UNDERSTANDING CHILDBEARING DECISION AMONG WOMEN LIVING WITH HIV/AIDS IN YANGON, MYANMAR

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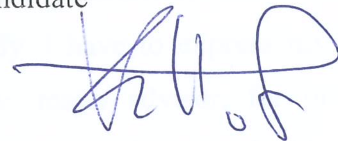

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UNDERSTANDING CHILDBEARING DECISION AMONG WOMEN LIVING WITH HIV/AIDS IN YANGON, MYANMAR

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ABSTRACT

The study aimed to identify the existing sociocultural contexts related with childbearing decision in terms of stigma, gender relation, notion of motherhood and healthcare service among WLHA and to analyse how they influence childbearing decision of WLHA. Qualitative case study design was used with in-depth interviews of fifteen WLHA, key informant interviews with two local women, one social worker, two husbands/partners of WLHA and two healthcare providers as well as participant observation and document review. Interviews were digitally recorded, transcribed and translated into English. Content analysis was done by using critical medical anthropology theory. The study highlighted the individual social context, social stigma, gender norm, gender-power relationship, peer communication and accessibility to healthcare services shaped the reproductive behavior, childbearing decision and local practices related with childbearing decision among WLHA. Six WLHA got unintended pregnancies, while other six WLHA intentionally got pregnancies and three WLHA got HIV diagnosis after getting pregnancies. Experience of social stigma made WLHA difficult to disclose their HIV status, difficult to discuss with healthcare providers resulted in poor family planning and condom use and got unintended pregnancy. Close communication with peer WLHA and perceived stigma of inferiortiy made some WLHA to take pregnancy intentionally. Gender norms trained WLHA as childbearing was mandatory. Economically and socially dependent state also made WLHA lack of power to assert their true reproductive desire and got unintended pregnancies. Despite of having concerns about perinatal transmission of HIV, WLHA finally decided for childbearing with the projections of positive social status, power and desire to enjoy normal woman life. Thus, this study highlighted many important gaps in healthcare services such as missed opportunity for reduction of unintended pregancny, perinatal transmission of HIV, transmission of HIV among sero-discordant partners. It pointed out the importance of male partner involvement , peer social network and attitudes of healthcare providers towards WLHA. These findings would assist policy makers in identifying the most appropriate, culturally-oriented, innovative interventions suitable at specific levels. The study would also inform healthcare providers about how sociocultural values and practices affect childbearing decision among WLHA; thus, they could work closely with communities and fill the unmet needs of WLHA in Myanmar.

KEY WORDS: WOMEN/ HIV/AIDS/ CHILDBEARING/ REPRODUCTION/ MYANMAR

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Highly Active Antiretroviral Therapy
ARV	Anti-retroviral prophylaxis
CBO	Community-based Organization
CPR	Contraceptive prevalence rate
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
KII	Key Informant Interview
MOHS	Ministry of Health and Sports
NAP	National AIDS Control Program
NGO	Non-government Organization
PLHA	People Living with HIV /AIDS
PMCT	Prevention of Mother to Child Transmission
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNFPA	The United Nations Population (or) the United Nations Population Activities
VCT	Voluntary counseling and testing
WHO	World Health Organization
WLHA	Women Living with HIV/AIDS

CHAPTRER I
INTRODUCTION

This chapter contains a brief overview of the statement of the problem, study significance, study purpose, research question, study objectives and operational definitions.

1.1 Background and Rationale

1.1.1 Background situation of HIV among reproductive aged women

There has been continuous increase in number of women living with HIV/AIDS (WLHA) throughout the world. The proportion of WLHA has tripled from the first decade of HIV epidemic to recent decade, from 7% in 1985 to 25% in 2014. In 2015, there were about 17.8 million women aged 15 and older living with HIV/AIDS. It was about 51% of all people living with HIV/AIDS (PLHA) (WHO, 2017). Among them, adolescent girls and young women are particularly affected. They took an estimated 60% of young people (15-24 years) living with HIV/AIDS. Besides, HIV/AIDS is still one of the leading causes of death among reproductive aged women (UNAIDS, 2015a).

With the advent of highly active anti-retroviral therapy (ART), there is substantial increase in life expectancy among people who get access to ART (Piggott, T.B., 2011). It also has effect on reduction of mother-to-child transmission of HIV (WHO, 2017). The implication is increase in number of PLHA who choose romantic partners , increase in number of PLHA who choose to get married and increase in number of PLHA who choose to do childbearing (Liamputtong, P. (Eds)., 2013b;WHO,2017).

Similar to global pattern, HIV incidence among reproductive aged women increases significantly in Myanmar. Female to male ratio for HIV incidence escalated from 1:8 in 1994 to 1:2 in 2008. In 2015, there were estimated 220,000 PLHA and

about one-third of them (70,000) were reproductive aged women (National AIDS Control Program (NAP), 2015). Most of them (about 78%) acquire HIV from unprotected heterosexual contact.

Although HIV prevalence is found to concentrate among female sex workers (6.3%), men who have sex with men (6.6%) and injecting drug users (23.1%), it coincides with significant proportions of male sexually transmitted infection (STI) clients and marriage of injecting drug users (NAP, MOH, Myanmar, 2015). In the meantime, male condom use among partner is very low with estimated 0.4% in 2015(Asian-Pacific resources and research center for women, 2016). Consequently, there has been increasing in number of HIV new infection (HIV prevalence) among reproductive aged women who are considered as “low risk”. In 2015, about 27 % of new HIV infection occurred among reproductive aged women while there was decreasing trend in general population (NAP, MOH, Myanmar, 2015). Therefore, HIV epidemic becomes epidemic of reproductive aged women in Myanmar.

At the same time, there has been progress in access to ART. In 2015, ART coverage reached to 47% (NAP, MOH, Myanmar, 2015). Thus, the increase in HIV incidence among reproductive aged women and the increase access to ART result in cumulative number of WLHA in Myanmar.

1.1.2 Justification for studying of childbearing decision among women living with HIV/AIDS (WLHA) in Yangon, Myanmar

Childbearing of WLHA is a significant health issue in Myanmar. Although ART could reduce the transmission of HIV between partners and perinatal transmission of HIV, not all PLHA get access to ART in Myanmar. An estimated half of all PLHA got access to ART in 2015 (NAP, MOH, Myanmar, 2015). For the meantime, condom use was very low with 0.4% in 2015 (Asian-Pacific resources and research center for women, 2016). Thus, unprotected sexual intercourse has been happening among WLHA either in sero-concordant or sero-discordant relationships. It results in risk of transmission of HIV between partners and perinatal transmission of HIV and getting unintended pregnancies.

Meanwhile, there is also low contraceptive prevalence and high unmet contraceptive needs in Myanmar. Contraceptive prevalence was only 48.7% and

unmet contraceptive need for married women was 19.6% in 2015. It was about 1.53 million married women do not get access to modern contraception in 2015(Asian-Pacific resources and research center for women, 2016). Although SRH services are provided in free-of-charge at public health facilities, there are limited contraceptive choices. Stock out and expired drugs in family planning are quite often in government health facilities (Asian-Pacific resources and research center for women, 2016). Access to sterilization is difficult for poor women because it costs about 250 USD and it is strictly controlled by law. Thus, there is a risk of getting unintended pregnancy among WLHA.

Additionally, there are also many women who get HIV diagnosis after getting pregnancy. Most women in Myanmar are reportedly limited knowledge about sexuality and SRH related information (Asian-Pacific resources and research center for women, 2016). Sex and sexuality are taboo subjects in Myanmar and women are not allowed to discuss them in public. When a woman seeks SRH related information, she is seen as indecent or immoral (UNAIDS 2014c). It is more difficult for unmarried and young women. Besides, HIV prevention and control response of National AIDS Control Program still focus on key population and voluntary counseling and testing (VCT) in general population is still low at 9% in 2015 (Asian-Pacific resources and research center for women, 2016). Most of the women get HIV diagnosis at the time of ante-natal care (ANC) after getting pregnancy (Asian-Pacific resources and research center for women, 2016). Thus, many HIV positive women are still left undiagnosed in community. They get married and get pregnant without knowing their HIV status (UNAIDS, 2014c).

At the same time, some WLHA who have got access to ART live longer and desire to get married and have children. Studies proved that many people living with HIV/AIDS (PLHA) had desire to get married and have children when they regained health (Agadjanian and Hayford 2009 ; Nduna and Farlane 2009 ; Cliffe et al. 2011, cited in Liamputtong, P. (Eds.),2013b; Khosla, R., Belle, N.V & Temmerman, M.,2015). Although there is no specific evidence of childbearing desire of WLHA in Myanmar, childbearing has been happening at a significant rate among WLHA in Myanmar. It is convinced by the HIV prevalence among pregnant women (0.7%) was

higher than the HIV prevalence in general adult population (0.54%) (NAP, MOH, Myanmar, 2015).

Although the national guideline on prevention of mother-to-child transmission (PMCT) focuses on voluntary contraception, there is no specific reproductive counseling for WLHA in Myanmar. According to UNAIDS review, SRH services for PLHA are inadequate and there is rare reproductive counselling for PLHA in Myanmar (UNAIDS, 2014c). In the condition of lack of knowledge and access to safe conception, the WLHA who desire to do childbearing take pregnancy without having knowledge and accessibility of safe conception.

In addition, there are limitations in coverage and accessibility of PMCT services (UNAIDS, 2014d). Representatives of Myanmar Positive Women's Group claimed that PMCT services are not accessible for WLHA who lived outside major cities and towns (UNAIDS, 2014d). Although most of the women get HIV diagnosis at the time of ANC, ANC coverage is not universal in Myanmar. Besides, there is still low VCT in ANC. In 2015, VCT in ANC was only 65% ((NAP, MOH, Myanmar, 2015).

Even after getting diagnosis of HIV, there is significant number of loss of follow-up before and after delivery, and not complete the PMCT program (UNAIDS, 2014d). In 2015, an estimated 80% of HIV positive pregnant women received WHO-recommended regimen for PMCT (Asian-Pacific resources and research center for women, 2016). Therefore, perinatal transmission of HIV is still high at 15% in Myanmar, although it is nearly zero in developed and other developing countries (UNAIDS, 2015c; Asian-Pacific resources and research center for women, 2016). And there is still risk of transmission of HIV between partners. Thus, childbearing of WLHA is a significant health issue in Myanmar.

1.1.3 Justification for studying of childbearing decision among WLHA in social context

Childbearing among WLHA is not only a health issue but also a social issue. People are social beings and everything they do in their lives is to accompany with others. Culture constructs the actions of people behave in a quite definite way. The culture constitutes ideas, beliefs, practices, values, norms and all the social

products defining the ways of life. People learn beliefs and practices through a process of socialization. Culture governs the thoughts and behaviors of its members (Stolley, K.S (Eds.), 2005; Jones. P (Eds.), 2003).

The rules that direct or prohibit the behavior of their occupants are known as norms (Hechter and Opp 2001, cited in Stolley, K.S (Eds.), 2005). Gender norms in society influence the reproductive behaviors and childbearing decision of WLHA. Women are expected to get married and deliver children in all social classes of Myanmar (Soe, 2008). Men perceived masculinity and women proved femininity on their ability to reproduce children (Cooper et al., 2009). Thus, childbearing is a cultural obligation of a woman (as cited in Piggott, T.B., 2011). Besides, masculinity is usually defined as dominant, decisive and active, while femininity as obedient, caring and passive. This condition influences the decision-making dynamic in the household. Husband is generally a household leader and takes the role of decision-maker, while a wife is expected to respect and obey her husband, giving him in superior position (Asian-Pacific resources and research center for women, 2016; Stolley, K.S, 2005, Ferguson, K. E., 1999, cited in Soe, 2008).

Moreover, the society's cultural rules apply not only to the individuals themselves, but also to the positions in the social structures they occupy (Stolley, K.S (Eds.), 2005; Jones. P (Eds.), 2003). For example, woman in a housewife position has to deliver children and look after the house. In a marriage, husband provides physical protection, while wife needs to fill the emotional and sexual needs of husband by childbearing. Husband generally owns wife's body and he uses to decide for SRH issues including childbearing (Cooper et al., 2009). According to Asian-Pacific resources and research center for women, 2016, husbands often do not allow women to take SRH services.

Childbearing is also found to be associated with cultural meanings of "proper" family. A married couple without children does not qualified as a family (Todd CS, Stibich MA, Laher F, Malta MS, Bastos FI, Imbuki K.,2011 ,cited in Akelo, V.et. al.,2015). Marriage is a mean of establishing alliances between groups, rather than simply a relationship between individuals (Phoenix, A. et al, (Eds.), 1991; Stolley, K.S (Eds.), 2005). In many societies, childbearing is not only an issue of a

woman but also an issue of relatives and communities at large (Liamputtong, P. (Eds)., 2013b). Thus, childbearing is necessary for a woman in a housewife position.

There are also some cultural rules that are not attached to any particular role, named cultural values. Cultural values provide general principles or approved ways of living in a society. In fact, reproductive is a slipper concept. Marxist notions of childbearing support the continuity of social system by reproduction of labor force and household sustenance (Stolley, K.S (Eds.), 2005). Having children and having a family are greatly valued in society. Women usually gain positive social status through childbearing due to ultimate fulfillment of women's roles (Phoenix, A. et al, (Eds.), 1991; Piggott, T.B., 2011). In contrast, childless women face family pressure, violence and stigmatization because of deviation from cultural rules (Phoenix, A. et al, (Eds.), 1991; Becker, G., 1994).

In addition, society is not always equal. Inequalities vary from ethnic, age, gender and socioeconomic classes. When there is an inequality, people are not only controlled by norms and values, but also by the advantaged ones who possess power and distribution of resources. Power exercise occurs within an intimate relationship of husband and wife (Stolley, K.S (Eds.), 2005; Potter and Wetherell, 1987 cited in Phoenix, A et.al., 1991). Myanmar is a Patriarchal society, where women are taught to think of men as superior and to serve them without questioning. According to gender hierarchy, women are placed in subordinate positions while domination among men (UNAIDS, 2014c). Women do not get equal opportunities with men in political participation, education and employment in Myanmar. In Myanmar parliament, women received only 4.6% of political participation in public decision making. In education, men have higher literacy levels than women in all States and Regions of Myanmar. In employment, only 50.5% of women are employed, while 85.2% in men (Asian-Pacific resources and research center for women, 2016). Women in powerless positions lead to economic dependency over men, lack of assertiveness in sexuality, poor negotiation of condom use, and lack of decision making power for family planning (UNFPA, 2008).

Furthermore, different individuals or groups possess unequal amount of power, authority and prestige. The interest of these groups cannot always be the same. They are often in conflict (Stolley, K.S (Eds.), 2005; Jones. P (Eds.), 2003). Studies

showed that childbearing of WLHA was influenced by the powerful figures in their lives such as husbands/partners, family and healthcare providers (Cooper et al., 2009;Kaida A et al. 2011; Schwartz S et al.2012; McClellan, M.K. et al. 2010). However, the interest and domination of one group can be varied from others and it cannot be different from context to context. Thus, the power domination of partner, family and healthcare provider compete with each other to reach the childbearing decision of a WLHA.

In addition, people live in social institutions which include political, economic, religious and medical system (Thomas and Thomas 1928, 233–34, cited in Stolley, K.S (Eds.), 2005). All these social institutions interrelate and influence the people inside (Jones. P (Eds.), 2003). Marxist Feminism argued that childbearing was a cultural service of women for capitalism. They needed to reproduce new generation of workers through childbearing (Jones. P (Eds.), 2003). In a polygamous marriage, a wife's influence in home is leveraged by the number of children she has (Akelo, V. et. al., 2015). Childlessness often triggers polygamous marriage and childless women are severely blamed. It sometimes leads to martial disharmony and lowers the wife's status (Soe,2008). Moreover, some religious beliefs also shape the childbearing decision and sexual practices. Furthermore, medical hegemony of Western medical beliefs and practices predominate in childbearing decision of WLHA (Baer, H. A et al., (Eds.), 2003; Haile, Z. T., Teweldeberhan, A. K., & Chertok, I. R. A. ,2016). Western medicine claims that unprotected sexual activities carry risks of vertical transmission of HIV to infants as well as risk of HIV transmission to uninfected partners or risk of getting infection with different mutated strain of HIV and other sexually transmitted infections (STIs) (Liamputtong, P. (Eds.) 2013b; Piggott, T.B.,2011).

In fact, childbearing of WLHA is not a simple issue. WLHA has to deal with various sociocultural expectations and pressures regarding whether they should or should not have children (Gruskin et al., 2008 cited in Fletcher. E.F, 2011). They have to deal with gender norms of being a woman, wife and living with HIV at the same time. Some people accepted childbearing of WLHA as irresponsive manner (Richter, Sowell, & Pluto, 2002, as cited in Fletcher. E.F, 2011; Piggott, T.B.,2011; Morrison and Guruge ,1997 cited in Kennedy V.L ,2012; Liamputtong, P. (Eds).,2013b), while

some others believed that childbearing was an opportunity to escape from negative social impacts due to HIV/AIDS (Kennedy, V.L., 2012; Kisakye, et. al., 2010 cited in Liamputtong, P. (Eds.) 2013b; MacCarthy, S., Jennifer, J.K., Ferguson, R.L., Gruskin, S., 2012). Clearly in a complex society, there are always competing social norms and values. Not everyone in a society shares the identical norms and values. Some groups or people follow strictly to certain values while rejecting others (Stolley, K.S (Eds.), 2005). In this way, human decision differs to what the influences are, and how they investigate and how they are explained in the society (Stolley, K.S (Eds.), 2005).

To sum up, increase in HIV incidence among reproductive aged women overlaps with sociocultural structures, norms, values and power relationships which restrict women's ability to access SRH services and reproductive decision making. Control and manipulation survive in the society because people who are disadvantaged in do not know they are underprivileged or they accept their deprivation (Stolley, K.S (Eds.), 2005). Some cultural norms and values teach them as the inequality is legitimate. It points out that socialization is like instrumentation of power by means of force and domination. And cultural norms and rules are not always neutral and benevolent (Stolley, K.S (Eds.), 2005). In order to provide effective interventions, the proper understanding of the background socio-cultural contexts and how these sociocultural contexts work and influence the childbearing decision are important.

Therefore, the detail examination of local sociocultural contexts such as individual, micro, intermediate and macro level is important for comprehensive SRH services for WLHA and effective HIV/AIDS response. Without proper understanding of the interaction of individual and group-level variables which influence childbearing decision of WLHA, SRH and HIV interventions will not be effective enough to meet the diverse health needs of WLHA.

To date, there are few studies related with WLHA in Myanmar. According to literature review, there are only three studies done among WLHA in Myanmar. They are study of quality of life among WLHA (Zaw, 2011), positive preventive behaviour among WLHA (Aye, 2013) and the accessibility to SRH services among WLHA (Shein, 2006). Although there are similar studies about childbearing decision of WLHA in African and Western contexts, they cannot be extrapolated into Myanmar context. People in one society think and behave differently from others

because they have learnt different rules in different cultures (Stolley, K.S (Eds.), 2005; Jones. P (Eds.), 2003). Data from distinct societies as well as distinct social groups within any given society is important because WLHA's thought and behaviour can be different from the women in general population. Childbearing decision is specific to a particular time and context and not static, unitary entities (Gergen,1985; Henriques et. al.,1984; Kitzinger,1987, cited in Phoenix, A. et al., 1991). Therefore, study related with childbearing decision among WLHA is required for Myanmar in order to design the culturally appropriate interventions specific for WLHA and their families.

1.2 Research Implication

This study brings local sociocultural contexts at various levels as well as experiences, thoughts, voices and reflections of WLHA related with childbearing decision and practices. The findings assist policy makers in identifying the most appropriate, culturally-oriented, innovative interventions suitable at specific levels. The study informs healthcare providers about how social values, practices and beliefs affecting WLHA in their communities, then, they could work closely with communities and fill the unmet needs. In this way, the linkage between SRH and HIV would be promoted by ensuring the accessibility of quality, women-centered, humanistic SRH services among WLHA. It is an opportunity to improve health outcome of WLHA and their families. Therefore, this study would become a big step forward taken to help the WLHA by opening up the opportunity to reconstruct their worlds and thereby offer them the prospect of freedom.

1.3 Purpose of study

The study aims to understand the sociocultural contexts of WLHA in terms of stigma, gender relation, notion of motherhood and healthcare services in Yangon, Myanmar. It finds out the local sociocultural contexts at different macro, intermediate, micro and individual levels about how they interact with each other to come out childbearing decision. In this way, the study helps in finding ways to address the things that need improvement at specific levels.

1.4 Research Questions

What are existing sociocultural contexts related with childbearing decision of WLHA in terms of stigma, gender relation, notion of motherhood and healthcare service in Yangon, Myanmar and how they influence the childbearing decision of WLHA?

1.5 Research Objectives

i) To identify the existing sociocultural contexts related with childbearing decision of WLHA in terms of HIV stigma, gender relation, notion of motherhood and healthcare service in Yangon, Myanmar

ii) To explore the sexual and reproductive behaviour, childbearing decision and local practices among WLHA

iii) To analyse how sociocultural contexts related with childbearing decision of WLHA in terms of HIV stigma, gender relation, notion of motherhood and healthcare service influence childbearing decision among WLHA.

1.6 Operational Definition

Childbearing decision: Childbearing decision is a decision whether to get pregnancy although WLHA knows her HIV status (or) a decision to maintain pregnancy if WLHA know her HIV status at the time of antenatal care.

Sociocultural context: Sociocultural context contains macro level social structure, intermediate level relationships at community, micro level interpersonal relationships within family and healthcare settings and individual social beliefs and practices related with HIV.

Patriarchal society: Patriarchal society is a social system in which husband controls household resources and hold authority over childbearing decision of WLHA.

Pronatalist society: The society where woman’s social values and power are achieved by childbearing.

Stigma: Stigma is a powerful and discrediting social label which comes out from social interactions. It influences on childbearing decision of WLHA.

CHAPTER II
LITERATURE REVIEW

This chapter is the lens to guide the study. It focuses on systematic literature review of published research articles, reports and related accessible literature related with childbearing decision of WLHA. It reviews critical medical anthropology theory, concepts of gender, stigma and notion of motherhood in order to construct an applicable conceptual framework to understand the childbearing decision among WLHA in Yangon, Myanmar.

2.1 Theoretical concepts

A theory is the analysis and statement of how and why a set of facts relates to each other. Theory helps to explain why and how society works (Collins 1988, 119, cited in Stolley, K.S (Eds.), 2005). To understand the complex realties of how WLHA in Yangon , Myanmar make childbearing decision , the study will use critical medical anthropology theory with gender, motherhood and stigma concepts.

2.1.1 Critical Medical Anthropology

Anthropology is the study of human and society in widest sense with the heart of culture and it lies between the poles of humanities and sciences (Pool and Geissler,2005). Medical anthropology is the study of health issues and problems under the influences of social organization, cultural and context (Hardon et al.,2001). McElroy and Townsend (2008) mentioned four perspectives in medical anthropology. They are medical ecological theories, interpretive theories, political economy or critical theories, and political ecological theories(Baer, H. A et al., (Eds.),1997 and 2003). Critical medical anthropologies has benefited from critiques framed from other perspectives (Baer, H. A et al., (Eds.),1997 and 2003).

At the theoretical level, there are two genres of CMA : the so-called political economy/world system theorists and the Foucaultian poststructuralist (Morgan,1987 cited in Baer. H.A et al (Eds.), 2003). Both share a commitment to the development of appropriate practical expression. Morsy (1996) and Singer (2004) argued that the purpose of CMA was not to ignore the micro analytical concepts of illness and healing, but to go beyond this and to the link with "power, control, resistance, and defiance associated with health, illness and healing". It tries to understand the impact of power relations in health related issue at three levels: macro social, intermediate and micro level (Baer, H. A et al., (Eds.),1997 and 2003). Mullings (1987) stated that CMA studied the vertical links that connected the social group under study to the larger regional , national , and global human society and to the configuration of social relationships that contributed to the patterning of human behavior, belief, attitude and emotion (as cited in Baer, H. A et al., (Eds.),1997). McNeil stated that CMA strives to understand the nature of the relationship between microparasitism (micro-organism, malfunction and individual behaviors that were proximate causes of illness) and macroparasitism (social relations of exploitation that were the ultimate causes of much disease).

CMA focuses about all knowledge relating to the body, health and illness which are culturally constructed, negotiated and renegotiated in a dynamic process through time and space. When the inequalities and hierarchy are institutionalized, people would impose by means of a dominant cultural ideology which inflict a negative self-image, distress and often ill health on the underprivileged and disenfranchised (Lock and Scheper-Hughes, 1987).

CMA claims that human biology and behavior are interactive set of adaptations to ecological and social challenges that support health and survival in a social context at a specific time. The ecological and social challenges include social practices, culturally constituted frames of meaning and result in the construction of "clinical realities". Human body itself is culturally constructed, sufferer experience _ the manner in which an ill person manifests her disease or distress is important in medical anthropology. Margaret Lock and Nancy Scheper-Hughes (1987) argued the concept of "mindful body". It delineated three bodies: individual body, social body and body politic. The individual body refers to self-evident level and understood as the

lived phenomena of the lived experience of the body self. Western notion of the individual described that “Individual is a quasi-sacred, legal, moral and psychological entity whose rights are limited only by the rights of other equally autonomous individuals” (LaFontaine 1985:124, cited in Lock and Scheper-Hughes, 1987). The individual body-self is likely to be attached with or engaged by the social body. The identity of I or the self is a state of permanent perception which is unique to the individual and stable through the life span until death (Webel 1983:399, as cited in Lock and Scheper- Hughes,1987).Peter manning and Horation Fabrega(1973, which is cited in Lock and Scheper-Hughes, 1987), summarized that body and self are understood as distinct and separable objects.

The social body referred to the uses of the body as a soical representation which need to think about the nature, society and culture. The social body was the body which was useful in sustaining particular views of society and social relations (Scheper-Hughes and Locak 1987 , cited in Baer. H.A et al (Eds.), 2003). *“The body politic refers to the regulation, surveillance and the control of bodies (individual and collective) in reproduction and sexuality, work, leisure and sickness”*(Lock and Scheper- Hughes, 1987). It also explained about the power and control over the individual and social bodies which focus more than descriptions and collective representations of the natural and the cultural. Hence, the sufferer experience involves a social product which is constructed and reconstructed between socially constituted categories of meaning and political-economic forces (Scheper-Hughes and Lock 1987 , cited in Baer. H.A et al (Eds.), 2003). For the case of childbearing, WLHA have to deal with sociocultural meaning of being woman, motherhood and living with HIV. They also have to adapt with the power relationships with partners, families, healthcare providers. Hence, the childbearing decision of WLHA might be a social product of an adaptations of social challenges with compete with each other.

Furthermore, CMA utilized critical approach that focus on social inequality. Health is not only related with human biology but also deeply influenced by social inequality, overt and covert social conflict, operation of power to shape dominant ideas and conceptions in society and internationally through the process of globalization(Baer, H. A et al., (Eds.), 2003). Health depends on the accessibililty and control over the basic material and non-material resources that sustained and

promoted life at a high level of satisfaction(Baer, H. A et al., (Eds.),1997 and 2003). In capitalist societies achieving health entails struggle against class-dominated powers. Marxist feminism argued that women subordination served the needs of capitalism because women constitute a source of unpaid domestic workers as well as a source of reproduction of new generation (Jones. P (Eds.), 2003). Women are marginal workers, who are poorly rewarded and recognized than men. Michele Barrett stated that when woman entered into family life, wifeliness and motherhood in domesticating women were crucial in reproducing the features of the world from which they are disadvantaged (cited in Jones. P (Eds.), 2003). Such universality of women oppression is known as "Patriarchy" where men exercise power over women (Jones. P (Eds.), 2003).

Besides, disease or illness is as much social as it is biological. Disease is not just the straightforward result of a pathogen or physiological disturbance. Humans in all societies perceive disease as a disruptive event that in one way or another threatens the flow of daily life (Baer, H. A et al., (Eds.),1997 and 2003). It is particularly true for HIV/AIDS because HIV is perceived as sinful due to promiscuous behavior or drug use and people living with HIV especially WLHA are treated as contagious or vectors who convey HIV infection to others (Liamputtong, P. (Eds).,2013a,2013b). Thus, examination of contending forces in and out of the health arena that impinge on health and healing becomes an essential task in building a critical approach to health issues. Friedrich Engels and Rudolf Virchow also claimed that "discussion of specific health problems apart from social contexts only serves to downplay social relationships and underlying condition" (Baer, H. A et al., (Eds.),1997 and 2003). Although HIV virus has material existence independent of social factors, its role and importance as a source of morbidity and mortality among humans cannot be understood in isolation from political economy. Placing emphasis on social origins of disease does not constitute a denial of the biotic aspects of pathogens, hosts, and environments. Rather, it is an affirmation of the critical importance of adopting a holistic and historically informed biopolitical economic approach to health.

In responding to disease and illness, all human societies create healthcare system. It includes social relationships that revolve around the healer and patient.

Dunn (1976) delineated three types of medical systems: local, regional and cosmopolitan (Western medicine) systems. According to Chrisman and Kleinman (1983), healthcare system could be divided into three overlapping areas of popular sector, folk sector and professional sector. The popular sector includes self-medication, care by family, social networks and communities. Folk sector comprises of various healers such as herbalist, traditional birth attendants and traditional healers. Professional sector includes practitioners and bureaucracies of both biomedicine and professional heterodox medical systems (Baer, H. A et al., (Eds.), 1997 and 2003). All healthcare systems compose of certain core values, metaphors, beliefs, and attitudes to communicate with patients. Rivers W.H. (1924) argued that medical practices were not disconnected and meaningless customs but rather an integral part of the larger sociocultural systems within which they were embedded (cited in Baer. H.A et al (Eds.), 2003). Social patterns in healthcare are intimately related to hegemonic ideologies and patterns. For the WLHA, the reproductive issue including childbearing is influenced by perception, attitudes and health beliefs of healers in all three medical systems. Like Navarro (1976), Krause (1977) , Doyal (1979), Waitzkin (1983) and Foucault (1975), CMA believes that power differences shape social processes and dominant ideologies (Baer, H. A et al., (Eds.), 2003).

All in all, CMA is a set of concepts for analyzing macro- micro connections. It allows consideration of a broad range of factors related to culture, policy, economic structure, and biomedicine that pattern human relationships, shape social behaviors, condition collective experiences, and situate cultural meanings, including forces of institutional, national, and global scale. They all affect the childbearing decision among WLHA. Specifically, the approach will allow an investigation of the sociocultural drivers which push WLHA to deliver children behind HIV program messages and healthcare providers' concern of mother-to-child-transmission of HIV. Using a critical medical anthropology approach will also allow a consideration of the trust that future WLHA and their families have in the safer reproduction and prevention of mother-to-child-transmission of HIV.

2.1.2 Gender concept

Gender is a social construct, which distinguishes the characteristics of male and female. It contains culturally defined set personality traits, attitudes, feelings, values and behaviors (Lorber. J.,1994). Gender is concerned about “what is meant to be male and female, and how that defines a person’s opportunities, roles, responsibilities and relationships” (Turme ,2003:411). At the individual level, gender works through gender identity development occurring through socialization of an individual’s life (Wyrod,2013a). The senses of “gender selves” decide how an individual thinks of herself as gendered and has particular expectations of herself as a gendered individual (Butler ,1990; Risman,2011; Wyrod ,2013a). Since gender is a social construct ,which is learnt through socialization, it varies from context to context (USAID,2013).

Gender does not operate in isolation. It often intersects with other social determinants including social class (Liamputtong et al.,2014b). Social class means the position of a person in a social system, which is grounded in unequal distribution of income, wealth, status, and power (Germov,2009:86 cited in Liamputtong et al.,2014b). The intersection of gender and social class has created health inequalities among women (Lorber ,1997; Broom,2009 cited in Liamputtong et al.,2014b). Gender shapes how individual interact with each other by structuring certain social orders about expectations and proper behaviors for gendered members of a given society. It creates gender hierarchies and inqualities (Risman,2004; Wyrod,2013 cited in cited in Liamputtong et al.,2014b).

In fact, gender is not only an individual characteristics but also a social structure (Wyrod,2013). It is a Patriarhal society, gender hierarchies are reinforced through organizational practices, allocation of resources and legal regulations which prejudice men over women (Risman,2004:437, 2011:20: Giddens,2984: Lorber,1994,997: Wyrod,2013 cited in Liamputtong et al.,2014b).

Gender norms define woman’s roles and standards for a woman as a wife and mother. Gender power relationships control women’s ability to protect their own bodies and decision making. In a Patriarchal society, women are treated as second class citizen who are inferior than men. Women do not get equal opportunities in education, employment and legal protection in divorce, property ownership. This in

turn compromises women's power in intimate relationships, making them difficult to refuse sex or insist on condom use , putting them at risk of contracting HIV/AIDS (UNAIDS,2014c). Therefore, gender concept is used in this study to understand the childbearing decision of WLHA.

2.1.3 Motherhood Concept

Motherhood is important in all women's lives, whether or not they want to be mothers. Women are defined in terms of their relationship to motherhood (Phoenix, A., Woollett, A., & Lloyd, E., 1991). Motherhood has meanings in symbolic, psychological and interpersonal meanings at variety of levels and these meanings interrelate in complex ways.

Motherhood is seen as mandatory and normative quality of a woman (Phoenix, A., Woollett, A., & Lloyd, E., 1991). Woman's maturation and achievement are accepted on the ability to become mother (Antonucci and Mikus, 1988; Busfield,1974; Rapoport et. al.,1977, cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991). Woman achieves full adult status and demonstrate feminine identity at the time of mother (Busfield,1987; Notman and Nadelson,1982; Salmon ,1985 , cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991). Hence, motherhood is placed high value symbolically as the key to adult female identity and it is often the most important job for the women (Baker, 1989 ,cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991).

Motherhood also attaches with psychological meanings. Through validataion of adult female identity, motherhood is an integral part of one's self-definition. Woman receive personal fulfillment and self-esteem (Phoenix, A., Woollett, A., & Lloyd, E., 1991). Motherhood enhances the menaing of life by providing enjoyment and fun during parenting. Motherhood is a kind of contribution of human resource to the society, woman receives appreciation and recognition from society in return. Women are able to allow their self-sacrific, less selfishness, responsible and mature women through childbearing. It contributes to personal development among women (Beckett ,1986; Sharpe ,1976 ,cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991).

Motherhood is associated with positive social value and social status because of their contribution of valuable human resource to society and ultimate fulfillment of women's identity. Women gain autonomy and power from the motherhood (Baker ,1989; Busfield,1987; Notman and Nadelson,1982; Salmon,1985, Sharpe, 1984 cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991; Hayford, Agadjanian and Luz 2012, cited in Piggott, T.B.,2011). In a polygamous marriage, a wife's influence in home is leveraged by the number of children she has (Akelo, V. et. al., 2015).

In this ideological context, women gain positive social identity, personal fulfillment and power from childbearing,thus, having children is central to married women (Baker,1989; Beckett,1986 , cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991). Childbearing is often favorable than other jobs (Sharpe,1984;Baker,1989 cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991). Threfore, women's decisions are not so much about whether or not to become mothers but they had to concern about when and how many to have or in which social context to have them (Antonis,1981; Busfiled,1974; Franklin,1989; Pfeffer and Woollett,1983, cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991).

Since motherhood has many posivities in soiceity, WLHA might hope for positive social life by childbearing. Some WLHA viewed motherhood as a source of strength and self-esteem to escape from negative social impacts of living with HIV (Sandelowski and Barroso 2003 : 477, cited in Liamputtong, P. (Eds).,2013b). Some WLHA desired to balance their negative social identity of HIV/AIDS with the positive identiy of motherhood (Sandelowski and Barroso 2003 : 477, cited in Liamputtong, P. (Eds).,2013b). Thus, motherhood was used as one of the theoretical lens to understand the sociocultural context of childbearing among WLHA.

2.1.4 Stigma concept

Goffmann(1963) defined stigma as "an attribute that is deeply discrediting". Stigma can occur in any condition, attribute, trait, or behaviour that symbolically marks off the person as culturally unacceptable or inferior with consequent feelings of shame, guilt and disgrace. Goffman explained that "stigma should be seen that a language of relationships" (1963:3). Stigma is not just an isolated

attribute or characteristic, but rather that it becomes defined as discrediting only through social interactions. If a person is stigmatized , that person is treated as not deserving of respect or less worthy than others. Stigma is further categorized into self or perceived stigma, experienced or enacted stigma (Brown, Macintyre & Trujillo,2003). The socially constructed beliefs of HIV/AIDS are absorbed and internatlized by HIV positive people and raised perceived stigma. Perceived stigma is referred to real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute or diseae (Simbayi, L.C et al., 2007).

Parker and Aggleton explained that “stigma and stigmatization function, quite literally, at the point of intersection between culture, power and difference – and it is only by exploring the relationships between these different categories that it becomes possible to understand stigma and stigmatization not merely as an isolated phenomenon, or expressions of individual attitudes or of cultures values, but as central to the constitution of the social order” (2003:17). Parker and Aggleton argued that power differentials can be based on gender, race, class or other marginalizations as a cause of stigma and stigmatization serves as a tool to reproduce exisiting and unequal power structures within social systems. They claimed the “intensifying interaction between multiple forms of inequality and exclusion” (Parker and Aggleton 2003:19 cited in Cuca. Y.P,2013).

Stigma occurred when there was a gap between “virtual social identity” about what a person should be and “actual social identity” about what the person actually was. When people are marked as difference, they are seen as tainted , discounted one and reduced in our mind from a whole (Goffmann, 1963). Goffmann also mentioned about different types of stigma as “abomination of body” , “ spoiled character” and “tribal stigma”. Abomination of body is related with infectious and contagious body. Spoiled character stigmatization is thought to be as weak morality, promiscuous characters ,unnatural passions and dishonesty. Tribal stigma is related with race, nation and religions. WLHA already has stigmatized identities of sex worker, promiscuous women and childbearing of WLHA is related with moral meaning of transmission of infection to others. They are likely to face with blame and stigmatization for allowing others to transmit infection. Crawford explained that HIV positive people are separated from an established boundaries created by uninfected

individuals. HIV positive people were distinguished as others (Crawford ,1994 cited in Cuca Y.P,2013). People who are unifected with HIV gain greater social power than HIV infected persons (Cuca Y.P,2013). Therefore, the cultural beliefs realted with HIV/AIDS, power differentials based on HIV infected and uninfected persons , moral meanings related with HIV/AIDS create stigmatization to WLHA. It ,in turn, influence the reproductive behaviors and childbearing decision. Therefore, the concept of stigma was used to understand the childbearing decision of WLHA in this study.

2.2 Related literature

The literature search entailed examination of following databases: Google Scholar, ProQuest, Science Direct, Springer Link and PubMed. The search included combination of following keywords: AIDS, mother-to-child transmission, women, people, fertility intention, childbearing, pregnancy and Myanmar. Abstracts of studies in Myanmar were obtained from annotated bibliography of research findings on reproductive, maternal, newborn, child and adolescent health in Myanmar (2007-2014) by Department of Medical Research and Marie Stopes International, Myanmar. For the additional knowledge about HIV/AIDS and SRH, reports,guidelines, national strategic plan of WHO, UNAIDS and Ministry of Health & Sports, Myanmar were reviewed.

2.2.1 HIV/AIDS epidemic in reproductive aged women

Globally, approximately half of all people with HIV/AIDS are reproductive aged women. In 2015, there were 17.8 million women living with HIV/AIDS around the world. The Asia-Pacific Region has the second largest HIV burden with 4.8 million people with HIV/AIDS. Similar to global burden, half of them were women (UNAIDS, 2015). Myanmar holds the fifth largest HIV/AIDS burden in Asia-Pacific Region. In 2015, there were about 220,000 PLHA and about one third of them were reproductive aged women. Although overall HIV prevalence reduced , the prevalence among women increased significantly within the past decade. Female to male ratio for new HIV infection increased significantly from 1:8 in 1994 to 1.1:2 in 2008. Besides, VCT among general population was still low with 0.4% in 2015. Many women do not

know their HIV status until they test VCT during ANC. It is convinced by the HIV prevalence among pregnant women was higher (0.7%) than HIV prevalence in general population(0.4%) (NAP, MOHS, 2015). Thus, HIV/AIDS becomes a significant problem among women of reproductive age in Myanmar.

2.2.2 Sexual and reproductive health rights of WLHA

PLHA have the rights to choose whether or not to have children, rights to have access to integrated health services promoting care and attention to sexual and reproductive (SRH) including family planning (FP), prevention of sexually transmitted infection (STIs) and HIV/AIDS ,irrespective of their serological status (UNFPA ,2008).

In the era of HIV prevention and control, UNAIDS and multiple international fundings applied Global Plan towards elimination of new HIV infection among children by 2015 and keeping their mothers alive as a focus for PMCT response. Its ambitious goals are to reduce 90% of new acquisition of HIV among children and to reduce 50% of AIDS related maternal mortality. It structures as 1) prevention of HIV among reproductive aged women through SRH services; 2) providing appropriate counseling and contraceptives support for WLHA to meet unmet needs of family planning; 3) ensuring HIV testing , counseling and access to ART for pregnant WLHA. Many countries use this Global Plan as a country level framework for PMCT responses. However, the Global Plan is criticized for its narrowly focus on infection prevention ,rather than holistic approach. It does not focus on affirmation of health, autonomy, life and rights for WLHA.

Thus, UNAIDS and 2 other United Nations agencies considered on SRH and rights of WLHA. Then, the June 2011 UNGASS Political Declaration on HIV/AIDS committed that national HIV/AIDS response has to meet the specific needs of women and girls including those living with HIV, across the lifespan, through measures for the promotion and protection of women's full enjoyment of all human rights (UNAIDS, 2014d). It includes gender equality; access to SRH services; and women's empowerment an economic independence. The international agencies such as the World Health Organization (WHO) and many United Nations agencies have declared the integration of SRH and HIV services(UNAIDS, 2014a,2014d).

2.2.3 HIV/AIDS prevention, treatment and support services in Myanmar

HIV/AIDS prevention, treatment and support services are provided by both public health facilities opened by Ministry of Health & Sports (MOHS) and non-government organizations (NGO). There were 184 health facilities providing ART services in Myanmar in 2015. About 45% of ART services were provided by MOHS health facilities and 52% were provided by NGO in 2014 (NAP, MOHS,2015).However, there are challenges in provision of quality of care in HIV preventin, treatment and support services in Myanmar (NAP, MOHS, 2015).

The advancement of ART reduces transmission of HIV between partners and perinatal transmission of HIV (WHO, 2014). However, not all PLHA in Myanmar get access to ART. In 2015, only half of the PLHA got access to ART. Besides, there are many people who do not know their HIV status because of low VCT rate in general population with 9% in 2015. It is particulary low in women. Most of the women do not know their HIV status until the disease advance (NAP, MOHS,2015). Thus, many reproductive aged women get married and take pregnancy without knowing their HIV status. At the same time, condom use between intimate partners is rare (Asian-Pacific resources and research center for women,2016). Unprotected sexual intercourse brings the risk of HIV transmission to uninfected partner in sero-discordant relationship as well as risk of HIV super infection between partners in sero-concordant partners. HIV super-infection has detrimental effects on clinical outcomes of PLHA. There are also risk of exposing to other sexually transmitted infections (STIs) between partners (WHO,2014).

There are many women who get HIV diagnosis at the time of ANC although HIV testing rate in ANC is still low. Approximately 65% of pregnant women who came for ANC tested for HIV in 2014. Although HIV testing at ANC was still low, HIV prevalence among pregnant women was higher (0.7%) than the HIV prevalence in general population (0.54%). Even after getting HIV diagnosis, not all WLHA get access to PMCT. There are also significant numbers of pregnant women lost to follow-up before and after delivery. Only 80 % of HIV positive pregnant women got access to ART or anti-retroviral prophylaxis for PMCT in 2015. Thus,

perinatal transmission of HIV is still high with 15% in Myanmar (NAP, MOHS, 2015 and Asian-Pacific resources and research center for women, 2016).

Moreover, PMCT services are only available in big cities and towns of Myanmr (UNAIDS,2014d). WLHA in some rural areas are not aware the availability of PMTCT services (UNAIDS, 2014d). The national guideline on PMCT in Myanmar includes counseling on voluntary contraception, natural vaginal delivery and exclusive breastfeeding (NAP ,2015 ;MCH, ,2014). UNAIDS points out that the access to reproductive counseling and services among WLHA is low. Healhtcare providers narrowly focused on HIV prevention and neonatal outcomes, rather than took into account of holistic approach (UNAIDS, 2014d). The provision of psychosocial support, nutrition and economic support for PLHA and the HIV affected families are still low and these supports mainly base on external (international) fundings (NAP, MOHS, 2015).

2.2.4 Childbearing decision: Intrapersonal level

Studies showed that childbearing among WLHA has been happening around the world. Richter showed that many people with HIV/AIDS delivered children after getting HIV diagnosis (Richter et al., 2007). Many PLHA did unprotected sexual intercourse with the desire to get pregnant and biological children (Barnes and Murphy 2009 ; Nattabi et al. 2009 ; Awiti Ujiji et al. 2010 ; Finocchario-Kessler et al. 2010 ; Kisakye et al. 2010 ; Wilcher and Cates,2010 cited in Liamputtong, P. (Eds).(2013a). Some studies showed that fertility desire of PLHA was lower than HIV negative women (Elul, B. et al.2009; Kaida A et al. 2011) while other studies indicated that pregnancy desire did not vary with HIV sero-status (Kyegonza C et al.2010, Smee N et al.2011).

The individual social contexts were found to influence childbearing decisions of WLHA. A number studies showed that childbearing desire was influenced by the age of WLHA. Craft, S.M et al., (2007) found that among the HIV positive African-American women, younger women were three times more likely to choose to have a child than the older women (Craft, S.M et al., 2007). Siegel,K., et al., (2001) also reported that younger age , stronger gender role orientation, decreased perceived threat of HIV, apparently healthy status, strong religious beliefs, having peer support

were associated with pregnant after getting HIV diagnosis (cited in Kessler S.F,2009). Other studies also expressed that the younger WLHA (<30years) were more likely to take childbearing (Cooper, D., et al. 2009 ; Peltzer,K., et al. 2009 ; Kakaire,O., et al. 2010 cited in Liamputtong, P. (Eds)., 2013b).

The number of parity was also found to influence childbearing decision of WLHA. Rocca, C.H. et al., (2009) claimed that nulliparous are more likely to endorse favorable attitudes toward pregnancy. Women with 2 or more children are less likely to desire children in future than women who have no or only 1 child (Rocca, C.H. et al., 2009). The younger WLHA with few number of existing children were more likely to pursue childbearing (Craft et al., 2007; Phaweni et al., 2010). Some WLHA did childbearing for their existing children. Piggot cited as some WLHA did childbearing to get support system for their existing children (Kanniappan et al.,2008 cited in Piggot. T.B,2011).

Knowledge of ART and PMCT services are also found to influence childbearing decision of WLHA. Radcliffee showed that WLHA with knowledge and accessibility to ART and PMCT services took pregnancy more than others (Radcliffe at al., 2007, cited in Piggot. T.B, 2011). Piggot also found that WLHA with low perceived susceptibility of HIV took more pregnancies (Craft et al., 2007; Nattabi et al., 2009 cited in Piggot.T.B,2011). Kaida showed that PLHA who had optimism about ART were more likely to choose childbearing (Laher, F., et al., (2009) cited in MacCarthy ,2012). Sharma indicated that increase in childbearing after getting access to ART was more significant among older and educated WLHA than the younger and less educated WLHA(Bearinger, L. H., Sieving, R. E., Ferguson, J., & Sharma, V. .2007).

Many studies prove that childbearing of WLHA increased after the development of ART. Bearinger, L. H studied that birth rate of WLHA who got access to ART was 150 percent higher than those with no access to ART (Bearinger, L. H., Sieving, R. E., Ferguson, J., & Sharma, V. ,2007). Liamputtong, P. (Eds).(2013b)also proved that childbearing desire was increased among WLHA who had access to ART. Piggot (2011) showed that birthrate of WLHA who had access to ART was higher than those who did not have access to ART (Massad et al., 2004; Van Benthem et al., 2000, cited in Piggott, T.B., 2011). However, there are also some

studies that suggest that pregnancy desire of PLHA do not depend on the accessibility of ART (Kaida A et al.2011; Liamputtong, P. (Eds).,2013b).

Spiritual and religious beliefs also have impact on childbearing decision among WLHA. WLHA who continued to take pregnancy after getting unintended pregnancies were associated with religious beliefs (Richter, Sowell, & Pluto, 2002 cited in Fletcher. F.E, 2011). WLHA who had relationships with God and strong religious beliefs continued pregnancy to (Jadhav S, 2010; De la Cruz, 2009 cited in Piggot.T.B, 2011).

The review of literature shows that individual social contexts are important in childbearing decision of WLHA. However, the influences are varied from context to context. Thus, there is a need to examin the individual social context related with childbearing decision of WLHA in Yangon, Myanmar.

2.2.5 Childbearing decision: Interpersonal level

Since humans are social beings, their decisions and practices are more or less influenced by the interpersonal contexts. Interpersonal context means a person's decision and practices are not able to free from the influence of powerful figures and power relationships (Stolley, K.S (Eds.), 2005). Desire and decision on having children among WLHA are developed within a powerful ideological context which influence the adjustment of childless women and women with reproductive problems (Campbell,1985; Veevers, 1980, cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991). Ideas and health beliefs came out from partners, families, communities and healthcare providers influence the childbearing decision (Liamputtong, P. (Eds.), 2013b). Powerful figures in their lives – physicians, nurses, parents, and partners – may tell them that they should not continue these pregnancies and encouraged them to abort. Negative public opinions about putting children into the risk of HIV transmission discourage WLHA's desire and decision (Nobrega et al. 2007; Sandelowski and Barroso 2003; Sanders 2008, cited in Liamputtong, P. (Eds).2013b).

Study showed that childbearing decision of WLHA was weighted more heavily by the partners' desire than their own desire (Finocchario-Kessler, et al.,2010). Fears of eviction from their matrimonial homes, marital infidelity, and domestic violence made many WLHA to deliver children (UNAIDS, 2014b). The satisfaction of

partner was the reason for childbearing of some WLHA (Cooper et al., 2009; Kessler S.F, 2009). WLHA decided to take pregnancy for the stability of their economic and emotional dependence on male partners (Craft, S. M., Delaney, R. O., Bautista, D. T., & Serovich, J. M. ,2007). For example, South Africa, Zimbabwe and Uganda studies showed that pregnancy desire among WLHA was associated with stable relationship status (Kaida A et al. 2011; Schwartz S et al.2010; McClellan MK et al. 2010).

Liamputtong, P. (Eds). (2013b) showed that the most salient barriers of HIV testing and disclosure are women's fear of their male partner's reaction. Many WLHA did not disclose their HIV status to their partners with the fear of partner's reaction (Sofolahan. Y. A,2013). Lack of disclosure of their status and poor negotiation on condom use increased pressure to have children (cited in Piggott, T.B., 2011; Liamputtong, P. (Eds.) 2013b). WLHA who insisted on dual protection are abandoned by their husbands (Sofolahan. Y. A,2013). The fear of rejection from their partners and avoidance of domestic violence were the reasons for some WLHA decided to have children (Akelo, V.et. al., 2015; Kessler S.F ,2009).

Childberaing decision of WLHA was related with power relationship of healthcare providers. Cuca Y.P (2013) found that the stigmatization from healthcare providers deterred WLHA in accessing SRH services and opening fertility desires (Cuca. Y.P.,2013). Sowell (1997) showed that PLHA believed believed that doctors focused on medications and encouraged them not to have children. They mistrust on medical community made them poor communication about their reproductive intentions (Sowell, 1997 cited in Cuca, Y. P., 2013). Study in Vietname also showed that WLHA were advised for abstainence or condom use. They were also advised to do abortion (Lisa.J.M et al.,2012).

The review of literature suggested that interpersonal influences are important in reproductive behaviors and childbearing decision. The influences can be either supportive or stigmatization towards childbearing of WLHA. Thus, the influence of interpersonal social contexts among WLHA in Yangon would be studied.

2.2.6 Childbearing decision: Intermediate level

2.2.6.1 Social norms related with childbearing

Social norms and constructs of femininity influenced the reproductive behaviors and childbearing decision of WLHA. Femininity was constructed as faithful, obedient and submissive while masculinity was constructed as risk taking, decisive and dominant. Sex was taboo for women and women who looked for sexual and reproductive health information were seen as indecent and immoral women (UNAIDS,2014c). Women were treated as subordinate, disadvantaged and mutated group who is routinely treated as inferior and who faces coerced sex and harmful cultural practices (Creighton and Yieke 2006, cited in Cuca Y. P, 2013). Husband owned wife's body and health, thus, he controlled reproduction of his wife. It was difficult for a woman to refuse sex or insist on condom use. This led to increase in risk of HIV transmission and unintended pregnancies (UNAIDS, 2014c).

Moreover, childbearing was accepted as mandatory or normative quality of a woman (Baker, 1989; Busfield, 1987; Notman and Nadelson, 1982; Salmon, 1985, cited in Phoenix, A., Woollett, A., & Lloyd, E., 1991). Woman's social identity and social status were based on her ability to bear children (Hayford, S. R., Agadjanian, V., & Luz, L.,2012). Childlessness was seen as undesirable in many societies (Phoenix, A., Woollett, A., & Lloyd, E., 1991). In African culture, infertile women were severely blamed (cited in Piggott, T.B.,2011). In Botswana, Papua New Guinea and Uganda, the main desire for childbearing among WLHA was cultural obligation to fulfil the duty of motherhood in order to gain positive social status (cited in Piggott, T.B.,2011).

Woman gained positive social status and power through childbearing (Phoenix, A., Woollett, A., & Lloyd, E., 1991; Piggott, T.B.,2011).WLHA also believed that motherhood gave the reason to live meaningfully. Studies also showed that WLHA viewed motherhood as the reason to live meaningfully and coped their stress from HIV/AIDS (Liamputtong, P. (Eds)., 2013b). In America, WLHA viewed motherhood that "birthing a child and mothering was an opportunity for shifting in attitude from dying to making progress toward living with HIV" (Liamputtong, P. (Eds).,2013b).

Childbearing brought an important cultural meaning that served to solidify marriage (cited in Akelo, V.et. al.,2015). Family norms also influenced childbearing decision of WLHA (Piggott, T.B., 2011). Family was defined as a group

of two or more people living together (Stolley, K.S (Eds.), 2005). Having a family was expected from marriage around the world. Even in U.S "a married couple without children did not qualified as a family". In India, the desire of child was related with family size norms (Akelo, V.et. al., 2015).

Therefore, childbearing had huge social and cultural meaning which triggered WLHA to consider childbearing.It was needed to understand about gender and social norms related with childbearing in Myanmar.

2.2.6.2 Social stigma related with HIV/AIDS

HIV related social stigma is important in childbearing decision. Society expected woman to become mother but at the same time society negatively judged WLHA who made childbearing (cited in Piggott, T.B.,2011). WLHA who chose to become pregnant or refused to abort pregnancy were negatively judged from the society(Cuca, Y. P, 2013).

As social ideology or social meaning of "living with HIV" included "contagious", WLHA who chose to bear children were often seen as "cruel, uncaring". They were blamed as "inappropriate or irresponsible" (Liamputtong,P. (Eds).,2013a,2013b). The main reasons were unprotected sexual activity brought the risks of HIV and other sexually transmitted infections (STIs) to the partners as well as vertical transmission to the infants. Negative public opinions about putting children into the risk of HIV transmission discouraged WLHA's desire and decision (cited in Liamputtong, P. (Eds).2013b). The perception of being HIV-positive lead WLHA to stop childbearing because of worry about risk of transmission of infection and leaving as orphaned children (cited in Liamputtong, P. (Eds).2013b). Moreover, inequalities in healthcare services had effect on childbearing decision of WLHA (Cuca, Y. P, 2013). WLHA who experienced more HIV related social stigma were found to less likely choose childbearing(Craft, et. al., 2007 cited in Cuca, Y. P, 2013).

In contrast, studies showed that WLHA used to negotiate their identities, to draw away from their "deviant" conditions and as a mean to escape from the hostile social impacts (Kisakye et al.2010; Kennedy, V.L., 2012; Liamputtong, P. (Eds.) 2013b). In Kenya, WLHA were offered back positive identity and recognition in the community through childbearing (Liamputtong, P. (Eds).,2013b).Therefore, it

was important to understand about the social stigma among WLHA in Myanmar and how these stigma shaped their childbearing decision.

2.2.7 Research Gap

Despite growing number of reproductive aged WLHA and childbearing among WLHA, there is limited empirical evidence examining the phenomenon. Although there is significant number of HIV/AIDS related research, to date few studies have examined the socio-cultural contexts related with childbearing decision of WLHA. Previous literature showed that childbearing decision of WLHA were influenced by multiple level socio-cultural contexts ranging from individual social contexts, gender power relatioships, social stigma, social norms and values in the society. Besides, research in other countries or other contexts were not directly applicable in another context because sociocultural factors and socio-cultural expectations varied from context to context and from time to time. Thus, evidence based knowledge on concrete, culturally and context-specific evidence was important to understand the real social contexts where WLHA make childbearing decision. To date, there is no similar study which studies on childbearing decision among WLHA in terms of sociocultural context in Myanmar. Therefore, the study found out the complex realities of sociocultural contexts in childbearing decision making among WLHA in Yangon, Myanmar. It was unique from other studies because it studied the existing social contexts in specific levesl of individual, micro, intermediate and macro level and it analyzed how these social contexts interacted with each other to reach the childbearing decision among WLHA in Yangon, Myanmar. Hence, this study contributed the existing knowledge on childbearing of WLHA and it was the first study which highlighted the issue of childbearing among WLHA in Myanmar.

2.3 Explanation of conceptual framework

For the case of WLHA, childbearing decision was a controversial and complex issue. It was governed by complex sociocultural contexts. Therefore, the researcher applied critical medical anthropology theory, concepts of gender,

motherhood and stigma to understand how sociocultural contexts influenced the childbearing decision of WLHA in Yangon, Myanmar.

This study aimed to explore childbearing decision of WLHA at individual level, micro level, intermediate level and macro level by applying critical medical anthropology lens. At individual level, various socio-demographic characteristics, cultural beliefs and practices related with HIV and childbearing of WLHA were explored. At micro level, gender power relationship of WLHA and their husbands/partners as well as power relationship of WLHA and healthcare providers were investigated. At intermediate level, the study focused on the community relationships of WLHA in terms of gender norms, social stigma and healthcare services. At macro level, existing social context of Myanmar like patriarchal society and medical hegemony were examined qualitatively.

In this way, the study aimed to find out the research objectives of understanding of the background social contexts related with HIV stigma, gender, motherhood and healthcare services which influenced childbearing decision and practices among WLHA in Yangon, Myanmar.

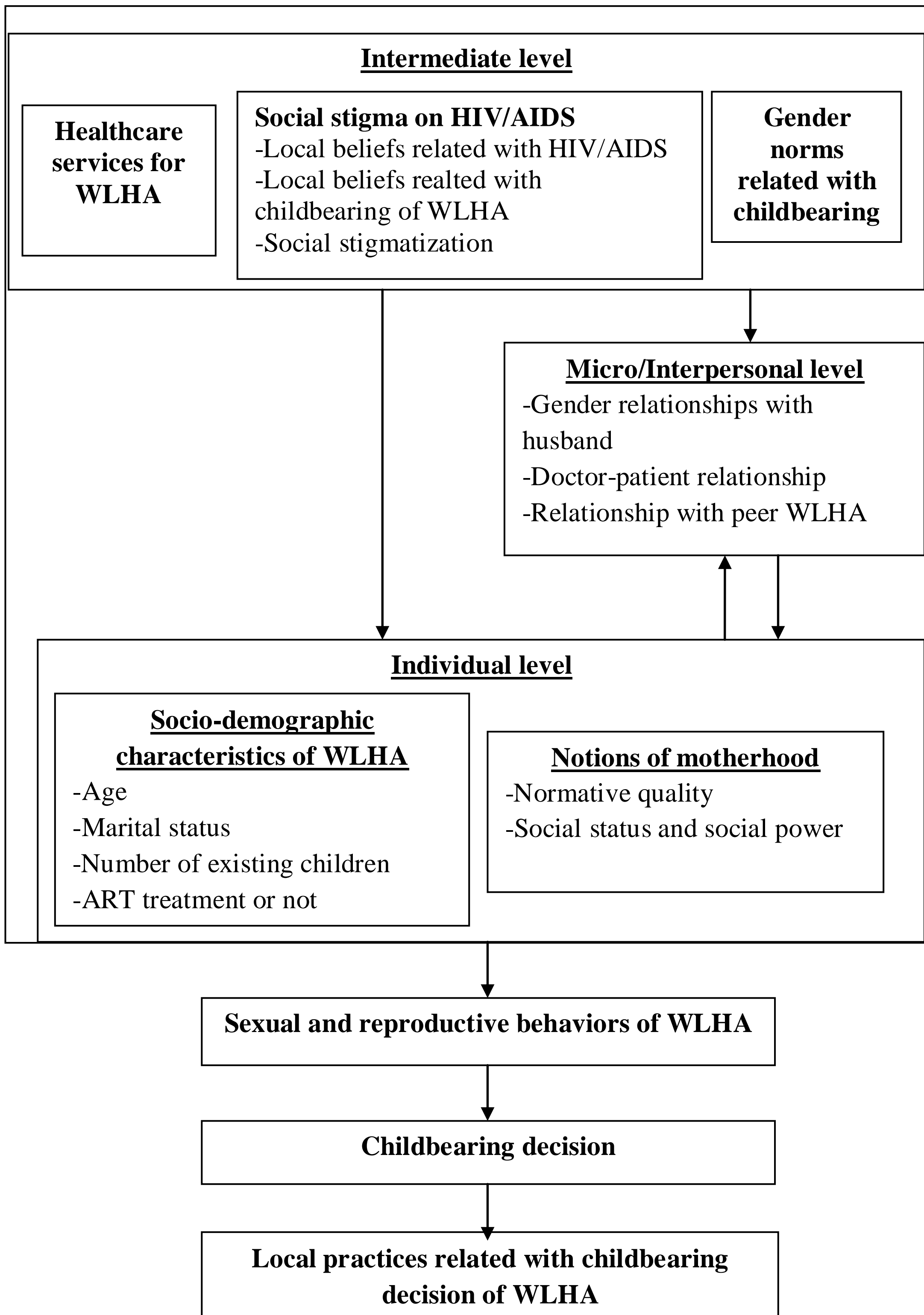

Figure 2.1 Conceptual Framework

CHAPTER III
RESEARCH METHODOLOGY

This chapter explains about how the study will conduct, analyze and interpret to understand the sociocultural context where WLHA make childbearing decision.

3.1 Study Design

The study aimed to understand the existing socio-cultural contexts of WLHA where they made childbearing decision in terms of HIV stigma, gender, notion of motherhood and healthcare services. The study used qualitative case study design.

Qualitative case study was an empirical inquiry that investigated contemporary phenomenon in-depth and within its real life context. It was particularly useful when the boundaries between the phenomenon and context are not clearly evident (Merriam, 1998). Case was a bounded system (person, a group, activity, process) and the boundary could be time and/or place. Case study studied biography of individuals focused on a phase or segment of life (Stake, 1995, cited in Zucker,2009).

Qualitative case study design was used because it tried to look in the phenomenon of childbearing among WLHA. It found the example or case (WLHA who had delivered child) that exemplified the specific phenomenon of childbearing decision among WLHA. The study of the case (WLHA who had delivered child) allowed better understanding towards what the forces were, how they played and how WLHA made childbearing decision. They are taking place bounded by specific time and place. It maintained the holistic approach that recognized the influence of range of social contexts on reproductive behavior and childbearing decision of WLHA. Besides, qualitative case study allowed multiple sources of data such as interviews, observation, document views to gain better understanding of the phenomenon of childbearing decision among WLHA. Through interviews, it allowed researcher to

understand human nature by talking directly to local people (informants) and listening to their stories under natural settings (Creswell, 2007). According to literature review, there were three types of WLHA who made childbearing decision. They were WLHA who took intended pregnancy, WLHA who got unintended pregnancy and WLHA who got HIV diagnosis after getting pregnancy. Hence, to understand the phenomenon of childbearing decision among WLHA, the study used multiple case study design and multiple cases were selected for various perspective of the issue of the concern.

Therefore, qualitative case study design was suitable for understanding of childbearing decision among WLHA in Yangon, Myanmar context. It allowed researcher to better understand the socio-cultural contexts that forced WLHA for making childbearing decision.

3.2 Study Site selection

The study was conducted in home town of the researcher, Yangon city. Yangon was chosen for the mixed of people from diverse socio-economic backgrounds (Department of Population, Ministry of Immigration and Population, 2014). It was the place mixed of traditional culture and effect of globalization significantly. Moreover, HIV prevalence in Yangon was higher than those of other places in Myanmar (NAP, MOH, 2015). Yangon was one of the cities where had highest ANC coverage in Myanmar (MCH, MOH,2015). Besides, it had the highest number public and private health care facilities in Myanmar. Most of the health facilities which provided ART and SRH services were based in Yangon. It was also the base of many international non-government organizations (NGOs) and community based organization (CBO). There were also many self-help groups of PLHA which provided social support services in Yangon (Asian-Pacific Resource and Research Centre for Women, 2016). There were also many temporary shelters opened for PLHA who moved to Yangon for the accessibility of ART. Due to these reasons, Yangon was selected as the most suitable study site to study the issue of childbearing decision among WLHA.

Figure 3.1: Yangon in Myanmar map (Source: Google map)

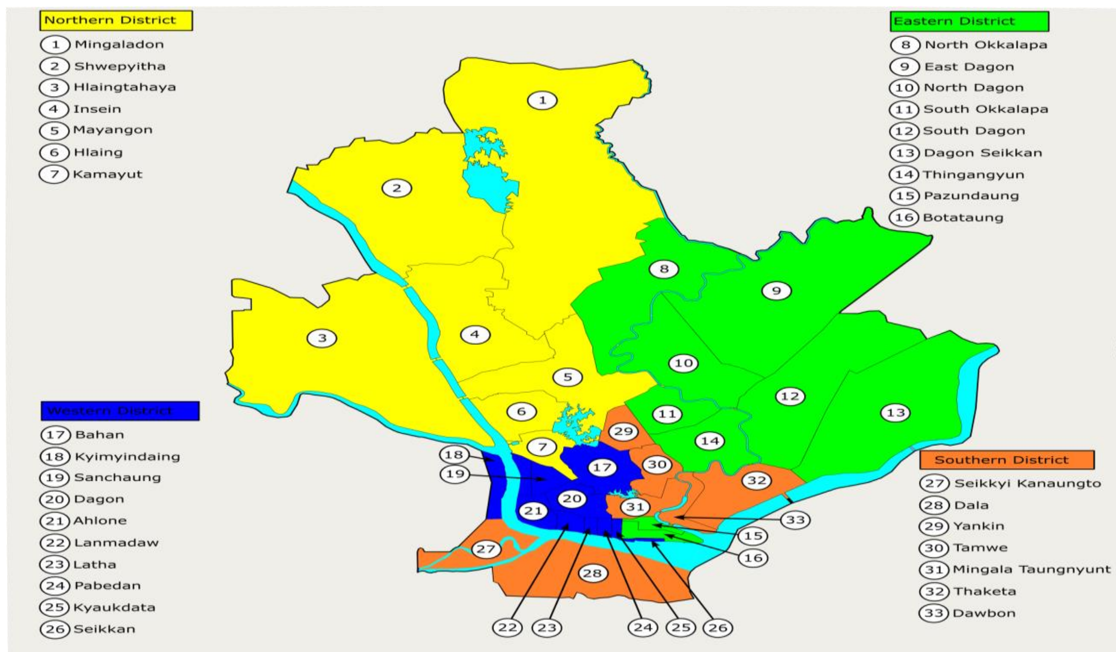

Figure 3.2 Map of townships in Yangon Region (Source: Google Map)

3.3 Entering into the field

Confidentiality is important in social research particularly in the study of sensitive issue of childbearing decision among WLHA. A person with HIV/AIDS does not want to expose her status to the community because of social stigma attached to HIV/AIDS. In order to maintain confidentiality and respect to privacy, the researcher put great concern on how to approach the informants in this study.

Since the time of developing proposal in April,2016, the researcher made contact with leader from self-help group named "Phoenix Association"."Phoenix" is a self-help group established by PLHA and they work for social support, care and support, income generation and advocacy/awareness/fund raising for PLHA and their families. It provides temporary shelter for PLHA who come from other provinces to Yangon for ART. It also has social support projects like building houses for PLHA, financial support for education of children from HIV affected poor families, income generation activities such as printing services and micro-finance projects, better life projects such as vocational training for PLHA and their families. Its care givers support PLHA during hospitalization. Then, when the researcher returned Yangon in July 2016, she made contact with the personnel from "Phoenix Association" in person and explained again about purpose and implications of study. Then, she made discussion about how to reach WLHA without breaching confidentiality and privacy, and how to include women who were willing to participate in voluntary basis. The personnel from "Phoenix Association" explained about the nature of their organizational activities and allowed the researcher to do volunteering in their organization.

After getting permission, the researcher used to spend about 5 days per week for volunteering. In some days, she visited HIV specialist clinics opened by NGO and HIV specialist hospitals with the care giver groups of "Phoenix Association". In some days, she stayed in the office of "Phoenix Association" and participated in providing stationaries and educational supply fees for the children from HIV affected families. In Saturday and Sunday, there was vocational "tailoring" training for WLHA and the women from HIV affected families. Since the data collection period coincided with rainy season of Myanmar, there were many places flooding in Yangon. Thus, social workers of "Phoenix Association" visited homes of

poor PLHA and the researcher followed with them. In this way, the researcher got a chance to learn the social contexts of where WLHA live. And the researcher got a chance to make chit-chat with WLHA who came to "Phoenix Association" and/or WLHA who came to HIV specialist clinics. Besides, the researcher learnt about provision of healthcare services for WLHA and got a chance to discussion with healthcare providers.

3.4 Study informant selection criteria and recruitment process

3.4.1 Informant for in-depth interview

The inclusion and exclusion criteria for informant selection for in-depth interview were as follow.

Inclusion criteria included:

-WLHA who have known her HIV status

-WLHA aged over 18 years old

-WLHA who have delivered at least one child within 2 years

-WLHA who are willing to participate in the study

Exclusion criteria included:

-WLHA who were seriously ill

-WLHA with mental disorder

-WLHA with cognitive defects

The informants for in-depth interviews were selected among WLHA who have identified themselves as HIV positive women with aged over 18 years old who were able to provide informed consent by themselves. The childbearing period was limited for 2 years in order to reduce recall bias and bias due to changes in socio-cultural contexts with time.

3.4.2 Informant for key informant interview

The following key informants were selected to gain deeper understanding of social contexts. In order to explore local beliefs related with HIV/AIDS, beliefs related with childbearing of WLHA, gender norms from society, 2 local women of

reproductive age were selected. To explore the partner's desire and beliefs related with childbearing, 2 husbands/partners of WLHA were chosen. Besides, to gain understanding of healthcare services and beliefs of childbearing of WLHA among healthcare providers, 2 healthcare providers were selected. Additionally, to gain the beliefs related with childbearing of WLHA among PLHA group, 1 peer social worker was interviewed.

3.4.3 Approaching and recruitment of informants for in-depth interview

During volunteering with Phoenix Association, the researcher got opportunities to chit-chat with WLHA. After spending about 2 months (July and August) for learning about background information and building trust with some WLHA, the researcher purposively selected potential 5 informants based on informant selection criteria. In order to enrich information and cover different cases, informants were selected from WLHA who intentionally took pregnancy, WLHA who got pregnancy unintentionally and WLHA who got HIV diagnosis after getting pregnancy. Then, the researcher applied snow ball sampling to achieve further 10 informants for in-depth interviews.

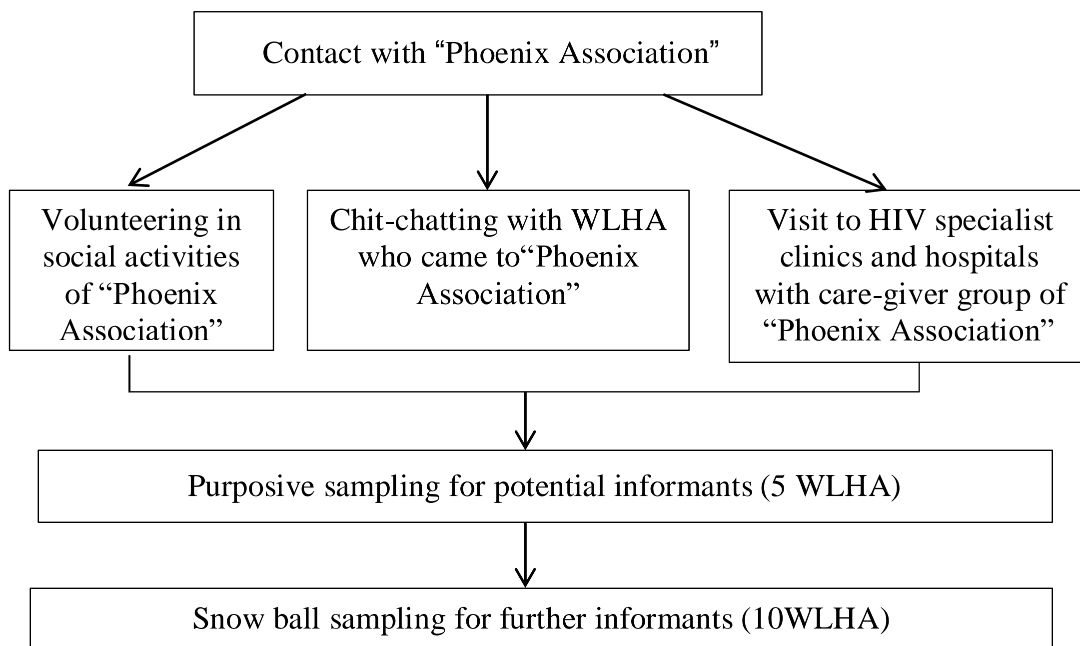

Figure 3.3: Overview of recruiting informants for in-depth interviews

3.4.4 Approaching and recruitment of informants for key informant interview

For the key informant interview, the researcher interviewed with 2 local women, 1 social worker, 2 healthcare providers and 2 husbands/partners of WLHA. To recruit 2 local women, the researcher approached to potential informative women in the community and asked their willingness to participate in interviews. The social worker was chosen from the peer PLHA self-help group who had been working with PLHA. To recruit 2 husbands/partners of WLHA, the researcher asked the WLHA involved in in-depth interviews if they allowed researcher to interview with their husbands/partners or not. After taking approval from WLHA, the researcher asked them how to contact with their husbands/partners and arranged for interviews. The most difficult part was the asking healthcare providers for interviews. The healthcare providers from government health facilities were reluctant to involve in the study. So, the researcher did not interview them. For the healthcare providers from HIV specialist clinics of non-government organizations, they were afraid of negative effects on their work and organizations. Thus, the researcher ensured the confidentiality of name of healthcare provider and name of organization before doing interviews.

3.5 Study methods

In order to understand the existing social contexts of WLHA related with childbearing decision, the researcher applied multiple qualitative data collection methods. They were participant observation, informal conversation, in-depth interview, key informant interview and document review. Total 22 informants involved in this study. They were 15 WLHA for in-depth interviews and 7 informants for key informant interviews.

3.5.1 Participant observation

Participant observation was done in a situation where all human beings acted as ordinary participants. The researcher did participant observation to gain insider point of view and to get complementary tool for interpretation of interviews in case study (Hardon.A (Eds), 2001). She did participant observation 5 days per week

from 9:00 AM to 5:00 PM started from July 2016. She learnt about local beliefs and practices related with HIV/AIDS, childbearing of WLHA, gender norms and practices of local community through participant observation. She also examined other social and structural contexts related with lives of WLHA throughout her study period in Yangon. With the support of Phoenix Association, the researcher visited HIV specialist clinics and hospitals where VCT, ART and PMCT services were provided. In this way, she learnt about healthcare services availability, accessibility as well as attitudes and behaviors of healthcare providers towards HIV positive people. During accompanying with social workers from Phoenix Association, she visited homes of 3 WLHA and observed the social structures, gender power relationships of WLHA in their families. During participating in educational support activities at Phoenix Association office, she got a chance to observe and did chit-chat with WLHA and their families. Although researcher did not attend any religious festival and social ceremonies, Yangon was home town of her and she was already familiar with the general social context of Yangon such as way of living, working environment, family pattern, ritual practices, social relationships, social support, cultural norms, values, and practices in Yangon.

3.5.2 Informal Conversation

Informal conversation was used to build trust and rapport with participants and to gain better understanding about their lives, culture and their desires and decisions (Creswell,2007). The researcher made informal conversations with local women, social workers, WLHA who visited Phoenix Association and WLHA who visited HIV specialist clinics, family members of WLHA and healthcare providers. It was just a friendly chatting with neither recording nor written down information during conversation. Field notes were written down only after meeting with them. The information gained from informal conversation was be used to understand the situations more.

3.5.3 In-depth Interview (IDI)

The same problem meant different things to different persons in different periods of time. It could depend on the relationship between experience and interaction

which could only be revealed in in-depth interview (IDI) method (Creswell, 2007). Thus, IDI was the crucial part to achieve insight in a qualitative study. In this study, 15 WLHA were interviewed for IDI. The interviews were done in a relaxing environment with strict privacy and confidentiality. WLHA were asked about their insight thinking, judgment and decisions with their unique sociocultural contexts.

Mouton and Marais (1996) stated that before IDI, it was essential to explain about the procedure of interviewing, objectives and advantages of study were necessary to explain beneficiaries. Thus, the researcher explained about the purpose of study, study methods, use of data and ethical consideration to the informants. They were asked for their willingness to involve in study. If they showed their willingness, the researcher took informed consent in both verbal and written documents before starting interview.

Hardon. A. et al (Eds.) (2001) explained that high degree of flexibility was important for in-depth interview. Thus, the researcher used semi-structured interview with open-ended questions, which allowed additional questions to achieve detailed information to meet the research objectives. Each informant was interview for at least 2 times according to the guideline. The first sessions started with introduction of the study, taking their agreements and then general discussion about socio-demographic characteristics, their beliefs and practices surrounding femininity, childbearing and thegender-power relationships within their family. Then, they were discussed about HIV stigmatization experiences and their perceptions on them. Finally, they were asked how they made childbearing decision and what they did in terms of their decision and from that whatever they wanted to tell. The first time interviews took about one to one and half hours. After reviewing the data got from first interviews, the researcher found gaps and incompleteness to reach the research objectives. The missing or incomplete information were listed down for further inquiry and organized for second time interviews. The second time interviews took about one hour and they were friendlier and more open than the first sessions. The researcher tried not to rush and not to interrupt in their telling but guided them to reach the research question. In this way, the researcher collected deep and sensitive information related to their lives and their final decisions related with childbearing.

The interviews were done at a private room in 1st floor of "Phoenix Association" according to the choice of the informants. WLHA were asked about selection of interview sites before conducting interview. All WLHA were reluctant to answer in their places. During the interview days, many of them brought their children together. Some WLHA were sent by their husbands/partners. All interviews were recorded by voice recorder and notes with the informants' consent.

Although the researcher expected it would be difficult in finding informants (WLHA who had delivered at least one child within 2 years after getting HIV diagnosis), it was not very difficult in reality. The researcher got to know with many WLHA who had delivered children at the time of volunteering but most of them were not allowed to involve in study because of the inclusion criteria of childbearing within 2 years. However, the informants were selected from the WLHA who came to "Phoenix Association" and/or WLHA who already had links/connections with NGOs and social support organizations. Thus, it did not reach to WLHA who were lack of support. Besides, the informants of this study only came from poor and middle socio-economic classes. Although the researcher tried to approach WLHA from rich families, they were not willing to answer interview. Thus, this study reached only poor and middle socio-economic classes WLHA.

3.5.4 Key Informant Interview

Key informant interviews (KII) were done to gain better understanding of social contexts surrounding WLHA to reach childbearing decision. First , 2 local women were interviewed to get understanding about local beliefs related with HIV/AIDS, local beliefs related with childbearing of WLHA and gender norms. Then, 1 social worker who had been working with PLHA was interviewed to gain insight on childbearing of WLHA. After that, 2 healthcare providers were requested to answer for their attitudes on the sexual and reproduction including childbearing of WLHA. Finally, 2 husbands/partners of WLHA were also interviewed to understand their views on WLHA, gender relationships and childbearing desire.

3.5.5 Document review

In order to gain better understanding of the childbearing decision among WLHA, the researcher reviewed the documents about HIV/AIDS and SRH, reports, guidelines, national strategic plan from WHO, UNAIDS and Ministry of Health & Sports, Myanmar were reviewed. Additionally, abstracts of studies in Myanmar were reviewed from annotated bibliography of research findings on reproductive, maternal, newborn, child and adolescent health in Myanmar (2007-2014) by Department of Medical Research and Marie Stopes International, Myanmar.

3.6 Study Tools

The study used the following tools:

- The researcher as a research instrument
- Participant observation guideline
- Interview guidelines for in-depth interview and key informant interview
- Paper and pen for note taking
- Voice recorder
- Laptop
- Key notes
- Field notes

The researcher used herself as a research instrument to achieve the research objectives because she was a native of Yangon and she was already homogenous with Yangon cultures. She was already familiar with appropriate and non-stigmatized words, facial expression, gesture, moral principles and standards. Thus, she applied reflective listening skills, interactive interview skill during interactions with informants of the study. Guidelines for participant observation, in-depth interviews and key informants interviews were already synthesized based on the research objectives. Jotting, taking notes and voice recording were done to avoid missing and misinterpretation of data. Field notes were written down in every evening after field work and document review.

3.7 Study Period

The whole study period was for 10 months from July, 2016 –April, 2017. The researcher started entering into the field for participant observations since July, 2016. After getting approval from IRB of Mahidol University, the researcher started key informant interviews with 2 local women,1 social worker and 2 healthcare providers in August ,2016. After building trust and getting general information about WLHA, the researcher started in-depth interviews with 15 WLHA in September and October, 2016. At the same time, the researcher did constant review of data and decided whether it reached the research question or not. The researcher wrapped up of constructed data and confirmed which parts were incomplete and filled the incomplete parts with subsequent interviews in first week of November. From mid-November, the researcher organized for key informant interviews with 2 husbands/partners of WLHA. Then, the researcher came back to Mahidol University in 1st week of December, 2016. Interpretation and report writing were carried out under the supervision of main advisor and co-advisor during December, 2016 to March, 2017. At the end of March, 2017, the researcher submitted draft report and revised in first week of April and then did thesis defense in April, 2017.

3.8 Data processing and analysis

Data processing and data analysis was done along with the data collection. Every evening after participant observations and interviews, the information was jotted down as field note. It included detail information about observation finding, subjective feeling, interpretation and findings from informal conversation and interview.

When interviews were completed, the interviews were typed and translated into transcript in Microsoft Word files. The data from transcript and field notes were read again and again to get sense of the data and to achieve intimate knowledge of data which was helpful in ongoing data construction and analysis. Then, memos were written down as short phrases, meaningful segments about ideas, or key concepts in the margins of field notes and transcripts.

After writing down meaningful short segments in each transcript or data document, the researcher made a list of all topics. Then, the list of all topics was typed

as one column per data document and placed all columns in same sheet of Microsoft Excel file. Then, the similar topics were highlighted in same colors. Then, the researcher chose the suitable names for each cluster of similar topics. They became the primary themes or titles of each finding. Then, the researcher tallied the number of informants gave that information. After that, the researcher put great attention in looking at the commonalities and differences of the actual contents. Then, the data was analyzed by using research question and research objectives by using theoretical concepts of critical medical anthropology theory, stigma, gender and notions of motherhood concepts.

3.9 Trust worthiness of data

3.9.1 Reflexivity

Reflexivity requires introspection in the moment, which needs to increase mindfulness, change and improvement. It includes continuous questioning and acknowledging multiple answers (Pillow, 2003). The study was a qualitative research which aimed to understand the childbearing decision among WLHA by collecting and reviewing subjective information and participant observations. Thus, the researcher tried herself to be aware of possible bias in order to accurately and correctly interpret the information.

Throughout the study, the researcher informed and requested opinions/guidance from the thesis supervisor committee to see any possible risk of bias in informants' selection and interpretation of data. Besides, the researcher considered every response and every information found out from the study as worthy and evaluated equally. She did not skew her feelings, experiences and knowledge in interpretation of the study. In order to reduce misinformation, she wrote field notes every evening after field work. She kept all voice recording, interview data and field notes. She described limitations in the study.

Since some topics under childbearing decision of WLHA were controversial, the informants were more likely to answer more likable answers. Thus, to get truthful answers on controversial issue, the researcher used indirect questions

particularly when asking healthcare providers and social worker. To reduce respondents' acquiescence bias, the researcher used open-ended question. In this way, the researcher revealed emotional responses, attitudes toward the controversial topic and got meaningful data from the informants. Moreover, the researcher maintained in neutral stance without implying the answer was right or wrong. She tried not to judge the responses. The researcher also kept her facial expression and behaviors not to express her personal feelings on the topic.

3.9.2 Inter-subjectivity

Inter-subjectivity means thinking and feeling like informants do and avoiding power relation that a research might give toward informants. In order to understand the respondents with their perspective in their context, researcher accepted their behaviors, ideas, and concepts and attempted to understand them by their own gaze. Thus, the researcher put herself in their situation to avoid an adjustment of own subjectivity to understand them. Every information and experiences shared by informants were accepted as very valuable, both positive and negative. In this way, the researcher overcome her own subjectivity about she had already known some things, rather than expressing the regards and encouraging them to tell what they wanted to say.

3.9.3 Researcher's Identity

The researcher showed her identity as a student from Mahidol University.

3.9.4 Trust Building

Participating in interview was quite a strange and unfamiliar for Burmese people who were reluctant to talk formally and involve in formal procedure. It was particularly difficult for the sensitive and controversial topic of childbearing of WLHA. Besides, the topic related with of gender-power imbalance, sexuality issue and stigmatized issue of living with HIV. Thus, building trust between researcher and informants was very important not only for the smooth operation of study but also for the reliability of quality data. The researcher spent significant amount of time in

informing researcher identity, friendship establishment by expressing sincerity, friendliness, non-judgmental attitudes and reliability throughout the study period.

During volunteering with “Phoenix Association”, the researcher got in touch with many WLHA and their family members. During the first few weeks, the researcher explained that she was the student from Mahidol University and she explained about the purpose of study and implication of study. When they used to familiar with the researcher’s background and personal information, the researcher started chit-chat with them and tried to get information related with study. The researcher accompanied with care giver group of WLHA to Waibargi HIV specialist hospital ,North Okkalapa General hospital and HIV specialist clinics opened by NGOs. In those days, the researcher used to talk informally with doctors, nurses, counselors, and outreach workers in healthcare facilities. And the researcher used to learn their attitudes and behaviors towards HIV positive people and their thoughts on the reproduction of WLHA. The researcher mostly spent her time in office of “Phoenix Association” by helping recording and provision of educational supplies to children from HIV affected families. Since the data collection period coincided with school opening season, many WLHA came to Phoenix with their children to draw educational supplies. Thus, the researcher got a chance to talk with them. In weekends, there was vocational tailoring training for WLHA, thus, the researcher got more in-touch with WLHA. The researcher used to chit-chat with them, had lunch and dessert with them during break time.

Throughout the study, the researcher cared on dress and non-discriminative manner. The researcher did not use private car during field works to avoid class differences. The researcher remained herself to avoid power relationship as being a medical doctor and a person from middle social class. However, the identity of being a medical person who had worked in HIV clinic of NGO was a barrier for some informants at first. They were reluctant to share about stigmatization experiences from healthcare providers particularly from medical doctors at first. The researcher tried to overcome this problem by repeatedly explaining about her current interest of study and requested to share the real situation which was neither right nor wrong. They were asked to share the insight decisions without judgment. If they were reluctant to share in first interview, the researcher moved to relatively insensitive topics and asked

them back in subsequent interviews. From time to time, they seem to feel free and share without any reluctance.

3.9.5 Data and Methodological Triangulation

Triangulation was a method used by qualitative researchers to check and establish validity in the study by analyzing a research question from multiple perspectives (Guion, L. A. ,2002; Hardon et al (Eds.),2001) . In order to increase confidence in research data and accurately reflect the situation, data triangulation and methodological triangulation were used in this study.

Data triangulation involved using different source of information to increase the validity of the study (Guion, L. A. ,2002). In this study, different sources such as researcher herself, in-depth interviews with WLHA, key informant interviews with WLHA's husbands/partners, social worker, healthcare providers and local women, and document reviews were used to gain insight into the social contexts related with childbearing decision of WLHA.

Methodological triangulation was done by using multiple qualitative study methods such as in-depth interviews, key informants interviews, informal conversation and participant observation. They were used to compare and draw similar conclusions.

3.10 Ethical Considerations

The study has been approved by institutional review board (IRB) of Mahidol University. Since the ethical practices were important in social science research, the researcher ensured not to break down the physical, mental and social well-being of informants. She strictly followed the ethical principles of the IRB, Mahidol University.

3.10.1 Informed Consent

The researcher informed them that she was a student from Mahidol University and requested for the needs of their voluntary participation in the study. They were asked about their willingness to involve in this study. If they showed their

willingness, they were explained about purpose of study, study methods, use of data, potential benefits and protection of confidentiality. They were given and explained translated participant information sheet where detailed written information purpose of study, study methods, use of data and ethic related with study. The researcher also gave her contact telephone numbers and address of Institutional Review Board of Mahidol University. As the informants were aware of the researcher identity as a medical doctor in participant information sheet, the researcher tried to overcome power imbalance by explaining about the rights to involve and withdrawal any time and requested their willingness to participate in the study.

After that, they were given time for consideration before making decision to participate in the study. In this way, they were allowed to exercise autonomy and rights in voluntary participation and/or withdraw at any time, rather than coercing or deceiving into the study, rather than coercing or deceiving into the study. After ensuring the willingness to involve in study, the informants were taken both verbal and written informed consents. They were also informed before tape recording, note taking and field visits. In order to get reliable quality data, the researcher informed them about the confidentiality of the data and name. Then, they were requested to share the real and the insight decisions without any judgment.

Since living with HIV was a sensitive issue, the researcher continuously took conscious on confidentiality to avoid further stigmatization from study. The researcher asked the informants before visits their places. The researcher used to ask if they allowed visiting researcher to their places or not. The researchers did not visit their places if they had concerns about confidentiality. Thus, the researcher visited to places (home) of only 3 WLHA. During visit, the researcher accompanied with them to their places as their friend. The researcher took great care about dress and manner to be matched as their friend.

3.10.2 Privacy

Both living with HIV and childbearing decision issues were sensitive, researcher ensured not to breaking the privacy of informants to other persons. The researcher informed informants before every field visit and interview. If they did not allow visiting their places, the researcher did not try to go there. The locations for

interviews were chosen upon the privacy and safety of informants and researcher. Nobody was allowed to involve in the interview process apart from researcher and individual informant.

3.10.3 Confidentiality

Confidentiality means to the protection of the anonymity of research subjects during research and public dissemination of research results. It is important to develop precautions to protect and prevent harm for informants. In order to protect identities, the researcher used operating pseudonyms in taking informed consent form and these forms were kept in a safety box hidden in the researcher private room. The hardcopies of the records and voice recording were destroyed after transcription. She avoided using cameras or video recorders in study sites. She used voice recording only after taking informed consent from the informants. She strictly followed the ethical guidelines. During transcription of quoted information, direct words of informants and detailed life stories were used in delicate fashion. During publication, the researcher protected individual anonymity and anonymity of others involved in the research. In order to avoid harm or risk and further stigmatization, the researcher maintained the role as objective observer and she studied the social contexts through non-intervention and non-interference. The researcher ensured that the findings were not use for business and people at risk.

3.10.4 Benefits to participants

The study was done to understand the existing social contexts influencing childbearing decision of WLHA. Thus, the findings enhance the understanding of WLHA and the social contexts where WLHA made childbearing decision. It provides valuable facts, inputs and recommendations to the healthcare providers, program managers, and policy makers in provision of health and social support services and interventions. In this way, this study would benefit to WLHA in terms of getting rights-based, women-centered, culturally appropriate healthcare services particularly in integration of SRH and HIV services.

For the immediate benefits, they were provided with small gifts and small amount of money as a token to compensate their time sharing. The researcher donated

some clothes and blankets for poor WLHA. As the study was done in rainy and school opening season, the researcher donated some stationaries, umbrellas and rain-coats for the children of WLHA. After finishing interviews, they were allowed to discuss with their SRH and HIV issues. Many of them were satisfied for getting open discussion and knowledge.

3.10.5 Other ethical consideration for respondents

During data collection, the researcher avoided discriminated words and manners. The dignity and rights of respondents were respected throughout the study. The unforeseen things that could harm due to study were also be considered and protected by the researcher.

CHAPTER IV
RESEARCH FINDINGS

In order to understand about complexity of the childbearing decision among WLHA in Yangon, Myanmar, the chapter describes the main study findings with detailed illustrative quotes. It starts with general social context of Yangon city, healthcare services related with SRH and HIV/AIDS in Yangon and socio- demographic characteristics of participants. Then, the findings about local beliefs related with HIV/AIDS, local beliefs related with childbearing of WLHA, social stigma towards WLHA and childbearing of WLHA are discussed. After that, gender norms related with childbearing, gender-power relationships with husband/partners as well as power relationship with healthcare providers were discussed. Later, relationships with peer WLHA , notions of motherhood and individual social contexts were discussed. Finally, reproductive behaviors of WLHA, their childbearing decisions and the local practices related with childbearing of WLHA are elaborated.

4.1 General social context of Yangon city

Yangon is the commercial capital and the main domestic and international hub for air, rail and ground transportation of Myanmar. Yangon Region covers a span of 10,171 km^2 administratively divided into 4 districts with 45 townships. Despite being Myanmar's smallest state by land mass, it is by far the most densely populated with the estimated population of 6 million and population density of 586 people per square kilometer. 67% of Yangon Region's population lives in urban areas, and the remaining 33% in rural areas; Yangon is the Region with the greatest percentage of people living in urban areas. Most of the Yangon residents are immigrants, who come for educational or economic opportunities from different states/regions. The majority of the population is Burmese but several mixed Indian-Burmese, Chinese-Burmese, and other ethnic minorities such as Kayin, Rakhine and Mon also exist in Yangon. The principal

language is Burmese. Yangon is also the city prominent of culture and religion. The main religion is Buddhism and over 95% of population is Buddhist. One of the world's famous historical pagodas, Shwedagon, is also located in Yangon. People usually go to pagodas, temples, monasteries and meditation centers to get advices from monks. Religion has a big influence on everyday life of people in Yangon.

Myanmar is basically a patriarchal society, with no exception of Yangon. Women have lower social status than their male counterparts in religious and family lives. Women are not allowed to some religious places and they are not able to become a monk, which is believed to be a noble status of human being in Myanmar. Women are able to hope to have a son who can become a monk and share merit to his parents. Besides, people expect to get merits and good deeds (A-Hmya) from their own children after their deaths. Hence, childbearing is important in religious aspect of Myanmar. Similarly in family life, men are believed to possess supernatural power, called "Hpone" and women have to pay respect to them. Men are accepted as "Eain-Oo-Nat" which means god of the family, household leader and decision-maker for the family. Women are not allowed to negotiate sex since gender norms train them as obedient and passive (UNADIS, 2014c). Theravada Buddhism, the main religion in Myanmar, teaches that abortion is prohibited as an act of killing one's life (Hyde & Shibley, 1979).

Although there is no gender discrimination law to access education, males generally get higher literacy levels than females in all places of Myanmar. In labor market, women participation is significantly lower than men. (About 50% of women participation in labor marker compared to 85% of men involvement). Likewise, women are under presented in political participation and public decision making with only 4.6% of women in parliament (Asian-Pacific resources and research center for women, 2016.

Moreover, various laws in Myanmar restrict women's marriage, divorce, and property rights in divorce. According to Myanmar's customary laws, polygamy is allowed for men while restricted for women (UNAIDS, 2014d). Women do not get equal divorce rights compared to the male counterparts. If both husband and wife want a divorce, it is possible for any reason. In contrast, if a man wants to divorce his wife, he can claim a divorce if she leaves him for 1 year with no maintenance from him. For a woman, she has to wait for 3 years to claim a divorce from her side. Again, these laws differ according to religious norms and practices. For example, Hindu women are not

allowed to divorce their husband, while Muslim women are governed by separate legislation and customary law (Asian-Pacific resources and research center for women, 2016). Besides, abortion is illegal. Both the perpetrator (women) and health practitioners can be fined and imprisonment from 3-10 years (UNAIDS 2014c and Asian-Pacific resources and research center for women, 2016).

Although traditional norms are still important in Yangon society, globalization also has significant impacts on the lifestyles of citizens. There are considerable increase in bars, night clubs, karaoke rooms and brothel houses in recent decades. At the same time, changes in sexuality such as living together, pre-marital sex and hidden marriages are common. Likewise, previously unpopular jobs like secret wives and sponsored girls, who take financial support from foreigners or local rich old men, increase in Yangon.

Figure 4.1 Infrastructures in downtown Yangon

Furthermore, Yangon is the place mixed with people from different socio-economic classes. There are huge disparities of socio-economic classes among Yangon citizens. Few local elites and wealthy communities hold large fraction of businesses, while majority of citizens struggle hard to survive in Yangon. Yangon's land and property market is the most expensive in Myanmar, which makes the majority of citizen

unable to possess a small apartment. They have to spend large fraction of their monthly income on room renting, while a few wealthy are several landlords. According to Myanmar Times news report in 2016, there are estimated 2 million squatters in Yangon.

Figure 4.2 Houses in slum area of Yangon

It is also the same in education sector. Although Yangon has several educational facilities, the accessibility and achievement between rich and poor is significant. Little support from government with high education fees force many poor students to drop out while the wealthy studies in international schools, and then move abroad for university education. Since the university education fees are high for poor, graduation from applied technological universities is challenging for them. There is no discrimination for the education of women but women from poor social classes are hard to achieve educational attainment. Most of the white-collar staff positions and well-paid jobs are usually filled with people who graduated from foreign universities and professional universities of Myanmar, who are already from fair and high socio-economic classes. Most of the poor work as blue-collar staffs and work in low-paid jobs, thus, they are difficult to escape from the poverty cycle.

Additionally, poor city plan and public transportation bring more challenges to the lives of people in Yangon. Improper transportation system and poor roads are not enough for booming number of population. It results in huge traffic jam and people who commute daily from outside the city and downtown spend many hours on the road. They usually arrive home late in the evening. Sexual harassments on public transportation (buses) are also common. Poor road safety procedure and poor public transportation system also lead to increase in road traffic accidents day by day. Besides, the cost for daily transportation is not cheap for a low-paid worker. For a basic staff, almost one third of the monthly income has to be spent on daily transportation. The high living expenses, poor education and poor job opportunity result in increased crime rates.

Figure 4.3 Women working as daily worker in garment industry

In recent years, there are significant rise in number of assaults and crimes. Yangon has the highest crime rates in Myanmar. Drug smuggling, sexual harassment, rape, theft, robberies and murders are found to happen every day. The lives of people in Yangon are struggling hard for daily survival. It is particularly difficult for the lives of women from poor socio-economic backgrounds.

All in all, Yangon is the most urbanized city with best infrastructures in Myanmar. However, the accessibility to services and structures between rich and poor is significant, which in turn, increases the imbalance of wealth and power. Through such institutional arrangements, women are marginalized from centers of power and more dependable over men. All these conditions made more difficult for the lives of women especially from poor socio-economic status. The safety and security of women particularly poor women are threatened and it is difficult to stand alone for a woman from poor socio-economic background. One of the common goals in all social classes of women in Yangon is to get married for the socially and economically secured lives. Since the transportation and working environment are not favorable for a woman, many women in Yangon tend to work in familiar contexts and they do not seek opportunity for further development. It makes them more powerless and dependent in their families.

Figure 4.4 Daily lives of people in Yangon

4.2 Healthcare services related with SRH and HIV/AIDS in Yangon, Myanmar

In comparison with other places of Myanmar, Yangon has the best healthcare facilities in Myanmar. Sexual and reproductive health (SRH) are provided by

a mix of Ministry of Health & Sports (MOHS), international and national non-government organizations (NGO), private providers and community based organizations (CBO) in Myanmar. MOHS provides free-of-charge SRH services in Maternal and child health unit (MCH), urban health centers (UHC), sexually transmitted infection (STI) campaigns, secondary and tertiary hospitals. Besides, there are 4 main UN agencies and 7 leading international NGO which work for SRH services. The leading NGO which provide SRH services in Yangon are Marie Stopes International (MSI), Population Service International (PSI), Medecins Sans Frontieres (MSF), Medecins Du Monde (MDM), Malteser International, Burnet Institute and Alliance Myanmar. These organizations provide free-of-charge SRH services such as family planning, STI treatment, voluntary counseling and testing (VCT), HIV prevention and treatment services (Asian-Pacific Resource and Research Centre for Women, 2016).

In general, there is no functioning health insurance system in Myanmar although government has allowed private insurance firms to operate health insurance since 2014. Although healthcare services are literally provided in free-of-charge at government health facilities, patients have to do cost-sharing in some medical procedures and medicines, which results in high out-of-pocket expenditure. Besides, people sometimes face to long queue in taking services. Thus, affordable people tend to look for health services in private sector, where registered general practitioners charge for services. For poor and most marginalized people, they tend to avoid healthcare services until the condition is severe. They first try self-medication and then seek “quack” or unqualified medical providers, who provide services with cheaper price.

For SRH services, there are limited choices in family planning services for women. Injectable contraceptive is the most common method among Myanmar women. Gender norms also limit access of family planning services among young and unmarried women. In some government health facilities, supply chain management for contraceptives is reportedly poor. Drugs and supplies often stock out and many expired supplies left (Asian-Pacific Resource and Research Centre for Women, 2016). In NGO, PLHA generally do not get a chance to discuss about their SRH matters because of high patient volume. Thus, contraceptive prevalence was only 48.7% and unmet contraceptive need for married women was 19.6% in 2015. It was about 1.53 million

married women do not get access to modern contraception in 2015(Asian-Pacific resources and research center for women, 2016).

Most women have limited knowledge about contraceptive choices and sex education. They usually learn from their peers and elder women in their surroundings. There are also myths and stigma around using contraception and taking SRH services. Husbands often do not allow their wives to use contraceptive and do not allow taking SRH services. However, the contraceptive pills and injectable contraceptive are relatively easy to access at public or private clinic and local markets. Thus, many women use family planning improperly and secretly. In the condition of difficult to access contraception, some women try to solve unwanted pregnancy with abortion although abortion is legally prohibited in Myanmar. In case of finding abortion, both woman and health practitioners are fined and imprisonment for 3-10 years. Hence, there is no safe abortion services in both NGO and government health facilities. They provide post-abortion care to prevent complications and deaths only. Women generally access abortion from traditional birth attendants and there is still high mortality rate related with abortion in Myanmar. Besides, condom use between intimate partners is very low, estimated at only 0.4% in 2015. Condoms are widely accepted as a symbol of "lack of trust" and "bad". Thus, many women described that negotiation of condom use in intimate partner relationship is very difficult and rarely succeed (UNAIDS,2014c). At the same time, sterilization is not easily accessible. To get permission for sterilization, woman has to complete 3-4 steps of approval. Even after getting permission, the procedure is unaffordable for poor women. It usually costs about 250 USD (Asian-Pacific Resource and Research Centre for Women, 2016).

For HIV/AIDS response, there has been significant increase in HIV prevention and control activities in recent years. However, not all PLHA get access to ART. In 2015, approximately half of PLHA do not get access to ART. Access to ART in government health facilities is limited by residency requirement, which is the evidence of house registration. Likewise, certain NGO has its specific target population group to provide services. For example, MDM limits ART treatment for its targeted population of sex worker, MSM, IVU and their partners. Although MSF provides ART for all population, it limits with requirement to stay in Yangon in first few months of starting ART. Some NGO and CBO try to fill this requirement of Yangon residency by

allowing PLHA to stay in temporary shelters but there are still many PLHA who are not able to stay there. Besides, the practices of visiting patients' homes for assessment of patients' condition and regularity of taking ART by of NGO make difficult to some PLHA who want to hide their HIV status. Thus, some affordable people with high perceived stigma try to take services from private clinics.

Furthermore, there are extremely limited skilled healthcare providers in HIV/AIDS related services. Even in NGO, there is no parallel increase in number of competent healthcare providers with the rise in number of PLHA. Some healthcare providers in MOHS have limited knowledge on HIV and they often misadvise patients. Poor confidentiality, one-way communication and stigmatization toward PLHA are more common in government health facilities than HIV specialist clinics opened by NGO. HIV positive pregnant women often reportedly face coerced sterilization, whereby doctors preform sterilization at the time of delivery often without taking consent from the women. Besides, PLHA are reportedly forced to pay double charges in medical and surgical procedures at government hospitals due to HIV positive status. These conditions lead to low quality of care for PLHA (UNAIDS, 2014c).

In addition, most of the HIV prevention and control activities focus on key population groups of sex worker, men who sex with men and intravenous drug users Among the general population, voluntary counseling and testing (VCT) is still low at only 9% in 2015 (NAP, MOH, 2015). Most of the women get HIV diagnosis at the time of ante-natal care (ANC), although not all pregnant women tested for VCT. In 2015, about 65% of pregnant women who came to ANC tested for VCT, although ANC coverage was not universal. However, HIV prevalence among pregnant women was (0.7%) which was higher than the HIV prevalence in general adult population (0.54%) (NAP, MOH, 2015). It convinces that childbearing has been happening at a considerable rate among WLHA in Myanmar. Even after getting HIV diagnosis, there are significant numbers of loss of follow-up before and after delivery, and not complete PMCT services. In 2015, only 79% of HIV positive pregnant women received WHO recommended regimen for PMCT (NAP, 2015).

Although the national guideline on PMCT focuses on voluntary contraception and natural vaginal delivery with exclusive breast feeding, there are still inadequate sexual and reproductive counseling for PLHA. PLHA are just informed to

use condom consistently and not to take pregnancy, rather than taking in account of their sexual and reproductive needs. Due to crowded clinic with limited number of healthcare providers, PLHA have little chance to discuss about their sexual and reproductive matters with healthcare providers. Sometimes, PLHA try to avoid discuss because of perceived stigma. As a result, poor condom use and improper contraceptive use are still common among PLHA and there is a risk of getting unintended pregnancy.

ART or ARV prophylaxis has been provided to all WLHA who entered into PMCT program in Myanmar. They are advised to deliver at hospital or nearby government health facilities to take ARV prophylaxis for the newborns. Some NGO provide financial support for daily allowances, transportation allowances and medical supply fees to HIV positive pregnant women. Some Peer Support Networks provide social support for hospital delivery of WLHA by helping as hospital attendance and giving information about services available from NGO. However, most of the social support and services from MOHS and NGO still depend on external sources of funding from UN agencies and donors. There is still problem in sustainability of services for PLHA. For example, NGO "A" support financial allowance for hospitalization this year but no guarantee for provision of support in next year. Besides, Ministry of Health & Sports has been trying to provide ART services in its health facilities and NGO supported HIV specialist clinics are trying to transfer their beneficiaries to MOHS. In the condition of poor health system with poor health workforce quality and competency, many PLHA are concerning about their future ART and quality of services. Therefore, there are still many gaps and barriers in provision of SRH and HIV/AIDS related health services for WLHA in Yangon, Myanmar.

Figure 4.5 Temporary shelters for people with HIV/AIDS in outskirts of Yangon (Photo:Gemunu Amarasinghe)

4.3 Socio-demographic characteristics of participants (WLHA)

The study participants consisted of 15 women living with HIV/AIDS (WLHA) aged 20-39 years who had known their HIV status. The brief descriptions about study participants for in-depth interview were as follow:

1. Ma Su Su, 38 years old woman, who came from a broken family and she grew up with her relatives. When she was 14 years old, she was kidnapped and sexually assaulted for about 2 weeks. Then, she got married with her 1st husband and he was HIV negative so far. He was kind to her. They had married for 20 years. She sold local foods in front of her house. Her husband was a carpenter. They had regular income and they owned a small wooden house in slum area of Yangon. She noticed her HIV status during her 2nd pregnancy about 12 years ago. Unluckily, her 2nd pregnancy aborted. She took 3rd pregnancy (2nd child) about 2 years ago after discussing with her husband and healthcare providers. Her 2 children are HIV negative. Her strong belief was family was important for the safety of woman.

2. Ma Yadanar, 37 years old woman, who got HIV diagnosis about 12 years after her 1st husband's death. She had been taking ART since that time. About 4 years later, she got married to 2nd husband, who was HIV negative. She was a straight-forward woman with certain confidence. She was the eldest daughter in her family and she had influential power over her family and her husband. They took 1 child about 1.5 years ago and the child was also HIV negative. She worked in a NGO as a volunteer and her husband was a basic staff in a local company. They lived together with her family happily.

3. Ma Wutthmone, 35 years old woman, who had been taking ART for 6 years. She got HIV from her 1st marriage and passed life with difficulty with 2 existing children. Then, she got married to her 2nd husband, who is HIV negative so far. She first hid her HIV status before marriage but they had sexual contacts. When he proposed her to marry, she disclosed her HIV status. He accepted the condition without any stigmatization. She was a basic staff from a NGO and her husband was a contractor in a small construction company. Their economic status was fair. She was a beautiful and tactic woman, who always considered for the prosperity of her children. She had 2 children with 1st husband and 1 child with 2nd husband. All of the children were HIV negative.

4. Ma Thuzar was a 36 years old woman, who was a former sex worker. She quitted her job since she married to her regular customer, who was a high-way bus driver. She got HIV from her work. She got HIV diagnosis 4 years ago and she started taking ART about 3 years ago. She disclosed her husband before marriage. Her husband was HIV negative although they had never used condom. They had 1 child, who was also HIV negative.

5. Ma Aye, 37 years old woman, got HIV from her 1st husband. She got HIV diagnosis about 14 years ago and she had been taking ART for 9 years. She was in 2nd line ART at the moment. About 3 years ago, she got married to her brother-in-law. He looked love and cared her. He was HIV negative. She worked in a NGO as a volunteer and her husband was a daily worker at construction site. They lived in a hired small house in slum area and they looked very poor. Her physical appearance looked weak and slim. She had 2 children, 1 with 1st husband and another 1 with 2nd husband.

She got 2nd pregnancy unintentionally during taking oral contraceptive pills. All children were HIV negative.

6. Ma Yin Yin, 36 years old woman, got HIV diagnosis about 16 years ago. She had been taking ART for 13 years and she was in 2nd line ART treatment currently. She acquired HIV from her 1st husband but she did not recognize until her illness was severe. When she got HIV diagnosis, she was severely stigmatized by her mother. She was separated with her own children (from 1st marriage) by her mother. Then, they were sold for domestic labor. Thus, she suffered depression and committed suicides. She quitted ART by herself. About 4 years ago, she met with her 2nd husband and she found love and serenity in mind. But the experiences of stigmatization still frightened her. So, she did not disclose her HIV status to her husband until now. They took 1 child last year and the child was also HIV negative. Although she looked poor in physical appearance, she seemed to be contented.

7. Ma Cho, 37 years old woman, whose 1st child from 1st marriage was HIV positive. She got HIV diagnosis during hospitalization of that child about 11 years ago. Both of them were taking ART. Her 1st child was now in 6th standard of basic education. As she spent all of her properties for the medical expense of 1st husband, she became homeless with debts after he passed away. She passed homeless life for 2 years until she met with her 2nd partner. Currently, she was living together with her sexual partner. He was 58 years old man who owned a small retail shop. He was separated from his previous wife but not legally divorced. Thus, she had concerns of return to homeless life again. She took a child with that sexual partner and the child was HIV negative.

8. Ma Nu was 34 years old graduated woman. She lived together with an old man for getting financial support during her university days. Then, she got married to her current husband, who was in same religion with her, Islamic. She was not aware her HIV status until the time of ANC. When she got HIV diagnosis, her husband was also tested for HIV. He was found to be HIV negative. Then, she had to admit her pre-marital sexual affairs. Since that time, she received severe stigmatization from him. She was a staff from a NGO and her husband was a staff from a local company. They had no financial problem but she looked unhappy.

9. Ma Nweni was 32 years old, former sex worker, who quitted her job since married. Her husband was a daily laborer at jetty and she was dependent. She did not disclose her HIV status to her husband. She got unintended pregnancy during taking oral contraceptive pills. Luckily, the child was HIV negative. She looked very poor, clumsy and careless person.

10. Ma Aye Khaing was a 35 years old, former sex worker. She had been taking ART for 8 years. She was on 2nd line ART and she looked weak. She got unintended pregnancy during taking injection Depo-provera irregularly. The child was HIV positive. She was dependent and her husband was a carpenter. They were very poor with unstable income. Although they never used condom, her husband was still HIV negative.

11. Ma Than Soe was a 34 year old woman, who got HIV from her 1st husband. She had 2 children with 1st husband and 1 child with 2nd husband. She had known her HIV diagnosis and she had been taking ART for 16 years. She disclosed her HIV status to her husband only after getting pregnancy with him. They did not use condom even after disclosure of HIV status. Her husband was generally kind to her but he sometimes cursed her for being HIV positive especially when he was drunk. She depended on her husband's income and he was a trishaw driver. They struggled hard to live with 3 children, who were HIV negative.

12. Ma Myint was a 20 years old woman, who got HIV diagnosis at the time of hospitalization for post-partum hemorrhage. She got HIV from her husband and her child was also HIV positive. He was a taxi driver and she was dependent. She looked helpless and stressful for knowing all the family members were HIV positive.

13. Ma Mya was 27 years old woman, who worked as a sponsored wife for an old man when she was a teenager. Then, she got married. She did not suspect for getting HIV infection from her pre-marital sex. She got HIV diagnosis during blood donation. She still kept her HIV status as a secret from her husband with the concern of being stigmatized. Her husband was a staff from local company and he used to travel frequently. She got unintended pregnancy during taking injection Depo irregularly. Fortunately, the child was HIV negative. Her general appearance was a nice woman from middle socio-economic class with polite manner.

14. Ma Zin Zin, was 36 years old woman, who got HIV from her 1st husband. She was working as a staff in a peer support group. She got married to her 2nd husband, who was also a staff from the same peer support group. He was also HIV positive. Both of them had been taking ART for over 7 years. After preparing the financial requirements, they discussed with healthcare providers about their childbearing desire and took pregnancy. Their child was HIV negative. They looked happy with mutual trust and respect.

15. Ma Myo Myo was a 38 years old active sex worker. She was forced into prostitution by her 2nd husband about 20 years ago. She was living together with her 6th partners. She had been taking ART for over 16 years but she did not disclose her HIV status to her partner. She did not use any contraceptive or condom. She had 5 children and the 3rd son was HIV positive. Her eldest son worked as a guard and 2nd child worked in teashop as a child laborer. They supported their siblings. She was frequently caught by police and off and on to jail. Her appearance looked messy with foul-smelling and dirty.

To sum up, the age of the informants were between 20-38 years, with a mean age of 34.13. All of them had been living in Yangon Region for over 3 years duration. 13 WLHA were Burmese and the 2 WLHA were Rakhine and mixed Kayin-Chinese ethnicity. 13 out of 15 WLHA were Buddhism and the rest 1 WLHA was Christian and another 1 WLHA was an Islamic in religion. 12 WLHA came from poor socio-economic status while 3 WLHA lived in fair socio-economic situation. 11 out of 15 WLHA had lower than secondary education, while 2 were at secondary education level and the other 2 were graduated. For occupation, only 4 out of 15 women had stable income, while others depended on their husband. 14 WLHA lived in nuclear family except 1 WLHA who lived in extended family with her parents.

All of them reported that they were being infected with HIV through unprotected sexual intercourse. 8 women got HIV infection-from their first marriages, 2 got from pre-marital sex, 1 got HIV from her current husband and 4 women received HIV during sex work. To date, 6 WLHA were in 2nd time marriage while 7 WLHA were in 1st time marriage and 2 were living together with their stable partners. 9 WLHA were in relationships with HIV negative partners while 4 WLHA did not know the HIV status of their partners and only 2 WLHA were in relationships with HIV positive partners.

12 WLHA got HIV diagnosis before getting pregnancy, while 2 got at the time of ANC and 1 got after delivery. 11 WLHA had used modern contraceptives to avoid pregnancy. 6 of them had used injection Depo-provera (3month) and other 3 WLHA had used injection Depo-provera (1month), while 3 WLHA had taken combined oral conceptive pills (COC) and 1 WLHA had used male and female condom inconsistently. 6 WLHA stopped contraception to get planned pregnancies while the other 5 WLHA got unintended pregnancies due to improper use of contraceptives. 1 WLHA got unintended pregnancy without taking any contraception.

For the discussion with healthcare providers, 10 WLHA informed after getting pregnancies, while only 4 WLHA had discussed in advance. Thus, 14 out of 15 WLHA took ART or ARV prophylaxis. 7 WLHA delivered LSCS at hospitals and 5 WLHA delivered vaginal delivery at hospitals, while the 3 WLHA delivered vaginal delivery at home with traditional birth attendants. 2 out of 15 children were born with HIV positive, while other children were free.

After delivery of recent pregnancy, 2 WLHA were forced to do sterilization and expressed sterilization regret, while other 6 WLHA voluntarily agreed to do sterilization. Among the rest of 7 WLHA, none of them had desire to take pregnancy in near future. 2 of them were using injection Depo-provera (3months) ,while 3 WLHA were using injection Depo-provera (1month) and 1 WLHA was using COC. The other 1 WLHA still did not use any modern contraception. When the researcher explored in-depth about the contraception methods, 4 WLHA were still using modern contraception improperly.

Table 4.1 : Socio-demographic characteristics of women living with HIV/AIDS

Pseudonym	SuSu	Yadanar	Wutthmone	Thuzar	Aye	Yin	Cho	Nu	NweNi	AyeKhaing	ThanSoe	Myint	Mya	ZinZin	MyoMyo
Age	38	37	35	36	37	36	37	34	32	35	34	20	27	36	38
Education (standard)	1	4	8	9	5	9	4	G	8	5	4	5	8	G	1
Occupation	E	E	E	D	E	U	E	E	D	D	D	D	E	E	SW
Marital status	M	M	M	M	M	M	LT	M	M	M	M	M	M	M	LT
Times of marriage	1st	2nd	2nd	1st	2nd	2nd	LT	1st	1st	1st	2nd	1st	1st	2nd	LT
Source of HIV	1st H	1st H	1st H	SW	1st H	1st H	1st H	BF	SW	SW	1st H	H	BF	1st H	SW
Partner's HIV status	NR	NR	NR	NR	NR	UK	NR	NR	UK	NR	NR	R	UK	R	UK
Existing children	+	-	+	-	+	+	+	-	-	-	+	-	-	-	+
No. of existing children	1	0	2	0	1	2	1	0	0	0	2	0	0	0	8
Duration of ART (years)	10	12	6	3	14	13	11	2	2	8	16	<1	5	7	16
Disclosure of HIV	H	P	H	H	P	N	H	H	N	H	H	H	N	P	N
HIV status of recent children	NR	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	R	NR	NR	NR
Prevention of future pregnancy	S	S	S	C	S	C	S	S	C	C	C	C	S	S	-

- Education: Graduated (G)
- Occupation: Active Sex worker (SW), Dependent (D) , Employee (E), Unstable job (U)
- Marital status: Married (M) , Living together (LT)
- Source of HIV: Husband (H), Sex Work (SW), Boyfriend (BF)
- Partner's HIV status: Non-reactive (NR), Reactive (R), Unknown (UK)
- Existing children: Present (+), Absent (-)
- Disclosure of HIV status: Husband (H), Family (F), Public (P), None (N)
- Prevention of future pregnancy: Sterilization (S), Contraception(C), Nothing (-)

4.4 Local beliefs related with HIV/AIDS

Local beliefs and practices related with HIV/AIDS were important social contexts which influenced the childbearing decision of WLHA.

4.4.1 HIV/AIDS as a deadly disease

In Myanmar society, HIV/AIDS was believed as a deadly disease and people living with HIV/AIDS (PLHA) were seen as people who were waiting for death. It was related with public health education messages, where HIV/AIDS was portrayed as "a deadly disease, with no curative medicine" and PLHA were portrayed as "people whose defense mechanism was weak to resist against infections and died soon". Many people in the society witnessed the severe condition and death of PLHA in their surroundings. Thus, HIV/AIDS was accepted as a deadly and scary disease in their beliefs.

The community leader, who involved in key informant interview shared as:

"HIV/AIDS is a deadly and scary disease. We learnt HIV health education every night from TV. It portrayed with skull bone and snake. And there was a saying "Human extinction would not be happened by land slide, but it would be by HIV/AIDS". And HIV/AIDS is so common todays. Many people

died with HIV/AIDS. About a few ago, a man from my neighbor died with HIV/AIDS"

4.4.2 HIV/AIDS as a contagious disease

Another social belief of HIV/AIDS was a contagious disease and PLHA were seen as diseased, which conveyed infections. People generally learnt health related beliefs and behaviors from public health messages and from healthcare personnel. Public health messages gave the messages of modes of transmission of HIV/AIDS as through the sex intercourse, through contact with blood and body fluids, through vertical transmission from pregnant mother to child. Besides, health messages give information about prevention of HIV/AIDS as consistent condom use in extra-marital affairs as well as prevention of contact with blood and body fluids of HIV infected persons. Moreover, people learnt the health practices from healthcare providers, who usually wore gloves, masks and protective clothing during handling HIV positive patients. Thus, people perceived PLHA as infectious and contagious bodies. Furthermore, the physical appearances of HIV positive people were more or less like to ill patients. People generally described PLHA as person who lost in weight as well as who had continuous cough and severe skin infections. This peculiar look made people with HIV/AIDS different from other people. Most of the people in the society were reluctant to communicate or stay close to HIV positive people because they were afraid of getting infections from them.

One local woman shared in key informant interview as:

"I am afraid of HIV/AIDS. It is transmitted through contact with blood and body fluids and semen and fluids from male and female genitals. It can transmit through razors and scissors from hair cutting. HIV positive people are still like normal person until disease is severe. But it is very rapid. If the disease is severe, AIDS look is typical. They lost in weight, diarrhea, and cough and then die soon"

4.4.3 HIV/AIDS as a disease of promiscuity

Furthermore, HIV/AIDS was accepted as a disease of promiscuity. The widespread public health messages gave information about prevention of HIV/AIDS as

abstinence of pre-marital and extra-marital sex, avoidance of multiple sexual partners, be loyal to husband/wife in a marriage and consistent use of condoms if unavoidable sex. Public health messages also portrayed people who got HIV/AIDS as sex workers, drug users and people with multiple sexual partners in social media, pamphlets, posters and billboards. Besides, condom promotion activities focused mainly on sex workers were frequently found in newspapers and journals. The negative stereotypes influenced the perception of people in society. Most of them perceived all PLHA involved in one of the stereotypes.

It was shared by one local woman in key informant interview as:

"We have learnt HIV information from TV and HIV pamphlets and posters. People who got HIV were mostly sex workers, people with multiple sexual partners and drug users. There might be a few people who got from blood transfusion and cuts from razors. But most are sex workers and bad people"

4.4.4 HIV/AIDS as a kind of punishment

The main religion in Myanmar was Buddhism. In Buddha perspective, pre-marital sex, extra-marital sex and drug misuse were sins. Thus, most people in the society believed that HIV/AIDS was a kind of punishment for the promiscuous and sinful behaviors. Unlike other diseases, people rarely sympathized on PLHA because HIV/AIDS was accepted as not only a disease but also a humiliating condition.

The community leader shared his thoughts on HIV positive people as:

"Everything has reasons in this world. They [HIV positive people] might have sins in their past lives but most commit sins in current lives. Drinking alcohol, having multiple sexual partners are sinful behaviors, thus, Buddha prohibited. If they do the things they shouldn't do, they will be punished. It is sure. So, they get humiliation and their family is also shameful"

4.5 Local beliefs related with childbearing of WLHA

4.5.1 Inappropriate task

Childbearing of WLHA was seen as inappropriate task in the society. Based on the belief of HIV/AIDS as a deadly disease, WLHA were accepted as persons who were not fit for childbearing. Childbearing was a long-term task, which did not finish only after delivery of children. It involved feeding, nurturing and education of children. Since WLHA were sick people and they spent their time on taking drugs and going to the clinics, they were not appropriate for childbearing. Besides, they were waiting for the time of death and they did not have certain future to look after their children. If they delivered children, their children would be either left as orphans or became bad children. Children from HIV affected families usually grew up with mental stigma and they became drug users or children who committed juvenile delinquency. There was a Burmese saying: "a person who does not have mother is like a fish in scare water" which illustrated the hard lives of children without mothers. Hence, there was a prevalent belief in society that childbearing was an inappropriate task for WLHA.

One social worker shared his thought on childbearing of HIV positive people as:

> "*I don't encourage childbearing of HIV positive people. They don't' know which day they die. And childbearing is a long-term task. How many of orphans have got good lives in our society? They need to think about how much they could do for the children before taking pregnancy. Todays, there are many contraceptives available. They can use free-of-charge. I don't encourage them to deliver children"*

4.5.2 Stupid decision

Society negatively judged WLHA when they tried to do childbearing. Based on the belief of HIV/AIDS as a contagious disease, childbearing was a stupid decision for WLHA. They were seen as cruel and uncaring women. The ideas came out from healthcare providers, parents and communities. The reason was unprotected sexual intercourse led to transmission of infection to uninfected partner It was immoral for doing someone infected with incurable disease. If both partners were HIV positive,

there was a risk of transmission of mutated, drug resistant strains of virus between partners. If their drug resistant virus spread, currently available ART would no longer be efficient and it was unethical too. Besides, childbearing of WLHA had the risk of perinatal transmission of HIV/AIDS. Although perinatal transmission was found to be low in developed countries, it was still high in Myanmar, where had limited facilities for safe conception and PMCT services. If an innocent child was born with HIV/AIDS, it was unfair for him/her. Therefore, childbearing of WLHA was accepted as a stupid decision.

One healthcare provider working in a NGO shared his concept on childbearing of WLHA as:

> *"We usually give them [WLHA] information about consistent condom use and family planning. Starting from post-test counseling session, we continuously give this information. There are so many negative consequences. In a sero-discordant couple, the partner is at risk of getting HIV. In a sero-concordant couple, both partners have risk of secondary transmission. Secondary transmission means transmission of different strains of virus , which may be drug mutated strain between partners. It is a big issue for drug resistance problem. The first line drugs are the most effective and less side-effects drugs. If drug resistant occurs, changing second line drugs have many disadvantages. If drug resistant persists, all PLHA have to die. It is very big problem. So, I dislike childbearing of HIV positive people"*

Another healthcare provider shared her thought on childbearing among WLHA as:

> *"I think childbearing of WLHA is not a good thing. Not only drug resistance problem but also many social problems exit behind childbearing of WLHA. If the child is infected, he/she has to take drugs for his/her life. It is very unfair and immoral behavior. Who will look after their children if they die? If we cannot take responsibility for the good future of the children, we should not do it"*

4.6 Social stigma towards WLHA and childbearing of WLHA

4.6.1 Experienced/Enacted stigma

All of the WLAH in this study had experience of discrimination from powerful figures such as healthcare provider, husband/partner and family members.

4.6.1.1 Stigmatization from healthcare providers

All of the WLHA shared they faced stigmatization from healthcare providers up to a certain extent.

4.6.1.1.1 Be accused as promiscuous and immoral women

2 WLHA in this study shared that they were stigmatized based on their dignity by some healthcare providers. It made women reluctant to take healthcare services.

For instance, Ma Yadanar, who got HIV infection from her 1st husband, was accused as promiscuous woman by one nurse. She shared as:

"Some people say discrimination of HIV positive people reduces today but I don't think so. Even nurses believe that HIV is related with morality. They behave like they know everything. They said like I laid them I got infection from my husband to hide my extra-marital affairs. They told me to be honest. I was not hiding the truth. I don't know what to do if they don't believe me. They even laughed at me when I said that I was telling the truth. It was in triage area during taking body measurement. When they said like this, I had no word to explain. If they didn't believe my dignity, I didn't want to explain"

Another example is Ma Thuzar, who was stigmatized for immoral behaviors of sex worker. She shared as:

"*In patient profile, they record our personal history. When they [nurses] know about I was sex worker, their facial expression changed suddenly. They talked to each other about I was sex worker. Then, they threw my book; acting like that they are reluctant to touch with me. When I asked some unclear information at counter, they shouted at me. They told me to concentrate on doctors' words, not always thinking about sex. I was*

ashamed to their words. I am sex worker, right. But I have my own life. There are so much discrimination between sex worker and other HIV positive women who dress nicely. Their behaviors made me sad. Sometimes, it is like a hell going to the clinic for follow-up visit"

4.6.1.1.2 Be controlled in sexual and reproductive matters

Many WLHA expressed that their lives were restricted by healthcare providers in sexual and reproductive matters. Once WLHA got HIV diagnosis, they were prohibited to marry and prohibited to take pregnancy. Starting from post-test counseling session to every follow-up visit, they were informed about consistent condom use and prevention of pregnancy. Besides, WLHA were continuously and seriously advised not to take pregnancy. Thus, many WLHA did not discuss their sexual and reproductive matters including childbearing desire with healthcare providers.

For instance, Ma Aye was informed not to marry again because of her HIV status. Thus, she was reluctant to inform when she found new partner. She shared as:

"They [healthcare providers] told me not to marry again because of my HIV status. When they asked if I found a boyfriend, I laid them "no". I also do not want to infect others....but when I found a suitable man; I want to lean on him. I was not able to obey their advices"

Similar experience was shared by Ma Than Soe, who hid her marriage to healthcare providers for not ready to disclose her husband about her HIV status. She shared as:

"They[doctors] advised me not to marry again and to use condom if I found new boyfriend. So, I did not inform them until I got pregnancy. If I informed them, they will definitely tell me to bring him for HIV testing. I was not ready to disclose my husband about my HIV status at that time. So, I hid doctors though I knew it was not good"

4.6.1.1.3 Forced to do sterilization

Not only WLHA were controlled in sexual and reproductive matter before getting pregnancy, but also they were controlled after getting

pregnancy. Although many WLHA tried to avoid discussion with healthcare providers about their childbearing desire or marriage, they opened to healthcare providers after getting pregnancy in order to receive PMCT services. At that time, many WLHA faced severe blame for doing stupid acts and some were forced to do sterilization. Before sterilization, many WLHA indicated that they did not receive counseling for sterilization. Thus, they were not allowed to choose long-term contraceptive methods suitable with their reproductive desire and some WLHA felt sterilization regret.

For example, Ma Yadanar was blamed by doctors for taking pregnancy being HIV positive. She was forced to do sterilization by all doctors from her HIV specialist clinic and government hospital. She felt sterilization regret for losing her fertility. She shared as:

> *"When I went to hospital, doctors blamed me "Don't you know your HIV status. Why do you take pregnancy? Don't you have any concern about transmission of HIV to your child"? I replied them in short as I took pregnancy because I wanted child. Their behaviors were so rude. Then, they said "you need to do sterilization". They did not ask and care about my feelings. When they saw the referral letter from clinic that described about HIV positive, they processed sterilization form by themselves. They did not ask anything about my desire. Honestly, I want to serve my fertility. One day if medicines are more advanced, I want to deliver one more child because I have only one child. But they did sterilization to me"*

4.6.1.2 Stigmatization at health facilities

4.6.1.2.1 Discrimination in placement and charges at health facility

Many WLHA had experience of discrimination at health facility. Discrimination included placement in separate areas, taking extra-charges in every medical and surgical procedure, prolonged waiting time for surgical procedures than HIV negative patients.

Ma Than Soe shared that she was placed in the worst area of hospital. She had to pay extra-charges than HIV negative people. Her HIV status was exposed to everybody in the same ward of hospital. She indicated as:

"Discrimination at government hospital is the worst. I was placed in dark and dirty area. It was not a room. It was the corner of the corridor. And it was close to toilets. So, it was moist and foul-smelling all the time. I come from poor class and I live in very bad slum area. But that hospital place was worse than I have ever lived. Though I was placed in bad area, I had to pay more than other people. I have to pay more in every procedure, even cleaner and trolley drawer took extra-charges from me. My HIV status was known by everybody in the ward. Because my place was the usual place for HIV positive people"

Similar experiences were shared by Ma Yadanar as:

"To hire a separate room at hospital, the requirement was already consulted with Obstetrician. For me, I was poor and I didn't consult with specialist in outside clinic. So, I was placed in dirtiest beds near the corner of the toilets. I had to pay extra-charges than HIV negative women. In the use of OT room [Operation Theater], HIV positive patients had to pay double charges because we were infectious. Although I paid more, I had to wait my turn until others finished. It took for the whole day. I was in starvation since last night and I was in catheter and urine pipe. I had to enter OT room when everybody finished because I was HIV positive"

4.6.1.2.2 Breaching confidentiality by healthcare providers

The most common experience faced by many WLHA was breaching confidentiality. In government hospitals, doctors tested HIV status of the patient without any informed consent. Once they were diagnosed, HIV positive results were publicly written down with red symbol of "R+" (which means "positive retroviral infection") in patient record charts. Everybody who saw the chart understood that was a sign of HIV positive. Some nurses did not respect about confidentiality of patient's result. They talked to each other loudly about which patient HIV positive over the counter. They sometimes informed to patient's attendants without taking consent from patient. At the time of discharge form hospital, some WLHA were given health educational messages including the HIV status of the patients loudly. In this way, their HIV status was involuntarily exposed to other patients, patients'

attendants and everybody in the ward. Thus, most of the WLHA in this study were reluctant to take services from government hospitals.

For example, Ma Aye's HIV status was known in public because of one nurse. She shared as:

"Everybody knows I am HIV positive now. At first, I told only to my husband and kept it a secret from other people. It started from one nurse, who was very talkative. When I hospitalized, my cousin sister, who was also a neighbor, visited me. At that time, the nurse told her about my HIV status. And my cousin told everybody in neighbors. At that time, I didn't know to whom I had to complaint about that issue. So, I was silent but very upset. She should respect patient's privacy"

Similarly, Ma Nu was very conscious about breaching confidentiality before she attended hospital. She tried to avoid it by hiring separate room. However, her HIV status was nearly exposed to her mother due to one nurse. She shared as:

"I learnt about lack of privacy and confidentiality in hospitals from my peers. I was afraid of my HIV status being known by attendants and visitors. So, I took pay room. But nurses did not have confidentiality. When my mother went to counter for medicines, one nurse told her that she wished my child would be free from infection. So, my mother was surprised and asked her. Then, she shut up her mouth. Then, my mother asked me. I lay her that I had Hepatitis, thus, nurses hoped my child was free from it. I was scared of dealing with nurses and attending hospitals. They did not have ethic. So, I try to avoid as much as I can"

4.6.1.3 Experience of ignorance and other forms of violence from husband/partner

In this study, 2 WLHA experienced ignorance and violence from their husbands/partners. Disclosing HIV status resulted in disclosing of extra-marital affair which was particularly severely blamed for women in Myanmar society.

For instance, Ma Nu got HIV diagnosis at the time of ANC. When her husband got HIV negative result, she had to admit her pre-marital sex. Since that time, her husband avoided sleeping with her and rare sexed with her. He used to

spend time outside at night and he avoided to face with her. He sometimes did violence to her. He cursed her as a prostitute and sometimes discarded her medicines and ART. She shared as:

"He is not kind to me. He seems to disgust me. Since he knew my HIV status and premarital affairs, his anger exploded. He shouts at me as a prostitute. He goes out from home early in the morning, sometimes before I wake up and he comes back very late at night. He sometimes disappears for 2-3 days without telling anything. He drinks every day. He sometimes throws my drugs. So, I keep my drugs away from him"

Similarly, Ma Than Soe received curse and bad words from her husband when he was drunken. She confessed her HIV status after getting pregnancy. So, he was upset and he accused her as unfaithful person for hiding her HIV status before. She shared as:

"I disclosed him after getting pregnancy. Because I didn't have courage to admit it. For me, it is difficult to tell someone who does not know about my HIV status. I just want to live as a normal woman. I didn't have desire to make him infected. But he was upset for hiding him. He is kind to me mostly but when he drinks alcohol, his real mind comes out. He curses me as a dirty woman, prostitute and HIV positive woman loudly. When he does like this, I am sad"

4.6.1.4 Be blamed and discriminated by parent

In this study, only 1 WLHA was blamed and discriminated by her mother, while there was no stigmatization from parent in other women. It was because 14 out of 15 WLHA lived in nuclear family. They did not have many interactions with parents and parent-in-laws. They also did not let them know about their HIV status. However, 1 WLHA was severely stigmatized by her mother. She was not allowed to eat together and she was not allowed to stay in the same house. She was separated at animal shelter in the same compound. She was separated from her 2 children. Then, they were sold by their grand-mother as domestic helpers. Because of severe stigmatization, she tried some suicidal attempts and then she left them totally.

It was Ma Yin Yin. She shared as:

"My mother is not good to me. She always blames me for getting HIV. It is not my fault. Everybody wants to be free from such disease. I did not have any extra-marital affair; I got it as a present from my husband. I had no choice. When my first husband died, I lived with her. Then, I got HIV diagnosis and she separated me everything. She does not allow me to eat together with her. She sent me to cow shelter in the same compound. When I left her and moved to Yangon, she took my children. She did not allow her grandchildren to stay with me because of HIV positive. Then, she did not feed well them. She sold them as housemaids. So, my children hate me and do not see me until today"

4.6.2 Perceived stigma

4.6.2.1 Inferiority and insecurity in relationship

Due to the local beliefs and experiences of stigmatization, most of the WLHA perceived themselves that they were inferior to HIV negative persons (normal persons). This kind of perceived stigma was found among WLHA who got married to HIV negative husbands/partners. They also depended their husbands/partners in financially and socially. They thought they could be left one day by their husbands/partners because of their HIV status. Due to the perception of inferiority based on HIV positive status, many WLHA felt insecure about their relationships and desired to tighten the knob in their relationships. The inferiority also made them lack of power in negotiation of condom and contraception.

For example, Ma Wutthmone felt she was inferior to other HIV negative women and she was afraid of being left by her husband. She shared as:

"My daughters and I all depend on my husband. I was afraid of his upset and dissatisfaction. He is HIV negative and he can marry HIV negative woman any time. For me, as a woman, it is not good from changing one partner to another. And I am HIV positive. Only he accepted and married to me even knowing my HIV status"

Another example is Ma Yin Yin, who was severely stigmatized by her mother. She was separated away from her children. So, she had inferiority in her mind and she did not disclose her HIV status to her husband. She shared as:

"As I am HIV positive woman, I am already inferior to HIV negative women. If he knows I am HIV positive, I know he will leave me. I am afraid of losing him. I know I would be crazy if he leaves me"

4.6.2.2 Concern about leaving as orphanage child

In the light of social stigma, many WLHA had fears about not seeing their children grew into adulthood, fears about being a sick parent who could not fulfill the parenting roles, as well as concerns about the future of their children if they passed away.

The sentiment was reflected by the quote of Ma Aye Khaing, who got unintended pregnancy during 2nd line ART. She shared her concerns about her parenting ability and fears about not seeing her child grew into adulthood.

"I did not want to get a baby….Childbearing is not an easy job…. Since I have changed to 2nd line drugs, my health condition deteriorates….I worry I am not able to look after my child. I worry if I could live until my child grows up well and stands on his own feet…"

Likewise, Ma Wutthmone had concerns about the future of her children if she passed away early. She reported as:

"I was so much confused what I should do…My husband wanted a child …but for me, I worried so much for the child. ….If I died a few years later, my husband would get married to another woman…then, how my children would survive... Who will look after them? Who will feed them? Who will educate them? I have so many negative thoughts...."

4.6.2.3 Concern about mother-to-child transmission of HIV

In addition, all of the WLHA expressed significant concern about mother-to-child transmission of HIV. Based on the social stigma of HIV/AIDS, many WLHA had concerns about short life span of their children due to HIV/AIDS. Some WLHA believed that taking ART and other medicines was like a punishment and they did not want to inherit this punishment to their innocent children.

It was shared by Ma Aye, who got unintended pregnancy decided to continue pregnancy. She shared her concern as:

"I don't want my kid to be infected with HIV. How medicines are advanced, they develop drug resistance after some years. For me, I have changed to

2nd line after 6 years of 1st line ART. I am afraid of my kid does not get full life span as other child. I want my kid to be happy and grow up normally as other child. I don't want to give me burden of taking drugs daily"

Equally, Ma Wutthmone concern for her newborn child infected with HIV. She shared as:

"For me, I have enjoyed half of my life span. I don't want my child to be infected with HIV/AIDS. He/she has to start his/her life. I don't want him/her passes his/her days with taking drugs"

4.6.2.4 Concern about HIV stereotype impact on child's future

Some WLHA indicated their concerns about HIV negatively impacted on their children's future. They were aware of local meaning of HIV positive people as promiscuous people. Thus, they had concerns about their HIV positive status negatively affected on their children's future. They were afraid of their children grew up with psychosocial stress, stigma and discrimination. They also worried about getting blaming from their own children for taking into risks.

The sentiment was shared by Ma Yadanar, whose HIV status was publicly known. She had concerns about her bad identity negatively affected on her child's childhood.

"I don't care others but I worry for my kid. I don't want him being separated *by other children in his school days because of my HIV status. I don't want him emotionally down and I don't want him passing his days by blaming his mother"*

Correspondingly, Ma Wutthmone worried about her HIV status negatively affected on her child's future relationship. She shared as:

"People still think as HIV positive people are promiscuous people. We use to face the question about the dignity, especially at the time of engagement and marriage. One day, my children might find their partners and want to get married. At that time, I am afraid of my HIV status ruin their lives"

4.6.2.5 Feel guilty for making unfair decision

Based on the social stigma related with HIV/AIDS and social stigma related with childbearing of WLHA, many WLHA felt guilt for making unfair or stupid decision. They blamed themselves for taking their children into risks. Both

WLHA who took intended pregnancies and other WLHA who decided to continue their unintended pregnancies were stressful until they got HIV negative result of their children.

For instance, Ma Thuzar was stressful with the thoughts of getting HIV positive child throughout the pregnancy. She indicated as:

"The worries of what if my child born with HIV killed me all the time. I passed many sleepless nights and my appetite has gone…I lost my weight during pregnancy….The stress was high until I got HIV negative result of him……"

Similarly, Ma Wutthmone , who decided to take pregnancy for the satisfaction of her husband , felt guilty for bringing innocent child into risk. She shared as:

"I was so much confused before taking this pregnancy. After getting it, I was very stressful. I am very selfish mother. In fact, I am not deserved to be called as a mother. I put my child into risk of getting infection for my better life. This thought killed me until I got HIV negative result of my child. I passed all days and nights with that thought. I cried in the day time when my husband was away. When he came back, I pretended as normal. But I was very stressful"

4.7 Gender norms and beliefs related with childbearing

Despite initial fears about having children, gender norms and beliefs related with childbearing attributed in childbearing decision of WLHA.

4.7.1 Mandatory requirement of a wife

In Myanmar, women were expected to get married in all social classes. It was particularly true for women from low socio-economic background because they were assumed as low power to protect themselves. Woman received physical protection from husband but, in return, she had to deliver children and leave inheritance for the family. Women in the society believed that having children enhanced self-esteem and masculinity of their husbands. Men usually received appreciation and recognition from

his colleagues after getting children. As a wife, they believed to fill the emotional needs of their husbands by childbearing. Hence, childbearing was seen as one of the mandatory requirements for a wife. All WLHA in this study accepted that childbearing was a "must do job" if they got married. They felt incomplete and irresponsible to their husbands until they fulfilled their childbearing responsibility. Although some women had already existing children with their previous marriages, they believed that they needed to deliver at least one child for their current husbands/partners.

It was shared by Ma Thuzar, who was a former sex worker, believed that marriage was important for a woman's life, even a sex worker's life. Woman took physical protection from her husband and she needed to fulfill her responsibility of childbearing in return. She shared as:

> *"I think marriage is important for a woman's life. Even for a sex worker, I need a man who protects me and who stands for me. If not, it is easy to be taken advantages by others. There are many men who sexually harass women in physically and verbally in our environment. So, women need protection. In return, wife has to deliver children and maintain the family legacy"*

Moreover, Ma Wutthmone accepted childbearing was her duty to make her husband proud of it. She regretted for refusing her husband's desire. She shared as:

> *"Normally, men are proud of their capacity to get children. My husband seemed to envy his friends. He used to say his friends' lives became better after getting children. I accepted it was my duty to deliver child for him after marriage. I sometimes regretted for refusing my husband's desire. I thought I should not be selfish"*

4.7.2 Proof of faithfulness to husband

Childbearing was believed as a proof of faithfulness or loyalty within a couple. As marriage was an establishing relationship between two strangers, they had to show mutual faithfulness to each other. In Myanmar society, husband was the household leader and wife was expected to be obedient to her husband's decision. Women were reluctant to use contraception without their husbands' consents or permission. If they were caught of using contraception or avoiding pregnancy, they

were seen as a cheaters or bad women who were trying to betray. In this study, 6 WLHA indicated that they wanted to prove their sincerity by childbearing.

For example, Ma Thuzar, who was a former sex worker, indicated that she was suspected as a cheater before she accepted to take pregnancy. She shared as:

> *"My husband did not seem to trust me before. He might think I still had connections with my previous customers. When he knew I was taking injection Depo at the clinic in our ward, he was upset. Later, he didn't inform me anything. He is a high-way truck driver and he uses to go trips. He didn't phone call me and didn't let me know about his arrival date. I was sad. I didn't want him doubted on my sincerity. The problem was clear only after I agreed to take pregnancy"*

Similarly, Ma Than Soe was misunderstood for avoiding pregnancy and using contraception by her husband. She shared as:

> *"He [her husband] asked me to have a child, but I told him no. Then, he used to ask me if I had another man. He had so many insecurities...He probably feels that I would not cheat him if we have children"*

4.7.3 Character of a legally married wife

In Myanmar society, legally married status was socially valued, while living together and hidden sex were severely blamed. Nowadays, the increase in secret relationship, hidden marriage, and living together promoted the belief of childbearing was a character of legally married wife. If a couple did not have any child for a long period, the wife was likely to face curiosity, judgment and gossips from the society. It was particularly for the women who lived in new environment. 5 WLHA believed that childbearing was a character of a legally married wife.

It was shared by Ma Nu as:

> *"If a couple does not have any child for a long period, neighbors tend to be curious. They tend to see wife as a hidden wife or living together or complicated relationship or something bad. If they get a child, people recognize the woman as a good woman and appreciate the relationship"*

Similar words were shared by Ma Wutthmone as:

"If couple do not have a child, the community becomes curious if they are married or just living together, and any problem in their relationship. Some people gossip that woman as an infertile woman"

4.7.4 Stability of heterosexual relationship

Childbearing was important for stability of heterosexual relationship between husband and wife. Most people believed that the bond between man and woman was not as strong as the bond between parent and offspring. There was a Burmese saying that "when a husband goes out 3 steps from home, he returns to a bachelor". It convinced the bond between husband and wife was loose. Many WLHA in this study believed that men's love was temporary and it was difficult to last for life-long. Besides, they had witnessed the divorce of many childless couples in the society. Thus, they perceived that childbearing was necessary to maintain stable relationship.

For instance, Ma Yadanar believed that childlessness made a couple to break down the relationship easily as:

"There is no couple who doesn't quarrel. The conflict is common when the two people live together in a house. The intensity and consequence depend on if they have child or not. If there is no child, they have nothing to care. Then, they stay away from each other and keep silent. If there is a child, they have many things to share, then, they forget small faults"

Likewise, Ma Mya believed that childbearing made the couple united and solidified the bond between them. She shared as:

"If married, childbearing is important. Generally, husband goes for work and more time to stay outside. He can fall in love with any woman in his work. And for a wife, she uses to stay at home. If she has no child, she has free time to interest others. If they have a child, they have many things to share and discuss. Time flies quickly in looking after child. They have common future and common goal for the child's future, education and health and so on. So, childbearing makes them united and difficult to betray each other"

4.7.5 Characteristic of a perfect family

In Myanmar society, children were important for the qualification of a family. A couple without any child was not qualified as a family. Besides, children were accepted as blessings for a family. For a newly married couple, people used to wish to get many children to owe a happy family. Children were seen as blessings that brought happiness into the family. Because of them, the couple life became more active and lively. Moreover, having a family had many advantages. Family members were able to depend each other. There was a Burmese saying: "a piece of bamboo stick is easy to break down but a pile of bamboo stick is hard to destroy". It convinced that having a family was a great asset in protection of harms from others. Besides, when the parents grew old, they could expect protection from their own children. Son was regarded as a strength and daughter as a shelter for the parents. They also anticipated getting merit from their children after their deaths. Thus, childbearing was important in building a perfect family.

For example, Ma Nweni described her belief about perfect family as:

"If a couple does not have any child, life is boring. When a child comes into the couple's life, their house becomes more active with cry and smiles of child. If they get baby girl, she can become a friend for her mother. If a baby boy, he can lead and protect the family. As we are Buddhism, we expect to get merit from our children after our deaths. It is not sure if other relatives do for it or not. And they might be helpful than others when we grow older. That's why we marry and deliver children"

4.8 Gender-power relationships with husband/partner

Gender-power based relationship affected the childbearing decision of WLHA. The decision to take pregnant or to continue pregnant was found to be predominantly influenced by gender-power relationship with their husband/partner. Gender-power relationship disempowered women and made them more dependent on men, reducing their ability to make own decision. Hence, husband/partner's desire to have children weighed more heavily on women's intention than their own desires. All of the WLHA described that their childbearing decision was mainly influenced by their

husband/partner's desire. Despite of having concerns related with HIV/AIDS, they were not able to overcome their husbands/partners' desire and finally decided for childbearing.

4.8.1 Economic and social dependence

Many WLHA were economically and/or socially depended on husbands/partners. Many WLHA in this study had low educational attainment and poor or instable income. Some WLHA had to look after their existing children from previous marriage. Increasing in living and daily expenses in Yangon made WLHA difficult to manage for household expenditure. Hence, their husbands/partners were critical for the survival of their children and themselves. Even for the WLHA who had stable income , they were also socially depended to their husbands/partners. Gender norms trained them that living under the shade of a man was secured and protective. Some women believed that the society would blame them if they were abandoned by their husbands/partners. Thus, all of the WLHA in this study depended in socially and economically on their husbands/partners. The economic and social dependency made some WLHA difficult to leave the relationships and the satisfaction of their husbands/partners became the first priority. They had lack of power in negotiation of condom use and family planning with their husbands/partners.

For example, Ma Wutthmone and her existing children depended on her 2nd husband in socially and economically. Thus, she did not have power to against her husband's desire. She shared as:

> *"For me, I had to think for my daughters and myself. He [her husband] was important for our livings. He is valuable for me. I don't want to lose him. If he leaves me, I have to struggle hard with my 2 daughters. I don't know how to earn money. I am afraid of his dissatisfaction and ignorance"*

Likewise, Ma Cho got stable life after meeting with her partner. She had passed life difficultly with her HIV positive child. Thus, her partner's desire was important for her.

> *"When he said he wanted to have a child, I was very confused. I was afraid of getting another HIV positive child. But I was not able to refuse him. If he disgusts me, I would be homeless again. I have to struggle hard with my*

HIV positive child again. Frankly, he was important for my survival as a human."

4.8.2 Risk of abandonment and rejection

In the condition of being dependent in socially and economically, some WLHA were threatened for abandonment and rejection if they did not agree the desire of husbands/partners. 5 WLHA in this study were threatened by their husbands/partners about abandonment and rejection if they continuously refused to take childbearing. In contrast, some WLHA who perceived inferior and insecure due to HIV positive, desired to protect their relationship with childbearing. In this study, 3 WLHA took pregnancy to avoid abandonment from their husbands if their HIV status were exposed in one day.

For example, Ma Su Su refused her husband's childbearing desire for about 10 years. One day, they quarreled for that issue and her husband left her for 9 days. She was anxious for being left by her husband and breaking family. Thus, she agreed to do childbearing. She shared as:

"We had many conflicts before taking pregnancy. He wanted a child more. I was afraid to take pregnancy since I got HIV diagnosis. So, I told him about childbearing was impossible for me. One day, we quarreled so much about that case. Then, he left me for about 9 days. When I followed him, he asked my promise to agree his desire"

Similarly, Ma Thuzar's husband was upset for not agreeing his childbearing desire and left her for 2 weeks without any information. She was scared of being left and she agreed her husband's desire when he returned. She shared as:

"He is a stubborn person. He left me for 2 weeks because I resisted his desire. He was a high-way bus driver and he used to sleep outside ...but just a few days. I was scared of being left when I didn't get any information for 2 weeks. When he came back, we made discussion and agreement for childbearing"

4.9 Power relationship with healthcare provider

4.9.1 One-way communication with poor chance of discussion

Power relationship of healthcare providers had effect on the childbearing decision of WLHA. Healthcare providers used to take superior role and provided advices in one-way communication, instead of shared decision making. Doctors gave the information of using condom consistently was the responsibility of the WLHA. When WLHA tried to discuss their problems, doctors rarely listened to in patience. They were sometimes shouted for making long conversation in unnecessary topic. Frequently, doctors' advices were inapplicable in real practices.

Besides, many WLHA indicated that they did not get enough time to discuss their specific problems. Due to increase in patient volumes with no parallel increase in doctors' ratio, there was poor chance of discussion for WLHA particularly in sexual and reproductive health matters. Often, they got only 5 minutes for consultation time and doctors did not perform physical examination.

For example, Ma Yadanar decided to take pregnancy without getting information of safe conception after 2 years waiting from healthcare providers. She shared as:

"I had asked doctors about my childbearing desire but they replied me to wait for a while. Then, I had waited for nearly 2 years, hoping that they would give me some good solutions. It took 2 years but nothing happened. I was not able to wait more. So, I decided to take pregnancy with no more dealy"

Another example is Ma Aye Khaing, who got unintended pregnancy during taking injection Depo (1month) irregularly. She shared as:

"Actually, I also did not want child. I was in 2nd line and I was weak. Doctors told me to avoid pregnancy but I did not get a chance to discuss which contraceptive method was suitable for me. I did not like the side-effects of injection Depo (3months) but I did not know what to use. But it was very difficult to discuss with doctors. About 5-6 years ago, we got about 15-20 minutes to meet with a doctor. Now, it is just 5 minutes. Sometimes, doctors did not perform physical examination. They asked if I feel well or not, and then approved to draw ART in the forms"

4.9.2 Breakdown of trust and poor communication between healthcare providers and WLHA

Many WLHA shared that they did not receive humanistic treatment, care and support from healthcare providers. Once they got HIV diagnosis, they were informed about preventive measures not to spread HIV to others such as consistent condom use, avoidance of blood donation, not to take pregnancy. They got neither psychosocial support nor proper reproductive counseling. WLHA were asked to bring their sexual partners for HIV testing and forced to disclose their HIV status. However, there were many difficulties to follow advices from healthcare providers. Some WLHA had difficulty in disclosing their status to their husbands/partners as soon as they got diagnosis. Other WLHA had difficulty in negotiation of condom use when their partners disliked condom. There were also some WLHA who were forced to take pregnancy by their husbands/partners. In these conditions, many WLHA kept their sexual and reproductive matters as secrets from healthcare providers. Some WLHA did not open about the presence of their sexual partners. Some WLHA lay that they used condom and contraceptive consistently although they did not use. Even after getting pregnancy, they used lies such as condom rupture and contraceptive failure as the reasons for getting pregnancy.

Ma Aye shared her experiences of keeping her marriage as a secret from healthcare providers as:

> *"They asked me to tell them if I found a boyfriend or sexual partner. But I didn't. I knew what they would tell me. They would tell me not to marry and consistent condom use but I could not follow. So, I didn't tell them"*

Similarly, Ma Than Soe did not inform healthcare providers about her marriage until she got pregnancy. She shared as:

> *"I didn't inform doctors about my marriage. They [healthcare providers] advised me to avoid sex. If I told them, they would blame me for getting married. They would explain again about side-effects of ART and advised us not to take pregnancy. Then, they would tell me to use condom to prevent spread of HIV to others.So, I informed them after getting pregnancy"*

4.10 Relationships with peer WLHA

4.10.1 Close communication with peer WLHA

Due to social stigma related with HIV/AIDS and poor communication with healthcare providers, many WLHA sought peer support to discuss about disclosure of their HIV status and sexual & reproductive matters. In finding peer supporter, many WLHA found peer WLHA who had similar background characteristics with them. However, peer WLHA did not have enough information and knowledge about sexual and reproductive health and it led to improper contraceptive use. Often, witnessing the delivery of HIV negative children among peer WLHA triggered WLHA to do childbearing.

For example, Ma Yin Yin who did not open the presence of sexual partner to healthcare providers took contraception advices from peer WLHA and got unintended pregnancy. She shared as:

> *"I didn't inform doctors about my marriage. I have my friends, peer. I asked them about contraceptive methods. They advised me to use injection Depo (1 month) and I injected it with a quack in our ward"*

Ma Yadanar who has been working in an NGO with peer WLHA, had witnessed her peer WLHA delivering HIV negative children. She envied them and decided for childbearing. She shared as:

> *"In my work, I have seen many women with HIV delivered HIV negative children. I envied them so much"*

4.11 Notions of motherhood for childbearing

4.11.1 Viewing motherhood as a joy

4 WLHA expected that motherhood would provide happiness and hope to continue living being HIV positive. They had passed miserable time with loss of hope and loss of meaning of life after getting HIV diagnosis. Thus, they desire to feel normal life as other HIV negative women. They desired to enjoy in nurturing and watching their

children grew up. They desired to see their children achieving higher status than parents in economic, educational and professional qualifications. In this way, they hoped to get happiness and meaningful life again by childbearing.

For example, Ma Zin Zin shared her thoughts on childbearing as:

"As a human, I also have a desire to enjoy and pass my time with happiness and hope. Since I was young, I got HIV and I passed my days with hopeless. I envied so much to women in similar age like me, whenever I saw them with their children. I got heartache when I did not have any child. I want to enjoy happy life like them"

4.11.2 Projection of power inside intimate relationship

Many WLHA expected to gain power inside the intimate partner relationship through childbearing. The power included financial management power and influential power over their husbands. After fulfilling their mandatory requirement of childbearing as a wife, they perceived that they had gained in power for assertiveness. Some of the WLHA did not satisfy their husbands/partners' behaviors, but they did not have power to discuss them before childbearing. They wanted to control their husbands' bad habits such as drinking alcohol every night, spending too much money on smoking and betel chewing and night out habits. Besides, some WLHA expected to involve in the financial management of their households. Their husbands did not let them know about their works and financial matters. They just gave pocket money to their wives for daily expenses of household. Thus, their childbearing decision was partly influenced by their desire to gain power inside the intimate relationships.

In reality, many WLHA received unexpected changes and good things from their husbands/partners since they agreed to take pregnancy. Some husbands/partners became worked hard and saved money, while others showed more love and care to their wives. Some husband even gave promise about better house and better future to their wives.

For example, Ma Wutthmone projected to gain financial management power through childbearing. She was not allowed to know her husband's income and she was restricted in spending before agreement of childbearing. She shared as:

"Before taking this pregnancy, my husband was quite reluctant to buy valuable things for me. He used to give me daily pocket money. But he didn't allow me to know his income and expenditure. As a wife, I wanted to know his income and expenditure. But since I agreed to take pregnancy, he changes so much. He opens me about his work and income. He gives me extra money for family saving. He even opens a bank account for me. He becomes generous in buying jewelries. For example, if I requested him to get gold bracelet, he bought it soon. If I requested two identical bracelets, he bought them without curiousness. For me, I have 2 daughters[daughters from previous marriage]. I have to save for them. In the past, he was reluctant to buy two similar items. Since I carried his blood, he is easy to agree. When I have something to say with him, I use the tactic of reminding him about delivering a HIV negative son. Then, he feels pity on me and easy to agree with me. I feel like I get all the happiness due to this son"

Similar experiences were shared by Ma Aye, who desired to control her husband behaviors but she was reluctant to take pregnancy because of taking 2nd line ART. When she got unintended pregnancy during contraceptive use, she decided to continue childbearing with the expectation of influential power over her husband. She shared as:

"My husband was a heavy smoker and drinker. He is a carpenter. At first, I forgave him because his work is physically demanding. But his daily wages were spent much on them. Sometimes, he didn't have work. At that time, I was headache but I didn't know how to tell him……..When I got pregnancy accidentally, he was so happy. He gave me promise that he worked hard and saved money. He actually does it. Even his friends say him that he becomes busy and stingy person after getting his son"

4.11.3 Projection of positive social status in society

By proving the legally married status through childbearing, some WLHA expected to gain positive social status in the society.

For example, Ma Than Soe faced curiosity from the society related due to absence of child for 3 years after setting in new province of Yangon. She was gossiped

as a hidden wife by some neighbors. Thus, she projected to prove her legally married status by childbearing. She shared her expectation as:

> *"People tend to think me as a hidden wife. My husband is a construction worker and he has to leave home early morning and arrive at late night. He sometimes has night shift and doesn't come back home. Thus, the neighbors tend to think me as a hidden wife. Some women asked me why I didn't take pregnancy, while others gossiped at my back. They thought I avoided pregnancy because I was not a legally married wife"*

4.12 Individual social context related to childbearing decision

4.12.1 Age

Age of the WLHA found to influence the childbearing decision among WLHA. Many WLHA in this study were over 30 years of age. Although they tried to avoid pregnancy for certain periods, they simultaneously expressed self-imposed time constraints for childbearing. They reported that they wanted to have children before they were too old. They believed that it would be difficult to conceive pregnancy and difficult to nurture children in old age. They also accepted that childbearing at old age had to deal with the risk of getting children with congenital abnormalities addition to risk of HIV positive children.

For example, Ma Yadanar , 37 years old WLHA, had avoided pregnancy for 6 years of marriage. She opened her childbearing desire to doctors 2 years before taking pregnancy. Doctors advised her to delay pregnancy. However, she decided to take pregnancy because she had concern of difficult to conceive pregnancy and congenital abnormalities in child if she took pregnancy in old age. She reported as:

> *"We have limit. Time is passing day by day. I cannot wait over 35 years old. They [doctors] delayed my needs all the time. I had no time. I was already 35 at that time [time of deciding for childbearing]. It is difficult to get pregnancy in old age.....and I am afraid of getting child with incomplete legs and hands. So, I decided to take risk by myself"*

Similar sentiment was reflected in the statement of Ma Nu, 34 years old WLHA, who had got HIV diagnosis at the time of ante-natal care. She first looked for abortion with the fear of getting HIV positive child. At last, she continued the pregnancy. She believed that it was her last chance of getting pregnancy because she was nearly 35 years old. She indicated as:

"I was shocked when I got HIV diagnosis. I didn't know how to deal with it. Pregnancy made me confused more....I didn't want to deliver this baby as well....I was afraid of getting HIV positive child......Honestly, I even seek for abortion....but I also thought that it might be my last chance.....I am almost 35. So, I continued the pregnancy"

4.12.2 Experience of chaotic life

The experience of chaotic life appeared to influence childbearing decision of WLHA. In this study, many WLHA had traumatic life experiences such as homelessness, sex worker, experience of sexual violence, experience of being divorced or widow, poverty, hunger and humiliation by the society. They got stable and better lives after meeting with their current husbands/partners. Hence, maintaining the current stable lives was seemed to be more salient than any other factors. Some WLHA decided to take pregnancy in order the stabilize their heterosexual relationship. Other WLHA got pregnancy for unable to protest their husbands/partners' desires and unable to protect their bodies from the possibility of getting pregnancy.

For instance, Ma Cho, who had experienced poverty, hunger and homelessness for about 2 years. She had experience of having HIV positive child and that son's health condition was worse. She got better life with place to sleep, foods and clean water for sanitation after meeting with current partner. Although she worried for having another HIV positive child, she tried to stabilize her relationship by childbearing. She reported as:

"Before meeting with him, I was homeless and my life was very difficult. We lived in a temporary tent on the river bank. Everything was moist and dark. It was difficult to have 3 meals per day and my son was HIV positive. Most of my daily wages were gone with his healthcare fees and transportation fees to and from the hospitals. I did not want to be back into my previous life. Now, I

have a house. Although it is not good, it prevents me and my son from rain, wind, cold and heat. I value this life with him. Honestly saying, he is important for me especially for my survival as a human. He makes me secure. I do not need to concern about foods and living but I had risk of being separated. I am not officially married wife. And he has his ex-wife. They didn't officially divorce and they had 3 offspring. Current they stay away from him but they have rights of division of property. If he leaves me or if he dies, I will be back to my previous life. I don't want to be. I am scared of getting another HIV positive child but I don't want to be back to bitter life again. So, I decided to take risk to tie him with child"

4.12.3 Presence of existing child

The presence of existing child found to influence the childbearing decision of WLHA. In this study, 6 WLHA had already had existing children with previous partners and 1 woman had with current partner. They shared that one of the reasons for taking pregnancy was for their existing children. It was particularly true if the existing children were daughters. They did not want to leave their daughters alone. They believed that having one more child was a support for the existing child; either they would depend on each other after parents passed away or creation of blood relationship within a new family.

For example, Ma Su decided for childbearing because she did not want to leave her daughter alone when the parents passed away. Actually, she had tried to get second pregnancy but it aborted. And she got HIV diagnosis at that 2nd pregnancy. Then, she avoided pregnancy for 10 years. When the conditions were favorable, she discussed with healthcare providers and decided for childbearing. She indicated as:

"Actually, I had desired for another child for many years....I don't want to leave my daughter alone....If she has sibling, she will be able to discuss everything and she will not be lonely.....But because of my HIV status, it was delayed for about 10 years...."

Similarly, Ma Wutthmone, who had two existing daughters in previous marriage, decided for childbearing for the consideration of her daughters. She felt inappropriate for living with a stranger man and girls under the same shelter when her

daughters reached puberty. She believed that creating a common biological relationship between her current husband and her existing daughters was the most suitable option. She shared her thoughts as:

> *"My husband [current husband] loves and looks after my 2 daughters....but they are not blood-related ……and sometimes I think it is inappropriate if they sit on his lap ……it will be more inappropriate if they reach puberty.....As a mother, I have to think of better solutions for living together with all of them.....and my husband always yearns for his own child....so, if I decided to take pregnancy, there would be blood-relationship between all of us and ...it is more suitable in the environment..."*

4.12.4 Improvement in health status

The improved health status of WLHA appeared to influence the childbearing decision. Many WLHA indicated that they did not have any childbearing desire when they were seriously ill. However, they desired to get married and desired for childbearing when they improved in health status. They believed that increased in CD4 count, reduction in viral load and free from opportunistic infections, were the signs about healthy. This condition was also related with low risk of HIV transmission to others, thus, they decided for childbearing.

For example, Ma Su Su had been taking ART for over 10 years believed that she was apparently healthy to take a child. She reported as:

> *"I used to attend health education sessions and peers' learning programs. I learnt that mother-to-child transmission was low when the CD4 count was stable and viral load was low. For me, I have been taking ART over 10 years and my CD4 count reached normal for many years, and my viral load is also undetectable...I am like a healthy person for many years. So, I think it was right time to take pregnancy"*

Likewise, Ma Yadanar had been taking ART for 12 years before childbearing. She believed that she was healthy with low risk of HIV transmission to others. She indicated as:

> *"About 1 year after taking ART, I regained normal weight and healthy again. I have been on ART for over 10 years and my CD4 count is normal*

and viral load is undetectable now. I have married for 8 years and my husband is still HIV negative. He tests regularly but still negative. I think HIV transmission is rare if we are healthy. I hoped it would be low in perinatal transmission"

4.12.5 Knowledge and accessibility to ART and PMCT services

The accessibility to ART and PMCT services seemed to influence childbearing decision among WLHA. 14 out of 15 WLHA in this study were taking ART for certain years and they had knowledge about PMCT. They obtained information from health education sessions and experiences sharing sessions of peer groups. Then, they prepared themselves to be fit in physically and prepared in financially to get access to PMCT services. Thus, their decision to take pregnancy and/or decision to continue pregnancy was related with the knowledge and accessibility to ART and PMCT services.

For example, Ma Zin Zin decided to take pregnancy due to advancement in PMCT. She shared as:

"I never thought I could deliver a baby. At the time of my HIV diagnosis, the risk of mother-to-child transmission was 50%, then 30% and now it is lower than 5% with LSCS and formula feeding. I have been taking ART for 7 years and my CD4 count regained to normal for many years. We also took advices from doctors. Then, we saved money to afford LSCS and formula feeding. And we took pregnancy"

Similar experience was shared by Ma Su Su as:

"We (WLHA and her husband) went to the clinic and listened to the counseling advice from doctors. Doctors said mother-to-child transmission was lower todays.....It was about 1 out of 3 children could be born with HIV, which was lower than in the past, about 50%.....If we delivered with LSCS and fed infant with formula feeding, the percentage could be lower to less than 10%.....So, we decided to deliver with LSCS and used formula feeding"

4.13 Sexual and Reproductive behaviors of WLHA

4.13.1 Poor disclosure to husband/partner leads to poor contraception and condom use between partners

Due to social stigma related with HIV/AIDS and economic dependency on the husbands/partners, many WLHA faced difficulties in disclosing their HIV status to their husbands/partners. It was particularly difficult for women who got HIV from their pre-marital sex. They were afraid of HIV stereotypes negative affected their dignity. In this study, 2 WLHA kept their HIV status as secret until they got pregnancy because of fear of abandonment and rejection. And 4 WLHA were still not ready to disclose their HIV status to their husbands/partners. Thus, they were not able to negotiate condom and contraception with the fear of suspicion from their partners. Sometimes, they faced extra pressure and misunderstanding from their husbands/partners for avoiding pregnancy and secret contraceptive use with no special reason.

For instance, Ma Mya who was a sponsored wife to an old man during her college years. She kept her HIV status as a secret because it was related with dignity. She was not able to tell her husband about family planning and condom use. She indicated as:

> *"I don't dare to open my HIV status to him [her husband]. How can I tell him? It is related with my dignity. I know he won't forgive me. He might disgust me and he might even divorce me. I don't tell him....never………I did not use any contraception.....If I told him about condom and contraception , he might suspect me.....So, I didn't dare"*

Likewise, Ma Myo Myo who was an active sex worker did not disclose her HIV status to others. Thus, she was not able to use condom during sexual intercourse with her intimate partner as well as with her clients. She described as:

> *"How can I tell others I have HIV? If they know, they don't come to me. It is important for my living. And I don't tell my partner as well. If he knows it, he might leave me. I don't want to be heartbroken again…….."*

4.13.2 Poor discussion with healthcare providers leads to improper contraceptive and condom use among WLHA

Due to social stigma related with HIV/AIDS and poor communication with healthcare providers, many WLHA did not discuss their sexual and reproductive matters with healthcare providers. Instead, they asked information from their peer WLHA. 4 out of 15 WLHA had discussed with the healthcare providers about their sexual and reproductive health matters before getting pregnancy. Other WLHA hid their sexual and reproductive matters. It resulted in improper use of contraception and poor condom use. Only 6 WLHA had used Depo-provera (3months) injection properly. Other 3 WLHA had used Depo-provera (1month) injection improperly. 1 another WLHA had used combined oral contraceptive pills (COC) but she did not know about missed pill management. The 1 WLHA had used male or female condoms inconsistently.

Ma Aye who took COC to prevent pregnancy but she did not know about missed pills management. She shared as:

"I took oral contraceptive pills. But sometimes, I missed. When I remembered, I sometimes took 2-3 pills at once. And sometimes, missed for 2-3 days. I was weak and it was difficult for taking drugs regularly"

4.13.3 Lack of power to negotiate condom use leads to poor condom use between partners

All of the WLHA in this study had knowledge about consistent condom use for the prevention of spread of HIV to others as well as between partners. Most of the WLHA were in relationships with sero-discordant partners but consistent condom use between intimate partners was few. There were only 2 WLHA (Ma Su Su and Ma Zin Zin), who had used condom consistently together with injection Depo-provera (3months). Thus, they were the only 2 WLHA who practiced dual contraceptive methods. Other WLHA were not able to use condom consistently. Some of them did not dare to negotiate for condom use for the fear of knowing their HIV status. Others had tried but they did not succeed in negotiation with their husband/partner. Many WLHA were economically dependent on their husbands/partners and they were afraid of their partners' dissatisfaction. Besides, gender norms and constructs of femininity trained them to be obedient and faithful. If they resisted taking pregnancy continuously,

they were suspected as cheater or unfaithful. Then, they were likely to get abandonment and rejection from their husbands/partners for against their wills. Additionally, women were not allowed to initiate sex within an intimate relationship. Some WLHA tried to use female condom but they did not guess the time of sexual intercourse. When they put female condom, there was no sexual intercourse. But when they did not put it, there was sexual intercourse. Hence, it was difficult to use both male and female condom if husband/partner disagreed. Consequently, there were increased in risk of unintended pregnancies as well as increase in risk of HIV transmission between partners. There were also some WLHA who intentionally did unprotected sexual intercourse for getting pregnancy.

Ma Cho was not able to use male condom due to her partner's dislike. She tried to substitute with female condom but it failed again. Then, she got unintended pregnancy. She shared as:

> *"My husband does not like to use condom. I tried to explain him about he needed to be HIV negative. But he didn't agree. He said he didn't care about contracting HIV or not. He wanted to get pleasure. He said nobody wanted to wear clothes during taking a bath. Condom is like this. He said condom affected his erection. He is over 60 years old man and he is not able to erect well with condom……Then, I tried to use female condom but it was also difficult. When I wore it, we didn't sex. When I didn't wear it, we sexed. I cannot control when sexual intercourse happened. Then, I got pregnancy"*

Another WLHA who did not use condom was Ma Thuzar. She was not able to use condom because of her husband's disagreement. She shared as:

> *"Men do not like to use condoms. How much I persuaded him, I gave up him and finally we did sex without condoms. I tried to use condoms but I cannot use consistently. It was difficult to use condoms among married couples"*

4.13.4 Late HIV diagnosis after getting pregnancy

There were also some WLHA who did not know their HIV status before getting pregnancy. Sex and sexuality were taboo subjects in Myanmar and women were not allowed to talk about them in public. Women who looked for such kind of

information were accepted as indecent. It was particularly difficult for women who were not officially married. Thus, many women in Myanmar had lack of knowledge about SRH and HIV testing. Besides, the local beliefs related with HIV/AIDS trained women as people who got HIV infection were promiscuous women and sex workers. It led to poor perceived susceptibility of HIV/AIDS among housewives and they did not try to test HIV. In this study, 2 WLHA got HIV diagnosis after getting pregnancy and 1 WLHA got HIV diagnosis at the time of delivery.

For example, Ma Nu who had pre-marital sex with an old man but she did not think about HIV/AIDS. She got HIV diagnosis at the time of ANC. She shared as:

"I got HIV diagnosis over 6 months of my pregnancy. I didn't think I had HIV. My parents advised me not to show ANC early because early ultrasound could damage to the child. So, I started ANC only after 6 months pregnancy at Central Women Hospital and I started notice my HIV status"

Another WLHA who got HIV diagnosis at the time of delivery was Ma Myint. She was a housewife and she did not think she had risk of HIV infection. She shared as:

"I got to know my HIV status at the time of delivery. I was very scared. I never thought I had such disease. I am not a bad woman. I thought my husband was also faithful to me"

4.14 Childbearing decision

4.14.1 Avoiding pregnancy for a certain period

11 out of 12 WLHA who got HIV diagnosis in advance had tried to avoid pregnancy for certain period. They had used modern contraception to prevent pregnancy for certain period.

It was reflected by Ma Zin Zin, whose husband was also HIV positive. They had avoided pregnancy for 5 years since marriage by using Depo-provera (3months) injection and male condom consistently. She shared as:

"Actually, we yearned for a child for many years. After marriage, everybody wants to get a child. So do us. But we didn't dare to take pregnancy. We didn't want to be guilty. So, we used contraception and condom"

Ma Yadanar had also avoided pregnancy for 6 years since marriage by using Depo-provera (3months) injection but she did not use condom. She shared as:

"We didn't have any child since marriage. I have wanted a child since marriage. But I am HIV positive. So, I couldn't do as I wish. In this way, we passed many years, nearly 6 years without any child. I used contraception, Depo (3month) injection. But I didn't use condom. I tried to use it at the beginning of our marriage but my husband didn't want to. Sometimes, I asked if he put on it. He said yes but actually he didn't. Later, I didn't tell him"

4.14.2 Taking intended pregnancy for satisfaction of husbands/partners

The most significant factor that encourage WLHA to do childbearing was their husbands/partners' satisfaction. Despite of having concerns related with HIV/AIDS, some WLHA decided to take intended pregnancy and stopped using contraception to please their husbands/partners. Other WLHA who got unintended pregnancy decided to continue their pregnancies due to the satisfaction of their husbands/partners.

For example, Ma Su Su decided to take pregnancy to please her husband. She shared as:

"My husband was eager to get another child. He continuously claimed about it. He envied his friends who had young children. As we had only one child, he asked me to take more children"

Similarly, Ma Thuzar shared as:

"My husband continuously claimed me that he wanted children. Since he was a bachelor, he has loved children so much. After marriage for 6 years, his desire for getting own children became stronger and stronger"

4.14.3 Taking intended pregnancy to enjoy motherhood

Some WLHA decided to take pregnancy to get meaningful and purposive life experiences through childbearing. Since they regained their health by taking ART, many WLHA believed that their lives were not much different from other HIV negative women. They wanted to complete the role of woman and to feel normal by leaving inheritance as other women. Some WLHA expressed that they expected enjoyment and pleasure by nurturing their own children. They wanted to feel positive and enriching life experiences which would help them to continue living. Other WLHA expected to see the better social status such as educational attainment and better economic standard in their future generations. It gave them hope to continue living. They believed that childbearing was the opportunity to escape from the sadness and inferiority due to social stigma related with HIV/AIDS.

It was shared by Ma Yadanar, who did not have any existing child, decided for childbearing to get happiness and meaningful life from childbearing. She shared as:

> *"I wanted child because I didn't have. I want to raise up my own children and want to get the feeling of they grow up well. I used to dream what to do if I got a child. If the child would be a girl, I dreamed how to dress. If it would be a boy, I dreamed how to educate him. I envied other women who had child. I used to listen to their talks about their children and their aims for their children"*

Besides, Ma Myo Myo, who was an active sex worker, delivered 5 children after getting HIV diagnosis, for her happiness. She shared as:

> *"I delivered many children because I enjoyed it. It is my only pleasure. I feel good in seeing my children. They love each other. Now, my eldest son becomes a police and he gives me money for feeding his brothers and sisters. I also want to see my other children with good works"*

4.14.4 Getting unintended pregnancy due to improper use of contraception

5 WLHA got unintended pregnancies due to improper use of contraception and 1 WLHA got unintended pregnancy due to lack of using contraception. They had known their HIV status in advance and they were not ready for childbearing. Thus, they

used contraception to prevent pregnancy. However, they did not discuss their SRH matters with healthcare providers. They took contraception advices and medicines through local medical stores and their peers. 3 WLHA got unintended pregnancies during taking injection Depo-provera (1 month) from quack. 1 WLHA got pregnancy during missed pills of COC. Another 1 WLHA used female condom to prevent pregnancy but it was inconsistent. The rest 1 WLHA was an active sex worker, who was not able to use any contraception because of side-effects, then, she got unintended pregnancy. Thus, they got unintended pregnancies.

For example, Ma Yin Yin got unintended pregnancies during taking injection Depo-provera (1month) from quack. She shared as:

"I don't know how I got pregnancy. I used to take injection Depo (1month) at the local provider (sae htoo sayar)"

In contrast, Ma Myo Myo was an active sex worker but she did not use any contraceptive for prevention of pregnancy. She shared as:

"I am not able to use any contraceptive. First, I tried to use injection Depo but its side-effect deterred my work. I got dropping of blood every day. So, I stopped using it. And I don't use condom because my partner doesn't like it. During my work, I sometimes tell customers to use condom and some people use. But some people become curious when I inform them to use condom. For me, if they know I am HIV positive, they will not come to me. So, I could not tell them. When they become curious, I don't tell anything and then sex without condom"

4.14.5 Getting unintended pregnancy due to lack of disclosure to their husbands/partners

Some WLHA got unintended pregnancy due to lack of disclosing their HIV status to their husbands/partners.

It was shared by Ma Mya who got unintended pregnancy due to lack of disclosing her HIV status. She shared as:

"I did not use any contraception.....If I told him about condom and contraception , he might suspect me.....So, I didn't dare....."

4.14.6 Seeking abortion but not succeed

3 WLHA in this study looked for abortion although they did not actually do it. 2 of them were WLHA who got HIV diagnosis at the time of ANC. And the rest 1 WLHA was taking 2nd line ART. They were afraid of getting HIV positive children with congenital malformations. At the same time, they were facing difficulty in financial problems and they were unable to nurture their children.

Ma Nweni was a former sex worker and she got her HIV status at the time of ANC. She was afraid of getting HIV positive child and her husband awareness about her HIV status. Thus, she first looked for abortion as a first option. She shared as:

> *"Before pregnancy, I didn't know I had HIV. I never tested for HIV. When I went for ANC in 4th month of pregnancy, I got HIV diagnosis. I worried so much for getting HIV positive child. And I was afraid of my husband leaving me if he was aware of my HIV status. I went to the home of abortionist but I didn't dare and come back. I had many hesitations. I also thought my mother's turn. If she aborted me, I could not be alive today. Then, I felt pity on this child and I didn't dare to do".*

Another WLHA who looked for abortion was Ma Aye. She got unintended pregnancy during taking COC. She was taking 2nd line ART and she was afraid of getting HIV positive child with congenital malformations. Thus, she first looked for abortion but she did not do. She shared as:

> *"I took oral pills but I missed it sometimes. Then, I got pregnancy. But I didn't notice it until 3 months. My period was irregular due to anemia. Later, I suspected and tested with urine test strip. I was scared when I found pregnant. Doctors told me not to take pregnancy. I am in 2nd line ART. My child had risk of deformities in legs and hands, addition to the risk of HIV positive. I didn't want him. I was confused so much. So, I bought abortion pills. But as Buddhism, I didn't dare to do. It was like killing my own child with my hand."*

4.14.7 No desire to deliver child in future

All of the WLHA in this study did not have desire for future pregnancy. Although they had taken risks, none of them showed desire for future pregnancy. Since

none could guarantee for getting HIV negative child, they did not want to take risk again. In this study, 7 WLHA did permanent sterilization, while the other 7 WLHA were using modern contraceptives to prevent pregnancy. The rest 1 WLHA did not have desire to deliver more child but she still did not use any modern contraception.

It was shared by Ma Su Su, who took pregnancy to comfort her husband but she did not have desire to take pregnancy in the future. She described as:

"As I could not combat my husband's desire, I took risks. But I decide not to take risk again. How much medicines advance, none guarantee the risk. I don't want to suffer more. So, I did sterilization"

Similarily, Ma Zin Zin , whose husband was also HIV positive decided not to take pregnancy again in the future. She shared her thoughts as:

"It is enough for me. Now, our dream is complete. I just want to do well for my child's future. I don't want to deliver more children"

4.15 Local practices related with childbearing decision among WLHA

4.15.1 Prepare financially before delivery

The common practice of all WLHA who got pregnancy intended or unintended, prepared financially after making childbearing decision. Some WLHA who decided to take pregnancy prepared financially in advance in order to deliver with LSCS and provide formula feeding for the infant. Even among the WLHA who got unintended pregnancies, saved money as much as they could with the aim to get access to LSCS and formula feeding. The reason of preparing financially also included the desire to reduce social stigmatization at hospitals. Many WLHA were aware of social stigmatization towards HIV positive people at health facilities and they accepted that it could be reduced by saving money to hire separate room and to give presents to healthcare providers.

The sentiment was reflected by the quote of Ma Su Su, who took about 3 years to save money after making decision to do childbearing. She shared as:

"After making agreement with my husband, I took him to the clinic and discussed with doctors. Doctors advised us that if we could follow PMTCT,

it could reduce risk of transmission of HIV to children. When we asked about prerequisites and costs, it might cost about 4-6 lakhs for LSCS and formula feeding for infants. So, both of us worked hard and saved money. My husband sometimes worked for the whole week without taking any rest day. My husband was energetic with hopes. I also sold foods in front of my house in both morning and evening. It took 3 years to save such amount of money for us. Then, we informed doctors when we saved about 5-6 lakhs. Then, doctors checked my health condition and taught us about ovulation period and how to take semen from male condom by syringe and put into my vagina. We had tried for 3 consecutive months"

Similarly, Ma Aye , who got unintended pregnancy during taking 2nd line ART and oral contraceptive pills. Since she was very poor and in 2nd line ART, she first considered for abortion but finally she decided for childbearing. Since that time, she prepared in financially to get access to LSCS and formula feeding. She shared her experiences as:

"I discussed with doctors after deciding for childbearing. Doctors explained me that HIV could be transmitted during pregnancy, during delivery and during breast feeding I could reduce risk during pregnancy by taking ART , during delivery by LSCS and feeding ART to newborn and formula feeding could avoid transmission during breastfeeding. For a parent, I wanted to reduce the risk as much as I could. So, I tried and saved money. I am happy because my son is HIV negative"

4.15.2 Prepare body to be fit for childbearing

Many WLHA prepared their bodies to be fit in order to reduce perinatal transmission and to stay healthy after getting children. They were found to follow strictly the advices about healthy life styles and ART regimes after making childbearing decision. They tried to take enough sleep even though they were stressful for risk of perinatal transmission of HIV. They took nutritious foods to balance the nutrition for the health and growth of baby. They followed every good advices from healthcare providers and their peer WLHA, and tried to be fit for childbearing.

It was shared by Ma Wutthmone as:

"I follow all advices from doctors. I eat nutritious foods and take enough sleeping hours. I try not to miss even a few minutes in taking ART. I feel like I have full of strength and hope. I want to see my children grow up well. So, I try my best to stay healthy"

4.15.3 Seeking peer support to encourage childbearing decision

The first and the most frequent person who was sought for emotional discomfort and social support was peer WLHA. It was same in making childbearing decision. All of the WLHA suffered stress and worries for taking the risks after deciding for childbearing. They usually selected peers who had commonalities with them. For example, WLHA who took 2nd line ART looked for the peer who took 2nd line ART. WLHA who was a former sex worker looked for sex worker WLHA. They took advices and suggestions from their peers. They met regularly in peer education sessions and attending health education sessions. They supported each other by providing information about available health and social services provided by NGOs. They also gave psychological support to each other. There were some peer social networks that helped in hospital attendance during delivery and after delivery.

For instance, Ma Aye, who got unintended pregnancy during taking 2nd line ART, looked for the peer, who had similar experiences. She received peer support as:

"I didn't really want this child at first. Once I knew about pregnancy, I looked for the ways to abort. Because I was on 2nd line ART and the side-effects were more severe. Since I started 2nd line ART, doctors explained me not to take pregnancy because of risk of congenital malformations in child….I didn't want it but I didn't dare to abort. Then, I looked for similar cases like me…and I found one woman who was on 2nd line and recently delivered HIV negative baby with no abnormality. I was very happy when I found her. I got confidence to deliver this baby"

Similarly, Ma Su Su sought peer WLHA to get encouragement for childbearing. She shared as:

"I became friend with peer WLHA on the day of my HIV diagnosis. I learnt many things from her. When my husband claimed his desire for child, I

discuss with her. She have already delivered HIV negative child. So, I took information about how and what to do from her"

4.15.4 Seeking medical support

Although WLHA were reluctant to discuss their childbearing desire with healthcare providers, they informed after getting pregnancy. In order to avoid perinatal transmission of HIV during accomplishing the childbearing, 14 out of 15 WLHA took PMCT services. They informed healthcare providers after getting pregnancy with the aim to receive ART or ARV prophylaxis. They were found to follow strictly to ART regime and advices from healthcare providers. In order to be fit in physically, they followed advices such as taking balanced diet and enough sleeping hours as well as avoidance of crowded places. Some WLHA prepared in financially to afford hospital delivery and formula feeding. 7 WLHA delivered LSCS at hospitals and 5 WLHA delivered vaginal delivery at hospitals. After delivery, 9 out of 15 WLHA fed their babies with formula feeding in order to reduce risk of transmission.

It was shared by Ma Su Su, who informed healthcare providers about her childbearing desire and she received safe conception method and PMCT services. She shared her preparation as:

"We (WLHA and her husband) went to the clinic and listened to the counseling advice from doctors. Doctors said mother-to-child transmission will be lower by LSCS and formula feeding but it might cost about 4-6 lakhs. So, we worked hard and saved money. It took about 3 year. When we saved nearly 6 lakhs, we informed doctors. Then, they taught us about putting semen into the uterus with syringe in my ovulation days. We tried it for about 3 months and then we succeeded."

Ma Aye also shared how she took advice from medical doctors as:

"I also discussed with doctors. They told me if I could afford formula feeding for my baby, the risk of transmission would be lower. So, I decided to feed formula feeding.Doctors explained that HIV transmission happened during pregnancy, during delivery and during feeding. We could reduce risk by taking ART , LSCS delivery and formula feeding. For a parent, I wanted to reduce risk as much as I can. So, I tried to save money for LSCS and

formula feeding. I followed advices of doctors and took medicines strictly. They cost a lot but deserved. Finally, I get HIV negative son"

4.15.5 Seeking spiritual support

In order to cope with the stress and worries related with childbearing, 10 WLHA tried to find out spiritual help. They did more good deeds and went religious places more during pregnancy period. They prayed day and night in front of Buddha and they did swear to get HIV negative children. They got serenity and calmness after doing good deeds. They also went to astrologers and calculate the chance of healthy child. They also prayed to spirits, who were believed to guard home and women.

It was illustrated by Ma Wutthmone, who decided to take pregnancy but she worried so much for her future child. She shared how she tried to escape from stress as:

"I was daunting with the thoughts of mother-to-child transmission…Then, I tried to get comfort from fortune tellers…and I prayed day and night to the Buddha and spirits to help me for getting HIV negative child…And I used to swear in front of Buddha that if my love is pure, my child would be born with HIV free….then, I got a little relief"

Similarly, Ma Aye got unintended pregnancy during her 2nd line drugs and she tried to cope with her stress by spiritual help. She shared as:

"Since that time, I spent most of the time on praying. Every night, I prayed at least 1 hour in front of Buddha. I also prayed in day time whenever I got free. Since that time, I was able to change my mind to positive things and good deeds. And I was ready to accept everything according to my Karma"

CHAPTER V
CONCLUSION, DISCUSSION AND RECOMMENDATIONS

This chapter aims to provide an overview of the whole study and it presents in discussion, conclusion and recommendation sessions.

5.1 Conclusion

The study originates on the background situation of increase in HIV incidence among reproductive aged women coincides with low contraceptive prevalence rate (48.7%) and high unmet contraceptive needs in Myanmar. Although ART could reduce the risk of transmission of HIV, only half of the people with HIV get access to ART. At the same time, condom use between intimate partners is rare about 0.4% (NAP, 2015 and Asian-Pacific resources and research center for women, 2016). Hence, many HIV positive women get pregnancy either intended or unintended. Moreover, VCT for HIV among general population is low (about 9%) and many women do not know their HIV status. Most of the women get diagnosis at the time of ANC. In 2015, HIV prevalence among pregnant women was higher than (0.7%) than the HIV prevalence among general adult population (0.45%). Even after getting diagnosis, there is considerable loss of follow-up before and after delivery. Approximately 79% of HIV positive pregnant women got PMCT services and perinatal transmission is still high at 15% in 2015 (NAP, 2015 and UNAIDS, 2015).

In fact, childbearing is not only a biological issue but also a social issue. It is shaped by social structures, social norms, values and power relationships, which in turn influence the beliefs and practices related with reproduction among WLHA (Stolley, K.S (Eds.), 2005; Jones. P (Eds.), 2003). Human decision and behaviors differ from contexts and time (Stolley, K.S (Eds.), 2005; Sarah, M.C. et al. 2012). Besides, childbearing of WLHA is a controversial issue. There are different sociocultural expectations and pressures, which are competing to reach the childbearing decision of

WLHA. However, the possibility of understanding the social context is still under explored in Myanmar. Thus, the study aimed to understand the influence of sociocultural context on the childbearing decision of WLHA in terms of HIV stigma, gender, notion of motherhood and healthcare services.

As a process, published research articles, reports and related accessible literature based on SRH and childbearing of people with HIV/AIDS are reviewed in order to find out research gap and to construct an applicable conceptual framework to understand the realities of childbearing among WLHA. The study used the qualitative case study in order to understand the complex social contexts at individual, micro, intermediate and macro levels. The study utilized in-depth interviews with 15 WLHA who had delivered children after getting HIV diagnosis, key informant interviews with 2 local women, 1 social worker, 2 healthcare providers, 2 husbands/partners of WLHA and participant observation of researcher in Yangon area for 4 months. Interviews were digitally recorded, transcribed and translated into English. Data analysis was done by via the process of content analysis , which included summarizing and categorizing data, identifying themes as well as contextual analysis via applying critical medical anthropology theory and stigma, gender and motherhood concepts.

The study found that childbearing of WLHA was a dynamic issue which varied according to time and background sociocultural contexts. HIV/AIDS was still believed as deadly and contagious disease and its negative stereotypes were still widely accepted among local people. Besides, childbearing of WLHA was severely blamed as inappropriate task and stupid decision in Yangon society. In the light of local beliefs, WLHA were stigmatized and discriminated in many social settings. Some WLHA were accused as promiscuous women by some healthcare providers. There was no respect in confidentiality of HIV status in health facilities. Some WLHA were controlled in sexual and reproductive matters. Some experienced forced sterilization. There were also discrimination towards WLHA in terms of placement and charges. Meanwhile, WLHA also experienced ignorance and violence from their husbands/partners. Few were discriminated by parents.

Due to local beliefs related with HIV/AIDS and stigmatization experiences, many WLHA had high perceived stigma of inferiority and insecurity in relationship. It triggered some WLHA to do childbearing. The concern about leaving as orphanage

child, concern about mother-to-child transmission and concern about HIV negative stereotype affected on child deterred WLHA in considering about childbearing. After taking pregnancy, many WLHA expressed that they felt guilty and stressful until got HIV negative result of their children.

Despite of having concerns related with HIV/AIDS, many WLHA finally decided for childbearing. It was related with gender norms and gender power relationships. Childbearing was accepted as mandatory requirement of woman in Myanmar society. Through childbearing, a woman was able to prove her faithfulness to her husband as well as her legally married status to the society. Many WLHA believed that children were necessary for the stability of the heterosexual relationship and for getting a perfect family. In this way, childbearing became obligatory for WLHA.

Gender-power relationships also seem to influence the childbearing decision of WLHA. Many WLHA in this study were poor and uneducated, thus, they were socially and economically dependent on their husbands/partners. It made them difficult to leave the relationships. They were also lack of assertiveness in family planning and condom use. Some WLHA were threatened to be abandoned and rejected from their husbands/partners if they did not do childbearing. Thus, some WLHA took pregnancy for the satisfaction of their husbands/partners while other WLHA got unintended pregnancy for lack of condom and contraception use.

Due to social stigma related with HIV/AIDS, there was breakdown of trust and poor communication between healthcare providers and WLHA. Many WLHA were found to be difficult to open their sexuality and true reproductive desire with healthcare providers. Concurrently, one-way communication with poor chance of discussion deterred WLHA to make discussion with healthcare providers. Instead, many WLHA used peer WLHA network to get psychosocial support and to make discussion for SRH matters. However, peer WLHA also did not have enough knowledge in family planning. In this way, many WLHA got unintended pregnancies during improper use of contraception. Often, witnessing the delivery of HIV negative children among peer WLHA encouraged WLHA to do childbearing.

At the micro level, notion of motherhood triggered many WLHA to make up childbearing decision. Many WLHA expected to regain meaningful life through

childbearing. There were also many WLHA who projected to gain positive social status and power from childbearing.

The individual social contexts also played an important role in childbearing decision of WLHA. WLHA decided to do childbearing at the time of improvement in health after taking ART for certain years. Some WLHA decided to do childbearing before they reached 35 years of age and they had improvement in health status. Some WLHA decided to do childbearing for the prosperity of their existing children from previous marriages and other WLHA did for them. The knowledge and accessibility of ART and PMCT services also found to influence the childbearing decision of WLHA.

Based on the influences of social contexts, the sexual and reproductive behaviors of WLHA varied. Many WLHA faced difficulty in disclosing their HIV status to their husbands/partners. It was particularly difficult for WLHA who got HIV from their pre-marital sex. As a consequence, they were not able to negotiate condom and contraception. Due to the poor discussion and communication with healthcare providers, there were many WLHA who used contraception improperly although they desired to prevent pregnancy. Although many WLHA were in relationships with sero-discordant partners, the condom use between them was rare. The study also found out that there were also some WLHA who got HIV diagnosis after getting pregnancy and/or at the time of delivery.

Likewise, childbearing decisions of WLHA also varied upon the influences of social contexts. After avoiding pregnancy for certain periods, some WLHA intentionally took pregnancy for the satisfaction of their husbands/partners while some WLHA took for the enjoyment of motherhood. Unluckily, there were some WLHA who got unintended pregnancies during improper use of family planning and condom use. Some WLHA got unintended pregnancies due to lack of disclosure of their HIV status. Some WLHA who got unintended pregnancies and who got HIV diagnosis at the time of ANC sought for abortion services but they did not succeed. Either getting pregnancy intentionally or unintentionally, no WLHA showed desire to deliver children in near future.

Local practices related with childbearing decision of WLHA also differed according to the existing social contexts. Many WLHA sought peer support to get encouragement in their childbearing decisions. Although many WLHA did not discuss

their childbearing desires and sexuality with healthcare providers, they informed healthcare providers and took medical support for PMCT services. There were also many WLHA who sought for spiritual support to relieve stress during pregnancy.

All in all, the study indicates that socio-cultural contexts are important in childbearing decision of WLHA. It also points out many important facts related with childbearing of WLHA in Yangon, Myanmar. It proves that childbearing of WLHA is unavoidable by providing health educational messages and healthcare providers' advices. Socio-cultural contexts train women to deliver children, with no exception towards WLHA. Hence, many WLHA continue childbearing if the society goes in this way. Besides, this study highlights many valuable points and gaps in healthcare services for WLHA. It shows the missed opportunities in reduction of unintended pregnancies and perinatal transmission of HIV among WLHA who desire to prevent pregnancy. It also shows the missed opportunities in reduction of HIV transmission between sero-discordant partners among WLHA who desire to get pregnancy. It points out the root causes of gaps in provision of healthcare services. Further, the study draws attention to the involvement of male sexual partner/husband in making decision of condom use, family planning and childbearing. It also shows the importance of peer social network in SRH services and childbearing. Peers are the sources of social support and sometimes the source of pressure for childbearing.

Thus, this study is a valuable addition to the existing literature of reproduction and childbearing among WLHA. According to the limited knowledge of the researcher, the study is the first study which investigates childbearing decision among WLHA in Yangon, Myanmar. Thus, it draws attention of policy maker about the childbearing issue among WLHA. It also informs healthcare providers by revealing the real social contexts, which trigger WLHA to do childbearing and barriers in accessing SRH services. Therefore, the study is a big step forward in provision of effective SRH services to meet the specific needs of WLHA at specific levels.

5.2 Discussion

5.2.1 Multiple socio-cultural contexts influencing childbearing decision of WLHA

Childbearing of WLHA is a dynamic issue which changes over time and context. Lock and Scheper-Hughes (1990) claimed that knowledge relating to the body, health and illness are culturally constructed, negotiated and renegotiated in a dynamic process through time and space. Although some WLHA had avoided pregnancy for certain periods after getting HIV diagnosis, they decided for childbearing according to changing social contexts and time. In fact, childbearing of WLHA is a social issue, which is unavoidable by only health education and healthcare providers' advices. WLHA are advised to use condom consistently for the prevention infection to un-infected partner, prevention infection between partners and prevention of perinatal transmission of HIV. However, the issue of childbearing among WLHA was not eliminated.

Byron J. Good (1994) explained that diseases are classified, diagnosed and treated according to various cultural medical systems (as cited in Baer et al., 2003). Saltonstall claimed that health actions are "social acts" that are a form of "practice which constructs the subject in the same way that the other social and cultural activities do" (Saltonstall 1993:12, cited in Wyrod. R., 2013). Barer also claimed that the core values, metaphors, beliefs, and attitudes of health system are integral parts of the larger sociocultural system within which they are embedded (Baer. H.A et al (Eds.), 2003). In complex societies, it is important to note the medical pluralism. Chrisman and Kleinman (1983) demonstrated the three healthcare systems (cited in Baer. H.A et al (Eds.), 2003). They are popular sector, folk sector and professional sector. Popular sector contains WLHA themselves, their families, their peer social networks and communities. Folk sector includes traditional birth attendants and quacks. The professional sector encompasses medical doctors, nurses, counselors and other Western medical providers. Hence, the childbearing decision of WLHA is not only influenced by perception, attitudes and beliefs from professional sector but also from popular and folk sectors. Clearly in a complex society, there are always competing norms, beliefs and power dominance (Stolley, K.S (Eds.), 2005). Often, the interest of healthcare providers and

interests of WLHA, their husbands/partners, their peer WLHA are conflicting.

Healthcare providers' advices are based on rational thoughts of medical knowledge. They focus on prevention of transmission of HIV to others. They use to communicate patients in terms of pragmatism, empiricism and militarism, rather than taking account of individual's well-being and reproductive desire (Baer. H.A et al (Eds.), 2003). Their decisions are more on etic point of view, instead of taking into account of WLHA's stand point. Due to failure to recognize gender-power relationships and socio-cultural contexts, their advices were inapplicable in real practice of WLHA. Many WLHA were not able to use condom consistently and unable to prevent pregnancy properly. The pragmatic and one-way communication, instead of shared decision making just resulted in break-down in trust and poor communication between provider and client. As consequences, there were high unmet contraceptive needs among WLHA and they got unintended pregnancies.

Furthermore, human body itself is culturally constructed (Baer. H.A et al (Eds.), 2003). People learn beliefs, norms and practices through socialization since childhood. The social norms and practices govern the beliefs and behaviors of its people (Stolley, K.S (Eds.), 2005; Jones. P (Eds.), 2003). Gender norms trained WLHA that childbearing was a mandatory requirement of a wife, thus, many WLHA felt incomplete until they delivered at least one child for current relationship. Saltonstall claimed that gender played a key role in how individuals constructed their bodies as healthy and their health decision was influenced by gender norm (Saltonstall 1993:12, cited in Wyrod. R., 2013). Lock and Scheper- Hughes claimed that the identity of "I" or the "self" is a state of permanent perception which is unique to the individual. The childbearing decision of some WLHA was found to be related with notions of motherhood. Since childbearing brought positive social meanings of characteristics of perfect family and stability of heterosexual relationship, some WLHA used childbearing for positive social representation.

Childbearing decision was used as a kind of body politics by some WLHA. The body politic refers to the regulation, surveillance and the control of bodies in reproduction, sexuality, work, leisure and sickness (Lock and Scheper- Hughes, 1990). Since childbearing brought positive social norms such as proof of faithfulness and characteristics of legally married wife, some WLHA decided for childbearing in order to

gain positive social status and power. These findings are consistent with other studies, which proved that WLHA used childbearing as an opportunity to balance the negative social identity of HIV/AIDS with positive identity of motherhood (Craft and colleagues ,2007, Kennedy, V.L., 2012, Kisakye, et. al., 2010 cited in Liamputtong, P. (Eds.) 2013b). Some WLHA decided to regain normal sense of womanhood, which is also consistent with study of Wesley et al., 2000. Other WLHA expected to gain positive enriching life experiences from childbearing (Tiphani,2011; Kirshenbaum, et al., 2004).

Additionally, childbearing of WLHA seems to be associated with individual lived experiences. Baer. H.A et al (Eds.), (2003) claimed that the individual body refers to self-evident level and understood as the lived phenomena of the lived experience of the body self. Many WLHA in this study had passed chaotic, traumatic lived experiences. They gained relatively stable lives in current relationships. The poor educational attainment and poor socio-economic status made them dependent on the current husbands/partners. Thus, maintaining the stability of current relationships seemed to be more salient than others. Although they had high concerns of perinatal transmission and negative consequences of childbearing, they finally decided for childbearing with the aim to stabilize the relationships. Cuca Y. P (2013) also indicated that women in powerless position due to unstable life experiences did not protect themselves well from contracting HIV and getting unintended pregnancies. Study showed that WLHA who were not valued in society put more value on childbearing (Barnes & Murphy, 2009).

In this study, many women were middle aged women and some of them had already had existing children from previous marriages. However, they decided to deliver at least one child for the stability of current relationships. Previous studies showed that childbearing desire was found to be higher among WLHA with low parity and fewer number of children before (Craft et al., 2007; Stanwood et al., 2007; Phaweni et al., 2010, Liamputtong, P. (Eds)., 2013b; Rossi AA et al.2010). In previous studies, childbearing desire was high among younger age women (under 30 years of age) (Nakayiwa et al. 2006 ; Cooper et al. 2009 ; Peltzer et al. 2009 ; Kakaire et al. 2010 cited in Liamputtong, P. (Eds)., 2013b; Craft et al., 2007). Similar to other studies, WLHA in this study desired to deliver children before they reached 35 years of age.

Moreover, childbearing decision of WLHA is found to be influenced by interpersonal contexts. Interpersonal context means a person's decision and practices are not able to free from the influence of powerful figures and power relationships (Stolley, K.S (Eds.), 2005). Power was situated within particular inter-subjective relationships (Friedman 1995, 18). Childbearing decision among WLHA was developed within a powerful ideological context of their husbands/partners. Many WLHA agreed to do childbearing for the satisfaction of their husbands/partners. Some WLHA were threatened for risk of abandonment and rejection if they did not agree for childbearing by their husbands/partners. Hence, in the context of social and economic dependency, WLHA were not able to escape from the influence of husbands/partners' desire.

Therefore, childbearing of WLHA is not only a biological issue, but also a social issue. It is greatly influenced by background socio-cultural contexts and it varies over time and contexts. Gender norms, gender power relationships in the society as well as local beliefs and practices related with HIV/AIDS shape reproductive behaviors and childbearing decisions of WLHA.

5.2.2 WLHA with multiple marginalization life and childbearing decision

In this study, WLHA were marginalized in various ways in the society. The unfavorable socio-cultural contexts of Yangon for women, gender inequality, social stigma surrounding living with HIV/AIDS and childbearing of WLHA, poor socioeconomic background with chaotic life experiences combined and increased vulnerability of WLHA and finally affected their childbearing decisions.

The huge disparity in socio-economic classes with high living charges, poor educational attainment and poor job opportunity made poor women difficult to stand alone in Yangon. To combat the high living expenses, some women tend to work as hidden wives rich men and some work at night club, bar and brothel houses and acquired HIV. In this study, 4 WLHA got HIV infection from sex work and 2 other WLHA acquired from pre-marital sex from their sponsored men. In contrast, there are also many housewives who acquired HIV from their husbands. In this study, 8 out of 15 WLHA acquired HIV from their previous husbands and 1 WLHA got from her current husband.

At the same time, certain legal restrictions of women in marriage, divorce and property rights in divorce made women more powerless and dependent over their husbands/partners. It resulted in difficult to assert their true reproductive intention, difficult to leave the violent relationship and poor disclosure of HIV status. They have impacts on reproductive behaviors and childbearing decisions of WLHA. In Myanmar, polygamy is allowed for men while restricted for women (UNAIDS, 2014d). And there is no law for protection of property rights of woman in divorce. Some WLHA in this study were threatened for abandonment and rejection from their husbands if they were stubborn not to take pregnancy. Hence, some WLHA took pregnancy intentionally with the projections of power to control property in the family and some WLHA took pregnancy to secure the relationships and positive social status through childbearing. It is found among WLHA who were financially dependent over their husbands/partners. In contrast, childbearing is also found to be important among WLHA who have stable income. Although they are not financially dependent over their husband, they are still socially dependent over their husbands. Since legally married status is socially satisfactory, while hidden marriage, sponsored wife and sex work are negative social presentation. Thus, these WLHA desired to prove their legally married wife status and projected to gain positive social status in society through childbearing as well.

Additionally, women faced gender inequality in the society. Sex and sexuality are taboo subjects and women are not allowed to discuss in public (UNAIDS,2014c). Women who are seeking for this information are seen as indecent women. Many women in Myanmar are poor knowledge in SRH. Thus, they do not know how to protect their bodies from contracting HIV/AIDS and getting unintended pregnancy. The lack of knowledge in SRH also results in late diagnosis of HIV after getting pregnancy. Besides, gender norms construct femininity as obedient, faithful and submissive (UNAIDS 2014c). It results in difficulty to negotiate condom and contraceptive use without the agreement of husbands/partners. Moreover, gender norms construct childbearing as a mandatory requirement of a wife. In Myanmar, women are expected to get married in all social classes (Soe,2008). Once marriage, women were expected to deliver children. Since marriage is an establishment of relationship between two strangers, each person has to fulfill his/her responsibilities. Husband provides physical protection while wife needs to deliver children for their inheritance (Stolley,

K.S (Eds.), 2005). Therefore, many WLHA felt incomplete and irresponsible until they fulfilled their roles of childbearing. Some women desire to prove the faithfulness to husbands by childbearing.

For the WLHA, they have to deal not only with gender norms and gender inequality in the society, but also with the social stigma related with HIV/AIDS. The stereotypes related with HIV/AIDS put additional layer for marginalization for WLHA. They are seen as "infectious" and "promiscuous" women, who deviate from the cultural standards of a good woman (Liamputtong, P. (Eds).,2013a,2013b). Since femininity is constructed as faithful, social stigma towards HIV positive people is more severe among women than their male counterparts (Liamputtong, P. (Eds).,2013a,2013b). In this study, some WLHA were accused as promiscuous and immoral women by some healthcare providers.

Due to the social stigma of HIV/AIDS, people who are uninfected gained greater social power than the infected ones. WLHA also perceived themselves as inferior than others and felt insecure in their relationships. It resulted in difficulty to disclose their HIV status to their husbands/partners and further difficulty in negotiation of condom and family planning. With the perceived stigma of inferiority and insecurity in relationship, some WLHA decided for childbearing as a mean to stabilize relationship.

By creating stereotypes, they are separated or distinguished boundary as "other". As social ideology or social meaning of "living with HIV" included "contagious", WLHA who chose to bear children were often seen as "cruel, uncaring". They were blamed as "inappropriate or irresponsible" (Liamputtong,P. (Eds).,2013a,2013b). In this study, childbearing of WLHA was seen as inappropriate task in the society. Some healthcare providers believed that it was a stupid decision even they knew the risk of mother-to-child transmission. Many WLHA expressed that they were controlled in sexual and reproductive issues by healthcare providers. They were forced to disclose their status to their partners, forced to bring their partners for HIV testing and advised them as consistent use of condom and prevention of pregnancy were their responsibilities to prevent spread of infection others. In fact, the providers' initiated contraception and condom use had negative effects of further stigmatization of WLHA (Sowell,–1997 cited in Cuca, 2013). This led to breakdown of trust and poor

communication of healthcare providers and WLHA. As consequences, WLHA who desired to prevent pregnancy got unintended pregnancy and WLHA who desired to take pregnancy did not aware about safe conception and increased in unprotected sexual intercourse among sero-discordant couples.

Furthermore, the vulnerability of a woman is more severe if she comes from poor socio-economic class with poor educational attainment. According to Foucault, the difference is socially constructed “in the service of power” (Cited in Cuca, 2013). Thus, stigma and stigmatization function at the point of intersection between culture, power and difference (Parker & Aggleton, 2003:17, cited in Cuca, 2013). In fact, stigmatization intensifies the existing social inequalities. Women who are already marginalized due to gender, poor socio-economic status are further stigmatized by being HIV positive. HIV positive status itself seems to make women chaotic life. Parker and Aggleton (2003) see stigma as an ongoing dialectical process that serves to reproduce the power inequalities (Cited in Cucua,2013). According to Goffman, 1963, power differentials reduce the “life chances” of others and participate in the creation and maintenance of structural discrimination. Studies proved that power differentials have effect on safe sex practices (Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002, De La Cruz, et al., 2010). Experiences of marginalization limit woman’s ability and power to protect their own bodies. These contexts are sometimes related with contracting HIV/AIDS and sometimes related with getting unintended pregnancies.

Such struggles are characteristics of WLHA in this study. In this study, many WLHA came from poor socio-economic classes with low educational attainment, unemployment and economically dependents on their husbands/partners. They had faced traumatic life experiences such as homelessness, sex worker, experience of sexual violence, experience of being divorced or widow, poverty, hunger and humiliation in the past. These contexts made women more vulnerable to protect themselves from contracting HIV/AIDS. 1 WLHA was forced into prostitution by her husbands. 1 WLHA was sexually abused in her teenage. Some WLHA entered into sex works for poverty. Other WLHA contracted HIV from their husbands/partners for lack of knowledge and power to protect their bodies. Further, they were aware of local beliefs and stereotypes related with HIV/AIDS. Some women experienced of stigmatization.

These all fueled their perceived stigma and made them insecurity in their heterosexual relationships.

Undoubtedly, these social contexts are related with lack of power, social marginalization and stigmatization. Some WLHA decided for childbearing in order to maintain their heterosexual relationships with current husbands/partners. Other WLHA got unintended pregnancies due to lack of disclosure and inability to discuss about reproductive matters. Even among the disclosed WLHA, they were not able to negotiate well for consistent condom use and contraceptive use, thus, result in unintended pregnancies. It is consistent with previous study about women in powerless position did not protect themselves well from contracting HIV and getting unintended pregnancies (Cuca, 2013). Therefore, multiple marginalizations in the lives of WLHA are related with childbearing decision of WLHA in Yangon, Myanmar.

5.2.3 Harsh struggle of WLHA in making choices for childbearing decision

This study proved that WLHA made their childbearing decision during their harsh struggle in lives as the last choices when there was no alternative option for them. This study showed that there were three groups of WLHA who did childbearing. They were 1)WLHA who got HIV diagnosis after getting pregnancy and no safe abortion option, 2) WLHA who got unintended pregnancy during improper use of condom and family planning , and 3) WLHA who took pregnancy intentionally. Whatever the underlying reason they got pregnancy, they had struggle too much to reach the childbearing and to get access to PMCT services. Instead of getting social and healthcare support, they just received stigmatization, discrimination and violence from other people in their community.

First of all, the study pointed out that there were still many WLHA who got HIV diagnosis after getting pregnancy. Sex was taboo subject in Myanmar and women who look for the SRH were seen as indecent women. Thus, women generally had lack of knowledge on how to protect themselves from contracting HIV/AIDS and how to prevent pregnancy. Besides, the stereotypes related with HIV/AIDS gave false sense of security to housewives, who were defined as low-risk group in HIV preventive health educational messages. Many WLHA in this study acquired HIV from their previous

marriages and they did not have extra-marital affairs. However, their monogamy did not protect them from contracting HIV and just created the false sense of security and late diagnosis. HIV testing in general population was still low with 0.4% in 2015 Myanmar. It was particularly lower among housewives. Thus, they got HIV diagnosis at the time of ANC (Asian-Pacific resources and research center for women, 2016). And there is no option for them other than continuing pregnancy in the condition of abortion is legally prohibited in Myanmar (Asian-Pacific resources and research center for women, 2016). Moreover, there were some WLHA who did not test for HIV although they had pre-marital sexual affairs. They gender norms and HIV negative stereotypes made them difficult to access HIV testing. Thus, they got HIV diagnosis after getting pregnancy.

Secondly, the study pointed out the gap of unmet contraceptive needs among WLHA which led to getting unintended pregnancies. Many WLHA expressed that they had concerns about perinatal transmission of HIV, concerns about leaving as orphanage children and concerns about HIV stereotype negatively impacted on the child's future. And they desired to avoid pregnancy. However, some WLHA were not able to disclose their HIV status due to fear of stigmatization and violence from their husbands/partners. Fears of eviction from their matrimonial homes, marital infidelity, and domestic violence make difficult for HIV testing and disclosure (UNFPA, 2014 and UNAIDS, 2014b). It was particularly difficult for WLHA who got HIV from the pre-marital sex. There were some WLHA who were not ready to disclose their HIV status to their husbands in this study. It resulted in poor negotiation of condom and family use and got unintended pregnancies.

Even among the WLHA who disclosed their HIV status to their partners, some WLHA got unintended pregnancies during improper use of contraception and condom. Although WLHA desired to discuss and take opinions about their fertility and reproductive desire, they did not get proper support from healthcare providers. They just received further stigmatization from the healthcare providers. Since they got HIV diagnosis, they were advised to use condom consistently and to avoid pregnancy. They did not receive proper reproductive counseling with informed choice of contraception. The provider's initiated contraception and condom use just increased the social stigmatization of WLHA. It started the breakdown of trust and poor communication between healthcare providers and WLHA. When they did not get proper support from

healthcare providers, WLHA tend to looked for SRH information from peer WLHA but the peer WLHA were not competent enough to provide counseling. As a result, there were high unmet contraceptive needs and got unintended pregnancies among some WLHA.

Thirdly, this study proved that there were some WLHA who intentionally took pregnancy. Since many WLHA were socially and economically dependent on their husbands/partners, the satisfaction of their partners was their first priority. Besides, the sero-discordance relationship made them felt inferior and insecure in their relationships. Within a sero-discordance relationship, male's power is largely strengthened (Wyrod. R., 2013). Therefore, they agreed to do childbearing for the satisfaction of their husbands/partners. Since childbearing brought positive social meanings, there were some WLAH who intentionally took pregnancy with the projection of motherhood. They projected to gain positive social status and social power through childbearing. However, they did not get a chance to discuss their childbearing desire with healthcare providers. Often, the social stigmatization deterred them to discuss with healthcare providers. Without having knowledge about safe conception, there was unnecessary increase in unprotected sexual intercourse among partners who desired to get pregnancy.

Whatever the underlying reason they got pregnancy, WLHA had to struggle to reach childbearing. Either getting intended or unintended pregnancy, WLHA opened their pregnancy status to healthcare providers with the hope to get PMCT services. However, they received blame and further stigmatization for taking pregnancy, instead of getting support. Some WLHA were blamed for doing inappropriate task and stupid decision. Some were accused as promiscuous and immoral women. Some healthcare providers explained the comprehensive PMCT services with LSCS and formula feeding, which reduced perinatal transmission significantly. However, there was no compulsory LSCS and formula feeding for the pregnant WLHA since the national guideline on PMCT in Myanmar includes counseling on voluntary contraception, natural vaginal delivery and exclusive breastfeeding (NAP ,2011 ;MCH, ,2014). With the high concerns related with perinatal transmission of HIV, many WLHA tried to save own money to get access to LSCS and formula feeding. There were still taking extra-charges for HIV positive people in hospitals. As HIV/AIDS was related with negative stereotypes, many

WLHA decided to keep as secret from community. However, there was risk of breaching confidentiality during hospitalization. To avoid this risk, some WLAH saved additional money to hire separate room.

Since they did not receive proper psychosocial support from healthcare providers, they tried to cope their stress by seeking support from peer WLHA and seeking spiritual supports. Although they tried to overcome the negativities related with childbearing, there were still many stigmatizations towards them. Some WLHA were sterilized without informed decision-making. Some WLHA were forced to do sterilization. After childbearing, some WLHA decided not to take pregnancy in near future but they did not get reproductive counseling and they were still practicing they were still practicing improper contraceptive methods.

All in all, childbearing was a difficult decision for a WLHA. They made childbearing decision as a last choice when they were not able to against the influences of socio-cultural contexts. However, they still had to struggle too much to fulfill their childbearing goal and getting HIV negative children. They did not get adequate support from healthcare providers, rather than further stigmatization and coercion. They had to cope their stress and worries by findings the ways themselves and they had to save own money to access comprehensive PMCT services. Therefore, this study proved many important gaps unmet contraceptive needs, poor condom use between intimate partner relationships, lack of safe conception and unnecessary increase in unprotected sex and gaps in provision of healthcare services towards WLHA particularly in SRH services.

5.2.4 Treatment related optimistic beliefs and childbearing decision

Drawback of increasing accessibility of ART is the development of optimistic beliefs on HIV/AIDS. It affects to childbearing decision among WLHA. Improvement in health condition due to ART is misinterpreted as low susceptibility and severity of HIV/AIDS. Besides, it is fuelled by health education messages for adherence of ART. WLAH are informed about advantages of ART as decrease risk of transmission to others. As a negative consequence, the belief supports unprotected sexual practices and risk taking behaviors among sero-discordant partners. The popularity is this belief is related with the needs of intimacy of men and needs of normalcy of WLHA. Men who dislike condom use this belief to cope anxiousness for taking risk. Likewise, WLHA use

this belief to deny the influence of HIV through the action of normalizing sexual behaviors such as unprotected sex and natural conception.

In this study, many WLHA expressed that they did not have any desire to get married and deliver children when they were seriously ill. These desires become stronger with improvement in health condition and optimistic beliefs. They believed that increased in CD4 count, reduction in viral load and free from opportunistic infections, were signs about healthy as well as signs of reduction in HIV transmission to others. Thus, they got married and took pregnancy. They learnt health information from healthcare providers and peer educators. Additionally, the witnessing experience about delivery of HIV negative children among their peer WLHA strengthened their decision. Thus, some WLHA decided for childbearing with the belief of minimal risk of perinatal transmission.

At the same time, the optimistic beliefs on HIV/AIDS and over-reliance of ART change the perception of husbands/partners in sero-discordant relationships. They had seen their wives being healthy and living as normal women for certain periods. Then, they believed that their perceived susceptibility for contracting HIV was low. Even if they got HIV, many husbands/partners believed that ART could help in living healthy and full life span as their wives. It led to low perceived severity and over-reliance of ART among WLHA and their partners. Thus, the significant reason for ignoring condom use was based on the optimistic beliefs of HIV/AIDS.

In this way, perceived susceptibility and perceived severity of HIV/AIDS become lower among WLHA and their partners. This belief results in shifting community norms regarding HIV/AIDS and increase in acceptability of unprotected sex among WLHA and their partners. The findings correlate with previous studies of people with HIV/AIDS. People who got access to ART believed that they were no longer infectious and engage more in unprotected sex (Kalichman et al,2000). Study in South Carolina also showed that WLHA considered childbearing for the result of living longer and healthier due to ART (Fletcher, 2011). Many studies also indicated that the availiability contributed the childbearing desire of PLHA (Chen et al., 2001, Heard et al., 2007; Kirshenbaum et al., 2004; Panozzo et al., 2003; Stanwood et al., 2007 , cited in Piggot T. B,2011).

5.2.5 Methodology limitation

These study findings should be interpreted in the context of study limitations. In order to protect confidentiality, the researcher chose informants among WLHA who came to peer social networks, instead of going directly to WLHA. Hence, there might be similarities between those informants. For example, all the informants are already connected to HIV related health and social services. It can be different from other WLHA who do not get access to ART and social support. Besides, most of the people who regularly come to peer social networks are low and middle socio-economic classes. It can be different from WLHA from high socio-economic classes who take ART from private clinic and more concern on confidentiality. Moreover, the study is done in Yangon urban area, where has highest number of HIV specialist clinics opened by NGOs and government hospitals for ART services. It can be different from WLHA from other areas which have poor accessibility to healthcare services. Therefore, the findings predominantly represent to the low socio-economic, poor, urban WLHA who have access to ART and social support services.

5.3 Recommendation

5.3.1 General Recommendation

The findings suggest the following general recommendations.

5.3.1.1 Recommendation for policy maker

- To create and strengthen women empowerment programs to promote the power of women and change their lives.

-To create a national policy with National Human Rights Commission for non-discrimination for HIV positive people and confidentiality of HIV status. The policy could provide guidance on priority areas of healthcare by making endorsement with Ministry of Health & Sports (MOHS), Myanmar. (UNAIDS, 2014).

5.3.1.2 Recommendation for policy maker of MOHS

-To ensure the universal coverage of comprehensive SRH services for all women that enable women autonomy and reproductive choices.

-To develop national policy and guideline for respect of SRH rights of people with HIV/AIDS as human rights.

-To consider cultural competency, welcome diversity and hold great promise for reducing healthcare stereotype threats in updating curriculum of medical schools for pre-service medical providers.

-To create strategies for capacity building of in-service healthcare providers in terms of SRH rights and quality of care.

-To create continuous medical education and professional regulation to ensure quality of care.

5.3.1.3 Recommendation for National AIDS Control Program (NAP)

-To set national strategic plan for scaling up of HIV testing accompanied with increase access to integrated treatment, care and prevention services.

-To encourage implementation of pre-conception counseling for people with HIV/AIDS.

-To put great care in re-framing public health messages not to create negative social meanings and negative stereotypes in defining HIV/AIDS and condom use.

5.3.1.4 Recommendation for healthcare providers

-To focus on individual's health and well-being including SRH of WLHA. The roles of healthcare providers should be assisting WLHA to reach their reproductive goals with minimizing risks and negative outcomes. They should provide complete information through reproductive counseling and assist in shared decision making. Reproductive counseling should include family planning choices, adoption option, and safe conception and PMCT services.

-To provider healthcare services in patient-centered, humanistic care with respect to human rights, confidentiality and privacy of WLHA.

-To be sensitive in sexual and reproductive needs of WLHA. Healthcare providers need to inquire immediate and long-term fertility desires and plan. They need to initiate and create a favorable environment for active discussion of individual's sexuality issue.

-To be sensitive to the influence of partner in contraceptive and condom use of WLHA. Healthcare providers need to find the ways to improve male involvement in reproductive counseling of WLHA.

5.3.1.5 Recommendation for WLHA

-To encourage WLHA to actively participate in regular group discussion, experience sharing session in order to provide support with each other.

-To empower WLHA to be open-minded and voice up their sexuality and reproductive issue in discussion with healthcare providers.

5.3.1.6 Recommendation for society

-To encourage women in getting equal rights to education, employment, healthcare access through community initiatives and advocacy.

-To involve in women's empowerment activities such as income generation and vocational training.

-To accept the negative effects of harmful gender norms on the lives of women.

-To encourage in development of peer support networks as they are the main sources for social and psychological support of WLHA.

5.3.2 Recommendation for further studies

The findings and limitations from the study suggest the following areas for further studies as:

1. Longitudinal study

The cross-sectional design of this study does not permit the explanation of causal relationship or temporality of events or conditions. Thus, further study should be in longitudinal nature to understand the relationship between fertility intentions and actual childbearing among WLHA.

2. Quantitative study

Because of convenience sampling with relatively small sample size, the study does not generalize its result for all the WLHA. Thus, there is a need to understand the proportion of WLHA with their reproductive desire, needs and practices in quantitatively.

3. Qualitative study

Further qualitative study should investigate the childbearing among WLHA from all socio-economic classes because the stigma and discrimination experiences and accessibility to services can be varied from classes to classes. Besides, further qualitative studies should explore childbearing decision by using behavioral model or theory that uses psychological perspective in order to document the decision making process in details.

4. Partner's perspective

Although many studies prove that childbearing of WLHA are significantly influenced by partner's desire, there is little information from partner's perspective. As the present study focuses on WLHA, further research should investigate reproductive desire and practices among husbands/partners of WLHA. Husbands/partners should be from both sero-discordant and sero-concordant husbands/partners of WLHA.

5. Assessment of knowledge among WLHA

The study shows that there are high unintended pregnancies and unprotected sexual intercourse among sero-discordant couples. Thus, there is a need to assess the knowledge on safe reproduction and family planning services among WLHA.

6. Need to understand providers' perspective

The study points out the variation in attitudes and pieces of advice of healthcare providers for the issue of childbearing among WLHA. Thus, qualitative studies related with provider's attitudes and perspectives on childbearing of WLHA should be carried out. Quantitative studies for assessment of knowledge and competency of healthcare providers in provision of SRH services for WLHA should also be done in the future.

7. Document the need for reproductive counseling among WLHA

Assessment of frequency and quality of reproductive counseling should be done for programmatic improvement of interventions.

8. Case study research for condom promotion between intimate partners

In order to promote consistent condom use between intimate partners, case-study research should be done more.

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APPENDICES

APPENDIX A

GUIDELINE FOR IN-DEPTH INTERVIEW

Research Objective	Key Main Concept	The Interview Questions
To explore the socio-demographic characteristics of respondents	-Personal Background	-How old are you? -What is your ethnic group? -What is your religion? -How long have you been in Yangon? -If you do not mind, could you tell me your education status? -What is your occupation? -Are you married? -How long have you been married? -Please don't mind, is it your first time marriage? -With whom do you live?
	-Family Background	-Could you please tell me briefly about your family life? -How old is your husband? -What is his occupation? -How many children do you have? -Please share me about your children delivery. -Have you ever used family planning methods? -If so, please share me.
	-HIV status and disclosure	-How long have you noticed your HIV status? -Who know your HIV status? -How did they know? -Do you know the HIV status of your husband? -Please share me the HIV status of your children. -How many children have you delivered after knowing your HIV status?
To identify the existing sociocultural contexts of WLHA related with childbearing decision in terms of notion of motherhood	-Normative quality of woman	-Could you please share me how you got married? -Why marriage is important for you? -Please share me about your roles in your family? -Please share me why did you deliver children. -Why childbearing is important for you? -Why do you get from childbearing? -How many children do you want?
	-Social status and social values	
	-Autonomy and Power	
	-Family norms	
To identify the	-Gender	-Could you please share me the relationship with

existing sociocultural contexts of WLHA related with childbearing decision in terms of gender relations	relationship with spouse and family	your husband? -How was your husband's thought on childbearing? -Could you please share me the relationship with your family? -How was your family's thought on childbearing?
	-Gender relationship with neighboring community	-Could you please share me the relationship with your community?
To identify the existing sociocultural contexts of WLHA related with childbearing decision in terms of HIV stigma	HIV status and experience	-Could you please share me about how you got HIV infection? -What are the changes in your life after getting HIV diagnosis? -Could you please share me your sexuality after your diagnosis?
	-Beliefs related with mother-to-child-transmission of HIV	- How do you think mother-to-child transmission? -Could you please share me your knowledge on PMCT? -Where did you learn? -Could you elaborate why did you decide for childbearing being HIV positive? -Could you please share me about how you tried to reduce mother-to-child transmission?
	-Social stigma on HIV	-Did you face any stigmatization related with HIV? -If so, could you please share me? -What are the changes in your life due to HIV status?
To identify the existing sociocultural contexts of WLHA related with childbearing decision in terms of healthcare services	-ART	-Are you on ART? How long have you been on ART? -Please share me where and how do you get ART and HIV support services?
	-Sexual and reproductive health services	-Have you ever discussed about your SRH with healthcare providers? -If so, what they discussed? Please explain in detail. -How do you feel about the services? -Did you follow the advices? -Why did you follow / not follow them?
	Future pregnancy desire	-Do you want to deliver children in your future? -If so, when? -If not, what do you use for prevention of pregnancy?

APPENDIX B

Key Informant Interview Guideline

List of Key Informants

Key Informants	Types of Information
1 Social worker	-To get additional information on the social support available for WLHA -To get local beliefs related with childbearing of WLHA
2 Healthcare providers	-To get additional information on healthcare services available for WLHA -To explore the attitudes, beliefs and perception on WLHA -To explore the attitudes, beliefs and perception on childbearing of WLHA
2 Local women	-To get information related with local beliefs related with HIV/AIDS - To get information related with local beliefs related with childbearing of WLHA -To get information related with gender norms and women's role in society
2 Husbands/ Partners of WLHA	-To get additional information about gender relationships of WLHA -To explore the attitudes, beliefs and perception related with sexuality of WLHA - To explore the attitudes, beliefs and perception related with childbearing of WLHA

Preparation

1. Select the informant
2. Set place and time for discussion
3. Prepare tools
4. Explain about study purpose, procedure and ethical consideration

5. Request informed consent

6. Request for recording and note taking

Research Objective	Key Main Concept	The Interview Questions
To identify the existing sociocultural contexts of WLHA related with childbearing decision in terms of notion of motherhood	-Normative quality of woman -Social status and social values -Autonomy and Power -Family norms	- How do you define a good woman? -How a woman is treated in a society?
To identify the existing sociocultural contexts of WLHA related with childbearing decision in terms of gender relations	-Gender relationship with spouse and family -Gender relationship with neighboring community	-How women are treated in their family? -How women are treated in the society?
To identify the existing sociocultural contexts of WLHA related with childbearing decision in terms of HIV stigma	Local etiology of HIV -Beliefs related with mother-to-child-transmission of HIV	-How do you think about HIV? Please share with me. -How do you think about WLHA? -How do you think about childbearing of WLHA?
To identify the existing sociocultural contexts of WLHA related with childbearing decision in terms of healthcare	ART and PMCT	-What are the criteria for provision of ART? -What are the PMCT services? -What kind of healthcare and social support services do WLHA get? -Are they free-of-charge? -Are they easily available? -Could you please share me about health and social services for WLHA during hospitalization? -Could you please share me the problems and

services		challenges in provision of health and social services for WLHA?
	- Reproductive counseling and support	-Please share with me about the counselling of WLHA. -How about the SRH services for WLHA?
	-Doctor-patient relationship	-How long does it take for patient consultation time? -What do you usually do in follow-up visit? -Do they satisfy on the services? How do you think?
	- Health practices related to HIV	-Please share me how you witness about WLHA are treated in health facilities
Suggestions of Key Informants		-What are your thoughts on SRH of WLHA in Myanmar? -What are your thoughts on childbearing of WLHA in Myanmar? -Could you please give me your recommendations?

APPENDIX C

Observation Guidelines

1) Preparationp
   1. Select the place and arrange time for general observation
   2. Set appointment with participant to follow their living and working place
   3. Prepare tools: note book, pen, modify guideline if necessary

2) Observe general situation
   1. Observe the living and working environment
   2. Observe relationship of women and family members
   3. Observe relationship of women in community
   4. Observe roles and responsibilities of women in community
   5. Observe SRH behaviour of women in community
   6. Observe HIV prevention, testing and treatment of women in community
   7. Observe childbearing behaviour in community
   8. Observe beliefs and practices related with childbearing in community
   9. Observe SRH and HIV service provision at health centres in the community
   10. Observe interaction of healthcare providers/ counsellor with WLHA in the health centres

3) Others
   1. Observe religious festival, religious building, ritual practices, and social ceremonies if there is.
   2. Observe is there any gender based violence in the community.
   3. Observe is there any discrimination against women living with HIV
   -

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