HIV PREVENTIVE WORK FOR CHILDREN AND YOUTHS IN
THAILAND:
A qualitative study based on experiences among staff in an HIV
prevention-oriented organization and a research group in Thailand

HIV-PREVENTIONSARBETE FÖR BARN OCH UNGA I THAILAND:
En kvalitativ studie baserad på erfarenheter bland personal inom HIV
prevention-orienterad organisation och forskningslag i Thailand

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ABSTRACT

Background

The development of HIV preventive measures in Thailand has led to a decrease in prevalence in HIV-infected persons. During 2021 there was an estimated number of 520,000 people living with HIV in Thailand amongst adults over 15 years and an estimated number of 2,000 children between 0 to 14 years old. Studies have shown that the current obstacles with HIV prevention in Thailand is correlated with HIV-related stigma and therefore being at risk to retrieve the infection. Non-governmental organizations (NGOs) and research groups, are important actors in HIV prevention.

Aim

The aim of this study was to examine experiences of HIV preventive work in children, adolescents and young adults among staff in an HIV prevention-oriented organization and a research group in Thailand.

Method

A qualitative design was used, and seven semi-structured interviews were conducted with a convenient selected sample. Participants were conveniently recruited from two different population groups, two participants from an HIV prevention-oriented organization and five participants from a research group in a clinical HIV-unit. The interviews were transcribed and analyzed through a content analysis with an inductive approach.

Results

Three main categories were identified: Success factors in HIV prevention, Barriers to HIV prevention and Future directions. Eight subcategories were identified: Access to HIV testing, Access to information, Sharing experiences, Collaboration between agencies working with HIV prevention, Decrease in Stigma, Limitations in time and money, Difficulties in adherence to HIV prevention and Stigmatization in HIV.

Conclusions

HIV prevention needs to be more accessible. Today HIV testing is available for free, however, there are still obstacles to preventive work that ought to be considered, stigmatization and discrimination are such barriers. Future directions in preventive work are increased accessibility to HIV prevention.

Keywords: Children, HIV prevention, Human Immunodeficiency virus (HIV), Thailand, Youths
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INTRODUCTION

Human immunodeficiency virus (HIV) is a communicable disease that has had and still has a major impact on health all over the world and is still considered an epidemic in Thailand. In Thailand the development of HIV preventive measures has led to a decrease in prevalence which can be seen as a success of various implements. It is of relevance to study HIV prevention in Thailand as it gives insight into how prevention work can affect the spread of a communicable virus. Furthermore, it is relevant for nurses and other health care workers to have knowledge about HIV, its transmission ways and risk groups but also how HIV affects one person's entire health, psychological as physical.

There are still many children and youths living with HIV (CYHIV) in Thailand. It is of relevance to study children and youths living with HIV as they are a vulnerable group in society. Studies have shown that the current obstacles with HIV prevention in Thailand, such as diagnosing HIV, is correlated with HIV-related stigma and not being able to self-identify with HIV and therefore being at risk to retrieve the infection. It is relevant for health care workers to understand how HIV not only affects physical health, but also the psychological aspects of the disease, such as self-stigma and mental illness.

Non-profit organizations have an important role in public health related activities such as HIV prevention as they provide free and accessible health care to people with HIV. A research group in a clinical HIV-unit provides important information about health care and public health related to HIV. There is a knowledge gap when it comes to the experiences of HIV preventive work in children, adolescents and young adults, among staff in HIV prevention-oriented organizations and research groups in Thailand, as to how they work with current challenges. It is important for healthcare workers to acknowledge all professions working towards better health in society, not only hospital care. It is therefore relevant to study how an NGO and a research group work with HIV prevention, as they are important actors in improving health in society.
BACKGROUND

Human Immunodeficiency Virus (HIV)

Globally, HIV is a public health issue, contributing to 40.1 million deaths so far. In 2021 there were 38.4 million people around the world living with HIV, and 650 000 persons who had died from HIV-related causes. Since there is no vaccine or cure, HIV prevention is essential (World Health Organization [WHO], 2022).

HIV is a retrovirus that infects T-lymphocytes, which are cells that have the protein CD-4 on their surface. T-lymphocytes have central functions in the immune system and as these are broken down the immune system gets weakened (Naif, 2013). HIV transmits through blood and body fluids such as breast milk, semen and vaginal secretions from people with HIV. It can, for example, be transmitted through unprotected sex and from mother to child during delivery or when breastfeeding (WHO, 2022). HIV can not be transmitted through social physical contact such as shaking hands, hugs, or kisses, sharing food or water (WHO, 2022).

Types of HIV and AIDS
There are two different types of HIV, HIV-1 and HIV-2. Acute HIV, also called HIV-1 is characterized by the appearance of a high viral load and antibodies in the blood (Cohen et al., 2011). HIV-2 has slow progression of HIV infection compared to HIV-1 (Berzow et al, 2021). Both HIV-1 and HIV-2 will develop into Acquired Immunodeficiency Syndrome (AIDS) if not treated (Berzow et al, 2021). AIDS is defined as a CD4 cell count <200 cells/microL or the presence of conditions related to AIDS such as infections of recurrent bacterial infections and pneumonia. With a CD4 count of less than two hundred, a person is more susceptible to opportunistic diseases such as tuberculosis and types of cancers (Justiz Vaillant & Gulick, 2022).

Symptoms and diagnosis
When a person gets infected with HIV, the first couple of weeks up to 11 months are often asymptomatic. Symptoms that may appear either acutely or after weeks or months are fatigue, muscle pain, skin rash, sore throat, night sweats, swollen lymph nodes, diarrhea and joint pain. The symptoms are collectively known as Acute retroviral syndrome. An increase in severity and frequency of symptoms is an indication of a poor prognosis (Justiz Vaillant & Gulick, 2022).

The symptoms of HIV are often vague and nonspecific to the diagnosis and therefore lacks clinical suspicion (Cohen et al., 2011). However, HIV can be diagnosed with different tests that detect specific antibodies and HIV antigens via a bioanalytical method called ‘immunoassay’ or the level of virus via Polymerase-chain-reaction (PCR). Rapid tests can detect an HIV infection through oral fluids (saliva) and blood within hours. The virus load can’t be detected until ten to fifteen days after transmission and the test of antigens and antibodies can’t be detectable until another five days after that (Justiz Vaillant & Gulick, 2022).

Treatment
There is no cure for HIV but with proper treatment it could be a manageable chronic health condition (Deeks et al., 2013). Antiretroviral therapy (ART) is a treatment that reduces the
virus load to low or undetectable level which lowers the risk for transmission and reduces morbidity and mortality. Highly Active Antiretroviral Therapy (HAART) is a combination of different antiretroviral agents that prevents or delays drug resistance and viral replication (Simon et al., 2006). If a person with HIV is treated with HAART and achieves a CD4 cell count greater than five hundred, they will have a normal life expectancy (Justiz Vaillant & Gulick, 2022). If HIV is not treated, the immune system gets weaker, and one becomes more vulnerable to severe illnesses (Naif, 2013). Acute HIV can progress to chronic HIV infection and depending on if one receives treatment, can be characterized with or without AIDS. Advanced HIV infection is characterized by a CD4 cell count greater than two hundred but less than five hundred in which there is a higher risk for retrieving, for example, various cancers than healthy people (Justiz Vaillant & Gulick, 2022).

**Prevention**

Primordial prevention is a prevention strategy aimed to reduce risk factors of retrieving a disease with focus on social and environmental conditions. Primary prevention is defined as a measure to prevent the appearance of sickness and disease. This can be done by limiting the risk of exposure or increasing immunity in populations at risk of retrieving a disease. Vaccination is a type of primary prevention. Secondary prevention is a prevention strategy of early disease detection. A healthy population with subclinical forms of disease is the target population, meaning that a person does not have any symptoms, however the person is in a latent stage of the disease. An example of secondary prevention is screening. Tertiary prevention is to prevent a negative progression of a disease and is a strategy to prevent negative physical, psychological or social effects of a disease (Kisling & Das, 2022).

**HIV prevention**

There are several preventative measures that are highly effective in reducing the risk of HIV. Using condoms, the correct way is proven highly effective in preventing HIV (Stover, 2022). Pre-exposure prophylaxis (PrEP) is a safe treatment of an antiretroviral (ARV) agent, for high risk-individuals, that decreases the risk of HIV infection when having sexual intercourse, for instance. An individual can decide when to start and to stop using PrEP as needed (Celum, 2020). Post-exposure prophylaxis (PeP) is a treatment much like PrEP, with an ARV agent with purpose to prevent an HIV infection from occurring, after being exposed to HIV. The first dose of PeP should be given within 24 to 36 hours of exposure and no later than 72 hours post-exposure (Sultan et al., 2014).

For people with diagnosed HIV, ART can reduce the amount of viral load in the blood to the extent that is undetectable (WHO, 2022). Treatment as prevention (TasP) is a concept where ART can be seen as a preventative method. For people diagnosed with HIV, ART can reduce the amount of viral load in the blood and thereby prevent onward HIV transmission to the extent that it does not transmit at all (Brault et al., 2019).

Using condoms and preventing drug users from sharing injection equipment are ways of limiting exposure to risk factors and thereby important factors in HIV prevention work (WHO, 2022). A study from the United States of America shows that High-school students that had received education on HIV/AIDS in schools were less likely to inject drugs and less likely to drink alcohol or use drugs before having sexual intercourse. The study also showed that students were more likely to use condoms. The study identified a delay in age
at first sexual intercourse and a reduced number of sex partners associated with HIV education (Zhen-qiang et al., 2014).

The first antiretroviral therapy agent for reducing mother-to-child transmission (MTCT) was available in 1994 and was called Zidovudine. A study conducted in the United States and France studied the safety and efficacy of Zidovudine for the prevention of mother-to-child HIV transmission. The result of the study showed that the treatment reduced the risk of HIV transmission with approximately two thirds (Connor et al., 1994).

The role of nursing in HIV prevention

In a literature study about nursing competency, it was found that nursing competency can be divided into three major components and seven elements. Nurses should have the ability to understand people in which the nurse should apply knowledge and build interpersonal relationships with persons. Furthermore, the nurse should have the ability to provide people-centered care in which the nurse provides nursing care, practices ethically and collaborates with other professionals within health facilities. Lastly the nurse should have the ability to improve nursing quality by expanding their professional capacity and ensure delivery of high-quality nursing (Fukada, 2018). Nursing and health promotion is the nurse's area of expertise and includes helping the patient to improve, maintain or regain their health. Nurses should have a holistic approach in order to support patients and their families in their engagement in health promotion activities. Different patient groups have different needs and therefore the nurse should have a person-centered and holistic approach in their work of health promotion. Furthermore, the role of nursing includes providing information and health education but also supporting patients and their family in making informed decisions (Kemppainen et al, 2013).

Nurses work with HIV and AIDS prevention primarily by educating about HIV transmission, treatment and prevention (Vandali, 2020). A study from Uzbekistan described the importance of the role of nursing in HIV prevention regarding educational purposes in sharing knowledge about HIV. The study included participants that were pupils from ninth through eleventh grade in schools as well as teachers and parents. All the participants in the study received information on HIV and AIDS from a school nurse. The participant’s knowledge of the subject was measured before and after they received education. The results showed improvements in understanding HIV (Sevara et al, 2021). According to a qualitative study on HIV nursing care that included 16 nurses, it was found that support for adherence was important in their roles as nurses in HIV nursing care. Furthermore, it was found that building a therapeutic relationship with a person living with HIV was a foundation for providing nursing interventions. Promoting acceptance and trust in relationships were important as persons living with HIV often had experiences of stigma and discrimination. Furthermore, it was discovered that the nurses assessed the overall health of persons living with HIV, shared knowledge about HIV, coordinated care and connected persons living with HIV to social and health-related resources. These activities were made to support people living with HIV to adhere to ART (Rouleau et al, 2019).

HIV in Thailand
Thailand is a country located in Southeast Asia with a population of 69.7 million people. The capital is Bangkok which has the highest population density in the country with approximately 11 million people (Central Intelligence Agency, 2023).

The first reported case of HIV in Thailand was in 1984 from a hospital in Bangkok. HIV became classified as a reportable disease with an established reporting system. Thailand’s public health response to the epidemic of HIV depended on investments in HIV control as well as funded treatment and prevention work. By 1996, the government of Thailand had placed 81.96 million US dollars in HIV-control (Siraprapasiri et al., 2016).

During 2021 there was an estimated number of 520,000 people living with HIV in Thailand amongst adults over 15 years and an estimated number of 2000 children between 0 to 14 years old. In 2021 the prevalence rate for adults between the age 15 - 49 was one percent. Of the 520,000 people living with HIV in Thailand 450,000 are on ART treatment. During the year 2021 there were 9300 persons who died from AIDS related causes (UNAIDS, n.d.). Thailand has a national strategy to end the AIDS pandemic in the country by 2030 (van Griensven et al., 2022).

Currently the populations with highest risk of infection are men who have sex with men (MSM) and transgender women (TGW) (Van Griensven et al., 2022). In a study conducted in 2020 in four provinces in Thailand with 1880 MSM and transgender (TG), there were 303 HIV-positives diagnosed by enrolment. Of these, 49 percent identified as gay, 24 percent as TG, 21 percent as heterosexual and 5 percent as bisexual. Of the 303 HIV-positive participants 81 percent reported inconsistent condom use, 63 percent reported receptive anal sex and approximately 50 percent reported insertive anal sex in the recent six months in which 78 percent of these reported inconsistent condom use (Kritsanavarin et al., 2020).

In 2020 there were 30,760 children and youths living with HIV (CYHIV) in Thailand (Desmonde et al., 2022). A study conducted in Thailand about the adolescent HIV epidemic during the time-period of 2005-2025. This study showed that 66,940 CYHIV aged 0–25 years were living with HIV in 2005, of these 66,940 youths there were 19,080 who had received HIV perinatally (mother-to-child transmission). The total number of CYHIV decreased to 30,760 by 2020, a percentage-decrease of 54 percent, of these, 14,360 were young MSM living with HIV which represented 47 percent of CYHIV. Projecting forward in time to 2025, this study estimated a number of 3,180 new infections among 0-25-year-olds. In 2005, Youth aged 15–25 represented the largest proportion (71 percent) and in 2020 this proportion increased to 95 percent. In 2020, new infections of perinatal transmission had decreased from 410 to 70 a year, a decrease of 82 percent. Furthermore, this study projected that in 2025, the proportion of MSM among CYHIV were to increase to 59 percent and account for 83 percent of new infections (Desmonde et al., 2022).

**Actors in HIV prevention and treatment in Thailand**

**Healthcare and nursing in Thailand**
The district healthcare system in Thailand consists of healthcare centers and district hospitals. Primary health care is provided in the healthcare center which is the first point of contact for the population. Nurses and health care workers provide basic treatment, prevention and health promotion within primary health care. While in the district hospital,
more comprehensive secondary-level care is provided by healthcare staff that are specialized in certain types of care. The private sector is rapidly growing with private hospitals, however public hospitals remain the majority of all hospitals and thereby dominate the Thai health delivery system.

Nurses are essential to the Thai health system due to their wide-ranged qualifications, patient-focused care and their contribution to public health. In 2016 there were 180 000 nurses working in the Thai health system. Due to the large number of nurses, they are essential in Thai health care (Tangcharoensathien et al, 2018).

The work of NGOs
NGOs have an important role in the work of public health-related activities such as providing necessary health facilities, equipment and human resources. In low-income countries, NGOs can provide free and accessible health care, particularly for poor and vulnerable groups as well as people with certain diseases (Sanadgol, 2021). NGOs have a holistic approach in their work, which means that they do not exclusively help with basic needs in terms of health, they are also adaptable to the situation and a person’s specific need with regard to social terms. An important factor in NGOs work is that they have a cultural understanding and awareness combined with professional competence (Berenguera et al., 2011).

NGOs have been seen to have had major influences on government policy related to HIV/AIDS in Thailand. NGOs have demanded government action regarding inclusion of ART in the universal access to health care policy which was preceded in 2001. However, in efforts to lower the cost of HIV treatment and increase availability, the NGOs pushed further together with health care providers to increase accessibility to basic care and low-cost medicine for opportunistic diseases. Furthermore, NGOs have worked to raise awareness about children and youths living with HIV/AIDS in Thailand and have through media promoted policies in order to reduce discrimination (Ford et al, 2009). NGOs in Thailand also have a part in working with education about sexual behavior and promoting behavioral changes, such as using condoms during intercourse (Thisyakorn, 2017).

The work of research groups
Health research is important as it provides an increased knowledge about, for example, particular diseases, risk factors as well as treatment of diseases. Clinical trials can provide information about the effects of and the efficiency of certain medical interventions. Health research has led to significant discoveries such as therapies and improvements in health care and public health (Gostin et al, 2009).

In Thailand, Thai Red Cross AIDS Research Centre [TRC-ARC] are working with HIV-prevention by developing and promoting prevention and treatment (UNAIDS, 2019). In 1996 TRC-ARC led a donation program in which the ART drug zidovudine was offered for free to HIV-positive pregnant women (Thisyakorn et al, 2000). Today TRC-ARC are offering PrEP to people that have a higher risk of getting HIV and ART to HIV positive persons. Furthermore, they opened the first clinic in Thailand offering sexual and reproductive health-care services including HIV testing and treatment, especially for transgender people (UNAIDS, 2019).
HIV prevention and treatment in Thailand

PrEP
PrEP has been included in Thailand's national HIV guidelines since 2014 and is a prevention method for people with high risk of infection, which at first was provided with a fee of 30 THB a day. The Thai Ministry of Public Health then provided free PrEP for people at risk in eight provinces in 2016 by the launch of the program PrEP2START (Muccini et al., 2019).

Screening
Screening for HIV with regular testing is a prerequisite for diagnosing and treating people living unknowingly with HIV. Screening programs have been conducted in Thailand to motivate key populations such as MSM, sexworkers (SW) and clients of SW, TG populations and people that inject drugs, to get tested by providing free testing and rapid results. Peer-led HIV testing has also been seen to have a positive impact on youths living with HIV in which they access information regarding HIV and get tested (Muccini et al., 2019).

Shortening the time between HIV-screening and ART initiation amongst key populations with high risk of HIV infection, within weeks or months of infection during the acute HIV infection, could preserve the immune system and achieve life expectancy similar to HIV-uninfected-people (Muccini et al., 2019). People undergoing ART are virally suppressed and thereby it can also prevent onward HIV transmission (WHO, 2022).

100% Condom use programme
Included in the prevention work was the well documented 100 % Condom Use programme with the purpose to promote condom use in commercial sex. The prevalence of HIV transmission among brothel-based SW was high during the beginning of the 1990s and growing rapidly. With the 100 % Condom use programme SW became unwilling to have sex without a condom which eventuated a decline of STDs and HIV prevalence (UNAIDS, 2000). The condom use increased in sex work from 14 percent to 94 percent between 1989 and 1993 (Siraprapasiri et al., 2016).

Prevention of mother-to-child transmission
According to the Asian Epidemic Model (AEM) the major spread of HIV occurred through heterosexual transmission in Thailand during the 1990s. The primary transmission of HIV occurred between client and SW and the infected men passed over HIV to their female partners which led to an increase in husband-to-wife transmission (Family Health International et al., 2008). There was an epidemic wave of HIV-infected women and children from the early to mid-1990s which caused a chain of mother-to-child transmission (MTCT) of HIV, in 1988 the first HIV-exposed infant in Thailand was born (Thisyakorn, 2017).

A programme was initiated in 2000 called ‘Prevention of mother-to-child transmission’ (PMTCT). This programme provided free and voluntary testing and universal access to ART for pregnant women and infants as well as free formula feeding for infants for the first 12 months (Siraprapasiri et al., 2016).

ART-Treatment
The first antiretroviral treatment was available in 1992 in Thailand and by 1995, up to 4200 people had received treatment. In 2000, ART was provided for free according to the Access to Care-programme (ACT). As ACT was renamed to National Access to Antiretrovirals Programme for People living with HIV/AIDS (NAPHA) it simultaneously scaled up, treating 58,133 people living with HIV. By 2010, more than 150,000 patients were receiving ART (Siraprapasiri et al., 2016).

**Discrimination and stigmatization**

According to the Discrimination Act in Sweden (DL 2008:567), discrimination means that a person is disadvantaged by being treated worse than someone else would be in a comparable situation. There are seven grounds for discrimination: gender, transgender, identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age (DL 2008:567).

Stigma can be described as a social process. Briefly the social process includes that a person gets labeled and linked with undesirable characteristics and negative stereotypes. The labeled person can experience loss of status and the stigmatization process can lead to unequal outcomes, disapproval, rejection, exclusion and discrimination (Link & Phelan, 2001). HIV-stigma is a result of a social mechanism that affects individuals by attributing negative values to HIV infection. A study made in central and eastern Europe about NGOs HIV prevention work shows that one of the greatest barriers to an effective HIV prevention program is stigma (Amirkhanian et al., 2004). According to Muccini (2019) the obstacles with diagnosing HIV are the lack of getting tested due to the experience of HIV-related stigma and not being able to self-identify with HIV and therefore being at risk to retrieve the infection. Concerns regarding the side effects of treatment with ART is also an obstacle of diagnosing HIV (Muccini et al., 2019).

**Stigmatization of HIV in Thailand**

A study conducted in Thailand illustrated the stigmatizing attitudes toward people living with HIV among the Thai adult population. There were 10,522 adults between 20-59 years old who participated in the study. The results of the survey showed that 76.9 percent had anticipated stigma, referring to expected stigma happening in the future. Of these 10,522 participants 69.2 percent had perceived stigma that can be regarded as the concern of expected stigma from others. 57 percent had fear of HIV infection, 52.1 percent would practice discrimination, 37.6 percent expressed social judgment and 24 percent want to keep HIV-positive children separate from other children (Srithanaviboonchai et al., 2017).

A literature study in 2013 in Thailand identified stigmatizing attitudes toward people living with HIV, among health care workers. These stigmatizing attitudes were based on perceptions of immoral behaviors and lack of knowledge about HIV among people living with HIV. People living with HIV have experienced fear, as well as acts of stigma and discrimination, in healthcare settings (Churcher, 2013).

**Theoretical frame of reference**

Aron Antonovsky’s theory of ‘Sense of coherence’ (SOC) is a salutogenic model that emphasizes to what extent people experience life as understandable, manageable and
meaningful. Experiencing life as understandable means to what extent a person comprehends certain events and hereby perceives the outside world whilst as experiencing life as manageable means to what extent a person believes that they can and have the resources to deal with these events. Experiencing life as meaningful means that a person feels motivated and engaged to overcome challenges (Antonovsky, 1991).

According to the model the more one experiences life as understandable, manageable and meaningful, the more sense of coherence one has. This will affect how one handles certain events in one's life. Meaning that people have different prerequisites for dealing with equivalent events in life. Antonovsky also described resistance resources as the foundation of an experienced sense of coherence; a person has these resources from early in life. The resistance resources mentioned were education, social support, self identity, engagement, cultural stability, preventive approach, faith, materialistic standard and genetic factor (Antonovsky, 1991).

Knowledge gap

HIV is a communicable disease with its first reportable case in Thailand 1984. Since then, HIV is known to be a public health issue in Thailand with 520,000 people living with HIV and contributing to 9300 deaths in 2021. The development of HIV preventive measures in Thailand led to a decrease in prevalence which can be seen as a success of various implements such as the 100% condom programme, prevention of mother-to-child transmission, PrEP and the ‘test and treat’ approach where early diagnosis and early treatment could preserve the immune system. There are still many CYHIV in Thailand, youths aged 15-25 representing the largest proportion of CYHIV. Studies have shown that the current obstacles with HIV prevention in Thailand, such as diagnosing HIV, is correlated with HIV-related stigma and not being able to self-identify with HIV and therefore being at risk to retrieve the infection.

NGOs and research groups are essential in public health-related activities, particularly in HIV prevention as they provide free and accessible health care and health information to people with HIV. There is a knowledge gap when it comes to the experiences of HIV preventive work in children, adolescents and young adults, among staff in HIV prevention-oriented organizations and research groups in Thailand, and how they face current challenges.

Aim

The aim of this study was to examine experiences of HIV preventive work in children, adolescents and young adults among staff in an HIV prevention-oriented organization and a research group in Thailand.

Method

Design
This study had a qualitative design using semi-structured interviews. Qualitative interviews illustrate people's experiences, perceptions, feelings, opinions and knowledge (Danielson, 2017). A qualitative research design is best suited when the objective is to understand a phenomenon through the experiences of people. The objective of qualitative studies is often to discover a meaning or uncover realities through people's experiences, therefore the most suitable participants are those who can provide relevant information within the subject (Polit & Beck, 2017). The objective with our study was to examine experiences of HIV preventive work among staff in an HIV prevention-oriented organization and a research group in Thailand, with alignment of our objective, a qualitative design with semi-structured interviews was suitable.

Selection criteria

In qualitative studies, participants are most often not selected randomly, but are chosen based on suitability in relation to the purpose of the study. In qualitative studies, samples are often small because of the expectation that each participant provides rich data (Polit & Beck, 2017). In order to guarantee that the participants in the interview aligned with the objective of the study, inclusion criteria were made.

Inclusion criteria
The participants in this study were persons who work with HIV-prevention in children and adolescents within an NGO and a research group in a clinical HIV-unit. These persons have documented experience and knowledge within HIV prevention work. The participants in this study were located within four hours of Bangkok.

Exclusion criteria
None.

Sampling

In this study convenience sampling was used. Convenience sampling means that the researcher recruits participants by either sending out a description of the study or contacting suitable participants for the purpose of the study. In which participants are asked to participate in the study. According to Polit & Beck, it is important to have a varied picture of the phenomenon being studied and this can be achieved with a variation in age, sex or experiences of the phenomenon (Polit & Beck, 2017). In this study the participants were recruited from two different population groups, two participants from an NGO and five participants from a research group in a clinical HIV-unit with varied experiences of HIV prevention.

In this study various organizations and researchers who worked with HIV-prevention were contacted with the purpose of offering participation in the study. In order to obtain a diverse presentation of HIV prevention in Thailand, it was decided that persons with different roles in working with HIV prevention would be interviewed. These were either staff working within a NGO or in a research group. Various organizations and researchers were found on the internet and contacted via email. The interviews were scheduled in agreement between interviewer and participant via email. There were two participants from an NGO that participated in this study. The staff in the NGO are non-health care workers
that offer a home to families and children with HIV and provide them with food, medications and education. The NGO primarily works with children, adolescents and young adults between the ages of 6-24. The NGO was located four hours from Bangkok. There were also five participants from a research group that participated in the study. The research group works clinically within a tertiary care hospital and has a program focused on HIV prevention in adolescence, young adult MSM and TGW. The age range in the research group’s targeted group is 13-24 years old. Among the research group, the staff provide pediatric infectious diseases services for children and adolescents living with HIV. The group of researchers have published various publications on PubMed and also given presentations about their work at various international conferences.

Data Collection

The study included seven qualitative semi-structured interviews in which the participants in their own words described their experiences of the particular subject. The interviews were semi-structured, meaning that it was structured to a certain extent. Semi-structured interviews are an interview form where the interviewer asks a set of open questions based on an interview guide and the participant answers freely (Danielson, 2017). The interviewer proceeds the interview from the interview guide, however, there is room to ask supplementary questions to get more detailed information when needed (Polit & Beck, 2017). According to Polit & Beck, the design of semi-structured interviews is a prerequisite for the participant to answer the questions freely at the same time the interviewer receives detailed information from the participant (Polit & Beck, 2017). The interviews were approximately 30-40 minutes long with 13 prepared questions and some supplementary questions.

The interviewer, aligned with Polit & Beck (2017), prepared a list of questions (appendix a) to be asked during the interview. The prepared questions were however few with some follow-up- questions written down as support, this structure was made accordingly with Danielson (2017) to avoid the interviewer relying on their interview guide and only using it for support. The optimal interview should be performed with short questions asked by the interviewer and the participants' answers should be longer (Brinkmann & Kvale, 2018).

In this study, the locations were set up in consultation between interviewers and participants. According to Danielson (2017), the surroundings for an interview is important to consider. It is necessary to be located in a quiet environment separated from disturbances. In this study the location and surroundings were considered as well as appropriate choice of clothing. In discussion with the participants about the language barrier, an interpreter was contacted when a participant could not make themselves understood in English. For all the interviews this was taken into account and an interpreter was contacted for five of the interviews. The researchers contacted the interpreter before to discuss the purpose of the interviews and the logistics of the interviews. The interpreter participated via Zoom and by telephone during the interviews.

The interviews in the study began with a short introduction about who the interviewers were and about the purpose of the study. Accordingly with the ethical considerations, the participant received all necessary information about participating in the study and that he or she could terminate participation at any time. The participant then signed a consent form. The interviews in this study were ‘self-reported’ meaning that there were almost no
required explanations. In alignment with Brinkmann & Kvale (2018) criteria for a qualitative interview, the participant’s answers were spontaneous, specific and relevant to the subject.

**Data processing**

According to Polit & Beck (2017) the technical equipment should be tested for preparatory purposes. This was done accordingly in the study. The interviews were recorded with two audio recorders and then transcribed to a rough transcript via ‘Microsoft transcribe feature’. The researchers proof-read the rough transcribed material while listening to the recordings, in order to validate the rough transcribed material. According to Polit & Beck (2017), the audio recordings should be transcribed word by word, the researcher therefore needs to be precise and accurate without adding any interpretations.

**Data analysis**

A qualitative content analysis with an inductive approach was used in this study. An inductive approach means that the researcher bases the study analysis on the participant's experience and the result will be discussed with a theory in the study's discussion (Henricson & Billhult, 2017). The qualitative analysis process is a complex and creative process that is not linear and can take form in many different ways (Polit & Beck, 2017).

In this study Graneheim and Lundman content analysis was used (Graneheim & Lundman, 2004). Important concepts in Graneheim and Lundmans content analysis are: manifest and latent content, unit of analysis, meaning unit, condensation, abstraction, content area, code, category and theme. In this study, the text was analyzed based on manifest analysis which means that the analysis focused on the visible and obvious components of the content. According to Granheim and Lundman the basic step in content analysis is to select the unit of analysis. The units of analysis are the objects of the study, in this study the units of analysis were the interviews. When the interviews were transcribed, the researcher read the data repeatedly to get a deeper understanding of the data. Another key concept in content analysis is the meaning unit, which includes words and sentences in the text that are related to each other and to the purpose of the study. The content analysis process continues in condensation which means that the meaning unit is shortened but the meaning of the text and the most important information remain. Abstraction is the stage in content analysis where codes, themes and categories are created. Content area is the parts of the transcribed interview that address a specific topic (Graneheim & Lundman, 2004).

Codes can be used to label a condensed meaning unit (Graneheim & Lundman, 2004). In Graneheim and Lundman content analysis the analysis of the data can involve grouping codes into categories, which are clusters of codes that share a commonality. Data should always fit into only one category and should not be excluded. The categories should be seen as a thread throughout the codes with potential subcategories of various levels of abstractions. Categories should answer the question “What?” with a descriptive level of content. According to Graneheim and Lundman, themes are a way to link the underlying meanings together and describe aspects of an experience with an underlying meaning. Themes answer the question “How?” and describe aspects of an experience with an
underlying meaning (Graneheim & Lundman, 2004). An example of the data analysis and the development of a category scheme can be seen in appendix e.

**Ethical considerations**

Ethical principles for research involving humans are described in the Declaration of Helsinki. The declaration of Helsinki consists of ethical paragraphs whose purpose is to look after the participant's best interests, health, wellbeing and rights (World Medical Association, 2013). Since this study is a qualitative study involving humans, our ethical considerations were based on the Declaration of Helsinki with an ethical awareness throughout the whole study process.

In qualitative studies the researcher could be seen as an instrument that is involved in the study’s different parts. Our experiences, knowledge and pre-understanding affects the research. Polit & Beck (2017) present attributes that researchers can aspire to, to perform a high-quality study. A researcher should strive for transparency in the research, meaning that the study should not keep secrets of bias or limitations from outside scrutiny. The researcher should be aware of one’s own interpretations based on one’s own experiences, values and opinions. It is therefore important to verify, self-reflect and self-correct during the preparatory work and during the course of the study, in order to fulfill impartiality. It is important to consider the participants during the course of the study in order to best reflect their experiences of the phenomenon being studied, a collaboration between researchers and interviewers is therefore necessary.

According to Graneheim & Lundman (2004) it is important to be aware that text and words have multiple meanings and can be interpreted in various ways. In qualitative research when using people’s experiences as data, it is important for the researcher to have awareness regarding one’s own subjective interpretation during interviews and when analyzing data. The researcher and participant should strive to have mutual and contextual bonds in order to achieve trustworthiness (Graneheim & Lundman, 2004). In this sense of matter, the researchers in this study were aware of how different cultural backgrounds one comes from can affect one's interpretation of a situation. This taken into account, the researchers were aware that the study was performed in another country with a different culture than Sweden and that different interpretations of the performed interviews could have occurred. In regards to the language barrier it is also important to acknowledge that different words or contextual meanings can be interpreted in various ways. Taking this into account, the researchers contacted an interpreter with the intention of having as clear a communication as possible where the participants could express themselves fully and the understanding were mutual. However, the researchers also considered the fact that an interpreter is third party bias. An interpreter has the purpose of interpreting the language but can also make their own interpretations of what the participant is saying.

**Anonymity and confidentiality**

The most secure protection of the participant’s data is anonymity. Anonymity occurs when the researcher cannot link together participants to their data. When it is possible, researchers should strive to achieve anonymity. In qualitative studies however, anonymity is rarely possible, since the researcher often is involved in the study with the participants (Polit & Beck, 2017).
Our study is a qualitative semi-structured interview study based on data from persons who work in an organization and in a research group. Since we were involved with the participants, we could not offer the participants anonymity but confidentiality. Confidentiality means that the identifying information about the participants will not be accessible to others, neither will identifying information received from the participants be accessible to others (Polit & Beck, 2017).

Risks and benefits of participation
When handling sensitive information there is a risk that the information reaches unauthorized persons which could lead to non-physical damage for the participant. Non-physical damages include social, psychological and economic harm (Helgesson, 2015).

In this study we have examined the experiences of HIV preventive work in children, adolescents and young adults among staff in an HIV prevention-oriented organization and a research group, therefore sensitive personal information was not of interest. However, some of the questions asked in the interview addressed personal experiences and personal views of the subject. It was therefore important to have knowledge about the risk of evoking emotions in the participant. According to Polit & Beck (2017) it is necessary for the researchers to have knowledge about the psychological consequences of study participation. The researchers have been aware of the need for sensitivity while doing qualitative studies in this sense of matter.

There were no direct personal benefits for the participant to participate in this study. However, we hope that the information obtained from the participants as a part of this study may lead to a greater understanding of the work with HIV-prevention in Thailand.

Safety practices
According to Helgesson, the risk of harm is minimal with adequate safety routines for handling sensitive information (Helgesson, 2015). In this study we had adequate safety practices when handling the participants’ information. The recordings were not accessible to unauthorized persons. As soon as the recordings were transcribed we deleted them. The transcribed documents did not contain identifying information about the participants, the organization or the research group. The identifying information we contained was the signed informed consent form which was held unaccessible to unauthorized persons (Polit & Beck, 2017).

In our study the results have been presented at a group level – which means it has been presented in a way that cannot identify single participants. To uphold confidentiality, the organization or the research group have not been referred to by name.

Informed consent form
It is of great importance to respect the participant's autonomy and personal integrity in research (Helgesson, 2015). With reference to the Declaration of Helsinki, a voluntary informed consent form is required in research involving humans (World Medical Association, 2013). We have collected informed consent from the participants, both verbally and in written form (appendix b). In order to sign the consent form, the participants received comprehensive information about the study and that their participation in the study was voluntary and that they at any time could withdraw their participation without explanation. According to Helgesson, to be able to make an informed
consent a person must be given relevant information, be competent to understand the information and be competent to make a decision about their participation (Helgesson, 2015).

RESULTS

Three main categories and eight subcategories emerged from the interviews, relationships between the categories are presented in Figure 1.

<table>
<thead>
<tr>
<th>Success factors in HIV prevention</th>
<th>Barriers to HIV prevention</th>
<th>Future direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to HIV testing</td>
<td>Limitations in time and money</td>
<td></td>
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<tr>
<td>Access to information</td>
<td>Difficulties in adherence to HIV prevention</td>
<td></td>
</tr>
<tr>
<td>Sharing experiences</td>
<td>Stigmatization of HIV</td>
<td></td>
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<tr>
<td>Collaboration between agencies working with HIV prevention</td>
<td></td>
<td></td>
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<tr>
<td>Decrease in stigma</td>
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Figure 1. Emerging categories and subcategories

Success factors in HIV prevention

This main category states the participants reflections of the success factors in HIV-prevention. Five subcategories were identified: Access to HIV testing, Access to information, Sharing experiences of HIV, Collaboration between agencies working with HIV prevention and Decrease in stigma.

Access to HIV prevention
According to one participant the risk of HIV is increased during a period of exploring sexuality, which often occurs during adolescence. It was explained further that they therefore aim to do prevention for a certain period of time until adolescents know how to navigate and practice safer sex, being more mature, find their partner and have a stable family.

It was stated that easy access to HIV-testing is important because the earlier HIV is detected, the sooner the person can receive treatment with antiretroviral drugs which prevents the spread of infection. All the participants in the study stated that HIV-testing, preventive medicines such as PrEP and ARV are available for people at risk of getting HIV, or people with HIV. Furthermore, it was mentioned that an important success factor in HIV prevention is that HIV-tests are available for free at the government hospitals and NGOs.
The government hospital offers the possibility for people to get free HIV-testing two times a year.

“For the government, government hospital, the Thai people can have the privilege to check for HIV-testing two times a year for free, so they need to submit the identification card to check their privilege of this and also they can go to NGO to have the free testing, HIV testing”

- Participant 3

According to several of the participants in the research group, one success factor with HIV prevention is to be a "one stop service". This means that adolescents will not need to go to different clinics or centers to have HIV-testing, HIV-treatment or PrEP where they need to tell their story all over again. They can get all the care they need in one place. It was mentioned that with a model of "one stop service", people can get psychiatric support and persons who are TG can get gender affirming hormones and help with regulating hormones properly. It was mentioned that adolescents who go to school can go to their clinic on weekends, which are times specifically adjusted to fit adolescents, during Friday afternoon and Saturday morning. Several of the participants in the research group mentioned that different clinics require an adult's consent. However, there are still clinics where adolescents aged 13 or above can get access to HIV-testing, PrEP or treatment without an adult consent, but where they are recommended to have an adult as support.

Access to information
It was mentioned in the research group that the internet is an important tool to reach out to the targeted group. Adolescents can easily search for “HIV-testing” on the internet and get information about HIV and where they can go to take HIV-test for free. One participant explained that their clinic has a facebook page where they publish information about HIV. The clinic can advertise their information on facebook to a specific gender, age range and location and in that way their facebook page can reach out to their targeted group. Many of the participants in the research group also stated that one success factor in HIV prevention is that the government hospital offers the possibility to book an appointment online.

“We have Facebook page and have the like/…/ application, a official one. And/…/ they have the website that the people can search for information and make appointment.”

- Participant 3

It was mentioned that knowledge is a prerequisite for accepting a person with AIDS and it is therefore very important to educate the community about HIV. According to several participants, education can include information about taking ARV to protect yourself and prevent onward transmission to partners. Knowledge and support were mentioned to also be important to make HIV-positive persons feel that they are not alone and that they do not need to hide themselves. Furthermore, it was explained by the participants from the NGO that they provide information to the community about AIDS and try to make the community get a deeper understanding about HIV and AIDS. They visit schools once a year to provide information about HIV to schoolchildren.

“While we work with HIV-infected people, we also intensely educate the community about AIDS infection”

- Participant 7
Sharing experiences of HIV
It is mentioned several times by the participants that adolescents and young adults feel more comfortable to go to an HIV-testing clinic together with a friend. There is a program called “Friend get Friend”, this means that a friend or partner can come along and also take an HIV-test and get free condoms. It is also mentioned that people who have visited an HIV clinic often advise their friends to pay a visit. It was explained that a person who is HIV positive can bring their partner who is HIV negative to get education about HIV prevention, as well as condoms and PrEP.

“Friends suggest friends to come to check about HIV, because normally the young generation do not want to come alone”

- Participant 3

According to one participant, it is important for a person with HIV to have a social context and therefore meet other people with HIV. Another participant stated that they have peer group meetings where friends that are HIV positive can meet and also where parents of HIV-positive children can conversate as well as partners of HIV-positive people. It was explained that by holding these group discussions for different target groups, they actively work with decreasing stigma as people can share their experiences of HIV to increase understanding. The participant believes that by communicating, sharing experiences, informing about transmission and treatment, stigma can be counteracted.

Collaboration between agencies working with HIV prevention
It was mentioned in the research group that they work together with NGOs to provide education, HIV prevention and treatment to the communities. According to several participants from the research group, some people are afraid to go to the hospital and therefore community workers can give information regarding HIV, which is a success. Cases with high risk of HIV are however, referred to the hospital. Furthermore, it was mentioned that a community-based organization is easy to integrate in the community. It was explained that a non-health care worker can be a provider of HIV prevention by learning skills of care and that these persons have experiences of intravenous drug use or LGBTQ and can therefore have an increased understanding of a person's situation. However, providing care is still in the context of health care which makes this difficult to implement according to one participant.

“Sometimes we/…/ provide education or like a mobile education to the community near the hospital and working with NGO, that we have the NGO who work with adolescent and children, sometime we have the event to work with them, children and community to provide like the education, prevention and treatment”

- Participant 2

Participants in the NGO, in tune with the participants from the research group, stated that some people are afraid of going to the hospital and therefore the NGO encourages people to visit the hospital in order to get the right treatment. The participants from the NGO stated that they work together with hospital staff who advise and give information regarding HIV. Once a month they have a meeting coordinated with government agencies at the hospital where they provide medication and health care.

Decrease in stigma
All participants except one gave examples of experiences of stigma and discrimination against people with HIV. One participant mentioned not having experienced any stigma or discrimination and believes that their position in work affects this.

It is mentioned that HIV is considered a general epidemic so therefore the acceptance for HIV is better in Thailand than other countries. The prevalence of HIV is high enough for many to be affected. Furthermore, it is mentioned several times that the attitude toward HIV has changed and stigma and discrimination of persons with HIV has decreased because of technology, innovations and education. One participant believes that access to good medicine and treatment in today's society has led to HIV positive people being treated as normal people.

“…in the past like this/…/ seems to be scary to many people, but now because of the technology and because of their amazing innovation and also some education, more education. The image or their. Yeah, the image of the passion is not it's, not that too scary for general people, and also because we have, like if they have good medicine and also can reach out for the treatment. And so this is not scary anymore”

- Participant 4

Several participants mentioned working with HIV prevention in terms of stigma and discrimination. Some explained that they work with stigma by raising awareness and providing correct knowledge about HIV are parts of preventing stigma in society. To give new information on treatment and facts of transmission to people was stated to decrease the fear of HIV.

**Barriers to HIV prevention**

This main category states the participants reflections of the barriers to HIV-prevention. Three subcategories were identified: *Limitations of time and money, Adherence to HIV prevention* and *Stigmatization of HIV*.

**Limitations of time and money**

It was mentioned that adolescents are unsure of how one can get help and have difficulties in navigating in health care settings. Many of the adolescents go to school or work during weekdays and therefore have limited time to get to a clinic or hospital. Participants in the research group mention the importance of having the possibility for adolescents to book an appointment when they are available.

According to some participants, adolescents do not have money for transportation and can therefore not afford to go to the hospital or do HIV testing. It was mentioned that NGOs offer free HIV-testing and government hospitals offer HIV-testing two times a year, however, the young generation do not know about this privilege, so they go to private clinics and private hospitals and pay for HIV-testing. One participant stated that the treatment for sexually transmitted diseases is not for free and that the young generation must pay out of their pocket in advance. Furthermore, it was explained that this is a problem because they do not have any money and are afraid of telling their parents. One participant mentioned that HIV affects the entire body and other conditions related to HIV can arise which the HIV treatment does not cover. These specific treatments can cost money that adolescents cannot afford.
“Sexual transmitted diseases, right now for the treatment is not free. So when the young generation they uncover this problem, they need to pay in advance, they have to pay by out of their pocket. And imagine that when they have some symptoms about their sexual transmitted disease and they have no money. And they are so afraid of telling their parents”
- Participant 3

Adherence to HIV-prevention
Many of the participants in the research group stated that there are many struggles with providing HIV-prevention. And explained furthermore, how adolescents, for various reasons, do not want to take PrEP or use a condom during intercourse. Adolescents are not aware of and cannot assess risky behavior and therefore have a lack of adherence to HIV prevention.

“...the young generation they cannot like assess the risks that they are encountering/…/ For example, when they have sex, they have the perception that if they have just one partner it mean that it is no risk. Or if there is no any symptom, sign of any symptom, it's mean that they do not have HIV. They can conclude in that way”
- Participant 3

It is mentioned that people who rarely have sex do not find it worthwhile to take PrEP every day. Furthermore, it was explained that adolescents in relationships don’t want to take PrEP because the partner will believe one has multiple partners. In regard to transgender women taking hormones, the same participant also mentioned that they do not want to take PrEP because of the several medicines, but also due to the fear of side effects when combining PrEP and hormones. Furthermore, it was mentioned that some do not like to use condoms and therefore do not use them in a sexual context and that sex workers often are offered more money to not use condoms during sex.

Stigmatization of HIV
Several participants stated that adolescent’s experience of stigma is often brought upon themselves, such as self-blaming and feeling hopeless. According to one participant there are mental health problems amongst adolescents, such as depressive symptoms. Persons who are HIV positive have a lot of mental health problems, due to discrimination and social isolation which have resulted in feelings of worthlessness and cases of suicide. It was mentioned that with early detection and good treatment, people can get helped. Furthermore, a participant explained that a person who has good mental health and has knowledge about one 's risks means that one is more self-confident and is able to protect oneself from HIV.

“/…/ because most of the patient might think that they are valueless and hopeless, and not a person who anyone would give respect or love”
- Participant 6

It was mentioned that stigma and negative attitudes come from misunderstanding. A person that does not understand HIV is afraid of being in contact with HIV, and therefore separates things, for example clothes, and chooses not to eat together with a HIV-positive person. According to the participants in the NGO the knowledge of HIV in the Thai community is minor and the acceptance of HIV-positive people is low. Furthermore, it was explained that people are afraid of becoming infected, even if they have knowledge about the ways of
transmission, that you only can get HIV from sexual intercourse or by blood, they still do not want to be socially engaged with HIV-positive people. It was stated that people with HIV don’t want to tell their friends about their HIV status as there is a risk of being abandoned by society and are therefore afraid of how it might affect their family and children. Furthermore, it was explained that HIV-positive people don’t want to be in contact with healthcare and that people unsuccessful have been trying to self-medicate with natural substances instead of getting the medication that is given at the hospitals.

It is mentioned that stigma regarding HIV today varies depending on the generation. The younger generation see HIV as a treatable virus and do not have a picture of AIDS. They do not have a problem to be partners or friends with HIV positive persons as long as the virus is suppressed. Several participants explained that the older generation, being the younger generation's parents, do not understand the young people's point of view and have a hard time to differentiate between HIV and AIDS. The older generation, people between 40-60 see AIDS whilst the younger generation, 20 years old and younger see HIV. It was mentioned that stigma today occurs due to the memory of AIDS. Furthermore it is explained that lack of communication between generations is the reason why education or entry point to access testing or prevention for young adults, is blocked.

“It is different in generation, for the young generation, they understand more about the HIV/.../many cases of the young generation below 18, they do not want to tell their parents that they have, they have the HIV. Because the parents and the older generation, they do not quite understand. And so it's better not to tell the parents and take the medicine, and so can make them healthier. /.../ about the HIV and AIDS, many people, when they heard about AIDS, they will quite scared of this word. Because they do not know that it's different between HIV and AIDS, it's not equal. And so we need to make them understand about these parts”

- Participant 5

It was mentioned that sex is not a subject openly talked about in Thai family’s or in society. Some participants stated that mental health and LGBT are also sensitive topics of discussion. Adolescents talk about sex with friends or on the internet, but not with family members. Furthermore it was mentioned by one participant that very few people share information on HIV to other friends or the public and that there is not a lot of information on HIV in the media or on television. People only use closed chats on facebook to talk about HIV.

Several of the participants mentioned that in some minor groups they do not understand and do not want to be associated with HIV positive people. Stigma still can be found in some schools, where children with HIV are treated differently by the teachers and they coat it with concerns for the children’s health. Various examples of discrimination against HIV-positive people within the working sector are also mentioned. One example mentioned was not being able to become a soldier when being HIV positive nor work within some positions in the private sector. It can be required to be tested for HIV and it is not allowed to have an infectious disease that cannot be treated within 30 days.

“... but in some places we can/.../ still found. Like at some schools, rejected children living with HIV, in some place. And it is more complex because the Thai policy in, for example, the Thai policy for education, for school, you cannot reject the children living with HIV, but in in some schools that they’re still afraid of HIV, but but they cannot directly
present that I have that this, “...I afraid you…”, something like that but. They, they will change to like “…I understand, but we concerned on your health, so please go stay home…” And sometimes they put they put them in the back off the classroom and afraid to near them.”

- Participant 2

Future directions

This main category states the participants reflections of the future directions in HIV-prevention.

A general opinion of the participants was that prevention needs to be easy to get and accessible. Currently HIV care is found in the hospital which many consider as scary. HIV related healthcare services are still linked to the hospital. One participant's opinion is that the service unit to provide prevention is still not enough in Thailand and want to implement digital health or telehealth nationwide and empower people to screen and test for HIV by themselves.

In addition, it is mentioned that there is no medicine specialized in adolescent medicine in Thailand, only pediatrician and adult medicine. In regard to HIV prevention, one participant wanted to see HIV as a lead program project, with the ambition to see the creation of adolescent medicine as a separate health care service. It was also stated that people in health care settings may overlook mental health in adolescents and do not follow up the given questionnaires, and therefore have the ambition to see people recognizing and noticing mental health in adolescents.

“What my ambition goal is to see HIV as a lead program project. And research to create adolescent medicine in this country because it's. It's not... just a service and in the mentality of people to really understand adolescent and young adult it's worth a specialty. Or separate health care services”

- Participant 1

It is mentioned that medication has become more advanced than it was before and HIV prevention is therefore more accessible today. A person with HIV in Thailand needs to take their medicine every day, whilst people overseas can take it monthly with an injection. It was stated by some participants that they wanted to see the innovation of medicine where you can take your medicine monthly and not daily.

DISCUSSION

Results discussion

The purpose of this study was to examine the experiences of HIV prevention in children, adolescents and young adults among staff in an HIV prevention-oriented organization and a research group in Thailand. Furthermore, this study examined the experiences in staff about their preventive work in terms of challenges and barriers. The results showed various
success factors, barriers, and future directions to HIV preventive measures but also important factors of stigma.

Success factors in HIV prevention
Within the success factors, access to HIV prevention was an important success factor in this study. Adolescents could access HIV testing for free two times a year at a government hospital or at an NGO, without an adult's consent. Accessing PrEP and ART does not require an adult's consent if aged above 13 in some clinics. According to Muccini et al. (2019), shortening the time between HIV-screening and ART initiation could preserve the immune system and achieve life expectancy similar to HIV-uninfected-people (Muccini et al, 2019). The earlier HIV is detected, the sooner a person can receive treatment with ART. Furthermore, it was shown in this study that adolescents could access all the care they need in one place at a “one stop service”. Which means that adolescents not only can access HIV prevention but also get psychiatric support and gender affirming hormones. According to Rouleau et al (2019) nurses working with HIV connected persons living with HIV to social and health-related resources. Being a “one stop service” or providing connections to social and health related resources for people with HIV, help manage living with HIV. Furthermore it was shown in this study that adolescents go to school or to work on weekdays and that they therefore can go to an HIV clinic on Friday afternoons or Saturday mornings, which are times specifically adjusted for adolescents.

Antonovsky's theory of sense of coherence which addresses to what extent people experience life as understandable, manageable and meaningful, it is mentioned that a person that experiences life as manageable and has the resources to manage certain events in life, have more sense of coherence and therefore the ability to handle these events (Antonovky, 1991). In the light of Antonovky’s theory, it is a prerequisite for an adolescent living with HIV to have resources in order to experience life as manageable, such as having one-stop-service where one can go in order to get all the care needed but also having the time to do so.

In this study it was found to be a success within HIV prevention to be a “people-centered-service” where all aspects of quality of life were considered, not just only the aspect of HIV. According to Antonovky’s theory, how one person handles a situation depends on how a person experiences life as meaningful. Seeing a person fully and not only the aspects of HIV, affect how a person experiences life as meaningful. According to Rouleau et al (2019), nurses working with HIV and AIDS should build a therapeutic relationship and promote acceptance and trust in that relationship. Furthermore, the nurse should assess the overall health of a person living with HIV (Rouleau et al, 2019). Health in addition to living with HIV can affect the quality of life, and therefore assessing the overall health is necessary.

The NGO’s and health care system collaborate and provide information and free HIV-testing to adolescents which have been successful. In our study it was found that the collaboration between NGO and health care to educate the communities on HIV, was a success factor in HIV prevention. A community-based organization is easily integrated in the community where a non-health care worker can provide HIV preventive measures. It is especially important for people that are afraid to go to the hospital to access information on HIV and preventive measures, to have the possibility of a community-based organization. It was found in this study that it was important to educate the community about HIV as knowledge is a prerequisite for accepting a person living with HIV. In Antonovsky’s
salutogenic model (Antonovsky, 1991), the more one experiences life as understandable, manageable and meaningful, the more sense of coherence one has and will affect how one handles certain events in life. Furthermore, education is described as a resistance resource which is the foundation of an experienced sense of coherence. Experiencing life as understandable means to what extent a person comprehends certain events, for a person living with HIV it is important to have knowledge on the disease such as how it is transmitted and how it can be treated and education is therefore an important factor for a person to experience a sense of coherence.

It was also found in our study, that peer-to-peer contact was a success factor in HIV prevention, where adolescents could reach an NGO or a clinic through a friend and meet other HIV-positive persons in group meetings. According to Muccini et al (2019) peer-led HIV testing has been seen to have a positive impact on youths living with HIV in which they access information regarding HIV and get tested (Muccini et al., 2019). In the light of Antonovky’s theory, a person that experiences life as meaningful will have more sense of coherence. Having a social context and sharing experiences when meeting other persons living with HIV are factors to experiencing life as meaningful.

It was found in this study that collaboration between agencies working with HIV prevention was a success factor. Community workers gave information to people with HIV who were afraid of going to the hospital. These community workers were non-health care workers who had an increased understanding of a person's situation with background in intravenous drug use or LGBTQ. In a study conducted in Malawi about patients and nurse’s perspective of a nurse-led community based model (NCAP), it was found that patients and nurses found it positive that nurses went to community based locations in order to give care to the patients. It was shown that the nurses felt that they could play a greater role in caring for the patients which resulted in a closer relationship between the patients and care providers. The patients felt less stressed and more quality time was dedicated during consultation (Sande et al, 2020).

**Barriers to HIV prevention**
Accessibility was an important factor, in our study, in order to carry out HIV preventive measures and not having access due to limitations in time and money was found to be a barrier to HIV prevention work in adolescents. It was found that adolescents had trouble navigating in health care. According to a study conducted in Southeast Asia, it was found that adolescents who had received information on sexual and reproductive health and therefore had found out they were HIV positive, found themselves unable to navigate in health care (Newman et al, 2021). Furthermore, in our study, it was found that adolescents had trouble accessing HIV preventive measures due to limited time and money. Many of the adolescents go to school or work during weekdays and therefore have limited time to get to a clinic or hospital. According to a study conducted in South Africa (2019), the challenges to living with HIV and adherence to ART amongst school going adolescents were described. It was found that participants experienced feelings of being conflicted between school activities and the need to attend clinic for appointment, furthermore it was found that there also was an economical barrier to it, where adolescents did not have money for transportation to the clinic (van Wyk & Davids, 2019). In our study it was also found that even though there was free HIV-testing in governmental hospitals and in NGOs, adolescents were not aware of this and go to private clinics where they have to pay out of their pocket, because they do not tell their parents about being HIV-positive. According to Sande et al (2020), it was found that nurses working with HIV and patients living with HIV
experienced that NCAP helped patients save time and money. Where instead of patients coming into hospitals, nurses went to the communities where patients lived in order to give care. It was shown for the patient that the money spent on public transportation to go to the clinic was saved and so did time, time commuting and waiting in lines at the clinic (Sande et al, 2020). According to Antonovsky's salutogenic model, having resources is a prerequisite to experiencing life as manageable and have a sense of coherence, not having the time or money makes it difficult to manage living with HIV.

In our study it was shown that adolescents did not adhere to taking their medication because they were not aware of their risks. It was also found that transgender women did not want to take their medicine whilst taking their gender-affirmative hormones because of the several medicines, but also due to the fear of side effects when combining PrEP and hormones. According to Muccini et al (2019) the obstacles with diagnosing HIV are the lack of getting tested due to the experience of HIV-related stigma and not being able to self-identify with HIV and therefore being at risk to retrieve the infection and also having concerns regarding the side effects of the medication (Muccini et al, 2019). In our study HIV related stigma and concerns of side effects in medication was not found to be an obstacle for HIV-testing and diagnosing HIV in adolescents, however, it was found that adolescents had trouble self-identifying with HIV and not taking their medicine, therefore being at risk to retrieve infection. According to Antonovsky’s theory on sense of coherence (Antonovsky, 1991), if a person does not experience life as understandable it will affect how a person handles certain events in life. Aligned with Antonovsky’s theory, if one does not understand nor have the knowledge on HIV, transmission ways and the risks of retrieving infection, it will affect how one handles taking medicine for preventive measures.

There are several international guidelines describing nurse’s role in improving HIV patients adherence to medication (Canadian Association of Nurses in HIV/AIDS Care [CANAC] 2013;Dumitru, 2017;WHO, 1988). It is of importance that nurses can provide information about medication and the possible side effects to it. Nurses should be able to support the patient's adherence by planning and enacting strategies and scheduling medications in order for the patient to remember taking his or her medication (CANAC, 2013). A study from Canada explained nurse’s activities to support people living with HIV to adhere to ART. These activities are to educate about ART, side effects, how it interacts with other medications and drug resistance. Nurses also provide practical tips on how to manage ART and potential side effects (Rouleau et al, 2019).

In our study it was mentioned by several participants that stigma and discrimination towards HIV-positive persons has decreased. Furthermore, it was found that sex and HIV are sensitive subjects in Thai society as well in families and are therefore not often talked about. The lack of communication between generations about HIV and AIDS is one of the reasons for young adults and adolescents not receiving information on HIV and therefore not accessing testing and prevention. Adults, being an older generation, have difficulties in differentiating HIV and AIDS whilst young adults and adolescents see HIV as a treatable disease one can live with. According to a qualitative study that examined the experiences of caring for adolescents among caregivers in Uganda, it was found that many caregivers experienced feelings of hopelessness, grief and fear when they found out that their child had received HIV. It was stated by some participants that they did not think that their adolescent children were engaging in sexual activity and were therefore shocked when they were diagnosed with HIV, since they themselves were HIV-negative (Kasande et al, 2022).
One consequence of the different views on HIV can lead to adolescents not telling their parents about their HIV-status. The same phenomenon is shown in a study made in Kampala, Uganda, and Western Kenya about social self-disclosure among adolescents living with HIV. The study shows that 43.5 percent of the participants had not told anybody except health care workers about their HIV-status (Nöstlinger et al, 2015). Being a HIV-positive child or adolescent, or being at risk of getting HIV and not having adults to talk to about sexuality, HIV and AIDS risks affecting that person's sense of coherence. Not being able to have an open and honest conversation about sexuality or HIV can make life less understandable and being HIV-positive or in risk of getting HIV without getting any support can make life less manageable.

**Future directions**

A key finding in our study was that the future directions of HIV prevention was to provide adolescent medicine with specialized care and with an increased focus in mental health. In our study it was found that promoting mental health among adolescents as a part of the prevention work, was a key finding. According to a study conducted in Southeast Asia, it was found that there was no or limited access to mental health care for adolescents (Newman et al, 2021). In our study it was found that HIV-positive adolescents and children had feelings of worthlessness, depressive symptoms and suicidal thoughts. A study from Zimbabwe explored the impacts of HIV-related self-stigma amongst adolescents and young adults with HIV. The study showed that the participants described a feeling of worthlessness related to their HIV-status. According to the study the feeling of worthlessness was more intense when the participants found out about their HIV-status but still present in their life years after they found out. The feeling of worthlessness was still impacting the participants lives and causing suicidal thoughts for many of them. The same study also showed that many of the participants had feelings of hopelessness, the participants described that they do not have any hope for themselves or their future and the feeling of hopelessness was often linked to interpersonal relationships (Rich, et al 2022). A cross-sectional study from the Swedish public health authority about life quality among people living with HIV in Sweden, shows that there is a strong connection between stigma and a lower life quality. There were two aspects of HIV-stigma that were related to a lower quality of life: concerns regarding the public attitudes towards people with HIV and a negative self-image due to the HIV infection, so-called self-stigma. A majority of the participants in the study from the Swedish Public Health Agency (2016) were worried about telling people in their life about having HIV. The study presents feelings of hopelessness as an important factor to estimated quality of life. Stronger feelings of hopelessness indicated lower quality of life (The Swedish Public Health Agency, 2016).

**Method discussion**

In this study the aim was to examine experiences of HIV prevention in children, adolescents and young adults among staff in an HIV-prevention oriented organization and a research group in Thailand, therefore a qualitative design was used. Qualitative design is suitable when the researchers want to understand a phenomenon through the experiences of people (Polit & Beck, 2017). In this study interviews were conducted since interviews can capture people's experiences and knowledge a qualitative study design was suitable for the aim of the study. The researchers were aware of their own interpretation and pre-understanding of the subject and discussed this in advance to limit the risk of bias. However, using a qualitative study means that the researchers will make interpretations of
the data received and therefore there is a risk of bias. The researchers made the decision to use a qualitative study and not a quantitative study as the purpose of the study was to examine the experiences of HIV prevention work.

We contacted various organizations and researchers via email in which one NGO and one research group accepted participation in the study. We had difficulties recruiting participants as it was difficult to come in contact with people working with HIV-prevention via email. Since we were going to do our study in Thailand for a limited time we needed to have a plan for the study before we arrived in Thailand. The study population consisted of seven participants, two participants from one NGO four hours from Bangkok and five participants from a research group in Bangkok. All the participants had documented experience and knowledge of working with HIV preventive measures of children and adolescents.

Convenience sampling was the most efficient sampling for us to use because our study required participants with experiences of working with HIV-prevention in children and adolescents. According to Polit & Beck (2017) convenience sampling is a type of non-probability sampling in which the researchers select participants for the study who are judged to have a particular knowledge of the phenomenon that is studied. Since we had limited time to prepare our study, convenience sampling was the most suitable sampling method. Another sampling method that could be suitable for our study is purposive sampling. There are various purposive sampling strategies, in common they share the goal to select participants that will be most suitable for the study. Using a purposive sampling could benefit our study with participants with different backgrounds and perspectives (Polit & Beck, 2017), which could have given us a broader image of HIV-prevention in Thailand.

In this study seven interviews were held, according to Polit & Beck (2017) samples are often small in qualitative studies because of the expectation that each participant provides rich data. The interviews were semi-structured which gave room for the participants to speak freely and openly about their experiences (Polit & Beck, 2017). Since we had difficulty finding participants for the study, no pilot interview was held. However, after the first interview we evaluated the interview guide and came to the conclusion that we were satisfied with the questions and the order of the questions. According to Danielson (2017), the surroundings for an interview is important to consider. In all of the seven interviews, the surroundings were considered. The locations for the interviews were quiet and separated from disturbances and were held in different locations depending on where the NGO and the research group were set. We wore appropriate and formal clothing that was suitable for the interview setting.

In the preparations for the interviews, we discussed with the participants about the language barrier and an interpreter was contacted for five of the interviews, as they could not make themselves understood in English. One interpreter was contacted for the interviews that were held with the participants from the NGO and another interpreter was contacted for the research group, this was due to the fact that the interviews were held on different days. Having an interpreter is a risk of third party bias. The researchers were aware that the interpreters could make their own interpretations of what the participants were saying. To prevent misunderstanding, the interpreters repeated the questions back to the interviewers, and asked the participant to develop further or explain when the interviewers did not understand the context. However, having an interpreter affects the trustworthiness of the data collected and this was taken into account. An article written by
Temple and Edwards (2002) highlights that when using an interpreter to translate languages, the cultural, social and political meanings can be lost in the process of translation. Furthermore, it was mentioned that the same words can mean different things in different cultures (Temple & Edwards, 2002). Even though there was a risk of misunderstanding or not getting the whole meaning when using an interpreter, we considered that the benefits were greater in this study, otherwise the interviews could have been incomplete or not been able to be done at all.

The interviews were recorded with two audio recorders and then transcribed to a rough transcript via ‘Microsoft transcribe feature’ and the transcribed material was then proof-read by the researchers while listening to the recordings in order to validate the rough transcript. According to Polit & Beck (2017), the audio recordings should be transcribed word by word, the researcher therefore needs to be precise and accurate without adding any interpretations. When listening to the recordings word for word, it was difficult to hear and understand some words. This was taken into consideration when analyzing the data, that we might not have the full picture of the context due to the loss of some words, which affected the trustworthiness of the study. According to Graneheim & Lundman (2004) it is important to be aware that text and words have multiple meanings and can be interpreted in various ways. The researchers were aware of one’s own subjective interpretation when analyzing the data.

It was not possible to know in advance the amount of data necessary to align with our objective and to answer our research question, as it varies depending on the complexity of the phenomenon and data quality (Graneheim & Lundman, 2004). Only after the results had been presented would we know whether the number of participants had provided rich enough data to align with the objective of the study. After the presented results we considered that we had enough participants and that the data was rich enough to align with the objective of our study. However, the data collection cannot be considered representative for the HIV prevention work in children and adolescents in Thailand in general but rather give insight in the prevention work. Furthermore the data can show a picture of HIV prevention work in children and adolescents in similar countries to Thailand, for example countries in Asia. As there were only two participants from an NGO and five participants from a research group, there was an uneven data collection and therefore a risk that the information was not representative for the HIV prevention work in NGOs in Thailand. Furthermore, of the seven participants, five of them were located in Bangkok and the other two were located four hours from Bangkok, which can be considered to not give a representative picture of the HIV prevention in Thailand, but more specifically, in Bangkok and four hours outside of Bangkok. However, we consider that the variety of professions and locations is a strength in this study since we got data of experiences from different perspectives and also a deeper understanding about the differences in experience of HIV preventive measures and the attitude towards HIV between an urban area and a rural area.

In this study Graneheim and Lundman’s content analysis was used (Graneheim & Lundman, 2004). When the interviews were transcribed, the researcher listened to the recordings and read the data repeatedly to get a deeper understanding of the data. The process of finding meaning units, condensing the text and labeling the meaning units with codes the researcher started to do separately. After this process the researchers compared their results and agreed on the final meaning units, which was used in the study. Further, the researchers worked together to group the codes into categories and subcategories. No themes were identified in this study.
The researchers have considered the ethical aspects of a qualitative study during the entire process. Aligned with the declaration of Helsinki’s ethical paragraphs, the study looked after the participants best interests, health, wellbeing and rights. In qualitative studies the researcher could be seen as an instrument that is involved in the study’s different parts. It was taken into consideration that the researcher's experiences and pre-understanding could affect the study, to prevent bias the researchers verified, self-reflected and self-corrected during the preparatory work and during the course of the study, in order to fulfill impartiality. The researchers were also aware of the different cultural backgrounds one comes from and that the study was performed in another country with another culture than Sweden and that different interpretations of the performed interviews could have occurred.

**Conclusion**

This study aimed to examine the experiences of HIV prevention in children, adolescents and young adults among staff in an HIV prevention-oriented organization and a research group in Thailand. The results in this study suggest both success factors, barriers and future directions.

Easy access to HIV testing and treatment was shown to be important success factors for HIV prevention. The results also showed that a one-stop service is successful where adolescents can get all the care they need in one place and where all aspects of life are regarded. These factors can make the situation of health care more manageable which can increase the sense of coherence and thereby increase the ability to handle living with HIV. In the study it was shown that stigma had decreased in general, with exception to minor groups. It was shown that receiving education on HIV decreased stigma and increased adherence to care.

One of the barriers to HIV prevention were shown to be lack of access to care due to limitations of time or money. Not having access to HIV preventive measures due to lack of resources and opportunities affect how one experiences living with HIV as manageable which decreases the sense of coherence. In this study it was shown that there was a need for adolescent care to be a specialized type of healthcare and the general opinion of the participants was that HIV prevention needs to be more accessible.

The sample in the study provided rich data aligned with our purpose, however, the results can not be generalized to HIV prevention work in children, adolescents and young adults among an HIV prevention-oriented organization and a research group in Thailand. This due to the fact that the study population only consisted of seven participants and were not geographically spread in the country. The results in this study are relevant and beneficial in a bigger clinical context, as it provides relevant information for health care workers on the success factors and barriers to HIV preventive measures and future directions. The knowledge about the success factors and barriers in HIV prevention is important for nurses since prevention work is a major part in nursing care and may therefore lead to improvement in HIV prevention work all over the world.

**Further studies**

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In our study it was found that the research group in Bangkok had experienced that stigma and discrimination had improved in recent years. Whilst the participants from the NGO located outside of Bangkok had more experiences of social exclusion and discrimination of HIV-positive people. Future studies could advantageously include participants from different areas in Thailand to be able to draw more conclusions and gain a greater understanding of HIV prevention and the attitudes towards HIV in Thailand. Our data showed that there were differences in experiences of stigma toward people with HIV in an urban area versus a rural area and therefore it would be interesting for future studies to explore these differences further.

In our study people working within a HIV prevention oriented NGO and research group were interviewed regarding their experiences of HIV-prevention and stigma and discrimination. It could be of interest to do further studies on the experiences of HIV prevention work amongst CYHIV. Furthermore, the experiences of stigma and discrimination amongst CYHIV.

Clinical relevance

The results of this study can be used to get a deeper understanding of the success factors, the barriers and the development areas of HIV prevention. This study was conducted in Thailand, however, HIV being a public health issue with patients all over the world is therefore relevant for everyone working within healthcare.

The global goals for sustainable development includes seventeen goals with the purpose of ending extreme poverty, reducing inequalities and injustices in the world, promoting peace and justice and solving the climate crisis (Globala målen, u.å.). Goal number three is called “good health and well-being” and includes the goal to fight communicable disease in the world and specifically by 2030 end the pandemic of AIDS (Globala målen, 2022). The results in this study can be of use to increase knowledge regarding the success factors, barriers and future directions within HIV prevention in order to reach the goal by 2030.

Swedish public health authority goals with their work with HIV is to limit the spread of HIV as well as limit the consequences of these infections for society and the individual. In order to reach this goal HIV needs to be identified and treated as early as possible, HIV prevention needs to be easily accessible and offered to everyone in the society, especially for people in the risk group. Another goal is that people with HIV are fully accepted in society. According to the Swedish public health agency, health care workers need to have knowledge in these fields to be able to contribute to these goals (The Public Health Agency of Sweden, 2023). This study contributes with knowledge about these topics and can therefore be considered beneficial for society.

In this study, one of the key findings was to be a person-centered one-stop-service. To be a one-stop-service made it possible for the patients to get all the help they needed at the same place. This is seen as a success factor in HIV prevention in adolescents since this group can find it difficult to navigate in healthcare settings and have to go to different clinics where they have to tell their story all over again. Easy access to prevention and health care is an important factor in order for people to seek health care when needed. One-step-services could advantageously be implemented in several healthcare facilities to make healthcare more accessible and convenient for the patient.
The results of this study showed the need for specialized adolescent care as a separate health care section in Thailand, however, this can also be clinically relevant in Sweden and in other parts of the world. In both Thailand and Sweden there are separate health care sections for children and elderly, but no section for adolescents and young adults. The results of this study showed that adolescents, being in a special time in life both identity-wise but also sexually, had an increased risk of retrieving HIV, as they were not aware of their risks. In addition, the results showed that many adolescents suffered from mental illness and depression, which also shows that adolescents and young adults are a vulnerable group in society in terms of health. It can therefore be necessary for adolescents to receive relevant information on their risks and receive specific care in terms of mental health and this can be done advantageously by persons who work with adolescents in specialized health care settings for adolescents. Furthermore this study showed that adolescents found it difficult to access care due to difficulties navigating in health care settings and limited time and money. Adolescents being a vulnerable group in society in terms of health and not knowing where one can get help nor have the time or money to access care, show an increased need for creating a specialized health care section for adolescents where these factors are taken into consideration.

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REFERENCES


Brinkmann, S., & Kvale, S. (2018). Doing interviews (2nd ed.). The SAGE Qualitative Research Kit


APPENDIX A

INVITATION TO PARTICIPATE IN STUDY

INFORMED CONSENT FORM

Researchers Name: Hanna Torres Milander & Saga Roos Redemo  
Contact: xxxxxxxxxxx@hotmail.com, xxxxxxxxx@gmail.com  
University: Sophiahemmet University  
Program: Nursing  
Address: Valhallavägen 91, 114 28 Stockholm, Sweden

Purpose of the study
You are invited to participate in a bachelor’s thesis research study. The aim of this study is to examine HIV prevention work in children, youths and young adults in Thailand, by interviewing various professions working with HIV-prevention. This study will examine a non-profit organization and a researchers group working with HIV prevention.

Procedure
If you consent to participating in the study you will be asked to answer questions about your work with HIV prevention. The interview will be audio-recorded.

Risks
We will have adequate safety practices which means that our records of interviews and written information are protected and will not be accessible to unauthorized persons. When the interviews have been transcribed, we will delete the recordings. We will treat the information with confidentiality which means that in the study we will refer to the participants as interviewees. The results will be presented at group level – which means it will be presented in a way that unable identification of single participants. To uphold confidentiality, the organization or the research group will not be referred to by name.

Benefits: There will be no direct personal benefit with your participation. However, we hope that the information obtained from you and this study may lead to a greater understanding of the work with HIV-prevention in Thailand.
APPENDIX A

INFORMED CONSENT

I have read and understand the provided information. I understand that my participation is voluntary and that I am allowed to withdraw my participation in this study, at any time, without giving a reason. By signing this consent form I give consent to you to use the interview material in your bachelor's thesis research study.

I hereby consent to participating in the study.

Name: Date:
Signature:
APPENDIX B

INTERVIEW GUIDE

1. How did you start working with HIV prevention?
2. For how long have you been working with HIV prevention?
3. Can you describe your work with HIV prevention within your organization/research group?
4. What access do people living here have to HIV-prevention including information, testing and HIV treatment?
5. How would you describe the overall attitude towards HIV in Thailand?
6. In your experience of working with HIV prevention, how are people with HIV treated by the public?
7. Have you experienced in your work that HIV is associated with stigma? If so, would you like to describe further?
8. How do you work preventatively in terms of stigma and discrimination?
9. Have you experienced any limits to working preventatively against HIV? (e.g. economics, attitudes, laws, regulations). If so, would you like to describe them?
10. What are, in your experience or opinion, the success factors in the prevention work?
11. How do you reach the targeted group? (e.g. women, children, men who have sex with men, sex workers)
12. What are your ambitions regarding HIV prevention? (e.g. results, goals, changes, attitudes)
13. Is there anything further you would like to talk or tell us about?

Thank you for taking the time to participate in the interview
### APPENDIX C

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Condensation</th>
<th>Codes</th>
<th>Subcategories</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>“While we work with HIV-infected people, we also intensely educate the community about AIDS infection”</td>
<td>Simultaneously working with HIV-infected people, educating the community about AIDS.</td>
<td>Educating community</td>
<td>Access to information regarding HIV and HIV prevention</td>
<td>Success factors in HIV prevention</td>
</tr>
<tr>
<td>“And I think it's very, extremely important for adolescents because they don't have a capability to navigate themselves to get several services or they have limited money to travel or to engage to medical care as long as we can provide in one service.”</td>
<td>Adolescents are not capable of navigating to get several services and have limited money to travel or engage in medical care.</td>
<td>Adolescents incapable of navigating and have limited money.</td>
<td>Limitations of time and money</td>
<td>Barriers to HIV prevention</td>
</tr>
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</table>
“...so when people have stigma in Thai culture, “what you're going to do?” You you stop talking about it, you not let your child really explore about it, so it's blocked the education or entry point for them to get access to testing or acts for prevention because the communication between generations it's hard to occur. Is that what I see is a as a structural barriers”

<table>
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<th>“...so when people have stigma in Thai culture, “what you're going to do?” You you stop talking about it, you not let your child really explore about it, so it's blocked the education or entry point for them to get access to testing or acts for prevention because the communication between generations it's hard to occur. Is that what I see is a as a structural barriers”</th>
<th>Education or entry point to access testing or prevention for young adults, is blocked due to lack of communication between generations.</th>
<th>Lack of communication between generations</th>
<th>Stigmatization of HIV</th>
<th>Barriers to HIV prevention</th>
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<tr>
<td>“What my ambition, goal, is to see HIV as a lead program project. And research to create adolescent medicine in this country because it's. It's not, it's not… just a service and in the mentality of people to really understand adolescent and young adult it's worth a specialty. Or separate health care services”</td>
<td>Ambition of seeing HIV as a lead program project and to see the creation of adolescent medicine as a separate health care service.</td>
<td>HIV as lead program project and creation of adolescent medicine</td>
<td></td>
<td>Future directions</td>
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