Stigma and Discrimination Faced by Women Living with HIV/AIDS (WLHA)

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INTRODUCTION

Human Immunodeficiency Virus (HIV) and acquired immunodeficiency syndrome (AIDS) continue to be among the most pressing global public health challenges. According to UNAIDS (2020), approximately 38 million people worldwide are living with HIV, with around 5.8 million of them residing in Asia. In India alone, the National AIDS Control Organization (NACO, 2020) reports that 2.349 million people are living with HIV, making it the country with the third-highest number of cases globally, with an estimated HIV prevalence rate of 0.22%. Despite significant advancements in public health interventions, several barriers still hinder access to HIV-related services. Chief among these barriers are stigma, discrimination, and negative attitudes toward people living with HIV (PLHIV). Such attitudes undermine efforts in HIV prevention, care, and treatment.

According to Campbell (1999) women, bear a 'triple jeopardy' impact of HIV/AIDS: as persons living with HIV/AIDS, as mothers of child, and as caretakers of partners, parents or orphans with AIDS. WLHA are at particularly high risk of living a painful, shameful life of exclusion (Busy and Gayle, 1996). Liamputtong et al. (2009) reported that stigma associated with HIV/AIDS as a sexually transmitted disease is more for women than men. A fear for death, isolation, humiliation, blame, character assassination all these circumstances are faced by WLHA. For women living with HIV infection in India, stigma is a pervasive reality and the greatest barrier to accessing treatment, quality of life and survival (Short and Vissandjée,

2017). According to Van Hollen (2011) HIV-positive widows face a double burden of discrimination owing to the fact that in much of Indian society 'not only AIDS, but widowhood itself carries stigma.' If expelled from their in-laws' home, widows may also be denied their husband's inheritance, leaving them both socially and economically excluded from the family.

HIV/AIDS epidemic is very much interwoven with underlying issues of gender inequality and sexism in India. Women are blamed for bringing HIV and the resultant sufferings to the family. Women are denied access to their husband's household, property and sometimes they are not even allowed to live with their children (Pallikadavath et al., 2005; Thomas et al., 2008). The in-laws' family generally does not support widows of HIV positive men. They have to seek support in their parental homes (Bharat et al., 2001; Pallikadavath et al., 2005).

Research has consistently identified family and healthcare settings as the primary environments where HIV-related stigma and discrimination are most evident (Bharat et al., 2001; Ekstrand et al., 2013, 2018). Banteyerga (2005) reported that HIV/AIDS related stigma and discrimination is prevalent everywhere but in health care settings it has very serious consequences which prevents people to visit these centres. HIV related stigma reduces the care seeking behaviour (Parker and Aggleton, 2003) of PLWHA and they do not participate in routine HIV testing (Babalola, 2007). The negative consequences connected to HIV stigma may force the infected people to delay or refuse treatment or hide their disease from others. The fear from stigma causes denial, secrecy, depression and shame. The disclosure of HIV status faces the person with the feelings of shame and self-suspicion (Varas-Diaz et al., 2005). They think disclosing their status may not only create a complicated and stressful situation, but also causes the person to lose family support and health care provision (Varas-Diaz et al., 2005 and Gosling, 2008).

In a systematic review conducted by Bharat (2011) approximately one third to half of the respondents, including the health care providers had blamed PLWHA for bringing the disease into the community. The negative attitude of staff is the result of fears related to get infected from HIV or a deficient understanding of what stigma is and what the cost of stigma are (Nyblade et al., 2009 and USAID, 2010). Bruyn (2002) reported that HIV positive women are treated very badly in health care services. They are blamed for getting infected with the dirty disease and many times they are compared to prostitutes. In health settings, women with HIV are asked embarrassing questions, which discourage them from seeking care for HIV-related treatment (Thomas et al., 2008). According to Bharat et al. (2001) many clinics refuse to admit HIV positive person. HIV infected patients experience a number of undesirable conditions in their life such as: hostility, denial of gainful employment (UNAIDS, 2000) forced resignation or forced early retirement (Ehiri, 2005). Stigmatization can lead to prejudicial actions and thoughts among governments, communities, health care providers, employers, family members and colleagues (Zierler et al., 2000). Community-level stigma remains widespread; for instance, Letamo (2004) reported that 68.6% of respondents said they would not buy vegetables from an HIV-positive vendor. Similarly, a study by Qian et al., (2007) found that 81.9% of participants would not allow their children to play with a child living with HIV and would avoid teachers or neighbors with the virus. These findings underscore the persistent and pervasive discrimination against PLHIV in society.

Buzy and Gayle (1996) argued that HIV-positive individuals are at high risk of social exclusion and lead lives marked by pain and shame. Women, in particular, face double discrimination due to both gender and disease status (Bunting, 1996). Community-level stigma remains widespread; for instance, Letamo (2004) reported that 68.6% of respondents said they would not buy vegetables from an HIV-positive vendor. Similarly, a study by Qian et al., (2007) found that 81.9% of participants would not allow their children to play with a child living with HIV and would avoid teachers or neighbours with the virus. These findings underscore the persistent and pervasive discrimination against PLHIV in society.

Research studies consistently show that women WLHA frequently experience stigma and discrimination across multiple spheres of their lives, including within their families, healthcare systems, and communities due to a complex interplay of gender norms, moral judgments, and misinformation about the disease. At the family level, WLHA may face rejection, blame, or emotional abuse, often being held responsible for their diagnosis, which can lead to isolation and psychological distress. In healthcare settings, WLHA may be subjected to substandard treatment, denial of care, unnecessary referrals, or breaches of confidentiality. Some healthcare workers may avoid physical contact, delay procedures, or openly express discomfort, all of which contribute to a hostile and unsafe environment. Within the broader community, WLHA often encounter social exclusion, gossip, and discriminatory practices that reinforce marginalization and hinder their ability to participate fully in social and economic life. These layered forms of stigma not only violate their human rights but also pose significant barriers to effective HIV prevention, treatment, and support efforts.

Objectives

- To explore the profile of WLHA living in Ludhiana district
- To discuss the type of Stigma and Discrimination faced by WLHA.

Method and Technique: For the present study, research design is partially exploratory and partially descriptive in nature. A sample of 67 WLHA visiting ART Centre in Lord Mahavir Civil Hospital, Field Ganj Road, Ludhiana district of Punjab was collected. HIV positive women in the age group of 15-60 years constituted unit of analysis. Theoretical sampling method was used. In theoretical sampling, the factor that determines the size of the sample is often 'saturation': information becomes repetitive and confirmatory, and no new information is derived from fresh interviews. WLHA visiting ART Centre were interviewed at length using Interview guide.

Results: The study sample consisted of 67 WLHA, 29 respondents were in the middle age group i.e. 35-45 years. There were 18 respondents whose age was between 25-35 years. There were nine respondents in the age group of 15-25 years. There were seven respondents in the age group of 45-55 years and four respondents who were above the age of 55 years.

With regard to marital status, it was found that only five respondents were unmarried, remaining 62 had once married. There was one respondent who became widow at the age of 19 years; there were 17 respondents who got widowed when they were in the age group of 20-30 years. There were 16 respondents who became widows in age group of 30-40 years and remaining four respondents became widows in age group of 40-50 years. There were 14 married respondents living with their husbands. The study sample consisted of 67 WLHA. Among them, 29 participants were in the middle-age group of 35–45 years, making it the largest age category. Eighteen respondents were between 25 and 35 years old, while nine were aged 15–25 years. Seven participants fell within the 45–55 age range, and four were over the age of 55 years.

In terms of marital status, only five respondents were unmarried, while the remaining 62 had been married at least once. Among these, 48 women were widowed: one at the age of 19, 17 between the ages of 20 and 30, 16 between 30 and 40, and four between 40 and 50. Fourteen of the previously married women were currently living with their husbands.

Religious affiliation showed that the majority of respondents (43) identified as Sikh, which aligns with the demographics of Ludhiana district in Punjab—a predominantly Sikh region. The second-largest group comprised 22 Hindu respondents. Additionally, one respondent identified as Christian and another as Muslim, both of whom were HIV positive. With respect to caste, 39 respondents belonged to the General category, while the remaining 28 were from reserved categories.

Among the respondents, 16 were illiterate, while seven had received education only up to the primary level. Seventeen had studied up to the middle school level, though some were unable to complete the 8th grade due to a lack of parental support. Thirteen respondents were matriculates, and 11 had completed education up to the plus two level. Only three respondents were graduates.

In terms of employment, 35 respondents were not engaged in any form of paid work. Among them, 12 were married and completely dependent on their husbands. Of the nine widows in this group, five were living with their parents, two with their in-laws, and two with their sons in rural areas after their husbands' deaths. This group also included four students and one respondent who was incarcerated at the time of the study. Fifteen respondents were employed, including six who were working on a contractual basis at healthcare centres. Among the employed, two graduates were working as school teachers. One respondent was employed as a staff nurse in a government hospital, while another worked as a housekeeper in a mall. Two respondents were factory workers, and one worked as a machine operator. Nine respondents were employed as domestic helpers (housemaids). Among the self-employed, five women ran their own businesses—four operated boutiques and one managed a beauty parlour from her home. Three respondents fell under the 'others' category: one was an orchestra dancer, and two were engaged in sex work.

In terms of income, 36 respondents belonged to the low-income group. The majority of participants lived in poverty, with either no steady income or very limited earnings. Out of the 67 respondents, 26 reported having no income. This group included 12 married housewives who were financially dependent on their husbands, and nine widows—five living with their parents, two with in-laws, and two with their sons. It also included four students and one respondent who was in prison. Among the remaining respondents, nine housewives earned income through agriculture. Others in the low-income group (earning up to ₹15,000 per month) included five factory workers, one ASHA worker, one Anganwadi worker, four paramedical staff, two school teachers, three self-employed women, one orchestra dancer, and two sex workers. Three women earned more than ₹15,000 per month: one was a beauty parlour owner, another was a widow of an army jawan receiving both a salary and a pension, and the third was also a widow of an army jawan with a pension and agricultural income. Only two respondents were classified in the high-income group—one was a staff nurse, and the other owned substantial agricultural land.

Stigma faced by Respondent

Goffman (1963) described stigma as a condition that marks an individual as fundamentally different—and less acceptable—compared to what society considers "normal." He emphasized that stigma can lead to a "spoiled identity," deeply affecting how a person is perceived and treated. Building on this, Parker and Aggleton (2003)

examined HIV-related stigma and argued that it should not be viewed as merely an individual psychological experience. Instead, they framed it as a social process rooted in systems of power, inequality, and domination. They stressed the importance of analysing stigma within broader social and cultural contexts, rather than reducing it to personal bias or misunderstanding. Furthermore, research by UNAIDS, UNFPA, and UNIFEM (2004) highlights that gender inequality is a major driver of the HIV/AIDS epidemic among women, and that women living with HIV often face compounded stigma and discrimination due to their gender. Women are more often blamed for getting infected with the disease. Through stigma, society often blames infected people for being ill and justifies the discriminatory behaviour against them while asserting innocence and health of those who stigmatize (UNAIDS,1999). Following table provides the response of 67 WLHA who were interviewed about stigma they faced.

Table 1 Stigma faced by WLHA

***Response**	**No. of Respondents**
Family	41
Health Sector	31
Work Place	14
Community	25
Family, Health Sector	32
Family, Work Place	40
Family, Community	38
Family, Health Sector, Work Place	29
Family, Health Sector, Work Place, community	16
Health Sector, Work Place	26

***Multiple responses were received as some respondents faced Stigma at more than one place.**

Family as the Core Source of Stigma: For most women, the family was the first and most profound site of rejection. Once their HIV status became known, the familial support system often crumbled—either through outright expulsion, neglect, or moral blame. Results indicate that widows were particularly vulnerable. 27 of the 41 women who faced family-based stigma were widows rejected by their in-laws, often forced out of their marital homes and deprived of basic needs.

Married and remarried women were sometimes mistreated by their husbands, reflecting how HIV infection was seen as a moral failing on the part of the woman, even when the husband was the source of transmission. Unmarried women and those separated or divorced faced rejection from parents or siblings, demonstrating how

a woman's value within the family is often contingent upon her perceived sexual "purity" and marital status. These family experiences reflect Goffman's concept of the "spoiled identity"—where the woman's value is diminished not just because of her illness but because of the moral meaning society attaches to that illness.

Health Care Settings: Stigma within the health care sector further compounded the pain of WLHA. Thirty-one women described facing stigma in both private and public health care institutions. Rather than being spaces of healing, these medical environments often became sites of humiliation, judgment, and neglect. Women described a range of discriminatory practices, including delayed or denied treatment, moral condemnation, character defamation, and, in many cases, the non-consensual disclosure of their HIV status—violating both their dignity and privacy.

Particularly troubling were the experiences of pregnant women, who reported being shamed or mishandled during antenatal checkups and childbirth. Seven expectant mothers, five widows and two married women shared accounts of being treated as morally suspect or medically unworthy. Eleven women reported being outright ignored or sidelined once their HIV status became known, while another eleven—including widows, married, and remarried women—faced open prejudice, ranging from verbal abuse to institutional neglect.

Twenty-three women faced mistreatment from paramedical staff such as nurses and lab technicians, who not only delayed essential care but also questioned their morality and, in some cases, disclosed their HIV status to others without permission. For five women, discrimination came directly from doctors, four of whom refused or mishandled care during pregnancy, and one during a surgical procedure. Three women were forced to seek treatment elsewhere after being denied care entirely.

Even class-IV hospital staff—ward attendants, cleaners, and support workers—were reported to have engaged in discriminatory behaviour. Three women described being spoken to harshly, refused assistance, and subjected to derogatory remarks based solely on their HIV status.

These experiences underscore a profound failure of the healthcare system to uphold the principles of equity and compassion. Instead of offering support, the system often acted as a mechanism of social judgment and exclusion, especially for women already burdened by familial and societal stigma.

The Workplace Only 14 women reported stigma at workplace, but their experiences were severe and diverse, especially among those in informal or stigmatized sectors. Four self-employed women (beauty parlour owners or tailors) faced gossip and client avoidance once their HIV status was known. Two Housemaids and two factory workers were either denied work or treated with hostility by colleagues. One respondent, a housekeeper and widow whose late husband had also worked in the same mall, was openly stigmatized at her workplace. Another respondent, an anganwadi worker, was subjected to character assassination by colleagues who urged her to resign due to her HIV status. The workplace, in these cases, became an extension of the moral scrutiny experienced elsewhere. Results endorse UNAIDS, UNFPA, and UNIFEM (2004) that indicate women living with HIV often face compounded stigma and discrimination due to their gender.

Community Women whose families disclosed their HIV status faced community-wide exclusion—neighbors distanced themselves, gossip spread, and informal support networks disintegrated. The findings reveal that 25 respondents were stigmatized by neighbours and community members, consistent with previous studies by Letamo (2004) and Qian et al. (2007). Among them were 16 widows whose HIV status became publicly known after the death of their husbands from AIDS. Seven married women were stigmatized after their family members disclosed their HIV status to neighbors. Additionally, two unmarried daughters, infected through their HIV-positive mother, were labelled immoral after their father revealed their status to the community. These women reported being socially excluded, with neighbors maintaining distance and avoiding any interaction with them. These community experiences align with Parker and Aggleton's (2003) argument that stigma operates through systems of power—the power to include or exclude, to label and shame, and to reinforce dominant cultural norms.

Overlapping and Intersecting Stigmas

Perhaps the most revealing aspect of the data is how many women faced stigma across multiple domains. This overlap suggests that stigma is not siloed, but cumulative and reinforcing:

- 32 women faced stigma from both family and the health care system.
- 40 women experienced stigma in both family and workplace settings.
- 38 women were stigmatized by family and community members.
- 29 women reported being discriminated against across family, health sector, and workplace settings.
- 16 women experienced stigma in all four spheres—family, healthcare, workplace, and community.

- 26 women were stigmatized in both health and workplace settings.

These patterns show how once a woman is marked as "HIV-positive," the stigma follows her—from the home to the hospital, from work to the streets. The interconnectedness of these experiences intensifies the psychological and social burden, leaving many women without any safe or supportive space.

Type Of Discrimination Faced by Wlha

HIV-positive women often face dual discrimination due to both their health status and gender, leading to stigma and social exclusion. They may encounter barriers in accessing healthcare, employment, and support systems, worsening their vulnerability and mental well-being. WLHA are stigmatized because their illness is associated with immorality, an unsanctioned behaviour by society, it is also seen as an unaesthetic form of death which is not well understood by the lay community and viewed negatively by health care providers (Alonzo and Reynolds, 1995). To understand the scope of discrimination experienced by WLHA, responses from participants were categorized into five overlapping types:

- Physical discrimination: Avoiding contact, refusing to share food, clothes, or living space, expelling women from the home, physical abuse, and enforced social distancing.
- Psychological discrimination: Blame, verbal abuse, character assassination, emotional neglect, demoralization, and being made to feel inferior or ashamed.
- Economic discrimination: Denial of money for essentials, refusal of inheritance or basic amenities, and job loss.
- Sexual discrimination: Denial of sexual intimacy and allegations of immoral behavior.
- Social discrimination: Social boycott, exclusion from functions, and shaming under the pretext of protecting family honor.

In the following table responses of 67 WLHA regarding the discrimination they faced have been displayed.

Table 2 - Types of discrimination faced by WLHA

Discriminator	Type of Discrimination	No. of Respondents
Family	Physical	24
	Psychological	41
	Economic	39
	Sexual	02
	Social	34
Healthcare System	Physical	14
	Psychological	25
Work Place	Physical	09
	Psychological	11
	Economic	02
	Social	04
Community	Physical	15
	Psychological	17
	Social	10

Multiple responses were received.

Discrimination within the Family The family, often considered a source of care and support, was the primary site of discrimination for most women. WLHA faced all type of discrimination within family.

- **Physical Discrimination:** There were 24 respondents who were denied the use of shared spaces and household items, forced to eat separately, beaten, or even thrown out of their homes. Among these, seven women were explicitly evicted by their in-laws, while others faced physical violence or neglect from husbands and parents.

- **Psychological Discrimination** There were 41respondents who were living with in-laws frequently subjected to verbal abuse, character assassination, and emotional neglect. Accusations of promiscuity were common, especially from in-laws, who blamed them for bringing shame or disease into the family.

- **Economic Discrimination** There were 39 respondents, especially widows without independent incomes, were denied financial support, inheritance, or access to household resources. Some were deliberately dispossessed of their late husbands' property.

- **Sexual Discrimination** Two women reported being denied sexual intimacy and targeted with insinuations or accusations of immoral conduct by male relatives.

- **Social Discrimination** There were 34 respondents, who were socially isolated within their own families, not invited to family functions, or treated as a source of shame. In two cases, even their children blamed them for being "immoral," reflecting how stigma is internalized and passed through generations.

- **Discrimination in the Healthcare System** Despite their role as caregivers, healthcare providers emerged as sources of judgment, fear, and neglect for WLHA. WLHA faced physical and psychological discrimination in the health care system.

- **Physical Discrimination** Fourteen women reported being ignored, denied treatment, or referred elsewhere at high cost. Three women were not attended by doctors, including two pregnant women and one suffering from kidney complications. Four were refused admission in public hospitals and forced to seek expensive private care.

- **Psychological Discrimination** There were 27 women who reported that health workers including doctors, nurses, and technicians frequently blamed these women for their illness, speculated about their character, and, in many cases, disclosed their HIV status to others without consent. This breach of confidentiality added to women's emotional burden and discouraged future medical engagement.

Such treatment reflects both lack of awareness about HIV transmission and deep-rooted moral prejudices, turning healthcare settings into another site of exclusion.

Discrimination in the Workplace Although fewer in number, the respondents who faced workplace discrimination described distressing experiences.

- **Physical Discrimination** Nine respondents stated that they were avoided or mistreated by colleagues and clients. This included housemaids who were dismissed, factory workers shunned by peers, and health workers ostracized by colleagues.

- **Psychological Discrimination** Eleven respondents were the targets of offensive remarks and humiliating jokes. Some were told they had no future and would die miserably, reinforcing hopelessness and emotional trauma.

- **Economic Discrimination** Two housemaids lost their jobs immediately after disclosing their HIV status.

- **Social Discrimination** Four women were excluded from office gatherings and social functions, with coworkers deliberately avoiding any form of interaction.

Discrimination in the Community Community-level discrimination often followed once a woman's HIV status became public. WLHA faced physical, psychological and social discrimination at community level.

- **Physical Discrimination** Fifteen respondents reported that neighbours avoided physical contact, refused to lend or borrow household items, and prevented their children from interacting with the respondent's children.

- **Psychological Discrimination** Seventeen respondents reported being the subjects of neighbourhood gossip, where their illness was linked to assumptions of moral failure. Many were unfairly held responsible for their husbands' deaths, and their HIV status became a source of rumour, speculation, and social shame within the community.

- **Social Discrimination** Ten respondents reported that they were not invited to local events, and avoided during sensitive occasions such as funerals. Even in death, stigma persisted—community members hesitated to attend the cremation of HIV-positive individuals.

DISCUSSION

The experiences of WLHA, as documented in this study, clearly highlight the multifaceted and deeply entrenched stigma and discrimination that they face in various aspects of their lives. These discriminatory experiences are not isolated but interconnected, reflecting broader societal norms that perpetuate gender inequality, misinformation about HIV, and moral judgment against those infected.

The family, typically a source of support and care, often becomes the first space where WLHA encounter stigma. The findings show that families tend to associate the HIV-positive status of women with moral failure, particularly blaming them for bringing shame or disease into the household. Many respondents, especially widows, were physically isolated, denied access to basic resources, emotionally abused, or even thrown out of their homes. These reactions are rooted in gendered expectations that hold women accountable for maintaining family honor and controlling sexual behavior. The perception that immoral behavior led to HIV infection fosters psychological and emotional abuse, further marginalizing women within their own homes.

Moreover, the data suggests that family stigma extends beyond the individual to collective stigma, where the entire family unit is seen as tainted. Families are often stigmatized by association, especially in conservative communities where individual behavior is seen as reflective of family values. This stigmatization exacerbates the vulnerability of WLHA, who are frequently dependent on family for financial and emotional support.

Healthcare institutions, expected to offer care and dignity, often become spaces of humiliation and neglect for WLHA. The study found that many respondents faced discrimination from doctors, nurses, and paramedical staff. Acts of discrimination included delayed treatment, refusal of services, character assassination, non-consensual disclosure of HIV status, and verbal abuse. Pregnant women, in particular, were singled out during antenatal visits and deliveries, reinforcing the intersection of gender bias and HIV stigma. As the findings align with prior research (e.g., Banteyerga, 2005; Bharat, 2011), the urgent need for stigma-reduction training in health systems is evident.

Although less frequently reported than in family and health sectors, workplace discrimination was also significant. Respondents reported being excluded, gossiped about, or forced to resign once their HIV status was known. For self-employed women, clients withdrew their support, while housemaids and factory workers faced job loss or social isolation. These forms of economic discrimination compound the challenges faced by WLHA, many of whom are already economically dependent or struggling to support children on their own.

The fear of disclosure in the workplace was also palpable among respondents, indicating that even perceived stigma can shape behavior and limit opportunities for livelihood and stability. This aligns with global findings (UNAIDS, 2000; Ehiri, 2005), where workplace stigma undermines not only economic well-being but also self-esteem and mental health.

At the community level, HIV-related stigma takes on collective and public dimensions. WLHA were often ostracized by neighbors and subjected to gossip, moral judgment, and exclusion from social events. In some cases, respondents reported being physically avoided or not allowed to participate in routine interactions such as borrowing items or having children play together. Such social exclusion leads to a profound sense of isolation, depression, and in extreme cases, suicidal thoughts. The belief that HIV is associated with immoral or socially unacceptable behavior exacerbates the stigma, reinforcing silence and secrecy around the disease.

The findings also demonstrate that many WLHA face stigma in more than one setting. A significant number of respondents experienced discrimination in both family and healthcare, while others faced stigma across all four domains—family, healthcare, workplace, and community. This intersectional discrimination reveals the compounded burden borne by HIV-positive women, often linked to broader issues such as poverty, widowhood, and gender-based violence.

Respondents reported experiencing various types of discrimination—physical, psychological, economic, sexual, and social. Physical discrimination, such as being asked to leave the home or being beaten, was most commonly reported within families. Psychological discrimination, including blame, verbal abuse, and loss of dignity, was widespread across all sectors. Economic discrimination, particularly among widows and non-working women, involved being denied access to money, property, or basic needs. Sexual discrimination emerged in forms of denial of intimacy and moral accusations, while social discrimination manifested through isolation and exclusion. These categories illustrate that stigma is not merely emotional or symbolic but material and structural. It affects every aspect of WLHA's lives—from health and livelihood to their personal identity and relationships.

CONCLUSION

In conclusion, stigma against WLHA is a multidimensional and intersectional phenomenon, manifesting across family life, healthcare systems, workplaces, and communities. These overlapping experiences of discrimination are shaped by entrenched gender norms, misinformation, and institutional shortcomings. Therefore, combating HIV-related stigma requires comprehensive, multi-level interventions that go beyond surface-level awareness efforts. Effective responses must prioritize targeted action at the family, community, institutional, and policy levels, with a strong emphasis on education, gender equity, and the empowerment of affected women. Crucially, policy must play a central role—not only by promoting awareness but by mandating systematic sensitization training for healthcare professionals, social workers, educators, and employers. These trainings should challenge harmful stereotypes, foster empathy, and ensure that discriminatory practices are identified and penalized within institutional frameworks.

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