

# Factors affecting and shaping the Perspectives and Experiences of Women living with HIV/AIDS

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## Abstract:

This paper explores the relationship between studying the socio-cultural and religious factors in shaping the perspectives and experiences of women living with HIV/AIDS. The study aims to deeply investigate the socio-cultural and religious domain of the Pakhtun culture of Malakand District, Pakistan, and to know how cultural beliefs, traditions and religious practices influence the experiences of women affected by HIV/AIDS. Through a qualitative research approach, this study engages in-depth interviews with the participants, participant observations and field notes to gain profound insights into the challenges these women face. The research objectives comprise a comprehensive exploration of the complex relationship between socio-cultural and religious factors that

influence the experiences and perspectives of women living with HIV/AIDS. The analysis of field data has been thematically analyzed and is presented in the form of themes and a discussion that is supported by theoretical data as well as data from field observations, field notes and personal data of the respondents. However, for the presentation of the personal data, ethical consideration of the research and field data coding was strictly observed.

## Introduction

Human Immunodeficiency Virus (HIV) is a widely known and feared disease across the world. HIV attacks the immune system of the body and gradually weakens the ability of the immune system to fight against infection and diseases (Willman, 1994), and it can progress to acquired immunodeficiency syndrome (AIDS), making the body highly susceptible to different opportunistic infections and diseases (Campbell, Ni, & Lim, 2019). HIV can be transmitted various ways, such as the exchange of body fluid from an infected person through sexual contact, exposure to infected blood, the sharing of needles or injectable equipment, and from mother to child (during pregnancy, childbirth, and breastfeeding). Further, the primary mode of HIV transmission worldwide is still sexual contact, as exposure to infected blood can also transmit the virus (CDCP, 2021). An estimated 38 million people were living with HIV/AIDS at the end of 2019. This number includes 1.7 million new infections that year, and there were approximately 690,000 AIDS-related deaths that year as well.

Although significant progress has been made in HIV/AIDS prevention, treatment and care, many people living with HIV/AIDS still face significant barriers to care and treatment, particularly in low- and middle-income countries. Unfortunately, this topic does not receive attention in the school curriculum (UNAIDS Report, 2020, Ihsan *et al* 2019). In Pakistan, HIV/AIDS is a growing concern. Poverty, gender discrimination, a lack of awareness about the disease, risky healthcare practices and cultural barriers to condoms make women vulnerable to HIV/AIDS (Bonnell, 2000; Mall, S., *et al.*, 2015; Sana Ulla and Naz, 2019). Gender-based power imbalances and women's subordination within societies contribute to their increased vulnerability to HIV/AIDS (Shacham *et al.*, 2009). However, in Pakistan, although the prevalence of HIV is rel-

atively low with approximately 220,000 individuals having HIV/AIDS in 2019 (NACP, 2020), addressing the HIV/AIDS epidemic in Pakistan is challenging due to socio-cultural and religious factors. These aspects result in limited access to prevention, inadequate testing and treatment services, and insufficient funding for HIV/AIDS programs (UNAIDS, 2020; Ullah, Naz, Khan, Khan, Gul, Khan, Khan 2019).

Protection from the disease becomes more difficult for marginalized and vulnerable communities because of their lack of access to appropriate healthcare facilities (Hargreaves and Boler 2006). Unequal access to healthcare facilities is also dependent on the description of gender roles, certain given responsibilities in societies and the status of gender discrimination. Moreover, in a society with gender discrimination, women's access to healthcare, assistance and treatment services, as well as their ability to manage the disease, all become more difficult (Population Council Report, 2009). It is important to understand the specific needs and challenges faced by women in the cultural context that are important for effective HIV/AIDS prevention and control in Pakistan (Abdool Karim *et al.*, 2010).

In the context of Khyber Pakhtunkhwa, a province in Pakistan, HIV/AIDS prevalence and healthcare access persist, with only 18% of women having access to Antiretroviral Therapy (ART) compared to 47% of men due to socio-cultural and religious factors (Azim *et al.*, 2008). Socio-cultural and religious factors have strong impacts on reducing the prevalence of HIV/AIDS among women and marginalized gender and sexual orientation communities in the region, as only 14% of HIV-positive women are registered, according to the National AIDS Control Program (NACP) Pakistan. The rest of them remain unregistered and untreated, as cultural and societal values restrict women from

talking about the disease, pushing them to conceal the fact that they have it instead (NACP, 2020).

### Study Rationale

Within the socio-cultural and religious domain of Pakhtun culture, existing research has investigated how cultural beliefs, traditions and religious practices influence the experiences of women affected by HIV/AIDS. The region has high poverty levels (Sana Ullah, Arab Naz, Muhammad Asghar Khan, Muhammad Hamayun Khan, 2021), experiences gender inequalities, possesses limited awareness of the disease, practices risky healthcare practices and additionally there are cultural barriers to condom use, making women more prone to becoming infected with HIV (Agha, 2019). Although research has been done on various aspects of HIV/AIDS studies in the context of gender and HIV/AIDS, these aspects have not yet been explored specifically in the Pukhtoon culture. The existing study is based on an investigation of the socio-cultural and religious factors in shaping perspectives and experiences of women living with HIV/AIDS in the Malakand division. This is indeed a challenging and sensitive issue, but at the same time it has far-reaching effects on the lives of women living in a society as conservative as the Pakhtun culture. The study is guided by research questions such as *What are the different sociocultural factors that create gender disparity?* and *What are the sociocultural and religious factors influencing the perspectives and experiences of women living with HIV/AIDS?* The data was collected to explore the socio-cultural and religious factors shaping the perspectives and experiences of women living with HIV/AIDS. In addition, the goal is to understand the experiences of women facing gender-based stigma, medical stigma and discrimination, and its impact on their access to healthcare facilities.

### Methodology

The study was delimited to two selected districts of Malakand Division i.e., District Dir Lower and District Swat. This choice was based on the fact that District Dir Lower has a higher number of HIV/AIDS patients in the province after District Peshawar, and District Swat was selected based on 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) with equal representation of both districts. There were 10 other stakeholders including the organizational head, doctors and key informants. The researchers used observations, field notes and key informants, and they developed case studies during various interactive sessions with respondents. The collected information was qualitatively analyzed following Braun and Clarke's (2006) six-step thematic analysis model, and a report was subsequently generated. Looking at 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. By meticulously organizing, coding and analyzing qualitative data, thematic analysis uncovered meaningful patterns and themes, providing valuable insights into the research topic. The major themes that emerged from the data were: socio-cultural and religious influences on women's perspectives and experiences of HIV/AIDS, followed by sub-themes of social stigma, medical-based stigma and discrimination, gender disparities, religious beliefs and practices, socio-cultural and religious influences on women's perspectives, and experiences with HIV/AIDS.

### Study Results and Analysis

In many societies worldwide, HIV/AIDS has a devastating impact that goes beyond its medical implications. Socio-cultural and religious factors play a significant role in shaping the perspectives and experiences of women affected by the disease (Parker et al., 2003; Mahajan et al., 2008). Similarly, the analysis of the existing research data reveals that socio-cultural and religious factors have a strong influence on women patients living with HIV/AIDS, and they develop fear and distress that shape their perspective about the disease. One interviewee shared her views accordingly:

*„Culturally, a woman is considered to be pure and pious, while the disease is thought of as an outcome of immoral relations between a man*

*and women that results in the suspicion of and rejection of a woman.*“ (WP112)

The primary data collected shows a strong link between the negative societal attitudes towards HIV/AIDS patients and feelings of rejection by society that hurt their health-seeking behaviors. Social and cultural norms have a strong connection with the health-seeking behavior of HIV/AIDS patients. This is especially true for women in Pakhtun culture, where the only cause of the disease is considered to be immoral action. This way of thinking, in connection with religious unawareness and misinterpretation, can put the lives of women at risk in terms of rejection by society. It can even threaten their lives, as honor killing is still practiced in some of the areas. Moreover, social stigma associated with HIV/AIDS, specifically the stigmatization of women, can hinder their access to testing, treatment and support services (Li et al., 2010). Such fear restricts women from talking about their illness and receiving medical assistance. Data collected through personal observations and focus group discussions revealed that fear of social isolation and rejection compel women to remain silent and not disclose the disease. This not only puts their lives in danger, it can also threaten the lives of others by allowing for the transmission of the disease in different ways. Secondly, prevailing societal norms surrounding masculinity imply that men are expected to have more extensive sexual knowledge and experience compared to women. These expectations often cause young men to underestimate the risks associated with sexual behavior, leading to a lack of awareness about preventive measures (UNAIDS, 2013). This unawareness about the disease among women leads to a high prevalence of HIV/AIDS. The analysis of field notes indicates that the majority of the respondents had no clear information about the disease, its transmission routes and treatment. The major issue when it comes to asking for information or guidance about HIV/AIDS was the social disapproval for discussing such issues both in person and in general. Mostly the respondents shared during focus group discussions that they can't ask for any information about the disease because if anybody initiates such a discussion, people perceive her as being shameless and immodest. This is due to the fact that this kind

of discussion is related to sexual relations and contacts.

Similarly, low literacy levels and educational disparities also impact women's knowledge and understanding of HIV/AIDS, potentially increasing their susceptibility to infection (Duff, 2012). The field data also demonstrated that a lack of knowledge has adverse effects on the prevalence of the disease. During the individual interviews, it was said by an interviewee that she had been transferred the disease through unscreened blood. Another one of the cases highlighted the death of a 22-month-old child because of a blood transfusion.

Moreover, the supportive literature also shows that despite the socio-cultural factors, stigma is also associated with misinterpreted religious beliefs, especially when HIV/AIDS is considered sinful or immoral (Khawja & Motlagh, 2016). The field data explored that misinterpretation of religious beliefs also causes stigma and discrimination. During the data collection from women participants, many of the interviewees expressed experiencing feelings of social isolation, lacking family support and facing stigma after being diagnosed with HIV/AIDS. One woman said:

*„I felt helpless, and my behavior changed a lot after getting this disease. I couldn't control my anger, and everyone treated me with hatred. I was blamed for having this disease, even though I wasn't at fault. There was nobody who showed sympathy, and I couldn't share my pain and worries with anyone.*“ (WPI02)

This quote portrays the emotional distress and desperation experienced by women living with HIV/AIDS facing stigma and discrimination. The stigma surrounding HIV/AIDS often leads to social exclusion, discrimination and negative attitudes towards those affected by the disease. Women, in particular, face additional challenges due to existing gender norms and societal expectations. Stigmatizing beliefs and a misunderstanding of HIV/AIDS contribute to fear, shame and silence, preventing individuals from seeking testing, treatment and support services (Parker et al., 2013; Mahajan et al., 2008). This stigma can have severe psychological and emotional impacts on women, increasing feelings of isolation and adding to the burden of living with HIV/AIDS. As another interviewee expressed,

*„I cried for many days, and I thought, ‘If I die, I can escape from this insulting life.’“ (WPI05)*

It highlights the impact of stigma on their mental well-being that causes strong emotional distress and desperation. This results from stigma and discrimination, which create significant barriers to seeking support, accessing healthcare services and adhering to treatment.

Similarly, religious teachings also play a strong role in shaping women’s perspectives about the disease. During a focus group discussion, it was concluded that religion has both negative and positive impacts on women living with HIV/AIDS. It was said by one participant that religion has a positive and sympathetic approach toward HIV/AIDS patients. She supported her point with the argument:

*„In Islam, it is taught that if you have a disease that can be transmitted to others, you should treat yourself and protect others from it. If I have this disease, I should not keep it a secret and should take all precautions to keep others safe.“ (WPI03)*

This interviewee, reflecting on Islamic teachings, emphasizes the importance of taking responsibility for one’s health and preventing the transmission of the disease to others. In contrast to the stigma and secrecy often associated with HIV/AIDS, religious aspects related to the disease promote openness, compassion and a sense of communal well-being. The misconception and misinterpretation of religious teaching regarding the disease create a social stigma around the disease, as one of the participants highlighted during a focus group discussion. She mentioned that people assume the infected person is a wrongdoer or had extra-marital relations. Islam does not allow physical relations before marriage, which is why people behave in an insulting way to such patients, and this also may have a drastic effect on the psyche (Humera Ali, Ayesha Gul, Mohammad Yousaf, Rahim Changezi, Arab Naz, 2019). Personal observation and field notes explore the religion-based stigma associated with HIV/AIDS. Due to the lack of coordination and cooperation between religious leaders and the health department, HIV/AIDS is mostly interpreted religiously as the outcome of extra-marital relations, which are not allowed in Islam. Other transmission routes

of the disease are not very known to people and among the religious community.

### **Social Stigma, Medical Stigma and Discrimination**

The broader theme of socio-cultural and religious influences on women’s perspectives and experiences with HIV/AIDS sheds light on the challenges faced by women living with the disease. Social stigma and discrimination highlights the negative societal attitudes, discrimination and restrictions imposed on individuals with HIV/AIDS. To investigate the problem, in-depth interviews and focus group discussions took place, and in some places, participant observations were carried out and field notes were taken. Women who were HIV/AIDS positive were encouraged to share their feelings of being stigmatized by society. The majority of the interviewed 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 as the main hurdle in the prevalence of the disease. According to Nyblade, MacQuarrie and Canales (2001), women living with HIV/AIDS are often subjected to stigmatization due to societal gender norms. During the interviews, 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 the interviewee highlighted that although she is not guilty of any wrongdoing, she was still facing the stigma for it. This shows that in her case, men are not held responsible for wrongdoing or perceived for wrongdoing, but the women’s status in society is always very vulnerable to social stigma. Furthermore, Herek, Capitanio and Widaman (200; Hardy, Vansac, Benca, Palun, Gallova, Susta, & Kimuli,(2018). highlight that the detrimental impact of social stigma on the well-being of individuals with HIV/AIDS is very high, and this 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 this interviewee quote that the illness is curable, but the negative behaviors of the people make them suffer more. This also shapes their perspectives, making them more vulnerable to the disease because of the social pressure they face along with the disease.

Another important factor highlighted during field data collection was the concealment of the disease, which is a potential threat to the lives of healthy people. The majority of the respondents discussed that they are not sharing the information with relatives or people outside of the family, and they might not even share their HIV/AIDS status during minor medical procedures. In such cases, the healthcare structure, which is already not following proper medical protocols, and malpractice are very prevalent in rural communities, can pose a threat when it comes to HIV/AIDS prevalence. In rural areas, deliveries are normally dealt with by traditional birth attendants at home in the absence of advanced medical techniques and procedures. This can increase the prevalence of the disease if the patient hides their HIV/AIDS status. Similarly, one of the patients said that because of social rejection and isolation, she does not share her illness with people, and if this is done on a large scale, it can create healthcare issues for the wider population.

*„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.“*

*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“.*

This fear doesn't allow them to talk about their illness outside of their family, and this fear hinders their access to healthcare facilities as well, which can increase the prevalence of the disease.

Mahajan, Sayles, Patel and Remien (2008) explore the stigma, as healthcare providers have been known to bar women from receiving treatment for HIV/AIDS. Similarly, field data collected from women living with HIV/AIDS also highlighted that they face medical-based stigma when it comes to healthcare services. The collected data further differentiated the medical-based stigma and showed that hospitals that have specialized places for HIV/AIDS treatment are very cooperative and patients don't experience negative behavior there. However, when patients initially tried to get treatment from a hospital that doesn't have an HIV/AIDS specialized staff, they were neglected and treated with hatred. This is an important factor because there is a lack of medical healthcare facilities in rural areas, where routine treatment is provided in an improvised manner. This means that in such cases HIV/AIDS emergency needs cannot be provided sufficiently. Additionally, the stigmatizing behavior shapes women's perspectives and restrains them from receiving medical services. The impact of stigma and discrimination on the quality of care provided is evident in one interviewee's statement about what happened when she took her 22-month-old HIV/AIDS-positive child to the hospital:

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

In conclusion, the interviewee's statements align with the findings of supporting literature, including Nyblade et al. (2001), Herek et al. (2002), Campbell et al. (2007), Aggleton and Parker (2002), Mahajan et al. (2008) and Earnshaw and Chaudoir (2009). 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 interviewee's statements with the supporting literature, this article highlights the significance of social stigma and discrimination and provides a basis for understanding and addressing these issues.

### **Sociocultural Factors and Gender Disparities**

The study and analysis of sociocultural factors and gender disparities are crucial in understanding the health status of communities

and identifying underlying health inequalities among different sub-populations (Marmot & Wilkinson, 2000). However, in the context of women living with HIV/AIDS, gender inequality persists due to discriminatory cultural and behavioral practices, both at home and within the community. These practices have given rise to considerable health obstacles for women that are driven by social disparities among different groups, thereby amplifying the difficulties confronted by women living with the disease (Nyblade *et al.*, 2004). Research shows that inequalities experienced by women living with HIV highlight the negative societal attitudes, discrimination and barriers to accessing healthcare and support (Earnshaw & Chaudoir, 2009; Khanna, & Patil, 2020).

First-hand data collected through in-depth interviews, focus group discussions, personal observations and case studies highlighted that woman living with HIV/AIDS face negative responses and discrimination in their communities. Moreover, the social restrictions imposed on women hinder their access to healthcare services. During data collection, it was highlighted that women face discrimination at the family level because of the cultural and societal status designated to women, and this further exacerbates their access to treatment services for HIV/AIDS. One of the interviewees highlighted that her health issues are not taken seriously at home and she has a lack of social support from her family. Socially, women are not empowered to live their lives according to their will, and they are bound to follow the cultural norms that restrict their social mobility and don't allow them free movement.

In the Pakhtun cultural context, women are not allowed to go to hospital without the support and approval of a man, and this can result in delays in treatment. Field data explored the fact that women can't receive health services on a regular basis because of the unavailability of family members to be at every checkup. One of the interviewees expressed the challenges faced by women in seeking timely healthcare due to cultural or logistical factors:

*„I go to Peshawar after months, but most of the time I just take medicines from Peshawar and do not meet with a doctor every month.“ (WPI02)*

This finding aligns with the research conducted by Campbell *et al.* (2003), who discuss the cultural and logistical barriers faced by individuals in accessing regular healthcare services:

*„Aw wali na, zmong kor ki kho nor sok nish-ta, khwand me bahar day, plar mi boda day kho gharib rala gham kai aw pa wakht rala golai rawri zka pa day ki qaza kawal nshta.“*

*Translation: „Why not, there is nobody at home. My husband is abroad, and my father is an elderly person. But he still arranges medicine for me in a timely way because we can't skip it.“ (WI02)*

Social and cultural factors play an important role in accessibility to healthcare services. In the cultural context of Pakhtun society, women are kept less empowered and lack access to income-generating activities that could result in economic dependency and impact their health status. The majority of the respondents shared that they don't have the financial resources to make free decisions about their health issues. Such problems have been highlighted by the majority of women, and one of the respondents shared:

*„They are providing it free of cost in Lady Reading Hospital, and there is now a separate ward for HIV/AIDS patients. This is provided by an international NGO, that's why it's free. If it was not free of cost, nobody would be able to afford the treatment, and normally women's illnesses are not taken seriously in our society. So for AIDS patients, it's more difficult, as people hate them.“ (WPI03)*

Socially and culturally, women's health issues are given less importance, which shows the discrimination they face in society. This finding aligns with the literature, as studies conducted by Nyblade *et al.* (2004) showed that women's illnesses are often not taken seriously in society, leading to difficulties in accessing healthcare services. Additionally, Earnshaw and Chaudoir (2009) discuss the barriers faced by women in accessing HIV/AIDS services and emphasize the importance of addressing social stigma and discrimination. Parker *et al.* (2005) explored the stigma experiences of individuals affected by HIV/AIDS and emphasized how perceived immoral behavior and blame contribute to negative attitudes towards them. Another interviewee shared her experience of being treated in a very

hateful way, isolated from her community and subjected to discriminatory practices:

*„My in-laws were treating me in a very insulting way. They separated their kitchen items from me. I was not supposed to hug or kiss my children, and even my shoes were kept at a distance from theirs.“ (WPI02)*

The social status of women affects their mental health, as they are blamed for bearing the disease even though they are not guilty. This highlights the unjust and discriminatory treatment of women by society. During focus group discussions, women discussed the negative behavior of the family and relatives, who tried to convince them to keep their relations limited to close family members. One of the respondents shared:

*„doi wayi sa ghalat kar ba yi karay yi. Allah kho da khpal banda ghalyani hm maaf kai kho khalak kho k da cha qasoor hm na yi bad warta gori.“*

*Translation: „They think that we might have done some kind of immoral act. Allah forgives sin, but people don't forgive even if they are not guilty. They still treat them badly.“ (WPI01)*

This finding aligns with the research conducted by Mahajan et al. (2008), which examines the social and cultural dimensions of HIV/AIDS stigma. The study highlights how societal norms and practices can contribute to the stigmatization and discrimination faced by individuals with the disease.

In conclusion, the findings from the interview quotes, which are supported by relevant literature, highlight the profound impact of sociocultural factors and gender disparities on the perspectives and experiences of women living with HIV/AIDS. The interview quotes provide valuable insights into the challenges faced by women, including societal attitudes, discrimination and restrictions on access to healthcare.

### Religious Beliefs and Practices

A lack of religious education emerged as a prominent theme from the interviewees. Religious beliefs and practices are pivotal in shaping perceptions and responses to HIV/AIDS, with their impact influenced by cultural contexts and interpretations (Agadjanian, 2005; Campbell et al., 2011). Some religions emphasize values like compassion, understanding and support for in-

dividuals affected by the disease, fostering empathy and community (Pargament et al., 2004).

The majority of respondents talked about the misinterpretation of religious teachings by society. They pointed out that people don't deeply study the Quran, as it restricts them from blaming others without knowing the reality of the situation. According to them, if people treated others according to religious teachings, their lives would be less difficult, and the spread of diseases like HIV/AIDS would be minimized. During the gathering of field notes, it was observed that HIV/AIDS is not openly discussed; it is only mentioned in personal meetings due to the fear of religious interpretations of the disease. Misconceptions about the disease and a lack of knowledge limit the understanding of its actual causes. In focus group discussions, it was noted that the general perception of the disease is that it results from deviating from Islamic limitations and it is perceived that the transmission of the disease is the result of extramarital relations that leads to this infection, which is not accurate.

In stakeholder interviews, doctors discussed that hospitals lack proper waste management facilities, leading to the potential reuse of needles and syringes by drug addicts and contributing to the prevalence of AIDS. The community tends to overlook these factors as causes of HIV/AIDS prevalence. The absence of proper knowledge among religious leaders hinders their ability to address the issue effectively and promote accurate understanding within their communities.

This lack of cooperation and information-sharing among stakeholders, including religious leaders, further exacerbates the misconceptions and stigma surrounding HIV/AIDS. The interviewees commented about the religious teachings regarding HIV/AIDS:

*„In Islam, it is taught that if you have a disease that can be transmitted to others, you should treat yourself and protect others from it. If I have this disease, I should not keep it a secret and should take all precautions to keep others safe.“ (WPI02)*

It demonstrates how certain religious teachings, like those in Islam, promote compassion, care and prevention, leading to positive attitudes and reducing stigma within religious communities. Moreover, another interviewee stated that,



„Culturally, people will talk about the religion of the woman, not of the man“ (STK01), underscoring the unique challenges and stigmatization faced by women living with HIV/AIDS. It emphasizes the need for targeted support and understanding within the community, taking into account the intersection of religious beliefs, gender dynamics and cultural norms. One participant mentioned that „People don't have much religious education. In our village, the younger generation is receiving education, but older people are mostly uneducated. They don't know about this disease, and it is discussed in such a negative way that nobody likes to ask about this disease“ (WPI03). This lack of education becomes a barrier to raising awareness, dispelling misconceptions and addressing HIV/AIDS openly. Additionally, societal opinions often overshadow religious teachings, perpetuating stigma and discrimination.

In summary, the interviewee's responses highlight the influence of religious beliefs, education levels, societal opinions and cultural norms on perceptions and responses to HIV/AIDS. Accurate education, respectful interpretation of religious teachings, challenging societal opinions and addressing gender disparities are crucial in combatting stigma and providing comprehensive support for individuals affected by HIV/AIDS (Bharat, Aggleton, & Tyrer, 2001; Pew Research Center, 2014). These findings directly contribute to achieving the objective, which aims to explore the socio-cultural and religious factors shaping women's experiences with the disease. The alignment between these findings and the objective underscores the critical role of sociocultural and religious factors in shaping the experiences of women affected by HIV/AIDS.

The field data collected through interviews strongly supports the notion that socio-cultural and religious factors shape perspectives and the experiences of women living with HIV/AIDS when it comes to accessing healthcare services. The field data provides valuable insights into the pervasive social stigma and discrimination faced by individuals affected by the disease, particularly women that are restricted from having doctor visits, and whose fear of social isolation never allows them to talk about their disease. Such social behaviors are prevalent in society because

of the access to information about disease and the social norms that restrict the dissemination of information on HIV/AIDS. Through a comprehensive analysis of themes, gender-related and medical-based stigma and discrimination, power imbalances, cultural norms, religious factors and socioeconomic constraints, the study explored the complexities that create barriers to accessing healthcare services and contribute to the HIV/AIDS epidemic.

## Conclusion

In conclusion, the study results emphasize the urgent need for interventions to address these interconnected barriers. Educational programs that challenge harmful cultural norms and promote gender equality can empower women to make informed healthcare decisions. Economic support, accessibility to healthcare services, transportation assistance and free medical treatment supplies at the village level can alleviate the burden of socioeconomic constraints, enabling women to access and receive treatment and prevention services. The study's findings have broader implications for advocacy, policy and awareness efforts. This is not only true at the community level, but also religious scholars and clerics must get on board to help overcome the negative impacts of social stigma and discrimination and to encourage women to talk about the disease and the available healthcare services. These aspects would help to reduce the risk of HIV/AIDS prevalence in the conservative Paktoon culture of Malakand Division. It is also important to initiate a comprehensive program that can provide trained medical staff with medical facilities and provide counseling to patients and their families about the disease, as well as volunteering for testing for HIV/AIDS. For the successful implementation of an HIV/AIDS program, it is more important that all stakeholders have strong communication and coordination, including religious leaders.

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