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Illness and Inequality: Lived Experiences of HIV-Positive Women and Socio-Economic Vulnerabilities in Muzaffargarh, South Punjab

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ABSTRACT

This study explores the lived experiences of HIV-positive married women of Muzaffargarh in South Punjab, Pakistan. The focus of the current paper is on the social and economic conditions of the HIV-positive women of South Punjab. This qualitative study uses the phenomenological research design. This study takes the ontological position of interpretivism and epistemological position of social constructivism. The theoretical lens of stigma theory is used to analyze data. Six interviews were conducted with married HIV-positive women who were selected purposely from HIV treatment center in Muzaffargarh. Data was collected through in-depth interviews and data analysis was done using thematic analysis. The study findings revealed social exclusion and economic marginalization of HIV-positive women of Muzaffargarh. The overarching themes from thematic analysis were economic dependency, social exclusion and gendered economic roles. The study showed how the structural arrangements in South Punjab amplify the consequences of living with HIV.

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1.0 Introduction

This study focuses on the lived experiences of HIV-positive women in South Punjab. It centers mainly on the socio-cultural issues and challenges faced by the women of this region. HIV/AIDS is globally a very major health challenge. If we look at the statistics, about forty million people are living with HIV (UNAIDS, 2024). Out of this population, half are women and girls. The concerning angle is that in the year 2024, more than 1.3 million new people were infected (UNAIDS, 2024). According to UNAIDS (2024), 6.7 million people in South Asia are HIV infected. This makes up a quarter of the global new annual infections. As far as Pakistan is concerned, according to WHO (2025), it now hosts a fastest-growing epidemic and in the last fifteen years, there has been a 200 percent surge in new infections. WHO (2025) reported that in 2010, the infected people were 16000 and in 2024, the number rose to 48000. According to the same source, the number of HIV affected people in Pakistan is 350,000 (2025) and nearly 80 percent do not know their status. Out of this affected population, women comprise of a 20 to 25 percent (Samarasekera, 2022). Ironically, women are not affected through any personal risk-taking behavior, but are usually affected through husbands and at time through unsafe medical practices, that too mostly, of their spouses. The spouses may receive the infection through injecting drugs etc., making their spouses collateral victims. Thus, gender dynamics are at work and women become collateral victims and face stigma and other socio-economic challenges. As stated, the infections that women have are usually transmitted through husbands, but even then, the women are labeled as immoral and the stigma and social exclusion follow them (Gillani, 2021). Women are accused of bringing shame to families and face isolation and abandonment (Gul et al., 2025). Violence is also one of the documented results of HIV disclosure by Pakistani women. Women also face barriers of mobility and access to healthcare due to the stigma and prevalent social and cultural norms that limits women's mobility. According to data from National Aids Control Program (2020, cited in Gul et al., 2025), there are 14 percent of registered HIV-positive women. This low percentage is a direct result of limiting women's agency and autonomy in seeking health-care. South Punjab, the region chosen for this study, is mainly rural and disadvantaged as compared to central and northern Punjab (UNDP, 2022). The conditions of poverty, and poor health indicators from the region increases HIV transmission risks. As reported by Saleem (2025), in late 2024, there was an outbreak of HIV in Taunsa, South Punjab, due to unsafe injections and many pediatric infections were witnessed, making it an emergency.

As stated earlier, this study explores the lived experiences of HIV infected women of South Punjab. The conservative culture of this region with strict purdah systems and gendered practices, marginalize women with HIV and limit their support-seeking. This study focuses on the social exclusion, stigma and economic marginalization. For the purpose of this study, Muzaffargarh from South Punjab is selected.

2.0 Literature Review

Women and girls are disproportionately affected by HIV/AIDS. According to data, women comprised a 53 percent of global population surviving with HIV (UNAIDS, 2024). As far as new infections and younger population are concerned, HIV rates in young girls are twice as compared

to males. They comprise of a 64 percent of new infections (UNAIDS, 2024). Literature shows feminization of the HIV epidemic and also shows how social as well as gender inequalities make women more vulnerable (Barr et al., 2024).

It was revealed during review of literature that stigma and social exclusion was a dominant theme in recent research. The stigma attached to HIV posed a barrier in diagnoses, treatment and quality of life of HIV-positive women. A study in Brazil (Brandelli Costa et al., 2024) found that nearly seventy percent of women with HIV experiences one or another form of stigma. Majority i.e., 51 percent faced discriminatory gossip. Women who are marginalized socially, faced higher stigma levels as they are more vulnerable (Boakye et al., 2024). Stigma has its roots in social and cultural norms and it is the cause of psychological distress. This in turn delays treatment etc. Structural gender barriers and gender-based violence remain key impediments in HIV response for women. It has also been noted in review of global literature that economic conditions and developmental factors also form intersection with gender inequalities and disparities. Women living in poverty are more vulnerable to HIV/AIDS. The dependence and financial insecurity push women towards risk taking as far as survival is concerned. It was revealed in a study by Lépine et al. (2024), that women engage in risky sexual behavior when they face economic shocks. They conducted the randomized trials in Cameroon and in trials they provided free health insurance to vulnerable poor women, which in turn showed reduction of a significant percentage in new infections. This was a good test case of economic intervention. Another study by Yermukhanova et al. (2025), showed that regions like sub-Saharan Africa, which are high-burden regions, remain under-represented with major research studies and collaborations. There is a need for equitable global partnership to challenge and resolve social and economic disparities related to HIV. Recent research shows focus on intersectionality and strategies based on equity to address HIV in women. As there is a nexus of social, economic and biological factors that shape women's HIV outcomes, multifaceted interventions are required. Barr et al. (2024) introduced a data-driven intersectional framework in their research. This framework is also equity-informed. They took into account factors like violence, substance abuse, and pregnancy and caregiving. Overall, the global literature advocates for closing gaps in underrepresentation of women in clinical trials and other research agendas.

When we look at literature from South Asia, a global pattern is also seen here in all countries i.e., India, Nepal, Bangladesh and Sri Lanka. Research from these countries also show inequalities, disparities, social stigmas and other social and economic challenges that shape HIV epidemic amongst women. In India, young women and adolescent girls are disproportionately at risk despite the overall decline in HIV prevalence in the country (Paul et al., 2025). Research by Paul et al., (2025) showed that many intersectional factors like child/early marriage, gendered expectations, limited access to information about reproductive and sexual health and poverty etc. are the reasons behind this vulnerability of women. A study from Nepal (Dhital et al., 2025) also confirms that HIV stigma stayed moderate to high. There are deeply embedded misconceptions about transmission of HIV and there are also the patriarchal social norms that blame women disproportionately about the burden of infections. Similarly, in Bangladesh, where HIV prevalence

is much lower, a study (Bhowmik et al., 2025) showed that women and transgender individuals face more barriers in accessing treatment. The epidemic is even smaller in Sri Lanka, yet a recent study by Navarana (2025) reported a in HIV cases in Sri Lankan youth and shows concern over the spike in widespread stigma and other intersectional factors like poverty, lower education and discrimination, which is increasing vulnerability of young women and other marginalized groups. Navarana (2025) reports that only one in four young Sri Lankan women aged 15 to 24 years have adequate knowledge of HIV. Across South Asia, there is a nexus of social stigma, inequalities and economic issues that has posed as barriers in effective HIV response for women. Literature suggests that to address these issues, there is a need of multi-level strategies including stigma reduction programs, economic empowerment programs for women who are at risk, and also legal protection against gender-based discrimination (Dhital et al., 2025).

Literature from Pakistan also suggests stigma and social exclusion as a dominant theme, and it is a barrier to disclosure, treatment and care-seeking, and overall quality of life (Gillani, 2021). There are many misconceptions about mode of transmission add fuel to discriminatory behavior towards HIV-positive people. A qualitative study by Kausar (2023), shows that women often become outcasts upon their HIV diagnosis. The extent of stigmatization extended to healthcare settings too. Healthcare workers maintain distance and remain cautious in non-clinical interactions (Gul et al., 2025). These dynamics are more forceful in South Punjab as it is a more conservative area, so patriarchal and cultural norms and the concept of family honor intensify HIV stigma. The HIV-positive status of a woman may be seen as evidence of sexual impropriety. A study from KP Province of Pakistan (Gul et al., 2025) observed fear of social ostracism that led to delayed treatment in order to keep the illness a secret. HIV-positive statement also led to divorce and abandonment of wives by husbands. The HIV-positive status of women may taint reputation of entire family and in case of unmarried girls, marriage prospects diminish (UNDP, 2020). HIV-positive women have a subordinate status and they are dependent on men. Men control family resources and decision making, so women's health needs may get neglected or get low priority. Mall et al. (2015) notes that in South Asia, women healthcare often requires male permission. If husbands or other male members are not supportive, women may struggle to attend clinical appointment. Research revealed high levels of depression and anxiety in women living with HIV. In a study by Kausar (2023), participants repeatedly talked about the fear of death or loss, and also described themselves as cursed or dirty. Numerous studies show that HIV-positive women experience increased economic marginalization. A qualitative study (Iqbal & Khan, 2020) showed that women felt economically trapped as they were stigmatized and unwell to work. Literature also showed that many healthcare providers have discriminatory attitudes about HIV patients. The current study builds on this body of knowledge to understand how these dynamics work in South Punjab.

2.1 Theoretical Lens

The theoretical lens of Stigma Theory is chosen for this study. Erving Goffman (1963) has defined stigma as a trait that discredits a person. It is a social process that points out, rather singles out differences as unwanted, undesirable and shameful. This leads to discrimination of the

individual with those particular differences. Goffman's theory defined enacted stigma and felt stigma. Enacted stigma stands for overt acts of discrimination and felt stigma stands for the internalized sense of shame internalized sense of shame. As far as the current study is concerned, both angles are relevant to women with HIV. They experience both external discrimination and internalized shame.

The contemporary Stigma Theory of Link and Phelan (2001) describe stigma as "convergence of several components". These include the labelling of human differences and associating them with negative stereotypes, the dichotomy of us vs them, and loss of status of the labeled and discriminated group. The people with HIV also face the labeling and stereotyping. It must also be kept in mind that power dynamics are also at work. As women already lack social and political power, the ability to contest discrimination and stereotyping in case of HIV-positive status is further reduced.

In context with Stigma Theory, Parker and Aggleton (2007) argue that stigma should not be taken as an individual experience, but it is a social tool. It reinforces existing inequalities and unequal social structures. Thus, HIV stigma also reinforces the prevalent gendered norms and patriarchal hegemony.

Stigma is also socially constructed. It is different according to the social norms and cultural contexts of any region. The local cultural construction and intersectionality of gender and illness must be considered to understand the indigenous meanings and context. For example, the HIV-positive woman may be stigmatized as she has HIV status which is a communicable disease, but she may also be stigmatized to contract the disease as a single person i.e., in local context this is the violation of gendered moral code.

In short, the stigma theory, in context of this research, provides the lens to understand the marginalization of HIV-positive women, interpreting their lived experiences in terms of labeling, stereotyping and exclusion by society and community.

3.0 Methodology

This is a qualitative study. It utilizes the ontological position of interpretivism and epistemological stance of social constructivism. Interpretivism holds that there are multiple interpretations of reality and according to social constructivism, the different interpretations are socially constructed. This position means that the researcher is not seeking generalizability, but concerned with understanding and interpreting meanings that individuals and groups assign to certain phenomena. In context of this research, it means recognizing every individual participant's experience with HIV and the stigma attached to it is shaped by the social and cultural background and contexts, and also their interpersonal relationships.

The research utilizes the phenomenological design, appropriate to explore lived experiences of individuals and the meaning they attach to their experiences (Creswell & Poth, 2018). The phenomenological approach is relevant and appropriate in the context of HIV-positive women as it allows the researchers to collect in-depth narratives and to identify themes that are common in these narratives.

As stated earlier, the study is conducted in Muzaffargarh District of South Punjab. It is

chosen for its socio-cultural representativeness of South Punjab. The sample comprised of six HIV-positive women. These were selected through purposive sampling. Women who are aged more than 18 years and had been diagnosed with HIV were selected. Also, married women were selected for this study who had lived with this condition for at least two years. This was important for phenomenological inquiry to ensure that the participants of the study had enough experience to manage illness and to face issues and challenges of socio-economic nature. Participants were recruited through HIV treatment center Muzaffargarh. To collect data, permission was acquired from the project director of Punjab AIDS Control Program. The HIV-positive women were purposely selected and officials from treatment center facilitated the contact with women. The interviews were also conducted in the centers. Informed consent was acquired from participants and pseudonyms were assigned to them to protect their identity. The identifying details were also anonymized in their narratives. The interviews were conducted in Saraiki, Punjabi and Urdu. Interviews were audio-recorded. The interviews were transcribed and translated into English. Data were collected through in-depth interviews. A thematic interview guide was prepared for this purpose. The format was semi-structured so that the participants could narrate their lived experiences in their own style and comfortably. Field notes were also kept during the interviews which aided later on in contextualizing the transcript during data analysis. Data analysis was conducted using thematic analysis. The six-phase approach of thematic analysis as outlined by Braun and Clarke (2006), was followed i.e., familiarization, coding, searching for themes, reviewing themes, defining and naming themes, and producing the report. As the topic of research is very sensitive, ethical considerations were very important. As mentioned earlier, informed consent was obtained and anonymity of data was ensured.

4.0 Findings and Discussion

This study explored the lived experience of HIV-positive women from South Punjab. In this research six HIV-positive women were interviewed. Creswell and Poth (2018) recommend a smaller number of participants i.e., 3 to 10 in phenomenological studies. It is important to select participants who have directly experienced a phenomenon and can unfold in meaningfully. As the purpose of the study was to explore the social and economic vulnerabilities of HIV-positive women, in a specific cultural context, i.e., South Punjab, a purposive and small sample is meaningful to warrant rich narrative. Also, this approach aligns with the interpretivist and social constructivist ontological and epistemological approach, as it values subjective depth and contextual understanding (Lincoln & Guba, 1985). The demographic table (see Table 1) shows, the HIV status of husbands of the participants as positive and the husbands are the suspected source of infection.

4.1 Demographic Profiles

Table 1 Demographic profiles of six HIV-Positive married women

Name	Age	Education	Years of HIV diagnoses	Years of Marriage	Number of Children	HIV status of husband	Suspected source of infection
P1	50	Uneducated	4	3	8	Positive	Husband
P2	35	Matric	3	5	3	Positive	Husband
P3	38	Matric	6	8	2	Positive	Husband
P4	42	Uneducated	6	0	5	Positive	Husband
P5	28	Primary	2	0	1	Positive	Husband
P6	45	Uneducated	5	2	4	Positive	Husband

The data gathered from in-depth interviews of six HIV-positive married women revealed an intricate and complex interplay of disease, stigma and gendered structures of society that shape up the social and economic conditions and realities of participants. As per the thematic analysis, three overarching themes were reached that focus on the lived experiences of HIV-positive women after the diagnosis (see Table 2). The themes shown in Table 2 reflect the direct effects of HIV and also the layered consequences on women's lives in a gendered and patriarchal settings of South Punjab.

4.2 Themes and Sub-themes

Table 2 Themes and Sub-themes

Themes	Sub-themes
Economic Dependency	Dependency on spouse Lack of financial autonomy
Social Exclusion	Community ostracism Family rejection and isolation
Gendered Economic Roles	Male control on finances Moral surveillance and mobility constraints

4.3 Economic dependency

This was a dominant theme that emerged again and again in the in-depth interview data. All women had limited income even before their diagnosis as a result of prevalent gender disparities and economic inequalities. Connecting this theme with the stigma theory, it is evident that HIV-related stigma is intertwined with social and economic gendered roles and conditions.

4.3.1 Dependency on spouse

Women in this study had never worked formally due to the traditional norms. So, their economic survival was directly linked to their marriage. The disease deepened this reliance. After diagnosis, P3 shared "I have no income of my own and I depend on my husband's income for medicines etc., and he frowns on the spending money on my treatment as I have brought this burden on the family." Despite the fact that husbands also had HIV status, women stayed more vulnerable as the finances were never in their hands. This was a condition of heightened vulnerability as their access to basic needs and healthcare was conditional and as per the willingness of their husbands. Their relationships were surviving but were financially strained. This dependency reinforced power asymmetries. The findings aligned with existing literature and emphasized that HIV status reinforced traditional gender roles and dependency of women on their partners, particularly in context of socially and economically disadvantaged position (Fauk et al, 2022).

4.3.2 Lack of financial Autonomy

Lack of financial autonomy emerged as an important sub-theme as it reflected structural inequalities and gendered norms, which became complex as a result of their HIV-positive status. All women shared that despite their immense contribution in making their houses as homes, they have no control over household income and financial decision-making. P6 shared that, "I have to ask my husband for every single rupee. If he is not in a good mood, he can simply refuse." This sort of restriction made women more vulnerable and affected their access to health-care, food, needs of children etc. This proves that the absence of decision power over economic matters can impact health and dignity both. This restriction as regards to autonomy was embedded in patriarchal norms that also restricts women's right to property and financial literacy. These experiences reflect the broader gender norms prevalent in South Asia, where women's economic agency is restricted (Bhatti & Imran, 2021; Mukerji et al., 2025). Multi-layered disadvantage is created due to the intersection of these norms with stigma of HIV.

4.4 Social Exclusion

Social exclusion was another theme that was recurrent and that was affecting women socially and economically. Stigma theory has three interconnected mechanisms i.e., enacted stigma, felt stigma and anticipated stigma (Scambler, 2004). Enacted stigma was observed in community ostracism and also family rejection where women were mistreated and excluded directly because of their HIV-status.

4.4.1 Community Ostracism

Community ostracism was also a powerful theme as regards to the lived experiences of HIV-positive married women in South Punjab. Upon the disclosure of disease, women faced immediate exclusion by relatives and neighbors. Participants shared that people avoided physical contact and discouraged others to interact with the HIV-positive women as well. P4 said, "People act like my touch could harm them." This avoidance directly affected their dignity. This stigma is also well-documented in literature, especially in the context of South Asia, where HIV is linked with immorality as well (Fauk et al., 2022). This rejection from community puts women in

psychological distress and increase their isolation.

4.4.2 Family Rejection and Isolation

Along with the rejection of community, family rejection also emerged as a theme. All participants shared details that revealed social exclusion because of the stigma attached to the disease. P1said that, "I have not told anyone about the disease, as those few who know have already cut me off from their lives." P4 said, "Once people began to learn about my HIV-positive status, they began to disconnect." P5 shared sadly about being expelled from a wedding. P2 said, "When my husband shared my status with the in-laws, they wanted him to send me away, despite the fact that their son was, ironically, already positive." This form of exclusion is particularly seen more in patriarchal and conservation communities like South Punjab. This rejection and marginalization take away social belonging from women and has lasting implications on their health and safety.

4.5 Gendered economic roles

This is a cross-cutting theme. Participants' experiences were shaped by gender norms that set the role of a woman in house and in economic decision-making. Stigma is structurally embedded within gendered economic roles. As Link and Phelan (2001) assert, stigma is reinforced through power differentials and institutional inequalities.

4.5.1 Male control on Finances

Male control over finances in s critical barrier over the autonomy of HIV-positive women. All participants had no say in decision making concerning economic matters. This had affected their health. P6 said that "Even if the clinic is free, I still need resources to reach their and get some medicines." The gendered financial dynamics, embedded in cultural norms, perceive men as primary earners and women as dependents. These ignore women's contribution to the house, children, dependent elders and community.

4.5.2 Moral Surveillance and Mobility Constraints

This theme was also reported during in-depth interviews again and again. Participants shared that they feel the constant monitoring by family and community. In conservative cultures, any deviance from usual domestic roles and prescribed behaviors, is stigmatized. P3 said, "I am not allowed to go to the nearby market as women who move around independently are characterless." The moral policing intensified with HIV-status, as it is attached to blaming women for bringing shame to the family name.

5.0 Conclusion

This study revealed socio-economic realities of HIV-positive married women in Muzaffargarh, South Punjab. Using the phenomenological lens, it showed how the intersection of disease, patriarchy, stigma and poverty yields layered forms of marginalization. The themes that emerged from this study underscore that HIV-positive status of women in not only a health issue but it structural and social as well for women who live in patriarchal, conservative and deprived settings. The lens of Stigma Theory also showed that the HIV stigma is also a form of social regulation. Women are seen as morally compromised and also face sanctions of social and economic nature which pose as barrier to their already limited autonomy and agency. The fear of disclosing about disease and internalized shame silence women's experiences. This also reduce their access to healthcare. A more holistic and intersectional approach is required to address issues

of HIV-positive women in South Punjab. This approach must take gender justice, economic empowerment and anti-stigma advocacy into account.

Contribution

Noshaba Asghar: Problem Identification and Theoretical Framework
Ambreen Salahuddin: Data Analysis, Supervision and Drafting

Conflict of Interests/Disclosures

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