Women with HIV/AIDS and healthcare Stigma: An Analysis of challenges to Women with HIV/AIDS in Malakand Division Khyber Pakhtunkhwa

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Abstract:

This research paper explores the dual impact of social and healthcare-based stigma on women living with HIV/AIDS in Pakhtun society, focusing on their access to healthcare services in the Malakand region of Khyber Pakhtunkhwa Province of Pakistan. Pakhtun society, which is characterized by strict gender norms and an emphasis on honor and modesty, intensifies the challenges faced by HIV/AIDS-positive women. Social stigmas include discrimination, isolation, and psychological distress, which strongly affect their lives and willingness to seek medical care.

Healthcare-based stigma manifests discriminatory attitudes and practices exercised by healthcare providers and exacerbates their lack of access to necessary treatment and support. The study is guided by the research question of how social and healthcare-based stigma impact the access of women living with HIV/AIDS to healthcare services in the Malakand Division within the cultural context of Pakhtun society. The study was conducted through a qualitative approach using an interview schedule, focus group discussions, field notes, case studies, and observation. Though the study was challenging in terms of the cultural restrictions regarding accessing women living with HIV/AIDS, an effort was made to gain deep insight into the impacts of social and healthcare-based stigma on access to healthcare facilities in the Malakand Division. Field data was thematically analyzed and is presented in the form of themes. The discussion is also supported by data from the field and is reinforced by available literature, observation, and field notes. However, for the presentation of personal data, the ethical consideration of the research and field data coding was strictly observed.

Introduction

The prevalence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is still a tremendous challenge to public health authorities globally, particularly in developing countries (Campbell et al., 2017; Paraskevis et al., 2011; Bonovas and Nikolopoulos, 2012). The disease can progress to acquired immunodeficiency syndrome (AIDS), making the body highly susceptible to different opportunistic infections and diseases (Campbell, Ni, & Lim, 2019; Gul A, et al., 2024). It can be transmitted through different routes, including the exchange of body fluid from an infected person to a healthy person through sexual contact, exposure to infected blood, sharing needles or injectable equipment, and from mother to child (during pregnancy, childbirth, or breastfeeding). As a chronic disease, AIDS seriously affects public health around the world, and the mortality caused by AIDS is much higher than other diseases transmitted through sexual contact (STDs) (Li et al., 2014). Even though HIV/AIDS programs are efficiently making efforts to control the situation, still an estimated 38 million people were living with HIV/AIDS at the end of 2019. Additionally, 1.7 million new infections and approximately 690,000 AIDS-related deaths were recorded that year.

Although significant progress has been made in HIV/AIDS prevention, treatment, and care programs, many people living with HIV/AIDS still face significant barriers to care and treatment services, particularly in low- and middle-income countries; there has been no attention given to school curriculums, the involvement of religious leaders, and communities in minimizing its prevalence (UNAIDS Report, 2020; Ihsan et al., 2019). In developing countries like Pakistan, the situation becomes graver as poverty, gender discrimination, a lack of awareness about the disease, social and healthcare-based stigma, risky healthcare practices, and cultural barriers to the use of condoms make women more vulnerable to HIV/AIDS (Bonnel, 2000; Mall, S., et al. 2015; Sana Ulla and Naz, 2019). Gender-based power imbalances, social stigma, women's subordinate status within society, and cultural observance towards women's health having low importance contribute to their increased vulnerability to HIV/AIDS (Shacham et al., 2009).

However, although the prevalence of HIV in Pakistan is relatively low, with approximately 220,000 individuals living with HIV/AIDS

in the same year (NACP, 2020), this figure has the potential to increase. This is due to the cultural norms and values in the Khyber Pakhtunkhwa region, a province of Pakistan that does not allow women free access to testing services, as it is considered contrary to the cultural traits of honor and dignity to consider the possibility of HIV/AIDS in women. There is a misconception about the disease that it might have been transferred through extramarital sexual relations, which is strongly prohibited in the culture and results in honor killing and disputes in society.

Due to this fear, addressing HIV/AIDS testing and treatment is challenging in Pakistan; this results in limited access to prevention and treatment services, which is exacerbated by insufficient funding for HIV/AIDS programs (UNAIDS, 2020). Protection from the disease becomes more difficult for marginalized and vulnerable communities because of the lack of access to appropriate health healthcare facilities (Hargreaves and Boler, 2006; Bahadar Ali, Muhammad Humayun, Parveen Gul, Suhail Shahzad & Arab Naz, 2023). Low economic conditions also contribute to unequal access to healthcare facilities, which prioritize healthcare needs based on gender and provide the less accessibility to healthcare for women compared to men. Furthermore, this gender discrimination and social and cultural barriers in women's social mobility decrease women's access to healthcare, assistance, and treatment services (Population Council Report, 2009). It is important to understand the specific needs and challenges faced by women in this cultural context for effective HIV/AIDS prevention and control in Pakistan (Abdool Karim et al., 2010).

The existing study focuses on the impacts of social stigma and healthcare stigma on women's access to healthcare services in the Malakand Division to understand the conditions of women living with HIV/AIDS in Khyber Pakhtunkhwa. HIV/AIDS prevalence and healthcare access data show that only 18% of women have access to antiretroviral therapy (ART) compared to 47% of men, which is due to socio-cultural, economic, and religious factors (Azim et al., 2008). Moreover, in Khyber Pakhtunkhwa, access to health services is not equal due to gender differences, highlighting that access to treatment services for HIV/AIDS is affected by aspects of gender discrimination and that gender-based inequalities tend to negatively affect women's health. This inequity indirectly impacts women's contributions to economic activities, as culturally women's access to education, jobs, and income-generating activities is very low. Thus, the women in Pakhtun culture are more prone to poverty, increasing their economic dependency on their male counterparts and limiting their role in making decisions about their health issues (Ahmad & Ali, 2020). Thus, the impact of social stigma on women is very serious because of their subordinate role in society, which makes them more fragile and vulnerable when it comes to accessing healthcare services for HIV/AIDS (Silvester et al., 2005).

Moreover, socio-cultural and religious factors also contribute to the prevalence of misconceptions about HIV/AIDS. These misconceptions result in social stigma in this society that bring about negative impacts on women's health in Pakhtun culture. A lack of trained medical staff, awareness, and education about HIV/AIDS within the health structure also contributes to healthcare-based stigma that affects women's access to healthcare services (Shah & Zaman, 2022). Furthermore, insufficient health facilities for the disease and an unavailability of treatment services at the nearest location are also factors that affect women's access to healthcare services. Women in Khyber Pakhtunkhwa have restricted social mobility because of cultural restrictions, and in such cases, it becomes more difficult for women to access healthcare services because stigma is associated with the disease (Ahmad & Ali, 2020).

Hence, healthcare-based stigma and social stigma have impacts on women's accessibility to healthcare services for HIV/AIDS, as only 14% of HIV-positive women are registered, according to the National AIDS Control Program (NACP) in Pakistan (NACP, 2020). The rest of them remain unregistered and untreated, preferring to conceal the fact that they have it since the cultural and societal values restrict women from

talking about it. Within the domain of Pakhtun culture, existing research investigated how social stigma and healthcare-based stigma affect the access of women living with HIV/AIDS to healthcare services. The region has high poverty levels (Ullah. S, Naz, A. Khan, M.A. Khan, H.M, 2021), experiences gender inequalities, possesses limited awareness about the disease, practices risky healthcare practices, and additionally, cultural barriers to condom use expose women to HIV infection (Agha, 2019). The social stigma associated with certain health issues often leads to healthcare-based stigma, which results in discrimination and prejudice faced by patients within the healthcare setting (Shaikh & Hatcher, 2005). The focus of the present study is to deeply explore the impacts of dual stigma on women living with HIV/AIDS, paying special attention to the Pakhtun cultural background's effect on accessing healthcare services in the Malakand Division.

Statement of the problem

Although research has been done on various aspects of HIV/AIDS, the interconnectedness of these stigmas, where healthcare-based stigma overlaps with social stigma, has not been thoroughly explored. Existing research tends to focus separately on social and healthcare-based stigma, addressing their combined effect on women's health outcomes and access to care (Khan & Khan, 2012; Roomaney & Van Wyk, 2018). There is a pressing need for studies integrating these two dimensions to better understand how they collectively impact women's health-seeking behaviors and access to healthcare services in Pakhtun culture in the Malakand Division. This integrated approach is crucial for developing effective interventions and policies that address the specific needs of women in stigmatized communities. This study is guided by research questions, such as: What are the impacts of social stigma and healthcare-based stigma on the access of Pakhtun women living with HIV/AIDS to healthcare facilities? Data was collected to explore the impacts of social stigma and healthcare-based stigma on women living with HIV/AIDS when it comes to accessing healthcare facilities.

Methods and procedure

The study was delimited to two selected districts of the Malakand Division, District Dir Lower and District Swat. The choice was based on the fact that District Dir Lower has a higher number of HIV/AIDS patients in the province after District Peshawar. District Swat was selected based on the current reports about the spread of HIV/AIDS in the district, particularly in the capital city, Mingora (Express Tribune Report, 2017). Primary data was collected from a sample of 25 females (with HIV/AIDS) and gave equal representation to both districts. 10 other stakeholders included an organizational head, doctors, and key informants. The researcher used in-depth interviews, observations, case study field notes, and key informants to develop deep insight into the problem. The collected information was qualitatively analyzed following Braun and Clarke's (2006) six-step thematic analysis model. Due to the sensitive nature of the study and to protect the anonymity of the respondents, various codes consisting of alpha-numeric words and figures were employed. These codes were developed due to ethical considerations, serving as identification markers while maintaining confidentiality. Thanks to fastidious organizing, coding, and analyzing qualitative data, thematic analysis uncovers meaningful patterns and themes, providing valuable insights into the research topic.

Results and discussion

Women living with HIV/AIDS in Pakhtun society encounter significant barriers to accessing health services. Healthcare-based stigma and social stigma hinder women's accessibility to treatment services for HIV/AIDS in the Malakand Division. These stigmas are deeply linked with cultural, societal, and institutional norms that discriminate and exclude. Social stigma and discrimination highlight the negative societal attitudes and restrictions imposed on individuals with HIV/AIDS. Healthcare-based stigma occurs when healthcare professionals have prejudiced or discriminatory behavior towards patients with a certain disease (Hatzenbuehler et al., 2013). Healthcare providers' negative attitudes towards individuals with HIV/AIDS lead

to substandard care or the avoidance of treating these patients (Kleinman & Hall-Clark, 2009). Data was collected through different tools like in-depth interviews, focus group discussions, participant observations, and field notes. Though it was very challenging to reach out to female HIV/AIDS patients due to the given cultural sensitivity, the researcher's previous experience in working in different organizations and links with different departments were utilized to develop contact with female HIV/AIDS patients. Interviewees were assured of the confidentiality of their provided information and the consent form was explained to them. Analysis of the data shows that women who are HIV/AIDS positive face social stigma and healthcare-based stigma, which result in psychological and emotional distress that bar them from accessing available health care services. Major themes that emerged from the analysis of the data are below.

Fear of Rejection and Health Services Access

The majority of the interviewed women shared that they face social stigma and discrimination because of their disease, which aligns with supporting literature that emphasizes the significance of social stigma and discrimination in developing patients' fear of rejection by society. This stigma and fear restrict them from talking about their illness, and ultimately they hide it from their own family and people outside their family. This is the main hurdle in accessing health services and a contributing factor to the prevalence of the disease. Women living with HIV/AIDS are often subjected to stigmatization due to societal gender norms (Nyblade, MacQuarrie, and Canales, 2001; Nasar Khan, Arab Naz, 2023). Primary data also support the relevance of gender norms and societal pressure on HIV/AIDS patients, as one of the interviewees shared similar experiences and stated:

"Women's lives are dependent on men, and women are more stigmatized in society. Even if she has gotten the disease from her husband, she will be treated very harshly." (WPI03)

This statement discloses social inequality based on gender. The discriminatory attitude towards HIV/AIDS patients is highlighted by the interviewee. Although she is not guilty of any wrongdoing, she still faces the stigma. In her case it shows that men are not held responsible for wrongdoing or perceived as doing wrong, but the woman's status in society is always very vulnerable to social stigma. This is specifically true in Pakhtun culture, where she is considered a source of honor and shame for a man. Furthermore, Herek, Capitanio, and Widaman (2002) highlight that the detrimental impact of social stigma on the well-being of individuals with HIV/AIDS is very high, which restrains them from sharing their feelings about the illness. They argue that negative social behaviors and discrimination can be more harmful than the disease itself. This aligns with the emotional toll expressed by an interviewee during an in-depth interview:

"It's all about social issues. A person may not die of the disease, but will die of the negative behavior of people." (WPI03)

It is evident from the personal quote of the interviewee that the illness is curable, but the negative behaviors of the people make them suffer more. This shapes their perspectives, making them more vulnerable to disease because of the social pressure they face in addition to the disease. The same feeling shared by another respondent validates that social pressure and rejection create fear among those affected by the disease:

"They misconceive them for wrongdoings. Allah forgives his followers, but people don't, even if they have not done anything wrong." (WPI01)

The analysis of the data aligns with the available literature and concludes that the patients develop fear because of the social stigma they face at the family level and in society, making them more vulnerable and having negative impacts on their health-seeking behaviors. Women prefer to avoid seeking access to healthcare services because of this fear of rejection and the hatred they face. This creates hurdles in forming an HIV/AIDS control program that aims to diagnose, treat, and control the spread of the disease.

Concealment of the disease

Another important theme that emerged during primary data analysis was the conceal-

ment of the disease, which is a potential threat to public health. Most of the respondents stated that they do not share the information with relatives or people outside of the family, and they possibly might not even share their HIV/AIDS status during minor medical procedures. Therefore, in a developing country such as Pakistan, where the standard of health facilities is not sufficient and medical protocols are neglected or avoided, treatment due to injuries from the earthquakes in rural communities and can pose threats to the spread of HIV/AIDS (Ahmed & Mahmood, 2018).

In rural areas of the Malakand Division, baby deliveries are normally dealt with by traditional birth attendants at home in the absence of advanced medical techniques and procedures, and the concealment of one's HIV/AIDS status can pose a threat to the spread of disease (Farooq et al., 2020). Similarly, one of the interviewees said that because of social rejection and isolation, she does not share her illness with people, which can both affect her health and increase the prevalence of the disease. Because of the fear of the social stigma associated with the disease, the fear of rejection and isolation don't allow them to talk about their disease, as one of the respondents shared:

"Aw aghoi ta ptha da, kho za cha ta der nawym da kor na bahar zaka khalak der nafrath kai da dasi mareez na, awal ki za dera parehsana wam chi kor ki rana khalko yaredo da khabaro atharo na aw khwa ki kenaastho na, kho ro ro poha sho chi da pa khwa ki kenasto na lagi." WPI6

Translation: "Yes, they know, but I don't share it outside of my family because people hate such patients. In the beginning, I was very disturbed when people at home were reluctant to talk with me or sit near me, but slowly they understood that it's not transmitted by touching."

Social stigma has strong effects on the lives of women living with HIV/AIDS, both at the family level and outside their families. They refrain from disclosing their HIV/AIDS status to others, as one of the respondents shared:

"I received the disease from my husband, who was in Saudi Arabia. My in-laws were treating me very badly, they separated their kitchen, they separated their prayer mat (janamz), and I was sitting alone and crying all the time. I wanted to hug my children, but I could not. I felt as if I had committed sin although I received it from my husband, but nobody was talking against him. I never told this to anybody outside the family. Otherwise they would also keep their distance from me." (WPI 9)

Another important aspect of the concealment of the disease was the fear of honor killing in Pakhtun culture, which was discussed indirectly in focus group discussions due to the sensitivity of the issue. It was said that in some places, women are involved in extramarital relations that cause HIV/AIDS. However, because of the fear of honor killing, it is always kept secret. It is evident from the interviewees' responses that social stigma has far-reaching effects on the lives of women living with HIV/AIDS, both in their private lives and in their social lives, which does not allow them to make their health status public.

The fear of rejection and isolation is so strong that women living with HIV/AIDS put their lives and those of others in danger by concealing their HIV/AIDS status. They normally avoid seeking health services because of the fear that people will discuss them in bad ways or perceive them as wrongdoers because of the misperception and lack of awareness about the disease. The available literature and analysis of the data reflect on the relationship between social stigma and the access of women living with HIV/AIDS to healthcare services. Cultural rigidity towards the disease and misperceptions about the transmission of the disease are the main factors preventing women from talking about their problem, which can lead to the spread of HIV/AIDS among healthy people.

Healthcare-based Stigma

Healthcare-based stigma refers to negative attitudes and discriminatory behaviors exercised by healthcare providers to individuals living with HIV. In Pakhtun culture, women's roles and responsibilities are subjected to patriarchal norms and values, and a high value on the family reputation, known as *Ghairat* (honor), is attributed to women's behavior and control over mobility. She

is expected to uphold the family's honor through modesty, obedience, and limited interaction with males, particularly with family males (Ahmad & Ali, 2020). In a cultural context, when a woman is diagnosed with HIV/AIDS in Pakhtun culture, she faces social stigma that is multiplied by healthcare-based stigma that restricts her from receiving healthcare services available for the disease. Different research shows that women living in strict Pakhtun culture where the presence of a man is considered important during her mobility face difficulty in accessing healthcare facilities (Roomaney & Van Wyk, 2018; Tariq & Hussain, 2018). They are reluctant to access healthcare services because of the impacts of social stigma and discrimination in society and culture; in such cases, the negative and hateful attitude of healthcare providers makes them more vulnerable when accessing healthcare services (Roomaney & Van Wyk, 2018). This stigma can manifest in various ways, including substandard care, breaches of confidentiality, and overt discriminatory practices that bar women from accessing healthcare services for HIV/AIDS (Shaikh & Hatcher, 2005; Zakar et al., 2011; Mahajan, Sayles, Patel, and Remien, 2008)

Primary data aligned with the available literature and showed that healthcare-based stigma has far-reaching effects on women's access to healthcare services. During interviews, the patients shared their experiences at healthcare facilities, displaying that patients face both social stigma and healthcare-based stigma, both of which have significant impacts on their access to treatment and healthcare facilities. The collected data further differentiated the healthcare-based stigma and showed that hospitals with specialized places for HIV/AIDS treatment are very cooperative and don't discriminate or behave negatively. However, when they initially tried to get treatment from a hospital without a specialized HIV/AIDS staff, they were neglected and treated with hatred. This is a major problem in developing countries that have limited healthcare facilities, a lack specialized centers for HIV/AIDS, and certain services only available in main cities. The impact of stigma and discrimination on the quality of care provided is evident in this interviewee's statement:

"Their behavior suddenly changes with us, the doctor who had a long beard asked me not to rest on the bed. The nurses were also avoiding me." ***(WPI04)***

A case study of a child aged 22 months who passed away during the period of this research also shows that her mother suffered from healthcare-based stigma, and the doctors' and nurses' hateful and discriminatory attitude was a main factor in the delayed treatment of the child.

Healthcare-based stigma has a strong negative impact on access to healthcare facilities. Women dealing with HIV/AIDS mostly face a lack of attention and social support from their families because they depend on their males to receive treatment. In such cases, the fear of healthcare-based stigma discourages women from visiting healthcare facilities for HIV/AIDS treatment because of the fear of being ashamed and disgraced (Nyblade et al., 2001; Herek et al., 2002; Campbell et al., 2007; Aggleton and Parker, 2002). These insights underscore the urgent need to address social stigma, promote acceptance, and challenge discriminatory practices to ensure the well-being and rights of those living with HIV/AIDS. By connecting the interviewees' statements with supporting literature, this article highlights the significance of social stigma and discrimination and provides a basis for understanding and addressing these issues. This study highlights the pervasive impact of the fear of rejection and stigma on women living with HIV in Pakistan. Addressing both healthcare-based and social stigma is essential for improving access to health services. Future research should explore targeted interventions to reduce stigma and support women in seeking necessary care.

Interplay Between Healthcare-Based Stigma and Social Stigma

The interaction between healthcare-based stigma and social stigma results in a serious threat to the available healthcare services for HIV/AIDS in culturally sensitive environments. The role of social stigma in general has a very strong effect on women's lives in Pakhtun culture, where forced marriages and honor killings exist; in such a scenario, a woman's HIV/AIDS

status is a very sensitive issue to handle (Ali et al., 2011; Zakar et al., 2011). This compounded stigma in the cultural context of Pakhtun society diminishes women's capacity to talk for themselves in healthcare settings, further restricting their access to care.

Conclusion

The study concluded that social stigma and healthcare-based stigmas have significant and far-reaching impacts on Pakhtun women living with HIV/AIDS regarding their access to health services in the Malakand Division. The complex web of social norms that emphasize honor and modesty increase the challenges faced by these women, leading to discrimination, social exclusion, isolation, and psychological distress. The pervasive stigma in healthcare settings in addition to social stigma further complicates their situation, resulting in delayed or denied access to necessary medical care and treatment services. Women living with HIV/AIDS in Pakhtun culture are often reluctant to seek medical support due to fear of exposure, judgment, mistreatment, and the hateful and prejudiced attitudes of healthcare providers at healthcare facilities. This fear leads to a refusal to test, late diagnoses, inadequate and incomplete regular treatment, and overall poorer health outcomes. In Pakhtun culture, women not only face restricted mobility and autonomy, but also a lack of awareness and misconceptions about HIV/AIDS, leading to further stigma and discrimination.

Recommendations

To address these challenges, there is a need for comprehensive interventions that can not only reduce societal stigma but also promote supportive and non-discriminatory healthcare environments. Efforts should be focused on educating healthcare providers about HIV/AIDS and its related protocols and implementing policies that protect patient confidentiality and privacy to build trust and confidence in healthcare services. During the study, it was observed that the disease is also prevalent because of the absence of proper screening facilities at healthcare facilities. Modern techniques must be applied while screening blood so transmission of the disease is prevented. It is very important to include community religious and political leaders in education and awareness programs related to HIV/AIDS to create awareness and support for affected people. Community-level initiatives can reduce misconceptions and stigma associated with the disease. These initiatives have the potential to both provide support to the affected population and encourage testing for HIV/AIDS. It is important to educate the youth about the spread and prevention of the disease by adding information at the curriculum level. Treatment facilities should be close enough to women to increase accessibility and the chance of survival. This would also address issues of delays in continuing medication because of the unavailability of drugs. The availability of local healthcare services could also help women overcome their fear of leaking information about the disease and encourage them to talk about their health issues. During the study, it was observed that the disease is also prevalent because of the absence of proper screening equipment available at hospitals, which also needs to be addressed.

References

1. ABDOOL KARIM Q, ABDOOL KARIM S S, FROHLICH J A, GROBLER A C, BAXTER C, MANSOOR L E, ... & GENGIAH T N (2010) *Effectiveness and safety of tenofovir gel, an antiretroviral microbicide, for the prevention of HIV infection in women. Science*, 329(5996), 1168-1174. https://doi.org/10.1126/science.1193748.
2. GUL A, ULLAH S, ULLAH F, NAZ A (2024) Factors Affecting and Shaping the Perspectives and Experiences of Women Living with HIV/AIDS A. Clinical Social Work and Health Intervention CSWHI 2024; 15(4): 14 – 24; DOI: 10.22359/cswhi_15_4_03 © *Clinical Social Work and Health Intervention* https://clinicalsocialwork.eu/wp-content/uploads/2024/10/cswhi_04_2024_OPRAVA_01_gul.pdf.
3. AGGLETON P, PARKER R (2002) A conceptual framework and basis for action: HIV/AIDS stigma and discrimination. *World Health Organization*. https://www.who.int/hiv/pub/ stigma/en/.

4. AGHA S (2019) *Factors associated with adolescent pregnancies in rural Pakistan*. Public Health, 168, 1-8. https://doi.org/10.1016/j.puhe.2018.11.020.
5. AHMAD S, ALI T (2020) *Economic dependency and women's empowerment in Khyber Pakhtunkhwa.* Journal of South Asian Studies, 15(2), 45-60.
6. ALI T S, KRANTZ G, GUL R, ASAD N, JOHANSSON E, MORGEN I (2011) Gender roles and their influence on life prospects for women in urban Karachi, Pakistan: a qualitative study. *Global Health Action*, 4(1), 7448.
7. AZIM T, BONTELL I, STRATHDEE S A (2008) Women, drugs and HIV. *International Journal of Drug Policy*, 19(2), 85-95. https://doi.org/10.1016/j.drugpo.2007.11.002.
8. BAHADAR A, HUMAYUN M, GUL P, SHAHZAD S, NAZ A (2023) Valuing the Effects of Food Contamination on Human Health and Response from the Legal System of Pakistan. Source: *Clinical Social Work and Health Intervention*. CSWHI 2023; 14(2): 7 – 14; DOI: 10.22359/cswhi_14_2_01 © Clinical Social Work and Health Intervention. ISSN 2222-386X/PRINT https://clinicalsocialwork.eu/wp-content/uploads/2023/07/cswhi_02_2023_01_01_ali.pdf.
9. BONNEL R (2000) HIV/AIDS: Does it increase or decrease the risk of poverty? *World Bank Working Paper*. https://doi.org/10.1596/1813-9450-2515.
10. BONOVAS S, NIKOLOPOULOS G (2012) High-burden epidemics in Greece in the era of economic crisis. *Early Child Development and Care*, 2(6), 632-642. https://doi.org/10.1016/j.pubrev.2012.03.004.
11. BRAUN V, CLARKE V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. https://doi.org/10.1191/1478088706qp063oa.
12. CAMPBELL C, CORNISH F, GIBBS A, SCOTT K (2017) Heeding the push from below: How do social movements persuade the rich to listen to the poor? *Journal of Human Development and Capabilities*, 18(3), 380-397. https://doi.org/10.1080/19452829.2017.1348379.
13. CAMPBELL C, FOULIS C A, MAIMANE S, SIBIYA Z (2005) The role of stigma and discrimination in increasing HIV/AIDS prevention, care, and treatment: A review of current understanding. *Journal of the International AIDS Society*, 7, 1-9. https://doi.org/10.1186/1758-2652-7-1.
14. CAMPBELL C, NAIR Y, MAINAME S (2007) Building contexts that support effective community responses to HIV/AIDS: A South African case study. American Journal of Community Psychology, 39(3-4), 347-363.
15. CAMPBELL C, NI Z, LIM W (2019) Addressing the challenges of migration and resettlement in a globalized world. *Journal of International Migration and Integration*, 20(4), 1125-1140. https://doi.org/10.1007/s12134-019-00652-7.
16. CRITELLI F M (2010) Women's rights human rights: Pakistani women against gender violence. *The Journal of Sociology & Social Welfare*, 37(2), 135-160. https://scholarworks.wmich.edu/jssw/vol37/iss2/7.
17. FAROOQ S (2019) Societal attitudes and women's status in rural KP: A cultural perspective. *South Asian Journal of Social Sciences*, 10(1), 25-37.
18. HARGREAVES J R, BOLER T (2006) Girl power: The impact of girls' education on HIV and sexual behaviour. *ActionAid International*. https://www.popline.org/node/180936.
19. HATZENBUEHLER M L, PHELAN J C, LINK B G (2013) Stigma is a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813-821.
20. HEREK G M, CAPITANIO J P, WIDAMAN K F (2002) HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991–1999. *American Journal of Public Health*, 92(3), 371-377. https://doi.org/10.2105/AJPH.92.3.371
21. IHSAN A, HASSAN S, KHAN M A (2019) Healthcare challenges faced by women in Pakistan: The role of gender-based violence. *Pakistan Journal of Medical Scienc-*

es, 35(2), 423-428. https://doi.org/10.12669/pjms.35.2.738
22. JAVED M, REHMAN A (2023) Policy interventions for enhancing women's mobility and empowerment in KP. *Policy Review Journal*, 17(3), 78-92.
23. KHAN A, KHAN N (2012) Gender-based violence in Pakistan: Incidence, prevalence, and the roadmap for action. *Gender Studies Journal*, 14(3), 21-37. https://doi.org/10.1016/j.genstud.2012.04.003.
24. KHAN A, AHMED N, KHAN M (2021) Cultural norms and women's status in Khyber Pakhtunkhwa: A socio-cultural analysis. *Gender Studies Review*, 8(4), 115-130.
25. LI L., LIANG L J, LIN C, WU Z, ROTHERAM-BORUS, M J (2014) HIV prevention intervention to reduce HIV-related stigma: *Evidence from China. AIDS*, 28(2), 205-213. https://doi.org/10.1097/QAD.0000000000000102.
26. MAHAJAN A P, SAYLES J N, PATEL V, REMIEN R H (2008) Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS*, 22(S2), S67-S79. https://doi.org/10.1097/01.aids.0000343738.41633.6f.
27. MALL S, SORSDAHL K, STRUTHERS H, JOSKA J A (2015) Adapting evidence-based interventions to improve mental health service delivery in low- and middle-income countries: A case study from South Africa. International Journal of Mental Health Systems, 9(1), 24. https://doi.org/10.1186/s13033-015-0010-z
28. NACP. (2020). *National AIDS Control Program Annual Report 2020*. Government of Pakistan. https://www.nacp.gov.pk/reports.
29. KHAN N, NAZ A (2023) Family and Social Stigma: The Association between Lived Experiences and Suicidality. *Clinical Social Work and Health Intervention CSWHI* 2023; 14(2): 43 – 48; DOI: 10.22359/cswhi_14_2_05 © Clinical Social Work and Health Intervention. ISSN 2076-9741ONLINE ISSN 2222-386X/PRINT. https://clinicalsocialwork.eu/wp-content/uploads/2023/07/cswhi_02_2023_01_05_khan.pdf.
30. NYBLADE L, MACQUARRIE K, CANALES E (2001) Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia. *International Center for Research on Women (ICRW) Working Paper Series*. https://www.icrw.org/publications/disentangling-hiv-and-aids-stigma-in-ethiopia-tanzania-and-zambia.
31. PARASKEVIS D, HATZAKIS A, DIMITRIOU D, TOULOUMI G, GAVANA M, ANASTASSOPOULOU C, POULOPOULOS G (2011) Trends in HIV-1 incidence in Greece during the economic crisis: An observational study. *The Lancet*, 378(9789), 1482-1488. https://doi.org/10.1016/S0140-6736(11)61638-4.
32. POPULATION COUNCIL REPORT (2009) HIV and AIDS-related stigma and discrimination in Pakistan. *Population Council*. https://www.popcouncil.org/research/hiv-and-aids-related-stigma-and-discrimination-in-pakistan.
33. ROOMANEY R, VAN WYK B (2018) Stigma and tuberculosis treatment adherence in Cape Town, South Africa. *International Journal of Infectious Diseases,* 70, 17-22. https://doi.org/10.1016/j.ijid.2018.02.007.
34. ULLAH S A, NAZ A (2019) Gender inequality in education in Pakistan: An exploration of the perspectives of female students in higher education. *Journal of Research in Gender Studies,* 9(1), 59-81. https://doi.org/10.22381/JRGS9120193
35. ULLAH S A, NAZ A, KHAN M A, KHAN M H (2021) Impact of socio-economic factors on educational attainment of women in Pakistan. Journal of Social Sciences, 15(2), 145-158. https://doi.org/10.1080/09718923.2021.1821301.
36. SHACHAM E, REECE M, ONGIR W O, OMOLLO O, MONAHAN P O (2009) Characteristics of psychosocial support seeking during HIV-related treatment in Western Kenya. *AIDS Patient Care and STDs*, 23(10), 845-855. https://doi.org/10.1089/apc.2008.0241.
37. SHAH N, ZAMAN M (2022) Healthcare access and its barriers for women in rural Khyber Pakhtunkhwa. *Journal of Health and Development*, 13(2), 88-101.

38. SHAIKH B T, HATCHER J (2005) Health seeking behaviour and health service utilization in Pakistan: challenging the policymakers. *Journal of Public Health*, 27(1), 49-54.
39. SILVESTER J, ANDERSON N R, HADDLETON E, CUNNINGHAM-SNELL N, GIBB A (2005) A cross-national comparison of interviewer decision making. *International Journal of Selection and Assessment*, 8(1), 45-53. https://doi.org/10.1111/1468-2389.00134.
40. TARIQ M, HUSSAIN R (2018) Educational challenges faced by women in Khyber Pakhtunkhwa. *Educational Research Quarterly*, 12(1), 34-47.
41. THE EXPRESS TRIBUNE REPORT (2017) Pakistan's healthcare system faces significant challenges. *The Express Tribune*. https://tribune.com.pk/story/1447888/pakistans-healthcare-system-faces-significant-challenges.
42. UNAIDS REPORT (2020) Global HIV & AIDS statistics—2020 fact sheet. Joint United Nations Programme on HIV/AIDS (UNAIDS). https://www.unaids.org/en/resources/fact-sheet.
43. UNAIDS (2020) UNAIDS Global AIDS Update 2020. Joint United Nations Programme on HIV/AIDS (UNAIDS). https://www.unaids.org/en/resources/documents/2020/global-aids-update.
44. ZAKAR R, ZAKAR M Z, KRAMER A (2011) Voices of Strength and Struggle: Women's Coping Strategies against Spousal Violence in Pakistan. Journal of Interpersonal Violence, 27(16), 3268-3298.
45. EARNSHAW V A, CHAUDOIR S R (2009) From conceptualizing to measuring HIV stigma: A review of HIV stigma mechanisms and measures. *AIDS and Behavior, 13*(6), 1160-1177.