as cultural heritage and knowledge of ancestry (11). Children are seen as future builders of the nation who can pass down relevant knowledge, values and skills to the next generations. In some ethnic groups, if women cannot become pregnant soon after getting married, they may be considered unstable and blamed for being unable to produce children for the family and community (13). Children are valued in societies because they play an important role in the lives of women and families. The reasons for choosing to have a child might differ in different societies. In Western societies, motherhood brings personal happiness and maintains marital relationships. But women in most non-Western societies desire to become mothers because it fulfills the hope and happiness of parents and relatives, empowers society development, improves women's status in society and it brings respect (14, 15). In many societies, it can fulfill emotional drives and gives socioeconomic strength (10).

A review of existing literature pointed to scant research on motherhood among Thai women, with the exception of one study that examined similar issues (16). But this study focused on Thai women in central Thailand. The study in central Thailand by Liamputtong and Haritavorn (16) suggested that women living with HIV/AIDS desired to be a mother although they faced many problems relating to their HIV status. The burdens they carried include the lack of confidence in becoming a mother, the need to be a caregiver for their children, partners and even family members, as well as negative attitudes from the community and healthcare workers (16). The authors found that many women learned about the pregnancy and HIV/AID status through antenatal care. The women wanted to continue their pregnancies and seek proper treatments during their pregnancy to protect their baby from HIV/AID transmission. Most women valued having a child as their social capital and this offered them strength. Motherhood was seen as a part of women lives as along with reflected the attribution of motherhood.

MATERIALS AND METHODS

Study design

A descriptive qualitative approach was adopted in this study to gain a better understanding of the reproductive decisions made by 30 HIV-positive mothers in a rural community in southern Thailand. Descriptive qualitative approach is crucial when we know little about the issues we wish to examine. This approach allowed us to better understand the perception of mothers living with HIV in southern Thailand. This required the use of an in-depth interviewing method for data collection. We also adopted the feminist framework as a study methodological framework as the framework allows the participants to be able to voice their concerns through an alternative means that help them to express their perceptions and needs with ease (17, 18). Feminist methodology offers a more caring research process than other methodologies. The methodology posits that research needs to be carried out in the way that the participants can express their voices with ease if they find it difficult to express verbally. Situated within this framework, the drawing method was adopted in this study.

Data collection

We combined two qualitative methods including in-depth interviews and drawing techniques for the data collection in order to gain better insight into the participants' worlds. The in-depth interviewing method was used with HIV-positive mothers because it provided them an opportunity to tell their perceptions in great detail. The method offers natural discussion and makes participants feel more relaxed during the conversation and allows researchers to hear about their own realities from their own perspectives.

After obtaining permission from the HIV service directors at three health care centers, we made appointments with HIV-positive mothers for in-depth semi-structured interviews. We visited each woman at her home or at a place where she felt comfortable. The most common place they preferred to meet and talk with us about their stories was a local Buddhist temple. The interviews were conducted in the local dialect since these encouraged participants to express their thoughts and perceptions with ease (19). The length of each interview was carried on between one and two hours. The set of open-ended questions we used included:
1) What does motherhood mean to you?
2) In your view, can HIV-positive mothers get pregnant or have a baby?
3) Why is having a child important for your life?
4) Who influenced you about reproductive decision-making?

After the initial interview, we invited each participant to the drawing session. The drawing method was adopted in this study to allow the participants to visually express their experiences and concerns. Situated within the feminist framework, the method has been adopted widely in sensitive research and with vulnerable individuals (17). The drawing session was introduced soon after we finished the interview. The drawing method added strength to study findings as it allowed participants to express issues they might not be able to discuss verbally. Each woman was invited to draw three pictures that cover their understanding of motherhood and living with HIV freely. We provided coloured pens and drawing materials for the activity. After the drawings were done, we asked the participant to describe each of their drawings which took from 20 to 40 minutes. A digital recorder was used to record data for data analysis.

Participants and recruitment

We adopted a purposive sampling method in this study (17). The eligible participants included: 1) mothers diagnosed as HIV-positive; 2) had children aged five years old and under; and 3) resided in southern Thailand and were willing to share their stories. We initially contacted health care providers who were working at three health centers in a locality that provided care for HIV mothers. We provided them with the study's background and objectives. They then introduced us to potential participants. The snowball sampling method was also used to expand the study to three health care centers which increased the available number of HIV-positive mothers (17).

The number of participants was determined by saturation theory; we continued to interview until little new data can be constructed, and this indicated saturation of the data (17, 20). We stopped interviewed when we reached saturation at number 30. Their socio-demographic characteristics are presented in Table I (21) (p. 71).

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

Socio-demographic characteristics	N	(%)
Age group (years)		
≤25	5	(16.7)
26–30	4	(13.3)
31–35	8	(26.7)
35–39	8	(26.7)
40–44	4	(13.3)
≥ 45	1	(3.3)
Education level		
Primary school	15	(50.0)
Secondary school	15	(50.0)
Marital status		
Married	26	(86.7)
Divorced	1	(3.3)
Widowed	3	(10.0)
Occupation		
Housewife	16	(53.3)
Farmer	4	(13.3)
Employee	8	(26.7)
Vendor	2	(6.7)
Monthly income (baht)		
< 1000	2	(6.7)
1000–5000	7	(23.3)
5001–10,000	15	(50.0)
10,001–15,000	6	(20.0)
Number of children		
1–3	26	(86.6)
4–6	4	(13.4)
Years living with HIV		
< 1	3	(10.0)
1–5	10	(33.3)
6–10	14	(46.7)
> 10	3	(10.0)

Data analysis

A thematic analysis approach was used to analyse the data from in-depth interviews and drawings (17, 21). The analysis process started with inductive coding. This step involved reading the transcripts of individual participants line by line a few times to identify and become familiar with the data. We used coloured pens to emphasise keywords and group them into categories and sub-categories. Axial coding then was continued to seek links between sub-categories and categories to identify better meaningful categories. These categories were then used to identify final themes and establish core stories about the phenomena being investigated. The process of analysis stopped when no new themes could be constructed.

Trustworthiness

The rigor of this study is demonstrated by having a triangulation of qualitative research methods; we

combined two methods for data collection: interviewing and drawing techniques. Member checking strategy was used for the accuracy of the interviews: the interview transcripts were checked with the participants for accuracy before the data was analysed. Peer review was also used to ensure rigor: the data were first analysed by the first author and closely examined by the second author. These three strategies helped to increase the trustworthiness of our data (17).

In terms of positionality, both authors have extensive experience in using qualitative methodology in health research. The first author was trained by the second author (as a PhD student) and has since then conducted much qualitative research in collaboration with the second author. The second author has been teaching qualitative research in universities, has written several texts on the approach, and trained many researchers on the approach. Both have the credibility to conduct the qualitative research on which this paper is based.

Ethical considerations

This study was approved by University's Ethics Committees, Thaksin University, Thailand (No. E006/2558). Before we started the interview session, they were fully informed about the study background and objectives and the length of the interviews, how they can participate in the study, risks and benefits of their participation. A consent form then was given to them to sign. They were allowed to withdraw anytime as they wished. We used a pseudonym when referring to an individual participant in presenting the findings to endure the anonymity of participants.

RESULTS

There are three themes that were constructed from the data: 1) meaning of motherhood and desire to have children, 2) what makes women to be more confidence to have more children, and 3) the importance of children: A social capital value. It must be noted that we used a fictitious name when presenting the results (below) to ensure confidentiality with respect to our participants.

Themes 1: Meaning of motherhood and desire to have children

Most participants described the meaning of motherhood similarly. Many women perceived womanhood as the most powerful word, and it could make their lives more meaningful and valuable. All the women pointed out that motherhood was about nurturing, caring and loving regarding the life growing in their womb. After giving birth, they could play the role of mother. Suree, a 34 years old mother, said: "*As a woman, we should become a mother because the mother can give lives to the world. I am proud of being a mother…*". The women desired to have children, although having an HIV-positive status. They embedded in their thoughts and culture that having children was a role attributed to being women.

The women reported they had self-valued if they could have children. This typical feeling was not only important to them, it also made family and relatives proud. One mother stated that a woman should be able to be a mother and bear a child as it is the nature of womanhood. Their children could continue the family line. In addition, they could bring up children and nurture them to be good citizens. They would gain more recognition from society as they could contribute by producing citizens for national development in the future. Waranya, a 40 years old woman, supported this: "*Being a woman should mean having a child. It is a bit ironic if one does not have one as we are women. People would question it if you do not have a child*". Whan, a 32 years old woman, stated: "*Mother plays a key role in society, raise a child to be a good person for the nation. Today we can do our best through motherhood*".

Many mothers claimed that having children made their life secure. They could fulfill family life and form a pleasant family. The couple that had did not argue made a happy family. They further pointed out that Thai society also expected that women should have a child soon after getting married. If they could not have one, it stigmatised them and brought on worry and stress. Tiya, a 32 years old mother of two, described her feeling about motherhood: "*I do not regret it. I can have children. They are my world. I can protect them and see them growing well and staying healthy. I can do everything for them*".

Having children can increase hopes for living a long life. All women agreed that children increased their sense of encouragement and hope. Tong, a 37 years old mother, said: "*They are everything in my life. Although I am an HIV woman, I would love to live longer as I can spend time with her. She always stays close to me. I never feel tired*".

The women also expressed their commitment to having a child because motherhood gave them an identity. They felt that if they could have a child, they at least had something that could make their life more valuable and lead a normal life as other women. This also did not make them different from other mothers of reproductive age. Becoming pregnant could reduce the stigma of HIV infection. Having children was a key factor in encouraging these mothers to want to live longer. Kittiya, a 38 years old mother, told us: "*We have kids. We have family life like other families*". Suree, a 34years old mother, stated: "*We want to be with them longer, want to see their future, complete their study, get married, have a wife and kid. We can then die peacefully.*"

Karan, a 36 years old woman, shared her thoughts through drawing as is shown in figure 1.

Figure 1: Unfortunate and fortunate: wishing to have a child like others

Themes 2: What makes women to be more confidence to have more children

There are several issues that made the women in this study to have more confidence to have more children as discussed below.

Advance medical treatments and adherence

The advances of modern medical care and its service systems fulfilled the feeling of fulfillment that motherhood brought to these women. They had confidence in continuing a pregnancy as the baby would have a high chance of survival and be less vulnerable to HIV infection. From their experiences during attendance at ANC services, health care providers provided good care and essential information, particularly for mothers who are HIV-positive.Furthermore, mothers received supervision concerning appropriate practices throughout the period of pregnancy. This was aimed at reducing HIV transmission from mother to child. This kind of service could reassure them that they could continue a pregnancy safely with no HIV transmission to their babies:

"The doctor said that you don't need to abort the baby but it is up to you. You will have to attend ANC clinic. There is a high chance that the baby will have no infection. The doctors provide information emphasising on how to take care of myself and baby and what I have to do." (Suree, a 34 years old mother)

Most mothers living with HIV in this study had remarried because their former partners had died because of HIV infection. Their current husbands who were HIV-negative wanted their wives to be mothers and to have their own children. In so doing, the couples were not using any forms of contraception available from health care services. Although these man knew that their wives were HIV-positive, they encouraged the women to continue their pregnancy because of the desire for children. They were confident that HIV would not infect the children because they had trust in the health service. They were happy when their wives became pregnant as the pregnancy increased the bonding of the couple.

"*When I knew I got pregnant, I told my husband. He was smiling and said to me not to abort, but let the baby be born and grow. I have not had a baby and I really want a baby. You can be a good mother.*" (Saimai, a 36 years old mother)

Junpen, a 34 years old mother, encountered the same situation:

"*I went to the hospital for a pregnancy test which was positive. When I came back home, I told my husband that I was pregnant. He did not allow me to abort it and begged me to live for the child.*"

Bun (merit) that they had cultivated

Some women pointed out that pregnancy was related to the bun [merit] of mothers. If a mother made good merit, the pregnancy and its progression would have no problems and would not be affected by any diseases. The women believed that if the baby wanted to come to the mother's womb, it would do so. This depended on the merit and sin as performed by the individual's mother. Mothers should thus allow them to be born. If there was any problem in the future, they would have to deal with it and solve it. Nearly all the mothers strongly believed that they performed good merit throughout their lives so that their babies would not be infected by the disease.

"*It is up to wane and kam [consequences of bad deeds] ... The child has come, so let him come. Any problem in future, we have to accept and solve it, otherwise, it will increase bap [bad deed] for us. But we just hope that we are not that too unlucky a person. I always make good merit.*" (Nupe, a 40 years old mother)

Cultural norms

People in the community had much influence on the women's reproductive decision-making. Couples were expected to have children soon after getting married. Communities would show suspicion if a couple did not have a child as usual. If a couple was married for some time and still had no child, people in the local community tended to conclude that a couple might be HIV-infected or suffered from a bad disease. Sunee, a 36 years old mother, faced this experience after being married for two years. She said: "*People seem to doubt us as to why we still did not have a baby. Other couples got married at the same time but they already had one.*" Figure 2 shows a HIV-positive mother and baby.

Themes 3: The importance of children: A social capital value

Although mothers in this study received varied forms of support from significant others, children were seen

Figure 2: HIV-positive mother and baby

as the most important source. What encouraged these women to stay strong was their bonding with children. Their children shared all responsibilities and provided special care to them. This offered them the best support which could increase their hopes for a better life with their health issues.

"*Very pleased … my kids are concerned about my illness. The older one always takes medicine for me. He knows how many tabs I have to take. The younger one is just kindergarten age. He saw me taking a tablet and also remembers how many tablets I have to take. He then prepared them for me.*" (Songkean, a 42 years old mother)

She illustrated the feeling of support she received from her children through drawing as shown in figure 3.

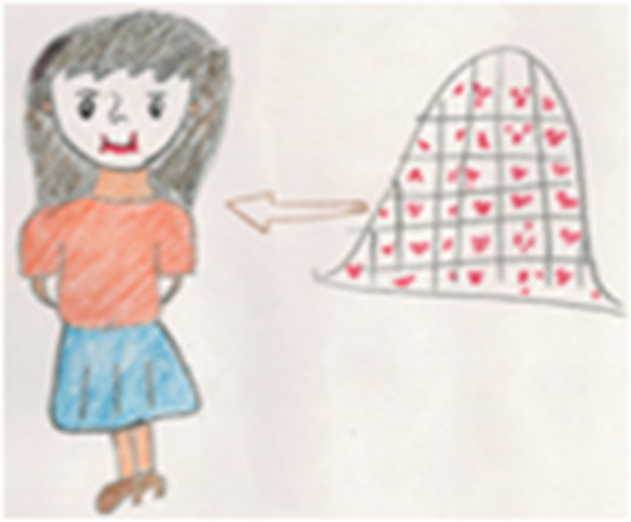

Figure 3: Support from child increase their hope

A child was recognised as the key source of stress management among mothers in this study. Several mentioned that their children took over their household tasks to release them from being tired and worrying. Mothers could then take more rest which reduced the chance of being more susceptible to poor health. Some told us that their children were very eager to search for and read health care information and thus inform them how to improve their health. Moreover, they showed their worries by staying home most of the time. If they had to go out, they came home soon: "*Since I became HIV-positive, he would always be with me. He did not go out to play with friends. He always asked if I needed any things to just let him know. I feel relieved and safe*" (Manee, a 35 years old mother)

Manee, a 35 years old mother, pointed out the positive support she received from her child after she had to stay home with HIV infection. Her child showed a high level of maturity compared to children with the same age. He could look after himself regarding daily activities.

"*After he reached home, he focused on his homework. After he finished homework, he went to the kitchen to cook rice for dinner…washed dishes. I am so happy for him…very glad…*".

Children provided most mothers with support to follow doctors' prescriptions. We found that all mothers adhered to appointments with doctors and practised positive health behaviors. The reason for this attempt was reflected in what Kanya said: "*I sometimes do not want to take medicine as they are very big tablets, or to go to see the doctor, but my child encouraged me to do so. I then agreed because I don't want to disappoint my children*".

DISCUSSION

The participants participated in this study were in their mid-thirty, obtained primary and secondary school levels. Most were married and housewives. The family income ranged from 900-12000 baht. They have children aged between one and eighteen years old. These characters were related to study objectives of this study focusing on mothers in reproductive age. The study conducted among HIV-positive mother in central Thailand conducted by Liamputtong and Haritavorn (16) showed that most mothers living with HIV were between 31-40 years old, living with husband, completed primary and secondary school education. They have 2-3 children and the family income showed between 5000-1000 baht. Less than one-third respond for home duties. The socio-demography of our study was in similar to the limited study in Thailand.

Most mothers living with HIV in this study continued their pregnancies in order to fulfill their family life and retain their sense of womanhood. Being diagnosed as HIV-positive does not eliminate the desire of women to have children because it is part of being a woman. According to a study in Thailand by Liamputtong and Haritavorn (16), motherhood is recognised as a crucial part of life and is given as a reason to live. With the status of motherhood, she can do everything for the health

and well-being of her child. Pregnant mothers wish to continue their pregnancy if they are convinced that the baby will have no or little chance of HIV transmission. This not only fulfills the happiness of an individual and family but also promotes parenthood. Hersey et al. (10) mention that although women are living with the condition of being HIV positive, they still desire to bear a child if they are of childbearing age. They also point out that although there are many factors influencing decisions regarding pregnancy, there are no differences between HIV-positive pregnant mothers and those who are HIV-negative. All need to satisfy their partners and fulfill their experience of maternity. Thus, they tend not to practise contraception.

The progress through medical treatment, such as antiretroviral drugs, in particular, has improved the lives of women living with HIV. This has allowed them the opportunity to enjoy reproductive health like other women in their society (16). Mothers with HIV in this study received close care and advice from health care providers at the early stages of their pregnancy. This has influenced mothers' decision-making with regard to pregnancy because they received the necessary information and care package for their HIV-positive pregnancy. Jones et al. (22) show that decisions regarding determining a pregnancy depend on whether they received sufficient medical information. They also suggest that providers be aware of HIV-positive mothers who desire to have a child. These women received service packages for healthy pregnancies that reduced the transmission of HIV to infants and even partners.

The advance in modern medicine could enable an HIV-positive mother to lead a normal life; one similar to uninfected persons (9). Liamputtong and Haritavorn (16), suggest that ART and HAART can prevent transmission from mother to child. The availability of such medical products in a government health system increases the number of HIV-infected mothers who can carry on pregnancies to their full term. According to Gutin et al. (23), HIV infection has less effect on the decisions about childbearing in Uganda because of the introduction of ART. ART increases their hopes of a better quality of life.

Many of the women in our study still wished to have children. This desire is seen as attributing to the role of motherhood and femininity (24) (p. 5). For most women living with HIV, despite living with a serious illness and its conditions, motherhood allows them to "come back to life". Motherhood enables them to "reclaim their social identity". Having a child is significant for many women as it allows them to manage the hostile social impacts experienced by being HIV-positive. Liamputtong (24) contends that many women living with HIV tend to use the discourse associated with motherhood to negotiate their individual identity and retain their status in society. It can reduce the impact of deviant conditions and enhance their role as mothers.

We found in this study that social support can be a source of buffering for all mothers living with HIV and it is a crucial factor to promote their well-being. They received support from varied sources to deal with different needs while living with a negative health condition, but support from children is the most crucial supplier. Children functioned as social capital for these women as children provided support to them, both now and in the future. Saleem et al. (6) remarked that children are perceived as countless gifts in a mother's world. Children can help to fulfill the role of motherhood and give value to women's lives, which provides emotional support to mothers. Schrag and Schmidt-Tieszen (25) also suggest that mothers accepted that children are a significant source of social support and the origin of their happiness. They feel good and are not alone as children are there for them. Children not only encourage them to keep doing good things in life but also perform positive behaviors. When they experience difficult situations, children can be a buffering factor to reduce the negative impact on their lives.

Paonil and Sringernyuang (26) (p. 98) suggest that good health based on Buddhist principles indicates "a result of previous good actions starting from last second, last year, or from the last life". According to Forman (27) and Kalra et al. (28), the key principle of Buddhism is to alleviate and prevent individuals' suffering. It can help the individual to deal with and overcome difficulties through empathy and peace of mind. Buddhist philosophy promotes certain basic teachings that encourage people to live a fulfilled life and achieve enlightenment. Its principal belief is that people's lives are heavily influenced by merit and sin. Whether one obtains happiness or suffering in the current life is directly related to individually created causes or sins. Sins that one generates in the current life can affect the present and future lives (26). What Buddhists seek to do is minimise suffering by doing good deeds and abstaining from bad practices. People also believe that participation in religious rituals can earn them merit and protection from bad outcomes. The need to accumulate merit, therefore, encourages Thai Buddhists to lead moral lives, with the hope of a better existence in their next life (27, 28).

Buddhist beliefs and practices could ensure peace of mind for mothers who have a baby although they are living with HIV. We found that the mothers in our study had no intention to abort. Rather, they believed in doing good deeds that would bring them a good life with less suffering. Thus, if one does perform merit regularly, a mother's baby will enjoy good consequences and good health.

We contend that having a child is a significant way for many women as it helps them to manage the hostile social impacts that life brings for a mother living with HIV. According to Liamputtong (24), many women living

with HIV used discourse associated with motherhood to negotiate their individual identities. Apart from this, it can also reduce deviant conditions and enhance the role of motherhood. However, women have to work very hard to achieve fulfilling motherhood. Social support from their children can be a key source of buffering for all HIV-positive mothers. An appropriate social support foundation is a crucial factor in promoting the health of mothers living with HIV and assists them to live better lives in the community.

CONCLUSION

Little is known about the meaning of motherhood among mothers living with HIV in southern Thailand. The findings of this study contribute to conceptual understanding about the meaning and desire of motherhood among women living with HIV in the southern region of Thailand. Motherhood is recognised as an important part of a woman's life. But because of their HIV status and the social and cultural contexts, continuing a pregnancy can cause stress and affect the lives of mothers of reproductive age. The advances available from modern medical care facilities can ensure that these mothers have a safe pregnancy.

Children were seen as social capital to mothers living with HIV and thus had a special meaning to them. The desire and the rights to become a mother among mothers who live with HIV deserve greater attention. All women, regardless of their health condition, should have their reproductive rights and health care providers need to make sure that this will occur. This will ultimately lead to equity in reproductive health care for all women in Thailand.

Basing on the qualitative approach, this paper provides insights and understanding about the desire for childbearing and the associated difficulties women possibly encounter. The findings offer health workers and allied health professions an in-depth understanding of mothers living with HIV and how much they cherish their reproductive abilities. A deeper understanding could support health care workers and allied health professions to develop appropriate health services and guidance in order to meet individual health needs. This could reduce the suffering and difficulties faced by mothers living with HIV during their childbearing years. Thus, future research should explore the role of men in HIV transmission, how are reproductive decisions made in couples living with HIV partners in Thailand, and the role of men and other family members in rearing children in their family.

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REFERENCES

1. UNAIDS. HIV and AIDS estimates. [Internet]. [Place unknown] UNAIDS; 2023 [Update 2023 October 20; cited 2023 October 19]. Available from: https://www.unaids.org/en/regionscountries/countries/thailand
2. HIV info HUB. Estimation of infected HIV. [Internet]. 2023 Mar [cited 2023 Oct 19]. Available from: https://hivhub.ddc.moph.go.th/epidemic.php
3. Department of Disease Control, Ministry of Public Health. State of HIV epidemic in Thailand in 2020. [Internet]. 2021 Oct [cited 2023 Oct 19]. Available from: https://hivhub.ddc.moph.go.th/Download/RRTTR/Factsheet2020_ENG_Final.pdf
4. Department of Disease Control, Ministry of Public Health. State of HIV epidemic in Thailand in 2021. [Internet]. 2021Jun [cited 2023 Oct 20]. Available from: https://hivhub.ddc.moph.go.th/Download/RRTTR/Factsheet_HIV_2564_TH_V2.pdf
5. Ddumba-Nyanzi I, Kaawa-Mafigiri D, Johannessen H. Barriers to communication between HIV care providers (HCPs) and women living with HIV about child bearing: a qualitative study. Patient Educ. Couns. 2016;99(5):754-59. doi:10.1016/j.pec.2015.11.023
6. Saleem HT, Surkan PJ, Kerrigan D, Kennedy CE. Childbearing experiences following an HIV diagnosis in Iringa, Tanzania. Qual. Health Res. 2016;26(11):1473-82. doi: 10.1177/1049732315605273
7. Bailey H, Zash R, Thorne C. HIV treatment in pregnancy. Lancet HIV. 2018;5(8):e457-67. doi: 10.1016/S2352-3018(18)30059-6
8. Proudfoot, D. Frozen in a moment in time: the experiences of mothers being diagnosed with HIV infection. JANAC. 2017;29(2):323-29. doi:10.1016/j.jana.2017.10.003
9. Huertas-Zurriaga A, Palmieri PA, Edwards, JE, Cesario SK, Alonso-Fernandez S, Pardell-Dominguez L, et al. Motherhood and decision making among women living with HIV in developed countries: a systematic review with qualitative research synthesis. Reprod Health. 2021;18(1):148. doi:10.1186/s12978-021-01197-6
10. Hersey AE, Norman B, and Reece R. Assessing reproductive decision-making among HIV-positive women in Kumasi, Ghana. Int J MCH AIDS. 2019;8(1):54-62.
11. Fortes M. Parenthood, marriage and fertility in West Africa. J. Dev. Stud. 1978;14(4):121-48. doi:10.1080/00220387808421692
12. Beyeza-Kashesya J, Kaharuza F, Mirembe F, Neema S, Ekstrom AM, Kulane A. The dilemma of safe sex and having children: challenges facing HIV sero-discordant couples in Uganda. Afr. Health Sci. 2009;9(1):2-12.

13. Wesley, Y. Desire for children among black women with and without HIV infection. J. Nurs. Scholarsh. 2003;35(1):37-43. doi: 10.1111/j.1547-5069.2003.00037.x
14. Liamputtong P, Benza S. 'Being able to bear child': insights from Zimbabwean women in Melbourne. Women Birth. 2019;32(2):e216-22. doi:10.1016/j.wombi.2018.07.002
15. Inhorn M. Infertility and patriarchy: the cultural politics of ender and family life in Egypt. Philadelphia: University of Pennsylvania Press; 1996.
16. Liamputtong P, Haritavorn N. My life as Mae Tid Chua [Mothers who contracted HIV disease]: motherhood and women living with HIV/AIDS in central Thailand. Midwifery. 2014;30(12):1166-72. doi.org/10.1016/j.midw.2014.04.003
17. Liamputtong, P. Qualitative research methods. 5th ed. South Melbourne: Oxford University Press; 2020.
18. Ferguson KE. Feminist theory today. Annu. Rev. Polit. Sci. 2017;20:269-86. doi:10.1146/annurev-polisci-052715-111648
19. Liamputtong P, Haritavorn N. To tell or not to tell: Disclosure to children and family amongst Thai women living with HIV/AIDS. Health Promot Int. 2016;31(1):23-32. doi.org/10.1093/heapro/dau057
20. Suwankhong D, Liamputtong P. Experiences of living with HIV: social stigma and discrimination among HIV-positive mothers in southern Thailand. MJMHS. 2021;17(3):36-42.
21. Suwankhong D, Liamputtong P. 'I was told not to do it but…': infant feeding practices amongst HIV-positive women in southern Thailand. Midwifery. 2017;48:69-74. doi:10.1016/j.midw.2017.03.007
22. Jones DL, Cook R, Potter JE, Miron-Shatz T, Chakhtoura N, Spence A, et al. Fertility desires among women living with HIV. PLoS ONE. 2016;11(9): e0160190. doi:10.1371/journal.pone.0160190
23. Gutin SA, Namusoke F, Shade SB, Mirembe F. Fertility desires and intentions among HIV-positive women during the post-natal period in Uganda. Afr. J. Reprod Health. 2014;18(3):67-77.
24. Liamputtong P. Women, motherhood and living with HIV/AIDS: an introduction. In Liamputtong P, editor. Motherhood and HIV/AIDS: a cross-cultural perspective. Dordrecht, The Netherlands: Springer; 2013. pp.1-24.
25. Schrag A, Schmidt-Tieszen A. Social support networks of dingle young mothers. Child Adolesc. Soc Work J. 2014;31(4):315-27. doi 10.1007/s10560-013-0324-2
26. Paonil W, Sringernyuang L. Buddhist perspectives on health and healing. J Bud Stud Chula. 2002;1(2):59-79.
27. Forman J. Believing is seeing: a Buddhist theory of credition. Front. Psychol. 2022;13:938731. doi:10.3389/fpsyg.2022.938731
28. Kalra S, Priya G, Grewal E, Aye TT, Waraich BK, SweLatt T, et al. Lessons for the health-care practitioner from Buddhism. Indian J of Endocrinol Metab. 2018;22(6):812-17. doi: 10.4103/ijem.IJEM_286_17