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FACULTY OF ARTS AND SOCIAL SCIENCES

DEPARTMENT OF SOCIAL SCIENCES AND DEVELOPMENT STUDIES

THE INFLUENCE OF POVERTY ON THE SOCIO-ECONOMIC STATUS OF WOMEN LIVING WITH HIV IN MALAWI: A CASE STUDY OF MCHINJI DISTRICT HOSPITAL

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A Thesis Submitted to the Faculty of Arts and Social Sciences in Partial Fulfilment of the Requirement for Master of Arts Degree in Development Studies (MDS) at the Catholic University of Eastern Africa, Kenya

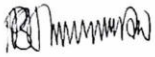
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DECLARATION

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This thesis is my original work. It has not been presented in any other University or institution of higher learning for any academic credit. All work sourced from other scholars and sources have been duly cited and acknowledged in this document.

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DEDICATION

I dedicate this thesis to my wife Violet and my two lovely children; Brian and Rejoice Henderson. I hope that this achievement will complete the dream that you had for me all these years. I am sure you are now proud of your husband and dad respectively for this achievement.

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ACRONYMS/ABBREVIATIONS

CUEA	**:**	Catholic University of Eastern Africa
SSA	**:**	Sub-Saharan Africa
HIV	**:**	Human Immunodeficiency Virus
ART	:	Antiretroviral Therapy
AIDS	**:**	Acquired Immune Deficiency Syndrome
HAART	**:**	Highly Active Antiretroviral Therapy
SES	**:**	Socio-Economic Status
DHO	**:**	District Health Office
DHS	**:**	Demographic and Health Surveys
MAP	**:**	Malawi Analytics Platform
MoH	**:**	Ministry of Health
EGPAF	**:**	Elizabeth Glaser Pediatric AIDS Foundation
SPSS	**:**	Statistical Packages for Social Sciences
WHO	**:**	World Health Organization
MK	**:**	Malawi Kwacha

ABSTRACT

For the purpose of this study, the Mchinji district hospital was used as a case study to investigate the ways in which poverty influences the socioeconomic position of women in Malawi who are living with HIV. The following objectives served as the foundation for this investigation: to determine the impact that household income has on the socio-economic status of women living with HIV at Mchinji District Hospital; to evaluate the effects that unemployment has on that status; to investigate the association between education level and that status; and to determine the impact that household characteristics have on that socio-economic status. Both the Behavioural Theory of Poverty and the Structural Theory of Poverty were used as guides throughout the research project. A mixed research method was utilized for the investigation since it provides the researcher with the opportunity to collect both qualitative and quantitative data. A combination of questionnaires and focus groups was used in the data collection process. The target population of the research consisted of 3,141 persons, and the sample consisted of 342 women who were recruited from the Mchinji District Hospital. The qualitative data was gathered via the use of focused group discussions, while the quantitative data was gathered through the use of questionnaires and analysed through the use of SPSS version 25. The findings indicated that women living with HIV who were impoverished were obliged to seek out various income-generating options. These chances included having several sexual partners and trading sexual favours, both of which are associated to earning money through selling or pawning things and working irregular jobs. Women living with HIV have a tendency to bring unregistered "helpers" to work, which puts them in risk of losing their jobs and costs employers money. This behaviour is a direct result of the negative impacts of unemployment. Regarding the correlation between the amount of education attained and the socioeconomic status of HIV-positive women, it is important to note that education provides a foundation for the growth of critical thinking, which encourages HIV-positive women to establish long-term goals for themselves. These assist women delay sexual activity, which in turn reduces their risk of becoming infected with HIV and protects them from additional infections. At Mchinji District Hospital, researchers found that the characteristics of HIV-positive women's homes had an effect on the relationships that existed between HIV-positive women's family members and themselves. It has been noticed that when a parent suffers from a chronic illness, it may change the dynamics of the family and cause others to feel guilty or furious. The Mchinji District Hospital has made the observation that the HIV awareness of the women who are living with HIV is having a negative influence in the sense that getting a diagnosis has substantial economic ramifications, such as the loss of a job, which may lead to a decline in or loss of wages for the family. According to the findings of the study, women who were surviving in low-income situations need financial aid. As a direct consequence of this, their risk of being infected with HIV will be reduced. For one thing, such interventions may minimize the need for them to stay in an abusive relationship or engage in sexual activity motivated by financial gain.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

In this part, the study's background, issue statement, research goals, study scope, conceptual framework, and potential study limits are described.

1.1 Study Background

Despite comprising more than half of the world's population, women confront discrimination in numerous spheres of life and are more likely than men to encounter problems in a variety of contexts (Daraz, 2015). It is undeniable that women are a particularly vulnerable group in society (Bari, 2016). Women have roles to perform in the economy, politics, and society. Sustainable development depends on empowering women and giving them the tools, they need to actively engage in and contribute to social, economic, and political activities. In America, the subject of women empowerment was often taken into consideration while developing policies or programs to address socioeconomic problems (UNDP, 2013).

According to the UN (2017), women contributed significantly to the economic development of society, accounting for between 7% and 76% of all development. While in other affluent nations it also impacted younger women, many of whom were still raising children, it particularly affected women in Britain, where they made up 65% of the workforce. Poverty has forced women to comply with patriarchal religious and customary norms and face discrimination in regard to inheritance rights across a broad variety of cultures. Many of these poor women experienced family member violence and exploitation, sometimes as a result of property disputes. Few instances made it to the end of the legal process; some offenders walked free while others went unreported. The loss of social standing and marginalization of

socioeconomically disadvantaged women occurred even in nations with more broad legal protection.

Because of their lack of social, economic, and political capital in China, women were not able to benefit from the same possibilities as males from the economic reform. The Chinese government has provided much-needed assistance to women to arrest the fall in an effort to develop China as a progressive nation. For instance, to safeguard women's rights, the government passed new laws, including the hotly contested one that penalized males who had extramarital relationships in divorce settlement (Mikkola, 2016). It also introduced quotas for women in the advancement of government officials. Extremely poor girls received assistance in finishing their education. Chinese women, meanwhile, still had a long way to go.

According to United Republic of Tanzania (2017), women in Tanzania contributed significantly to the country's economy and were more involved in agriculture, which employs 82 percent of the labour force. 16.9 million of the 17.8 million economically active persons were categorized as being employed, with women making up 50.6 percent of this group. In comparison to males, who had a labour force participation rate of 79.6 percent, women had an overall rate of 80.7 percent (United Republic of Tanzania, 2017). Unlocking women's economic potential required access to land, workspaces, and resources for production, but despite encouraging land reforms, Tanzania's land tenure system still discriminates against women due to their socioeconomic level, traditional beliefs, and customary rules. This was especially true when it came to inheritance and situations involving a spouse's death or divorce. According to estimates from IFAD (2015), women owned roughly 19 percent of registered land, and their plots were much smaller than those of their male counterparts (0.21-0.30 ha vs. 0.61-0.70 ha).

According to UNAIDS (2008), the majority of HIV-positive women worldwide reside in the third world, where extreme poverty is pervasive. According to UNAIDS (2008), out of

the 79.3 million persons who have contracted HIV, 50% are women, with 60% living in sub-Saharan Africa, 45–50% in the Caribbean, 30–40% in Asia and Latin America, and 30% in Eastern Europe and Central Asia. Sub-Saharan Africa, a low- and middle-income area, continues to have the highest rate of HIV infection worldwide. According to Cohen (2006), the infection is more prevalent among women than males in this area and is concentrated in the socially and economically active groups of people between the ages of 15 and 45.One of the highest rates in the world is reported to be 19.8% in Malawi among pregnant women visiting prenatal clinics. A further estimate puts the number of HIV-positive adults and children at 1,000,000. In Malawi specifically, 10.8% of women and 6.4% of men aged 15 to 49 have HIV/AIDS, making up 8.8% of the population (WHO, 2021). Additionally, 34 000 new HIV infections are estimated to occur annually. Contrary to common epidemiological belief, higher socio-economic status (SES) persons tend to do better on the majority of health metrics (Reither and Mumah, 2009), wealthy women have a greater risk of developing HIV than poorer women. Due to socioeconomic conditions, in Malawi, more than 50% of women are HIV positive. Masanjala (2007) makes the case that poverty may be to blame for the high prevalence rate.

Although the Ministry of Health and Population (MOHP) of Malawi's government attempted to implement a national HIV program that included HAART in 54 hospitals across the nation, including all 23 MOHP district hospitals, in order to increase employment, improve the infrastructure of the health sector, and provide education to her population, it is unclear whether these efforts had any impact on the socioeconomic status of women living with HIV at Mchinji district hospital in Malawi. Socioeconomic characteristics have been demonstrated to be significant determinants of HIV transmission and treatment. The regional heterogeneity of the HIV pandemic in sub-Saharan Africa has been the subject of much study (Cuadros et al., 2017; Dwyer-Lindgren et al., 2019; and Schaefer, 2017).

There had been no regional studies conducted in Malawi on how poverty affected the socioeconomic standing of HIV-positive women. Regarding this, the research makes the assumption that higher socio-economic status (household characteristics, family income, job status, and educational attainment) may lead to a lower HIV prevalence as well as higher levels of health and wellbeing for women living with HIV. This research examined the impact of poverty on the socioeconomic status of women living with HIV at Mchinji District Hospital based on household characteristics, household income, unemployment, and education level (Independent Variables).

1.2 Statement of the Problem

The frequency and incidence of female vulnerability in Malawi are significantly influenced by their socioeconomic level (SES), which always plays a significant effect. Through greater access to land, financial resources, education, and skilled employment, women should get the same assistance as men to successfully engage in the key production sectors. The World Bank (2016) observes that despite the fact that women make up a significant share of the population in all civilizations, thorough research on their position in developing nations is limited, with a few commendable exceptions. Despite efforts by the Malawian government to include women's rights in the constitution, these rights were not explicitly stated, and women continued to experience oppression in the patriarchal culture of Malawi.

According to Riley, Gandhi, Hare, Cohen, and Hwang (2017), socio-economic status encompasses more than simply a person's monetary assets; it also takes into account the individual's degree of education, financial stability, and self-perceptions of their place in society. This information comes from Latkin, German, Vlahov, and Galea (2013). Poor women in Malawi have reduced access to health care, education, and professional prospects, as well as knowledge about HIV, as a result of the precarious financial positions in which

they find themselves. They also have less ability to negotiate safer sexual behaviors inside their close relationships, which makes it more difficult for them to do so. At the Mchinji District Hospital, women often had lower levels of educational attainment, lower rates of literacy, lower salaries, and more restricted property rights than men did. They fell into poverty as a result, and the situation in families run by women was much more dire. At Mchinji District Hospital, there was always a social and economic imbalance that disproportionately harmed women of a lower socioeconomic level (Pellowski, Kalichman, Matthews, & Adler, 2014). This was a problem that plagued the hospital throughout its history. There is a correlation between a lack of available socioeconomic resources and the adoption of risky health behaviors that may lead to HIV infection. According to Pellowski et al. (2013), using drugs is one of the activities that lowers the likelihood of someone using a condom.

The HIV/AIDS epidemic poses a major public health crisis for numerous developing countries, particularly those in Sub-Saharan Africa. Reither, Eric, and Joyce (2019) reported that a significant number of individuals in Sub-Saharan Africa are affected by the disease, with an estimated 25 million people being infected. Additionally, in 2016, there were over 2.8 million documented cases of the disease in the region. The illness has tragically claimed the lives of more than 2.1 million people, highlighting its alarming severity. A significant proportion of individuals worldwide who are affected by HIV/AIDS are women, as they are more susceptible to contracting the disease. In contrast, Western nations typically have percentages that fall below 10% of their total population. Young, Wheeler, McCoy, and Weiser (2014) highlight Malawi as an intriguing case study within the western region due to its comparatively high prevalence of HIV infection, particularly among women, when compared to other countries in the same area.

Research has been conducted on the socioeconomic status of women who have HIV; however, in the specific case of the Mchinji district hospital, the study on the impact of poverty on that status in relation to household income, unemployment, education level, and household characteristics remains undermined and undocumented. This is because the study on the impact of poverty on that status in relation to household income, unemployment, and household characteristics has not been completed. It was essential to fill this gap in the existing body of literature. The objective of this study is to address the gap in current knowledge by examining the impact of poverty on the socioeconomic status of women who are living with HIV in Malawi. Specifically, the research will focus on the Mchinji district hospital as a case study. By conducting this investigation, we aim to shed light on the relationship between poverty and the socioeconomic circumstances of these women in order to contribute to a better understanding of their experiences.

1.3 Research Objectives

The overall objective of the study examined the influence of poverty on the socio-economic status of women living with HIV in Malawi: a case of at Mchinji district hospital.

1.3.1 Specific objectives

The study addressed the following specific objectives:

1. To determine the influence of household income on the socio-economic status of women living with HIV at Mchinji district hospital.
2. To evaluate the consequences of unemployment on the socio-economic status of women living with HIV at Mchinji district hospital.
3. To examine the relationship between education level and socio-economic status of women living with HIV at Mchinji district hospital.
4. To identify how household characteristics, affect socio-economic status of women living with HIV at Mchinji district hospital.

1.3.2 Research Questions

The study sought to answer the following questions:

1. What influence does income had on the socio-economic status of women living with HIV at Mchinji district hospital?
2. What are the consequences of unemployment on the socio-economic status of women living with HIV at Mchinji district hospital?
3. How does education level affect the socio-economic status of women living with HIV at Mchinji district hospital?
4. How do household characteristics affect the socio-economic status of women living with HIV at Mchinji district hospital?

1.4 Research Assumption

According to the research, HIV prevalence among women with low socioeconomic level grows and negatively impacts their health and wellbeing. The research also makes the assumption that poverty is pervasive in developing nations and that the majority of those impacted are women who are HIV-positive. The research makes the assumption that since HIV-positive persons endure widespread stigma, it will be difficult to get accurate information during interviews with respondents. As a result, many of them may be reluctant to discuss their experiences.

1.5 Justification of the Study

In this research, the socioeconomic situation of women living with HIV in Malawi was evaluated in the context of the Mchinji district hospital. In every nation's progress, women are essential. But there are elements that influence their beneficial impact on development (Masanjala 2007; UNAIDS, 2021). The socioeconomic situation of women living with HIV at Mchinji District Hospital was the main focus of the research, which also looked at the effects of family income, unemployment, education level, and household

features. Findings showed that poverty forced women living with HIV to explore for different income-generating opportunities, including having several sexual partners and trading sexual favours, which are connected to earning money through selling or pawning possessions and working irregular jobs. Due to unemployment, women living with HIV tend to bring unrecorded 'helpers' to work, which puts them in danger of losing their jobs and causes a financial strain on employers. Regarding the association between education attainment and socioeconomic standing of HIV-positive women, education offers a framework for the development of critical thinking, which motivates them to set long-term objectives. These aid in postponing sexual activity, helping these women prevent further HIV infection and lowering susceptibility. Relationships between family members and women living with HIV were shown to be impacted by the household features of HIV-positive women at Mchinji District Hospital. The research concluded that women who were living in poverty needed economic assistance. They will be less susceptible to contracting HIV as a result. These treatments could lessen the need for them to continue in abusive relationships or have transactional sex.

Based on the results, it is clear that this research was crucial since it would enable policymakers and other stakeholders to particularly intervene in the economic position of women living with HIV/AIDS. Like any other academic study, this one is crucial for the discovery of new information since it not only adds to the body of knowledge already available on HIV/AIDS but also motivates other academics to do more research.

The research will support the adoption of policies that take into account the socio-welfare of women by governmental, non-governmental, and other entities. The organizations will be aware of the socioeconomic factors, customs, and guidelines that are most beneficial to women's wellbeing. Additionally, by including a suitable and supportive atmosphere for

women, the research will aid society in gaining from the corporate social obligations supplied by women.

1.6 Significance of the Study

The results of this research were supposed to aid women in the study region in creating more effective plans to improve their economic standing. It will be made easier for participants in gender empowerment, particularly policymakers, to refocus their choices on improving the economic standing of women. The study's results, particularly those that are published in reputable publications, will add to the body of knowledge concerning the economic condition of women and provide a solid groundwork for future research.

1.7 Scope and Delimitation of the Study

The study was carried out at Mchinji district hospital. It examined the influence of poverty on the socio-economic status of women living with HIV in Malawi: a case of Mchinji district hospital. Study target population was 3,141 and a sample size of 342 of women at Mchinji district hospital was used. Four variables focused were: influence of household income, unemployment, education level and household characteristics on socio-economic status of women living with HIV at Mchinji district hospital. Respondents were drawn from women living with HIV at Mchinji district hospital. Data that was collected was strictly on women living with HIV at Mchinji district hospital and should cautiously be generalised to other countries in Africa where there may be other peculiar underlying factors not common to the area of study.

1.8 Limitation of the Study

The Mchinji District Hospital was the only study location. It was anticipated that financial resources and time would be very constrained, which may prevent complete research since the study participants had to travel great distances, there was a weak transportation network, and there was a large sample population. Due to their lack of research

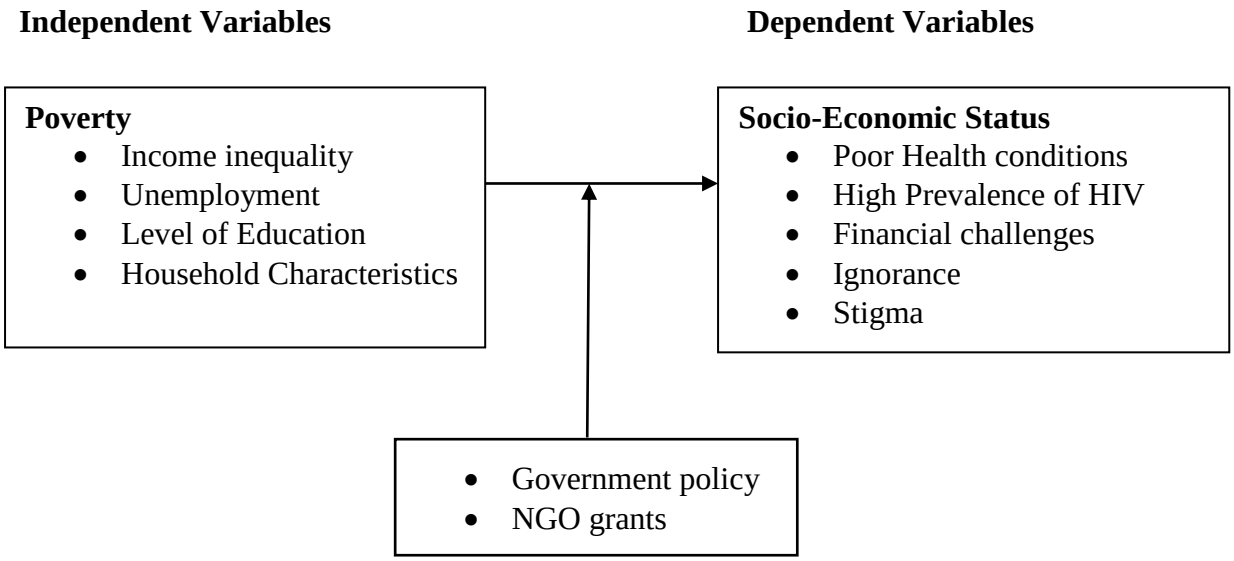
involvement experience, respondents' lack of collaboration would restrict the study. It was anticipated that some women could regard this study as an opportunity for the researcher to further mock them given the stigma they had endured over the years. The researcher did their best to explain the study's objectives to them, nevertheless. The study's sample size, calculated using the Krejcie and Morgan (1970) method, was 342 out of 3,141 women.

1.9 Conceptual Framework

This study puts into conceptualisation that the dependent variable depends on the independent variable. This implies that poverty caused by income inequality, unemployment, level of education and household characteristics is considered the independent variable which has influence on dependent variables (socio-economic status of women living with HIV at Mchinji district hospital). Income inequality of women leads to poor health as women on ARVs need to eat balanced diet which they cannot afford if they are in abject poverty, unemployment leads to unstable income, stress, anxiety, stigma, increase in crime rate etc which may affect the uptake of ARVs among women who some are breadwinners and on level of education; higher level of education leads to better understanding on how ARVs work, high chances of employability.

Hence, this study as an important initiative looked for the findings and recommend solution to poverty created by income inequality, unemployment, level of education and household characteristics on the socio-economic (poor Health conditions, high prevalence of HIV, financial challenges, ignorance and stigma) status of women living with at Mchinji district hospital, through the intervention of the concern from the non-government Organizations (NGOs) and the government of through policies and grants.

The relationship between the dependent and independent variable and the intervening variables illustrated in Fig 1.1 below.



Source; Researcher (2023)

Figure 1.1: Figure 1 Conceptual Framework

1.10. Operational Definition of Terms

Income inequality: refers to differences in income earnings as a result of economic activities, which stratify women into ultra-poor, poor and better off.

Unemployment: refers to women not involved in any formal jobs in public service or private (however they could be doing small scale businesses earning less than a dollar per day).

Level of education: refers to the status of attaining formal education either primary, secondary or tertiary which has a bearing on one's involvement in economic and developmental activities.

Poverty: When an individual or a group faces a situation where they do not possess the necessary means for basic sustenance, it can be described as a state of poverty. Insufficient resources to meet fundamental needs such as nourishment, clothing, and shelter are indicative of poverty. However, poverty encompasses more than just a financial deficit.

Socio-economic status: A word that describes a person's place in society according to a variety of vocational, economic, and educational characteristics.

CHAPTER TWO

LITERATURE REVIEW

2. 0. Introduction

The important theoretical and empirical research on how poverty affects women with HIV's socioeconomic position is presented in this section. The first part of the section examines the study's theoretical foundation, which includes ideas of poverty. The next sections will examine female HIV prevalence and the connection between HIV prevalence and poverty. Finally, the segment looked at empirical research on how poverty affects HIV prevalence.

2.1. Critical Review of Relevant Theories

The Behavioural Theory of Poverty and the Structural Theory of Poverty served as the study's guiding theories.

2.1.1 Behavioral Theory of Poverty

According to this theory, behaviour plays a central role in causing poverty. It suggests that individuals living in poverty often engage in risky behaviours such as unemployment or unproductive activities (Bertrand et al. 2004, Durlauf 2011). The prevalence of these behaviours contributes to the widespread occurrence of poverty in certain communities.

Most behavioural theories highlight two primary factors influencing behaviour: incentives and culture. When discussing incentives, scholars emphasize the rational choices made by individuals pursuing their goals, which can sometimes lead to detrimental behaviour. In the case of culture, the focus is on the belief systems and behavioural patterns that shape the actions of individuals living in poverty (Bertrand et al. 2004; Durlauf 2011). Research into the origins of poverty often takes into account the interactions between incentives and culture.

The concept of the "culture of poverty" refers to a group of individuals living in impoverished areas or disadvantaged social conditions who share a common set of values, beliefs, and behavioural norms that differ from those of the broader society. In the context of community development, initiatives aimed at reducing poverty must work to transform these cultural values and attitudes if they are considered a theoretical cause of poverty.

2.1.2 Structural Theory of Poverty

Regarding poverty, another school of thinking emphasizes social and economic inefficiencies. Theorists in this paradigm focus on the economic and social institutions that restrict people's possibilities and resources to obtain income and well-being rather than cultural beliefs as the root of poverty. First, research on poverty reveals that, despite their potential competence, poor individuals lag behind because of the way the economy is set up. The inability of certain groups of individuals, such as women, persons with disabilities, or their families to be financially independent is part of the issue (Jencks, 1996). The social stigmatization of some groups of individuals due to their colour, gender, handicap, religion, or other affiliations also falls under the general category of system defects linked with poverty, which results in them having few chances regardless of their own talents. Without admitting that populations that are the targets of discrimination, notwithstanding legal safeguards, have restricted possibilities, no discussion of poverty can be considered thorough. According to academics, rather than the poor themselves, it is the systems that cause poverty, hence changing the systems must be a goal of community development. There are three levels at which the systems may be altered. Social movements have the ability to exert pressure on vulnerabilities within the system at the community level in order to drive the desired transformations. According to Rank (2004), it is possible to strategize change efforts that aim to enhance employment opportunities for those in need, even when a majority of research findings suggest a decline in support for the social initiatives of disadvantaged

individuals. The women's movement and civil rights movements, for instance, have made substantial contributions towards eliminating official constraints and barriers.

2.2 Concept of Human Immunodeficiency Virus (HIV)

HIV specifically targets the immune system, making it challenging for individuals to effectively protect themselves against various illnesses and cancers that a healthy immune system can typically handle (World Health Organization [WHO], 2021). Infected individuals gradually experience a decline in their immune function as the virus both kills immune cells and hampers their activity. The evaluation of immune function often involves monitoring CD4 cell counts. The progression to acquired immunodeficiency syndrome (AIDS), which represents the most advanced stage of HIV infection, may vary in duration from person to person. AIDS is characterized by the emergence of specific tumors, infections, or other severe long-term clinical symptoms.

HIV remains a significant global public health concern, with an estimated death toll of 36.3 million people (27.2-47.8 million) thus far. It's important to note that HIV infection remains incurable. However, advances in comprehensive HIV prevention, diagnosis, treatment, and care, including management of opportunistic infections, have enabled individuals living with HIV to enjoy extended and healthy lives. In the year 2020, approximately 1.5 million people (1.0-2.0 million) contracted HIV, resulting in 680,000 deaths (480,000–1.0 million) attributed to HIV-related causes.

According to the World Health Organization (WHO) in 2021, it is imperative to intensify efforts in order to avert a dire scenario that includes the projection of 7.7 million HIV-related deaths over the next decade. This alarming outlook stems from the increase in HIV infections due to disruptions in services caused by the COVID-19 pandemic, as well as a lacklustre public health response to the HIV crisis.

2.3 Concept of Gender and Women empowerment

Compared to their male counterparts, women worldwide encounter limited opportunities for economic participation, reduced access to primary and secondary education, heightened health and safety risks, and diminished political representation. Safeguarding women's rights and affording them the opportunity to fully realize their potential are essential steps toward achieving gender equality and various international development goals. Society benefits collectively when women and girls are equipped with the tools necessary to enhance themselves.

Genuine gender equality necessitates equal authority and access to opportunities for personal growth, education, and financial independence for both genders (UNFPA, 2020). A critical aspect of attaining gender equality revolves around empowering women, which encompasses enhancing their self-esteem, decision-making capacity, access to resources and opportunities, autonomy, and influence over their lives, both within and outside the family, as well as their ability to instigate change (UNFPA, 2020).

It's important to note that addressing gender issues extends beyond women; it also encompasses examining how men and women interact within society. Achieving gender equality hinges on the behaviour and attitudes of both men and women, making the involvement of men and boys crucial in this endeavour.

2.4. Review of Empirical Studies

Women living with HIV in their communities encounter various challenges. In general, a woman's susceptibility to HIV and her quality of life while dealing with the virus can be influenced by a range of factors, both biological and non-biological (Rodrigoa and Rajapakse, 2010).

Scientific research indicates that HIV transmission is more likely to occur from men to women compared to the reverse scenario. This discrepancy may be attributed to higher

viral loads in semen, increased male-to-female transfer of genital fluids, and heightened exposure of the vaginal epithelium during sexual intercourse. Females encounter certain biological challenges related to gender-specific health concerns, such as gynaecological infections and the presence of precancerous lesions in the vaginal and cervical regions. Moreover, pregnancy presents a considerable obstacle, as it has been linked to increased maternal death rates in HIV-positive women. These higher mortality rates can be attributed to various factors related to childbirth itself, as well as complications that arise indirectly.

There is ongoing research focused on exploring gender-specific differences in the efficacy, side effects, safety, and metabolism of antiretroviral drugs. This area of study aims to understand how these medications may affect individuals differently based on their gender. While there are currently no specific guidelines based on gender for starting and managing highly active antiretroviral treatment (HAART), recent studies indicate that there may be variations in the side effects experienced by males and females. Women patients have a higher likelihood of developing certain medical conditions, including lactic acidosis, lipodystrophy, and glucose metabolism problems.

Biological factors have a universal impact on women across the world, while non-biological factors differ among various societies. Based on the research conducted by Rodrigoa and Rajapakse (2010), it has been found that women in specific countries experience significant challenges due to severe poverty, societal norms that restrict their independence, increased instances of violence, and limited access to education and employment opportunities. It is crucial to thoroughly examine these non-biological factors, as they have the potential to be modified and prevented.

In the region of sub-Saharan Africa, there are four countries namely Zimbabwe, Botswana, Lesotho, and Swaziland, where the prevalence of HIV among adults is higher than 20%. Additionally, there are six other countries, namely South Africa, Namibia, Zambia,

Mozambique, and Malawi, where the rates of HIV prevalence among adults exceed 10%. It is a valid argument to state that HIV poses a substantial health challenge in underdeveloped nations, considering the heavy impact of this disease in these specific areas. Nevertheless, it is essential to thoroughly analyse the complex correlation between HIV and poverty. There is currently a significant emphasis on comprehending the interplay between women, HIV, and poverty, which is attributed to the increasing prevalence of the pandemic among women.

2.4.1 Household Income and Socio-economic Status of Women Living with HIV

Within the field of social epidemiology, a recurring finding is the existence of a negative relationship between socio-economic status (SES) and health outcomes. Research has indicated that individuals with a lower socioeconomic status (SES) are more likely to experience a range of health issues, diseases, and higher mortality rates. Recent research has revealed that... Conversely, communities that experience higher levels of prosperity often exhibit better health outcomes in different aspects, including access to healthy food, rates of illnesses and mortality, and utilization of healthcare services. This correlation holds true for both individuals and societies, not only in affluent nations but also in emerging economies.

Epidemiological studies have provided support for the correlation between socioeconomic status (SES) and the risk of HIV infection in developed countries, as discussed by Okigbo et al. in 2002. The impact of socio-economic status on the prevalence of HIV/AIDS is widely acknowledged. Studies have shown that people from disadvantaged socio-economic backgrounds are at a higher risk of experiencing various health issues, such as HIV/AIDS. Consequently, underprivileged communities in developed nations often experience a greater incidence of HIV. The phenomenon of this pattern is particularly evident in the African American and Hispanic communities, where individuals frequently encounter economic challenges that are linked to a higher occurrence of HIV/AIDS. Furthermore,

people who experience financial disadvantages may face considerable challenges in adopting safe sexual behaviours (Okigbo et al., 2002).

Regions with lower socioeconomic status (SES) often experience higher rates of HIV infection and AIDS-related mortality, both at a global and regional level. Sub-Saharan Africa is a region that is characterized by several unique factors that set it apart from other areas. This country is recognized for having the lowest Gross Domestic Product (GDP) globally, along with the highest rates of HIV prevalence worldwide. Furthermore, over 60% of the population in this area manages to sustain themselves with less than $1 USD per day, indicating the presence of considerable economic difficulties (Mbirimtengerenji, 2007; Whiteside, 2002). For instance, a study conducted by Mishra and his team in 2007 explored the relationship between socioeconomic status and the risk of acquiring different sexually transmitted diseases (STDs). Their study aimed to offer a thorough examination of the techniques employed in gathering national-level HIV prevalence data through the utilization of Demographic and Health Surveys (DHS). They emphasized the significance of this data in monitoring the HIV epidemic on a national scale. The study focused on administering HIV tests to adult men and women across various nations. The findings indicated variations in the prevalence of HIV across the surveys, with an average rate of 16%. Nonetheless, the research consistently identified comparable patterns in the prevalence of infections when considering variables such as age, gender, and residency in urban or rural regions. Although there was a slight inclination towards higher projected HIV prevalence among individuals who did not undergo testing, an examination of non-response bias indicated that it had a negligible effect on the recorded national estimates of HIV prevalence. Based on this research, it is suggested that the high occurrence of HIV in these regions is linked to challenging economic conditions.

However, the relationship between socioeconomic status (SES) and HIV infection is complex and varies across different geographical areas. It is not always the case that the countries with the lowest economic status in a specific region will necessarily have the highest rates of HIV prevalence. Consider Botswana and South Africa as prime examples of economically successful African nations. These two countries have managed to achieve remarkable levels of prosperity within the continent. Unfortunately, they also encounter considerable obstacles when it comes to the prevalence of HIV. The correlation between socioeconomic status (SES) and HIV infection is less pronounced in regions with lower economic development when compared to wealthier countries like the United States.

Wojcicki (2005) conducted a comprehensive study that examined 35 distinct research studies investigating the correlation between socioeconomic status (SES) and HIV status in different countries across Sub-Saharan Africa. The analysis included a total of 30 cross-sectional studies and five cohort studies, offering significant and valuable perspectives on this crucial subject matter. Among the numerous research studies conducted, it has been observed that seven of them have identified a connection between households with lower socioeconomic status (SES) and an increased vulnerability to HIV infection. In contrast, there were ten studies that found a positive correlation, suggesting that higher socioeconomic status (SES) within households was associated with a higher risk of contracting HIV. In addition, another independent research study found different outcomes regarding the impact of marital status. Additionally, twelve other studies have consistently concluded that there is no substantial link between socioeconomic status (SES) and the risk of contracting HIV. Among the cohort studies that were examined, it was found that three of them did not establish any link between high socioeconomic status (SES) and HIV infection. On the other hand, one study revealed a positive correlation, suggesting a potential association between high SES and HIV infection. Interestingly, another study uncovered a negative association, implying

that high SES might actually be linked to a lower risk of HIV infection. These findings highlight the complexity of the relationship between socioeconomic status and HIV infection, warranting further investigation and analysis. Limited research studies have been conducted in Sub-Saharan Africa to investigate the relationship between local socioeconomic status (SES) and the risk of HIV. The findings of these studies have been inconsistent and inconclusive.

The scarcity of crucial resources like food and water appears to play a significant role in the elevated mortality rates associated with HIV in different communities across Sub-Saharan Africa. The limited availability of resources exacerbates the problem of malnutrition and compromises the strength of the immune system, rendering individuals more susceptible to various illnesses. The unequal distribution of antiretroviral medications, crucial for HIV treatment, may play a role in the higher mortality rates observed in specific communities. Lower-income communities often face challenges in accessing healthcare services and professionals, leading to limited availability of crucial information that could aid in reducing the transmission of diseases. In regions with limited transportation options, individuals residing in rural areas may choose not to seek medical help, especially if it interferes with their primary source of income, such as farming (Ngwakongnwi and Quan, 2009).

The relationship between socioeconomic status (SES) and HIV becomes increasingly intricate when analysing it on an individual level. Numerous research studies carried out in Sub-Saharan Africa have consistently revealed a strong association between socioeconomic status (SES) and the likelihood of acquiring HIV. Numerous research studies have consistently demonstrated that individuals who come from less advantaged backgrounds are at a higher risk of contracting HIV when compared to those who are more financially privileged. Some argue that individuals who are less fortunate may possess knowledge about recommended behaviours, but they often encounter obstacles such as limited resources and

lack of motivation to put them into practice (Booysen and Summerton, 2002; Mbirimtengerenji, 2007). According to Fenton's research (2004:1186), poverty has been identified as a major contributing factor to the heightened vulnerability of individuals to HIV/AIDS. According to a publication in The Lancet, Fenton emphasizes that individuals living in poverty are exposed to conditions that increase their vulnerability to certain diseases. This conclusion highlights the significant connection between poverty and the increased vulnerability to HIV/AIDS.

2.4.2. Unemployment and Socio-economic Status among Women Living with HIV

The assessment of occupational status is impacted by an individual's theoretical viewpoint on the importance of various aspects of their work-life. This makes it a multifaceted element of socioeconomic status (SES), according to Adler and Newman (2002:64). Multiple research studies have explored the correlation between employment status and health outcomes in relation to the HIV/AIDS pandemic

Studies have shown that people working in low-income jobs in Sub-Saharan Africa, such as waiters, bartenders, and individuals involved in commercial sex work, are more susceptible to HIV infection due to their interactions with travellers (Wojcicki, 2005). In addition, studies have shown that there is a higher occurrence of HIV infection among African individuals who work as migrant laborers, truck drivers, or driver's assistants (Mosoko et al., 2009; Wojcicki, 2005).

Additionally, the impact of occupational status in relation to gender could potentially be influenced by other factors. A study conducted by Msisha et al. (2008) found that women in professional occupations had the highest prevalence of HIV infection, while unemployed males were more susceptible to being HIV positive. There is a viewpoint suggesting that professional women might have a higher vulnerability to HIV infection due to their involvement with wealthy men who engage in risky behaviour (Msisha et al., 2008).

According to a study conducted by Msamanga et al. in 2006, it was discovered that there was a higher occurrence of HIV infection among women who had their own source of income. This could be attributed to their associations with successful men who also had a high prevalence of HIV infection.

2.4.3 Education Level and Socio-economic Status of Women Living with HIV

There is a widespread perception that education is one of the most important factors in determining future career opportunities as well as prospective income, making it a critical component of socioeconomic status (SES). Research that was carried out in sub-Saharan Africa (SSA) showed a significant association between the level of education one has and the rate at which HIV/AIDS is prevalent. According to the conclusions of the research conducted, there is a connection between finishing one's secondary school and lower rates of HIV infection. The association is clearer when looking at data from females. According to the findings of a research project that was carried out by Lopman and colleagues in 2007, there is a connection between greater levels of education and a decreased risk of having partners who are HIV-positive. This points to the possibility that education might play a role in lowering the risk of HIV transmission between partners in romantic relationships. Several research studies have been conducted in several African nations, including Tanzania, South Africa, Cote d'Ivoire, Cameroon, and Uganda, amongst others. When it comes to marriage, these studies have repeatedly demonstrated that persons with higher salaries are more inclined to place an emphasis on education and look for spouses who also have educated backgrounds. Numerous research studies have been conducted to study the association between educational attainment and the prevalence of HIV in both males and females. These studies have been conducted in both developed and developing countries. It is important to keep in mind that various investigations have arrived at contrasting conclusions. Several research studies have been conducted to investigate the connection between the amount of education and the

prevalence of HIV, and these investigations have produced a variety of findings. Some studies have not shown any significant association between greater education and the rates of HIV infection, whereas others have found that the probability of catching HIV decreases with each additional year of education. These results shed light on the complicated dynamics that exist between education and HIV, highlighting the importance for future study to get a thorough knowledge of the underlying mechanisms at play in this relationship. Education seems to have a considerable influence on decreasing the risk of HIV transmission, according to the primary conclusion obtained from a number of research investigations (Barnighausen et al., 2007; Gillespie, Kadiyala, and Greener, 2007; Glynn et al., 2004; Lopman et al., 2007; Msisha et al., 2008). This finding was derived from numerous research studies.

Those who have achieved a greater level of formal education are often seen to have more favourable possibilities for learning information, accessing resources, and adopting better lifestyle choices in comparison to those who have completed a lower level of formal education or have no formal education at all (Adler and Newman, 2002). However, several research studies have discovered a connection between higher education levels and an increased risk of HIV infection, particularly in various countries in Eastern and Southern Africa (Glynn et al., 2001; Hargreaves and Glynn, 2002; Johnson and Way, 2006; Reither and Mumah, 2009). This correlation is very similar to the correlation that exists between wealth and the susceptibility to HIV. It is important to note that Johnson and Way (2006) did research that revealed there was no significant difference in the risk of developing HIV between those who had finished secondary school or higher and those who had not pursued any type of formal education. The results of this study can be seen here. The findings of this study put light on the fact that the level of education a person has does not necessarily play a role in the spread of HIV. In addition, recent studies have shown that those who have

completed just a basic school are twice as likely to get infected with HIV as those who have no formal education at all.

An intriguing investigation on the link between women's educational attainment in Cameroon and the rate of HIV infection within the population of the country was carried out by Reither and Mumah in 2009. The research was published in 2009. The results of their investigation showed that there is a clear link between these two aspects. According to the results of the study, there is a link between a rise in the percentage of women who have obtained higher education and a greater vulnerability to HIV infection. This conclusion is supported by the fact that the proportion of women who have acquired higher education has increased over time. There is a possibility that communities that have the opportunity to participate in primary school education may face HIV risk factors that do not exist in communities that do not have access to educational opportunities. There are many different facets to the link between an individual's socioeconomic level (SES) and the risk of contracting HIV. Glynn et al. (2004), Hargreaves and Glynn (2002), and Msisha et al. (2008) all found that the link between higher levels of education and a lower risk of HIV infection did not always hold (despite the fact that other studies have shown a correlation between higher levels of education and a higher risk of HIV infection). This finding contradicts the findings of earlier study that found a correlation between higher levels of education and a lower risk of HIV infection. Several researchers [Glynn et al., 2004; Hargreaves and Glynn, 2002; Msisha et al., 2008] looked at this issue and came to different conclusions.

It is becoming clearer that the link between money, education, and the possibility of contracting HIV may not be as straightforward as was at first assumed. Alternately, it is likely that these characteristics are directly connected to one's job position, in particular in professions that give more flexibility or higher opportunity to engage in sexual encounters with prospective partners. This is especially true in occupations that allow for greater

personal autonomy. Mishra and his colleagues noticed, in their research that they carried out in 2007, that those who had greater earnings tended to travel more often than those with lower incomes. Because of this increased travel, the chance of participating in sexual encounters of a non-committal kind is raised. According to findings from recent studies carried out by Mishra et al. (2007b) and Wojcicki (2005), it has been seen that people from Africa, regardless of their gender, who have gone to central Africa, Europe, or North America have a tendency to participate in activities that entail a higher degree of risk. These findings are based on observations that have been made. The investigation was carried out in a number of different areas, such as the middle of Africa, Europe, and North America. Numerous research investigations, such as the ones carried out by Johnson and Way (2006) and Seeley et al. (1994), have come to the conclusion that there is no significant association between the likelihood of African men contracting HIV and variables such as travel or socioeconomic position. Johnson and Way were the ones who ended up carrying out the research projects.

2.4.4 Household characteristics and Socio-economic Status of Women Living with HIV

Based on available research findings, households where individuals are living with HIV (PLWHIV) face a heightened risk of food and nutrition insecurity. This increased vulnerability can be attributed to several factors, including the diminished capacity of key household contributors, reduced economic resources within the household, lower agricultural output, and the added burden placed on caregivers. Consequently, this situation elevates the likelihood of stunted growth among household members. Furthermore, HIV-infected family members typically exhibit compromised growth and metabolic processes, rendering them more susceptible to recurring morbidity related to malnutrition-related ailments, which further exacerbates their nutrient deficiencies (Oleske, 1987).

This depletion of essential nutrients is exacerbated by the complex interplay of economic, health, and socio-cultural variables within the household, including the gender of

the household's leader (McClelland et al., 2018). These variables, which encompass the gender of the household leader, assume even greater significance due to the sociocultural and economic disparities that disproportionately affect women in terms of both HIV infection rates and their ability to afford nutritionally adequate foods for their families (Frew et al., 2016). The situation becomes even more challenging if the head of the household is a woman, given their heightened vulnerability to HIV infection.

Studies that utilize extensive datasets to explore the relationship between gender disparities within households, HIV status, and the occurrence of stunting in Sub-Saharan Africa remain limited in number. In light of the global efforts to employ nutritional interventions to combat stunted growth, the intricate connection between household HIV status and the gender of the household leader poses a particular challenge for nations in sub-Saharan Africa. Specifically, it underscores the need for a comprehensive understanding of how household HIV status and the gender of the family's leader are intertwined.

2.5 Chapter Summary and Research Gaps

This chapter provided an in-depth discussion of the theoretical framework, which serves as the foundation for this investigation, as well as the empirical studies that are relevant to the issue that is the focus of this study. Given that it seems that not enough research has been done on the study issue at Mchinji district hospital, the gaps are obvious. It is also abundantly obvious that the effect of poverty on the socio-economic position of women living with HIV is a severe health and social concern that affects children, men, parents, members of the community, and the nation as a whole. Poverty has been connected with certain consequences on the socio-economic status and well-being of women in Malawi, and although some of the elements that contribute to these impacts are recognized and others are not, there are still some unknown reasons. All of these things have varied effects on women who are living with HIV, and we need to find strategies to lessen their effects. As a

result, the research endeavoured to assess, from a variety of perspectives, how living in poverty impacts HIV-positive women receiving treatment at the Mchinji district hospital.

CHAPTER THREE

RESEARCH METHODOLOGY

In this part, we will explain the research methods that were used by the researcher. These include the research strategy, the research design, the population being studied, the selection of sample, the sample size, the technique of data collecting, the data processing, ethical issues, and study limits.

3.1. Research Design

Because it combines the particular and comprehensive insights from qualitative research (such as focus groups) with the generalizable and readily repeatable data from quantitative research (such as surveys), the Mixed research technique was chosen for the study (Cresswell, 2012). Mason (2006) proposed that the integration of various research methodologies offers a valuable avenue for devising innovative strategies to understand the complexities and contexts of social encounters. Furthermore, it enhances the proficiency in providing explanations and making generalizations about social phenomena. In the current investigation, the researcher collected both qualitative and quantitative data by employing a mixed research strategy. In order to gather data, we employed a combination of questionnaires and focus groups. The qualitative data were acquired via the use of focused group discussion, while the quantitative data were collected through the use of a questionnaire.

3.2 Study Area

Mchinji district hospital is located in Mchinji district, Central region of Malawi.It shares the country's international boundaries with Zambia and Mozambique and district boundaries with Kasungu to the North and Lilongwe to the East. Mchinji district has a total land area of 3,131 square kilometers and it is linked with other parts of Malawi through M12 and M18 roads. According to 2018 population and housing census, Mchinji had a population

of 602.305 (313, 199 males and 289, 106 females) and a total of 134,799 households. Dominant tribes in the district are the Senga, Ngoni and Chewa, while Chisenga and Chichewa are the dominant languages. Christianity pre-dominates other religions. The economy of Mchinji is Agro-based, 90% of the population depends on agriculture and they rely on rain fed agriculture. The major crops grown are Maize, Tobacco, Soya, and Groundnuts. Politically, Mchinji has six Constituencies, which are headed by Members of Parliament. The study took place at Mchinji district hospital which is in Mchinji Central Constituency.

Since the rain fed agriculture is not adequate as the source of food and income, the district promotes irrigation by small scale farmers. As of 2017, Mchinji had a total of 205 primary schools, with 179, 717 learners and 2, 330 primary school teachers. The teacher pupil ratio is high (77:1) making the number of teachers inadequate. The district also has 27 secondary schools with 9, 365 pupils. There are 378 secondary school teachers of which 142 are not qualified. The health sector has 18 health facilities which provide services to the population. Only 46% of the population are able to access the health services from the facilities within the radius of 5km. Malaria is the leading cause of morbidity in both children and adults.

The security in the district is provided by the Malawi Police Services and other private institutions. The district does not have prison services or Fire department. It has a magistrate court which adjudicates legal disputes and carries out justice in accordance with the rule of law and the convicted persons are sent to Lilongwe. In spite of the numerous problems that Mchinji faces, the district has potential for development but resources are under-utilized. Mchinji has fertile land good for crop production and flow of the Bua-river water and natural pastures.

3.3 Study Population and Target population

According to Vonk (2017), a target population can be defined as the specific group of individuals that the researcher intends to examine in their study. Asiamah, Mensah, and Oteng-Abayie (2017) offer a similar perspective, defining population as the collective set of elements sharing common characteristics that the researcher aims to investigate. The researcher's approach to dealing with this population may vary depending on its size.

In data obtained from the Malawi Analytics Platform (MAP) database for the Ministry of Health (MoH) and managed by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the Cohort Disaggregated Report for the second quarter of 2022 revealed that at Mchinji district hospital, there was a total population of 12,053 women (comprising 62.43% of the population) who were on ART. Within this group, 3,141 women (equivalent to 62.79%) were actively receiving ART. Consequently, this study specifically targeted a population of 3,141 women living with HIV at Mchinji district hospital. The selection of these participants was informed by their potential to provide valuable insights into the impact of poverty on the socio-economic status of women living with HIV in Malawi, with a focus on Mchinji district hospital as a case study.

3.4 Sample and Sampling Techniques

Sampling is a fundamental procedure that involves the careful selection of individuals from a larger population to gather data. The process entails the selection of a specific group of individuals from a larger population, which is subsequently examined to obtain valuable insights into the overall characteristics of the entire population. In order to ensure that a sample effectively represents the intended population, it is crucial to consider its size, as highlighted by Mvumbi and Ngumbi (2015). According to Ghauri and Gronhaug (2005), researchers have a range of methodological choices when it comes to sampling techniques.

These techniques can be broadly classified into two main categories: probability sampling and non-probability sampling.

Probability sampling is a widely used approach in research that encompasses various methods to ensure a fair and unbiased selection of participants. These methods include "simple random sampling," "stratified sampling," "cluster sampling," and "systematic sampling." Each technique has its unique characteristics and advantages, allowing researchers to obtain representative samples and draw accurate conclusions from their studies. By employing these probability sampling methods, researchers can enhance the validity and reliability of their findings. In contrast, non-probability sampling includes various methods such as "convenience sampling," "purposive sampling," and "snowball sampling." In order to determine the suitable sample size for this study, we utilized the formula developed by Krejcie and Morgan (1970). This method is particularly useful when the target population consists of more than one hundred individuals (N>100). Thus,

$$\mathbf{S= X^2 NP(1-P) \div d^2 (N- 1) + X^2 P (1-P)}$$

$$S=3.841 \times 3141 \times 0.50(1-0.50) \div 0.05^{2} (3141 -1) + 3.841 \times 0.50 (1-0.5)$$

$$S=3.841 \times 3141 \times 0.50(0.5000) \div 0.0025(3140) + 3.841 \times 0.50(0.5000)$$

$$S=3.841 \times 3141 \times 0.2500 \div 7.85 + 3.841 \times 0.2500$$

$$S= 3016.14525 \div 7.85 + 0.9603$$

$$S=3016.14525 \div 8.8103$$

$$S=148{,}037.9015 \div 386.3728$$

$$S= 342.3$$

Sample Size was = 342

In the context of determining the required sample size, various factors come into play. To calculate the sample size, we employ a formula that incorporates several variables.

By plugging these values into the formula, one can determine the appropriate sample size for their study.

As an illustration of this concept, consider a study conducted at Mchinji District Hospital. In this case, the sample size for the Respondents category was determined to be 342. These individuals were selected from among HIV-positive women receiving care at the hospital.

3.5 Data Collection Tools

The instruments that were used for collection of data relevant to this study were questionnaires and focused Group Discussion.

3.5.1 Questionnaire

The researcher opted to employ a survey to gather quantitative data to facilitate the attainment of the study's intended objectives. As Orodho (2018) suggests, surveys prove to be a suitable and cost-effective method for data collection. They offer the advantage of swiftly amassing a significant volume of data, as highlighted by the author. Additionally, Kothari (2014) emphasizes that surveys are unbiased, particularly when reaching out to respondents who might be inaccessible. When the researcher possesses a clear understanding of the required information and how to measure the relevant variables, surveys emerge as the most appropriate data collection technique.

For the purpose of this study, a total of 342 female HIV patients at Mchinji district hospital were surveyed. The survey encompassed both structured and unstructured questions. Structured questions provided predefined response options, commonly referred to as closed questions. In contrast, unstructured questions allowed respondents to provide detailed explanations within certain boundaries. Notably, open-ended questions were not included in the survey. The questionnaire was organized into five distinct sections, with the initial section focusing on gathering demographic information, followed by the subsequent four sections aligned with the study's research objectives.

3.5.2 Focused Group Discussion.

Focus group discussions, often abbreviated as FGDs, represent a qualitative research approach and data collection method wherein a specific topic or issue undergoes in-depth examination by a group of selected individuals. This group is guided and supervised by an external moderator, as emphasized by Dollar and Merrigan (2002). The primary objective of employing this methodology is to equip researchers with a means to amass information that can be integrated into a comprehensive portrayal of the subject under investigation. Krueger and Casey (2000) contend that this technique proves particularly valuable as it allows researchers to uncover the subjective viewpoints and personal experiences of participants, which are typically inaccessible through alternative research methods. This distinctive attribute underscores its significant utility.

In the context of this study, focus groups proved instrumental, facilitating participant interaction and the collective elaboration of their insights. Moreover, it empowered facilitators to delve into specific details and access participants' individual experiences, thereby facilitating the efficient collection of substantial data aimed at describing, comparing, or explaining a societal phenomenon, as noted by Fink (2006). This essential tool was also harnessed to gather data from women residing at Mchinji district hospital who are living with HIV. These women were organized into groups based on their respective locations within the hospital's premises, with each group comprising between five to ten participants.

3.5.3 Reliability of Research Instruments

According to the definition provided by Mugenda & Mugenda (2018), dependability is the capacity of a research instrument to assess features of interest in a consistent manner throughout time. It refers to the extent to which a research instrument produces the same outcomes or data regardless of the number of times it is used. If a researcher gives a

participant the same test twice and receives the same score on both occasions, they might conclude that the instrument being used is dependable.

According to Orodho (2018), the test-retest process was used to guarantee that the tools' dependability was maintained. During the primary research, it was helpful in detecting probable difficulties; providing clarity on the instruments; and ensuring that the language used was suitable. In the same way that it measured how well one could comprehend the research methods, the test also evaluated how relevant the research topics were. The reliability test was used to determine the degree to which the findings are stable over a period of time. The researcher gathered information from 45 individuals who did not take part in the actual data gathering process. As a result, the reliability of the instruments was established by re-administering the questionnaires to the same sampled respondents at an interval of two weeks in order to establish the re-productivity of the instrument. In order to calculate the reliability coefficient, the scores that were acquired from each test were correlated. Gupta (2017) said that a standard minimum value of 0.6-0.9 is suggested in order to acquire correct reliability. This recommendation was made in order to obtain accurate reliability.

As a result, in order to ascertain the subject's level of stability, a measurement or test was administered to them at a later time. In order to have a better idea of how stable the results are, we compared and correlated them with the first test. The reliability coefficient was calculated using a correlation matrix, and the responses that were acquired during the piloting phase were utilized in the calculation. Cronbach's Alpha Coefficient, which is a measure of internal coefficient, was used in order to get at an assessment of the instrument's reliability. It was sufficient for the dependability to be at least 0.70 when compared to the significance threshold of 0.05.

Table 3.1 Cronbach's Alpha Values

Variables	Cronbach's Alpha Values
Household Income	0.769
Unemployment	0.848
Education Level	0.756
Household Characteristics	0.824

According to the data shown in the table that is located above, all of the variables had a reliability level that was higher than 0.7, and as a result, they were accepted for use in analyzing how the independent variable, which was the socioeconomic status of women who are living with HIV, was affected by them.

3.5.4 Validity of the Research Instruments

According to Kothari (2018), validity is the issue of whether or not a method really measures the thing that it purports to measure. Construct validity was maintained in the research by developing suitable representative questions to cover the study goals. The researcher began by conducting a pilot test at Mchinji district hospital with ten percent of the total number of respondents who were sampled. The purpose of this test was to test and enhance the validity of the questionnaires. The researcher sought the advice of other researchers in order to determine whether or not the instruments are reliable. Following the completion of the surveys, the researcher enlisted the assistance of supervisors in order to conduct an item review. In order to verify the instruments, the ideas that were made were taken into consideration.

3.6 Data Analysis Procedures

According to Mugenda & Mugenda (2013), the act of providing order and meaning to the raw data that has been acquired is what is known as data analysis. The goal of arranging one's data in order to obtain meaningful insights is to accomplish what is known as data analysis. The qualitative data were subjected to a process known as thematic analysis, which consisted of locating, examining, and reporting on recurring themes or patterns within the

data. The research questions were provided in a narrative format, and the data were interpreted according to the numerous parts of the study subject that were grouped and classified based on the research questions. The quantitative data that was acquired via the use of a questionnaire was then coded and analysed with the use of descriptive statistics and the statistical software designed specifically for the social sciences (SPSS). This included presenting statistical data in the form of frequency tables, with an explanation that was mostly descriptive in nature. The study goals guided the development of each individual item that comprised the questionnaire. The results of the calculation of the frequencies and percentages of the scores were provided in the form of frequency distribution tables, graphs, and figures.

3.7 Ethical Considerations of the Study

According to Mugenda (2013), ethics may be defined as a rule of behavior that the researcher is expected to go by when carrying out study on a certain issue. Because the research included people, great caution was used to prevent the participants from being harmed in any way, and no attempt was made to conduct the study with the intention of profiting from it in any manner. The researcher took precautions to verify that all participants gave their informed permission before taking part in the study. The information that was gathered was handled with the strictest secrecy, and it was not disclosed to any other parties. This was done to prevent the misuse of the information that was gathered. In addition, the data obtained were intended only for the use of the academic study project. The most essential thing is that at the conclusion of the research, the informants were given a summary of what had been found. It was ensured that the participants' identities would not be revealed on the questionnaire forms, and the participants themselves were instructed not to enter their names anywhere on the forms. This ensured that the participants' confidentiality and anonymity would be preserved.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, AND INTERPRETATION

4.1 Introduction

The methods, strategies, and procedures that were employed in order to evaluate, present, and interpret the data that was acquired utilizing the questionnaires and the focus group discussion are explained in this chapter. This chapter provides a detailed quantitative data analysis, as well as cross tabulation tables and percentages, on the effect that poverty has on the socio-economic status of women who are living with HIV at Mchinji district hospital.

4.2 Rate of Response

In this section, we will break down and clarify the rate at which participants actively contributed data to support the research. Out of a total of 342 individuals in the sample group, 336 responded, constituting 98.2% of the Women on ART who took part in this study. The remaining 6 individuals (1.8%) did not provide a response. This response rate is viewed as representative of the sought-after population. This aligns with Mugenda's (2013) perspective that, for descriptive research, a response rate of over fifty percent is deemed favorable, while a rate of fifty percent or lower is considered acceptable. These findings affirm the credibility of the research investigation, as supported by the 336 respondents, in line with Taherdoost's (2017) recommendation of a minimum response rate of fifty percent for research studies.

4.3 Descriptive Statistics

In this part, descriptive statistics are presented. Descriptive statistics entail describing, summarizing, and organizing the data in a way that makes it simple to comprehend. It provides information on the respondents' background characteristics as well as an analysis of the research goals in the following manner.

4.4.1 Socio-economic Characteristics of Respondents.

This part includes the demographic information of the respondents, which was based on their age group, marital status, number of individuals living in their homes, and length of time lived with HIV. The tables and figures that are shown here are a representation of the results that were acquired from this section.

4.4.1.1 Age Bracket.

The distribution of respondents' ages was another factor that was examined. According to the study's results, 25.9% of respondents were between the ages of 29 and 38, followed by those between the ages of 18 and 28 (54.8%). According to Figure 4.1 below, the percentage of respondents who were aged 39 to 49 years was 15.8%, while the percentage of respondents who were over 50 years old was only 3.6 percent. This suggests that the majority of HIV-positive women at the Mchinji District Hospital were young, between the ages of 18 and 28.

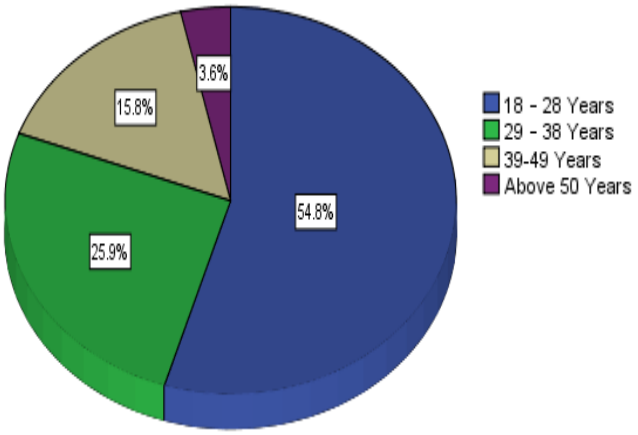


Figure 4.1 Respondents' Age

4.4.1.2 Marital Status

The majority (53%) of the women who took part in this survey were widows or widowers, followed by separated people (18%), single people (13%), married people (8%) and divorced people (8%) in Figure 4.2's findings. According to this, the majority of responders were widows or widowers. The HIV status of women is greatly influenced by

their marital status. Widowed women had much higher incidence of HIV infection. Other investigations, including one from Malawi, have produced comparable findings (Reither and Mumah, 2009). It would seem that the present female HIV status at Mchinji District Hospital may be related to the loss of spouse (or change in marital status) brought on by prior HIV infections of married women and/or their companions.

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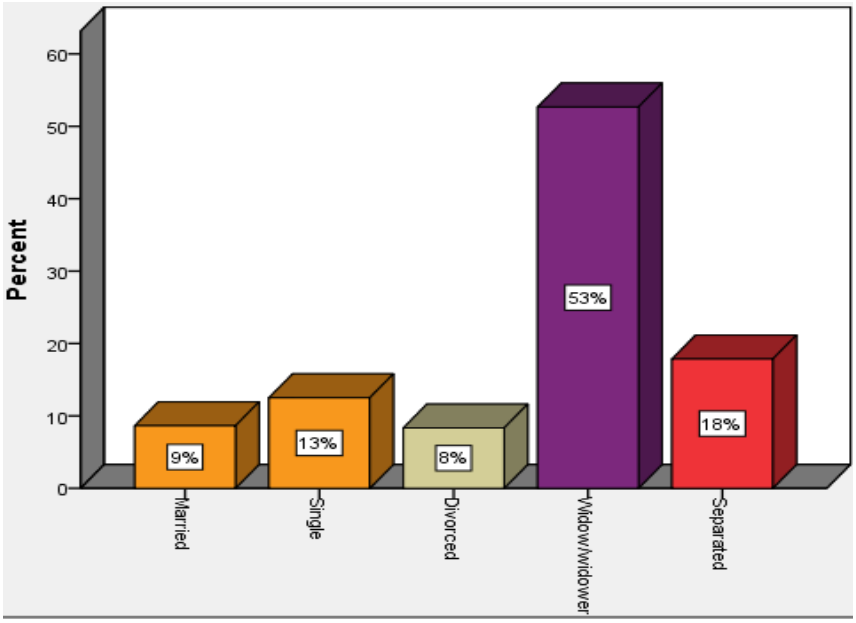


Figure 4.2 Marital status of Respondents

4.4.1.3 Number of Household

The research at Mchinji District Hospital aimed to determine the number of families with women who were HIV positive. The results were shown in Table 4.1.

Table 4.1 Number of Household

Household	Frequency	Percentage (%)
Less than 2 people	8	2.4
2-5 people	100	29.8
6-9 people	208	61.9
10 and above	20	5.9
Total	**336**	**100**

Findings in Table 4.1 revealed that majority 208 (61.9%) of the respondents indicate that the number of households were between 6-9 people, 100(29.8%) indicated between 2-5 people, 20(5.6%) indicated 10 and above while 8(2.4%) indicated less than 2 people. This implies

that there is increase in poverty with increase in household size that has an influence on socio economic status of women living with HIV.

4.4.1.4 Period of living with HIV

Participants were asked to indicate the period they have been living with HIV. Findings were presented in Table 4.2

Table 4.2 Period of living with HIV

Period of living with HIV	Frequency	Percentage (%)
Less than two years	12	3.6
More than two years	54	16.0
Five years and above	270	80.4
Total	**336**	**100**

According to analysis presented in Table 4.2, the findings indicate that the majority 270(80.4%) of the participant indicated that they have been living with HIV for a period of five years and above, those who had lived with HIV more than two years were 54(16%) and less than less than two years were 12(3.6%).

4.4.2 Income and Socio-economic Status

The impact of income disparity on the socioeconomic situation of women living with HIV at Mchinji District Hospital is discussed in this portion of the study's primary aim. The respondents were asked to provide information about their monthly income. The conclusions were laid forth in table 4.3.

Table 4.3 Income per Month in Malawi Kwacha currency (MK)

Income per Month	Frequency	Percentage (%)
Less than MK1,000	169	50.3
MK1,000-MK10,000	98	29.2
MK10,000-MK20,000	60	17.9
More than MK20,000	9	2.7
Total	**336**	**100**

Results in Table 4.3 showed that the majority of the 169 (50.3%) HIV-positive women who participated in the research at the Mchinji District Hospital earn less than MK1,000, followed by 98 (29.2%) who earn between MK1,000 and MK10,000, 60 (17.9%) who earn between MK10,000 and MK20,000, and 9 (2.7%) who earn more than MK20,000. The researcher

came to the conclusion that women with HIV in the lowest income quintile were more likely to test positive for HIV infection than women in the highest wealth quintile based on the information from Table 4.3. This result is consistent with Fenton's (2014) contention that "...poverty plays a role in creating an environment in which individuals are particularly susceptible and vulnerable to HIV/AIDS...," coming to the conclusion that poverty is the primary cause of people's apparent higher risk of HIV/AIDS.

Respondents were farther asked whether they had any debts. Findings in this section were presented in Table 4.4

Table 4.4 Debts

	Frequency	**Percent**
Yes	179	53.3
No	157	46.7
Total	**336**	**100.0**

According to the data shown in Table 4.4, a significant majority of respondents, namely 179 individuals (53.3%), reported having debts. In contrast, a smaller proportion of respondents, specifically 157 individuals (46.7%), claimed that they did not have any obligations. The HIV status of women at Mchinji district hospital has a detrimental influence on their socio-economic standing, since it restricts their capacity to engage in employment and generate revenue. One of the consequences of HIV infection in women is the impact it has on their physical and mental well-being, which in turn hinders their ability to sustain consistent work, leading to financial vulnerability and reliance on debt as a means of survival.

The participants were afterwards asked to identify the presence of chicken, goat, pig, cow, bicycle, or automobile inside their respective households. The results were shown in Table 4.5.

Table 4.5 Properties in the Household.

Item	Frequency	Percent
Chicken	99	29.4
Goat	59	17.5
Pig	15	4.4
Cow	112	33.3
Bicycle	44	13.0
Car	7	2.0
Total	**336**	**100.0**

As per analysis presented in Table 4.5 most, 112(33.3%) of the participants indicated they owned cows in their households, 99(29.4%) owned chicken, 59(17.5%) owned goats, 44(13%) owned bicycle, 15(4.4%) owned pigs while 7(2%) owned cars. It was generally concluded that most women living with HIV at Mchinji district hospital posses' variety of households' properties. The findings could also be interpreted that woman living with HIV experiences low family and societal support systems, along with depleted family income due to loss of work, and poor disease management present additional vulnerabilities. This at makes most of them to relay on their household's properties such as chicken and goats which they sell in order survive.

> 'Properties in the households of women living with HIV are linked to HIV infection through complex pathways. The first link is through the income effect that may be in the opposite direction. People with high income tend to lead lifestyles associated with increased number of sexual partners which increases their vulnerability to HIV, while those with low income may be unable to access HIV services also leading to increased vulnerability. Poverty makes people vulnerable to HIV in diverse ways including dropping out of school; marrying early; loss of livelihood; and being homeless due to displacement by war, all of which have been linked to increased HIV vulnerability **(FGD, January, 2023).**

4.4.3 The Effect of Unemployment on SES of women living with HIV/AIDS

The second goal of the study is to assess the impact of unemployment on the socio-economic condition of women who are living with HIV and receiving treatment at Mchinji district hospital.

The participants were requested to specify their current job position, as shown in Table 4.6.

Table 4.6 Employment Status

Employment Status	Frequency	Percent
Self-employed	70	20.8
Formally employed	30	9.0
Total	**336**	**100.0**

Based on the findings shown in Table 4.6, a total of 336 participants were included in this research. Among these participants, a significant majority of 236 individuals, accounting for 70.2% of the total sample, reported being jobless. Out of the whole sample, 70 individuals (20.8%) were categorized as self-employed, whereas 30 individuals (9%) were classified as formally employed. Hence, it can be seen that out of the total participants in this research, a significant proportion of 100 individuals (29.8%) were employed, while the majority were unemployed. The findings presented herein provide estimations on the influence of HIV on labour productivity. The presence of undisclosed 'helpers' among women living with HIV in professional settings poses a potential threat to attendance and job security, hence placing an additional financial strain on employers.

The participants were asked to report whether their HIV status had any impact on their employment. The results were shown in Figure 4.3.



Figure 4.3 Effects of HIV Status on Work Place

53.3% of the participants, the majority, acknowledged that their HIV status had an impact on them at work. 46.7%, however, rejected the assertion. It was determined that HIV has a significant impact on the workplace, particularly for those who are living with the virus, because it decreases the supply of labour and skills, raises labour costs, lowers productivity, endangers the livelihoods of both employers and employees, and fosters work environments that violate workers' rights.

Table 4.7 Occupation of the Respondents

Occupation	Frequency	Percent
Farmer	81	24.1
Business	205	61.0
Unskilled labour	50	14.8
Total	**336**	**100.0**

As shown in Table 4.7's analysis, the majority of the 205 women with HIV who took part in the research (or 61% of them) worked in business, followed by 81 farmers and 50 unskilled workers. According to the research, Mchinji District Hospital's HIV-positive women continue their treatment more effectively when they have jobs than when they do not. This is mostly because they regularly have the financial resources to pay for necessary medical care, supplies, and assistance, as well as to buy enough food.

On a Likert scale of 1 to 5, where 1 is Strongly Disagree, 2 is Disagree, 3 is Neutral, 4 is Agree, and 5 is Strongly Agree, respondents were asked to rate statements about how employment affects women living with HIV's socioeconomic status. The conclusions were laid forth in table 4.8.

Table 4.8 Influence of Employment on SES of women living with HIV

Influence of Employment	**1 (%)**	**2 (%)**	**3 (%)**	**4 (%)**	**5 (%)**
Do employment improve the socio-economic status of women living with HIV	9.1	13.1	9.1	18.2	54.5
I am satisfied with my current employment	9.1	18.2	7.0	20.3	45.5

Table 4.8 analysis shows that most (54.5%) of the respondents strongly agreed that employment improve the socio-economic status of women living with HIV, 18.2% disagreed, 13.1% disagreed, those who strongly disagreed while 9.1% were neutral.

On whether respondents were satisfied with their employment they were in, 45.5% indicated that they were very satisfied, 20.3% were satisfied, and 18.2% were unsatisfied and 9.1%very unsatisfied and 7.0% not sure.

> HIV status of women at Mchinji district hospital often has a negative impact on their socio-economic status by constraining their ability to work and earn income. The effects of HIV on physical and mental functioning always make it difficult in maintaining regular employment difficult **(FGD, January, 2023).**

4.4.4 The Relationship between Education Level and SES of women living with HIV

The third goal of the study was to investigate the association between the socioeconomic position of HIV-positive women at the Mchinji District Hospital and their degree of education.

The respondents were asked whether they had attended school. The solution was shown in Table 4.8.

Table 4.9 Education Background

	Frequency	Percent
Yes	279	83.0
No	57	17.0
Total	**336**	**100.0**

Two hundred and seventy-nine, 279(83%) of the participants agreed that they had gone to school while 57(17%) indicated they had no education background. From the analysis it could be concluded that education is associated with social economic status of women living with HIV in that schooling keeps people both young and old especially women away from environments which would increase their vulnerability.

Education provide platform with idea of developing critical thinking which inspires students to develop long term goals. These contribute to delaying sex, which makes young people avoid farther HIV infection. Higher educational attainment (defined here as complete secondary or higher education) provides knowledge, which individuals use to avoid HIV infection and provides employment, which enhances the capacity of people to act on their plans to reduce vulnerability **(FGD, January, 2023).**

4.4.4.1 Highest level of Education Attained

Participants were asked to indicate their highest level of education they had attained. Findings were represented in Figure 4.4

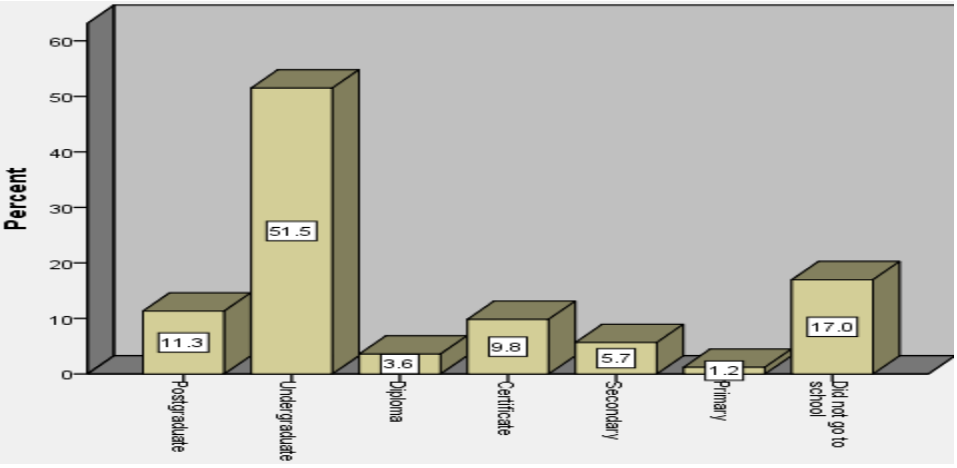


Figure 4.4 Highest level of Education

According to analysis presented in Figure 4.4, the findings indicate that the majority (551.5%) of the women living with HIV who participated in this study at Mchinji district hospital were undergraduate, 17% did not go to school, 11.3 were postgraduate, 9.8% were certificate holders, 5.7% were having secondary as their education background, 3.6% were diploma holders while 1.2% only reach primary level of education. Education increases tolerance and empathy of people who have the disease by addressing fears and changing attitudes. Education also reduces discrimination and stigmas, which are the main reasons why kids and teenagers drop out of school. This is why most HIV-positive women at Mchinji District Hospital have at least some education backgrounds.

4.4.4.2 Role played by Education in improving socio-economic Status of people

The goal of the research was to determine the influence that education plays in raising people's socioeconomic standing. On a Likert scale of 1 to 5, with 1 denoting "Strongly Disagree," 2 denoting "Disagree," 3 denoting "Neutral," 4 denoting "Agree," and 5 denoting "Strongly Agree," participants who were women living with HIV were asked to rate their degree of agreement. The conclusions were laid forth in table 4.9.

Table 4.10 Role played by Education on Socio-Economic Status

Statement	1%	2%	3%	4%	5%
Do education plays a role in improving socio-economic status of people	4.0	9.0	10.0	15.0	62.0

Table 4.9 reveals that 62% of HIV-positive women at Mchinji District Hospital strongly agreed with the assertion that education helps those living with HIV improve their socioeconomic position, whereas 15% agreed, 10% were unsure, 9% disagreed, and 4.0% severely disagreed.

4.4.4 Household Characteristics of women living with HIV

The home characteristics of Mchinji District Hospital's HIV-positive women are covered in this section. Participants in the research who were HIV-positive women were asked to rate

how much they agreed or disagreed with the statement on the features of HIV-positive women's households. The following tables show the findings.

Table 4.11 The household characteristics of women living with HIV

Statement	Yes	No
Do you experience any stigma because of your status?	94%	6%
Do you hold any position within your community?	54%	46%
Do you belong to any corporative within your community?	59%	41%
Is anyone apart from you affected by the pandemic within your family	88%	12%

Majority (94%) of the respondents agreed that they experience stigma because of their HIV status however, 6% of the participants declined the statement.

On whether respondents belong to any corporative within their community, 54% agreed with the statement while 46% disagreed, 59% agreed that they belong to corporative within their community while 41% declined. On whether anyone apart from them had been affected by the pandemic within their family, 88% agreed while 12% declined. The research showed that relationships between family members and women living with HIV are impacted by HIV. It has been observed that a parent's chronic sickness might alter family dynamics and cause resentment or guilt. Isolation among family members might cause children's frustration.

Table 4.12 HIV Awareness of the women living with HIV

Statement	1%	2%	3%	4%	5%
I am well informed about HIV issues.	4.0	9.0	10.0	15.0	62.0
HIV awareness activities improve the well-being of people living with HIV.	4.0	6.0.0	2.0	56.0	32.0

I take part in HIV awareness campaigns. The majority (62%) strongly agreed that they are knowledgeable about HIV-related concerns. The remaining 15% agreed, 10% were neutral, 9% disagreed, and 4% strongly disagreed. 56% of respondents agreed, and 32% strongly agreed, that HIV awareness campaigns had enhanced the wellbeing of women living with the virus. However, 4% strongly disagreed, 6% disagreed, and 2% were undecided. It was concluded from the results that many women who are HIV positive are aware. However,

it has been noted that the Mchinji District Hospital's HIV-positive women are suffering unfavourable outcomes as a result of their increased HIV knowledge. Receiving a diagnosis and having HIV have an adverse economic impact on women and their families through a number of mechanisms, including women's inability to work due to poor physical health, loss of employment leading to a decrease in or loss of family incomes, and increased health expenditure.

When asked whether they take part in HIV awareness campaigns, respondents said yes. On a Likert scale of 1 to 5, where 1 equal "never," 2 "likely," 3 "uncertain," 4 "only when I have time," and 5 "always,"

It was discovered that 66.6% of the participants said they always take part in HIV awareness events, 19.3% said just when they had time, 12.6% said they've never taken part, 12.4% said they were likely to, and 9.2% were unsure.

Table 4.13 Distance traveled to access ART treatment

Distance	Frequency	Percentage
1-2 Km	38	11.3
3-5 Km	67	19.9
6-10 Km	140	41.6
More than 10Km	91	27.0
Total	**336**	**100**

Majority 140(41.6%) of the women living with HIV who participated in this study indicated that they travelled between 6-10 Kilometres access ART treatment, 91(27%) travelled for more than 10Km, 67(19.9%) travelled between 3-5 Km and 38(11.3%) travelled 1-2 Km.

Table 4.14 Means of Transport

Means of Transport	Frequency	Percentage
Walking	245	72.9
Bicycle	7	2.0
Motor Cycle	44	13.0
Minibus	40	11.9
Total	**336**	**100**

According to the analysis presented in Table 4.13, majority 2245(72.9%) of participants are walking as means of transport in order to access ART treatment, those who are using motor cycle were 44(13%), 40(11.9%) use minibus while 7(2%) use bicycle.

4.5 Discussion of Findings

4.5.1 Household Income on the socio-economic Status of women living with HIV

At the Mchinji District Hospital, the research examined the impact of income disparity on the socioeconomic condition of women living with HIV. Overall, the research indicated that women with HIV in the lowest income quintile had a higher risk of testing positive for the virus than did women in the highest wealth quintile. Food shortage is a consequence of poverty at the Mchinji District Hospital. This has caused women who are HIV-positive to search for other methods to get money, including having several sex partners, swapping sex, selling or pawning possessions, and taking on odd jobs. These sources of revenue are unreliable, which often causes monthly income to fluctuate. Women look for new romantic or sexual partners who can help them financially or engage in transactional sex when they are short on cash. Consequently, women look for new partners who can provide them presents or money for basic expenses like rent or feeding their kids.

> This finding concurs with Fenton (2014) who argued that "…poverty plays a role in creating an environment in which individuals are particularly susceptible and vulnerable to HIV/AIDS…" concluding that poverty is the main reason individuals seems to be at an increased risk of HIV/AIDS.

“Women with high income tend to lead lifestyles associated with increased number of sexual partners which increases their vulnerability to HIV, while those with low income may be unable to access HIV services also leading to increased vulnerability,” (FGD, January, 2023).

4.5.2 The Effect of Unemployment on SES of women living with HIV/AIDS

The study at the Mchinji District Hospital looked at the effects of unemployment on the socioeconomic status of women living with HIV. It found that these workers frequently bring unrecorded "helpers" to the workplace, which puts them in danger of losing their jobs and places a financial burden on their employers. When they are employed, HIV-positive women at Mchinji District Hospital are better able to stick with their treatment regimens. Those who are jobless often struggle to make ends meet in order to pay for necessary medical care, drugs, and assistance, as well as to buy enough food. These results are consistent with those of Liu, Canada, Shi, and Corrigan (2012), who suggested that job candidates with HIV were inept and unable to carry out the job's specified duties. This may affect how employment decisions are made and the financial possibilities available to those living with HIV/AIDS.

“HIV status of women at Mchinji district hospital often has a negative impact on their socio-economic status by constraining their ability to work and earn income. The effects of HIV on physical and mental functioning always make it difficult in maintaining regular employment difficult,” **(FGD, January, 2023).**

4.5.3 The Relationship between Education Level and SES of women living with HIV

The third goal of the study was to investigate the association between the socioeconomic position of HIV-positive women at the Mchinji District Hospital and their degree of education. According to the data, education improves the socioeconomic position of women living with HIV because it keeps individuals of all ages, particularly women, out of circumstances that might make them more vulnerable.

> “Education provide platform with idea of developing critical thinking which inspires students to develop long term goals. These contribute to delaying sex, which makes young people avoid farther HIV infection. Higher educational attainment (defined here as complete secondary or higher education) provides knowledge, which individuals use to avoid HIV infection and provides employment, which enhances the capacity of people to act on their plans to reduce vulnerability (FGD, January, 2023).

Women who contract HIV at Mchinji District Hospital generally possess some level of education. This observation suggests that beyond aiding in HIV prevention efforts, education plays a vital role in enhancing the tolerance and empathy of those afflicted with the disease. It helps address their fears and fosters a shift in attitudes. Furthermore, education serves to diminish discrimination and the associated stigmas, which are primary factors leading to the dropout of school-going children and adolescents.

This aligns with the findings of Adler and Newman (2002), who highlighted that formal education equips individuals with knowledge and life skills, granting them improved access to information and resources. Consequently, this facilitates the adoption of healthier behaviours compared to those with minimal or no formal education.

4.5.4 How household characteristics affect SES of women living with HIV

In this section, we explore the socioeconomic status of HIV-positive women who receive treatment at Mchinji District Hospital, focusing on household-related factors. Respondents who were living with HIV were requested to provide ratings on a Likert scale ranging from 1 to 5. The scale ranged from "Strongly Disagree" (rated as 1) to "Completely Agree" (rated as 5), assessing whether household variables influenced the economic situation of women affected by HIV. The outcomes are presented in Table 4.7.

Table 4.15 Effect of Household Characteristics socio-economic

Statement	1%	2%	3%	4%	5%
Higher socio-economic status women present higher rates of HIV infection compared to low socio-economic status women	3.6	18.5	8.0	32.4	37.5
Women with increased resources had higher rates of HIV	0.0	17.0	5.4	33.0	44.6
Poor Health conditions in the household greatly affect socio-economic status of women living with HIV	10.1	13.4	16.4	53.9	6.3
Financial challenges affect socio-economic status of women living with HIV	4.8	24.7	10.1	47.0	13.4
Women living with HIV experience stigma because of their socio-economic status	2.7	6.5	5.4	22.9	62.5
HIV awareness activities improve the well-being of women living with HIV	8.6	4.5	7.1	71.7	8.0

Based on the findings shown in Table 4.15, it is evident that a significant proportion of participants, namely 37.5%, expressed a strong agreement with the proposition that women belonging to higher socioeconomic strata exhibit higher rates of HIV infection compared to those with lower socioeconomic status. Among the remaining participants, a total of 32.4% expressed agreement, while 8% remained uncertain. Additionally, 18.5% disagreed with the statement, and 3.6% strongly disagreed.

A total of 44.6% of the participants exhibited a strong agreement with the proposition that women possessing more wealth were more likely to have higher rates of HIV. In comparison, 33% of the respondents expressed agreement, while 17.0% disagreed, and 5.4% remained uncertain.

A big proportion (53.9%) of the participants expressed agreement with the assertion that adverse health circumstances inside the household have a noteworthy influence on the socioeconomic standing of women who are afflicted with HIV. A smaller percentage (6.3%)

strongly endorsed this viewpoint, while a substantial portion (16.4%) remained neutral. Conversely, similar proportions (13.4%) of respondents held a strong disagreement, and a lesser amount (10.1%) expressed a strong disapproval of this statement.

A significant proportion of participants, namely 47%, expressed agreement with the notion that financial difficulties had an influence on the socioeconomic status of women who are afflicted with HIV. Conversely, 13.4% and 10.1% of respondents held opposing viewpoints, while 24.7% and 4.8% strongly disagreed with this assertion.

A significant proportion of participants (62.5%) expressed strong agreement with the link between the stigmatization of women living with HIV and their socioeconomic circumstances. In contrast, 22.9% agreed to a lesser extent, 5.4% were uncertain, 6.5% disagreed, and 2.7% strongly disagreed.

A majority of the participants (71.7%) expressed agreement with the notion that HIV awareness programs have a positive impact on the overall welfare of women who are affected by the virus. Among this group, 8% strongly endorsed this viewpoint. Conversely, a smaller proportion (8.6%) strongly disagreed with this perspective. A notable percentage (7.1%) remained uncertain about the relationship between HIV awareness campaigns and the wellbeing of women living with the virus. Lastly, a minority (4.5%) expressed disagreement with the notion that such campaigns have a beneficial effect.

Based on the findings, it can be shown that domestic circumstances exert influence on the socioeconomic level of women living with HIV at Mchinji District Hospital, thereby affecting the prevalence of HIV infection. This study illustrated the potential influence on familial connections and women living with HIV. The phenomenon of a parent's chronic illness has been shown to have an impact on family relations, perhaps leading to feelings of anger or guilt among family members. The potential consequence of familial isolation is the potential for children to experience feelings of dissatisfaction. Nevertheless, it has been

shown that HIV-positive women at Mchinji District Hospital are experiencing adverse consequences due to their heightened awareness of HIV. The economic consequences of receiving a diagnosis of HIV on women and their families are significant, manifesting via many mechanisms. These include the hindered capacity of women to engage in work owing to compromised physical health, the loss of employment resulting in reduced or eliminated family revenues, and the escalation of health-related expenditures.

McClelland et al. (2018) suggest that the home's ability to mitigate stunting among its members is contingent upon a combination of economic, health, and social factors, as well as the gender of the household head. This finding is consistent with the outcomes of the investigation. 4.6 Chapter Summary

The chapter delves into presenting research findings regarding the effects of poverty on the socio-economic condition of women living with HIV at Mchinji district hospital. The findings have been organized into four distinct thematic areas. These themes involve an exploration of the influence of income disparity on the socio-economic position of women with HIV, an evaluation of the consequences of unemployment on the socio-economic status of these women, an examination of the relationship between educational achievements and the socio-economic situation of women living with HIV, and the identification of household characteristics specific to women residing at Mchinji district hospital who have HIV. These aspects closely align with the existing literature review conducted in the research. The study encompasses a comprehensive analysis of both qualitative and quantitative data, culminating in conclusions related to Chi-square statistical analysis.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Summary

The research is summarized in this chapter. This included summarizing the earlier chapters and outlining the research's results. In accordance with the study's research questions, it also examined the study's conclusion. The recommendations and ideas for more research based on the study's results are presented last. At the Mchinji District Hospital, a study was conducted to assess the impact of poverty on the socioeconomic condition of women living with HIV. Four research goals served as a framework for this: determining the impact of income inequality on the socioeconomic status of women living with HIV; assessing the effects of unemployment on this status; examining the relationship between education level and socioeconomic status of women living with HIV; and identifying the household characteristics of women living with HIV at Mchinji District Hospital. The study's presentation of the results may be found in chapter four. This was also presented topically in line with the goals of the research. The research identified the impact of poverty on the socioeconomic status of women living with HIV at the Mchinji District Hospital via data analysis in chapter four, which was then analyzed thematically as follows.

5.1.1 Socio-economic Characteristics of Respondents

This research focuses on the respondent's age range, marital status, the number of individuals living in the home, and the length of time they were HIV positive.

According to the study's analysis of respondents' age distribution, the majority (54.8%) of respondents were between the ages of 18 and 28. This showed that the majority of HIV-positive women at the Mchinji District Hospital were young, between the ages of 18 and 28.

The majority (53%) of the women who took part in this research were widows or widowers in terms of marital status. According to this, the majority of responders were widows or

widowers. The HIV status of women is greatly influenced by their marital status. Widowed women had much higher incidence of HIV infection. It would seem that the female HIV status at Mchinji District Hospital may be related to the loss of spouse (or change in marital status) brought on by prior HIV infections of married women and/or their companions.

The majority of 208 (61.9%) respondents suggest that the number of households was between 6 and 9 individuals based on the findings about the number of households. Therefore, it was a sign that poverty was rising along with family size, which in turn affected the socioeconomic situation of HIV-positive women.

The majority of the participants, 270 (80.4%), said that they have had HIV for at least five years. This demonstrated that women who have had HIV for a longer time experience negative economic effects on themselves and their families through a variety of mechanisms, including their inability to work due to poor physical health, their loss of employment resulting in a loss of family income, and increased health expenditures.

5.1.2 The Influence of Income Inequality on the socio-economic Status

In Mchinji District Hospital, the results showed that women with HIV in the lowest income quintile were more likely to test positive for the virus than women in the highest wealth quintile. The major reason people seem to be at a higher risk of HIV/AIDS is because poverty contributes to the environment that makes them more receptive to and vulnerable to the disease.

According to research conducted at the Mchinji District Hospital, living in poverty led to a lack of food. This has caused women who are HIV-positive to search for other methods to get money, including having several sex partners, swapping sex, selling or pawning possessions, and taking on odd jobs. These sources of revenue are unreliable, which often causes monthly income to fluctuate. Women look for new romantic or sexual partners who can help them financially or engage in transactional sex when they are short on cash. Women can look for

new partners who can provide them presents or money to pay for needs like rent or food for their kids.

It has been shown that women's socioeconomic standing is negatively impacted by their HIV status, which limits their capacity to work and generate money. The physical and mental impairment caused by HIV in women makes it difficult for them to retain stable work, forcing them to take on debt in order to exist.

The research went on to show that women living with HIV had weak social and familial support networks, as well as diminished family income owing to job loss and poor illness management, which creates additional vulnerabilities. The majority of people are forced to rely on selling family possessions like chickens and goats in order to live due to this at the Mchinji District Hospital.

5.1.3 The Consequences of Unemployment on the socio-economic Status

According to the study's results, 236 people, or 70.2%, were jobless. Estimates of the effect of HIV on labour productivity were given by these findings. Due to the prevalence of unrecorded 'helpers' brought to work by women living with HIV, participation at these events often puts employees in danger of losing their employment and poses a financial strain on businesses. HIV has a significant impact on the workplace, especially for those who are infected. It decreases the supply of labour and skills, raises labour costs, lowers productivity, threatens the livelihoods of employees and employers, and creates environments that violate the rights of the Mchinji District Hospital's HIV-positive women who work because they are able to maintain their treatment more successfully when they are employed. This is mostly because they regularly have the financial resources to pay for necessary medical care, supplies, and assistance, as well as to buy enough food.

Women's socioeconomic situation at Mchinji District Hospital is often negatively impacted by their HIV status since it limits their capacity to work and generate revenue.

Maintaining a normal job has always been challenging due to the impact of HIV on physical and mental performance.

5.1.4 The Relationship between Education Level and Socio-economic Status

Education helps keep both young and elderly people, particularly women, away from circumstances that might make them more vulnerable, hence it is related to the socioeconomic position of women with HIV. According to the research, Mchinji District Hospital offers educational opportunities with the aim of fostering critical thinking, which encourages women living with HIV to set long-term objectives. These assist in postponing sex, helping these ladies prevent further HIV infection. Increased levels of education empower women with the knowledge required to reduce the risk of contracting HIV. Furthermore, it enhances their employment opportunities, enabling them to effectively implement strategies aimed at reducing vulnerability.

A significant proportion (55.15%) of the women diagnosed with HIV who participated in the research conducted at Mchinji District Hospital had a history of formal education. This finding implies that education serves not only as a means of HIV prevention but also fosters greater empathy and understanding toward individuals living with the disease, as it addresses misconceptions and reshapes societal attitudes. Additionally, education plays a pivotal role in reducing discrimination and eliminating the stigmatization associated with HIV, which are major factors contributing to school dropouts among children and adolescents.

5.1.5 Household Characteristics of Women Living with HIV

The research findings reveal that HIV significantly influences the dynamics within families and their relationships with women living with the virus. It is evident that a parent's enduring illness can disrupt family dynamics, potentially leading to feelings of resentment or

guilt. Consequently, family members may become distant, causing frustration among children.

Furthermore, it has come to attention that the HIV awareness programs conducted by Mchinji District Hospital are adversely affecting HIV-positive women. The diagnosis of HIV and its subsequent impact on women and their families have negative economic repercussions through various channels. These include women's reduced ability to work due to deteriorating physical health, job loss resulting in decreased family income, and elevated healthcare expenses.

5.2 Conclusions

In conclusion, Mchinji district hospital research revealed that women with HIV in the lowest income quintile were more likely to test positive for the virus than women in the highest wealth quintile. Women living with HIV are forced by poverty to seek out many income-generating opportunities, including several sexual partners, sex exchanges, selling or pawning possessions, and sporadic employment. These sources of revenue are unreliable, which often causes monthly income to fluctuate. Consequently, women look for new partners who can provide them presents or money for basic expenses like rent or feeding their kids. Concerning the effects of unemployment on socioeconomic position, women with HIV often bring unregistered "helpers" to their workplaces at the Mchinji District Hospital.

These visits put women employees in danger of losing their jobs and cause a financial strain on their employers. Additionally, this is having an impact on their physical and mental health, which makes it challenging for them to hold down a steady job. Regarding the association between education attainment and socioeconomic standing of HIV-positive women, education offers a framework for the development of critical thinking, which motivates them to set long-term objectives. These assist in postponing sex, helping these ladies prevent further HIV infection. Higher levels of education provide women the

information they need to prevent getting HIV, as well as the employment that increases their ability to carry out their plans to lessen susceptibility.

Relationships between family members and women living with HIV were shown to be impacted by the household features of HIV-positive women at Mchinji District Hospital. It has been observed that a parent's chronic sickness might alter family dynamics and cause resentment or guilt. HIV knowledge among the female patients at the Mchinji District Hospital has been noted to be having negative impacts, since getting a diagnosis may have detrimental implications on the economy, such as losing a job that reduces or eliminates family income..

5.3 Recommendations

The research offered the following suggestions in light of its findings:

1. Women who are living in poverty require economic solutions. They will be less susceptible to contracting HIV as a result. For instance, such treatments could lessen their need to continue in abusive relationships or partake in transactional sex.
2. The Mchinji District Hospital must scale up its programs to lessen the impact of HIV/AIDS on communities, families, and orphans.
3. Workers' and employees' participation in HIV policies and initiatives is necessary.

5.6 Area for Further Research

In light of the fact that this study investigated the impact that living in poverty has on the socioeconomic position of HIV-positive women receiving treatment at Mchinji district hospital, comparable research has to be conducted in other nations and hospitals for the sake of making comparisons and enabling the conclusions of this study to be generalized.

To have a better understanding of the impact that low income has on the socioeconomic position of women who are living with HIV, more research should be carried out using a bigger sample size.

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APPENDICES

Appendix I: Questionnaire for female ART clients

Dear respondent,

My name is Prince Henderson, Reg. No. 1042532I, a student from Catholic University of Eastern Africa (CUEA) undertaking my Master of Arts in development studies. I am carrying out a study on; the influence of poverty on the socio-economic status of women living with HIV in Malawi. I have taken my case study to be the Mchinji district hospital, ART Department. Thank you for agreeing to participate in this study by filling this questionnaire which will be a great contribution for the successful completion of this academic work. Remember that participation in the study is voluntary and your decision to participate, or not participate will be treated kindly and will not affect you in any way. Remain assured that your responses will be treated with utmost confidentiality and will be used only for the purpose of this study. Therefore, kindly respond to the questions with honesty and sincerity and do not write your name on the questionnaire. Thank you in advance for your cooperation.

SECTION A: Demographic background of respondents

1. Age bracket.

18 – 28[ ]29 – 38 [ ] 39-49 [ ] Above 50 years [ ]

2. Marital status

Married [ ] Single [ ] Divorced [ ] Widow/widower [ ] Separated [ ]

3. How many are you in your household?

Less than 2 people [ ] 2-5 people [ ] 6-9 people [ ] 10 and above [ ]

4. For how long have you lived with HIV?

Less than two years [ ] More than two years [ ]Five years and above [ ]

SECTION B: Income Inequality

5. How much income do you earn in a month?

Less than MK1,000 [ ] MK1,000-MK10,000 [ ] MK10,000-MK20,000 [ ]

More than MK20,000 [ ]

6. Do you have any debts?

Yes [ ] No [ ]

7. Do you have the following at your household (Tick all that applies)?

Chicken [ ] Goat [ ] Pig [ ] Cow [ ] Bicycle [ ] Car [ ]

SECTION C: Unemployment

8. Employment status

Employed [ ] Unemployed [ ]

9. If employed tick below. If not, skip to question 10

Self-employed [ ] Formally employed [ ]

10. Are you affected at your workplace in any way because of your HIV status?

Yes [ ] No [ ]

11. Occupation

Farmer [ ] Business [ ] Unskilled labour [ ]

12. Employment may improve the socio-economic status of women living with HIV

1. Strongly disagree [ ] 2. Disagree [ ] 3. Neither 4. Agree [ ] 5. Strongly Agree [ ]

13. I am satisfied with my current employment

1. Very Unsatisfied [ ] 2. Unsatisfied [ ] 3. Not sure 4. Satisfied [ ] 5. Very satisfied []

SECTION D: Level of education

14. Have you ever gone to school?

Yes [ ] No [ ]

15. If yes, what is the highest level of education attained?

Postgraduate	[ ]
Undergraduate	[ ]
Diploma	[ ]
Certificate	[ ]
Secondary	[ ]
Primary	[ ]
Did not go to school	[ ]

16. Education plays a role in improving socio-economic status of people

1. Strongly disagree [ ] 2. Disagree [ ] 3. Neither 4. Agree [ ] 5. Strongly Agree [ ]

SECTION E: Household Characteristics and Socio-Economic Status

17. Do you experience any stigma because of your status?

Yes [ ] No [ ]

18. Indicate to what extend you agree or disagree with the following statement in rating the influence of household characteristics on socio-economic status of women living with HIV in Mchinji District, Malawi on a Likert scale of 1-5 where 1= **Strongly Disagree, 2= Disagree, 3= Undecided, 4=Agree, 5= Strongly Agree.** Specify by a tick in the spaces provided.

STATEMENTS	1	2	3	4	5
Higher socio-economic status women present higher rates of HIV infection compared to low socio-economic status women					
Women with increased resources had higher rates of HIV					
Poor Health conditions in the household greatly affect socio-economic status of women living with HIV					
Financial challenges affect socio-economic status of women living with HIV					
Women living with HIV experience stigma because of their socio-economic status					
HIV awareness activities improve the well-being of women living with HIV					

THANKS FOR YOUR COOPERATION

Appendix II: Interview Guide schedule for Focused Group Discussions

Dear Respondent,

I am a student from Catholic University of Eastern Africa undertaking my Master of Arts in Development Studies. I am carrying out a study to evaluate effects of poverty on the socio-economic status of women living with HIV in Malawi. Thank you for agreeing to participate in this interview which will be a great contribution to the successful completion of this academic work. Remember that participation in the study is voluntary and your decision to participate, or not participate will be treated kindly and will not affect you in any way. Remain assured that your responses will be treated with utmost confidentiality and will be used only for the purpose of this study. Therefore, kindly respond to the questions with honesty and sincerity. The interview should take approximately one hour depending on how much information you would like to share. With your permission, I would like to audio record the interview because I don't want to miss any of your comments. Thank you in advance for your cooperation.

Questions

1. What is your main source of income?

   ……

   ……

   ……

2. How much do you make from your source of income if you have any?

   ……

   ……

   ……

3. To what extent does your income cover your daily needs?

   ……

   ……

   ……

4. Do you experience any discrimination when making a living because of your status?

   ……

   ……

   ……

5. Have you ever lived without any source of income since the time you acquired your status?

……

……

……

6. How would you describe your experience living without any source of income?

……

……

……

7. How far did you go with education?

……

……

……

8. Do you participate in any HIV awareness activities in your community?

……

……

……

9. Have you ever been employed in any formal sector?

……

……

……

10. How does your marital status affect your status?

……

……

……

11.How does the size of your family affect your well-being?

……

……

……

THANKS FOR YOUR COOPERATION

Appendix III: Research authorisation letter from Catholic University of Eastern Africa

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

Faculty of Arts and Social Sciences

Department of Social Sciences and Development Studies

14th September 2022

The Director of Health and Social Services (DHSS)
Mchinji District Hospital,
P. O. Box 36
Mchinji - MALAWI

RE: PRINCE HENDERSON **REG. NO. 1042532**

I am writing to introduce to you **Prince Henderson** who is a finalist student pursuing Masters of Arts in Development Studies Degree at The Catholic University of Eastern Africa, Nairobi – Kenya, and to request you to assist him to accomplish his academic research requirements.

Prince has completed all course work requirements for this programme. However, every student in the programme is required to conduct research and write a report/thesis submitted during the final years of studies.

Accordingly, Prince's research topic has been approved. He will conduct research on the following topic:

> ***"The Influence of Poverty on the Socio-Economic Status of Women Living with HIV in Malawi: A Case Study of Mchinji Central Constituency's District Health Office (DHO)"***

Thanking you in advance for any assistance given to Prince.

Sincerely yours,

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA HEAD OF SOCIAL SCIENCES DEPARTMENT 14 SEP 2022 P.O. Box 62157 - 00200, NAIROBI

Dr.S. Ngacha Njeri, PhD, OFS
Head, Department of Social Sciences and Development Studies

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA (CUEA) P.O. BOX 62157 00200 Nairobi – KENYA
Tel: 020-2325811-5, 8890023-4, Fax: 8891084, Website: www.cuea.edu
Founded in 1984 by AMECEA (Association of the Member Episcopal Conference in Eastern Africa)

Appendix IV: Research authorisation letter from Mchinji District Hospital

All correspondence address to DHO

Phone: +265 01242310/906

E-mail: mchinjidho@sndp.org

Mchinji District Hospital,
Box 36,
Mchinji.

26th September 2022.

Dear sir

LETTER OF SUPPORT TO CONDUCT RESEARCH, "THE INFLUENCE OF POVERTY ON THE SOCIAL ECONOMIC STATUS OF WOMEN LIVING WITH HIV IN MALAWI: A CASE STUDY OF MCHINJI CENTRAL CONSTITUENCY'S DISTRICT HEALTH OFFICE (DHO)".

I have the pleasure to inform you that Mchinji District Health Research Coordinating Committee has agreed that you conduct research ***"The Influence Of Poverty On The Social Economic Status Of Women Living With HIV In Malawi: A Case Study Of Mchinji Central Constituency's District Health Office (DHO)"***.in Mchinji District.

The hospital management and staff of Mchinji Hospital will support the study as it has benefits for the district. The staff will ensure availability of the information for you to use in for the study and give you any other support that we can to ensure the success of the study.

Looking forward to getting feedback from you after the findings.

Yours faithfully

Dr. Juliana Kanyengambeta.

DIRECTOR OF HEALTH AND SOCIAL SERVICES

The Director For Health and Social Services
Mchinji District Hospital
27 SEP 2022
P.O Box 36, Mchinji

Appendix V: Antiplagiarism Certificate One

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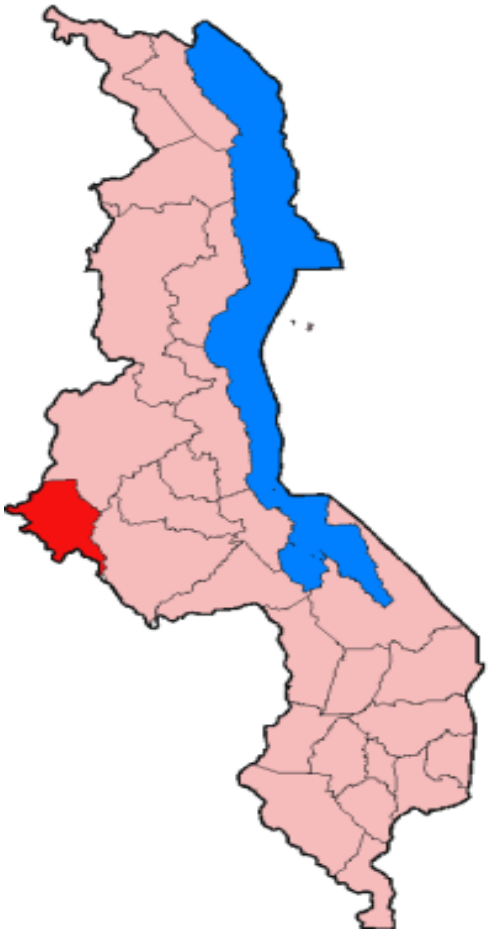
Appendix VII: Research Schedule

Oct (2022)-Oct (2023)										
Activity	**Oct Year 2022**	**Nov Year 2022**	**Dec Year 2022**	**Jan Year 2023**	**Feb Year 2023**	**March Year 2023**	**April Year 2023**	**May Year 2023**	**July Year 2023**	**Oct Year 2023**
Identification or research topic										
Literature review										
Drafting research proposal										
Developing research instruments										
Proposal writing										
Proposal presentation and correction of the proposal										
Data collection										
Data analysis and report writing										
Submission of report										
Graduation										

Appendix VIII: Research Budget Plan

ITEM	COST PER UNIT	Ksh.
Printing and photocopying	10	10, 000
Transport and communication	300	9, 000
Questionnaire administration		8,000
Data collection		10,000
Data analysis		15,000
Stationeries		1,000
Miscellaneous expenditure		4, 700
Proposal writing and binding		15,000
Total		**72,700**

Appendix IX: Map of Malawi, showing Mchinji District



KEY

Mchinji District