



# 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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**Abstract:** *This study investigated poverty's impact on the socio-economic status of women living with HIV in Malawi: A case study of Mchinji district hospital. Female vulnerability in Malawi is a huge factor in the incidence and prevalence of the disease across the region and a woman's socio-economic status (SES) frequently plays a substantial role in increasing her risk of being HIV positive, especially for women in the low socio-economic categories in Malawi. The objectives that guided this study were: to determine the influence of household income on the socio-economic status of women living with HIV, to evaluate the consequences of unemployment on the socio-economic status of women living with HIV, to examine the relationship between education level and socio-economic status of women living with HIV and to identify how household characteristics affect socio-economic status of women living with HIV at Mchinji district hospital. Findings showed that these women face poverty and income generation challenges, resorting to risky behaviours. Unemployment increased their financial burdens. Education played a role in critical thinking and preventing further infections. Household characteristics influenced family and HIV-positive women. Recommendations include economic interventions, scaling up programs for caregivers, households, orphans, and communities, and involving workers in HIV policies and programs.*

**Keywords:** Antiretroviral therapy, Poverty, Socio-economic status, HIV epidemic, Women

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## 1. Introduction

The study aimed to investigate the impact of household income, unemployment, education level, and household characteristics on the socio-economic status of women living with HIV at Mchinji District Hospital, Malawi.

In its broadest sense, poverty refers to the absence of essential needs. However, "necessity" can vary from person to person. Therefore, it is crucial to clearly understand what constitutes a necessity when identifying individuals living in poverty. Augustyn (2020) identifies two categories of necessities: the first comprises essentials required for basic survival, while the second encompasses the essentials needed to maintain a decent standard of living within a community.

Globally, many women living with HIV are concentrated in economically disadvantaged regions, particularly in the developing world, where extreme poverty is widespread. According to UNAIDS (2023) epidemiological estimates, 39.0 million [33.1 million–45.7 million] people globally were living with HIV in 2022. 53% of all people living with HIV were women and girls. Sub-Saharan Africa, categorized as a low and middle-income region, continues to bear the heaviest burden of HIV worldwide. Within this region, the infection is primarily prevalent among socially and economically active individuals aged 15 to 45, with a higher prevalence observed among women than men. While HIV infections are not solely limited to the poorest countries, economically disadvantaged individuals and countries are disproportionately affected by the epidemic (Cohen, 2006).

The most significant challenge faced in Sub-Saharan Africa (SSA) for decades has been the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic. This is because the infection rates continue to increase at high rates due to the region's poverty, weak health systems, and inadequate prevention and care resources to address the crisis. Fauci (2008) succinctly states, "The HIV/AIDS catastrophe has been one of the defining features of the past quarter of the century." In 2000, estimates revealed that twenty-five million Africans were living with HIV infection, representing 70% of people living with HIV worldwide (Buvé, 2002). Msisha (2008) emphasizes the pandemic nature of this disease by noting that in 2006, SSA alone had about 2.8 million new HIV infection cases and a further 2.1 million AIDS-related deaths, accounting for 72% of AIDS deaths worldwide.

HIV/AIDS is a severe issue in Malawi, with the country having one of the higher rates in West/Central Africa, despite having a lower rate than other countries in Sub-Saharan Africa. Surprisingly, women from wealthier backgrounds in Malawi are more likely to be infected with HIV than their poorer counterparts. This goes against the common belief that those with higher socio-economic status tend to have better overall health. This phenomenon's root cause is related to cultural factors, particularly gender-based norms, which impact how women behave and control their exposure to HIV. Economic prosperity or hardship can increase the risk of HIV for women, according to a recent review of available research (MacLachan, 2009).

Research shows that there is a link between poverty and the spread of HIV. Some experts believe that poverty can lead to a faster progression from HIV-zero positivity to full-blown AIDS. They argue that the shape and form of the AIDS epidemic is influenced by the economic, political, and cultural characteristics of a society. Poverty and inequality can push people towards risky livelihood and coping strategies, increasing their chances of contracting HIV.

Although national HIV prevalence decreased from 12% in 2004 to 10.6% in 2010, Malawi continues to face a severe epidemic. There are an estimated 1,000,000 Malawians living with HIV. Women are disproportionately affected, and there are approximately 790,000 children orphaned because of AIDS. In Malawi, over 50% of women are living with HIV, and this is attributed mainly to socioeconomic factors. According to Masanjala (2007), poverty significantly contributes to the high prevalence rate. The study suggests that improved socio-economic status could lead to lower HIV prevalence and better health outcomes for women living with the virus. Therefore, the study aims to investigate the effects of poverty on HIV prevalence among women who use health services at Mchinji District Hospital in Malawi. Specifically, the research will focus on the economic and HIV statuses of women, considering the

negative impact of socio-economic factors on their health and well-being.

## 2. Literature Review

The human immunodeficiency virus (HIV) is a virus that targets the immune system and weakens the body's ability to fight off infections and cancers that a healthy immune system can combat (WHO, 2021). As the virus destroys immune cells, infected individuals gradually become immune-deficient. CD4 cell count is used to measure immune function. If left untreated, HIV can progress to acquired immunodeficiency syndrome (AIDS), which may take years to develop, depending on the person. The development of certain cancers, infections, or other severe long-term symptoms identifies AIDS. HIV remains a significant global public health concern, claiming 36.3 million lives and no cure. However, increasing access to effective HIV prevention, diagnosis, treatment, and care, including for opportunistic infections, has made HIV a manageable chronic health condition, allowing individuals living with HIV to lead long and healthy lives.

Across the globe, women face limited economic participation opportunities compared to men. They also have less access to primary and higher education, face more significant health and safety risks, and have less political representation. Ensuring women's rights and providing them with opportunities to achieve their full potential is crucial not only for achieving gender equality but also for attaining various international development goals. Goals

Women living with HIV face various challenges within their communities. These challenges can be classified into two broad categories: biological and non-biological factors (Rodrigo & Rajapakse, 2010). From a biological perspective, it is observed that HIV transmission from men to women is more likely compared to the reverse scenario. Additionally, while there are no gender-specific guidelines for initiating and maintaining highly active antiretroviral therapy (HAART), growing evidence suggests that the side effects experienced by females and males differ. Females are more susceptible to complications such as lactic acidosis, lipodystrophy, and disturbances in glucose metabolism.

Rodrigo and Rajapakse (2010) highlight that women in certain societies face more significant disadvantages compared to others due to factors such as extreme poverty, restrictive gender norms, a higher prevalence of violence, and limited access to opportunities for employment and education. In several sub-Saharan countries, the adult HIV prevalence exceeds 20% (e.g., Zimbabwe, Botswana, Lesotho, and Swaziland), while in others, it surpasses 10% (e.g., South Africa, Namibia, Zambia, Mozambique, Malawi). While it is evident that HIV disproportionately affects poorer countries in the developing world, it is crucial to examine the complex

relationship between poverty and HIV critically. As the epidemic increasingly affects women, it becomes essential to explore the interplay between women, HIV, and poverty.

## **2.1 Household income and the socio-economic status of women living with HIV**

One of the most consistent findings in social epidemiology is the relationship between socio-economic status (SES) and health. Researchers argue that individuals with lower SES are more likely to experience health problems, diseases, and death. Conversely, those in wealthier populations tend to have better health outcomes, including nutrition, morbidity, mortality, and healthcare utilization. This pattern is observed not only in developed countries but also in developing countries. (Adler and Newman, 2002; Lynch and Kaplan, 2000; Mishra et al., 2007a; Mulatu and Schooler, 2002; Williams and Collins, 1995).

Households affected by HIV typically experience poor growth and metabolism, putting them at higher risk for recurring malnutrition-related illnesses that further deplete their valuable nutrients (Oleske, 1987). Coping strategies for these households depend on a complex mix of economic, health, and sociocultural factors, including the gender of the household head (McClelland et al., 2018). This situation becomes even more critical if the head of the household is female, as sociocultural and economic factors often put women at a disadvantage when contracting HIV and affording nutritionally-rich diets for their families (Frew et al., 2016). The interplay between household HIV status and the gender of the household head poses a unique challenge for countries in sub-Saharan Africa.

Okigbo et al. (2002) state that the risk of contracting HIV/AIDS is higher among individuals with lower socio-economic status. Poverty is often associated with poorer health outcomes, including HIV/AIDS. In developed countries, HIV/AIDS is more prevalent among those with lower incomes. In the United States, for instance, African Americans and Hispanics are more likely to contract HIV/AIDS, as they tend to have lower socio-economic status. Even when education is provided about AIDS prevention, economic barriers can hinder the adoption of safe sex practices among these groups (Okigbo et al., 2002).

At the global and regional levels, low SES countries or regions seem to have the higher HIV rates with the poorest regions having the highest rates of HIV infection and mortality from AIDS. A good example is Sub-Saharan Africa, which has the lowest gross domestic product (GDP), with more than sixty percent of the population spending less than one US dollar a day, and the highest HIV rates in the world (Mbirimtengerenji,

2007; Whiteside, 2002). Mishra et al., (2007), for example, observed that there is evidence of positive relationship between socio-economic status and the risk of most sexually transmitted infections. In the study, Mishra et al, 2007 intended to describe the methods used in the Demographic and Health Surveys (DHS) to collect nationally representative data on the prevalence of human immunodeficiency virus (HIV) and assess the value of such data to country HIV surveillance. The study involved national samples of adult women and men in Burkina Faso, Cameroon, Dominican Republic, Ghana, Mali, Kenya, United Republic of Tanzania and Zambia were tested for HIV. Dried blood spot samples were collected for HIV testing, following internationally accepted ethical standards.

## **2.2 Unemployment and Socio-economic Status among Women Living with HIV**

Determining one's occupational status is a multifaceted aspect of SES, as its measurement can vary based on the significance of different aspects of an individual's work-life, depending on one's theoretical perspective (Adler & Newman, 2002, p. 64). In the context of the HIV/AIDS epidemic, various studies have identified correlations between occupational status and health outcomes.

In their study, Dunkle et al. (2004) discovered that women with lower socio-economic status tend to have occupations that expose them to higher risks of contracting HIV. The study's objective was to estimate the proportion of heterosexual HIV transmission occurring within married or cohabiting couples in urban areas of Zambia and Rwanda annually. The researchers utilized population-based data from the Demographic and Health Surveys (DHS) to examine heterosexual behaviour in Zambia (2001-02) and Rwanda (2005). Additionally, they collected data on the HIV status of married or cohabiting and non-cohabiting couples through a voluntary counselling and testing service for urban couples in Lusaka, Zambia, and Kigali, Rwanda. This approach allowed them to investigate the dynamics of HIV transmission within these populations.

In Sub-Saharan Africa, certain low-income occupations, including waitressing, barmaids, and engaging in sex work, have been identified as increasing the risk of HIV transmission due to the potential for contact with individuals who travel (Wojcicki, 2005). Additionally, studies have demonstrated that individuals in occupations that involve travel, such as truck drivers, driver's assistants, military personnel, and migrant workers, have significantly higher rates of HIV infection (Mosoko et al., 2009; Wojcicki, 2005). These findings underscore the specific occupational factors that contribute to heightened vulnerability to HIV within the African context.

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

Education is often considered a fundamental socio-economic factor influencing future occupational opportunities and earnings. In Sub-Saharan Africa (SSA), research indicates that education is associated with lower HIV prevalence, particularly among individuals with secondary education, with a more pronounced effect observed among women. Studies suggest that young individuals in higher wealth groups are more likely to be educated and have educated partners, which is associated with a reduced likelihood of having HIV-positive partners (Lopman et al., 2007). This assertion is supported by research conducted in Tanzania, South Africa, Cote d'Ivoire, Cameroon, and Uganda, which either found no significant association between increasing education and HIV prevalence for both genders or observed a lower risk of HIV infection with each additional year of schooling. Overall, these studies suggest that education has a protective effect against the risk of HIV infection (Bärnighausen et al., 2007; Gillespie et al., 2007; Glynn et al., 2004; Lopman et al., 2007; Msisha et al., 2008).

Education is commonly thought to provide individuals with more access to information and resources and encourage healthier behaviours. However, some studies have shown that higher education can also be associated with an increased risk of HIV, particularly in certain countries in Eastern and Southern Africa. Research has indicated that individuals with only primary education had twice the likelihood of being HIV positive compared to those with no education. At the same time, there were no significant differences between those with secondary or higher education and those without education.

According to a study conducted in 2009 by Reither and Mumah, it was observed that the rate of HIV infection among women in Cameroon increases with their level of education. The study suggests that individuals with basic primary education may be exposed to HIV risk factors not shared by those without access to education. Interestingly, research has shown that while there is a positive correlation between wealth and HIV, the same does not necessarily hold for education. This indicates that the relationship between socio-economic status and HIV is complex (Glynn et al., 2004; Hargreaves & Glynn, 2002; Msisha et al., 2008).

## 3. Methodology

The study adopted Mixed research approach because it combines specific, detailed insights from qualitative research (such as focus groups) and the generalizable, easily replicable data from quantitative research (such as surveys) (Cresswell, 2012). According to Mason (2006),

mixing methods offers enormous potential for generating new ways of understanding the complexities and contexts of social experience, and for enhancing capacities for social explanation and generalisation. In this study mixed research approach enabled the researcher to collect both qualitative and quantitative data. Questionnaire and focus groups approach was used to collect data. Focused group discussion was used to collect qualitative data while quantitative data was collected using questionnaire. The study took place at Mchinji district hospital in the central region district of Mchinji. It is a border district which shares the country's international boundaries with Zambia and Mozambique and district boundaries with Kasungu to the north and Lilongwe to the east. It 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 has a population of 602,305 (313, 199 males and 289, 106 females) and a total of 134,799 households. Politically, Mchinji district has six Constituencies, which are headed by Members of Parliament. Mchinji Central Constituency accommodates Mchinji district hospital, a facility where the study took place.

Based on the size of the population, the researcher had various options of dealing with the population. According to Malawi Analytics Platform (MAP) database for the Ministry of Health (MoH) and managed by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Cohort Disaggregated Report for quarter two of 2022, the total population of women on ART at Mchinji district hospital was 12,053 (62.43%). Out of this, 3,141 (62.79%) women were on ART Mchinji district hospital. Therefore, this study had a target population of 3,141 of women living with HIV Mchinji district hospital.

Since the target population in this study was greater than 100 ( $N > 100$ ), Krejcie and Morgan (1970) formula was used to compute sample size of 342. Thus,

$$\begin{aligned}
 S &= \frac{X^2 NP(1-P)}{d^2 (N-1) + X^2 P(1-P)} \\
 S &= \frac{3.841 \times 3141 \times 0.50(1-0.50)}{0.05^2 (3141 - 1) + 3.841 \times 0.50(1-0.50)} \\
 S &= \frac{3.841 \times 3141 \times 0.50(0.5000)}{0.0025(3140) + 3.841 \times 0.50(0.5000)} \\
 S &= \frac{3.841 \times 3141 \times 0.2500}{7.85 + 3.841 \times 0.2500} \\
 S &= \frac{3016.14525}{7.85 + 0.9603} \\
 S &= \frac{3016.14525}{8.8103} \\
 S &= 148,037.9015 \div 386.3728 \\
 S &= 342.3 \\
 \text{Sample Size was} &= 342
 \end{aligned}$$

Where,

S = Required sample size,  $X^2$  = the table value of chi-square for 1 degree of freedom at the desired confidence level (3.841), N = the population size (3,141), P = the population proportion (assumed to be 0.50 since this

would provide the maximum sample size) and D = the degree of accuracy expressed as a proportion (0.05).

Therefore, the sample size (Respondents) used in this study was 342 of women living with HIV Mchinji district hospital.

The instruments that were used for collection of data relevant to this study were questionnaires and focused Group Discussion. In order to achieve the expected objectives for the project, the researcher used a questionnaire to solicit quantitative. The questions in the questionnaires were both structured (present the respondents with a fixed set of choices, often called closed questions) and unstructured (they do not limit responses but do provide a room for respondents' answer, sometimes referred to open-ended questions). It contained demographic information of the respondents. Some of the questions were designed with alternative answers expressed in a Likert scale. The questionnaire was structured according to the specific objectives of the study.

Interview guides was used to collect information from 5 randomly chosen participants from the sampled size. Therefore, a total of 5 participants participated in focused group discussion. The researcher allowed them to participate by choice and they were assured of

confidentiality for the gathered information. The interview guides for focused group discussion were designed according to the research objectives.

The test assessed the relevance of the research questions as it tested the understand ability of the research tools. The test for reliability established the extent to which results are consistent over time. The researcher collected data from 45 participants who did not participate in the actual data collection. Therefore, reliability of the instruments was ascertained by re-administering the questionnaires to the same sampled respondents in two weeks' interval to determine its re-productivity. The scores obtained from each test were correlated to get the coefficient of reliability. In order to obtain accurate reliability, Gupta (2017) asserted that a standard minimum value of 0.6-0.9 is recommended.

Hence, to determine stability, a measure or test was repeated on the subject at a future date. Results were compared and correlated with the initial test to give a measure of stability. Responses obtained during the piloting were used to calculate the reliability coefficient from a correlation matrix. The reliability of the instrument was estimated using Cronbach's Alpha Coefficient which is a measure of internal coefficient. A reliability of at least 0.70 at  $\alpha=0.05$  significance level of confidence was acceptable.

**Table 1: Cronbach's Alpha Values**

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

From the table above, it was found that the entire variables had a reliability level of above 0.7 and thus they were deemed appropriate in determining their influence of the dependent variable which was socio economic status of women living with HIV.

The study ensured construct validity by deriving relevant representative questions to cover the study objectives. To test and improve the validity of questionnaires, the researcher first carried out a pilot test with 10% of the total sampled respondents' Mchinji district hospital. The researcher consulted research experts to verify whether the instruments are valid. After the construction of the questionnaires, the researcher reviewed items with the help of supervisors. The suggestions given were incorporated to validate the instruments.

The researcher obtained an authorization letter from the Catholic University of Eastern Africa, the department of social sciences and development studies and then sought an authorisation letter from Mchinji district hospital. When the letters were provided, the researcher proceeded to collect data from the respondents. In the study area,

the researcher then sought permission from the administration to collect data from the respondents.

The respondents were informed about the purpose of the study. The researcher issued the questionnaires to the respondents. Research assistants were used in the data collection process since it is quite involving. Data collection was done using both primary and secondary sources. The primary sources of data collection methods were including the administration of questionnaire to the 342 ATR female clients at the district hospital and interviews was conducted with clients that was purposively selected. On the other hand, secondary sources were involving the use of hospital's reports, UNAIDs reports, books, and journal articles on HIV/AIDs. Data from these sources was helping the researcher in determining the effects of poverty on HIV prevalence among women, particularly in developing countries. The researcher followed up on the respondent and ensures that the questionnaires are filled appropriately and collected.

Quantitative data was collated and analysed using descriptive statistics through the use of SPSS (version

25). The analysed data was presented in form of figures, tabulation, graphs and charts in order to establish the relation between the variables under study. Qualitative data on was collected through focus group discussions with women to share their experiences of being on ART. On the other hand, focused group discussions were used to collect qualitative data which was analysed using content analysis. Here the researcher was interested in the common themes that emerged from data collected through interviews. Since the study involved human participants, care was taken to ensure that they are not affected negatively in any way and the research will not undertake for personal gain.

The study ensured that participants should give consent for their involvement in the research. To ensure there is no abuse of information, the data collected as treated with utmost confidentiality and was not shared with other parties. Furthermore, the collected data aimed for the academic research project only. Most importantly, the informants were furnished with a report of the study at

the end. Confidentiality and anonymity of the research participants were protected by ensuring that their identities are not disclosed on the questionnaire forms and participants did not write their names.

## 4. Results and Discussion

### 4.1 Age Bracket

Respondents were analyzed based on their age distribution. The study findings revealed that 54.8 percent of the respondents were between 18- 28 years of age, followed by those in the 29-38 years' age bracket at 25.9 per cent. Respondents in the 39-49 years' age bracket were 15.8 percent and the least that were above 50 years at 3.6 percent as illustrated in Figure 1 below. This indicates that most of the women living with HIV Mchinji district hospital was of youthful age between 18-28 years.

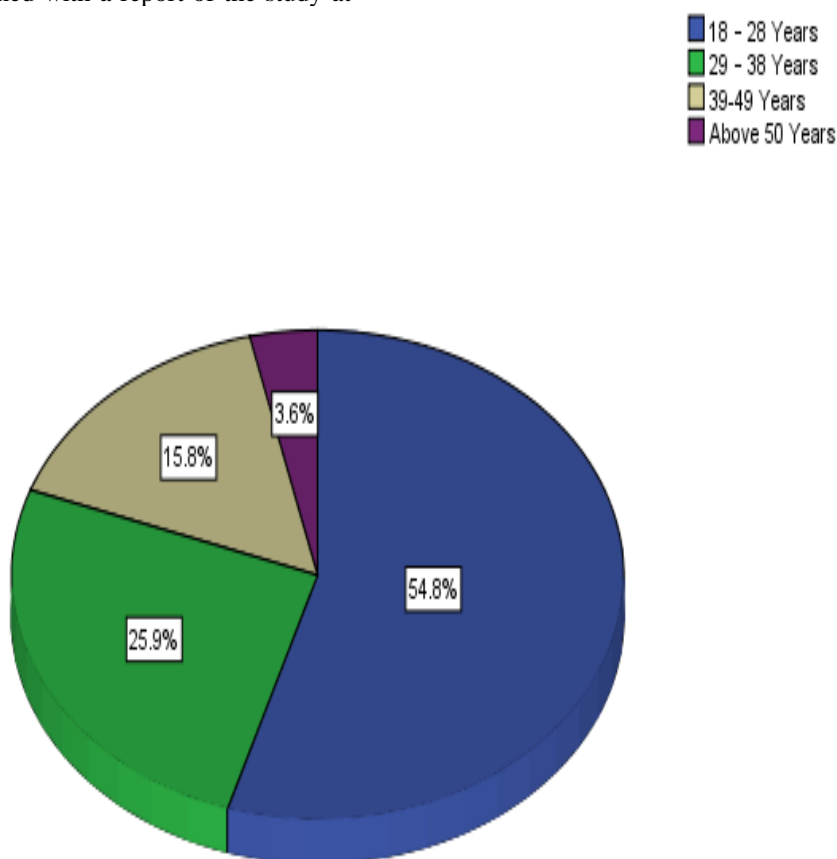
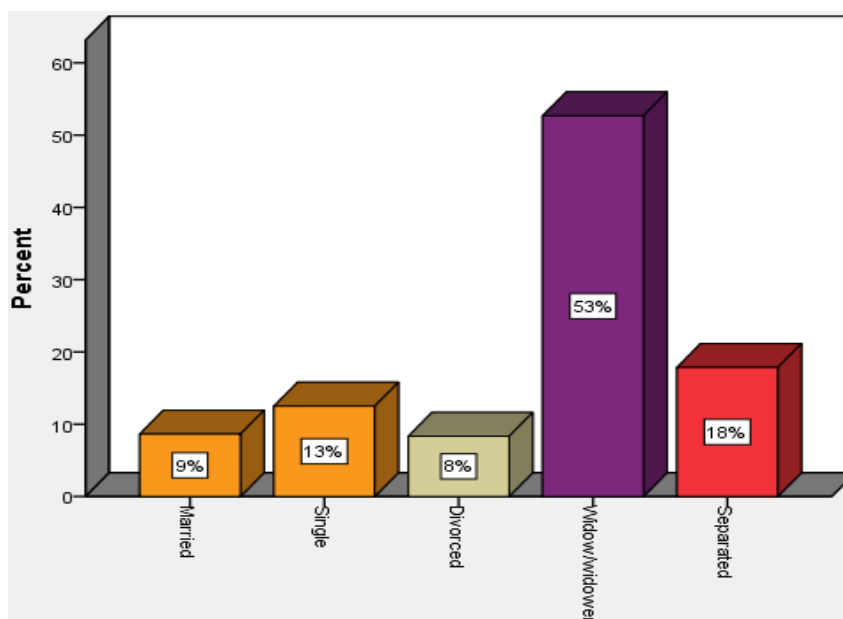


Figure 1: Respondents' Age

### 4.2 Marital Status

Findings in Figure 2 show that majority (53%) of the women who participated in this study were widow/widower, 18% separated, 13% were single, 8% were married and 8% divorced. This implies that majority of respondents' widow/widower. Marital status

is significantly related to a woman's HIV status HIV infection rates were significantly higher for women who were widowed. Similar results were obtained from other studies, including Malawi (Reither and Mumah, 2009). It would appear that the loss of husband (or change in marital status) due to past HIV infections of married women and/or their partners could be linked to current female HIV status Mchinji district hospital.



**Figure 2: Marital status of Respondents**

### 4.3 Number of Household

The study sought to know number of households among women living with HIV in Mchinji District Hospital. The findings were presented in Table 2.

**Table 2: 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
<b>Total</b>	<b>336</b>	<b>100</b>

Findings in Table 2 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 Period of living with HIV

Participants were asked to indicate the period they have been living with HIV. Findings were presented in Table 3

**Table 3: 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
<b>Total</b>	<b>336</b>	<b>100</b>

According to analysis presented in Table 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%). This was an indication that women who have lived with HIV for a longer period of

time have negative economic consequences on them and their family through several mechanisms such as their inability to work because of poor physical health condition, loss of employment leading to loss of family income and increased health expenditure.

## 4.5 Income and Socio-economic Status

This section of the first objective of the study outlines the influence of income inequality on the socio-economic

status of women living with HIV at Mchinji district hospital.

The respondents were asked to indicate their income per month. The findings were presented as shown in table 4.

**Table 4: Income per Month in Malawi Kwacha (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
<b>Total</b>	<b>336</b>	<b>100</b>

Findings in Table 4 revealed that majority, 169(50.3%) of women living with HIV at Mchinji district hospital who participated in this study earn less than MK1, 000, 98 (29.2%) earn between MK1, 000-MK10, 000, 60 (17.9%) earn between MK10, 000-MK20, 000 and 9 (2.7%) earn more than MK20, 000. Based on the analysis from Table 3, the researcher concluded that women living with HIV in the lowest wealth quintile were found to be more likely to test positive for HIV infection than woman than women in the highest wealth quintile. This finding concurs with Fenton (2014) 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.

The respondents were further asked their main source of income. Findings were analyzed as below.

*At Mchinji District Hospital, living in poverty has resulted in food insufficiency. This has made women living with HIV to look for several ways in order to received income from both having multiple sex partners and exchanging sex which are associated with acquiring income through selling or pawning items and irregular jobs. These sources of income are unstable which in many cases result in variable income over a monthly period. When money is low, women seek out new partners for relationships or transactional sex, who can provide economic support or exchange sex for money. Women may seek out new partners, who can provide gifts or money for necessities like rent or food for their children (FGD, January, 2023).*

Respondents were farther asked whether they had any debts. Findings in this section were presented in Table 5.

**Table 5. Debts**

	Frequency	Percent
Yes	179	53.3
No	157	46.7
<b>Total</b>	<b>336</b>	<b>100.0</b>

From the table 5 majority 179(53.3%) indicated that they had debts while 157(46.7%) declined the statement. HIV status among women at Mchinji district hospital has a negative impact on their socio-economic status by constraining their ability to work and earn income. One of the effects of HIV on women is on their physical and mental functioning which affects them in maintaining

regular employment subjecting them to acquisition on debts in order to survive.

The participants were farther asked to indicate whether they have chicken, goat, pig, cow, bicycle or car in household. Findings were presented in table 6.



**Table 6: Properties in the Household**

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

As per analysis presented in Table 6 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 at Mchinji district hospital possess variety of households' properties. The findings could also be interpreted those women 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 Mchinji district hospital makes most of them to rely 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).*

#### **4.6 The Effect of Unemployment on SES of women living with HIV/AIDS**

In the second objective of the study, the researcher sought to evaluate the consequences of unemployment on the socio-economic status of women living with HIV at Mchinji district hospital. Respondents were asked to indicate their employment status which was presented in Table 7.

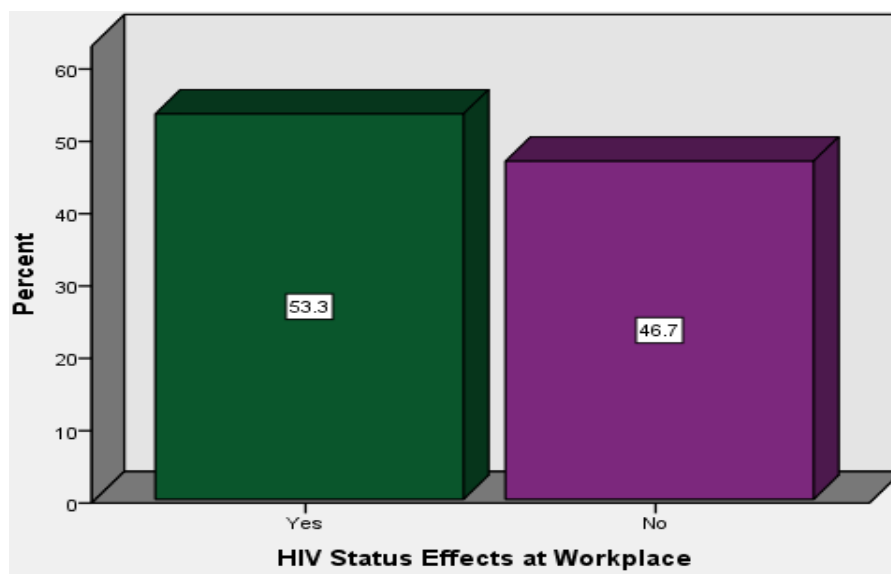
**Table 7: Employment Status**

<b>Employment Status</b>	<b>Frequency</b>	<b>Percent</b>
Self-employed	70	20.8
formally employed	30	9.0
<b>Total</b>	<b>336</b>	<b>100.0</b>

From the Table 7 out of 336 participants in this study, majority 236(70.2%) were unemployed. Those were self-employed were 70(20.8%) and 30(9%) were formally employed. Therefore, a total of 100(29.8%) of those who participated in this study had jobs while majority were jobless. These results provide estimates of the impact of HIV on labour productivity. As women living with HIV in workplaces often bring unrecorded 'helpers',

attendance and these often-put workers in jeopardy of losing their jobs and impose financial burdens on employers.

Participants were asked to indicate whether their HIV status affect them at workplace in any way. Findings were presented in Figure 3 .



**Figure 3: Effects of HIV Status on Workplace**

Majority, 53.3% of the participants agreed that they are affected at your workplace because of their HIV status. However, 46.7% declined the statement. It was concluded that HIV has a huge impact on the world of work especially with on people living with HIV because

it reduces the supply of labour and available skills, increase labour costs, reduces productivity, threatens the livelihoods of workers and employers, and creates environments which undermine the rights of workers in at Mchinji district hospital.

**Table 8: Occupation of the Respondents**

Occupation	Frequency	Percent
Farmer	81	24.1
Business	205	61.0
Unskilled labour	50	14.8
<b>Total</b>	<b>336</b>	<b>100.0</b>

Analysis in Table 8 indicate that majority 205(61%) of women living with HIV who participated in this study were doing business as their occupation, 81(24.1%) were farmers and 50(14.8%) were unskilled labour. The study found evidence that women living with at Mchinji district hospital maintain treatment more successfully when they have a job than when they do not. This is mainly because they have regular financial means to pay for related health services, medications and support, and to afford sufficient food.

The respondents were asked to indicate the extent to which they agreed or disagreed with statements in rating effects of employment in improving the socio-economic status of women living with HIV on a Likert scale of 1-5 where, 1= Strongly Disagree; 2=Disagree; 3= Neutral, 4=Agree; 5= Strongly Agree. The findings were presented as shown in table 9.

**Table 9 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 9 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).*

## 4.7 The Relationship between Education Level and SES of women living with HIV/AIDS

On the third objective of the study, the researcher had sought to examine the relationship between education level and socio-economic status of women living with HIV at Mchinji district hospital.

Respondents were asked to indicate whether they had gone to school. The response was presented in Table 10

**Table 10: Education Background**

	<b>Frequency</b>	<b>Percent</b>
Yes	279	83.0
No	57	17.0
<b>Total</b>	<b>336</b>	<b>100.0</b>

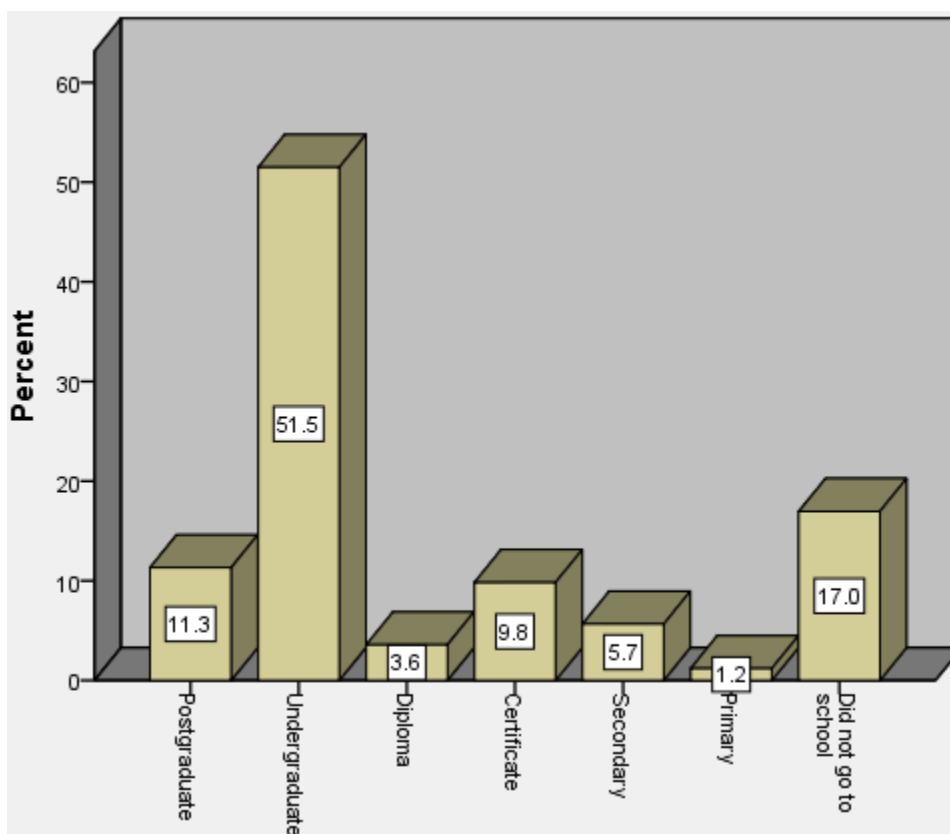
Two hundred and seventy-nine, 279(83%) of the participants agreed that they had gone to school while 57(17%) indicated they had no education background. From the analysis it could be concluded that education is associated with social-economic status of women living with HIV in that schooling keeps people 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).*

## 4.8 Highest level of Education Attained

Participants were asked to indicate their highest level of education they had attained. Findings were represented in Figure 4



**Figure 4: Highest level of Education**

According to analysis presented in Figure 4, the findings indicate that the majority (51.5%) 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. Generally, in Mchinji District women living with HIV have at least education background an indication that apart from helping them in farther HIV prevention, education increases the tolerance and empathy of individuals who have contracted the disease by addressing fears and changing attitudes, education also reduces discrimination

and stigmas – the leading causes for children and adolescents to drop out of school.

#### **4.9 Role played by Education in improving socio-economic Status of people**

The study sought to find out role played by education in improving socio-economic status of people. Women living with HIV who participated in this study were asked to indicate their level of agreement on a Likert scale of 1-5 where, 1= Strongly Disagree; 2=Disagree; 3= Neutral, 4=Agree; 5= Strongly Agree. The findings were presented as shown in table 11.

**Table 11: Role played by Education on Socio-Economic**

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 11 shows that majority (62%) of women living with HIV at Mchinji district hospital strongly agreed with the statement that education plays a role in improving socio-economic status of people living with HIV, 15% agreed, 10% were non-committal and 9% disagreed and 4.0% strongly disagreed.

#### **4.10 Household Characteristics of women living with HIV at Mchinji district hospital, Malawi**

This section addresses the household characteristics of women living with HIV in at Mchinji district hospital. Women living with HIV who participated in this study were asked to indicate the extent they agreed or disagreed

with the statement related to household characteristics of women living with HIV. Findings were presented in the following tables.

**Table 12: 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. From the analysis, it was revealed that HIV has an effect on relationships between family members and women living with it. Chronic illness in the parent has been witnessed to change family roles causing anger or guilt. Family members can become isolated and leading to frustration among children.

**Table 13: HIV Awareness of the women living with HIV at Mchinji district hospital**

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 do participate in HIV awareness activities	12.6	12.4	9.2	19.3	66.6

Majority (62%) strongly agreed that they are well informed about HIV issues, 15% agreed, 10% were neutral, 9% disagreed while 4% strongly disagreed. On whether HIV awareness activities had improved the well-being of women living with HIV, 56% agreed and 32% strongly agreed. However, 6% disagreed, 4% strongly disagreed and 2% remained noncommittal. From the findings it was deduced that many women living with HIV are aware. However, HIV awareness of the women living with HIV at Mchinji district hospital has been observed to be having negative effects. Receiving a diagnosis and living with HIV have negative economic consequences on women and their family through several mechanisms, such as women's inability to work due to

poor physical health condition, loss of employment leading a reduction in or loss of family incomes, and increased health expenditure.

Respondents were asked whether they participate in HIV awareness activities. On a Likert scale of 1-5 where, 1= Never; 2=Likely; 3= Not sure, 4=only when I have time; 5= Always.

It was revealed that 66.6% of the participants indicated that they always participate in HIV awareness activities, 19.3% indicated only when they had time, 12.6% indicated they never participated in HIV awareness activities, 12.4% indicated likely and 9.2% were not sure.

**Table 14: 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
<b>Total</b>	<b>336</b>	<b>100</b>

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 15: Means of Transport**

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

According to the analysis presented in Table 15, 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.

## Discussion of Findings

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

The study assessed the influence of income inequality on the socio-economic status of women living with HIV at Mchinji district hospital, Malawi. Overall, the study revealed that women living with HIV in the lowest wealth quintile were found to be more likely to test positive for HIV infection than woman than women in the highest wealth quintile. At Mchinji district hospital, living in poverty has resulted in food insufficiency. This has made women living with HIV to look for several ways in order to received income from both having multiple sex partners and exchanging sex which are associated with acquiring income through selling or pawning items and irregular jobs. These sources of income are unstable which in many cases result in variable income over a monthly period. When money is low, women seek out new partners for relationships or transactional sex, who can provide economic support or exchange sex for money. Women then seek out new partners, who can provide gifts or money for necessities like rent or food for their children.

*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).

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

The study examined the consequences of unemployment on the socio-economic status of women living with HIV at Mchinji district hospital, Malawi and revealed that women living with HIV in workplaces often bring unrecorded 'helpers', attendance and these often-put women workers in jeopardy of losing their jobs and impose financial burdens on employers. Women living with at Mchinji district hospital maintain treatment more successfully when they have a job than when they do not. Those who are unemployed have regular financial constrain to pay for related health services, medications and support, and to afford sufficient food. These findings corroborate with findings of Liu, Canada, Shi, & Corrigan (2012) who argued that job applicants with HIV were incompetent and could not perform the functions of the job stated. This has implications for hiring practices and economic opportunities for people 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).*

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

On the third objective of the study, the researcher had sought to examine the relationship between education level and socio-economic status of women living with at Mchinji district hospital. From the analysis it was 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).

At Mchinji district hospital women living with HIV have at least education background an indication that apart from helping them in farther HIV prevention, education increases the tolerance and empathy of individuals who have contracted the disease by addressing fears and changing attitudes, education also reduces discrimination and stigmas the leading causes for children and adolescents to drop out of school.

This concur with Adler and Newman (2002) who noted that knowledge and life skills associated with formal

education are normally believed to provide better educated persons with greater access to information and resources and to promote healthier behaviours than individuals with little or no education.

### How household characteristics affect SES of women living with HIV

This section addresses the how household characteristics affect socio-economic status of women living with HIV V, Malawi. Women living with HIV who participated in this study were asked to indicate the extent they agreed or disagreed with the statement in rating whether household characteristics affect socio-economic status of women living with HIV on a Likert scale of 1-5 where, 1=Strongly Disagree 2= Disagree, 3= Undecided, 4=agree 5= Strongly Agree. Table 16 present the findings.

**Table 16: Effect of Household Characteristics socioeconomic**

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

Table 16 shows that majority (37.5%) of the respondents strongly agreed with the statement that higher socio-economic status women present higher rates of HIV infection compared to low socio-economic status women, 32.4% agreed, 8% were non-committal and 18.5% disagreed and 3.6% strongly disagreed.

Forty-four-point six percent (44.6%) of the respondents strongly agreed that women with increased resources had higher rates of HIV, 33% agreed, 17.0% disagreed and 5.4% were undecided with the statement.

On whether poor Health conditions in the household greatly affect socio-economic status of women living with HIV, most (53.9%) of the respondents agreed with the statement, 6.3% strongly agreed, those who were neutral were 16.4% and those who disagreed were equal (13.4%) while 10.1% strongly disagreed.

Forty-two percent (47%) of the respondents agreed that financial challenges affect socio-economic status of women living with HIV, 13.4% agreed, 10.1% neither

agree nor disagree while 24.7% disagreed and 4.8% strongly disagreed with the statement.

Majority (62.5%) of the respondents strongly agreed that women living with HIV experience stigma because of their socio-economic status, 22.9% agreed, 5.4% remained non-committal while 6.5% disagreed and 2.7% strongly disagreed with the statement.

HIV awareness activities improve the well-being of women living with HIV, 71.7% agreed, 8% strongly agreed, 8.6% strongly disagreed, 7.1% were undecided and while 4.5% disagreed.

From the findings it was evidenced that household characteristics affect socio-economic status of women living with HIV at Mchinji district hospital in that it affects the rates of HIV infection. This was an indication that HIV has an effect on relationships between family members and women living with it. Chronic illness in the parent has been witnessed to change family roles causing anger or guilt. Family members can become isolated and leading to frustration among children. However, HIV awareness of the women living with at Mchinji district

hospital has been observed to be having negative effects. Receiving a diagnosis and living with HIV have negative economic consequences on women and their family through several mechanisms, such as women's inability to work due to poor physical health condition, loss of employment leading a reduction in or loss of family incomes, and increased health expenditure.

In the view of McClelland et al, (2018) who argued that in that matrix, household coping strategies in abating stunting in household members depend on a complex of economic, health, and socio-cultural characteristics of the household include the gender of the household head. This concurred with the findings of this study.

## 5. Conclusion and Recommendations

### 5.1 Conclusion

In conclusion, women living with HIV in the lowest wealth quintile at Mchinji district hospital were found to be more likely to test positive for HIV infection than woman than women in the highest wealth quintile. Poverty has made women living with HIV to look for several ways in order to received income from both having multiple sex partners and exchanging sex which are associated with acquiring income through selling or pawning items and irregular jobs. These sources of income are unstable which in many cases result in variable income over a monthly period. Women then seek out new partners, who can provide gifts or money for necessities like rent or food for their children.

On the consequences of unemployment on the socio-economic status, women living with HIV at Mchinji district hospital workplaces often bring unrecorded 'helpers', attendance and these often-put women workers in jeopardy of losing their jobs and impose financial burdens on employers. This is also having effects on their physical and mental functioning which always make it difficult for them in maintaining regular employment.

About the relationship between education level and socio-economic status of women living with HIV, education provide platform with idea of developing critical thinking which inspires women living with HIV to develop long term goals. These contribute to delaying sex, which makes these women avoid farther HIV infection. Higher educational attainment provides knowledge, which women use to avoid HIV infection and provides employment which enhances their capacity to act on their plans to reduce vulnerability.

Household characteristics of women living with HIV at Mchinji district hospital were found to affects relationships between family members and women living with it. Chronic illness in the parent has been witnessed to change family roles causing anger or guilt. HIV awareness of the women living with HIV at Mchinji

district hospital has been observed to be having negative effects in that receiving a diagnosis has negative economic consequences such as loss of employment leading a reduction in or loss of family incomes.

## 5.2 Recommendations

Based on the findings, the study made the following recommendations:

1. There is need for economic interventions to women living with poverty. This will decrease their vulnerability to HIV infection. Such interventions, for example, may mitigate their need to stay in violent relationships or to engage in transactional sex.
2. There is need of scaling-up programmes to mitigate the effects of HIV/AIDS on cares, households, orphans and communities at Mchinji district hospital.
3. There is need to engage HIV policies and programs taken by workers' and employees.

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