Discrimination Experienced by Women Living with HIV and AIDS Accessing Reproductive Health Service

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ABSTRACT

Women with disclosed HIV status experience different barriers and are stigmatized and discriminated against in health services. The sexual and reproductive health of women living with HIV is critical when compared to those who are not living with HIV. Discriminatory behaviour in health settings decreases the morale of women and limits the care of their health. Women living with HIV hide their status because of fear of discrimination, which puts the health personnel at high risk of transmission. The goal of this study was to learn more about the reasons for and types of discrimination faced by HIV-positive women seeking reproductive health services in healthcare settings. The researcher found three significant findings. To begin with, pre-existing social attitudes, perceptions, and information regarding women with HIV are at the foundation of stigma and discrimination in healthcare settings. Second, the forms of stigma and prejudice that WLHIV perceived or experienced differed from each other, regardless of which service under reproductive health they sought. Finally, due to such discrimination, WLHIV refuses to disclose their HIV status, delaying or avoiding seeking medical help, experiencing emotional stress, and having low self-esteem.

Keywords: *Reproductive health services, HIV, AIDS, Gender-based discrimination*

Introduction

The Right to Safe Motherhood and Reproductive Health Act, 2075 (2018), states, "Every woman and teenager shall have the right to obtain education, information, counselling, and services relating to sexual and reproductive health." The sexual and reproductive health of women living with HIV/AIDS is fundamental to their well-being and that of their partners and children. In Nepal, the estimated number of people living with HIV is 31,020, out of which 12,000 are females and 1,192 are children under 14 years (NCASC, 2019). However, there is a tendency for women living with HIV to be treated only on account of HIV, and often sexual and reproductive health is neglected. Key populations, including women and youth living with HIV, mostly experience discrimination and stigma in accessing sexual reproductive and other health services.

The Sustainable Development Goals and the Millennium Development Goals before them include the goal of universal access to sexual and reproductive health (SRH) services. The World Health Organization has released guidance overtime on the types of services to be included in comprehensive SRH care, including for HIV-positive women specifically. Women with disclosed HIV status are stigmatized and discriminated against in health services. The sexual and reproductive health of women living with HIV is critical compared to others. Discriminatory behaviour in health settings decreases the morale of women and limits their access to care. Women living with HIV hide their status because of fear of discrimination, which puts health personnel at high risk of transmission (HIV Stigma Index, 2011).
HIV was a severe epidemic in early 2000 in Nepal. Many people lost their lives because of HIV, and many families were displaced just on account of HIV. Along with the discovery of medicine to strengthen the immune system of people living with HIV and awareness programs, the rate of HIV-infected people decreased. To this day, however, people living with HIV are not openly accepted. Women encounter various problems, such as violence from family members, verbal

abuse from society, discrimination in accessing health services, and the inability to disclose their status readily. The sexual and reproductive health of women living with HIV is crucial but often neglected. Various factors come into play for the stigmatization and discriminatory behaviour, which limits women living with HIV's access to services (Kore, 2021).

The main objective of the study is to explore the reasons behind the discrimination in accessing sexual and reproductive health by women living with HIV and the types of such discrimination. The Nepal PLHIV stigma index report (2011) reports that almost half of the people living with HIV experienced at least one situation where they were offended and felt stigma and discrimination in their life after testing positive. One of the common and general ways such events occur is being "gossiped about" and making a major topic of discussion or action. In comparison with their male counterparts, females living with HIV experience more discrimination and stigma. The forms of such stigma and discrimination come in various ways: psychological pressure by intimate partners, sexual rejection, being ignored, rejected, and stalked. Due to their disclosed HIV status, women experience discrimination in different settings. The study explored the prevailing types of discriminatory actions in health settings, especially while accessing sexual and reproductive health services.

Methodology

Research Design

A descriptive research design was applied to analyze and interpret the qualitative data from the concerned field. A qualitative approach was used for descriptive analysis. When studying a phenomenon involving interactions and attitudes, using questions about how something is perceived, a qualitative approach is sufficient (Polit & Beck, 2009). The study aimed to examine encounters of HIV-positive women with stigma from medical professionals and other employees in healthcare settings. The area of research was the 'Right to Health Women' group formed by the National Federation of Women Living with HIV and AIDS. The researcher used both primary and secondary sources of data in the study. The researcher provided questionnaires to the informants and conducted focused group discussions as a form of primary data collection. Secondary sources of data included books, journals, reports, blogs, and newspaper articles written regarding discrimination against women living with HIV in healthcare settings.

Research Environment

The study area of research was the 'Right to Health Women' group formed by the National Federation of Women Living with HIV and AIDS. The study aimed to examine HIV-positive women's perceptions of rejection from healthcare providers during reproductive health checkups. As a result, the National Federation of Women Living with HIV's Right to Health Women's Community was selected as the study's setting because it was appropriate for the study's population.

Informants

One of the main criteria set for the study was that the participants were women living with HIV who were regularly under ART medication and seeking reproductive health services from a doctor. Reproductive health services included pregnancy care, contraception usage, counseling, abortion services, menstrual health, and any other reproductive health-related issues. To meet this criterion, informants had to be in contact with healthcare providers and institutions. The study universe comprised members of the 'Right to Health Women's Group' of the National Federation of Women Living with HIV and AIDS, representing various regions of Nepal. In this research, a woman is defined as any adult between the ages of 24 and 50, regardless of marital status. With these criteria, the researcher selected 20 members as informants and conducted in-depth interviews.

Sampling Procedure

The recruitment of women living with HIV was facilitated through the non-profit organization, the National Federation of Women Living with HIV and AIDS. There are ten 'Right to Health Women' groups located in different parts of Nepal. The researcher selected two participants from each group, totaling 20 informants for the in-depth interviews. The study employed purposive sampling as it focused on women living with HIV, ensuring that each member of the groups had an equal opportunity to participate.

Data Collection Procedure

This study employed a case study research design conducted among 20 women living with HIV who were selected through purposive sampling for participation in in-depth interviews. Additionally, a questionnaire was administered to 10 women living with HIV. Out of these, five were interviewed via telephone, while the remaining five were asked to fill out a Google form. Each respondent received a formal informed consent form to participate in the study. For those who required assistance, the details on the form were read aloud to them. During the interview, questions were asked, and oral consent was obtained prior to proceeding. All participants were informed in the consent form that they could withdraw from the interview at anytime. Given the sensitive nature of the study's topic, which involved participants' personal lives, it was recognized that discussing these matters could evoke discomfort or other negative emotions. To

address this, only women who expressed interest in participating and providing support were invited to be part of the study. The information gathered was processed and examined privately and confidentially.

The main topics of investigation were predetermined based on the study goals and qualitative results sought. These included exploring stigma, methods, and consequences of disclosure, adherence and potential apprehension surrounding disclosure, use of contraceptives, seeking abortion and reproductive health services, family planning practices and challenges, as well as experiences of discrimination by health providers.

Data Analysis Procedure

One-on-one interviews were conducted with ten women living with HIV, while five interviews were conducted over the phone, and five informants were asked to fill out Google forms. The interview questions were categorized into six thematic areas. Each area had specific questions, progressing from general to specific to facilitate analysis. The questions were formulated and asked in Nepali to ensure the comfort of the informants. Quotations, related passages, and memos for each topic were compiled into matrices, organized into categories and subcategories, and analyzed for prevalent themes and divergent viewpoints. These themes emerged during the analysis of questionnaire responses. For instance, common issues such as 'rejection, referral, and abandonment by others,' 'fear of being shunned,' 'name-calling,' 'self-isolation,' 'being prioritized after other patients,' and 'reluctance to visit the clinic' were categorized under the theme of 'stigma and prejudice.'

Ethical Consideration

The study's topic was extremely sensitive because it involves the participant's personal life and, therefore, can be difficult to discuss. There was a chance that the person may feel uneasy or have other negative feelings. This was considered, and as a result, the people who were interested were only asked. The information gathered was processed and examined in a private manner. Therefore, the researcher consulted with the National Federation of Women living with HIV and had a common understanding of confidentiality and respecting the women living with HIV's perception and experience and solely utilizing for the research purpose of the researcher.

Results and Discussion

The results of the study are divided into different themes and analyzed accordingly. The themes are based on the demographic details, characteristics, and the types of services related to reproductive health.

Stigma and discrimination from health care providers while seeking pregnancy-related services

Table 1 shows the experiences of women living with HIV while accessing pregnancy-related services. The responses of the participants have been categorized into four themes, along with the direct quotes made by them during in-depth interviews. When analyzing the first theme, which is related to the attitudes of the employees in healthcare settings, most women living with HIV experienced stigma from non-medical staff when seeking pregnancy-related services. People in healthcare settings gossiped, made negative comments, judged them based on their HIV status and even stalked them. Similarly, another theme, accessibility of pregnancy-related services, indicates that, especially during the delivery of pregnant women living with HIV, the healthcare units are not as accessible as others.

Table 1. Discrimination while seeking pregnancy-related services

Theme	Discrimination	Sample significant statements
Attitudes	Judgmental communication, Gossiping, Physical Distancing	"Non-medical staffs of health care units gossiped about how can WLHIV give birth to child? She will also give birth child with HIV and it cannot survive" (Respondent 18, age 40)
Accessibility	Separate ward for lactating mother with HIV, Procrastinating appointment	"I still remember, after my delivery I was taken to separate ward and I was all alone, staff nurse hardly came to see me and ask about me, my husband had to call them instead" (Respondent 4, age 46)
Convenience	Denial/ Referring to other hospitals	"For counselling service hospital was open but directly referred to other hospitals at the time delivery." (Respondent 10, age 30)

Confidentiality	Lack of Privacy	"Even though the doctors try their best to keep privacy other staffs at reception, lab and registration do not respect our privacy and leak our status." (Respondent 13, age 28)
Cost	Extra burden, charge extra amount for surgery items	"When my friend was hospitalized for her delivery, hospital told that they cannot use the surgical item which were available as it is for the other people without HIV, therefore they asked her to buy bed sheet, and all the other surgical items I guess they paid double as compare to normal charge" (Respondent 9, age 35)

Mostly, they are kept in isolation due to the perceived threat of transmission. Likewise, another theme on convenience states that for counseling services, healthcare settings were welcoming, whereas, during delivery or labor, women were often referred to other hospitals. Finally, the theme related to cost: many informants did not have much to say, but one stated that during her labor, she was asked to buy all kinds of items. All these types of discriminatory actions and stigmatization revolve around the cognitive model and its four defined potential reasons for discrimination. Around half a percent of WLHIV experienced stigma and discrimination in healthcare settings, not only from medical personnel but also from other staff in healthcare settings.

Case Story 1

"I have been infected with HIV for five years now. I have been married to an infected man. Like everyone else, we too desired to have children after marriage, so I went to the nearest hospital to have children because I knew that an infected person could not imagine giving birth without consulting doctors. I expressed my interest to the doctor, and he advised me to take various tests. At the test site, the employee told me with sarcasm, 'Why would an HIV-positive person want to give birth knowing that the child will be in danger?' While the doctors behaved well, other people working in the hospital did bad things, like delaying our tests, not naming names, spreading rumors about us, and backbiting. Sadly, it is very difficult for the infected to survive in such a society."

WLHIV faced discriminatory actions such as not being treated, especially in rural parts of Nepal. Doctors were often unavailable for treatment, and there were instances of invasive questioning about private matters, as well as inadequate attention to issues and problems. People employed in healthcare settings, like lab technicians, pharmacists, security guards, ward attendants, and others, also displayed poor and discriminatory behavior. This included not registering names and cases and calling names last when issuing medication.

Case Story 2

A woman living with HIV in her late 40s, whose husband died of AIDS, found out about her status when she went to a hospital in Dhangadi. At that time, she was four months pregnant. The doctor at the hospital inquired about her pregnancy. She informed them that her husband had died of HIV. The doctor advised her to take an HIV test, and unfortunately, she tested positive. The doctor explained that because she was not under ART medication, they could not treat her at that hospital. They advised her to go to Kathmandu. Being a single mother and recently diagnosed with HIV, she was in trauma. She could not share her status with others, as she feared they would abandon her. Consequently, she gave birth to her child, but sadly, it did not survive.

Stigma and discrimination in health care settings while seeking abortion-related services

Informants did not openly discuss abortion, and only one respondent reluctantly shared her experience with her friends and community members, indicating an apparent hesitation to talk about aborting a child. The gender of the interviewer played a significant role in the informants' willingness to answer the question. If the interviewer had been female, the scenario might have been different. Additionally, due to abortion being a sensitive and still largely unaccepted topic in Nepalese culture, the data related to abortion did not emerge as expected. However, abortion remains a critical issue, particularly in the lives of WLHIV. Because of their status, many service providers tend to neglect or refuse to perform such procedures.

Case Story 3

A member from Kailali attending the Right to Health Women's Group meeting discovered she was HIV positive after becoming pregnant. The group members advised and accompanied her to a doctor for counseling and consultation. After consulting with the doctor, it was determined that her viral load suppression was very high, and the doctor recommended an abortion. She was then referred to an abortion hospital. At another hospital, it was challenging for her to disclose her condition. However, as a group, they advocated for her and provided full disclosure to the doctor. The referred hospital also learned about her condition, as documented in the referral. The hospital clearly stated that they were unable to

perform the abortion due to the high viral load suppression. Finally, she was referred to Kathmandu, where the abortion was conducted. Denial of services at the hospital significantly impacts the lives of women living with HIV.

Stigma and discrimination in health care settings while seeking family planning related services

As shown in Table 2, respondents experienced stigma and discrimination in the health care settings while seeking family planning-related services. WLHIV does not find family planning services accessible, respecting their privacy, non-judgmental, and in a healthy environment. Approximately half of the informants use contraception for family planning. However, most seek family planning counseling services as they believe it is unnecessary and that the service is not available in their area.

Table 2. Discrimination while seeking family planning-related services

Theme	Discrimination	Sample significant statements
Attitudes	Judgmental communication, Gossiping,	"I do not think that not only the woman living with HIV, but other women also cannot easily buy condoms and emergency contraceptive pills, the pharmacist and people around stares and gossip about women" (Respondent 12, age 35) "If I need contraceptives, I do not go where it is available in free of cost, I visit our own groups or organization because I fear about what people will say in public places." (Respondent 13, age 29)
Accessibility	Avoided, Uncomfortable, Rejection	"While in a counselling session I was discomfort to notice counselors change in tone and way of talking after I disclosed my status." (Respondent 17, age 40)
Convenience	Denial/ Referring to other hospitals	"For counselling service hospital was open but directly referred to other hospitals at the time service delivery." (Respondent 10, age 30)
Confidentiality	Lack of Privacy	"I fear to disclose my status because though I trust the doctors and nurses but other employ at registration desk look at my file and delay my routine and tells others." (Respondent 11, age 28)

One respondent stated, "I do not want to seek family planning services because I have to disclose my status for that purpose. Since most employees at the hospital are from my village, I do not think they will respect my status. I feel confidentiality will be just a name, and people will defame me." WLHIV live in fear that their status might be disclosed, and they will not receive the same level of respect as others when accessing services. On the contrary, two of the informants who were in the family planning process mentioned, "At first, there was a male doctor in the counseling service, and he did not respond to our queries. But after a female counselor came, they received family planning services in a much more considerate manner."

Case Story 4

"I needed a permanent means of family planning service. Since I was infected, two hospitals refused to provide me with a permanent contraceptive device. After visiting several hospitals, with the help of one of the organizations advocating for the rights of women living with HIV, in the end, one of the hospitals agreed to provide the service. Just being a woman living with HIV, it is difficult to access health services. I do not think other women without HIV have to face the same problem."

Experiences of Stigma and discrimination in Health care settings regarding reproductive health diseases

Table 3 shows that several informants indicated that they are at risk of reproductive health problems related to cervical, breast, vaginal, and menstrual issues. Participants felt uncomfortable sharing their problems with male doctors, fearing they might face double stigma due to their HIV status. Consequently, they chose not to disclose their status to service providers to avoid potential discrimination. One informant recounted her experience when she sought cervical cancer counseling, "I went to the hospital with a problem in my cervix. Initially, I did not talk about my condition because I was afraid I would be treated differently. After undergoing all the tests, I was diagnosed with uterine cancer and had to

undergo immediate surgery. Then, my husband informed the doctor about my condition. Immediately, the hospital advised me not to have the operation there and instructed me to go to Kathmandu. It was very disheartening to be left alone because of my infection."

Table 3. Discrimination while seeking reproductive health services

Theme	Discrimination	Sample significant statements
Attitudes	Verbal insult, indifference of staff, lack of acceptance, look down	"Non-medical staffs of health care units gossiped about how can WLHIV give birth to child? She will also give birth child with HIV and it cannot survive" (Respondent 5, age 47)
Accessibility	Differential treatment, difficulties in disclosure of status, lack of acceptance	" When there is a male doctor present to treat the reproductive health diseases of women, it is really difficult to share problem and for WLHIV the rate of difficulty rises as they cannot share their problem along with disclosing the status" (Respondent 4, age 46) "The doctor who treats our HIV aspects do not look after our reproductive health diseases, therefore going to the specific health centers, we get differential in treatment" (Respondent 15, age 33)
Convenience	Anger in response, hesitant, late treatment, fear of getting disclosed in society by hospital staff	" I do not know why after disclosing my status and shared about my cervical cancer, there was anger in doctor's response and I did not ask him again because I was afraid." (Respondent 14, age 30)
Confidentiality	Lack of Privacy	"Even though the doctors try their best to keep privacy other staffs at reception, lab and registration do not respect our privacy and leak our status." (Respondent 13, age 28)

Many informants shared that during major surgeries, they experienced inhumane treatment from healthcare providers. The discriminatory actions took various forms, including demanding extra money for additional materials in surgery under the guise of precautionary measures, referring patients to other hospitals, claiming that surgical supplies were limited, and suggesting a higher risk of transmission to other patients. Additionally, some healthcare facilities allocated different wards for HIV-positive patients, causing delays in surgery and compromising confidentiality.

Case Story 5

A 33-year-old woman residing in Ramdhuni VDC got married at an early age. It has been six years since her husband passed away; her child is now 13 years old. She had a love marriage, and her husband was actively involved in politics then. He frequently fell ill and had to undergo checkups. After one such checkup at Biratnagar Hospital, he was diagnosed as HIV-positive and subsequently referred to Teku Hospital in Kathmandu. Unfortunately, her husband did not survive. During the testing, Sita and her child were both screened; Sita tested positive for HIV, while her child received a negative result. While she was saddened by her own diagnosis, she found solace in the fact that her child was not infected. Four months ago, she had a fall while washing clothes, resulting in injuries near her ovary and subsequent bleeding. She was taken to Matahari Health Center, where they stated their inability to provide the necessary care and referred her to Dharan B.P. Koirala Health Center. Upon arrival, she was promptly admitted to the Gyno Board Emergency. Due to her HIV status, there was a delay in her operation, but she chose not to disclose her condition initially. However, it was eventually discovered during the checkup process. Following this revelation, her treatment process slowed down, and she encountered disrespectful words from a nurse.

Causes of Discriminatory Actions

Linking HIV with immoral activity

WLHIV stated that they were vulnerable to public or communal stigma due to being infected with HIV and being women. Several WLHIV believed that they were being blamed for transmitting the virus to their husbands, and people questioned their character and worth. Many individuals in society held WLHIV responsible and cast doubts on their character. One participant explained that her husband suspected her activities and questioned her choice of friends, attributing blame for the transmission. Regarding healthcare settings, one respondent stated: "There are friends in our community who have been infected through involvement in sex work and drug use. There is a prevailing misconception that women become infected through immoral activities such as extramarital relationships, sex work, or drug use. Health

providers are hesitant to serve us with this mindset. When a woman is infected, she must endure contempt and discrimination everywhere."

Fear of contamination

The majority of WLHIV expressed that they believed non-HIV healthcare workers' attitudes and behaviors reflected a fear of contracting HIV from providing services. One person described their experience: "I needed a permanent means of family planning. Since I was infected, two hospitals refused to provide me with a permanent contraceptive like Kaparti. In the end, they agreed to do it, but it was very expensive. The doctor asked me to buy gloves, a PEP suit, a mask, and other items. I had no choice and paid much money to get the service. I felt that they did this out of fear of getting infected themselves."

Lack of holistic knowledge on HIV issues

There is a significant need for understanding and awareness about HIV transmission among healthcare providers. The majority of WLHIV expressed concerns and worries about non-HIV care professionals and employees in healthcare settings. One WLHIV emphasized: "At times, there is no discrimination in the healthcare field, but reproductive health is a sensitive part of a woman's health. Some healthcare providers turn away from us because they do not know about the medication we take, the CD4 test, or the viral load test. Therefore, it is important to impart comprehensive knowledge about HIV to everyone working in the healthcare sector, including doctors, nurses, and hospital workers."

Lack of HIV-sensitive and friendly service

There is a significant need for HIV and women-friendly health services. The majority of WLHIV expressed concerns and worries about gender-friendly services. Participants highlighted that women's reproductive health issues cannot be adequately addressed by male doctors. They also emphasized that the lack of HIV-sensitive and friendly services hinders WLHIV from receiving quality care.

Lack of feeling of safety

Health professionals do not feel safe when treating PLHIV. They require personal protective equipment and other items for major surgeries and procedures involving blood. As is commonly understood, such items cannot be reused for other patients due to the high risk of disease transmission. Respondent 10 noted that the government does not guarantee the safety of health professionals, leading to a lack of a sense of security. Hospitals should allocate special suits, surgical items, and other necessary equipment to ensure the safety of all individuals seeking medical attention.

Consequences of stigma and discrimination

The major repercussions of stigma and discrimination, according to respondents, include unwillingness to reveal their HIV status when seeking care, poor self-esteem accompanied by emotional stress and sadness, and avoidance or delay in obtaining health treatment. At least one type of self-stigma, such as shame, guilt, blaming others, low self-esteem, suicidal thoughts, and a readiness to be punished, had been experienced by women living with HIV. This has directly hampered their day-to-day life, as they cannot easily access stigma-free services. One of the respondents shared her thoughts, saying, "I got infected by my parents, and now I cannot openly live my life like other people. My friend circle is limited, and for this, I am ashamed of my life. People question me when they know about my status."

Not disclosing HIV status in treatment

Due to past negative experiences of stigma and discriminatory behavior from people in healthcare settings, most of the informants stopped disclosing their HIV-positive status. Some informants reacted according to the situation. They would inform about their status whenever they wanted or felt it was easy to do so, especially in crucial medical situations. One informant shared her experience, saying, "I understand why hospitals take preventive measures while treating HIV patients like me, and such actions are not against people but for protection. However, even though I am under ART medicine, and while going for a regular medical checkup, employees of healthcare settings gossiped about me and stared at me. That is why, knowing the long-term effect of disclosing my status, I stopped sharing it whenever I visited other hospitals."

A pattern of seeking health service

The major pattern of seeking reproductive health services is that informants stopped visiting the healthcare units where they faced stigma and shifted to others. One informant explained, "Whenever I have issues with my reproductive health, I come to Kathmandu for treatment because the hospitals in my hometown do not treat me well. They also refer patients to Kathmandu, so before they order, I come on my own. Though it is costly for us, we do not have any choices. I wonder what other women living with HIV would do." Similarly, informants visited hospitals only when necessary so that they would encounter people for only a short time. Some delayed seeking services, and one respondent completely stopped going to the hospital to avoid discrimination. She stated, "It is better to not go to the hospital rather than be the topic of gossip."

Things need to be considered for making services accessible and non-discriminatory

Table 4. Suggestions to make healthcare settings more accessible

Themes	Sample Significant Statements
Policy and Plan	HIV bill should be approved, the laws should be updated and made gender friendly (Respondent 1, age 25), Existing policy on HIV should be implemented and issues of women living with HIV like sexual and reproductive health, livelihood must be addressed (Respondent 7, age 24) Universal Guideline on Medical Treatment for People Living with HIV must include the sexual and reproductive health aspect of women and made sure it is contextual enough to implement by the health care workers in health care settings. (Respondent 6, age 31) The provision of stigma and discrimination free health services should be provided in all parts of Nepal and should not focus on only Kathmandu. (Respondent 6, age 31) Providing free medicine is not only enough, program for other aspects of health should also be implemented by the government. (Respondent 20, Age 36) Well facilitated hospitals and qualified human resources should be there at least in a province which can treat all problems of women living with HIV and provide comprehensive treatment services (Respondent 2, age 37)
Monitoring	Not only the ART site centers employees and dedicated doctors should know about the issues of WLHIV, all other government hospitals and primary health care centers medical and non medical staffs must be trained and oriented about the overall aspect of the PLHIV (Respondent 3, age 40) In our provincial hospitals designated ward is there for women living with HIV and it is not livable at all, such things be monitored by NCASC and help to build better environment for over all PLHIV. (Respondent 8, age 36) Complaining mechanisms must be established in hospital and dedicated group should be created by the hospital administration to solve the problems faced by people living with HIV. (Respondent 9, age 35)
Collaboration between NGOs and Government	Care and Support Program and Community Based Care and Home Support Program are run by HIV NGOs, such programs should include the component like sexual and reproductive health. (Respondent 16, age 37) CHBC workers should not only focus on testing and finding new cases but orient WLHIV on SRHR and help them in all aspects. (respondent 16, age 37)
Treatment and capacity building	WLHIV groups should be oriented on women's health rights and ways to enjoy such rights, capacity building training would be good. (Respondent 9, 33)
Create working environment	For betterment of women and to empower them job should be created, so they can earn their livelihood and make their own living and do not have to be dependent on others.

Conclusion and Recommendation

The goal of this study was to gain deeper insights into the reasons and types of discrimination faced by HIV-positive women seeking reproductive health services in healthcare settings. Three significant findings emerged. First, pre-existing social attitudes, perceptions, and information regarding women with HIV form the foundation of stigma and discrimination in healthcare settings. Second, the forms of stigma and prejudice perceived or experienced by WLHIV varied regardless of which reproductive health service they sought. Finally, as a result of such discrimination, WLHIV refrains from disclosing their HIV status, delay or avoid seeking medical help, experience emotional stress, and suffer from low self-esteem. Not only do healthcare workers and service providers demonstrate stigma and prejudice in their

profession, but they also reflect the perceived stigma from their communities. Healthcare workers are members of society and may hold similar perceptions. However, the same level of compassion and concern should be extended to HIV-positive women as to any other patients. They should be treated like any other mother in need of medical attention during pregnancy and delivery rather than being solely identified as HIV patients. Interventions among healthcare workers are crucial to reduce stigma and, consequently, enhance nursing care in reproductive health for HIV-positive pregnant women.

The following recommendations are made to the actors directly and indirectly involved in working towards stigma and discrimination-free health services for WLHIV at different levels:

Policy Level

Policy-level changes are imperative to bring about positive impacts in the lives of women living with HIV, particularly in relation to reproductive health and overall health:

a) Formulate new policies, guidelines, and working procedures, as the National HIV policy was last updated in 2011.
b) Develop a separate policy specifically addressing health service centers to make healthcare services more accessible and friendly for women living with HIV.
c) Establish and update ethics guidelines in healthcare centers for all staff and employees in accordance with the national HIV policy.

Management Level

Healthcare centers and programs developed by the Nepal government play a crucial role in the reproductive health of women living with HIV. Therefore, improvements are needed in the management of these areas:

a) In the new federal context, ensure that every province has HIV-centric services in provincial hospitals beyond just ART treatment.
b) Ensure that all programs are gender-specific, covering the overall issues faced by women living with HIV.
c) Implement regular training programs to equip healthcare personnel and non-medical staff with comprehensive information about HIV.
d) Incorporate sexual and reproductive health components into care and support programs and community house-based programs, facilitating the dissemination of information from the ground level to benefit women living with HIV.
e) Run programs and projects related to anti-stigma and discrimination through government channels rather than just NGOs and INGOs, ensuring the government takes accountability.

Individual Level

At the individual level, enhancing understanding of HIV, reducing stigma, and appreciating the benefits of stigma reduction among health providers and healthcare settings employees is crucial. Addressing fears and misconceptions about HIV transmission among new and practicing healthcare workers is also essential, requiring proper guidelines and laws. Regular training programs are necessary to provide healthcare personnel with comprehensive information about viral load, ART, CD4, and how HIV is transmitted, as well as how universal measures can alleviate anxieties. By sensitizing healthcare providers and separating them from behaviors considered improper or immoral, healthcare practitioners can provide improved care to women living with HIV.

Contributions of Authors

The authors confirm the equal contribution in each part of this work. All authors reviewed and approved the final version of this work.

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All authors declare that they have no conflicts of interest

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