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HIV Positive Women in Bangladesh: Lived Experiences, Vulnerabilities and Sexual Health Knowledge

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Abstract Though HIV prevalence has taken downward stream around the world, a gradual rise of HIV status has been detected among the women in Bangladesh. Women in Bangladesh usually face various challenges due to lack of unequal power relation and poor negotiable capacity with their counterparts during sex. This study intended to explore and document the psychological, social and sexual challenges faced by the women living with HIV/AIDS (WLWHAs) in the context of Bangladesh and to identify the gaps in their HIV/AIDS related knowledge. A qualitative research approach including in-depth interview and case study has been applied to understand the nature of prevalent challenges. Interviews were conducted at Ashar Alo Society, a renowned NGO which works with people living with HIV/AIDS (PLWHAs). Findings include women's powerlessness for negotiation and lack of knowledge about the spread of HIV infection such as how to prevent mother-to-child transmission of HIV. Lack of accessibility and availability of HIV information and its prevention aggravate their situations and make their lives more challenging, vulnerable and complicated. Further research related to counterparts' beliefs and perception on women's sexual autonomy, nature of stigma and discrimination among women have been recommended. Finally, a meaningful engagement and participation of women in policy making has been proposed for assuaging the agonies of women in the long run.

Keywords: *HIV, women, stigma and discrimination, vulnerabilities, sexual health knowledge, Bangladesh*

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1. Introduction

Though the HIV prevalence rate is less than 0.1% in Bangladesh, the proportion of women infected with HIV has risen day by day. Globally 35.0 (33.2-37.2) million people are infected (as of 2013) whereas 16.7 million are women. In South and South-East Asia, 40% of all young people living with HIV (PLWHIV) infection among girls are rapidly outstripping the rate among boys [1]. The actual HIV prevalence among the women is not known, but data reserved by the National AIDS & STD Programme (NASP) showed that 117 of a total of 343 new HIV cases recorded from November 2009 to October 2010 were women and 82 of them were housewives [2]. This is now a serious concern for us that many women are newly infected with HIV virus which was low a decade ago. Biologically women have the more chances to be infected with sexually transmitted infection (STIs) than their counterparts [3]. Limited access to knowledge, unsafe sex practices, and less sexual autonomy make women more susceptible to HIV/AIDS. Women compared to men are four times more likely to contract HIV [2]. Due to biological nature of the process and the vulnerability of the reproductive tract tissues to the virus, Women and adolescent girls are very vulnerable to HIV/AIDS.

Our socio-cultural situation makes a conservative atmosphere for women where they have few options to know sex-related information. Societal people have negative conception regarding discussions about safe-sex and gender issue; it is almost a taboo. Due to lack of knowledge and imbalance power relations, women are biologically more vulnerable to HIV/AIDS. The consequences of gender inequalities in terms of low socio-economic and political status, unequal access to education and fear of violence add to the greater biological vulnerability of women and girls being infected with HIV [4].

With biological vulnerability, there are lots of social obstacles for women, which make them difficult to cope up with HIV/AIDS. Previous studies show that after disclosing HIV status, situation becomes more complicated for women throughout the world. HIV positive male rarely face negative comments from societal members compared to women living with HIV/AIDS who are frequently referred to as 'vectors', 'diseases' and 'prostitutes' [5]. In Bangladesh women are frequently accused of being their HIV status if it is disclosed publicly. Hence, socio-cultural beliefs, values and morals within the local contexts have played a major role in contracting stigma and discrimination [6]. Goffman who was one of the most influential sociologists of the twentieth century, identified stigma as the phenomenon whereby an individual with an attribute is deeply discredited with his/her society and is rejected as a result of the

attribute. Stigma is a continuous process which spoils normal identity [7]. Stigma connected to HIV and AIDS works as a barrier for HIV prevention, treatment and care, including voluntary counseling and testing (VCT) [8]. Stigma and discrimination associated with HIV/AIDS create difficulties for women to get treatment and counseling from health care centers. Moreover, information and counseling are critical components of all sex and reproductive health (SRH) services and to support PLWHAs in making these decisions and carrying them safely and voluntarily [9].

Goffman's classic study of stigma provides one of the most notable accounts of the management of stigma by individual stigma bearer. Stigma is like an attribute which is a discreditable matter. According to Goffman, society distinguished two types of identity for the individual, one is 'normal' another is 'deviant'. The individuals who possess the 'deviant' identity, are actually the stigmatized person because they have some undesired differences and discrediting representation (like, physical or mental) from others who are according to the judgment of societal members as normal. This attitudes and social responses of societal members create huge tensions and stigma among them. Goffman identified the main problem in such situations for people with a discrediting condition as being the 'management of tensions' – how to manage information about one's own failing and how to manage tension when social contacts are made. The main task is to 'manage information' about the failing- 'to display or not to display; to tell or not to tell; to let or not to let, to lie or not to lie; and in each case, to whom, how, when and where. Goffman identified three strategies e.g. passing, covering and withdrawal, which are employed to cope with a stigmatizing attribute in social encounters. These strategies are not unique to stigma bearers but whereas they may be employed occasionally by normal when their identity is threatened, they must be employed continually by stigma beaters. In the context of HIV/AIDS, stigma and discrimination gives birth to one kind of sense among the HIV-positive that they are the only people who are different from others and the entire world is against them [10]. This type of societal stigma create alienation for themselves from community, family, friends and even from oneself.

Instead of various initiatives from the government of Bangladesh, the number of HIV-positive people had increased to 2533, an increase of more than double in four years [11]. The HIV and AIDS related (published) studies mainly concentrated on knowledge, prevalence of male, as a result, we know very little about the feminization of this epidemic. Though the HIV prevalence rate is decreasing day by day among males but the new infections among females are facing the opposite. Limitation regarding women vulnerability, coping mechanism about how women perceive negative social construction of people still exists in present day. Since Bangladeshi women are now experiencing challenging situation due to HIV status, preventive measures need to be identified in order to provide more gender sensitive health care facilities and to ensure zero infection in the near future.

The primary objective of this study is to examine and analyze the major challenges of HIV-positive women. The purpose is to develop and recommend a pragmatic woman friendly policy to emphasize their meaningful involvement, participation and contribution in planning. The specific objectives for the study are: 1) to evaluate the existing health services and their accessibility to these organizations; 2) to identify the barriers of women in getting treatment services; 3) to determine and measure the main vulnerabilities that contribute to HIV/AIDS and 4) to gather suggestions from HIV-positive women how to improve their situation.

2. Methodology

A focused qualitative study was conducted to reach the objectives of the study. Data were collected through in-depth individual interview and case study method. The holistic approach of qualitative methodology allows flexibility for the participants to raise issues and topics that may not have been asked by the researcher, but can be added as valuable information [12]. This study purposively selected the WLWHAs from Ashar Alo Society (AAS), a well-known NGO in Bangladesh. Participants were chosen through purposive sampling by identifying profiles of underrepresented PLWHAs group and it was selected purposively considering inclusion and exclusion criteria. An inclusion criterion was conducted with only WLWHAs who were ready to share and provide information. Exclusion criteria was involved for those who were unable to provide information and refused to give consent and absent in interview time.

Due to the sensitive nature of this topic and limited number of registered people in the NGO, the study included 30 individual in-depth interviews and 5 case studies. Data were collected from HIV-positive women directly by conducting face-to-face interview session. Since standard random sampling technique is difficult to implement for sensitive cases, purposive sampling was used to gain underlying experiences of WLWHAs. Five case studies provided valuable information for determining real picture of HIV-positive women.

Before conducting the study, the ethical issues were maintained firmly. All interviews were conducted with the prior consent of the participants. At the time of interview session, participants were informed clearly about the purpose of research and participation was voluntary for them. HIV-positive women provided oral permission, which was tape recorded at the beginning of interview questions. Participants got full freedom to withdraw her from interview process at any time during interview. A semi-structured interview guideline and checklist was used to discover the problems women face due to their status. Interviews were conducted in the office of AAS. A tape recorder and a note book were used to collect authentic information from participants and interviews were conducted in Bengali language to explore real meaning of the participants' statement. Pseudonym was used in this research to maintain participants' confidentiality.

A general qualitative approach was used to analyze the data. All transcripts and tape recorded interviews were transcribed, translated into English, coded and analyzed. Data analysis was manually performed to build codes against the themes and sub-themes of findings i.e. followed content, contextual and thematic analysis [13]. The quotations included in this paper are taken verbatim from the interview transcripts and fictitious names of participants were used in presenting their verbatim.

3. Findings and Discussion

3.1. Profile of the Participants

Table 1 summarizes socio-economic characteristics of women participants of AAS. The table provides a clear picture of their demographic information like age, marital status, home districts, occupation, and number of children. The mean age of the participants was 29. Among the total 30 women, 28 were married; only 2 were unmarried. Most of the participants reported that they were inflicted with HIV from their husbands. The husbands of 25 women among 30 respondents were migrant returnee from different countries, especially from middle income countries. Every year, a large number of Bangladeshis go abroad for working but the migrant workers have less access to get HIV/AIDS information, voluntary counseling and treatment. Due to this reason, most of the women participants in this research were suffering from HIV/AIDS. With limited awareness about HIV and AIDS, they may get infected during their stay abroad and return to Bangladesh and transmit the virus to others especially their wives who could in turn transmit infection to their babies in ignorance [14]. In terms of education, 20 participants had received some form of formal education; the residual women were deprived of educational facilities. All but three were unemployed at the time of data collection.

Table 1. Socio-economic characteristics of the women

Characteristics	Categories	Frequency
Age (in years)	10-20	3
	21-30	14
	31-40	11
	>40	2
Religion	Islam	28
	Hindu	2
Marital Status	Unmarried	2
	Married	28
Home District	Dhaka	9
	Narayanganj	3
	Noakhali	2
	Khulna	2
	Jessore	6
	Manikgonj	2
	Mymensingh	1
	Brahmanbaria	1
	Gazipur	2
	Bagerhat	1
	Bogra	1
Migrant Returnee From	Husband worked in USA	1
	Husband worked in Kuwait	6
	Husband worked in Saudi Arabia	7
	Husband worked in India	3
	Husband worked in Malaysia	3
	Husband worked in Dubai	5
	N/R	5

Note: N/R = Non-Returnee.

3.2. Knowledge Level of Women

Knowledge level of women participants in this study was very poor. They were less knowledgeable about the risk factors of HIV/AIDS and how HIV infection can be prevented. The research reports that only 3 women heard the word HIV/AIDS before knowing their status, other were in darkness. This finding also supports the reports of Bangladesh Demographic and Health Survey (BDHS) 2014 that only seven in ten ever married women age 15-49 have heard about STDs and HIV/AIDS [11].

Table 2. Knowledge about HIV/AIDS among all participants

Knowledge about HIV/AIDS before HIV-positive	Knowledge about HIV/AIDS after HIV-positive
3	27

Some of the women in this study have misconception that HIV/AIDS can be transmitted through saliva, mosquito bite and sharing of foods. Knowledge is deemed necessary for women to protect themselves against HIV infection. The risk factors can spread the chances of infection due to the low levels of awareness and knowledge [15]. Participants reported they never received HIV-prevention methods such as condom use and reproductive health information from school, college and anywhere else. Recent joint research by Rainbow Nari O Shishu Kallayan Foundation and L.R.B Foundation in some three districts of the northern region of Bangladesh has shown that providing HIV information through discussion of safe-sex and gender issue are discouraged for young girls and women. The misconception behind this is that to inform them about sexuality and safe-sex is to encourage sexual activity.

Despite the efforts of many national and international organizations for providing a progressive approach to deal HIV/AIDS, people still have little information about sexual-life, safe-sex, condom usage and unwanted pregnancies. Two young participants of this study whose age was only between 16 and 20 informed that they were denied by their mothers to know about safe practices. Likewise, the situation of women throughout Bangladesh is similar; here talking about sexuality is one kind of taboo topic. In the context of HIV, lack of power of negotiation, knowledge and skills to take the appropriate harm reduction measures translate directly to vulnerability to infection [4]

Even after HIV infection, women are found poorly informed about the ways in which the HIV virus can and cannot be transmitted. Though media has played an important contribution for spreading the knowledge of HIV, participants are not much aware of this. The silent role of this disease makes the people to develop wrong conception about HIV/AIDS. Bangladesh also has a high prevalence of malaria. The families of PLWHAs also believe that HIV could be transmitted through mosquitos, similar to the transmission of the virus causing malaria [10]. There is a lack of correct information about HIV/AIDS among women and this causes women patients vulnerable.

3.3. Accessibility and Availability of Sexual and Reproductive Health Services

In 1985, HIV/AIDS prevention program first started in Bangladesh. The scenario of government and NGO responses to HIV/AIDS is quite good in Bangladesh, where services have been providing to PLWHAs for a long term basis. They are described below:

National Responses to HIV/AIDS:

- National Aids Committee (NAC) was formed under the patronage of the president of Bangladesh.
- Ministry of Health and Family Welfare (MOHFW) is the lead ministry to provide services of HIV/AIDS
- National AIDS/STD program (NASP) was formed to formulate policies; coordinate information and regulate the implementation of the HIV/AIDS prevention efforts under the Directorate General of Health Services (DGHS)

Non-Governmental responses to HIV/AIDS

- Ashar Alo Society (AAS): Lead organization to provide confidential HIV testing, counseling, life-skill training, and treatment and medicine facilities.
- Confidential approach to AIDS prevention (CAPP): Provide telephone counseling, education, advocacy program and training facilities.
- Mukto Akash Bangladesh (MAB): Provide awareness raising sessions, counseling, treatment and moral support.

Though a good number of initiatives are seen both at the government and NGO levels in Bangladesh, HIV-positive women have very limited access to the organizations. Respondents were asked to explain their personal experiences regarding accessibility and availability of HIV/AIDS related services. Most of them reported they do not have access to affordable and basic treatment services. One respondent revealed that when she was found HIV positive, she was not allowed to get treatment from doctor. Nobody showed interest to provide her with medical needs; she went door to door of some public and private hospitals but no doctor agreed to provide treatment. She got treatment after coming to AAS. We do not have any information desk facilities for PLWHAs, due to low prevalence rate of HIV/AIDS in Bangladesh, said she. The recent report released by the government on World AIDS Day 2017 shows that only 2475 PLWHAs in Bangladesh as of 2016 are now taking ARV (antiretroviral therapy) out of 11,700.

Stigma and discrimination create another barrier for WLWHAs in Bangladesh. Because of stigma and discrimination, PLWHAs do not want to take Sexual and Reproductive Health (SRH) services, even if such services are made available [16]. WLWHAs expressed that they think they will be identified by others if they counsel with doctors or get treatment. This fear makes them reluctant to be conscious about their health situation. A large number of PLWHAs failed to get reproductive health services and proper treatment due to their privacy problem. Limited access to family planning services can result in unwanted pregnancies and high infant and maternal mortality rates, and further contributes to the HIV/AIDS epidemic [16].

3.4. Lack of Power to Negotiate Safer Sex

Married women who are faithful to their husbands and have no history of pre-marital or extra-marital relationship also have chances to be infected with HIV-virus [17]. Though there is no exact data on how many women are infected with HIV by their husbands, most of the participants in this study claimed to have got HIV infection from their husbands. This study found 25 respondents out of 30 were carrying HIV virus in their body after knowing HIV status of their husbands. Unfortunately, most of them did not get informed by their husbands that their husbands were also carrying HIV virus in their body. According to the report, published by UNFPA, marriage is not always safe and cannot provide safety against HIV infection [17].

Women are unequally treated everywhere in Bangladesh because of the dominant patriarchal point of view. Women in our society are not allowed to show their interests or decisions regarding sexual intercourse. It is the common view of all males in our society that wives are just like their property. They can use their wives as per their wishes. If husband is willing to sex with their wives, wives have no right to refuse their husband or say "No". One respondent reported that she was forced to involve in risky intercourses with her husband without using any safe guards even after knowing HIV status of her husband.

Box 1:

A remark made by an HIV-positive female respondent:

My husband was sent back from Saudi Arabia due to HIV-positive status. But he did not disclose his status to me. One day, I got the news from one of our close friends. Then I denied to sex with him and that's why he bit me and tortured every night. He forced me to sex with him and at that time I did not know that condom can prevent HIV. At last after diagnosis I also found myself as HIV-positive. I was so helpless.

Women do not usually have the power to negotiate safer sex with their partners even if they suspect and know that they are involved in risky behavior for HIV and STIs [13].

From childhood, women are taught that they should be faithful and obedient to their husbands. In the voluntary counseling and testing (VCT) center of CAAP, 6702 sample of blood had been tested for HIV since 1996 to date and 451 persons were found HIV positive. Out of them 159 were women and unfortunately most of them got HIV infected through the legal bondage, marriage [17].

Sex negotiation power of women is highly discouraged in our society. Women are expected to be ignorant of infidelity of their husbands. Some of the participants believe that it is justified to refuse sex offer of their husbands, if husband has HIV and other sexually transmitted infection. But the gendered power dynamics makes women marginalized to raise voice for safe-sex practices. One respondent revealed that she requested her husband to use condom but her husband denied using it because it would reduce sexual pleasure. This imbalance power relation makes women vulnerable to insist their husband on the usage of condom. The young married women of our societies usually do not have any voice on sexual matters with their husbands; in other words, they have no control over the situation in which sexual intercourse takes place with their male partners [18].

3.5. Stigma and Discrimination

Within family and community, women are significantly more likely to experience personalized stigma than men,

including ridicule, harassment, physical assaults and being forced out of their homes [19].

Most of the respondents revealed that they had faced bitter experiences from health service providers during treatment. One participant reported that knowing her HIV status, her doctor did not touch her and maintained a long distance by wearing gloves and masks. Moreover, he refused to provide treatment. Her doctor did not hide the information even from her husband. She felt embarrassed when the doctor revealed her HIV status in front of her husband. After getting the information, her husband abandoned her. She is a divorcee now.

PLHIVs frequently faced discrimination from public hospitals, local clinics, or from health care providers during the time of treatment [20]. Most of the respondents reported that in hospital there is always a separate ward for the HIV positive. Medical staff and nurses most often misbehave with them. One participant reported that the nurse of the hospital did not want to push injection due to fear of contagion. Due to the common experience of HIV-related stigma and discrimination in the health care sector, PLHIV are less willing to seek health care services for themselves [21] Some participants expressed, now they are not willing to go to a hospital due to the discriminatory attitudes of the doctors. Stigma and discrimination are recognized as two key factors that need to be addressed to create an effective and sustained response for HIV prevention, care, treatment, and impact mitigation [22].

The cultural structure of our society may be described discriminatory against women which may sometimes place them at a voiceless position which is more vulnerable to STIs and HIV/AIDS [22]. Participants stated that their status and role in the family starts changing soon after disclosing the fact that they are HIV-positive. Their close one avoided them when they heard about their HIV status. One Hindu respondent pointed out that she was not allowed to enter the other rooms of their house and she was discharged from her daily activities like cooking, cleaning etc. Now life becomes very boring to her; she has nothing to do. Seven respondents of this study did not provide their status to their family members or others because of fear of social ostracism. Other residual respondents faced the worst realities because they shared their status to others. Though most of them were infected by their husbands, they were accused of responsible for the virus.

Box 2:

A remark made by an HIV-positive female respondent:

When I was 15 years old I got married. I was completely virgin when I got married. I was faithful to my husband. I tested HIV after disclosing my husband's status. It was known to all that my husband was involved in illegal sexual relations when he worked in Malaysia. Yet, I was accused of spreading this virus. My mother-in-law always misbehaved with me; even, my husband tortured me both physically and mentally because of his stressful life. But I was not responsible for anything. I experienced intolerable torture and brutality of my family member due to my status.

Women experience greater stigma than men because they are accused of the virus. Women may suffer more stigmas. Women with HIV and AIDS are viewed as having been promiscuous, despite the evidence that in the majority of cases, they acquire the infection from their husbands or male partners [23]. The situation of HIV positive female prostitutes is more challenging. Only one respondent of this study was a sex-worker who faced discriminatory attitudes from police.

Box 3:

A remark made by an HIV-positive female respondent:

I served as a sex worker in Narayangang brothel where I was sold by my uncle. One day, I was arrested by some police officer and the brothel was closed. The reason was unknown to me why I was arrested. I passed six months at prison without knowing anything. Two male police and one female police officer severely scolded and misbehaved with me. The food was served under the door. After that some NGO men rescued me from police custody. I was badly blamed for spreading the epidemic.

People label the epidemic HIV/AIDS as Gods' punishment for sinners especially for injecting drug users (IDUs), prostitutes and those who are involved in extra marital relationship. In brothel, sex workers are more likely to become infected with HIV-virus due to their less bargaining power to insist customers to use condom.

3.6. Exemption from Motherly Role

It is very difficult to provide knowledge about how to prevent mother-to-child transmission (MTCT) of HIV and how to use antiretroviral medication before delivery [11]. Women in this study were asked to express their knowledge about how to prevent mother-to-child transmission of HIV. A dissatisfactory result came from their answer. Despite the counseling session provided by AAS, women are still confused about the process like pregnancy, labor and delivery or breastfeeding. UNAIDS say that at the end of 2011 there were an estimated 3.3 million children (under 15 years) living with HIV, most of whom were infected by their mother. It is difficult to save these babies till adulthood. Because of social ostracism, HIV positive mothers are reluctant to follow breastfeeding guideline or to take antiretroviral drugs. Many HIV positive mothers do not want to maintain breastfeeding instructions for their child due to the avoidance of family observation, suspicion and questions [10].

One respondent reported she blamed herself for the situation of her own daughter. Because of her ignorance, now her daughter is suffering from HIV virus.

12 participants reported that they already decided not to take another child or any child due to their uncertain future. Another respondent expressed she was so distressed and helpless when her child got rejected from school due to her HIV status. Most of the educational institutions do not allow HIV students to study at their institutions. She reported that none at the school treats her child amicably after disclosing her HIV status. The headmaster of the school told her to shift her child from there. Another participant reported that due to her HIV status known to all, her child was deprived of admission opportunity. She tried her best for her child's admission but no institution allowed her. Even after the counseling

with AAS, the school authority did not provide her the permission. Although it is rarely written policy, children have been denied entry into schools because of their HIV status and that of their parents [20].

3.7. Internal Stigma and Women

Societal stigma leads the PLWHAs to grow a feeling of self and internal stigma. In response to experiencing stigma, PLWHAs may adopt protective actions that, in turn, lead to reinforce and legitimize internal stigma [24]. PLWHAs are forced to believe that they carry the virus because they have done something wrong and they deserve it [10].

One respondent expressed that due to moral punishment she is now carrying the virus in her body. These diseases create psychological isolation and depression. Some participants reported that they were rejected by their family members to perform their house oriented activities. They were not allowed to participate any family gossip and to provide their decision about any family matters. Personalized/internalized HIV-related stigma affects PLWHAs severely. As it is internalized into their self-perception and sense of identity, it impacts on the person's perceptions and how they interact in the world [23].

WLWHAs blamed themselves for their disease and they felt shame and guilt. Added to these emotions were many deep-seated fears that included the following: fear of dying; fear of hurting and infecting others; fear of being discovered; and fear of causing pain, disappointment, and sufferings to family members [25].

WLWHAs try to visualize what other people think about them, how society imagine and judge about themselves. When they found negative conception of societal people, they feel distressed about themselves. Being a conservative nation with a Muslim majority population, not only are promiscuity and extra marital affairs looked down upon, pre-marital sexual relationships are also severely treated [20]. Internal stigma forced the individual to avoid public dealings and social interaction.

Box 4:

A remark made by an HIV-positive female respondent:

I am responsible for my own fate. I am carrying the virus because I was faithful to my husband. He betrayed me by hiding his status. I did something wrong, that's why God punished me. I am a sinner, a debased person who has nothing to offer for anyone. I am just the burden of my family. I felt like committing suicide.

PLWHAs have a spoiled identity that deviate them to perform traditional social norms and morality and they believe they deserve severe sanction [10].

4. Discussion

According to the study, the data consistently and strongly shows that WLWHAs in Bangladesh face widespread harassments, tortures, discriminatory behavior, and various forms of stigma and discrimination from their family members, peer groups and community which motivate them to undermine HIV prevention efforts. WLWHAs are marginalized because they do not have power to negotiate safer sex practices with their husbands. The structural and social injustices, inequalities and patriarchal ideologies force women to maintain inferior status [10]. Goffman pointed out that in such a situation a discrepancy may exist between an individuals' virtual and actual identity. These discrepancy, when known about an apparent, spoils his/her social identity, it has the effect of cutting him/her off from society and from himself/herself so that he/she stands a discredited person facing an unaccepting world [7].

Women are more likely exposed to HIV/AIDS epidemic, because they are poorly informed about their sexual and reproductive rights. The knowledge and accessibility or availability of the services is often incomplete and inadequate for them. Women in our society even do not feel free to discuss about sexuality. Throughout Bangladesh women are still not providing treatment facilities that they need. There are governmental and nongovernmental organizations which are working against the fatal disease by providing supportive care and treatment facilities for PLWHAs. There is no doubt these NGOs are trying their best to serve for those vulnerable PLWHAs who combat with HIV/AIDS. But the question is how many WLWHAs have the idea about the service delivery centre? Do women even know that they are carrying the virus in their body? For this study, only three women heard about HIV/AIDS before infected with HIV. Knowledge level of women is very poor in Bangladesh.

Our socio-cultural surrounding makes the people reluctant to go to the service centre. HIV is a catalyst for inherently harmful social labeling followed by discriminatory practices which may create a multitude of obstacles for PLHIV in life and in health care services. According to the estimation of Asar Alo Society (AAS), there are nine thousand five hundred HIV positives in Bangladesh. But still all are not identified. Around three thousand PLWHAs are under the treatment services. Most of the participants of this study reported that the existing health services need to be intensified in order to reverse the still increasing prevalence. According to the recent report of UNAIDS, 70% HIV positive Bangladeshis are out of the service of medicine and treatment which can make the situation more complicated. It is very important to provide treatment and counseling to WLWHAs because through the services they can make decisions regarding some issues like contraceptive methods, pregnancies and infant feeding. Limited access to treatment and services can result high deaths and further contributes to the HIV/AIDS epidemic.

5. Limitations and Conclusions

This paper argues that AIDS prevention campaign has failed to address women's situation. Ensuring long term preparedness is very necessary for enhanced AIDS prevention capacity. Long term preparedness includes participation of women, sexual and reproductive education and availability of treatment services. This study also poses some limitations. As this study is a specific area

based study, the results, therefore, are not sufficient to generalize. Moreover, since this study is restricted to certain number of WLWHAs (purposively taken sample), the result might not give the representative picture of the whole community. Still findings from this study are believed to have large scale implication to change people's negative perception towards WLWHAs. Findings from this study may contribute to minimizing the prevalent sufferings, challenges and discriminatory attitudes towards WLWHAs. We should change our mentality towards WLWHAs by providing a platform for their meaningful participation. The study emphasizes the importance of conducting more research on counterparts' beliefs and perception on women's sexual autonomy, women's protection, availability of treatment services and coordination among various agencies to further integrate the theory and practice. These are but a few examples of actions that can be taken-up by institutions to create zero new HIV infection in the nearer future. The author intends to recommend more in-depth research to unveil the existing reality and harmful impacts of HIV/AIDS on women.

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