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Exploring the Experiences of HIV Positive Pregnant Women on Prevention of Vertical Transmission of HIV/AIDS in Rural Malawi

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Mother-to-child transmission (MTCT) of human immunodeficiency virus (HIV) continues to be the primary conduct that HIV is transmitted to children worldwide. The problem of HIV/acquired immunodeficiency syndrome (AIDS) is having a great impact on the world's children. The prevalence of HIV/AIDS in Malawi continues to be a serious public health issue, especially for expectant mothers. The health outcomes of mothers and children remain significantly threatened by vertical HIV transmission, even with improvements in preventive and treatment efforts. The purpose of this thesis was to explore the experiences of HIV-positive pregnant women in Malawi. I conducted semi structured interviews with thirteen HIV positive pregnant women and seven health workers in Balaka at Mbera health center from 27 July till August 25, 2023.

The main findings were that HIV-positive pregnant women face difficulties related to family dynamics, poverty, vulnerability, stigma and being dependent on their husbands for financial support. Pregnant women living with HIV also face numerous obstacles, such as limited access to medical facilities, long travel times that make it more difficult to obtain treatment and having to wait a long time to receive necessary care. The health workers emphasized how critical it is to attend to the HIV-positive pregnant woman's specific needs as well as the dynamics of her family, particularly her marriage.

The findings highlight how important it is to include husbands in HIV/AIDS counseling and talks, even if they test negative for the virus. Based on the findings I offer some conclusions and recommendations for different stakeholders.

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Contents

List of acronyms

PMTCT- Prevention from Mother to Child Transmission

MTCT - Mother to Child Transmission

HIV - Human Immuno Deficiency Virus

WHO- World Health Organization

HCW- Health Care Worker

AIDS- A cquired Immuno Deficiency Syndrome

STIs- Sexual Transmitted infections

ICASA- International Conference on AIDS and STIs in Africa

UNAIDS- United Nations program of HIV/AIDs

ARVs- Antiretroviral Treatment

UNDP- United Nations Development Program

GoM- Government of Malawi

WCBA-Women of Childbearing Age

ART-Ant-Retroviral Therapy

ANC- Antenatal Care

EmOC-Emergency Obsteric Care

SBA-Skilled Birth Attendants

PLHIV-People Living with HIV

MoH- Ministry of Health

MDG- Malawi Development Goal

PreP- Pre-exposure Prophylaxis.

PEP-post-exposure Prophylaxis.

VMMC-Voluntarily Medical Male Circumcision

MACRO-Malawi Aids Counselling and Resource Organization

CHAM-Christian Health Association of Malawi

OPD-Out Patient Department

HTC-Hiv Testing and Counselling

HSAs-Health Surveillance Assistance

MNCH-Martenal Neutal and Child Health

DHO-District Health Office

VCT-Volunteer Counselling and Testing

CDC-Center for Disease Contro

CHAPTER 1: Introduction

Mother-to-child transmission (MTCT) of human immunodeficiency virus (HIV) continues to be the primary conduct that HIV is transmitted to children worldwide. The problem of HIV/acquired immunodeficiency syndrome (AIDS) is having a great impact on the world's children. The prevalence of HIV/AIDS in Malawi continues to be a serious public health issue, especially for expectant mothers. The health outcomes of mothers and children remain significantly threatened by vertical HIV transmission, even with improvements in preventive and treatment efforts. Extensive study is necessary to fully understand the experiences of pregnant women living with HIV as they navigate pregnancy's challenges, HIV management, and the possibility of HIV transmission to their unborn child. The purpose of this thesis was to explore the real-life experiences of HIV-positive pregnant women in Malawi, and what they go through by being pregnant and HIV positive at the same time. This research aimed at providing insight into these experiences to guide focused treatments and policy actions that would lessen the effects of HIV vertical transmission and enhance mother and child health outcomes in Malawi.

Malawi is a surrounded by land country located in southeastern Africa, bounded by Zambia to the northwest, Tanzania to the northeast and Mozambique to the east, south, and west. Formerly known as Nyasaland. Malawi obtained independence from the British colonial rule in 1964. Since gaining its independence, the nation has had to deal with

several serious socioeconomic issues, such as periods of political instability and economic hardship. Malawi is one of the least developed nations in the world, with a mainly agricultural economy and a strong reliance on subsistence farming, despite its rich supply of natural resources. Malawi has been badly affected by the HIV/AIDS epidemic. Since the early 1980s, when Malawi saw its first instance of HIV, the virus was rapidly spread throughout the nation. As of 2021, 9.2% of adults in Malawi were predicted to be HIV positive, making it one of the countries with the highest prevalence rates worldwide.

The government is the primary supplier of healthcare services in Malawi, and the healthcare system is mostly organized around a combination of public and private healthcare providers. Malawi's public healthcare system is governed by the Ministry of Health. There remain several stages of healthcare services in this system, from district hospitals and central hospitals to primary health centers and community hospitals. Numerous healthcare services, including preventive, curative, and promotional care, are offered by these establishments. The foundation of Malawi's healthcare system is provided by primary healthcare services. Those looking for healthcare services frequently start by visiting primary health centers and dispensaries. The government offer community health education, family planning, vaccines, maternity and child health services, and basic medical treatment. District hospitals offer more specialized care, such as inpatient services, surgical operations, and obstetrics, and they also act as referral hubs for primary health centers.

The government, donors, user fees, and health insurance plans all contribute to the cost of healthcare in Malawi. A portion of Malawi's budget is set aside for healthcare, with additional cash coming from foreign donors and agencies like USAID and the Global Fund. Malawi is dealing with issues with the scarcity of healthcare staff and their unequal distribution, especially in rural regions. To overcome these gaps, efforts are being made to train and assign additional medical personnel, such as physicians, nurses, midwives, and community health workers. High rates of maternal and infant mortality, a high prevalence of infectious diseases like HIV/AIDS, malaria, and tuberculosis, as well as newly emerging non-communicable diseases like diabetes and hypertension, are just a few of the health issues Malawi's healthcare system must deal with.

To address these issues, the Malawian government has put in place several health policies and programs. These include measures to strengthen health systems, improve access to necessary medications and vaccines, improve maternity and child health, and fight HIV/AIDS. Pregnant women are among the most vulnerable groups in Malawi affected by HIV. HIV vertical transmission, or the virus passing from mother to child during pregnancy, childbirth, or nursing, is still a serious worry. The danger of vertical transmission remains despite attempts to expand prevention of mother-to-child transmission (PMTCT) programs due to issues such delayed diagnosis, restricted access to antiretroviral medication (ART), discrimination, stigma, and limited resources. Understanding the issues that HIV-positive pregnant women in Malawi face—such as obtaining healthcare services, adhering to treatment plans, needing psychosocial support,

and the negative effects of stigma on their lives—requires investigating their experiences with vertical HIV transmission.

I conducted semi structured interviews in Balaka at Mbera health center from 27 July till August 25, 2023. The interviews lasted about 30 minutes due to nausea and other things especially the pregnant women, and they were conducted on one on one. I was mostly conducting two interviews each day. The interview guide included a set of common questions asked for all the participants except the health workers. Most questions focused on what made them come for antenatal, and what they learned when they come for antenatal. All the pregnant women that I interviewed were pregnant and HIV positive. The interviews were conducted in Chichewa by me as I know the language. The facility in-charge was the first one to be informed about the general idea of the study, i.e. to explore the experiences of HIV positive pregnant women on the prevention of vertical transmission of HIV /AIDS in Malawi. Fortunately, at Mbera Health Center they have a special day which is set aside for antenatal and then a special day for HIV patients. This arrangement made it easy for me to find participants.

The main points that came out on the experiences of HIV-positive pregnant women is that these women face difficulties related to family dynamics, poverty, vulnerability, and being dependent on their husbands for financial support. Stigma as encountered in the interviews has a major negative influence on HIV-positive pregnant women, affecting their general well-being throughout pregnancy as well as their ability to seek healthcare and social assistance. It became evident that stigma exerts a substantial and harmful effects on pregnant HIV-positive women, leading to various aspects of their lives. Pregnant women

living with HIV face numerous obstacles, such as limited access to medical facilities, long travel times that make it more difficult to obtain treatment and having to wait a long time to receive necessary care. On vulnerability women explained how a family tries to eat a balanced diet that includes foods from all six food groups even though they are poor, the families are un able to buy food as a result of their financial difficulties, the women choose less expensive, smaller fish, vegetables are reasonably priced and easy to find. Sharing food among neighbors makes it easier for families to cope. The role of the husband is to purchase Matemba, a little fish, to bring back to the family when he is abroad.

The health workers emphasized how critical it is to attend to the HIV-positive pregnant woman's specific needs as well as the dynamics of her family, particularly her marriage. The findings highlight how important it is to include husbands in HIV/AIDS counseling and talks, even if they test negative for the virus. The goal of this inclusive strategy is to strengthen mutual respect, understanding, and shared accountability in married life. These, however, also draw attention to a major obstacle to receiving appropriate counseling and support: spouses' hesitation or open unwillingness to seek medical attention or take part in counseling sessions. There are several reasons for this hesitation such as cultural norms around manhood and health-seeking behavior, fear of HIV transmission. HIV-positive pregnant women find it difficult to tell their husbands about their HIV status since in certain situations, this is causing abandonment, even divorce. Pregnant women living with HIV feel psychological discomfort to a greater extent due to fear of stigma, discrimination, and relationship breakup. This worry also hinders their access to essential healthcare and support services.

In order to guarantee a thorough understanding of the experiences of HIV positive pregnant women, future research ought to seek to recruit larger and more diverse samples. Access to a larger participant pool can be facilitated by partnerships with several healthcare providers and neighborhood organizations. To reduce biases, researchers should use strong recruitment practices, such as random sampling methods and guaranteeing privacy and anonymity when gathering data. Triangulating data from multiple sources, such as interviews, focus groups, and observational methods, can also enhance the validity of the findings. Longitudinal studies are needed to capture changes in family dynamics, economic status, and health outcomes across time. Future studies are needed to acquire adjustments in family changing aspects, economic status, and health outcomes over time. Future studies should utilize mixed methods approaches that combine qualitative and quantitative methods to provide a more comprehensive understanding of the experiences of HIV positive pregnant women.

Based on the findings of this research, HIV positive pregnant women in rural Malawi require care and attention from various stakeholders, to ensure their well-being and to prevent vertical transmission of HIV. These stakeholders include health workers, Government and policy makers, non-governmental organizations, community leaders and association. Pregnant women require antenatal care, HIV testing, treatment, and counseling. Healthcare professionals, such as physicians, nurses, midwives, and community health workers, are essential in this area. They oversee making certain that pregnant women who are HIV positive receive the proper medical attention and assistance during their pregnancy and delivery.

CHAPTER 2: Background

This chapter gives a thorough overview that is required to fully understand the discussions that follow in this thesis. It starts with a study of Malawi's historical background, following its socio-political and economic advancements. It is important to fully understand Malawi's past because it has shaped the country's current health care system. After that, the chapter explores the design and operation of these health care systems, emphasizing the difficulties that they encounter. The concept of medical diversity is important to Malawian health care. The integration and interaction of many medical practices—traditional, complementary, and biomedical—that are essential to Malawians' everyday life is examined in this section. The crucial topic of HIV in sub-Saharan Africa is discussed in chapter's conclusion, with an emphasis on Malawi. This conversation covers the incidence, consequences, and responses to the HIV pandemic, offering a background for the health issues and initiatives in the area. The chapter provides a broad background that lays the groundwork for a deeper examination and understanding of the relationships between medical practices, history, health care institutions, and the current HIV/AIDS crisis in Malawi and the larger sub-Saharan African region.

2.1 History and institutional context of Malawi

It is believed that the San (Bushmen) were associated with the first people who lived in what is now Malawi. People who spoke Bantu moved to present-day Malawi between the first and fourth centuries of the common era. Around the turn of the 14th century, a fresh wave of Bantu-speaking peoples arrived, and they quickly came together to form the Malavi kingship, which ruled across the shire River valley from the late 15th to the late 18th century. The kingdom captured parts of present-day Mozambique and Zimbabwe in the eighteenth century. But soon after, it started getting worse because of internal conflicts and Yao attacks, wherein they sold slaves from Malawi as slaves to Arab and Swahili traders who lived along the Indian Ocean coast. When the Warlike Ngoni arrived from South Africa in the 1840s, the area had fallen into even more chaos. Lagasse P. (2018)

A threat of Portuguese incorporation, missionary activity, others influence prompted great Britain to dispatch a diplomat to the area in 1883. In 1859, other people visited Lake Nyasa and brought interest to the impacts of the slave import there in Europe. The British founded the Central African Protectorate in 1891 (known as Nyasaland from 1907 until 1964), which covered the majority of modern-day Malawi. British military put an end to the slave import in the protectorate in the 1890s. African laborers were employed by Europeans who created coffee plantations in the same area at the same time. In 1915 a small protes against British rules was easily silenced but it was an inspiration to other African resolved on ending foreign quantity. Moderate Nyasaland African Congress, the

protectorate's first political force, was founded in 1944, and the authority declared the primary Africans to the congressional parliament in 1949. Lagasse P. (2018).

Banda led protests against British people administration that resulted in an announcement of national emergency. Nyasaland and Rhodesia were dissolved as federation in 1963, and Nyasaland attained independence as Malawi on July 6, 1964. Following Malawi's independence in 1966, Banda governed the nation as prime minister until taking office as president in 1971. He was appointed president for life. His dictating control, his willingness to support white-minority rule in South Africa, and his allowance of Europeans to maintain significant power within the nation swiftly made him unpopular with other leaders. Banda put down uprisings. Lagasse P. (2018).

Declaring in 1967 peaceful ties with white-run government in South Africa were essential to the country's economic prosperity, Banda established diplomatic links between Malawi and South Africa. South African Prime Minister B.J. Vorster traveled to Malawi in 1970, and Banda was the leading head of an standalone Black African nation to travel to South Africa in 1971. The public was highly critical of this relationship. Nonetheless, Malawi had significant economic growth in the 1970s, largely due to foreign investment. Over the course of the decade, Malawi served as a haven for anti-government rebels from neighboring Mozambique, which led to tensions between the two countries. Malawi was forced to incur significant costs in using South African ports. Banda started to remove influential officials through expulsions and maybe assassinations in response to the passionate speculation about his successor. Malawi experienced the worst drought of the century in 1992. In response to the violent demonstrations against

Bandas' reign that year, western countries withheld their funding from the nation. Malawians voted in a 1993 referendum to remove one-party control, and the parliament enacted laws ending the life presidency and establishing a multiparty democracy. Banda's former president Bakili Muluzi defeated him in a free election in 1999 by advocating for a national reconciliation program. Muluzi assembled members of the opposing and his own party to establish a coalition cabinet. Lagasse P. (2018).

Muluzi launched a campaign to change the formation in 2002 to be eligible to govern for a third base, but initiative was shelved the following year due to strong political and public resistance. Many UDF members, including former president Muluzi, were offended by Munthalika's anticorruption effort. As a result, Munthalika quit the UDF in 2005 to found the Democratic Progressive Party (DPP). The UDF then made fruitless attempts to remove Munthalika from office. A 2005 harvest failure that led to severe food shortages and rising food costs also prompted the creation of new regulations aimed at boosting agricultural output. Lagasse P. (2018).

2.2 Health care system in Malawi

Malawi is among the world's poorest nations; its low health spending per person, at 32.2 USD, is far less than the average for sub-Saharan Africa, which is 98 USD. Despite having signed the Abuja Declaration, the Republic of Malawi's government only committed 9.8% of the country's budget on health in 2018. Even in this little-pay nation with little income tax, a larger well-being budget result in underfunded healthcare system. For instance, the government only paid for an average of 25.5 percent of all health

expenditures between 2012–2013 and 2014–15 (households paid 12.9 percent of the total, or direct payments for medical services). Malawi, however, is among the few nations to have met the Millennium Development Goals for child health, demonstrating that improvements in health may be made even in the face of scarce resources. The National Health Policy 11 (NHP 11) was created by the government in 2017 and closely corresponds with Sustainable Development Goal 3 (guarantee health survives and welfare of all people). According to the definition, universal health care (UHC) is when everyone has access to high-quality, necessary medications and immunizations without experiencing unjustified financial hardship as a result of seeking care. Masefield. S (2020)

The majority of healthcare is provided by public hospitals (63%) that offer certain service are free. Additionally, private for-profit and civil society providers provide 11 percent of healthcare, as does the Christian Health Association of Malawi (CHAM: 26%) for a little pay. The medical system is heavily reliant on donations. Donor aid accounted for 53.5% of all health spending in the country in 2014–15. But because of donors' withdrawal of direct funding (via a basket fund) for the Ministry of Health's (MoH) strategic and implementation strategies in response to a financial corruption scandal that occurred in 2013, this was down from 68.3 percent in 2012–referred to as Cashgate The health sector is facing an accountability dilemma as a result of the decline in donor confidence. The health minister understands how much the country's health system depends on foreign financing and how important it is to keep getting such funding in order to support improvements in health. Rebuilding the gap connecting the authority and contributors is essential to ensuring support and a additional organized method financing,

providing well-being in Malawi. This entails showcasing enhanced governance and developing closer bonds with stakeholders. Consequently, steps have been taken to improve the physical condition sectors. Masefield. S (2020)

2.3 Medical pluralism in sub–Saharan Africa, and Malawi

In my point of view separate descriptions of health and illness, as well as of recognizing and applying the healing arts, occur surrounded by the same physical location when it comes to "medical pluralism." In Africa, like to another place, medical pluralism is the reign instead of the exclusion, and individuals coordinate to use the several medical traditions to which they have retrieve in ways that may be limited, progressive, or favorable. For this justification, any findings focused on medical traditions in isolation, as if their history, expansion, and features were separate of collaborations with other healing assets, is unavoidably not fully formed. A wide range of themes are covered by medical pluralism, which is broad and varied. ‘These include the formal and informal relationships between traditional medicine and biomedical institutions, how illnesses are represented as mixtures of elements from different sources, and the considerations that people have when selecting a medical system over another.’ (Ribera, J. M. (2007, P 105)

In many parts of sub-Saharan Africa, particularly Malawi, medical pluralism—the existence and interaction of several medical systems within a society—is an important component of healthcare. Traditional healers, medical professionals, and religious/spiritual healers all contribute significantly to Malawi's population's access to

healthcare. Traditional healers have a strong cultural and traditional foundation in Malawi. They are sometimes known as herbalists, diviners, or traditional birth attendants. In addition to herbal treatments, spiritual healing, ritual ceremonies, and help with birthing, they offer a variety of healthcare services. Due to their accessibility, cultural significance, and perceived efficacy, traditional healers are consulted by many Malawians, particularly those who reside in rural regions, for a variety of health issues. Biomedical healthcare, based on Western scientific principles, is also widely available in Malawi. This includes government-run hospitals, clinics, and health centers staffed by trained healthcare professionals such as doctors, nurses, and midwives. (Ribera, J. M. (2007,)

Biomedical services in Malawi encompass preventive care, diagnosis, treatment, and management of a wide range of health conditions, including HIV/AIDS, malaria, tuberculosis, and maternal and child health. Religion and spirituality have a big influence on Malawians' decision to seek medical attention. In times of disease or hardship, many Malawians turn to religious leaders, prophets, or faith healers for spiritual healing, prayer, and divine intervention. The mix nature of health beliefs and practices in Malawian society is reflected in the frequent intersections between traditional and biological treatments and religious and spiritual healing traditions.

In Malawi, medical pluralism entails detailed discussions and exchanges between various medical systems. Patients frequently combine aspects of each system based on their beliefs, preferences, and perceived effectiveness while seeking therapy concurrently

from biomedical professionals, traditional healers, and religious/spiritual healers. In Malawi, several biomedical healthcare facilities work in collaboration with traditional healers to advance culturally appropriate healthcare and enhance service accessibility. Ribera, J. M. (2007)

Medical pluralism gives Malawians access to a variety of healthcare options, but it also brings with it difficulties in integration, coordination, and communication between various medical systems. Problems include poor communication, incompatible treatment philosophies, and postponements in getting the right therapy can occur. Improving cooperation, respect for one another, and cultural competency among medical professionals from various backgrounds is crucial if Malawi is to see improvements in healthcare delivery and patient outcomes.

Malawi's medical pluralism is a dynamic and multifaceted phenomenon defined by the coexistence and interplay of biological, traditional, and religious/spiritual treatment systems. It is imperative to comprehend and tackle the consequences of medical diversity in order to advance fair, culturally sensitive, and efficient healthcare in Malawi. In Malawi's medical pluralistic environment, traditional healers are an important part of the variety of healthcare options that the populace has access to. This is how Malawi's medical pluralism relates to traditional healers: The customs and culture of Malawi are firmly rooted in traditional healing methods. Ribera, J. M. (2007)

Many Malawians have strong cultural values and believe that traditional healers are effective, especially those who live in rural areas. Because of this, traditional healing

is still a valued and commonly used type of treatment in the nation. In isolated or underserved communities where formal healthcare infrastructure may be lacking, traditional healers are frequently more accessible than biological healthcare facilities. Because they are a part of the community, traditional healers are easily available to those who might find it difficult to receive biomedical services because of cultural preferences, expense, or distance.

In addition to treating physical symptoms, traditional healers often address spiritual, social, and psychological elements of health in a holistic approach to health and well-being. They emphasize the connection of mind, body, and spirit and often combine spiritual ceremonies, herbal medicines, therapy, and lifestyle recommendations into their therapeutic techniques. Because they are deeply versed in the customs, beliefs, and healing practices of the area, traditional healers are considered by many Malawians to be culturally competent healthcare professionals. Because they are familiar with the customs and values of the community, they can build trustworthy connections with patients and offer individualized care that is culturally relevant.

In Malawi's healthcare system, traditional healers and biomedical professionals frequently coexist and enhance one another. Many patients combine traditional and biomedical therapies, using biomedical care for some problems and traditional healing for others, such as cultural rites. Some biomedical professionals work in tandem with traditional healers to offer integrated care that incorporates components of both systems. Traditional healers in Malawi encounter difficulties and issues despite their

widespread use and cultural relevance. These include a lack of official training and regulation, the possibility of harmful activities, and conflicts with biomedical norms and standards. To advance safe, efficient, and culturally sensitive healthcare in Malawi, it is essential that these issues be addressed while recognizing the important part that traditional healers play in the delivery of healthcare.

2.4 Therapeutic pathways

Therapeutic pathways are structured plans or protocols that define the procedures needed in providing healthcare or therapeutic interventions to people who have specific illnesses or needs. They are sometimes referred to as treatment paths or clinical pathways. These pathways are made to ensure that patients receive timely and appropriate interventions based on evidence-based practices by standardizing and optimizing the delivery of care. Whether the goal is to prevent or treat disease in the home or workplace, illness behavior is included in the research of therapeutic pathways. It also covers the processes and environmental, social, and political circumstances that influence the behaviors associated with sickness.

A systematic and detailed method of understanding the healthcare journey of HIV-positive pregnant women can be achieved by using the concept of therapeutic pathways as a research framework. Determine the critical points in HIV-positive pregnant women's medical direction, from diagnosis to postpartum treatment. HIV testing, starting antiretroviral medication (ART), prenatal care, delivery planning, birthing, and postpartum follow-up are a few examples of these phases.

Therapy pathways place a strong emphasis on integrating care across contexts and phases. I was able to assess how successfully prenatal, obstetric, and postnatal care facilities coordinate and provide healthcare services by looking at the experiences of pregnant women living with HIV within this framework. Therapeutic routes draw attention to any gaps or obstacles in the provision of healthcare. Since I was concentrating on HIV-positive pregnant women's experiences within this framework, it will be easier to pinpoint the particular difficulties they have at every step of care, such stigma, access obstacles, or problems communicating with medical professionals. All things considered, employing therapeutic pathways as a framework to examine the experiences of HIV-positive expectant mothers will aid in developing a comprehensive understanding of their medical journey, he said ‘’it requests us to reflect in interpersonal terms and embraces as objects of study all of the therapeutic incomes present in a given public, symbols of illness and the use of therapeutic earnings of the population”.

2.5 Maternal mortality in Malawi

In Malawi, low health outcomes are a result of poverty, a lack of education, and insufficient access to resources like clean water, wholesome food, and medical treatment. Socioeconomic variables may also have an impact on medical treatment adherence and health-seeking behaviors. Every year, an anticipated 303,000 women pass away from gestation, delivery, and adolescence. 99% of these fatalities take place in low- and middle-income nations of sub-Saharan Africa. Universal approach to healthcare remains inaccessible particularly in rural areas, due to a lack of labor, a lack of basic health-

facility infrastructure, poor managing practices, and insufficient funding. Msokwa R, 2023.

High maternal mortality, low child survival, and mother to child HIV transmission are key challenges for countries in sub-Saharan Africa, and Malawi is no exception. Malawi is one of the poorest countries in the region and has one of the highest maternal mortality ratios of 574/100,000 (National Statistical Office, 2014). Although there have been improvements in Malawi's maternal mortality rate in recent years, research shows, however, mothers often do not take advantage of free antenatal care (ANC) until their last trimester (Waiswa et al.2008). Malawi currently ranks 30th out of 193 United Nations member countries in maternal mortality.

Access to Emergency Obstetric Care (EmOC) if a female has obstetrical problems and Experienced Birth Attendance through giving birth are two evidence-based, effective interventions to lower maternal morbidity and mortality. Despite a notable rise in skilled attendance at birth and institutional deliveries from 51 and 55% in 1992 to 91 and 90% in 2015, correspondingly, efforts to meet the MDG target in Malawi were unsuccessful. Most maternal deaths are still assigned to direct obstetric causes, such as bleeding, sepsis, complications from abortion, and hypertensive disorders. Despite improvements in coverage and access to healthcare, it is crucial that the care that is provided is of high quality, which is characterized by six attributes: efficacy, safety, timeliness, equity, and efficiency. (F. Mgawadera, 2017).

The most often utilized framework for analyzing the circumstances surrounding a maternal death is the three delays model created by Thaddeus and Maine. Delays in making the decision to seek care and getting to a medical facility are the first two. A wait period while seeking medical attention at the hospital. Financial expenses, as well as sociocultural and decision-making factors, all have an impact on type 1 delays. Type 2 delays are caused by a variety of factors, including road conditions, availability and expense of transportation, travel duration, and distance to the closest healthcare facility.

Type 3 delays include things like lacks of materials, kit, and skilled staff; things like the capability of available professionals and the excellence of attention; and things like factors impacting how quickly a woman receives appropriate care once she gets to a healthcare institution. (F. Mgawadera, 2017). Malawi's death rate increased by 0.3 deaths per 1,000 people (+4.47%) in 2021 compared to 2020. In 2021, there were 6.98 deaths per 1,000 people. This was the overall death rate. The number of deaths each year, expressed per 1,000 people, is known as the crude mortality rate. In countries, such as Mozambique, where maternal mortality remains high, the greatest contribution of mortality comes from the poor and vulnerable communities, who frequently reside in remote and rural areas with limited access to health care services. Maternal mortality and morbidity continue matters of public health concern. It is estimated that 385,000 maternal deaths occurred worldwide in 2015. Unsafe abortions, maternal hemorrhage, and hypertensive disorders of pregnancy simultaneously account for nearly 50 % of all maternal deaths. Although universally, there has been a 43 % failure in maternal mortality between 1990 and 2015 sub-Saharan Africa still underwrites 62 % of maternal deaths in

most cases, the highest mortality rates group among the demoted and poor, who frequently inhabit in remote and rural areas with no access to health care services. (K. Munguambe, etal.)

In Mozambique, strategies have been in place to improve maternal and neonatal health, such as those aiming anaemia and underfeeding, the prevention of malaria in pregnancy, enlarged recognized deliveries, behind age of first pregnancy, and a decrease in unsafe miscarriages Along with these, increasing the coverage of skilled birth attendance and guaranteeing resources for extra obstetric care are crucial involvements. Government programs and health policies attempt to put such strategies into practice; however, their success likewise depends on the support from pregnant women and their communities. Policy suggestions must consider existing behaviors, as well as the difficulties and facilitators to desired care-seeking practices. (Khátia Munguambe, etal.)

2.6 HIV/AIDS in sub-Saharan Africa and Malawi

It seems that a variety of causes may have brought HIV to Karonga District in the very early 1980s. In the late 1980s, immigration and residing outside the district continued to fuel the local pandemic; people with higher socioeconomic level had the greatest rates of HIV prevalence. Fine, Crampin, and Glynn (2021) Africa has a history of strange normality. Africans, as opposed to the indigenous populations of other globe regions, have withstood these experiences, setting them apart from all other parts of the world in terms of the sustained nature of disruption, exploitation, and poor governance. The misfortunes of this history have been made worse during the past 30 years by an

extended period of economic instability. The 1973 increase in oil prices was swiftly followed by the collapse of the economy. Many of the recently independent republics' rash decisions began to show their effects during this time. These policies were either forced from outside by organizations like the World Bank, or they were created inside the inexperienced and occasionally dishonest governments (Barrat Brown, 1995, pp. 65–66). Occasionally, both events occurred simultaneously as cold war alliances were formed and dissolved throughout Africa.

As nations looked for help in last resort, like the International Monetary Fund, they were subject to structural adjustments policies, which had their roots in the World Bank's "Gerg report." These policies resulted in a significant exodus of skilled workers. Throughout these decades, 80,000 teachers and other healthcare professionals lost their positions in Zaire (now Congo); in Ghana, the number of doctors decreased by half. The number of nurses in Senegal has decreased sixfold. 13,000 medical professionals, including doctors and nurses, are thought to have fled Zimbabwe for South Africa and Europe following the introduction of structural changes in the early 1990s. Zimbabwe's economic collapse in 2004 and 2005 has accelerated this movement. Sexually transmitted infections were more likely to remain untreated as a result of the death of health services and the implementation of user fees (Epstein, 2001, pp 33-8) Inequality, poverty, relative deprivation, disorder, and geographic disadvantage have all been represented in various ways in the case studies in this chapter. All of them are traits of high-susceptibility risk situations. These are the horsemen of the African apocalypse of the twenty-first century: (Tony Barnet and Alan Whitside: 2006)

Sub-Saharan Africa faces one of the most severe HIV/AIDS epidemics globally, with overwhelming prevalence rates and profound social, economic, and health consequences. This region, encompassing 46 countries south of the Sahara Desert, bears the highest burden of HIV/AIDS worldwide. While advancement has been made in current years, the epidemic continues to pose significant challenges, impacting individuals, families, and communities across the continent. The prevalence of HIV varies widely across countries, with some nations experiencing particularly high rates of infection. The impact of HIV/AIDS in sub-Saharan Africa is multifaceted, affecting individuals of all ages and socioeconomic backgrounds. The epidemic has led to millions of deaths, orphaned children, and increased healthcare costs. It also exacerbates poverty and inequality, disproportionately affecting marginalized populations such as women, young people. (A. S. Muula, 2004)

The main way that HIV is spread in sub-Saharan Africa is through heterosexual sexual activity. Additional routes of infection include injectable drug usage and blood transfusions, as well as mother-to-child transmission during pregnancy, childbirth, and breastfeeding. Populations in sub-Saharan Africa are more susceptible to HIV infection due to a number of circumstances, such as poor access to healthcare, stigma and discrimination, gender inequality, poverty, food insecurity, and migration. The fight against HIV/AIDS has advanced significantly a result of greater access to antiretroviral medication (ART), enhanced regional and international collaboration, and stepped-up preventative initiatives. Many obstacles still exist, nevertheless, such as restricted access to HIV testing and counseling, a deficient healthcare system, discrimination and stigma,

and limited funding. In order to address these issues, a thorough and multisectoral strategy that includes prevention, treatment care and support services, as well as efforts to address social and structural determinants of health. (A. S. Muula, 2004).

In Sub-Saharan Africa, 26 million (65%) of the 40 million HIV-positive people in the region at the end of 2003 were residents. Cultural, diplomatic, financial, and historical reasons all provide to the extreme infection incidence. In Sub-Saharan Africa, the region's diverse population, poverty, diplomatic and financial unrest, and lack of food have given rise to a variety of disease-fighting plans. These include the use of condoms consistently and correctly, reducing the number of sexual partners, increasing access to antiretrovirals, encouraging community involvement, voluntary counseling and testing. (C. Lau, A. S. Muula, 2004).

Despite being the most afflicted region, Sub-Saharan Africa cannot afford to ignore the issue. HIV prevalence and incidence are still on the rise. Adequate control is unattainable even with the expansion of management choices. Globally, illness is causing damage to society and the economy. In the region, there were over 3.2 million new cases of HIV in 2003. Over 2.3 million Africans lost their lives to HIV at that time. More than thirty percent of the population in Zimbabwe, Botswana, Lesotho, and Swaziland had the infection by the end of 2001. Zambia and Namibia had rates higher than 20 percent. In Kenya and Malawi, the infection rate was at least 15%. Women in Sub-Saharan Africa are the most affected demographic. In 2001, they made up 58% of all infected adults, with 10% being younger than 14 years old. Moreover, the illness has left over 11 million

children in the area orphans. Women in the 15–24 age range had a 2.5-fold higher risk of contracting HIV than men in 2003. (C. Lau, A. S. Muula, 2004)

The HIV/AIDS pandemic's morbidity and mortality have significant negative effects on the economy and society, including rising rates of poverty and hunger, children becoming more vulnerable as a result of the epidemic, declining educational standards, AIDS-related isolation, shorter life expectancies, and more. These socioeconomic repercussions now affect countries and regions on a national and worldwide scale, in addition to homes and communities. HIV sequelae are a massive resource drain. For instance, in Malawi's main government hospital, the prevalence of HIV among hospitalized medical patients was 70%; among patients aged 30 to 40, the rate rose to 91%. (C. Lau, A. S. Muula , 2004)

Due to significant resources supporting health systems' responses to HIV, the care pathways of populations living with HIV (PLHIV) in Southern and Eastern Africa have seen major changes the past 20 years. Access to diagnostic tests and treatment has expanded globally, improving the health and well-being of people staying with HIV and changing the nature for HIV care. HIV testing used to be a crucial, but isolated, step in uncertain and disorganized care pathway for people without treatment. A sort of "confessional technology," early emphasis on voluntary testing served "know your status" and aid in the control of group threat.

HIV testing became recognized as the first step toward prompt access to treatment as antiretroviral therapy (ART) developed more broadly, and healthcare practitioners bore

the primary duty for ensuring the continuity of care. Reorganizing the health workforce to implement HIV programs was a key component of global plans to reach specific HIV-related targets. These strategies were frequently referred to in the organizational words of service deliverance, such as roll-out, rule-up, decentralization, and integration. Simultaneously, obtaining PLHIV commitment to lifetime ART adherence turned the promise of universal test-and-treat programs into a fresh focus on patient and family responsibility in many high-burden nations.

Therefore, it is important to remember how the modern motivation regarding universal test-and-treat models have changed in terms of geographical, worldly, and relational characteristics. HIV testing and counseling protocols have been significantly revised over the last 20 years. Tests are quick and routine, and they happen outside of clinics. New testing locations encompass a spectrum of social spaces, from the privacy of mobile testing centers and public testing campaigns to the closeness of homes and domestic settings.

Despite the rapid self-testing is praised, rapid testing technologies may ironically deprive people of the program needed to process assessment result and its implications, as well as to consider when and with whom to communicate test results. This is true even though they shorten the time between the choice to test, the actual testing, and the disclosure of test results. Diagnoses and disclosures now must come from providers, sometimes even self-testing, rather than being voluntary. The right to test remains entwined with the need of mass screening programs in various sub-Saharan African

situations, as a way for people to acquire ownership and belief in the technology. (Kielmann K. 2017)

While there has been a reduction in system delays related to the HIV cascade of care, this may come with undesirable shortcuts in providing compassionate care, as seen, for instance, in the shift from individualized counseling sessions to prescriptive guidelines or lectures on group health education. The standardization of duties can have a negative impact on patient care when rules are strictly followed without taking unique situations into account. HIV testing is now part and parcel of the logic of care the progression, in which people move through testing and diagnosis, get connected to HIV attention, start ART, stay involved in care, and eventually achieve viral defeat. From a common and "lived experience" standpoint, this line of reasoning remains not obvious.

Obtaining medical attention is certainly not a one-time occurrence; rather, it is a lifetime track of involvement or detachment with the healthcare system. Although navigating places and the progressive reason of medical care routes may be necessary for being a "good patient," these behaviors are learned rather than instilled. Presently available studies on "implementation barriers" and difficulties with loss to progress-up demonstrate the complexity of variables impacting each patient's health knowledge, autonomy in constructive decisions, and ability to adopt the "good patient" part. (Kielmann K, 2017)

Health systems are being compelled to reorganize the identities, roles, and obligations of all parties involved in HIV care due to the constant changes in how it is

organized and given. Health care professionals may use strategies that many studies have characterized as heading towards threatening to fulfill new targets for starting and keeping patients on treatment. In response to the shortage of healthcare personnel, decentralized care—which includes task-everchanging and task-allocation strategies—has been implemented to handle an increase in patient volume. (Kielmann K, 2017)

In places where access to basic medical supplies was limited in the past, care practices are being altered by the introduction and widespread adoption of new diagnostic and therapeutic techniques, let alone costly treatment plans and prognostic technology. A closer look at the connections and disconnections that exist between the broader objectives of these programs and the local changing aspects of breadwinner-patient and communal interactions at each pivotal point in the HIV treatment pathway is necessary given how swiftly the HIV care environment is changing. (Kielmann K, 2017).

Determined application plans that frequently depend on current healthcare professionals and unstable health systems have been transformed into global health imperatives, such as the roll-out of ART and novel ways to speed diagnostic and treatment initiation. Front-line caregivers bear the responsibility of operating within complex technological care systems and adhering to model targets to serve as the intermediary between the implementation of local programs and the aspirations of national policies. The documentations in this different issue provide insightful and compelling instances of how communal and ethical dealings are at play and, to some

degree, function to anger goals of popularity within changing outlines of HIV care, in keeping with the dynamics we have just described. (Kielmann K, 2017)

As in other countries in the region, HIV started to blowout silently in Malawi during the early 1980s, primarily because of individuals having sex with several men, few people using condoms, and a high occurrence of other infections. As of 2012, approximately 1,100,000 people in Malawi were HIV positive, which represents 10.8% of the country's population. Because the Malawian government was initially slow to respond to the epidemic under the leadership of Hastings Kamuzu Banda (1966–1994), the prevalence of HIV/AIDS increased drastically between 1985, when the disease was first identified in Malawi, and 1993, when HIV prevalence rates were estimated to be as high as 30% among pregnant women. The involvement of government resulted in a gradual decline in HIV prevalence, and, in 2003, many people living in Malawi gained access to antiretroviral therapy and condoms became more widely available to the public through non-governmental organizations. (Ministry of Health 2012).

So far, Malawi has put in place several HIV prevention programs such as: prevention from mother to child transmission (PMTCT), condom use promotion, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), voluntarily medical male circumcision (VMMC) and others. Among the HIV prevention strategies, Malawi was the first country to adopt option B+ to help reduce vertical transmission. Option B+ is the strategy that involves mandatory testing of pregnant women and administration of ARVs soon after being found to be HIV positive. Malawi pioneered the Option B+ strategy in

late 2011 in response to a CD4-based PMTCT program fraught with delays in ART access. Option B+ was designed for simplicity and impact, offering all pregnant and breastfeeding women free lifelong ART at diagnosis, regardless of CD4 count or clinical stage.

It also found that 36% of the women were more than 28 weeks into gestation at their first antenatal clinic visit, compared to 51% at 21-28 weeks gestation and 11% who were at 20 weeks gestation or less. The 2010 WHO PMTCT guidelines recommend that as early as 14 weeks, HIV-positive pregnant women should start taking AZT and be counselled on adherence. Only 19% of the women received single-dose nevirapine at their first visit to the clinic to take them home with them, as recommended by the guidelines (Lesly Odendo, 2014)

2.7 Previous research

There have been several studies that have been conducted on a similar topic. These studies have focused on different areas regarding the prevention of HIV vertical transmission. In her research in Mozambique, Rachel Chapman, made a follow up on women to understand the influence of the HIV epidemic on their daily lives and choices. Her work focused on finding out why HIV positive pregnant women frequently did not access antiretroviral treatment for themselves and their unborn or newborn infants and to find ways to decrease loss to follow up of HIV+ pregnant women in prevention of mother-to-child transmission and their own antiretroviral treatment. In her research, it was found that the influence of social structures, cultural values, religious values, poverty

and the social relationship between the community and service providers. For example, it was pointed out that some religious groups encouraged their members who were on ARVs to stop taking them and focus on praying for their healing. (Chapman 2021)

Another important factor was that poverty affected their access to treatment in that some women were unable to go and get their medications as a result of having no funds to use for transport to go to the health centers that were located at distances that would not be easily accessed without proper mode of transportation. These aspects have great implications on their decisions regarding access to health services (Chapman, 2021)

Mulenga, Chisomo, and Joanne R. Naidoo conducted research in 2017 to investigate and designate the experience, opinions, and methods of nurses concerning indication-based prepare in PMTCT at a particular clinic in Malawi. The outcome revealed that nurses had little idea of proof and despite their opinions being promising, their method was very low**.** Certain social demographic variables such as age in service and professional level such as having a diploma, or a degree gave an impact on the defendant's experience, positions and procedures.

Additionally, findings suggested that indication-based method was mainly vulnerable by inadequate materials and obstacles in gain access to study objects. Unlike many other studies that have been conducted within the same region that focused on the nurse’s knowledge and attitude, this study also looked at factors that affect knowledge acquisition among health workers in the reproductive health sector. The problems that were said by health workers was lack of materials, problems in accessing research

materials, no knowledge on how to get proper research reports, and hard to know the results of the research for clinical practice.

Cherrie et al, *conducted a* study in Ethiopia in 2022, In which he aimed at assessing the knowledge, attitude, and practice of pregnant women towards the prevention of mother-to-child transmission of HIV. The study revealed that women had fair knowledge of HIV transmission from mother to child but there was a problem in practicing properly preventive measures against the spread of HIV from mother to child. The study also revealed that one-third of the women had negative attitudes towards the prevention of mother-to-child transmission of HIV. Therefore, creating a positive attitude and good practice among pregnant women are the most important components for the prevention of mother-to-child transmission of HIV. But in order to achieve that, we must better understand what leads different women to have negative attitude and substandard practice.

A report by the National Evaluation of Malawi's PMTCT Program (NEMAPP) indicates that non-participants who include mothers who declined participation, too sick to present themselves for HIV testing, may be another issue to be considered a risk for vertical transmission.Looking at the results of these studies, it shows that there are mixed opinions on knowledge of avoidance of mother to child spread to both nurses and HIV positive pregnant women. The studies have also shown that the strategies that are in place to reduce HIV vertical transmission are not properly utilized by those for whom the

initiatives are intended. This research have investigated the experiences of HIV positive pregnant women and nurses to try to find ways to help to improve the situation.

Although there is not much anthropological data regarding HIV positive pregnant women in Malawi, there are several organizations working with the Ministry of Health that focus on different areas such as HIV education which is done by Malawi Aids Counselling and Resource Organization (MACRO), HIV prevention which is done by Population Services international (PSI), and HIV management, which is done by Centre for Disease Control (CDC).To recognize their experiences, I just focused on learning from them about the prevention of vertical transmission of HIV. I was not judged in any way so that the information I got from them should not be biased towards anything.

2.8 Theoretical Framework

Since the research involved the study of human health, illness and disease, and care networks, I used theory of Medical Anthropology in framing besides analyzing my explore. Medical Anthropology is a branch of anthropology that explores human healthiness and disease, systems of care, and modern ways of dealing with illness and diseases. Medical Anthropology acknowledges that health systems should include the intricate web of connections among individuals, medicines, and organizations that shapes the landscape of health care delivery and patient outcomes (Lock and Scheper-Hughes, 1996, 43). One of the major drawbacks with standard medical anthropology is that it claims that practical research be able to help prove what people already know about the population under study. It claims that the wellbeing of the people can be explained

through the knowledge of science and technology. This belief in the end suggests that all healthcare should follow the model of biomedicine in understanding how illness and diseases should be dealt with (Lock and Scheper-Hughes, 1996)

Critical Medical Anthropology is not just another way of looking at how illness and disease should be studied, but it looks at the way knowledge about human beings, health and illness is culturally represented and understood in a place over a period (Lock and Scheper-Hughes, 1996).

2.9 Critical interpretative medical anthropology

To understand the experiences of HIV positive pregnant women and nurses within the social cultural and political economic context, a critical interpretive approach was more ideal for this study.

Critical Interpretive theory is a branch of Medical Anthropology that blends critical theory and interpretive approaches in the consideration of the political economy of health, and the effect of social inequality on people's health. While using this theory one is mainly concerned with exploring the connection between the life of a human being to cultural beliefs and practices, in connection with health and illness. (Lock and Scheper-Hughes, 1996). The social cultural part of the theory looks at people’s interaction within their cultural beliefs and how they impact their health status, while the political economy looks at how the economic status of a society and power structures impact the lives of the people in the society in which they live.

For example, Lock and Hughes says that it is out of anthropological research that revealed the importance of considering the social cultural and political economy in understanding human health, which uncovered the role played by Christianity on the lives of its believers that cannot be provided by biomedicine alone. Therefore, it was found to be necessary to consider the social, cultural and political economy when looking at illnesses and treatment, bearing in mind that these too play an influential part in the lives of people in society. Above all, the theory seeks the inclusion of the people's experiences in understanding and dealing with illness.

2.10 Structural violence

Structural violence is the understanding of the global-scale social and economic structures in which weakness is rooted.(Farmer, 2004) This concept was used by Paul Farmer during his study of HIV and Tuberculosis in Haiti. The appearance and continuation of these epidemics in Haiti, where they were the heading causes of young-adult death, was embedded in the bearing influences of European increase in the New World and in the slavery and bias with which it was linked.(Farmer ,2004). Malawi is one of the developing countries with a struggling economy that has different impacts of the health and wellbeing of the people.

The concept was used to explore the experiences of HIV positive pregnant women to understand if their experiences include some challenges that are caused by the social, economic and political structures of their community as well as the country. Structural violence was used by Rachel Chapman during her studies in Mozambique. It was used to

investigate factors that affect how HIV positive women make decisions regarding access to HIV treatment. The study found out that poverty, cultural beliefs, and religious beliefs contribute to their choices that end up putting their lives and the lives of babies in danger of getting the virus from their mothers.

In exploring their experiences, this study will also look at the factors raised by chapman to see how they affect HIV positive women. Structural violence was also used by Paul Farmer when investigating the harms that came as a result of structural adjustment from colonial rule to independence of Haiti. It was used to point out the social ills that were systematically imposed on the people. One of the notable challenges that Farmer describes was the emptiness of the hospitals due to the inability of the people to pay hospital fees even though they were sick.

2.11 Vulnerability

In the background of HIV/AIDS, vulnerability refers to having tiny or no restrain over one's risk of contracting the virus, for those that are HIV positive, they have very small or no opportunity to proper care and funding. Exposure also means that somewhat or somebody can be broken or injured; it means to be exposed to hazard or damage, to be vulnerable. A variety of ethnic, learning, demographic, lawful, efficient, and electoral variables can enhance vulnerability. Vulnerability is the overall result of the interaction of numerous elements, including personal (including biological) and societal factors (World Council of Churches, 1999:11).

To better comprehend this complex disease, numerous studies and data sets have been assembled over the last 20 years. Even if there are plenty of studies on AIDS in Africa, the research agenda is still dominated by epidemiological and biological modes of inquiry. Through investigations into the relationship between HIV contamination and viral load (Quinn et al. 2000), the prevention of perinatal transmission by chemotherapy (Wiktor et al. 1999, Connor et al. 1994), and the relationship between HIV infection and commonly happening STDs and UTIs (Wasserheit 1992, Grosskurth et al. 1995, Diallo et al. 1997), biomedical studies have contributed to our growing knowledge of the functional mechanisms of HIV.

However, epidemiological and biomedical research fall short on multiple counts. First, it is incorrect to place more emphasis on occupational category than on social practice when focusing primarily on so-called risk groups. Thus, they assumes that everyone in each category is either HIV-positive or has already contracted the virus, and thus gives the false effect that no one in a different place of these groups is at danger. These findings neglect to focus on the social, political, cultural, and economic variables that create situations that make people vulnerable to HIV because they do not address the question of why people participate in the activities that they do. According to anthropologist (Waterston, 1997:1383), the prevalent approaches to AIDS prevention and treatment center on the individual as the source of the illness, making them the least disruptive to the existing status. In addition to ignoring the underlying causes of HIV, educational outreach and condom availability programs operate under the erroneous

premise that people will automatically alter their behavior once they are informed of the disease and have access to contraception.

For instance, trends in male outward migration can provide understandings into demographic shifts and labour market dynamics powered by having trouble countrywide economies and labor-concentrated mining industries in South Africa is one of the main factors driving HIV transmission in that region (Adepoju 2003, Girdler Brown, 1998, Decosas et al. 1995, Brockerhoff and Biddlecom 1999, Haour Knipe and Rector 1996, Upton 2003). Men who work long hours away from their families suffer as a result, and women find it harder and harder to support themselves when their partners are gone (Chirwa1998, Campbell 1997, Zuma et al. 2003). Extended conflict has also caused population displacement and economic disruption in other locations. It is hard for relatives to remain together in one location or for persons to continue practical returns without turning to potentially dangerous sexual economies in the majority of sub-Saharan Africa due to the region's failing economies and widespread poverty (Akeroyd 1997, Addai 1999, Becker et al. 1999, Decosas , 1996, Fourn and Ducic, 1996, Rugalema ,2004, Lurie et al, 2004). Accordingly, Eileen Stillwaggon's research on the factors influencing HIV transmission eliminates the myth of the overly sexualized African and argues that the circulation of HIV prevalence in sub-Saharan Africa can be explained by differences in the spatial distribution of other social, economic, and health determinants (see Stillwaggon 2000, 2001, 2002, 2003).

CHAPTER 3: Methodology

3.1 Study Setting

In this chapter, I will introduce Balaka, a district in southern Malawi, and Mbera, a rural village in the eastern side of Balaka district where this study was conducted, I will explain how the specific community hospital was selected, and I will describe the site in demographic, environmental, and socio-economic detail.

The health center for the field study of this chapter is located in southern Malawi, where both food insecurity and HIV prevalence, are substantially higher than in the other regions (Devereux et al. 2006b:21). The criteria for the selection of the research health center, were set by myself and for the safety reasons, I also looked at the accessibility even during rainy season or not, and I was also looking at the place where there is a connection to mobile phone services with internet connection.

Balaka district is in the north-central part of the southern region. It has one of the highest levels of food insecurity within Malawi (AAH 2007). This part is a result of the unfavorable climate, as Balaka is one of the hottest and driest districts of Malawi. It therefore remained sparsely populated until population pressure increased and the Banda's land confiscations (During this time, the first black president after independent wanted land for the development of estates for agriculture) The estate development

pushed families to move here in the 1970s. The estimated HIV prevalence in Balaka of 16 percent is significantly higher than the national average of 8 percent. The district is mainly inhabited by the Yao people who are mainly a Muslim community. Their language is called Chiyao.

Most young people, especially men move to south Africa for general labor jobs, leaving their families behind. This makes it difficult for the district to have many people working in different professions, hence much of the professional jobs are occupied by people from other districts. Balaka is a predominantly rural district. It is inhabited by over 590,131 People and 128,685 households. The district has a population density (145 people per square kilometer). Balaka town is home to approximately 22.000 inhabitants (GoM 2008b: 29). (Janneke Verheijen, 2013)

The terrain is relatively flat, the elevation level is low, the climate is hot and dry, only one collection of buildings is called a town, this boma as district capitals are called-exists of one tarmac road which connects the district hospital, bus station, open market, police station, government extensions offices, field offices of a number of NGOs, maize ware houses, small super markets, beer halls, several cheap hotels and cheaper rest houses, restaurants that serve nsima (a staple food made from corn flour) or rice with chicken, fish or beef stew, Cement building, cosmetic shops, and a train station.

Balaka District has ten health facilities, five of which are government and five of which are Christian Health Association of Malawi (CHAM) facilities, the Balaka hospital has maternal ward, pharmacy, under-five clinic, OPD, theater, HIV department, HTC, and

it has nurses, physicians, HSAs, mostly they rely on government and Non-governmental organizations when it comes to resources and other projects, for example, Maternal, Neonatal and Child Health (MNCH) is one of the NGOs that is available for suitable infrastructure, supplies, and equipment in rural communities and health institutions at Balaka district.

Moving to this rural health center was ideal for me, I had to speak to the District Health Office (DHO), the District commissioner (DC), the Group village Headman (GVH), the chief and the facility in-charge, about my topic and permission to stay in their community. Most of my data was handwritten, and I had to transcribe it every day after the collection, it took a week for me to realize that there is a project being implemented by BAYLOR that works directly with the HIV department targeting HIV patients at the health center. I had to interview them as well.

Mbera is located thirteen kilometers down a dirt road from Balaka town, a good two-hour bike ride away. Public transport does not travel to the place, only by foot, cycling, bike taxi, or private car. There is a small weekly market at about 1 kilometer distance, and a trading center 1 kilometer away. Mbera health center has a catchment area with a population of 70,238 people. The catchment area has 189 villages that goes to Mbera health center. And the total number of women of childbearing age 22,022(WCBA) on average, the expected pregnancies per year is 7000, expected pregnancies monthly is 580, and the expected deliveries each year 7000, while expected pregnancies per month is 500. Balaka is one of the districts with a high HIV prevalence rate at 16.3%. It is

estimated that the prevalence rate is high among women which is at 12.1% and 4.3% for men. Mbera health center has 15 midwives, 2 clinicians, 12 nurses and 33 Health Surveillance Assistants (facility in-charge personal interview).

Most people living in this area, grow cotton, maize and groundnuts but most of them both men and women move to south Africa to find jobs and leave behind the children with their grandparents to be taken care of. Mbera Health center is operated by the Malawi government. It has 2 mobile clinics. It also collaborates with non-governmental organizations in different areas of practice just like BAYLOR which focuses on HIV/AIDS. The health center has a bed capacity of 10. It runs a mixed HIV/AIDS prevention project. The mechanisms are PMTCT, Voluntary Counselling and Testing (VCT), management of sexually transmitted infections (STIs), youth-friendly health facilities, family planning (FP), establishment of antiretroviral therapy (ART), nutrition, and outreach mother and child health services. Currently, it is mainly funded by Baylor**.**

Mbera health center was introduced in July 2004 as a PMTCT Plus program, which implies provision of specialized care to HIV-infected women with ART, treatment of STIs3, support for baby-feeding practices and nutrition. It further adopts national and international standards according to the World Health Organization.The antenatal clinic registers all pregnant mothers who come for the services. In addition to general ANC services, health education on HIV/AIDS and the importance of HIV testing is given to all the mothers. Those who opt to take the HIV test undergo pre- and post-test counselling

sessions, and if found HIV positive, they are included in the PMTCT program. They are also given information regarding antiretroviral prophylaxis (in this setting, NVP) and the importance of delivering to the hospital. After giving birth, the baby is given nevirapine syrup for 6 weeks, then after that they give Bactrim up until the baby is 2 years old, the baby is given this Nevirapine in 72 hours of birth. In case a mother is not capable to make it to the hospital for delivery, she is estimated to return within 72 hours of birth to ensure the management of NVP to the baby.

Preferably, mothers and their babies are followed-up for 24 months. The primary six months are concentrated as mothers are skilled about baby-nourishing practices, optional feeding, provisional feeding and limited breast feeding for at least four to six months, and now it has been extended to one year, at one year, the baby stops breast feeding but continues to take Bactrim 240 mg daily until 24 months as prophylaxis. At 24 months, the child's HIV status is known.

Mbera contains a government shop for maize and subsidized fertilizer, and there is a clinic that is located approximately four kilometers in the opposite direction, about an hour walk. This clinic only attends to maternal and child health issues, but they also started to offer counselling and testing services for HIV and AIDS at the time of this study, they also offer antenatal services twice a week, during antenatal. Another village of about an hour walk, there are houses, and a fuel generated mill, where women can have their maize grounded into flour which is used for making nsima (Malawian staple food). The nearest primary school is located approximately two kilometers away, next to Roman

Catholic church. Churches from other denominations are located at further distances. (Janneke Verheijen, 2013, 55) the health center has maternity ward with 10 beds, HIV department where I worked, OPD, under-five.

Understanding how knowledge was acquired is something required beforehand for evaluating the validity and significance of any research findings; in this study, data gathering was simple. My research approach was as precise as I had hoped. I took on the responsibility of data collection myself and was quite severe about sticking to the interviewing procedure. I reasoned that since I am a mother and I speak their language, the women felt more comfortable talking to me directly.

The participants talked about going for antenatal several times until they give birth, for instance; one participant said that they weigh on scale, and they do the blood test, and after that they give them medicine. She said that they receive the ARVs and Bactrim when it is available, and they also give the pregnant women Fansida, a malarial drug that they take on the first trimester, but when you are HIV positive, they don't give you the Fansida because it can cause miscarriage, in addition to this, the participant said that they give them mosquito nets, and tell them to sleep in the mosquito net to protect themselves from malaria.

On counselling, the participants said that they are taught about taking the ARVs according to how they have been advised, and they are taught about the nevirapine drug that is given to the child when it is just born, and they are taught about the clotrimazole that they are supposed to give to the child from 6 weeks until 2 years old. They are also

encouraged to give birth at the hospital not at home. They are also told to eat heathy foods, they also talked about being helped by Baylor Foundation Malawi, a not- for-profit organization working in partnership with the Malawi Government in the Health Sector.

Baylor Foundation Malawi is the implementing partner of the Texas Children's Global Health Network in Malawi. The Network was created by BIPAI in 1999 to catalyze pediatric and family HIV care and treatment and health professional training at the HIV department.

3.2 Baylor

Baylor is the college of medicine children's foundation, they have been working in Malawi since 2005, their aim is to improve the health lives of HIV infected children and families, it also helps the Ministry of Health in improving prevention from mother to child transmission, early infant diagnosis, pediatric HIV care in other selected districts of Salima, Lilongwe, Mangochi, Machinga and Phalombe. They focus much on HIV, and their workers are well trained by themselves. Baylor Foundation Malawi has now been operating in Malawi for nearly fifteen years and has broadened their mission to include maternal health care services.

The Baylor program collaborates with partners in regions of greatest need, to increase access and improve delivery of women's health services. These wide-ranging obstetric and gynecological services include family planning, maternity care, and identification of pre-existing conditions that may hamper a healthy delivery such as malnutrition and obstetric fistula. They offer community education on the benefits of

smaller families, childhood nutrition and a host of other maternal and child health subjects. Their clinical research leads to better outcomes for mothers and children worldwide. At Mbera health center they have their own offices and health workers, for example, BAYLOR has HIV Diagnosis Assistants, Treatment Supporters, and ART service providers who specifically work at the HIV department.

3.3 Study participants

I planned to recruit 13 participants to participate in semi-structured face to face interviews but I ended up interviewing 20 participants, 10 of them were HIV positive pregnant women and 10 health workers both the government and the BAYLOR staff, The study population consisted of health care providers, nurses, and some that work at HIV department with BAYLOR, such as Treatment supporters, HIV diagnosis assistants, and HIV positive pregnant women. The HIV positive pregnant women were coming direct to me after finishing their antenatal sessions or before the antenatal, after checking their health profile book with the help of the facility in-charge.

I approached and recruited them after explaining the objectives and nature of the study in Chichewa, a language that they speak and understand. I obtained the informed consent for inclusion in the study and for the recording of the interviews. I also included the male health workers in different professions, the participant could choose to speak Yao or Chichewa for the interviews, as I am fluent in both. Among all the 10 health workers that I interviewed, all of them said that they have a good relationship with the patients.

Getrude Finyiza.

I'm 38 years old. My dad's hometown is in southern Malawi in a place called Mangochi. Even though my dad's family comes from the Ngoni group, most of the people in our village are Yao. So, I learned both Yao and Chichewa languages from my friends. My mom used to work as a midwife and later as a Traditional birth attendant. My dad worked at a Catholic mission nearby, doing all sorts of jobs. When he passed away, the Italian sisters offered to help take care of me.

When I was 18, I wanted to be a journalist. But in 2008, I met Janneke Verheijen, a researcher from abroad, who inspired me to become an anthropologist. I helped her with her research in Malawi, taking notes and traveling with her to different places. This experience made me really interested in anthropology. We studied how AIDS affects farmers' food supply and how young adults deal with HIV in Malawi.

After finishing high school and later my first degree in 2013, I continued to work as a research assistant for different anthropologists from around the world. I also worked with other institutions like ICRISAT, the University of Denver, and others. Most of our work involved going to villages and collecting data. I also did research on how local governments work in Blantyre, Malawi. I volunteered at an HIV department in Mpemba health center, helping with data entry for HIV-positive children.

One day, a child getting ARV medication whispered to me, "Let's put some cotton in the ARV bottle so it doesn't make noise when we run home." This made me want to study the experiences of HIV-positive pregnant women and their children.

Since 2008, I've been working as a research assistant. Because of my experience, it was easy for me to choose a topic for my own research. I decided to go back to Balaka for my thesis because I know the people and the language there.

3.4 Data collection

Semi structured interviews are commonly used qualitative research method to gather in depth information from participants, these interviews provide a balance between the flexibility of open ended questions and the structure of predetermined questions, allowing researchers to explore topics in depth while also ensuring some consistency across interviews, H. Russel Bernard 2013, P 181. Therefore, with my research I conducted semi structured interviews on 27 July till 25 august, 2023. In Balaka at Mbera health center, the interviews lasted about 30 minutes due to nausea and other things especially the pregnant women, and they were conducted on one on one. I was mostly conducting two interviews each day. The interview guide included a set of common questions asked for all the participants except the health workers, but most questions focused on what made them come for antenatal, and what they learn when they come for antenatal. The interviews were conducted in Chichewa by me as I know the language. The facility in-charge was the first one to be informed about the general idea of the study, i.e. to explore the experiences of HIV positive women on prevention of vertical transmission of HIV /aids in Malawi, luckily at Mbera health center they have a day special for antenatal and then especial day for HIV patients, so it was easy for me to find participants.

3.5 Data analysis

The audio recordings of the interviews were translated and transcribed from either Yao or Chichewa into English. I personally reviewed all the transcripts and checked the transcribed notes. Then I imported all the 20 interviews to the external hard drive. I then selected the emerging themes and pile sorted them. 13 themes were identified for the HIV pregnant women and 13 themes were identified for the health workers.

3.6 Ethics

I received the ethics approval by the institutional review board, of university of Denver, (IRB) IRBNet ID 2058016-1 and Balaka district health office, all participants received 2500 Malawian kwacha (equivalent of approximately 2.5usd) as compensation for taking part in the study.

3.7 Ethical consideration.

Semi-structured interviews were conducted in a private place within the clinic assigned by the facility in charge where no one got suspicious. Their privacy and rights were respected, and their confidentiality was protected**.** They were not forced to answer questions that were not comfortable to answer, and they were permitted to stop answering the questions when they no longer wish to do so without being penalized. Their identities were not revealed during the interviews and in all the writings. I asked them to sign the consent form, when they agreed to participate, considering that the literacy level of the people of the community where the research was conducted is low, those who didn't manage to write their signature were asked to use a thumb print to consent for their

participation in the research. To make sure that they fully understood the nature of the research, I led the consent form for them. No one had access to the signed consent forms, apart from the investigator who had them stored in a lockable file cabinet, and all computer files were stored in a secured hard drive to make sure that only those concerned had access to the data.

All participants were informed about how the results of the research will be disseminated to make sure that dissemination does not violate the rights of the participants. The goals, purpose, nature and sponsorship of the research were clearly communicated to participants so that their decision to take part in the research should not be made by misleading them or manipulation. After every interview I gave the respondent lunch allowance for spending their time with me.

I also informed the participants that I will be attending the antenatal visits. This is the time when pregnant women (both HIV positive and HIV negative) meet with a midwife or doctor, who provide useful information to help pregnant women to have a healthy pregnancy. Other information provided includes advice about healthy eating habits and choices about general care during pregnancy. Considering that most people in that community do not speak or understand English, I used Chichewa for communication and interviewing to make sure that participants understood what I am asking from them.

CHAPTER 4: Findings

The main point that came out on the experiences of HIV-positive pregnant women is that these women face difficulties related to family dynamics, poverty, vulnerability, and being dependent on their husbands for financial support. HIV-positive pregnant women often encounter several challenges in addition to their medical condition. Apart from having a great responsibility about managing their own health, they must navigate through a complex system of family dynamics. For example, from those who were interviewed, some of them indicated that they got married while HIV positive but did not inform their husbands for fear of being divorced, since they depend on them for their survival.

This is facilitated by the perceived limited access to finances and the limited opportunities available to them. Trapped in a cycle of vulnerability, these women often find themselves reliant on their husbands for financial support, since most of them do not have enough education to grant them a reliable job hence enhancing feelings of dependence and powerlessness. As they navigate through this complex landscape, they must confront not only the physical implications of HIV but also the profound social and economic implications that accompany it.

Stigma as encountered in the interviews has a major negative influence on HIV-positive pregnant women, affecting their general well-being throughout pregnancy as well as their ability to seek healthcare and social assistance. It became evident that stigma exerts a substantial and harmful effects on pregnant HIV-positive women, leading to various aspects of their lives. The burden of stigma weighs heavily on their general well-being throughout the time of their pregnancy journey. From example, one respondent indicated that she usually takes all her children to the hospital during refill, to avoid suspicion from the people within the village. It acts as a widespread force, hindering their willingness to freely seek essential healthcare services and social support networks. This harmful influence not only increases the challenges associated with managing their HIV status but also imposes emotional and psychological strains. Thus, fighting stigma is essential, in ensuring the holistic health and welfare of HIV-positive pregnant women, enabling them to access the care and support necessary for a healthy pregnancy and childbirth experience.

These components form the backbone of comprehensive care, providing not just medical attention but also crucial emotional support and guidance. Through consistent monitoring and counseling, women with HIV indicated that these services help them to better navigate the complexities of their condition, manage any health issues effectively, and cultivate a positive outlook on their lives. HIV testing not only serves as a preventative measure but also empowers women to take charge of their health, enabling early detection and timely intervention when necessary.

For example, as explained by one respondent who said that “One of the most important ways in which women discover their HIV status is the hospital checkups. Since it is a requirement that if one is pregnant, they should go for HIV testing, most women discover that they are pregnant during these tests. Even when they discover that they are HIV positive, it is also very difficult for them to easily inform their spouses about their status for fear of divorce. However, most women who participated in the study said that they benefited a lot from the counseling services. They said that counseling services played a great role in making positive choices which have helped them to accept their status and move on.

Fear of mistreatment by medical professionals often acts as a formidable barrier for HIV-positive pregnant women, delaying their approach to vital prenatal care services. This fear can have profound consequences, not only for the mother but also for the well-being of the unborn child. In addition, the reluctance to seek medical assistance due to past experiences of mistreatment or discrimination greatly increases the danger of difficulties and transmission to the child. Overcoming this fear is crucial in ensuring the holistic health of both mother and baby, emphasizing the need for supportive and non-judgmental healthcare environments. During the interviews, one respondent indicated that some health workers do not treat them with respect and that they also wait for a long time before getting assisted.

HIV positive pregnant women encounter a multitude of challenges, including accessibility constraints to healthcare facilities, geographical distances that amplify the

struggle to access treatment, and enduring lengthy waits before receiving essential care. These barriers collectively hinder their ability to obtain timely and adequate medical support, increasing the already tiresome task of managing HIV during pregnancy. Efforts to address these obstacles are crucial to ensure these women receive the care they need, to safeguard their health and that of their unborn children. As indicated from one of the respondents, who said that: 'HIV positive pregnant women travel long distances to access HIV care and treatment services. This makes it difficult for them to consistently seek medical attention as required.

4.1 HIV positive pregnant women

4.1.1 Family

Mbera health center is located thirteen kilometers down a dirt road from Balaka town, a good two-hour bike ride away. Public transport does not travel here – only by foot, cycling, bike taxi, or private car. There is a small weekly market at about two kilometers distance, and a trading center five kilometers away. Mbera health center has a catchment area with a population of 70,238 people. The catchment area has 189 villages that goes to Mbera health center. And the total number of women of childbearing age (WCBA) 22,022, On average, the expected pregnancies per year 5,396. And the expected pregnancies monthly is 580, and the expected deliveries each year 5,396, while expected pregnancies per month is 500. Balaka is one of the districts with a high HIV prevalence rate at 16.3%. It is estimated that the prevalence rate is high among women which is at 12.1% and 4.3% for men. Because of the high HIV rate among women, the population of

HIV positive pregnant women is also high. Since Mbera health center is in a rural setting, where most of the people living below the minimum poverty line, their reproductive health is associated with many challenges. This includes the views of some participants, mostly those who are married and being HIV positive and pregnant at the same time. For example, one mother in the study reported that their husband has been unfaithful as she explained that: 'When we got married, I was okay, I contacted the virus from him, what caused this was the difference in cultural background. I am from the village, and he is from town, I am not sure it is because my immunity was low, because I was the one who started receiving medication in 2020 and he has started in 2023. I don't really know why his immunity was low'.

While some said that the husband always came to their wife 4 months after delivery: 'They come whenever they want to and as the result, they find a girlfriend and start staying there and come home once when they want to, and mostly after delivery when the child is 4 months that's when the husband comes back because they know that you are feeling well, and you can now have sex with him without excuses. (laughed) it happened to me with the other child my husband had to leave me and got himself another wife and soon after giving birth at 3 months he came back, and I just welcomed him because my mother said it will be difficult to take care of the child myself'.

Another woman said that sometimes they stay without eating because the husband used the money with the other woman**. '**This life will be more difficult, maybe staying without eating because my husband spends time with other women, forgetting me and the

4 children that we already have'. And another woman complained that her husband has sex with another woman without even using condoms. **'**We need to be faithful to one another as husband and wife, we should not have sex outside marriage, but I don't think my husband can listen to me, you may find that he has sex with other women even without using a condom, so it becomes so bad considering our conditions'.

On the same point of not using condoms the other woman said: 'Some men go beyond and forgets to use a condom, so it may happen that a baby could be born negative but can be infected with HIV during delivery or in the uterus. 'Another woman said that they don't disclose their HIV status if they are not married yet. 'Unless when you are married that's when you disclose otherwise you can't get married if the men know that you are HIV positive'.

Unfaithful husbands who have extramarital affairs while their wives are receiving antiretroviral medication (ARVs) put their partners at serious risk. They put their wives' health in danger by having unprotected sex outside of marriage, and they may even be contributing to the spread of HIV and other STIs. These men's actions show a disregard for the health and safety of their partners; by not using condoms during extramarital affairs, they raise their wives' risk of contracting HIV. This puts the spouses at danger of major health implications in addition to undermining the relationship's commitment and confidence.

While antiretroviral therapies (ARVs) are essential for managing HIV and lowering the viral load, which in turn improves the health and excellence of lifetime for

those living with HIV, a woman's exposure to the virus due to her partner's infidelity and non-usage of condoms can result in treatment failure, drug resistance, and a decline in her health. Increased awareness and easily accessible, reasonably priced health care services are necessary to enable women to take charge of their own health and make educated decisions regarding their relationships.

4.1.2 Reproductive health among HIV positive women

HIV positive women's reproductive health in Africa is a complicated and multifaceted topic with many social, medical, and ethical factors to consider. When it comes to reproductive health, HIV-positive women face difficulties, such as problems with conception, pregnancy, birthing, and preventing HIV from being passed from mother to child. Making the decision to become a parent while HIV positive is not simple. One participant said: 'I was just afraid the moment I was found positive, but now there is nothing stressful. Am used because I know that I am not the only one they are a lot of women here who are HIV positive and pregnant for the 3rd time without any problem.'

Many HIV positive women in Africa desire to have children, and access to reproductive health services, including fertility counseling and assisted reproductive technologies can be limited. Taking care of their HIV status might be a big worry for some women who are trying to get pregnant. Many women livings with HIV worry about getting access to appropriate medical care, HIV medication, and support services, which can cause pregnancy anxiety. They can also be worried about how being pregnant might

affect their own health. The course of an HIV treatment program may be impacted by pregnancy. One other participant said: 'My big problem was fear. I was even failing to have a child for my husband, because of fear on not being able to take care of the child, so we were having problems because we have stayed four years then later, I just decided to accept it.'

Most HIV infections occur sexually or are associated with pregnancy, childbirth, and breastfeeding in numerous parts of the world, which emphasizes the need for HIV/AIDS and sexual and reproductive health activities to be mutually supportive. Many healthy HIV-positive individuals will wish to start a family, and highly active antiretroviral medication gives AIDS-affected men and women the ability to envision new life goals like parenting by improving their health. Still, there are challenging decisions to be made about one's sexual orientation, desire, motherhood, and family life. The right to adequate sexual and reproductive health care, as well as the encouragement to start a family, is impeded by structural, social, and cultural factors. One participant said: 'They encourage us that if found with the virus is not the end of the world, but it is another phase of your life and they also encourage us to take our medication accordingly so that the child should not be infected'.

In order to enhance the reproductive health of HIV-positive women in Africa, a comprehensive strategy that tackles structural, societal, and medical care hurdles is needed. Assuring access to HIV treatment, providing thorough reproductive health services, and defending the rights and dignity of HIV-positive women are all part of this. It's crucial to address more general social and economic issues like gender inequality and

poverty in order to support all women's reproductive health and wellbeing, including those who are HIV positive.

4.1.3 On set of prenatal care OR early prenatal care

All pregnant women should begin antenatal care as soon as possible; if a woman is HIV positive, this is even more critical. Prenatal care enables medical professionals to monitor HIV infection during pregnancy and ensure appropriate management; early ART initiation can also significantly lower the risk of HIV transmission from mother to child (MTCT). Antenatal care covers a range of topics related to mother health, such as routine check-ups, screening for additional infections, and general wellbeing. It also enables medical professionals to plan for the delivery and postpartum period, including discussing the best delivery mode, infant feeding options, and postnatal care plans. Sufficient preparation guarantees that suitable protocols are implemented to reduce the likelihood of MTCT during childbirth and lactation.

In this study, every participant started their antenatal at different times from each other and everyone had a reason for that, as explained by participant. One of them said that she didn't recognize that she was pregnant because she was seeing her menstrual and also, she was coming to the hospital for other issues**.** 'I didn't realize until after three months because I was seeing my menstrual regardless, I was coming for other issues here today and that is when the doctors broke the news to me that I am pregnant, I was just coming to get the ARVs and then I started having some fever two days ago and the doctor run some test today and says am pregnant. 'While another participant said that she didn't

know that she was pregnant until five months. ‘No, I did not know myself that I was 5 months, but when I came here for pregnancy test to start antenatal that is when they told me that I am 5 months pregnant’.

Another participant said that sometimes they hear parents advising children that are pregnant, telling them to start antenatal when they are pregnant.‘You know women we love gossiping, they start looking at you and say that remember to start antenatal early, and sometimes our parents advise their children when they notice that they are pregnant to go and start antenatal, I remember when I was 0ne month pregnant I was at my grandmother’s house but she noticed me even when I didn’t know, she said my face was changing’. In real life, this demonstrates that each person began prenatal care at their own pace. Additionally, some women might not recognize the significance of receiving treatment early in pregnancy or may not be informed about the options that are available. this can be because of inadequate health literacy, restricted access to healthcare resources, or a lack of knowledge on the subject.

The advantages of early prenatal care should be emphasized. These benefits include keeping an eye on the mother's and the developing fetus's health, recognizing and addressing any potential risks or issues, and offering support and information for a healthy pregnancy and delivery. Attempts to increase prenatal care service accessibility, awareness, and education can assist in addressing some of the obstacles women encounter while beginning care early in their pregnancies.

4.1.4 Hospital check ups

Pregnant women who test positive for HIV should have frequent hospital checkups. These visits enable medical professionals to monitor the woman's general health, including her weight, blood pressure, general wellbeing, and any possible pregnancy-related complications. These examinations are even more important for women who are HIV positive since HIV might impact the immune system and raise the possibility of certain pregnancy-related problems. Participants discussed having multiple prenatal visits before giving birth. For example, one participant mentioned that they weigh themselves on a scale, get a blood test, and then receive medication. She said that they receive the ARVs and Bactrim when it is available, and also, they give them Fansida a malarial drug that they take on the first trimester, but when they are HIV positive, they don’t give Fansida because it can cause miscarriage. In addition to that she said that they give them mosquito nets, they tell them to sleep in the mosquito nets to avoid malaria.

Current guidelines recommend inclusion of HIV testing in routine screening tests for all pregnant women. For this reason, antenatal care (ANC) represents a vital component of efforts to prevent mother-to-child transmission (PMTCT) of HIV. One of the respondents said that they also do the viral load and CD4 count when they are pregnant during antenatal, that is to say HIV positive pregnant women need to have their CD4 count regularly monitored during pregnancy, this hospital checkups provide an opportunity for health care providers to assess the risk of mother to child transmission, provide guidance on infant processes, one participant said that; ‘They do some tests to see the functionality of the body and they also advise us to eat well and healthy. In

addition to that, they conduct HIV test, they take blood samples, they take you to different rooms, they check blood pressure, they give you malaria drug three tablets and they advise you to take them at once, but if you are already HIV positive then they don't give you malaria drug because it can cause miscarriage as you are already taking ARVs but if you just found that you are HIV positive then they give you the malaria drug but then they give you a week to start taking the ARVS.'

HIV testing must be incorporated into regular ANC services in order to improve PMTCT programs' ability to contact pregnant women who test positive for the virus. The provision of outreach services for women in rural areas should be increased, and untrained attendants should be trained, supervised, and integrated into official programs for maternity and child health. Reducing stigma and raising HIV awareness requires educating pregnant women and their communities. Counseling plays a crucial role in supporting HIV positive pregnant women by providing essential information, emotional support and empowerment, ultimately contributing to improved maternal and child health outcomes in the context of HIV, Knowledge of HIV status, through HIV testing and counselling is very important during pregnancy, childbirth and breast feeding. One of the participants said: 'They encourage us that if found with the virus is not the end of the world, but it is another phase of your life and they also encourage us to take our medication accordingly so that the child should not be infected'. Through counseling, pregnant women who test positive for HIV can get understanding about their status, available treatments, and services. This can assist them in making well-informed

decisions for both their own and their child's health, improving outcomes for both. One of the participants said that:

‘What they do is that after every three months I get tested to see my immunity system they say, they advise me on how to eat well, what to buy for the baby. They give me condoms so as to have sex with my husband when the baby is born, they say 6 months after the baby is born it is ok to have sex and eating all six groups of food. They call us together with my husband frequently for more counselling so that we should all hear and remind each other, I have been with him for long but he gets tested and still found HIV negative and that’s why we are advised to take condoms It also provides an opportunity for the woman to discuss their productivity choices, and considerations for future pregnancies in the context of their HIV status. This can empower women to make informed decisions about their reproductive health and overall wellbeing.’

For expecting mothers who test positive for HIV, counseling is a crucial component of comprehensive prenatal care. I have underlined how important it is to provide accurate information to these mothers about HIV transmission, therapies that are accessible, and child prevention strategies. Moreover, it is evident that skilled counseling can empower expecting moms living with HIV to make choices regarding the health of their fetus. Medical personnel assist these ladies in overcoming challenges and encourage them to continue antiretroviral therapy and routine check-ups by providing a consoling and judgment-free environment. One of the participants said*:* ‘The advice that we receive is that when we are pregnant we need to be protecting our selves by taking the ARVs as

advised, and when the ARVs are finished we are advised to come back as shown in the health profile book, they give us a date that is related to our day of the antenatal visit.'

4.1.5 Breast feeding

For a variety of reasons, HIV-positive mothers in sub-Saharan Africa continue to breastfeed their children. In addition to meeting an infant's nutritional needs, breastfeeding is typically recommended by other family members as a cultural norm. Women who do not start and continue breastfeeding give rise to suspicions in the community about their HIV status, which may eventually reveal the woman's status. In addition, non-dairy breast milk alternatives are either prohibitively expensive or unsafe to use due to a scarcity of clean water, and baby feeding containers are readily polluted, particularly in rural regions. An infant who is breastfed is protected from upper respiratory infections and diarrhea. The most significant method of postnatal HIV transmission to the child, however, is nursing.

It is widely accepted that mothers living with HIV should breastfeed their children exclusively until they are six months old, at which point they should suddenly wean them from the breast in situations where formula feeding is not economically feasible. According to this study, some women were just following their breastfeeding practices when they were HIV negative because they were dissatisfied with the information they were receiving from counselors, while others had a fair understanding of how HIV might spread from mother to child. Therefore, the most crucial elements in preventing HIV

transmission from mother to child are fostering a positive attitude and excellent practices among pregnant women.

One of the women said that when she was HIV negative, she was breastfeeding for 2 years. ‘For me, the time I was negative, I was breastfeeding for two years but now the way I am HIV positive it may be difficult unless I get advice from the doctor saying that with this baby right now you should be doing like this or that so that the baby should not be infected with HIV’. And another woman said they can’t breastfeed up to 2 years because the nurse will be harsh on them.

‘We breastfeed some of them about one year and seven months, and sometimes one year and eight months. But we haven’t exceeded two years because doctors can be harsh to you as they advise us to stop breastfeeding when the baby is almost 2 years.’ One woman also said that they make sure that they are following the advice that they have been given. ‘Because the baby is being monitored by the doctors from birth till 2 years so that is why we make sure that we follow the advice that they give us’.

Another woman talked about the babies having sharp teeth that she can bite and transmit the virus. ‘They say a baby can be infected with the HIV virus, because by the time the baby is almost 2 years you can easily transmit the virus because her/his teeth are very sharp she can easily bite you and sack the blood and it will be difficult to stop her from being infected. ‘

Breastfeeding is the best method for nursing babies and has been shown to provide long-term advantages for moms and kids. However, breastfeeding while HIV

positive is a complicated matter that needs to be carefully considered considering the risks as well as the benefits. Development of guidelines and measures to lower the risk of HIV-related mental health tests (MTCTs) through breastfeeding has received a lot of attention in Africa, where HIV prevalence is rather high. In the past, formula feeding was advised instead of breastfeeding for moms who tested positive for HIV, even though this was not a practical choice for many women in settings with limited resources because of things like cost.

4.1.6 Impacts of ARVs Effects of ARVs OR outcomes of ARVs

HIV is treated with antiretroviral medications, which also stop the virus from spreading from mother to child during pregnancy and childbirth. Although these medications are generally helpful, they can also have certain negative consequences. It is crucial to remember that each person will respond differently when thinking about the side effects of ARVs in pregnant HIV-positive women in Africa. Skin rashes can occur as a side effect of some ARVs; these are usually not serious but can be unconfirmable. Diarrhea is another common side effect of certain ARV medication and can lead to dehydration and nutritional deficiencies if not managed effectively. Some ARV drugs cause nausea and vomiting, which can be particularly difficult for pregnant women. One participant said: ‘I am Being allergic to the medication by vomiting because of lack of Bactrim and when we tell the doctor that taking the medication without Bactrim it is not helping at all, the reasons that they give us lack of enough medicine because it is given by the government, and that is why if you have realized a lot of people are coughing, they have headache. ’An antibiotic called cotrimazole is frequently used as prophylaxis in

HIV positive patients, including pregnant women, to prevent opportunistic infections like pneumonia. Patients with weakened immune systems, such as those living with HIV, are especially vulnerable to these illnesses. One participant said: ‘At first, I was thinking that the Bactrim it’s just nothing but I have realized that it supports the ARVs they work together, imagine staying 8 months no Bactrim, people are sick and if you are sick and give you the cough tablets it is a bit risky with the pregnancy, but the doctor said that they just give the Bactrim to those that have low immune system so that they cannot get sick more often.’

To effectively manage their HIV and lower their risk of opportunistic infections, HIV-positive pregnant women should have access to proper Antiretroviral therapy (ART) and preventative drugs, such as Cotrimazole. If a pregnant woman living with HIV lacks access to prenatal care, it is imperative to safeguard the health and well-being of both the mother and the developing fetus. This includes regular monitoring and assistance from health care providers.

Perinatal HIV prevention and management protocols

An antiviral drug called nevirapine is used to treat HIV/AIDS. Nevirapine is frequently given to a newborn when the mother is HIV positive as a preventative measure to lower the likelihood of HIV transmission from mother to child. The time of administering NVP to a newborn varies based on the particular situation and established protocols. Nevirapine is often administered to newborns within 72 hours of their birth, in most circumstances. The goal of this early administration is to lower the possibility that

the mother would transmit HIV to the kid through breastfeeding or childbirth. One participant said: ‘When the baby is born, you tell the doctor that I am HIV positive, then the doctor gets the medicine then puts it in his/her mouth before you start breastfeeding, after that it is when you start breastfeeding’. Every expectant mother who visits the antenatal clinic is registered for services. All women receive health education on HIV/AIDS and the significance of HIV testing in addition to general ANC care. They are also informed about the significance of giving birth in a hospital and antiretroviral prophylaxis (in this case, NVP). Additionally, the doctor administers the NVP as soon as the baby is delivered.

Nevirapine syrup is administered to babies born to HIV-positive mothers in accordance with the doctor's instructions. For instance, the baby receives the first dose of the syrup shortly after birth—ideally within 72 hours of the baby's birth—as this early administration is critical in lowering the risks of HIV transmission from mother to child. The baby also receives additional nevirapine for six weeks after birth, as determined by healthcare providers in accordance with established protocols. One participant said:

‘When the child has reached six weeks, they take a blood test, and then they start giving the child Bactrim’.

In addition to this, health care providers monitor the baby’s health and response to the medication for at least 2 years in total, and they conduct regular follow up visits to ensure that the infant is receiving appropriate care and support. The mothers are given the NVP to keep it with them at home when they are 6 weeks pregnant so that if the labor

pain starts and accidentally, they give birth at home then they should be able to remember to give to the baby, or by asking the guardian to provide. And the mothers and the babies are followed up for 2yrs, the first 6 months are intensive as mothers are focusing on baby feeding practices, at 6 weeks the baby is stopped to get NVP and start taking the Bactrim every day until 2 years when the baby graduates from taking the Bactrim. One of the participants said: 'The baby is given a small bottle of liquid stuff, and they advise me to give the baby for 6 weeks, after that we should go back to the doctor and tell him that six weeks is completed and they run the HIV test by taking the blood at the toe, and after that they start giving the baby the Bactrim tablets to take one every day for 2 years and after that 2 years the baby graduates from taking any kind of HIV related drug. The baby should not stop from breast milk until two years and six or seven months'. Before stopping the baby taking the Bactrim some tests are supposed to be taken on the process to make sure that the baby don't have HIV. The women are also advised to remind the nurses when they are in the delivering room about the NVP.

4.1.7 Stigma

Bias, denying, distancing, and discrimination against those who are thought to have AIDS or HIV, their loved ones, associates, and the groups and communities they are affiliated with are all considered forms of stigma. Stigma is a socially constructed experience in which the stigmatized person does not feel completely integrated or accepted into the culture or society. Stigma can lead to feelings of shame, guilt, fear, and isolation in HIV positive pregnant women. It can have a negative impact on women's mental health and wellness, which can result in elevated levels of stress and anxiety. It

may be challenging for them to seek the right medical attention and help because of this emotional weight. Stigma can make HIV-positive pregnant women less likely to seek out or adhere to antiretroviral therapy (ART) and other necessary medical interventions. They may fear discrimination or judgment from their community, which could result in treatment outcomes that are poor for the mother and the fetus.

One of the participants explained that she takes all her children when going to collect ARVs. 'If we can leave the child behind people may also think other things, they will start asking a lot of questions, because we just leave home as if we are going to the market or town while we know that we are going to collect ARVs it is not easy to tell anyone about your status'. Another respondent said that sometimes they have to tell a lie that they are going to the market while going to collect the ARVs. 'Maybe we'll say we are going to the market, but in real sense we are going to the hospital, but when coming back we carry a plastic bag and people don't know anything. It's not easy, I feel sorry for myself when I think that maybe he will say that today we are ending our marriage, so he may be going to Balaka and because I don't have transport it may be difficult for me to go and get the medicines, I don't have peace.'

This is the result of pregnant women who are HIV positive fearing unwelcome disclosure to the public. The fear of stigma may deter pregnant women living with HIV from telling their community about their status. If this happens, the community may not be able to support the woman emotionally or jointly decide on treatment and childbirth or prevent new infections from occurring. One respondent said that she will be ashamed to come to the hospital, but she can get used. 'I can choose this hospital because it may not

need money for transport, I can just walk of course I will be ashamed but I can get used after some time, only that here they give medicines Monday or Tuesdays so I may be coming here in the afternoon hours or I may agree with the doctor that I should have my own time to get the medicine. ’HIV-related stigma must be addressed to ensure that pregnant women who are HIV positive receive the support, care, and treatment required to protect both their own health and the health of their unborn children. Many efforts are needed to lessen the stigma associated with HIV/AIDS, such as community engagement, education, advocacy, and legislative changes.

4.1.8 Poverty OR financial hardships

Like many other African nations, Malawi has seen severe poverty. According to the World Bank, almost 50% of Malawians live below the country's poverty line, and a significant portion of the population subsists on less than the worldwide poverty threshold of $1.90 per day. The expense of receiving health care services is a burden for low-income women. Many pregnant HIV-positive women in Balaka experience food insecurity, which exacerbates the health effects of the virus and their financial struggles. Adequate nutrition is essential for maintaining maternal health and preventing HIV transmission from mother to child.

Due to distances and a lack of reliable transportation, Malawi's rural population and numerous isolated settlements make it challenging for people, particularly those who live in rural areas, to obtain health care facilities. This makes it difficult for people to get to health care facilities due to the distances needed and the lack of accessible

transportation, especially for those who reside in rural areas. One participant said: ‘Distance is a barrier, because we stay very far from here. So, we walk by foot as we can’t afford for a bike taxi as it is not easy, you know as a pregnant woman we have cravings, so we walk and use the money to buy a snack on the way. Sometimes when you have a good husband when coming for antenatal, they give us money to use on the way to the hospital.’In many parts of Malawi including Balaka where the data was collected the conditions of roads and transportation is very poor, this makes the travel to health facilities challenging, especially during the rainy season when the roads are impassable. To fix the roads in Malawi takes forever. One respondent said*:* ‘The problem we face is we travel long distances and as a pregnant woman, we have difficulties in walking, we do have swollen feet after coming back and forth to the hospital, most of the times we sit on the trees and rest for some minutes.’

Protein is essential to the growth and development of the fetus. Pregnant women who do not get enough protein may put their unborn children at risk for stunted growth, low birth weight, and other developmental problems. Protein is necessary to maintain overall nutritional status, and a diet low in protein can exacerbate malnutrition, which further jeopardizes the developing fetus's and mother's health. One participant said: ‘We don’t manage, because of poverty but in one area we do try our best to eat six food groups. Like fish, the small ones are cheaper we eat, the vegetables are the easiest thing to find and cheap but mostly neighbors share. And if you are married when the husband is out, he buys the Matemba when coming back. It’s difficult when you have a lot of kids.’

To guarantee that pregnant women who test positive for HIV have access to a healthy diet both during their pregnancy and during lactation, health facilities can provide nutritional support and counseling. Additionally, they can work with non-governmental organizations (NGOs) and other groups to offer HIV-positive pregnant women economic empowerment programs, such as microfinance programs, vocational trainings, and assistance with income-generating activities. By empowering women economically, poverty can be lessened because they can better support their families and themselves. One participant said:' 'It is some people are pregnant and also with the disease but then a way for them to find resources to do businesses, they fail. What is missing here is where to get help. The capital for business is hard to find.'

4.1.9 Penalty

Due to several cultural, social, economic, and practical factors, women in Africa gave birth at home around 1900. In many African cultures, giving birth is viewed as a natural and normal event that frequently involves the support of female family members, traditional birth attendants, or community midwives. These cultural customs and practices have frequently revolved around generation-by-generation home childbirth methods. Access to medical facilities, especially maternity hospital and clinics, may be restricted in rural and isolated locations. As a result, women may choose to give birth at home rather than struggle to get to a medical facility in a timely manner.

Although giving birth at home has long been a customary and major cultural practice in many African communities, there are risks involved, especially when there are no trained birth attendants or immediate access to medical treatment. To lower the rates of maternity and infant mortality in Malawi, efforts have been made to encourage women to give birth in hospitals rather than at home. To this end, organizations and the government have introduced incentives to encourage women to give birth in hospitals, while some governments have even considered penalizing women who choose to give birth at home. However, these approaches are typically divisive and may encounter resistance. One participant said*:* 'But at first, they were charging 7000kwacha to the chief that was equivalent to the goat (6$) and then 5000 kwacha 4$ that was equivalent to the chicken a big one. So those who didn't manage to pay they were paying the goat or they were paying the chickens may be 2 to 3 to make it equivalent to the goat.'

The fear for the mother's and the child's safety and health is a major factor in African communities' penalties or discouragements against home deliveries. Medical professionals and authorities may support hospital or clinic births because these settings are better equipped to handle any complications that may arise during childbirth, and by enforcing penalties, they ensure that the rules are followed. One participant said: 'If you have delivered at home, to get help here at the hospital you are required to pay money before they help you. That is the law that we had from 6 years ago and it is still there that's why you see that nowadays there is no home births because people are scared.'

There are birthing-related traditions and rituals in many African communities. Although in many localities home births are still practiced, they may have been the norm in the past. The trend of hospital births has increased with the development of the health care system. Penalties for home births may occasionally be connected to initiatives to update medical procedures and conform to guidelines supported by regulatory bodies. Monitoring maternal health indicators and birth outcomes may be of importance to the government and healthcare institutions. Home births may be discouraged in some settings since hospital births are easier to record and monitor.

4.2 Health Workers

4.2.1 Baylor

Since its establishment in 2005, the College of Medicine Children's Foundation, or BAYLOR, has worked to improve the health of children and families affected by HIV. It also supports the Ministry of Health in enhancing prevention of HIV transmission from mother to child, early infant diagnosis, and pediatric HIV care in Salima, Lilongwe, Balaka, Mangochi, Machinga, and Phalombe. Their workers are highly trained on their own, and they place a lot of emphasis on HIV. After over fifteen years of operation, Baylor Foundation Malawi has expanded its goal to include maternal health care service.

To improve the delivery of women's health services and expand access to them, their program works with partners in areas where there is the highest need. These comprehensive obstetric and gynecological treatments include family planning, maternity care, and the detection of preexisting problems like obstetric fistula and malnourishment

that could prevent a safe birth. In addition to our clinical research improving outcomes for mothers and children globally, they provide community education on the advantages of fewer families, childhood nutrition, and a number of other topics related to maternal and child health.

Tingathe, which translates to "together we can" in Chichewa, helps Malawi's Ministry of Health meet the UNAIDS 95-95-95 targets by offering comprehensive HIV care across the country. The Technical Support for PEPFAR Programs in Southern Africa (TSP) project, a five-year (2016–2021) bilateral cooperative agreement between USAID Malawi and the Baylor College of Medicine Children's Foundation Malawi, is responsible for implementing the Tingathe program. In partnership with the MoH, the Tingathe Program lays out a clear plan for managing Malawi's HIV/AIDS response through targeted capacity building and service delivery with the goal of controlling the HIV epidemic.

Some of the treatment supporters said BAYLOR is doing a lot for the community for example when they want to make some follow ups on treatment interrupters (defaulters) they use bicycles that they got from BAYLOR:‘BAYLOR donated a motor bike, and we have some treatment supporters that do the follow ups, those motor bikes I think they travels about 10 kilometers or 12 kilometers from this hospital. So, for anyone who is staying away from the 10 kilometers the motor bike goes there for follow up, but for those who are staying within, there are some community health workers, they go on bicycle for follow up and encourage them to come back on care.’

And one of the nurses said that: the only challenge that they face is that they don't have any one from BAYLOR who works over the weekend where a lot of births occur and due to that it is difficult for them to realize whether the patient is HIV positive or not: 'When we go in labor ward, maybe it is over the weekend, so our friends who help with HIV testing the BAYLOR people they work from Monday to Friday, Saturday, Sunday they don't work, but also Friday it's like half day for them. ''So, if the woman has come Friday after 12 noon, she can give birth, but her HIV status will be the same for the past showing negative results, even though she was tested seven months ago, maybe she was not even tested she comes from other locations where there is no BAYLOR partners.'

Despite the challenges another nurse said that BAYLOR is doing a great job because without them they could have had overloads of work: 'What is also good is that we have partners (BAYLOR workers) who sometimes help us on other issues that we have more especially with these women because once we found someone HIV positive, before us advising her it happens that they have already given her advice that she deserve and when she come to us nurses, we just start from where BAYLOR workers have stopped. 'Like many other nations, Malawi faces enormous obstacles when it comes to tackling the effects of HIV, especially for vulnerable groups like pregnant women living with the virus. NGOs like the Baylor College of Medicine Children's Foundation Malawi are crucial in helping pregnant women living with HIV/AIDS by offering them prenatal care, antiretroviral therapy (ART), and assistance in preventing HIV transmission from mother to child. These services play a critical role in safeguarding the health and welfare

of the expectant woman as well as the unborn child. They also greatly enhance the lives of marginalized groups and further public health objectives in Malawi and elsewhere.

4.2.2 Good relationship with patients

Building strong relationships with patients who are HIV positive helps to establish trust and create a comfortable environment where they feel safe to discuss their concerns, ask questions, and actively participate in their care. Patients who are HIV positive may experience a range of emotions, including fear, anxiety, and stigma. Additionally, it has a good effect on treatment adherence; patients who have a sense of connection and support from their healthcare providers are more likely to adhere to their antiretroviral therapy regimen, which improves outcomes for the mother and the unborn child.

A supportive relationship with health care providers can offer emotional and psychological support, helping patients to manage stress and maintain a positive outlook throughout their pregnancy. Pregnancy can be a stressful time, especially for women who are HIV positive and pregnant. One of the nurses said: ‘They are more stressed, so their stress is based on complaining, “I am HIV positive and pregnant, how will my baby be born? How will my baby be protected?” Maybe some other challenges that we face is stress, so we try to encourage them, ’And the HIV diagnosis assistant said:‘ Because they even tell each other about the care that they are receiving, and during the counselling session if we forget to tell them something the other day when you meet the women, you will find that they come to you saying that my friends told me this this, and that’s when

you'll realize that oooh yes I really forgot that one. And it makes you happy knowing that they listen to what you tell them.'

Building a strong relationship with pregnant HIV positive patients enables healthcare professionals to effectively educate them about the value of antiretroviral therapy (ART), PMTCT (prevention of mother to child transmission), and methods for preserving both their own and their unborn child's health. By arming patients with information, patients are better able to make decisions and participate actively in their care.

4.2.3 Counselling

Ensuring pregnant women understand the significance of taking their antiretroviral medications as prescribed is made possible in large part by counseling sessions. Maintaining regular ART compliance can dramatically lower the risk of HIV transmission from mother to child. Pregnant women who receive counseling can learn about PMTCT interventions, which can lower the risk of HIV transmission to the unborn child. These interventions include exclusive breastfeeding, early baby diagnosis, and the significance of giving birth in a medical facility. One of the treatment supporters said:

'The same pregnant woman, we advise her not to give birth while at home or anywhere, but she needs to give birth only at the hospital so as to prevent the baby from getting HIV. When someone is on delivery stage, we make sure that her blood status in well known by the nurse.'Counseling sessions provide a secure area for women to share their fears, anxieties, and emotional issues as well as get psychological support. Receiving an HIV

diagnosis during pregnancy can be an extremely taxing experience. Through counseling, women can learn about HIV, how it spreads, and how to live a healthy life while living with the virus. Equipped with this knowledge, women are better able to make decisions regarding their own health as well as the health of their unborn child.

Everyone should eat a variety of meals, but pregnant women especially need to do so. This is especially true if they are HIV positive. Eating a variety of foods guarantees that a pregnant woman gets a wide range of vital nutrients, like vitamins. One of the HIV diagnosis assistants said: ‘In order the child they are expecting should be born without the virus and also, we encourage them to be eating healthy (six food groups) so that their body should be healthy too, so that she should be healthy and have strength at the time of delivery so that there should be no complications’.

Nutrients, healthy fats, and proteins. Both her own health and the good growth of the fetus depend on these nutrients. Eating a variety of foods can assist regulate weight and ensure that both the mother and the developing baby receive the required nourishment. HIV can also have an impact on a woman's weight and nutrition during pregnancy. One of the HIV diagnosis assistants said: ‘These are ante-natal women, but we also encourage that they should be eating healthy foods with all six groups, like fish, either small matemba or bonya, not just chambo, vegetables, beans, fruits and any kind of food that they find’.

Nevirapine is brought up when counseling pregnant women who test positive for HIV because it's critical to give them clear information and assistance so they can comprehend the advantages, possible hazards, and appropriate use of the drug. One of the

treatment support explained that: ‘We also advise this woman that once she gives birth, before her baby start breastfeeding should be given medication which is called Nevirapin, and it is given to the baby for six weeks and we advise this woman to give Nevirapin to the baby once per day for six weeks.’

Nevirapine is given to the mother during pregnancy and childbirth as well as to the newborn after delivery to provide additional protection. The primary function of nevirapine in HIV-positive pregnant women is to lower the risk of virus transmission to the baby during pregnancy, labor, delivery, and breastfeeding. The exact directions and suggestions given by the medical professionals and national health authorities may affect the timing and length of the nevirapine treatment. Some of the treatment supporters said: ‘For me as a counselor, it is my job to advise women. I make sure that every woman who is pregnant but also HIV positive has been told to start taking medication, and she should be taking this medication every day for the rest of her life. We also advise this woman that once she gives birth, before her baby start breastfeeding should be given medication which is called Nevirapin, and it is given to the baby for six weeks and we advise this woman to give Nevirapin to the baby once per day for six weeks.’

4.2.4 Access to medication

The risk of HIV transmission from mother to child during pregnancy, childbirth, and breastfeeding is greatly decreased by ARVs. When taken as directed, antiretroviral drugs (ARVs) can significantly reduce the risk of vertical transmission, safeguarding the health of the fetus while simultaneously managing the mother's HIV infection and

enhancing her personal well-being. ARVs can extend a mother's life and enhance her quality of life by lowering her viral load and boosting her immune system. To ensure its effectiveness, improve public health outcomes, and support people in need of accurate and timely guidance regarding HIV diagnosis and care, BAYLOR placed a strong emphasis on training its employees. Appropriate training guarantees that the assistant can accurately interpret symptoms, risk factors, and test results. One of the participants said:

'Our training was all about the unborn baby who is still in the womb of the mother, so we were trained that we really need to take care of that woman to make sure that she is on ARVs, and when we can't manage some problems should be referred to a nurse, but the main goal is to have a HIV negative child, and we need to take care of the baby for two years, we can only discharge him/her when she /he is negative, but if found HIV positive we also need to take care of him/her until ARV process and do some follow up so that a baby should live a health life'

Some of the participants talked about nevirapine, a drug given to the infant shortly after birth to help lower the risk of vertical HIV transmission from mother to child during childbirth. By taking nevirapine, the mother's body has less virus, which lowers the chance of the virus infecting the baby during delivery. It has been discovered that the one-dose NVP given at the time of delivery effectively lowers the risk of transmission. One of the HIV diagnosis assistants said: 'We also advise this woman that once she gives birth, before her baby start breastfeeding should be given medication which is called Nevirapine, and it is given to the baby for six weeks and we advise this woman to give Nevirapine to the baby once per day for six weeks. Then after that, she needs to come to

the hospital so that we should do HIV test to the baby for us to know if the baby was born with HIV or not.'

Access to ARVs helps with the larger public health objective of decreasing the transmission of HIV throughout communities and populations. It benefits not just the present pregnancy but also lays the groundwork for continued HIV treatment and care, which benefits the mother and any future pregnancies. Providing pregnant women with access to antiretroviral vaccines (ARVs) is an essential part of comprehensive HIV care and treatment, and it has the potential to have a major impact on the health of mothers, children, and communities.

4.2.5 Prep

When taken regularly and as directed, PrEP (preexposure prophylaxis) has been demonstrated to be very effective in preventing HIV. For those who may participate in high-risk behaviors, such as unprotected sex or injectable drug use, PreP can offer an extra line of defense against HIV transmission. HIV positive pregnant women are becoming less common, according to an HIV diagnosis assistant, who noted that PREP had made a significant difference. She said:'If men have sex with the woman who is HIV positive they are given PreP that they take within the 72hrs, and if the woman is taking the ARVs accordingly that means there is no danger to the man that's is why I think it is very rare to find new HIV positive mothers, those that are pregnant like 80 percent of the women are already on ARVs, but the new mothers that are tested positive are just 10 percent of it.'

In this data it shows that the health workers are well informed about PreP and they are effectively educating their patients about the benefits, usage, and possibly the potential side effects. One of the treatment supporters said; ‘Aaaaah maybe a woman is HIV positive and a husband is negative they can still get married and have HIV negative child and HIV negative husband by taking the PREP soon or before sex. That’s what the government have done now, and what the government want to do now is to give every man PREP so that they should end HIV by 2030 (laughed) I heard rumors that the vaccine is coming for everyone in Malawi. Despite all the efforts for the health workers, they have the youths that take the PreP any how because they are available at their services so the treatment supporter said that if the girls/boys come to ask for PREP here is what they tell them: ‘we just warn them that PEP should be taken a maximum of three times, when you exceed number three then it’s danger. So, they are afraid. And in addition to that the girls fear the nurses that they will be harsh on them that is why they come through me, and I take them to the nurse. they do this in order to protect them from having unprotected sex.’

4.2.6 Marital affairs

The well-being, adherence to treatment, and quality of life of an HIV-positive partner are dependent upon the understanding and support of family members. Establishing a nurturing and supportive environment within the family can have a profoundly positive impact on the individual's capacity to manage their HIV and lead a fulfilling life. Insufficient knowledge about HIV transmission and treatment can result in irrational decisions, such as filing for divorce in reaction to the diagnosis. Learning that a

partner is HIV positive while pregnant can be emotionally taxing for some men, who may find it difficult to process the information and may act impulsively, including filing for divorce.

Some males may be concerned about their own personal future, including their health and the possible effects of HIV on the welfare of their families. The choice to file for divorce may be motivated by this uncertainty and fear. One of the HIV diagnosis assistants said: ‘The challenges that we face on our job when advising these women is the problems that they face with their husband, families’. Find that the wife is HIV positive while the husband not we still need to do the counselling on their present not only the woman because they need to understand and know how to help each other, So when her husband is not willing to come to the hospital, there is a challenge for a woman to disclose herself to her husband because it will lead to divorce in so many families’.

Some women may worry that telling their husbands they are HIV positive may result in abuse, violence, or rejection from their spouses; this worry can be especially intense during pregnancy, when a partner's support can be most important.

One of the treatment supporters said: “We have received such kind of scenarios, men come here with angry faces shouting at the wife asking where she got the disease but yet when we ask the men to do the HIV test they most give excuses then we just encourage them to use condoms” Since HIV is linked to stigma and prejudice, women who disclose their status may fear rejection or judgment, especially when they are pregnant. The desire to avoid stigma can be a strong incentive for people to hide their

condition. The main issue that health professionals have when assisting HIV positive mothers during antenatal care, according to one of the HIV diagnosis assistants, is that sometimes these women have different health passports, one of which shows HIV negative because it was used when the woman was HIV negative. The passport that shows the woman's true status, however, remains at home.

It is crucial to understand that choosing to reveal or keep one's HIV status confidential is a very personal choice that is impacted by a variety of social, cultural, and individual variables. It is possible to foster an atmosphere where women feel more comfortable disclosing their HIV status by addressing stigma, offering support services, and encouraging open communication. This is especially important during pregnancy, when prompt medical attention is vital for the mother's and the unborn child's health. Stigma. There are many people who do not completely understand how HIV is transmitted and may hold onto outmoded notions that lead to stigma. These common misconceptions about HIV transmission cause fear and discrimination against persons who are living with the infection. Lack of knowledge about HIV and its treatment may exist in some communities, which may lead to stigmatizing attitudes and behaviors as well as fear and discrimination toward persons who are HIV positive. If women reveal their HIV status, they often fear that their confidentiality will be violated, especially in situations where privacy and security may not be sufficiently protected. Reluctance to disclose their status can be attributed to a fear of unwanted disclosure by coworkers, medical professionals, or other parties. One of the HIV diagnosis Assistant said: ‘Now the women that comes for antenatal here change their health profile book, mostly they

bring the health profile book that shows that they are HIV negative, the right one with the right HIV status is hidden at their homes.'

Pregnant women who are HIV positive can choose when, how, and with whom to disclose their status, all while maintaining control over their personal health information. Their sense of agency and emotional health depend on this autonomy. Knowing that their privacy would be protected can assist pregnant women living with HIV feel more confident in the systems and providers of healthcare, and they are also more likely to seek prenatal care and stick to ART regimens. One of the treatment supporter explained that : 'Since there is freedom to choose the hospital where you want to be getting the medications based on your privacy and distance as well, so it happens that they are coming from certain area away from here, and may be they do ante-natal care here, but getting ARVs from Balaka which is 13 KMs away, In the register, it is indicated that she comes from other hospital and we understand that but the only problem is for us to make some follow ups to make sure she is telling the truth.'

It is critical to acknowledge that the decision to reveal one's HIV status is complicated and greatly influenced by social context as well as individual circumstances. Reducing stigma, maintaining confidentiality, and providing support to those living with HIV are essential in fostering an atmosphere where women feel comfortable and supported in disclosing their status when they are ready. One of the treatment supporters said: 'When we visit them to their homes, I told you already that we have experts that makes some follow ups and after following them they come back to the hospital because she is afraid that her friends from the community will notice why we visited her/him so

when we visit them in their communities we act like there is certain project from the hospital, we do this so that no one asks questions or gets suspicious about our visits.'Pregnant women who test positive for HIV must be addressed with a well-thought-out strategy that includes community outreach, education, and efforts to increase compassion and understanding. Communities can try to lessen the stigma by dispelling myths, giving correct information, and encouraging compassion and support.

4.2.7 Challenges faced by Health workers.

Insufficient space in health centers can make it difficult for employees to carry out their jobs effectively. Overcrowding can result in inefficient patient flow, longer wait times, and higher levels of stress for both patients and staff, all of which can lower the facility's overall productivity. One of the treatment supporters said: 'There are other women who are coming from long distance locations, so because they are coming from far away, they are failing to meet their appointment dates to get medications. Sometimes it happens that some women do some default for two months, when you visit and ask them why they are not coming to get their medicines, the reason they give is "I don't have any means to travel the distance is too long'.

The standard of patient treatment might be impacted by a shortage of space. Accessing essential supplies and equipment may be difficult for healthcare professionals, and maintaining patient confidentiality may make delicate interactions difficult. In the end, these elements may influence the general standard of the medical services rendered.

One of the treatment supporters said*:* 'The other challenges we face is that our facility has limited place, so it is found that those people whom we are testing are just moving from one door to another door without being helped, so it is difficult. If we had enough space, it would be better, because we don't have counseling ward, we use HTC ward to counsel those people which may sometimes disclose privacy for other people. Here, we don't have special counseling room which we can use separately, so that are other.'

Patients' sense of dignity and support may be compromised during medical tests, consultations, or treatment if there is insufficient infrastructure in place to protect their privacy. As a result, they may be unwilling to seek out essential care. Maintaining patient confidentiality requires privacy. Without private areas, conversations concerning private health matters and sensitive medical information could be overheard by others, breaching patient confidentially and raising ethical and legal questions. One of the HIV diagnosis assistants said:'The main challenge is lack of infrastructure, we don't have enough space here, the government need to buy another place, it may happen that the same day they are helping people who are on ARVs, and some people are doing under-five. So, it happens those women, their privacy is not being protected those who come for ARVs, because we use the same rooms with people who are getting services that are different from them. Most of the times these women want their things to be done in privacy, so I think their privacy is a little bit being disturbed due to lack of enough infrastructure.'

The risk of undetected health issues that could affect the pregnancy increases when pregnant women lack regular access to prenatal care, which includes vital services like ultrasounds, check-ups, and screening for potential complications. Long distances

can make it difficult to get regular prenatal care, which is essential for monitoring the health of the mother and developing baby. Long hospital commutes can cause mothers to lose access to emergency medical treatment in the event of labor or pregnancy difficulties. This can have major repercussions for both the mother and the unborn child, particularly if urgent medical attention is needed.

The quality of care that nurses can provide patients, can be directly impacted by their lack of resources, including staffing, medical supplies, and equipment. Because nurses already work in high-stress environments, their lack of resources can make this stress worse. Additionally, when nurses are consistently forced to work in environments with limited resources, they may experience high levels of burnout, which can lower job satisfaction and increase staff turnover. It is crucial to consider tactics like assisting pregnant women with transportation and expanding access to prenatal care in remote locations. and making certain that women's homes are adjacent to sufficient facilities for childbirth. For women who live in distant locations, telemedicine and mobile health clinics can also help close the gap by enabling them to obtain crucial prenatal care without having to travel far.

4.2.8 Beliefs

It is noteworthy that most prophets and religious leaders do not counsel individuals who are HIV positive to forego ARV treatment. If a follower has HIV, most religious leaders advise them to get the proper medical care, including ARV treatment. Nonetheless, there have been a few rare instances when some people—often those with a

strong religious or spiritual influence—have advocated against using ARVs in favor of putting all of your faith in God to heal you. This advice may not be backed by medical consensus or scientific facts; rather, it is based on religious beliefs.

When religious leaders advise against using antiretrovirals (ARVs), it is crucial that people seek the advice of licensed healthcare providers who can accurately teach them about HIV treatment options and assist them in making health-related decisions.

One of the treatment supporters said*:* 'Others they stop taking the medication because may be the pastor from Pentecostal church told them that they are healed, or they will be healed if they do fasting for 3 days, so after that fasting they stop taking ARVs believing that they are healed.'

And on of the HIV diagnosis assistant said*:* 'Maybe these prophets telling them aah… you can stay now without taking any medication, you are fine you are healed in Jesus name, then they start speaking in tongues to the member of the churches and then they completely stop taking ARVs.'It is important to recognize that HIV is a dangerous illness that has to be treated with the right care. Stopping ARV treatment can have serious health consequences, including the disease progressing to AIDS and an increased risk of HIV transmission. ARVs are proven to be effective in managing HIV and improving the quality and length of life for people living with the virus. One of the treatment supporters said: 'Yes, so some of the women because of those beliefs from their churches they start ante-natal care late, because what I found out is that the women are the ones that goes to the prophets than men.'

It's critical to approach health-related issues from a balanced standpoint that respects both religious convictions and scientific knowledge, aiming to combine the two in a way that enhances the wellbeing of those living with HIV. It is crucial to understand that attitudes toward antiretrovirals (ARVs) are influenced by a complex interplay of religious, cultural, social, and personal factors. Addressing these attitudes frequently calls for culturally sensitive strategies that involve community and religious leaders, accurately inform people about HIV/AIDS and ARV treatment and promote candid communication to clear up any misunderstandings.

4.2.9 Treatment interrupters

Pregnant women living with HIV may neglect to take ARVs because they lack the support from their families, communities, or healthcare providers. It is essential for treatment adherence that partners, family members, and healthcare providers provide for pregnant women living with HIV. One of the HIV diagnosis assistants said: ‘When we visit them to their homes I told you already that we have experts that makes some follow ups and after following them they come back to the hospital because she is afraid that her friends will notice why we visited her/him so when we visit them in their communities we act like there is certain project from the hospital so that no one asks questions or gets suspicious, so when they come back here at the health Centre my partner from BAYLOR they have like welcoming care’.

Pregnant women, including those who are HIV positive, are frequently entrusted to nurses for prenatal care. They might help, information, and counseling regarding HIV

management throughout pregnancy. Lack of nurses may cause patients to wait longer for appointments or receive less time for one-on-one care, which could lower the standard of care. One of the treatment supporters said: ‘But the main thing is that nurses who are working here are few, So, their results sometimes like on ante-natal visits they wait up until 2:00 pm from 8AM so people get tired of waiting and they default, because what happens is that when they come to the hospital they have to meet with the nurse, and then the nurse does there tests and then the HIV diagnosis assistant does the HIV testing ’.

Some women may face barriers in accessing health care services, including the availability of ARV medications, transportation to health care facilities. On of the nurses said: ‘Some people it’s because it is far away…. because they came because they are sick either malaria or diarrhea and when they get tested, they are found positive, so for them to come back to the hospital they see that it’s a burden.’ Many countries still stigmatize HIV, and some people may have long-standing anxieties and misconceptions about the infection. When a partner's HIV status is revealed when they are pregnant, it can cause severe anxiety, shame, and worries about one's own health. As a result, some men may think about divorcing to reduce the perceived danger.

One of the HIV diagnosis assistants said: ‘When we visit them to their homes I told you already that we have experts that makes some follow ups and after following them they come back to the hospital because she is afraid that her friends will notice why we visited her/him so when we visit them in their communities we act like there is certain project from the hospital so that no one asks questions or gets suspicious, so when they come back here at the health Centre my partner from BAYLOR they have like welcoming

care, so that when those people come back to the hospital we should not be furious to them, we treat them properly and keep them on track again'.

Misconceptions regarding HIV transmission endure despite advances in medical knowledge and treatment. Some people may not have access to correct information about HIV transmission and management, which can cause them to worry unnecessarily about their own health as well as the health of their unborn child. One of the treatments supporters said:'We do tracing for defaulters who are not coming here or those who are missing appointments, we also test viral load, follow up people's viral load, but also follow up for all babies to be on medication if they are found HIV positive. That is what we do. The challenges that we are mostly facing, there are some clients who don't really understand maybe sometimes she defaulted, while advising her, she just respond that "I do take medication'.

In some cultural contexts, the stigma associated with HIV combined with societal pressure to maintain a healthy and perfect family image may lead some men to consider divorce to protect their public image and social standing. Cultural norms and societal expectations regarding marriage, family, and health can significantly influence individuals' decision-making. Furthermore, some women stop taking antiretrovirals after prophets declare that they have been healed because they believe in divine intervention or faith healing. In certain instances, people may think that their spiritual or religious practices have the ability to heal illnesses, including HIV. As a result, they may decide to forgo treatment, including ARVs, in favor of relying only on faith. One of the treatment supporters said: **'**Yeah, maybe these prophets telling them aah… you can stay now

without taking any medication now you are fine you are healed in Jesus' name, then they start speaking in tongues to the member of the churches and then they completely stop taking ARVs.'

Every relationship is unique, and the decision to divorce in such circumstances is deeply personal. Therefore, it is important to note that many men respond with empathy, support, and commitment to navigating the challenges together when they learn that their partner is HIV positive during pregnancy. Accurate information, counseling, and access to appropriate health care services are crucial in addressing the emotional, psychological, and medical aspects of such situations. Additionally, the treatment and assistance offered to pregnant women who test positive for HIV can be significantly impacted by a shortage of nurses. To provide this vulnerable group with comprehensive treatment, it is imperative that health care facilities address the lack of nurses and maintain appropriate staffing levels.

CHAPTER 5: Conclusion

The prevention of vertical transmission of HIV is still a crucial part of the healthcare in Malawi and sub-Saharan Africa in general. This region is among regions that have high prevalence rates of vertical transmission of HIV. This research was conducted to dive deep into the experiences of HIV positive pregnant women in rural Malawi regarding their knowledge of the prevention of the vertical transmission of HIV/AIDS.

Through the interviews that I conducted at Mbera Health Center in Balaka district, Malawi, insights were gathered from both HIV positive pregnant women, nurses working in the HIV section, Treatment Supporters and HIV Diagnosis Assistants from Baylor College of Medicine. The interviews uncovered various factors from both the HIV positive pregnant women and healthcare providers, that affect PMTCT efforts. The main point that came out on the experiences of HIV-positive pregnant women is that these women face difficulties related to family dynamics, poverty, vulnerability, and being dependent on their husbands for financial support. While for health care providers, the factors that came out were understaffing, stigma and Lack of resources.

Some pregnant women offered the insight into the experiences that they have as an HIV positive pregnant women, they talked about family dynamics, some of the things that surround cultural backgrounds and access to health care, the role of cultural

background in HIV transmission within marital relationships, they talked about the differences that they have with their husbands in cultural practices, behaviors, and beliefs that influence the spread of HIV, in Malawi especially rural areas, there is limited awareness and understanding of HIV/AIDS that leads to higher rates of transmission. The HIV positive pregnant women talked about inequalities in access to health care, between rural areas and urban areas, one woman mentioned being from a village while her husband is from town, suggesting potential differences in health care, infrastructure and services, rural areas in Malawi often face challenges such as limited health care facilities, health care professionals and access to medication that impact the timely diagnosis and management of HIV/AIDS.

Another HIV positive pregnant woman accounts of starting medication in 2020 while her husband started in 2023, highlight disparities in accessing antiretroviral therapy (ART). Late initiation of treatment can have significant consequences, including progression to advanced stages of HIV/AIDS and increased risk of vertical transmission to the unborn child, the woman expressed uncertainty about why her husband's immunity was low compared to hers, this reflects a common concern among HIV positive individuals, regarding the factors influencing immune health and disease progression, factors such as viral load, adherence to medication nutritional status, can impact immune function and disease out comes.

There is a feeling of stigma or blame associated with HIV transmission withing marital relationships that contributes to guilty, shame, and isolation impacting individuals' willingness to disclose their HIV status and seek support.

Mixed with the stigma attached to the illness, the worry of spreading the virus to partners and kids stresses relationships and can result in betrayal and infidelity. Women are more likely to be in vulnerable situations, where they feel pressured to stay with their relationships, even after being abandoned or betrayed. They also frequently have fewer choices when it comes to making decisions about their sexual and reproductive health. A pattern of male dominance and control in relationships, is reflected in the representation of husbands leaving their wives and returning whenever it suits them. The woman mentioned welcoming her husband back on her mother's advice, highlighting the significance of familial support and the impact of cultural norms on women's behavior.

Family dynamics, poverty, vulnerability, dependence on husbands for financial support, and stigma significantly contribute to the body of knowledge on HIV/AIDS prevention and maternal healthy, particularly in remote areas like Balaka, this research provided insights into the experiences that HIV positive pregnant have, there are unique challenges faced by HIV positive pregnant women, such as limited control over sexual decision making, economic insecurity, and social marginalization. Understanding these vulnerabilities is crucial for designing targeted interventions that can address the specific needs of this population. Family dynamics, poverty, and dependence on husbands can act as barriers accessing health care and HIV testing and treatment,

recognizing these barriers helps in developing strategies to improve health care accessibilities, such as mobile clinics, community outreach programs, and economic empowerment initiatives for women. Furthermore, the stigma attached to HIV/AIDS contributes to the difficulties faced by pregnant women who are infected by the virus. This stigma causes them to be reluctant to seek medical attention, to feel alone and discriminated against in their families and communities. Efforts to minimize stigma and discrimination through community education, awareness campaigns, and advocacy can help to create a more accepting environment where pregnant women who are HIV positive can access care and support.

Economic empowerment such as microfinance programs and skills training, can reduce women dependence on their husbands for financial support and enhance their ability to make autonomous decisions regarding their health well-being. Empowered women are more likely to prioritize their health and that of children, including adhering to HIV/AIDS treatment regimens and seeking antenatal care. In additional to that, engaging men as partners in maternal health and HIV/AIDS prevention is essential for improving outcomes. Medical initiatives and legislation can encourage male involvement through policies that promote joint decision making, couple counselling, and participation in antenatal care and HIV testing. This can foster mutual support within relationships and reduce the risk of vertical transmission of HIV/AIDS. Investing in health care infrastructure, health care work force training and supply chain management, is crucial for ensuring the availability and accessibility of essential maternal and HIV/AIDS services in remote areas like Balaka. Initiatives aimed at

decentralizing health care delivery and integrating maternal, and HIV/AIDS services can improve health outcomes for women and children in these underserved regions.

Rather than sorely focusing on deficits and vulnerabilities, researchers are increasingly adopting strengths-based approach that recognizes the resilience, resourcefulness of HIV positive pregnant women. This approach acknowledges women's ability to navigate challenging circumstances, draw upon social support networks and mobilize community resources to protect their health and that of their children. Studies highlighting the importance of women's economic independence and decision-making autonomy have led to a greater emphasis on empowerment strategies in HIV/AIDS prevention and maternal health programs.

These strategies include initiatives to improve women's access to education, economic opportunities, and reproductive rights, thereby enhancing their ability to negotiate safer sexual practices and access to health care services. Recognizing the role of family and community dynamics in shaping women's health outcomes, there has been a shift towards community-based interventions that engage multiple stakeholders, including men, elders, and community leaders. These interventions aim to challenge harmful gender norms, reduce stigma, and promote supportive environments for HIV positive pregnant women and their families. Researchers are increasingly recognizing the importance of culturally tailored approaches that are sensitive to the socio-cultural context of HIV/AIDS prevention and maternal health. These approaches involve collaborating with local communities, incorporating with local communities,

incorporating traditional healing practices, and respecting indigenous knowledge systems to ensure the relevance and effectiveness of the interventions.

In summary, considering family dynamics, poverty, vulnerability, and women's independence has enriched my understanding of HIV/AIDS vertical transmission by offering fresh perspectives and approaches that prioritize empowerment, community engagement and cultural sensitivity. These approaches hold promise for addressing the root causes of health disparities and promoting equitable access to health care for all women and their families.

A small sample size may restrict the range of experiences recorded and the practical relevance of the conclusions. It could fail to accurately represent the diversity among HIV-positive expectant mothers, especially in remote areas like Balaka where the socioeconomic and cultural landscapes are different. Therefore, in order to guarantee a thorough understanding of the experiences of HIV positive pregnant women, future research ought to seek to recruit larger and more diverse samples. Access to a larger participant pool can be facilitated by partnerships with several healthcare providers and neighborhood organizations. To reduce biases, researchers should use strong recruitment practices, such as random sampling methods and guaranteeing privacy and anonymity when gathering data. Triangulating data from multiple sources, such as interviews, focus groups, and observational methods, can also enhance the validity of the findings. Longitudinal studies are needed to capture changes in family dynamics, economic status and health outcomes over time. Future studies are

needed to capture changes in family dynamics, economic status and health outcomes over time. Future studies should utilize mixed methods approaches that combine qualitative and quantitative methods to provide a more comprehensive understanding of the experiences of HIV positive pregnant women.

For the future study it will be good if researchers involve active engagement with affected communities to co- create research questions, methodologies, and interventions, exploration of innovative data collection methods such as participatory visual methods or digital storytelling, to capture the diverse experiences and perspectives of HIV positive pregnant women, collaborating with multidisciplinary teams, including health care providers, social workers, and policy makers, to translate research findings into actionable policies and interventions that address the underlying determinants of health for HIV positive pregnant women**.**

Moving forward, addressing the gaps identified in this research requires a multifaceted approach involving various stakeholders, including government agencies, non-governmental organizations, healthcare institutions, and communities. Investments in healthcare infrastructure, human resources, and training programs are paramount to strengthening PMTCT services and achieving the goals set forth by the 2030 UN agenda of eliminating vertical transmission of HIV. Additionally, there is a need for greater community engagement and awareness-raising efforts to destigmatize HIV/AIDS and encourage early antenatal care attendance and HIV testing among pregnant women. Empowering women with knowledge about PMTCT options and supporting them throughout the antenatal, intrapartum, and postnatal periods are crucial

steps toward reducing HIV transmission rates and improving maternal and child health outcomes.

In conclusion, this research contributes valuable insights into the challenges and opportunities in PMTCT efforts in Malawi. By amplifying the voices of HIV-positive pregnant women and healthcare providers, it highlights the importance of collaborative efforts to strengthen health systems, improve service delivery, and ultimately, prevent HIV exposure through the birthing process. Only through sustained commitment and collective action can we realize the vision of an AIDS-free generation and ensure the well-being of mothers and their children in Malawi and the sub-Saharan African in general.

CHAPTER 6: Recommendation

Based on the findings of this research, HIV positive pregnant women in rural Malawi require care and attention from various stakeholders, to ensure their well being and to prevent vertical transmission of HIV. These stakeholders include health workers, Government and policy makers, Non governmental organizations, community leaders and association.

Healthcare Professionals: Pregnant women require antenatal care, HIV testing, treatment, and counseling. Healthcare professionals, such as physicians, nurses, midwives, and community health workers, are essential in this area. They are in charge of making certain that pregnant women who are HIV positive receive the proper medical attention and assistance during their pregnancy and delivery.

Government and Policy Makers: In Malawi, policies and initiatives meant to stop HIV from spreading vertically must be developed and put into action by government authorities and policymakers. This entails removing obstacles to rural healthcare access, encouraging HIV testing and counseling services, and guaranteeing pregnant women's access to antiretroviral medication (ART).

Non-Governmental Organizations (NGOs): NGOs and community-based organizations are frequently essential in helping marginalized groups—such as pregnant

women living with HIV in rural areas—by offering healthcare services, education, and support. They might provide services including peer support groups, counseling, HIV testing, and help getting in touch with social services and healthcare.

Community Leaders and Traditional Authorities: In rural communities, community leaders and traditional authorities can promote acceptance and support for HIV-positive pregnant women, reduce stigma and prejudice, and increase public understanding of HIV/AIDS. Their participation is crucial to creating a welcoming atmosphere that motivates pregnant women to get tested for HIV and receive treatment.

Family and Social assistance Networks: HIV-positive pregnant women can receive priceless emotional, practical, and financial assistance from friends, family, and neighbors. Creating robust social support networks can aid in lowering mental health outcomes, promoting adherence to ART and other medical treatments, hence reducing feelings of loneliness.

Educational Institutions: By including HIV/AIDS education into their curricula and organizing outreach programs to increase public awareness of the value of HIV testing, treatment, and prevention among young people, including pregnant women, schools, colleges, and universities can support efforts to prevent HIV.

International Donors and Development Partners: These entities offer financial resources, technical support, and specialized knowledge to aid HIV/AIDS prevention, treatment, and care initiatives in Malawi. Enhancing maternity and child health outcomes,

expanding access to HIV services, and strengthening healthcare systems all depend on their help.

In general, a multi-sectoral strategy combining cooperation between governmental organizations, healthcare professionals, NGOs, community leaders, families, and foreign partners is needed to care for HIV-positive pregnant women in rural Malawi. Together, these parties can guarantee that pregnant women living with HIV/AIDS receive the resources, support, and care necessary to have safe pregnancies and avoid HIV transmission from mother to child.

Researchers should also be curious to learn about HIV-positive pregnant women's experiences to learn from their experiences and help find better strategies of preventing HIV from spreading vertically in rural Malawi. HIV vertical transmission is still a major public health concern, especially in areas with low resources like rural Malawi. Gaining information into the experiences of pregnant women living with HIV can help develop more effective treatments to lower the rate of transmission by highlighting the obstacles these women face in obtaining and maintaining preventive care. Researchers should explore areas such as:

Maternal and Child Health Outcomes: For women living with HIV, pregnancy and childbirth can present difficulties, such as worries about their own health and the possibility of passing the infection to their unborn children. Studying the experiences of pregnant HIV-positive women can assist find solutions to improve pregnancy outcomes

and prevent vertical transmission by highlighting the factors influencing mother and child health outcomes.

Empowerment and Advocacy: Research that promotes the experiences and voices of HIV-positive expectant mothers can enable them to speak up in the healthcare system on behalf of their own needs and rights. Researchers should assist efforts to advance patient-centered treatment, to help lessen stigma and prejudice, and improve pregnant women's access to comprehensive HIV services in rural communities by highlighting their perspectives and lived experiences.

Development of Policies and Programs: Research on the experiences of HIV-positive pregnant women will provide valuable insights for the creation of evidence-based policies and initiatives that aim to stop HIV transmission vertically and enhance the health of mothers and children in Malawi. Researchers should help the healthcare system make better decisions and allocate resources by producing solid data and evidence.

Global Health Equity: Reaching the Sustainable Development Goals (SDGs), especially those pertaining to health, gender equality, and the end of the AIDS epidemic, would require addressing the prevention of vertical HIV transmission. Studies on the experiences of pregnant HIV-positive women in rural Malawi can help close the gap in health and guarantee that everyone has fair access to medical treatment.

In conclusion, examining pregnant HIV-positive women's experiences with preventing HIV vertical transmission in rural Malawi is crucial to enhancing maternal and child health outcomes, fortifying healthcare systems, empowering women, and furthering

international efforts to put an end to the AIDS epidemic. Research in this field can significantly improve public health if it is given priority.

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Appendices

Appendix A

1 Can you please describe the process you follow when giving out information about HIV-to-HIV positive patients? How different are HIV positive pregnant women treated when they come for counselling and collection of medicine?

2 What are the main challenges that affect your work. (Probe:)What do you think is working better and what is not working better?

3 What change would you recommend for the situation to improve? (probe: how can that be done) for how long you have been working at this health center?

4 start from this department, what do you like most at this department)

5. What was your major when you were in college, (how long was your college, what did you like most on the courses you took)

6. How did you find yourself in this department? What are the standard qualifications that qualifies one to work in this department?

7. Do you have enough resources for your day-to-day duties? How many patients do nurses see on a daily basis?

8. Was MTCT part of your curriculum at college? What are the current interventions that are in place for reducing HIV vertical transmission?

9. According to your experience. How do you describe the impact of the interventions over the time you have been at this institution?

10. How can you describe your knowledge about MTCT? How often are you updated with information about the interventions? (who provides the information)

11. If you were to describe your services in terms of quality. How do you rate yourself? Rate 1 to 3
12. What do you think could be done to help improve the situation? Depends on the answer from the previous question.
13. Do you have cases of defaulter for antiretroviral therapy? How do you follow up?

Appendix B

1. Can you tell me what has been your experience while attending antenatal care at this health center?
2. Can you describe the type of care that you get from this health center since you started attending antenatal care? What has been your experience during counselling?
3. What are the challenges that you face while attending antenatal? (why do you think is like that)
4. What do you think can be done to improve your knowledge about HIV vertical transmission? What are you advised to do to prevent spreading the virus to the unborn child?
5. What concerns do you have about pregnancy?
6. What can happen if you stopped following the advice that you were given at the hospital?
7. How do you describe HIV/AIDS and how is it spread? (probe: from mother to child, where did you get the information about HIV/AIDS? What procedure do you follow when you come for visits like today?
8. What interventions are there to help prevent the spread of the virus from mother to child? (probe: where did you get this information, can you explain) probe: Do you think the interventions are helpful? How?
9. What advice are you given to make sure the virus is not passed to the unborn child?

a- During antenatal

b- During delivery

10. How easy or difficult is it to follow the advice given, What risks are there in getting pregnant while living with the virus? What could be done to help reduce the risks.

Appendix C

Study Title: Exploring the experience of HIV positive pregnant women on prevention of HIV exposure through the birthing process in rural Malawi.

IRBNet #: 2058016-1

Principal Investigator: *Getrude Finyiza, Anthropology Master of Arts candidate, University of Denver.*

Faculty Sponsor: *Alejandro Cerón, Associate Professor of Anthropology, University of Denver.*

Study Site: *Malawi in Balaka District at Mbera Health Center*

Sponsor/Funding source: University of Denver Department of Anthropology

You are being asked to participate in a research study. Your participation in this research study is voluntary and you do not have to participate. This document contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate.

The purpose of this form is to provide you information that may affect your decision as to whether or not you may want to participate in this research study. The person performing the research will describe the study to you and answer all of your questions. Please read the information below and ask any questions you might have before deciding whether or

not to give your permission to take part. If you decide to be involved in this study, this form will be used to record your permission.

You are being invited to participate in this study conducted by Getrude Finyiza from the University of Denver because you are a woman who is HIV positive and also pregnant. And also I am asking for your permission to observe the group counseling session and any antenatal visits.

Purpose

If you participate in this research study, you will be invited to respond to questions about your experiences of being HIV positive while at the same time pregnant. There are about 20 questions that will take about an hour of your time. Your participation will be voluntary, and you are free to withdraw at any time without any consequences.

This research project will investigate the experiences of HIV positive pregnant women to understand what they go through while being pregnant and at the same time being HIV positive. The research will also investigate the experiences of nurses about prevention of vertical transmission of HIV. This research will run for 30 days. The interview of this research contains interview questions that will ask you to explain more about your experiences regarding the prevention of vertical transmission of HIV. If you are not comfortable with any of the questions that will be asked, you are free not to answer and that will not affect you in any way.

Risks or Discomforts

There are no expected risks to you as a result of participating in this study. However, participation in this research may have risks of having your confidentiality breached if some people may have access to this information without my permission such as by hacking my computer and other ways. However, there are several measures that have been put in place to make sure that such things should be avoided. For example, the computer in which the information will be kept will be protected using a password that cannot be easily guessed. The computer I am using for this study will always be kept in a lockable shelf to make sure that it should not be easily accessed by anyone who is not part of this study. should you be willing to listen to this conversation, there is an opportunity for you to have access to the recording. To make sure that you are protected from the risks of having your confidentiality breached, your name will not appear on any sheet of paper that I am going to use while having this conversation with you. You should be aware that the information you are sharing with me, but not your name or date of birth, will be shared with the institution from where I am a student and the information might also be used in public presentations and publications.

Benefits

You should be aware that participating in this research will not have immediate benefits to you. However, your participation may help different stakeholders to understand what you are going through and make decisions that may help to improve your access to

information about the prevention of vertical transmission of HIV which may also help in reducing the rate of HIV vertical transmission in the country.

Source of Funding

The study team is receiving financial support from the University of Denver Department of Anthropology.

Confidentiality of Information

All information collected during this study will be treated confidentially. Your identity and personal information will be anonymized and stored securely. Only authorized researchers will have access to the data and any published results will not include any personally identifiable information.

Limits to confidentiality

All of the information you provide will be confidential. However, if we learn that you intend to harm yourself or others, including, but not limited to child or elder abuse/neglect, suicide ideation, or threats against others, we must report that to the authorities as required by law.

With your permission, I would like to audiotape this interview so that I can make an accurate transcript. Once I have made the transcript, I will erase the recordings. Your name will not be in the transcript or my notes.

The information that you give in the study will be anonymous. Your name will not be collected or linked to your answers.

Use of your information for future research

All identifiable information (e.g., your name, date of birth) will be removed from the information collected in this project. After we remove all identifiers, the information may be used for future research or shared with other researchers without your additional informed consent.

Data Sharing

De-identified data from this study may be shared with the research community at large to advance science and health. We will remove or code any personal information (e.g., your name, date of birth) that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information or samples we share. Despite these measures, we cannot guarantee anonymity of your personal data.

Incentives to participate

By participating in this research, you will be provided with $2.50 (2500Malawi Kwacha) immediately after the interview as lunch allowance.

Consent to audio recording / photography solely for purposes of this research.

This study involves audio recording, and/or photography. If you do not agree to be recorded, you (CAN STILL) take part in the study.

_____ YES, I agree to be audio recorded/photographed.

_____ NO, I do not agree to audio recorded/photographed.

Questions

For questions, concerns, or complaints about the study you may contact the Principal investigator, Getrude Finyiza on +265888724690 or email Getrude.Finyiza@du.edu. You may also contact 0074he faculty sponsor and research supervisor Dr. Alejandro Cerón on +(206)427-1284 or email Alejandro.CeronValdes@du.edu

If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the University of Denver (DU) Institutional Review Board to speak to someone independent of the research team at 303-871-2121 or email at IRBAdmin@du.edu.

Signing the consent form

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form**.**

Please take all the time you need to read through this document and decide whether you would like to participate in this research study.

If you decide to participate, your completion of the research procedures indicates your consent. Please keep this form for your records.