# LIVED EXPERIENCES OF STIGMATIZATION AMONG PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (PLHIV)

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# LIVED EXPERIENCES OF STIGMATIZATION AMONG PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (PLHIV)

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In Partial Fulfillment of the

Requirement for the Degree

Bachelor of Science in Nursing

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## CERTIFICATE OF PANEL APPROVAL

In partial fulfillment of the requirements for the degree of Bachelor of Science in Nursing, this thesis entitled **"LIVED EXPERIENCES OF STIGMATIZATION AMONG PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (PLHIV)"** conducted by Omar P. Taclob, Jan Anthony R. Origenes, Cecille Chantal A. Peque and Franzlyn Feby O. Villar and is hereby recommended for acceptance and approval.

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## ABSTRACT

Stigmatization remained a significant challenge for people living with Human Immunodeficiency Virus (PLHIV). It greatly affected their health, social connections, and daily lives. This study examined the lived experiences of PLHIV in Misamis Occidental, Philippines. The aim was to understand how stigma shapes their realities and well-being. This study employed a qualitative phenomenological research design, taking place in Ozamiz City and involving three participants from diverse backgrounds. In-depth interviews collected rich personal stories, and the data were analyzed through Van Manen's phenomenological approach to capture the essence of the participants' experiences. The analysis identi ed ve main themes: navigating spaces of stigma and safety, the embodiment of stigma and resilience, from crisis to acceptance, negotiating support and stigma in relationships, and everyday objects as markers of stigma and care. These themes highlighted the complex nature of HIV-related stigma, which appears as social exclusion, internalized shame, emotional distress, and changed interactions with the physical world. The ndings revealed not only the emotional weight carried by PLHIV but also their impressive resilience in facing everyday challenges. In conclusion, this research emphasized the urgent need for programs that reduce stigma, improve healthcare education, and develop culturally sensitive support systems for PLHIV. It is essential for public health policies to prioritize inclusive and compassionate care, alongside community-based interventions, that respect the dignity and well-being of PLHIV. By promoting better understanding and support, society can help create safer, more accepting spaces for individuals living with HIV, ultimately improving their quality of life and health outcomes.

***Keywords***: attitude, HIV stigma, knowledge, lived experiences, resilience

## DEDICATION

We dedicate this thesis to the people living with HIV in Misamis Occidental and beyond. Your courage, resilience, and openness have driven this research. Your willingness to share your personal journeys has shaped our work and inspired us to be more vigorous advocates for compassion, dignity, and understanding. We are truly thankful for your trust and for allowing us to amplify your voices through this study.

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Finally, we dedicate this thesis to all healthcare workers, advocates, and organizations committed to ghting stigma and supporting people living with HIV. We hope this work contributes to building a more compassionate and inclusive society for all.

The Researchers

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To our respected panel members— Ginalyn C. Elmedulan, MAN, RN, Amie G. Tojino, MAN, RN, and Chona J. Robles, MAN, RN, —thank you for your insightful comments, helpful suggestions, and constructive evaluations, all of which significantly improved the quality of our research.

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To our families and friends, thank you for your patience, emotional support, and understanding throughout this academic endeavor. Your love and encouragement kept us motivated and grounded.

To one another, we extend our gratitude for the teamwork, dedication, and perseverance that carried us through the challenges of this study. Each member's contribution was essential to our success, and this accomplishment stands as a testament to our shared commitment.

Lastly, we express our deepest appreciation to all the individuals who participated in this research. Your openness, honesty, and willingness to share your experiences made this study possible. Your voices are the foundation of this work, and we are truly honored to have listened to your stories.

Thank you all for being part of this meaningful journey.

The Researchers

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# INTRODUCTION

## *Rationale/Background of the Study*

Human Immunodeficiency Virus (HIV) is a retrovirus that primarily attacks the immune system, specifically targeting CD4 T cells, which are crucial for maintaining the body's defense against infections. HIV is primarily transmitted through contact with certain bodily uids, including blood, semen, vaginal fluids, and breast milk, most commonly during unprotected sexual intercourse or by sharing injection drug equipment (HIV.gov, 2023). Although HIV can also be transmitted from mother to child during pregnancy, childbirth, or breastfeeding, it is important to note that everyday interactions such as hugging or sharing food do not pose a risk for transmission (World Health Organization [WHO], 2023).

HIV is classifed into two main types: HIV-1 and HIV-2. HIV-1 is the most prevalent form worldwide and is responsible for the majority of HIV infections. In contrast, HIV-2 is less common and primarily found in West Africa. Both types of the virus share similar modes of transmission and mechanisms of infection, but they differ in terms of their genetic structure and pathogenicity. While both types can lead to severe immune system damage if untreated, individuals infected with HIV-2 often experience a slower disease progression compared to those with HIV-1 (UNAIDS, 2023). Awareness of how HIV is transmitted can help individuals take necessary precautions to protect themselves and others from infection (UNAIDS, 2023; Planned Parenthood, n.d.).

If left untreated, with HIV-2 often experience a slower disease progression compared to those with HIV-1 (UNAIDS, 2023). Awareness of how HIV is transmitted can help individuals take necessary precautions to protect themselves and others from

infection (UNAIDS, 2023; Planned Parenthood, n.d.). If left untreated, HIV can progress to Acquired Immunodeficiency Syndrome (AIDS), the most severe phase of the infection characterized by a signficantly weakened immune system and increased susceptibility to opportunistic infections and certain cancers (World Health Organization, 2024). The progression from HIV to AIDS can take several years, often estimated to be around 8 to 10 years without treatment. The window phase of HIV, the time between infection and detectable antibodies, can bring about significant psychological distress and fear of stigma. People worry about receiving a positive diagnosis and facing discrimination. Before getting a con rmed diagnosis, many may internalize stigma and pull away from social interactions due to anxiety and uncertainty about their status (HIV.gov, 2023). It is important to recognize these experiences when studying the realities of stigmatization for those living with HIV.

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with AIDS may experience a range of symptoms, including rapid weight loss, persistent fever, extreme fatigue, and various opportunistic infections that exploit the compromised immune system (Cleveland Clinic, 2024). The implications of progressing to AIDS are profound, as individuals face not only a decline in health but also an increased risk of mortality. Without effective treatment, the life expectancy for someone diagnosed with AIDS can be signi cantly reduced, often limited to just a few years (Mayo Clinic, 2024). Acquired Immunodeficiency Syndrome (AIDS), caused by the Human Immunodeficiency Virus (HIV), remains a critical public health issue globally. Since its identification, significant progress has been made in understanding and managing the disease. Modern antiretroviral therapies (ART) have transformed HIV from a fatal condition into a manageable chronic illness, improving life expectancy and quality of life for many patients. However, challenges persist, particularly in low resource settings where access to treatment and prevention services is limited. Structural inequalities, especially in regions like sub-Saharan Africa, contribute to disproportionate infection rates, particularly among women and adolescent girls (UNAIDS, 2024).

While global efforts have reduced new infections and mortality, the dynamics of the epidemic are in uenced by social, economic, and cultural factors. Stigmatization and discrimination continue to hinder effective prevention and treatment efforts. Additionally, funding shortfalls pose significant challenges to meeting global targets for eliminating the disease as a public health threat (WHO, 2024). Comprehensive approaches that integrate education, prevention, and equitable access to healthcare are essential for further progress. Globally, 39.9 million people were living with HIV in 2023, with 38.6 million adults and 1.4 million children. 53% of people living with HIV were women and girls (WHO, 2023).

According to the AIDS Data Hub, as of the end of 2023, the Philippines is estimated to have 189,000 PLHIV. According to the Philippine National AIDS Council, in the rst semester of 2023, there were 457 newly diagnosed HIV cases in Misamis Occidental, Philippines. In the first quarter of 2023, the number of newly diagnosed female HIV cases increased by 52%.

Stigma is defined as a set of negative beliefs and attitudes that society holds towards individuals based on speci c characteristics or conditions, such as living with Human Immunode ciency Virus (HIV). This social phenomenon can lead to discrimination, social exclusion, and a significant impact on the mental health and well being of those affected. According to Link and Phelan (2001), stigma involves a process of labeling, stereotyping, separation, status loss, and discrimination that collectively devalues individuals or groups perceived as different. In the context of people living with HIV (PLHIV), stigmatization manifests in various forms, including social stigma, which involves negative attitudes and beliefs held by society towards PLHIV, resulting in discrimination in areas such as employment, healthcare access, and social relationships; self-stigma, where individuals internalize societal prejudices, leading to feelings of shame and reduced self-worth, causing PLHIV to avoid disclosing their status or seeking care due to fear of judgment (Kumwenda et al., 2023); and institutional stigma, which refers to policies and practices within organizations that perpetuate discrimination against PLHIV, such as healthcare systems reinforcing stigma through discriminatory practices or inadequate training of staff regarding HIVrelated issues (Fauk et al., 2021). The origins of stigmatization can be traced back to cultural beliefs, misinformation about HIV transmission, and historical contexts surrounding the disease, with early fears during the

HIV epidemic contributing to widespread panic and negative labeling of those affected; this stigmatization is often exacerbated by media portrayals that associate HIV with high-risk behaviors or moral failings (AIDSmap, 2021).

The lived experiences of stigmatization among people living with HIV (PLHIV) have been extensively documented in various studies, revealing the profound impact stigma has on their daily lives and mental health. For instance, a study by Kumwenda et al. (2023) explored the experiences of PLHIV in Malawi, highlighting how internalized stigma leads to feelings of isolation and fear of disclosure, signi cantly affecting their emotional well being due to negative societal attitudes toward HIV. Similarly, research by Fauk et al. (2021) investigated experiences of discrimination within healthcare settings in Indonesia, nding that negative labeling and avoidance by healthcare providers deterred individuals from seeking necessary treatment, further exacerbating their health challenges. In Taiwan, Yu et al. (2021) examined the emotional challenges faced by PLHIV during the process of HIV status disclosure, revealing that fear of stigma often complicates this critical moment in their lives. Additionally, a qualitative analysis by Senyurek et al. (2021) focused on the perceptions of PLHIV regarding their social spheres and interactions with healthcare professionals. Participants described daily challenges related to stigma that adversely affected their self esteem and access to care. Furthermore, research by Buseh et al. (2022) explored coping mechanisms employed by PLHIV in the United States, revealing that many individuals rely on social support networks as a vital strategy to combat stigma and foster resilience in the face of adversity. These studies underscore the pervasive nature of stigmatization and its detrimental effects on PLHIV, emphasizing the urgent need for targeted interventions aimed at reducing stigma and promoting

acceptance within society to improve the quality of life for those affected. Overall, this research endeavors to elucidate in depth how people living with HIV feel in daily situations through the process of qualitative 1 method of research. Specifically, it examines social isolation, discrimination, and self-perpetuated shame, through which stigma occurs among these individuals. Analyzing these lived experiences provides our study with the objective of identifying the deep seated psychological and emotional burden that stigma imposes on individuals, affecting their self-esteem, mental well-being, and overall quality of life.

This study is significant not only for its contribution to academic literature but also because it has the potential to affect public health policies and community practices. Stigmatization remains one of the most significant barriers to healthcare and support services offered to PLHIVs, often leading to delays in treatment and poorer health outcomes. In documenting these experiences, we hope to raise the levels of attention and action by healthcare providers, policymakers, and the general public to address some urgent strategies against stigma associated with HIV. Our results informed targeted interventions aimed at educating communities about HIV transmission and reducing misconceptions that feed stigma. This way, we will create an environment that is more understanding, knowledgeable, and secure enough for persons living with HIV to seek care without fear of judgment or discrimination.

In conclusion, this research serves as a call to action for stakeholders at all levels, including government agencies, healthcare organizations, and community groups, to initiate antistigma initiatives and advocate for inclusivity. Through the ampli cation of PLHIV voices and the discussion of systemic issues that have led to stigma, we can move

towards a future where people living with HIV are treated with dignity and respect, which will improve their overall well-being and quality of life. In the process, we will support not only individual empowerment but also contribute to the general goal of achieving social justice and equality for all marginalized communities.

***Theoretical Framework***

This study was grounded in Dorothea Orem's Self-Care De cit Theory (1971) and Irwin Rosenstock's Health Belief Model (1952). Dorothea Elizabeth Orem (July 15, 1914 – June 22, 2007) was a prominent American nursing theorist best known for developing the Self-Care De cit Nursing Theory, also referred to as the Orem Model of Nursing. This theory emphasizes the importance of self care in maintaining health and well-being, proposing that participants have the innate ability and responsibility to care for themselves. The theory is centered around key components of self-care de cit, each of which can be correlated with the lived experiences of PLHIV.

A self-care deficit occurs when participants are unable to meet their own self-care requirements due to various factors, such as physical limitations, psychological barriers, or a lack of knowledge. In the context of HIV, this might manifest as difficulties due to stigma associated with the disease or a lack of social support. Identifying these deficits is essential for developing appropriate interventions and support systems that can help participants regain their ability to care for themselves. In the context of HIV, stigma can lead to feelings of shame and isolation, which signi cantly impact an individual's ability to engage in self-care practices. For example, they may avoid seeking medical care or adhering to treatment regimens due to fear of discrimination or judgment from others.

By applying Orem's theory, healthcare practitioners can better understand the complexities surrounding self-care among those living with HIV. They can implement supportive nursing systems that not only address the physical health needs of these people but also consider the psychological impact of stigma. Such an approach empowers these people to reclaim their self-care agency, fostering resilience and encouraging proactive health management despite the challenges posed by societal stigma. Thus, this theory serves as a critical lens through which to examine and enhance the health outcomes of individuals affected by HIV-related stigmatization. This study is vital for several reasons. First, the theory provides a structured framework for understanding how stigma can lead to self-care de cits in this population. This population often faces significant social stigma, which can hinder their ability to engage in essential self-care practices. By applying Orem's theory, it can identify specific areas where these people may struggle with self-care due to the psychological and social impacts of stigma.

This study will also be grounded in the Health Belief Model (HBM), developed by Irwin Rosenstock (1952). Irwin M. Rosenstock (born January 15, 1925) is a distinguished American social psychologist best known for developing the Health Belief Model (HBM) in 1952. The HBM is a widely recognized framework for understanding health behaviors, focusing on how stigmatization influences their action towards health taken to prevent or manage health conditions.

Perceived susceptibility is what people think about susceptibility to HIV infection or experiencing negative health consequences associated with the virus. In this study, it can aid in explaining how individuals perceive vulnerability to health complications intensified by stigma when living with HIV. Most of these people may underestimate

their susceptibility in view of misconceptions among individuals or internalized stigma that may bring about risky behaviors and avoidance of health services. For instance, these individuals living with HIV might believe that they are not at risk for complications if they appear healthy, despite the reality of their condition, which can hinder proactive health management.

Perceived severity involves beliefs about the seriousness of HIV and its consequences. This aspect is important in this study because it addresses how stigma influences perceptions of the disease's severity. Those who view HIV as a severe and life-threatening illness may be more motivated to seek treatment and adhere to self-care practices. On the other hand, if stigma causes them to deny the seriousness of their disease, perhaps because they perceive it as a moral failing, then they might forgo crucial health measures. Likely, those with high levels of stigma often suffer from a higher mental health problem that may compound their health situation.

Perceived barriers refer to the obstacles that individuals perceive as preventing them from taking recommended health actions. These barriers might include fear of discrimination, lack of social support, and feelings of shame about their HIV status. Stigmatization can create significant barriers to accessing healthcare services; for instance, the fear of being judged or ostracized by healthcare providers or society in general may deter people from seeking testing or treatment. This can highlight such barriers and emphasize the need for interventions that address both the psychological impacts of stigma.

Overall, this theory served as a comprehensive framework for how perceptions about susceptibility, severity, and barriers affect health behaviors in people living with

HIV. The model is not only helpful in individualized analysis but also apprises healthcare providers of strategies to enhance support and education for this population, ultimately reducing stigma and improving health outcomes.

### *Conceptual Framework*

This study explored the lived experiences of stigmatization among people living with Human Immunode ciency Virus (PLHIV). Grounded in narrative inquiry, this framework highlights how stigma is embodied, resisted, negotiated, and transformed through the personal and social narratives of PLHIV. It draws upon ve emergent themes: navigating spaces of stigma and safety, safety, embodiment of stigma and resilience, from crisis to acceptance, negotiating support and stigma in relationships, and everyday objects as markers of stigma and care. These themes interact to shape how PLHIV experience and make sense of stigma in their daily lives.

#### Navigating Spaces of Stigma and Safety

This theme captures how PLHIV constantly assess their environments—whether social, healthcare, or familial— to determine whether they are safe spaces or sites of potential discrimination. Participants recount altering behavior, concealing their status, or avoiding speci c settings to manage exposure to stigma. This spatial navigation illustrates the adaptive strategies individuals employ to maintain personal dignity and minimize harm, while also revealing the pervasive nature of social surveillance and judgment.

#### Embodiment of Stigma and Resilience

Stigma becomes inscribed not only in how PLHIV are treated but also in how they view and carry their own bodies. Participants share experiences of shame, fear, and internalized stigma, as well as narratives of bodily resistance and resilience. They speak

of transforming their understanding of HIV from a “mark of disgrace” into a symbol of survival. This tension reflects the dual reality of living with a stigmatized condition while also cultivating personal strength and agency.

**From Crisis to Acceptance**

The trajectory from initial diagnosis to eventual acceptance emerges as a significant emotional and psychological journey. Many participants describe a period of emotional collapse, identity crisis, or hopelessness immediately after learning their status. Over time, with support, self-reflection, and engagement in care, they gradually reframe their identity and regain a sense of normalcy. This theme emphasizes the nonlinear but transformative process of adapting to life with HIV.

**Negotiating Support and Stigma in Relationships**

Interpersonal relationships serve as critical arenas where stigma and support are negotiated. Disclosure of HIV status is often fraught with fear, yet it also opens the door to intimacy, advocacy, and care. Participants describe navigating the risk of rejection or discrimination by partners, friends, or family, while also identifying those who provide unwavering support. These narratives show how relationships can both perpetuate and alleviate the burden of stigma.

**Everyday Objects as Markers of Stigma and Care**

Items such as medication, clinic appointment cards, and even digital reminders act as symbolic artifacts of both stigma and healing. For some, these objects trigger anxiety about being "found out." For others, they serve as reminders of survival, self-care, and empowerment. These material dimensions of stigma reveal how tangible items become emotionally and socially charged in the lives of PLHIV.

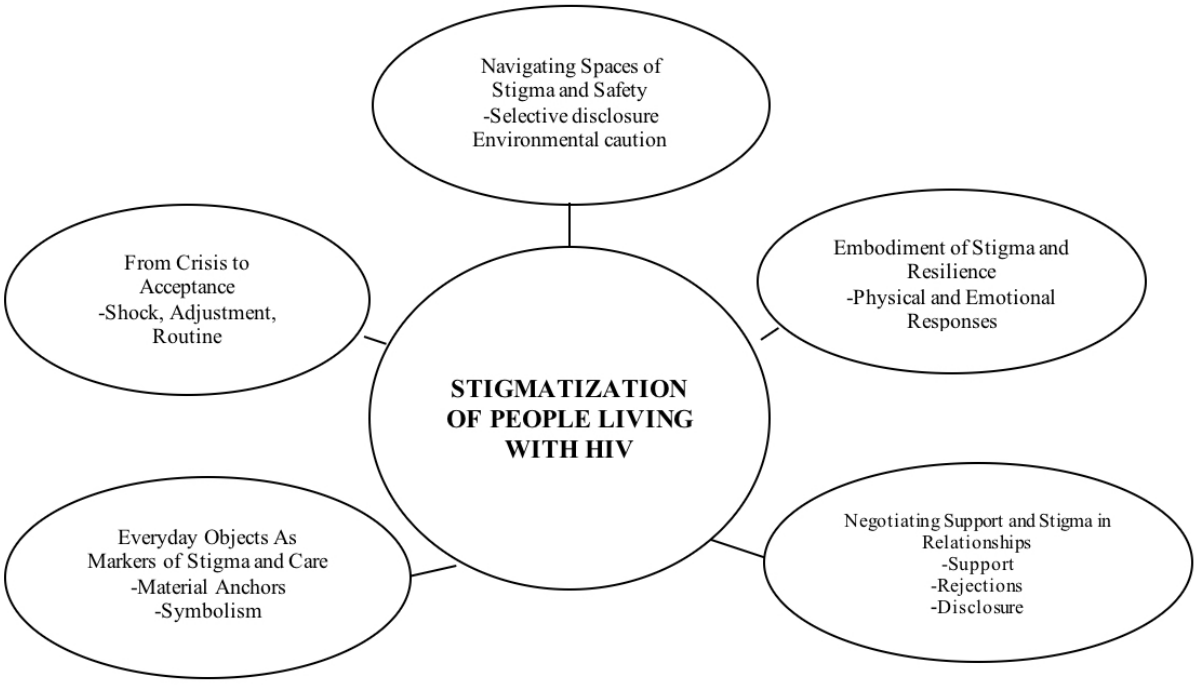


Figure 1. Esssences of lived experiences of stigmatization among people living with human immunodeficiency virus. (J.A. Origenes, C.C. Peque, O. Taclob, F.F. Villar, 2025).

The lived experiences of People Living with HIV (PLHIV) revealed a complex interplay of stigma experienced through ve existential dimensions: temporality, spatiality,

corporeality, materiality, and relationality. Each dimension reveals that stigma is not a singular event, but an ongoing process that shapes individuals' day-to-day existence, emotions, social interactions, and coping strategies. Participants' narratives revealed that stigma is often first encountered during the moment of diagnosis, which brings an overwhelming sense of shock. This emotional upheaval gradually transitions into a period of adjustment, where individuals begin to come to terms with their condition, navigate the complexities of treatment, and reconcile their identities.

Eventually, a routine is established, suggesting a movement toward acceptance and normalization of life with HIV. These phases reflected the dynamic temporal nature of living stigma, highlighting the psychological evolution over time. PLHIV often navigate their physical and social environments with environmental caution, carefully evaluating where it is safe to reveal their status. Selective disclosure is a common strategy used to manage potential exposure to discrimination. Participants shared experiences of altering their behavior in public, avoiding specific healthcare settings, or choosing not to disclose their status in professional environments due to fear of being stigmatized. These findings emphasize how spatiality becomes a site of both threat and protection in the daily lives of PLHIV.

The body emerged as both a bearer of illness and a symbol of social meaning. Participants described physical responses such as fatigue and illness-related changes that marked their bodies as "different," often attracting scrutiny. Additionally, emotional responses like fear, anxiety, and internalized shame appear closely to bodily experience. However, the same body was also a site of resilience, as individuals spoke about reclaiming control through medication adherence, self-care, and resistance to societal judgment. This dual experience underlines the corporeal complexity of living with HIV related stigma. Objects associated with care, care particularly antiretroviral medications,

carried dual meanings. They functioned as material anchors, ensuring survival and stability, but also served as potential markers of illness when seen by others. Symbolism was embedded in these items; for some, they represented hope and responsibility, while for others, they were reminders of social isolation or difference. The physicality of stigma thus extended beyond the body into the objects of everyday life, reinforcing or resisting societal narratives about HIV. Stigma was deeply experienced through interpersonal relationships. Participants highlighted the fear and risk involved in disclosure, particularly to family, intimate partners, or close friends. Reactions ranged from support to rejection, with both having profound effects on emotional well-being. Many described relational negotiations as ongoing, reflecting an effort to strike a balance between trust, vulnerability, and protection. These relational dynamics underscore the social burden that PLHIV navigate in sustaining meaningful connections while managing stigma. The study's findings revealed that stigmatization of PLHIV is a multidimensional phenomenon that touches all aspects of lived experience. The interplay of temporal, spatial, corporeal, material, and relational domains provides a holistic understanding of how stigma operates and is managed. These insights call for more nuanced, empathetic, and person-centered approaches in healthcare, policy, and community support systems. Reducing stigma must involve addressing both societal attitudes and the structural conditions that perpetuate exclusion and marginalization.

***Objectives of the Study***

This study examined the lived experiences of stigmatization among people living with human immunodeficiency virus (HIV) within the province of Misamis Occidental.

***Significance of the Study***

The findings of the study aimed to help individuals with HIV in addressing speci c challenges that they face in our society. This study lies in its potential to illuminate the unique challenges and realities faced by this marginalized population. By employing a qualitative approach, the study delved deeply into personal narratives, revealing how these people navigate the complexities of HIV within their specific cultural and social contexts.

This study is crucial for people living with HIV (PLHIV) as it sheds light on their lived experiences and the profound impact of stigma on their health and well-being. By documenting these experiences, the researchers were able to empower them by validating their feelings and challenges. This understanding has led to improved self advocacy, encouraging PLHIV to seek necessary healthcare services without fear of discrimination. Furthermore, insights gained from this study can inform tailored interventions that address speci c self-care de cits caused by stigma, ultimately enhancing their quality of life.

In the community, this showed widespread levels of HIV related stigma and has deleterious effects on social cohesiveness and public health. The awareness of the issues about PLHIV can be used for educating the community to embrace it with empathy and a better understanding, thus improving acceptance and reducing stigma against this population. This change may lead to the establishment of more support structures for PLHIV, while fostering inclusive practices that promote testing and treatment. Indeed, community engagement initiatives informed by our ndings can help create supportive

environments that facilitate open discussions about HIV, contributing to the ongoing reduction of stigmatism.

This research can be used for health policymakers and the DOH, providing critical data that could inform public health strategies on combating HIV-related stigma. Findings could guide targeted educational campaigns against misconceptions about HIV transmission and treatment. Knowing that these stigmatizing issues hamper PLHIV access, the DOH could ensure, through its policies, equitable provision to those under its health service that would ensure the well-being of all in similar positions, regardless of their HIV status. That way, alignment in achieving broader objectives concerning the control and treatment of HIV among populations can be guaranteed. In nursing education, this underscores the importance of integrating knowledge about HIV-related stigma into curricula. By educating future nurses about the complexities of stigma and its impact on patient care, this study can enhance cultural competence and sensitivity among healthcare providers. This knowledge will equip nurses with the tools needed to provide compassionate care to PLHIV, recognizing the psychological and social dimensions of their experiences. Incorporating these insights into training programs will foster a generation of healthcare professionals who are better prepared to advocate for their patients' needs. Lastly, this study can be a foundation for further research on on HIV-related stigma. In identifying gaps in current literature, it will allow future researchers to build on our findings, making their own inquiries about intersectional aspects of stigma, including race, gender, and socioeconomic status as intersecting factors with HIV status, and hence enrich our understanding of the public health issue. Our work can further open

avenues for methodological innovations in studying stigma through qualitative approaches that ensure the voices of those affected are heard.

Overall, by highlighting personal stories, this study aimed to contribute to broader public awareness campaigns that reduce stigma and promote understanding within the community. Ultimately, this study not only enriches academic discourse on HIV but also serves as a vital tool for advocacy, aiming to improve the quality of life for people living with HIV. This holds signinifcant implications for several stakeholders in addressing HIV-related stigma. It contributed toward making the understanding of stigma a more nuanced one in health behaviors and outcomes while fostering an environment more supportive of the people living with HIV.

## RESEARCH METHODOLOGY

### *Design*

The study employed a qualitative research design, specifically an interpretive phenomenology research design, to explore and understand the subjective experiences of people living with HIV. Qualitative research design is a methodology focused on understanding human experiences and the meanings individuals assign to them. It involved collecting rich, detailed data through methods such as interviews, focus groups, and observations, allowing researchers to explore complex social phenomena (Stangor & Walinga, 2019). Interpretive phenomenology is a specicifi qualitative approach that seeks to understand how individuals interpret their lived experiences within their unique contexts. This method combines the phenomenological principle, focusing on the essence of experience, with interpretive techniques that consider the meanings individuals attach to those experiences (Smith et al., 2020)

Interpretive phenomenology is particularly suitable because it enables an in-depth exploration of how participants perceive and make sense of their realities. This approach acknowledges the emotional, social, and cultural factors that shape their experiences. By employing interpretive phenomenology, the study was able to capture nuanced narratives that re ect the unique challenges faced by individuals living with HIV, providing valuable insights into their lived realities and contributing to a broader understanding of their experiences (Finlay, 2022).

### *Locale of the Study*

This study was conducted in one of the cities of the province of Misamis Occidental, Philippines, particularly in one of the public hospitals in the province that

provides support to people living with HIV. This setting has been selected for its accessibility and relevance to the target population, as it plays a crucial role in delivering medical care, counseling, and social support to those affected by HIV. Misamis Occidental is home to several health institutions dedicated to HIV awareness and treatment. Conducting research in these familiar environments fostered a sense of safety and trust among participants, encouraging them to share their experiences openly and freely.

***Participants of the Study/ Unit of Analysis and Sampling Procedure***

The target number of participants was 3. Participants were selected using a purposive sampling technique, where they were intentionally selected based on specific characteristics relevant to the study. The participants met the research criteria and were potentially willing to participate in the study. The criteria in the selection of participants were: (1) Individuals who are clinically diagnosed with HIV, (2) from or currently residing within the province of Misamis Occidental, and (3) who have given consent to participate in the study.

***Data Gathering Instruments***

For the in-depth interviews, an interview guide containing a set of questions and recording devices was used, with permission sought from each participant. These interviews aimed to gather insights from participants about their lived experiences with HIV. By carefully designing our interview guide with clear objectives, structured questions, and rigorous testing, while simultaneously implementing measures for trustworthiness as outlined by Lincoln and Guba (1985), we sought to enhance the reliability and validity of our qualitative research ndings. This comprehensive approach

not only facilitated effective data collection but also contributed signi cantly to the overall quality of this research study.

***Data Gathering Procedure***

Before conducting the interview, the researcher sought permission from relevant authorities to ensure ethical compliance. Initial approval was obtained from the Dean of the College of Nursing, Midwifery, and Radiologic Technology. Another letter will be sent to one of the public hospitals in Misamis Occidental and to their existing HIV hub (s) for approval, seeking permission to conduct the study and distribute questionnaires to selected participants from the community. A single designated member of the research team conducted the interview. By utilizing in-depth interviews and observation in our research, the researchers were able to gather comprehensive data that not only captures individual experiences but also contributes to a broader understanding of the challenges faced by individuals living with HIV. The researchers also utilized an unstructured observation technique to gather a wide range of information and gain a comprehensive understanding, wherein researchers observed nonverbal cues without prede ned categories. This method captured spontaneous behavior and interactions during interview sessions, allowing insights into emotional state and social dynamics surrounding their experiences in their current situation. Once collected, the data were transcribed and analyzed using a qualitative phenomenological approach. The findings were interpreted in alignment with the study's objectives, aiming to provide a rich and nuanced understanding of the lived experiences of individuals with HIV.

***Data Analysis***

The collected data were analyzed using Van Manen's interpretive phenomenological approach (Smith, J. A., Flowers, P., & Larkin, M., 2020).

Van Manen's six-step interpretative phenomenological approach:

*Considered the nature of lived experience.* This first step emphasized the importance of understanding what lived experience entails. Van Manen emphasizes that phenomenology aims to investigate human experiences as they are lived, rather than as abstract concepts. This involves recognizing the subjective nature of experiences and how they shape individuals' views of the world. The researcher approached the participants with an open mind, setting aside preconceived notions to grasp the essence of their experiences.

*Investigated the experience as it is lived*. In this phase, researchers collect data through various methods, including conversational interviews, narrative accounts, and observations. The aim was to gather rich, detailed descriptions of participants' lived experiences related to the phenomenon being studied. This step was crucial for obtaining authentic insights into how individuals perceive and make sense of their experiences in context. Van Manen emphasizes that this process was iterative, involving multiple rounds of interaction with participants to deepen understanding.

*Reflected on the essential theme.* After collecting data, researchers engaged in re ective analysis to identify and articulate the essential themes that emerged from participants' descriptions. This involved revisiting the data to extract commonalities and signifcant insights that encapsulate the essence of the experience being studied. Van

Manen encourages researchers to consider how these themes relate to broader existential questions, thereby connecting individual experiences to universal human concerns.

*Described the experience through writing and rewriting.* Writing is a fundamental aspect of van Manen's approach. Researchers are encouraged to describe participants' experiences in a narrative form, capturing the richness and complexity of those experiences. This step often involves multiple drafts; rewriting allows researchers to re ne their interpretations and ensure that they accurately re ect the voices of participants. Van Manen argues that this process not only clarifies understanding but also serves as a means of engaging with the text in a meaningful way.

*Maintained a strong connection to the phenomenon.* Throughout the research process, it is essential for researchers to maintain a strong connection to the phenomenon being studied. This means continually reflecting on how their interpretations relate to participants' lived experiences, ensuring that ndings remain grounded in those realities. Van Manen highlights that this connection helps prevent researchers from drifting into theoretical abstractions that may obscure the essence of the lived experience.

*Balanced the research context by considering the parts and the whole*. The final step involves achieving a balance between understanding individual elements of participants' experiences (the parts) and their overall significance (the whole).

Researchers considered how specific themes interact within the broader context of human experience. This holistic perspective enabled a richer interpretation of the data, facilitating a deeper understanding of how individual experiences contribute to collective meanings. Van Manen suggests that this dual focus enhances the interpretive depth of phenomenological research.

***Ethical Considerations***

This study implemented several ethical considerations to safeguard the dignity, rights, and welfare of the participants. The researchers sought ethics clearance from the Misamis University Research Ethics Committee. Participants were provided with an Informed Consent Form, which detailed the research process, potential risks, and benefits associated with their participation Their involvement in the study was entirely voluntary, ensuring that no coercion would be applied. The study emphasized respect for participants by providing them with resources for support related to HIV and ensuring that their voices were central to the research process. It was made clear to the participants that they retain the right to withdraw from the study at any time without penalty, thereby exercising their autonomy in deciding whether to engage in the research.

Confidentiality was paramount; all responses were treated with strict con dentiality and were used solely for academic purposes. To further protect participants' identities, data were anonymized, and recorded interviews will be deleted within 6 months after the final presentation. Additionally, all personal information was kept con dential, ensuring that participants could share their experiences without fear of exposure. Pseudonyms or code numbers were used to identify study participants, and measures were in place to ensure that they were not linked with any identifying information of the participants. This study scrutinized the selection of participants to prevent any systematic bias or discrimination and implemented equitable recruitment practices that do not exploit vulnerable populations. This included providing timely access to results and ensuring that participants understand how their contributions informed our conclusions. By disseminating findings responsibly and inclusively, we honored the contributions of

our participants and promoted transparency throughout the research process. By adhering to these ethical standards, this study aims to contribute meaningfully to understanding the lived experiences of individuals with HIV while prioritizing their rights and well-being throughout the research.

The protection and con dentiality of the participants (PLHIV) were of utmost consideration following RepublicAct No. 11166, also known as the Philippine HIV and AIDS Policy Act.

## RESULTS AND DISCUSSION

The participants of this study consisted of three person's living with Human Immunodeficiency Virus (PLHIV), each coming from diverse backgrounds and unique life circumstances. The group included one transwoman, one married male sales worker, and one single male vendor. Their ages ranged from 32 to 41 years old. All participants had been diagnosed with HIV between 2 to 5 years prior to the study and were currently undergoing antiretroviral therapy. Each had personally experienced forms of stigma—whether social, relational, or internalized—and had varying levels of openness about their condition. While some chose to disclose their status only to a select few, others had embraced advocacy and education within their communities. Despite their differences in gender identity, work, and lifestyle, all participants shared one common reality: navigating life under the weight of both illness and societal judgment.

From the analyses of the data, five key themes have emerged as follows: such as navigating spaces of stigma and safety, embodiment of stigma and resilience, from crisis to acceptance, negotiating support and stigma in relationships, everyday objects as markers of stigma and care. Navigating spaces of Stigma and Safety included two subthemes such as selective disclosure, and environmental caution. Embodiment of Stigma and Resilience included two sub-themes such as physical responses and emotional responses. From Crisis to Acceptance includes three sub-themes such as shock, adjustment and routine. Negotiating Support and Stigma in Relationships includes three sub-themes such as support, rejection, and disclosure. Everyday Objects as Markers of Stigma and Care includes two sub-themes such as material anchors, and symbolism.

## THEME 1: NAVIGATING SPACES OF STIGMA AND SAFETY

It refers to the ongoing tension experienced by People Living with HIV (PLHIV) as they move between environments that either expose them to judgment or offer protection and acceptance. This theme captures how PLHIV must continually assess their surroundings—be it in the workplace, healthcare settings, family circles, or public spaces—determining where they feel safe to disclose their status and where concealment is necessary for self-preservation.

According to Earnshaw & Chaudoir (2009), stigma can be internalized, enacted, or anticipated, and PLHIV often respond by selectively managing their identity and visibility. These behavioral adaptations—such as concealing medication, avoiding healthcare visits in familiar areas, or withholding disclosure—are forms of "stigma navigation" meant to avoid rejection, discrimination, or harm. However, this constant vigilance leads to emotional exhaustion, social withdrawal, and diminished access to care (Turan et al., 2017).

The participants in this study described experiences of hiding their diagnosis from co-workers and friends while seeking solace in support groups or within safe, affirming communities such as the LGBTQ+ network. In these safer spaces, they could speak freely, receive support, and embrace their identities without fear. Thus, navigating stigma and safety is not only a social process but also a psychological balancing act where PLHIV attempt to protect their dignity, mental health, and physical well-being in the face of persistent societal stigma. This is what the participants said:

*"There are times na di jod sha pwede nako pwede ipanabi, itago nako sha kung tan-aw nako na murag wala siyay knowledge ana na butang…" (PA) stated*

*"Naa jod times na maulaw ko kay pareha bitaw aning maingnan ta ug "hala yucks ayaw ug duo ana kay makatakod na siya", maguol ko bitaw…" (PC) stated.*

**SUB-THEME 1. 1 SELECTIVE DISCLOSURE**

Selective Disclosure refers to the intentional decision by People Living with HIV (PLHIV) to reveal their HIV status only to specific individuals or in particular contexts, while concealing it from others. This behavior is often influenced by the perceived risk of stigma, discrimination, or social rejection. For PLHIV, disclosure is not merely about sharing medical information—it is a complex, emotionally charged process that requires weighing potential benefits (such as emotional support or improved treatment adherence) against possible negative outcomes (such as judgment, isolation, or loss of relationships).

It acts as a protective mechanism. Many PLHIV choose to confide only in trusted family members, partners, or fellow members of HIV support groups, where empathy and understanding are more likely. Conversely, they may withhold this information from co-workers, employers, or broader social circles due to fear of gossip, discrimination, or being treated as "unclean" or morally flawed. As highlighted by Chaudoir, Fisher, and Simoni (2011), the decision to disclose is often shaped by anticipated stigma and past experiences with disclosure.

While selective disclosure helps preserve emotional safety and social functioning, it can also lead to internal stress and isolation. The constant vigilance required to maintain secrecy—such as hiding medications or avoiding clinic visits in familiar areas—can affect mental health and hinder consistent care. Hence, selective disclosure reflects

the ongoing negotiation between the need for connection and the fear of rejection in a society where HIV-related stigma remains deeply entrenched.

*"There are times na di jod sha pwede nako pwede ipanabi, itago nako sha kung tan-aw nako na murag wala siyay knowledge ana na butang…" (PA) stated.*

*"Ga duha-duha ko ug istorya about sa akong mama kay basin dili sila maksabot sa akong sitwasyon labi kay tiguwang na…" (PB) stated.*

**SUBTHEME 1.2 ENVIRONMENTAL CAUTION**

Environmental Caution refers to the heightened sense of vigilance and awareness that People Living with HIV (PLHIV) adopt when navigating social, occupational, and healthcare spaces due to the fear of being identified, judged, or stigmatized. This concept reflects how PLHIV continually assess their surroundings for safety—emotionally, socially, and physically—before disclosing their status or even engaging in routine actions like taking medications or visiting clinics.

For PLHIV, the environment is not neutral; it is filled with potential threats to their dignity and well-being. A workplace might appear supportive, but a careless remark about HIV can make someone retreat into silence. A neighborhood health center might offer treatment, but the fear of being seen entering it can discourage someone from seeking care. These real or anticipated risks cause PLHIV to constantly modify their behavior—masking medications, avoiding questions, or choosing distant healthcare facilities—to maintain privacy and avoid stigma.

This cautious navigation is not a sign of weakness, but a form of resilience and survival. It demonstrates how stigma reshapes the meaning of space, transforming ordinary environments into places of risk or refuge. Environmental caution, therefore, is a

product of social stigma and a reflection of how deeply embedded discrimination influences the lived experiences of PLHIV**.** These are the following statements expressed by participants B and C.

> *"Naa jod times na maulaw ko kay pareha bitaw aning maingnan ta ug "hala yucks ayaw ug duo ana kay makatakod na siya", maguol ko bitaw…" (PC) stated.*
>
> *"Ga duha-duha ko ug istorya about sakong status sa among workplace kay basin tungod ana malahi ila panan-aw sa ako or matanggal ko…" (PB) stated.*

**THEME 2: EMBODIMENT OF STIGMA AND RESILIENCE**

Embodiment of Stigma and Resilience reflects the deeply personal and lived experience of People Living with HIV (PLHIV) as they carry not only the physical realities of the virus but also the psychological and social weight of societal judgment. The term embodiment signifies how stigma is not just perceived cognitively but is physically and emotionally felt—manifesting in the body through stress, shame, avoidance behaviors, or health deterioration. At the same time, resilience emerges from within as PLHIV adapt, survive, and reclaim their identity despite these social burdens.

Participants in the study revealed how stigma infiltrated various aspects of their lives: self-perception, relationships, and health-seeking behaviors. Feelings of "being dirty," "being judged," or "being excluded" were not abstract fears but daily lived realities. This internalization of stigma often led to silence, self-isolation, and emotional distress. However, amid these struggles, participants also demonstrated remarkable resilience—drawing strength from their families, their children, support groups, spiritual faith, and a desire to live meaningfully.

This theme highlights the dual process where the body becomes a site of both suffering and survival. For some, advocacy and education became pathways to healing, while others found strength in adherence to treatment and reclaiming their future. As Parker and Aggleton (2003) explain, stigma is a social process rooted in power, but it is also something that can be challenged through resistance, solidarity, and education.

Thus, "Embodiment of Stigma and Resilience" captures both the scars and the strength PLHIV carry—how they internalize, navigate, and ultimately resist the stigma imposed on them by society.

**SUB-THEME 2.1 PHYSICAL RESPONSES**

Physical Responses refer to the bodily manifestations experienced by PLHIV as a consequence of stigma-induced stress. Participants reported changes such as weight loss, fatigue, and sleep disturbances, which were often triggered not just by the virus itself but by the emotional burden of hiding their status or being treated differently. These physical symptoms reflect the body's response to chronic psychological distress, highlighting how stigma is not only a social issue but also a somatic one.

Stigma can lead to hypervigilance, avoidance behaviors, and compromised health routines—all of which affect the body over time. For example, participants expressed exhaustion from the effort of concealing their medications or avoiding local clinics to prevent being seen. These physical repercussions of stigma can hinder recovery and reduce the quality of life, showing how discrimination indirectly affects the body**.** These were what the participants said:

*"Niubos gyud akong timbang ug half gikan 80-49 kilos in less than 3 weeks ug grabe akong pagniwang ato na time, tas ang pagtubo ug rashes ug ayo…" (PA) stated.*

*"Nagka-rashes ko sa akong likod mga pula-pula nanubo ug pag ubos sa akong timbang gikan 72-62 kilos…" (PB) stated.*

*"Grabe akong pagniwang ato na time gikan sa 70-55 kilos, tas gitubuan kog rashes, akong dila gaputi ug ayo…" (PC) stated.*

**SUB-THEME 2.2 EMOTIONAL RESPONSES**

Emotional Responses involve the psychological effects of living with HIV in a stigmatizing environment. Participants revealed emotions such as fear, sadness, shame, and anxiety, which were often rooted in past experiences of judgment or rejection. The constant fear of disclosure and social exclusion created an emotional burden that was, for many, more difficult to carry than the virus itself.

Internalized stigma—the acceptance of negative beliefs about oneself—was particularly damaging, as it often led to self-blame and diminished self-worth. Several participants recounted avoiding relationships, withdrawing from social spaces, and questioning their own dignity. Yet amid these emotional struggles, some began to rebuild their resilience through spirituality, advocacy, or the support of understanding peers.

"*Nakulbaan nako kay ga research ko dayon possibly na HIV gyod ako nabati ato…" (PA) stated.*

*"In-denial gyod kayo ko maski naka research ko tas maoy nigawas na mao lagi basin HIV daw tong akong mga symptomas na nabati…" (PB) stated.*

*"Nakulbaan ko kay mutug-an kos tinuod wala gyod kayo koy nahibaw-an kung unsa ang HIV ug iyang epekto sa akong lawas.." (PC) stated.*

**THEME 3: FROM CRISIS TO ACCEPTANCE**

The theme "From Crisis to Acceptance" captures the evolving emotional and psychological journey of PLHIV as they move from the destabilizing moment of diagnosis to a state of personal acceptance and resilience. For most participants, receiving an HIV-positive diagnosis marked a profound personal crisis. This moment was often characterized by fear, disbelief, shame, and emotional paralysis—heightened by the anticipation of social stigma and discrimination. Some recounted feeling like their life had ended, while others described withdrawing from loved ones or struggling with anxiety and depression in the days and months that followed.

However, as time passed, participants began to shift from this crisis state toward a more empowered position. Through access to antiretroviral therapy (ART), the support of understanding individuals or groups, spiritual grounding, and personal reflection, many began to reshape their perspective. Acceptance was not simply the resignation to living with HIV, but an active process of rebuilding identity, finding meaning, and reclaiming agency despite societal stigma. For some, it also sparked a drive to educate others and break the silence surrounding HIV, turning pain into purpose.

This movement from crisis to acceptance underscores the human capacity for adaptation. It also reflects the transformative potential of inner strength, community support, and stigma reduction efforts. This is what the participants said:

**SUB-THEME 3.1 SHOCK**

The initial reaction of shock upon HIV diagnosis was a universal experience among participants. This phase was characterized by emotional paralysis, fear of death, and panic from potential stigma and social judgment. Research has long confirmed that the diagnosis of HIV is not only a medical event but a psychological rupture that invokes fear of discrimination and social isolation (Brown et al., 2003). The following are statements stated by the participants A-C.

"*Pagconfirm gyud nako sa akong status akoa gitawagan dayon akoang mama kay nakaingon gyud kog pila nalang ka semana o bulan nalang kaha ang nabilin nako, abi nakog mamatay na jud ko kay hinganlan na HIV nakuyawan gyud ko kay sa ka active nako kas ang laag nako sa BGC didto gyud nako nakuha…" (PA) stated.*

*"Akong hunahuna pagkahibalo sa akong status kay gihunahuna jud nako akong asawa og mga anak… nakulbaan ko gadecide na musulti sa akoang asawa kay gatuo kog awayon ko o biyaan ko niya…" (PB) stated.*

*"Abi nakog gikan lang sa akong TB ang akong mga gibati na sakit, ubo og hilanat… HIV na diay, wala ko kabalo sa kong angay bation kay una, wala gyud koy hanaw bahin aning sakita…" (PC) stated.*

**SUB-THEME 3.2 ADJUSTMENT**

As participants processed their diagnosis, they entered a period of emotional adjustment. During this phase, many struggled with selective disclosure, fear of rejection, and stigma in social and work environments. However, with limited but meaningful support, they began to reframe their diagnosis and found ways to cope. Stigma, while still

present, became a manageable factor in their journey toward acceptance (Holzemer et al., 2009).

> *"Medyo lisod gyud labaw na na ning hugno gyud ang akong lawas, pero pasalamat rasad ko na wala nawala akong gana sa kaon, padayon lang gyud…" (PA) stated.*

**SUB-THEME 3.3 ROUTINE**

Over time, participants developed a sustainable routine that integrated ART adherence, self-care, and in some cases, advocacy. While stigma never fully disappeared, individuals learned to live beyond it, focusing on health, purpose, and daily responsibilities. The shift from a crisis identity to one of resilience and adaptation reflects findings in the literature that show PLHIV often move toward greater autonomy once stigma is better managed (Rintamaki et al., 2006; Russell et al., 2010). These statements were expressed by Participants A-C.

> *"Karon, busy ra gyud ko magtravel-travel tungod sa ako field, muoli ta halos aron magkuha og stocks sa tambal sa hub, pasingot everyday kaon bisag unsa, ana lang…" (PA) stated.*
>
> "*Sukad ato, naga research jud ko og mga remedies, naga exercise jud ko kada adlaw halos dili na mukaon og karne, puros utan, og akong tambal na dapat on time…" (PB) stated.*
>
> *"Hantod ron muadto ra kog hub pud og magkuha sa akong stocks sa tambal og gaplano pod kog inom na og vitamins dungag proteksyon…" (PC) stated.*

## THEME 4: NEGOTIATING SUPPORT AND STIGMA IN RELATIONSHIPS

The theme "Negotiating Support and Stigma in Relationships" captures the delicate balance that people living with HIV (PLHIV) manage in navigating their social worlds. For many participants, interpersonal relationships—whether with family, romantic partners, or friends—were marked by a constant negotiation between seeking emotional support and avoiding potential stigma. The fear of being judged, rejected, or misunderstood created emotional boundaries that limited authentic connection.

Disclosure, in particular, became a deeply emotional and strategic decision. Participants often evaluated the risks and benefits of revealing their status to those closest to them. This aligns with findings by Rintamaki et al. (2006), who noted that stigma-related concerns significantly influence HIV disclosure, with many individuals choosing selective disclosure to safeguard themselves from social harm. Relationships, therefore, were not static, but evolving spaces of tension between vulnerability and protection.

In some cases, support systems were strengthened—especially when families or peer groups responded with acceptance and empathy. Supportive relationships helped participants maintain treatment adherence and psychological stability (Holzemer et al., 2009). In contrast, unsupportive or stigmatizing responses led to emotional withdawal, secrecy, and feelings of unworthiness. As noted by Brown et al. (2003), stigma can cause PLHIV to avoid even those who might otherwise be sources of care due to fear of rejection.

Ultimately, this theme illustrates that PLHIV do not passively receive support or stigma—they actively negotiate their place within relationships to manage both. These negotiations reflect ongoing emotional labor as they strive to preserve their dignity while

living with an illness that society often misjudges**.** These were what the participants A, B and C said:

> "*Lahi ra gyud ang lawas atong wala pay gibati, karon naa na koy sakit na gidala nya naa pay lain na mga sturya ang uban tawo, lisod pero laban lang gyud kay naa naman ni…" (PA) stated.*
>
> *"Wala gyud ko biyae sa akoang asawa, og sila maoy kusog nako sa akong pagpadayon karon, akong asawa og mga anak…" (PB) stated.*
>
> *"Nakadawat ra baya pud kog mga pangumusta, mga suporta sa mga FB groups og mga tunay na friends…" (PC) stated.*

**SUB-THEME 4.1 SUPPORT**

Support emerged as a vital element that helped participants navigate the psychosocial challenges of living with HIV. Emotional, informational, and practical support from family, friends, LGBTQ+ communities, or healthcare workers acted as buffers against the impact of stigma. Participants who received genuine affirmation reported higher self-worth, better adherence to antiretroviral therapy (ART), and greater hope for the future. According to Holzemer et al. (2009), support systems are instrumental in mitigating the negative outcomes of stigma, promoting treatment compliance, and reinforcing emotional resilience. For many PLHIV, safe relational spaces became sanctuaries where they felt understood, accepted, and empowered to live meaningfully despite their diagnosis. These statements were expressed by participant A-C.

> "*Grabe akoang nadawat na suporta labina sa kwarta ubay jud pod akoang nadawat kay wa pod ko naulaw mangayo aron matabangan akoa kahimtang…" (PA) stated.*

*"Og suporta lay hisgotan, dili mn directly gyud ko gisuportaan sa akong asawa pero sa kuan pa lang na naa ra siya, wala nibiya, dakong pasalamat na gyud nako na…" (PB) stated.*

**SUB-THEME 4.2 REJECTION**

Conversely, the sub-theme of Rejection reveals the emotional wounds inflicted by stigma, often from the very people participants hoped would stand by them. Some were subjected to subtle distancing, gossip, or overt discrimination after their status was disclosed—fueling feelings of worthlessness, shame, and isolation. Rejection was especially painful when it came from intimate partners or family members, leading some participants to withdraw emotionally or socially. As Brown et al. (2003) argue, HIV stigma is deeply rooted in moral judgment, resulting in social exclusion that exacerbates psychological distress and interferes with healing. The fear and experience of rejection perpetuate cycles of silence and secrecy in PLHIV. Succeeding statements were expressed by participants A and B.

*"Nay kas-a na syempre naa juy masulti ang tawo, labaw na kay bayot dayon in ani pa gyud og kahimtang… naa gyuy mga binuang kunuhay pero tinud-anay na diay…" (PA) stated.*

*"Naay kaon, nya nakabnatay ko na kung unsa na sud-an akoang kwaan, dili sila musunod og kuha, kay basin siguro hadlok sila na matakdan, bisag wala kabalo kayo sa pamaagi sa pagtakod…" (PB) stated.*

**SUB-THEME 4.3 DISCLOSURE**

Disclosure was portrayed not as a single act, but as a continuous and emotionally charged process. Participants disclosed selectively choosing only those they trusted or

those who already belonged to a supportive HIV or LGBTQ+ community. The fear of stigma and rejection made disclosure a strategic decision rather than an open conversation. Rintamaki et al. (2006) highlighted that disclosure among PLHIV is shaped by perceived social risks, and that secrecy can be both protective and psychologically taxing. For some, disclosing their status opened doors to support and advocacy. For others, it came at the cost of damaged relationships or public scrutiny. This complex process reflects the deep negotiations PLHIV engage in to balance truth, protection, and social connection. Following statements were expressed by participants B and C.

> *"Pagkaconfirm nako sa akoang status, gitawagan nako akoang mama og gipost dayon nako sa social media akoang status, para unhan ang mga judgments sa tawo…" (PC) stated.*
>
> *"Sa akoang asawa ra gyud nako nasturya, mas na sturya pa gali nako pod sa akoang workplace kaysa sa akoang mama og mga igsuon, kay gusto ko na once muingon na ko nila, balik na sa sauna ang akoang lawas o health…" (PB) stated.*
>
> *"Pagkabalo gyud nako, nag wonder gyud ko aha nakuha, pero active gyud man ko, halos tanan sa amoa kabalo man sa akoang sakit, so far, wala ra gyud pod kaayoy lain na trato sa ako…" (PC) stated.*

**THEME 5: EVERYDAY OBJECTS AS MARKERS OF STIGMA AND CARE**

In the lived experiences of people living with HIV (PLHIV), everyday objects—such as antiretroviral (ARV) pill bottles, medical IDs, or appointment slips—carry profound emotional and social meanings. These are not neutral items; rather, they become symbolic markers, shaping how individuals perceive themselves and how they are perceived by others. For some participants in the study, even the sound of pills

rattling in a container could trigger fear and anxiety—reminders of their condition and the risk of involuntary disclosure in stigmatizing environments.

These items, while essential to health maintenance, can inadvertently expose one's HIV status, thus transforming them into silent agents of stigma. This aligns with Goffman's (1963) concept of "discreditable" identity, where objects can become visual cues that betray a hidden stigma. Participants reported strategies such as hiding their medication, relabeling pill bottles, or waiting until they were alone to take their medicines—demonstrating how material items required careful management in social contexts.

On the other hand, these same objects also represented care, survival, and commitment. For many, ARVs symbolized control over their health and a tangible step toward living a longer, meaningful life. As van Manen (1990) emphasizes in his hermeneutic phenomenology, objects gain lived meaning through the context in which they are experienced. Here, everyday medical items were imbued not only with fear but also with strength and hope

This duality—of stigma and care—shows how PLHIV constantly negotiate the material world, balancing secrecy with self-preservation. The way participants interacted with these objects reflected their broader journey: a continuous effort to protect themselves from judgment while nurturing their own healing and resilience. This is what the participants said:

**SUB-THEME 5.1 MATERIAL ANCHORS**

Material anchors refer to the tangible objects in a PLHIV's daily life that ground them in their health journey—most notably, their medications, clinic cards, and medical

paraphernalia. These items serve as anchors of routine and survival, reminding individuals of the importance of adherence and the commitment to healing. For participants, taking their antiretroviral (ARV) medications wasn't just a physical act—it was a moment of psychological grounding, reinforcing a sense of control over their condition. These materials became an essential part of their identity and daily ritual, anchoring them in their reality as both patients and survivors. The presence of these anchors reinforced continuity and discipline amidst emotional and social instability.

As Van Manen (1990) articulates, the material world is central to how humans live and understand experience—these items are not passive objects but are tied to lived meaning and emotional memory. Material anchors help PLHIV stay connected to care pathways, reinforcing their journey not just through medical treatment but through symbolic endurance. These statements were expressed by participants B and C.

> *"Pagkaconfirm nako sa akoang status, gitawagan nako akoang mama og gipost dayon nako sa social media akoang status, para unhan ang mga judgments sa tawo…" (PC) stated.*
>
> *"Sa akoang asawa ra gyud nako nasturya, mas na sturya pa gali nako pod sa akoang workplace kaysa sa akoang mama og mga igsuon, kay gusto ko na once muingon na ko nila, balik na sa sauna ang akoang lawas o health…" (PB) stated.*
>
> *"Pagkabalo gyud nako, nag wonder gyud ko aha nakuha, pero active gyud man ko, halos tanan sa amoa kabalo man sa akoang sakit, so far, wala ra gyud pod kaayoy lain na trato sa ako…" (PC) stated.*

**SUB-THEME 5.2 SYMBOLISM**

Objects associated with HIV are also rich in symbolism—often embodying the dual emotional responses of empowerment and fear. A simple pill bottle may symbolize life-saving treatment for one individual, while simultaneously representing shame, illness, or judgment for another. Participants in the study expressed that these objects carried emotional weight; they were visible reminders of their diagnosis and social difference. Some viewed their medication as a sign of their strength and perseverance, while others saw it as a potential source of unwanted exposure and stigma.

This symbolic nature of objects reflects Goffman's (1963) idea of stigma cues—tangible indicators that can mark individuals as "other" in social spaces. The symbolism of these objects was shaped by past experiences, social interactions, and personal belief systems. For some, even concealing these objects was a symbolic act of reclaiming privacy and agency. The following statement were expressed by Participant A.

> *"Sukad na diagnose ko, cellphone gyud akoang gipadagan tanan, gi live nako akong mga gamit, maong wa na gyuy sulod akong balay, kay ato na time need gyud nako og funds…" (PA)* stated.

Clearly the most intense obstacle to meeting their needs, no matter how great it may have been, was not simply their presence on the path to recovery, but the social stigma imposed over them by living with HIV. In these forms—from implicit avoidance or passive rejection to harsh discrimination—the discrimination was profound in permeating the participants' experience. It excluded them from initiating discussion of their condition and prevented them from engaging in social and support networks and

provoked feelings of shame and isolation. For many, the fear that they might be labeled “unclean” or “immoral” became more important than illness itself.

This persistent social prejudice perpetuates a vicious circle of silence and concealment, creating not just a health, but a personal and communal struggle. This persistent social bias reinforces a cycle of silence and secrecy, making recovery not just a medical journey, but a deeply personal and societal struggle. In response, contemporary research increasingly emphasizes the need to deconstruct stigma as a social barrier—advocating for community education, inclusive healthcare practices, and visibility of PLHIV voices in reshaping public perception. UNAIDS reports that in 52 of 58 countries with recent population-based survey data, more than 25% of people aged 15 to 49 years reported holding discriminatory attitudes towards people living with HIV, highlighting the pervasive nature of stigma and the urgent need for comprehensive interventions (UNAIDS, 2022).

## FINDINGS OF THE STUDY

There were three participants-PLHIV's living with Human Immunodeficiency Virus (HIV) from the province of Misamis Occidental who participated in this study. From the transcribed interviews, the lived experiences of stigmatization emerged with heartfelt emotion and compelling honesty. Each participant revealed the deeply personal and sometimes painful encounters they have faced as a result of their HIV status. Their stories carried a range of emotional depth from resilience and isolation to courage and silent strength.

Every interview shed light on the societal and internal battles these individuals continue to endure, exposing how stigma manifests in both subtle and overt forms. The participants spoke of being misjudged, avoided, or discriminated against in settings that should have offered care, compassion, or understanding. They shared how these experiences influenced their self-worth, mental well-being, and interactions within their families, communities, and workplaces.

The participant-PLHIVs have been living with their diagnosis for varying periods, ranging from two to over ten years. Most of them are in their early thirties to late forties and come from diverse socioeconomic backgrounds. Despite the challenges brought by their condition and the social stigma attached to it, they each described unique coping strategies and personal growth developed through their journey. Their narratives provide insight into the resilience and strength it takes to reclaim identity and dignity in a world that often marginalizes them. As Munhall (2012) asserts, the meaning of being is uncovered from various perspectives—and within these narratives, the complex realities of stigma and survival are laid bare.

The materials produced from the interviews and reflective journaling reveal eight distinct perspectives from people living with HIV, each narrating their own encounters with stigma in various aspects of life. No single interview left me untouched, as I found myself deeply moved by the courage and vulnerability of each participant while recounting experiences of rejection, discrimination, and silent suffering. Whether in healthcare settings, workplaces, or within their own families, the realities they face reflect a profound struggle for dignity and acceptance. A pseudonym was assigned to each participant as their stories are shared in this study.

**Patient A**, a single 32-year-old PLHIV, makes a living by selling Nature's Spring water in their local community. Living alone, they find joy in traveling and discovering new places, a passion that gives him a sense of freedom and purpose. They shared that their journey with HIV has not been easy, having faced numerous forms of stigmatization from different people and institutions. They experienced being anxious of what might happen and verbalized of having depression. These experiences have left lasting marks, yet they remained resilient and determined to make a difference. They expressed a strong desire to challenge the misconceptions surrounding HIV by becoming a speaker and advocate, bringing awareness and education to communities in hopes of fostering acceptance and understanding.

**Patient B**, a married 36-year-old college-educated salesman, works at a local sales center. Described by those close to them as reserved and introverted, they carry a quiet strength shaped by personal battles and transformation. In 2023, at the age of 35, they were diagnosed with HIV—a result of a sexual encounter with a woman. Although protection was used, a wound from a bite on the mouth during the act is believed to have

transmitted the virus. Before this life-altering diagnosis, Patient B openly admitted to a lifestyle marked by vices such as gambling, drinking, and casual encounters. For them, HIV became a sobering revelation—a spiritual and moral wake-up call. They describe it as a turning point that challenged them to break free from destructive habits and reevaluate their purpose. From November to May, they experienced deep anxiety and depression, accompanied by a significant weight loss from 70kg to 62kg. Despite their introverted personality, they had disclosed their condition to a small, trusted circle—their family, a few friends, and select co-workers. Though not publicly outspoken, their silent resilience and dedication to their family reflect their quiet defiance against the stigma surrounding HIV.

**Patient C**, a 41-year-old transwoman, currently works at a local karenderia and lives alone, fighting their daily battles with quiet strength. Identifying as a proud member of the LGBTQ+ community, is open about their HIV status, especially among their LGBTQ peers. Their shared experiences have become their main source of support and understanding. Diagnosed with HIV at the age of 38. They recall having little to no knowledge about the condition before their diagnosis. They suspect to have contracted the virus either through unprotected sexual encounters with multiple male partners or through contaminated needles, as she has several tattoos. Following their diagnosis, they independently sought help from the City Health Office and began their journey of treatment and healing. They were also previously diagnosed with tuberculosis, which further complicated her condition. Though they embraced their truth, there were still moments of self-doubt and discomfort—times when they felt ashamed or worried that others may judge them as unclean or less worthy. Despite this, they chose to remain

strong. They took hormones regularly as part of their gender-affirming process and held on to their Born Again Christian faith, which kept them grounded. Their formal education ended in their first year of college, but their life experiences have shaped their resilience. They stand as a voice for others, who is like her, navigating stigma with grace, openness, and a fierce determination to live life fully and authentically.

**Uncovering Thematic Aspects: Process and Findings**

Through a rigorous iterative process grounded in phenomenological reduction and van Manen's hermeneutic approach, a total of thirty-six **(**36) significant statements were extracted from the transcribed interviews and reflective notes of the participants. These statements were then clustered and analyzed to draw thirty-six (36) formulated meanings that captured the essence of the participants' lived experiences of stigmatization. The significant statements and their corresponding meanings are presented**.**

To preserve the authenticity of the participants' voices, a member-checking process was conducted wherein the emergent themes were presented back to the individuals involved. This step ensured that the themes accurately reflected their intended meanings. Patterns emerging from recurring meanings were clustered into meaning units, resulting in-five (5) refined units. These were further grouped into five (5) sub-themes, which were then synthesized into five (5) essential themes that encapsulate the core experiences of PLHIV in the context of social stigma. The table below presents the analytical pathway undertaken in uncovering these thematic aspects of living with HIV under the lens of stigma.

Table1. Themes, Themes Clusters and Main Themes of Person's living with Human Immunodeficiency Virus (PLHIV).

| THEMES | THEME CLUSTERS | MAIN THEMES |
|---|---|---|
| Only disclosing in LGBTQ gatherings or to trusted individuals.<br><br>Avoidance of disclosure in rural areas.<br><br>Segregation of utensils at home and in other's homes<br><br>Adjusting behavior based on safety of environment | Selective Disclosure and Environmental Caution<br><br>Selective Disclosure and Environmental Caution | Navigating Spaces of Stigma and Safety<br><br>Navigating Spaces of Stigma and Safety |
| Anxiety, insomnia, sweating, weight after diagnosis.<br><br>Self-imposed segregation (using disposable utensils, avoiding close contact with children).<br><br>Using routines (reading, cooking) to cope. | Physical Responses and Emotional Responses | Embodiment of Stigma and Resilience |
| Shock and fear at diagnosis<br><br>Anticipation of death<br><br>Gradual shift to acceptance<br><br>Developing daily routines for stability (reading, cooking, taking medication) | Temporal Shifts: Shock, Adjustment, Routine | From Crisis to Acceptance |
| Strong support from some family, friends, and community | | |

| | | |
|---|---|---|
| Experiences of discrimination and negative comments<br><br>Careful selection of whom to trust<br><br>Support group as safe spaces<br><br>Redefining relationship | Support, Rejection and Disclosure | Negotiating Support and Stigma in Relationships |
| Segregated utensils as reminders of stigma<br><br>Gifts, food, and financial help as care and solidarity<br><br>Daily routines as comfort and structure | Material Anchors and Symbolisms | Everyday Objects as Markers of Stigma and Care |

**The Thematic Categories**

The following thematic meaning emerged from the various analyses of the interaction of all research materials (Munhall, 2012), which is consistent with the analytic interactions using the hermeneutic phenomenological approach (Van Manen, 1990). The PLHIV participants experienced stigmatization in various forms because of a lack of awareness towards PLHIV.

**Navigating Spaces of Stigma and Safety**

This theme reflects how PLHIV continuously move between environments that either threaten or protect their sense of self. Participants shared how everyday spaces—such as homes, clinics, and workplaces—can be sites of both comfort and risk. Fear of judgment often shaped their behaviors and decisions, especially when it came to disclosure or treatment adherence. At the same time, they found refuge in supportive

spaces, such as select relationships or community groups, where acceptance helped counteract stigma. These experiences reveal how space becomes emotionally charged, influencing how PLHIV manage their identity and well-being.

**Selective Disclosure**

This highlights how PLHIV carefully choose who to tell about their diagnosis, balancing the need for support with the fear of rejection or judgment. Participants described revealing their status only to trusted individuals—such as family, close friends, or fellow PLHIV —while keeping it hidden from others to avoid gossip, discrimination, or loss of relationships. Disclosure was not a one-time act but a strategic, ongoing decision in influenced by the perceived safety of each relationship. This selective sharing served as both a protective mechanism and a way to maintain dignity in the face of social stigma. This experience is expressed when Participant A stated;

> **"***Dili kaayo ko komportable mo istorya bahin sa akong sitwasyon kay tungod mahadlok ko lahi ilang pagsabot*." (interpretation: "I'm not very comfortable talking about my situation because I'm afraid they might misunderstand me") reveals the emotional and social tension experienced by the participant in relation to disclosure and stigma.

This response highlights the theme of "Selective Disclosure" and reflects the participant's fear of being misjudged or misinterpreted by others. Despite the possible need for emotional support, the individual chooses to withhold information due to anticipated stigma—worrying that people may react negatively, jump to conclusions, or view them through a lens of moral judgment.

**Environmental Caution**

This theme reflects how PLHIV develop heightened awareness of their surroundings to avoid exposure, discrimination, or social judgment. Participants described adjusting their routines—such as hiding medications, avoiding clinics near their homes, or altering behavior in public—to reduce the risk of being identified or stigmatized. Their movements and choices were shaped by a continuous assessment of who might be watching, listening, or judging. This constant vigilance reveals how physical environments are navigated with caution, turning everyday spaces into potential threats or sanctuaries. This experience is classified as stated by Participant A (PA).

> "*Di na kaayo ko ganahan mutubag sa mga pangutana og makig interact nila kay kapoy pasabot nila"* (interpretation: I no longer feel like answering their questions or interacting with them because I'm tired of explaining") reveals emotional fatigue and social withdrawal stemming from repeated misunderstandings or lack of empathy.

This response reflects the emotional toll of stigmatization and the burden of continually explaining oneself. The participant expresses a sense of exhaustion —not only from being questioned but also from having to justify or clarify their condition repeatedly, often to people who may lack understanding or empathy. This suggests a pattern of social fatigue, where the energy required to maintain relationships or defend one's identity outweighs the benefits.

**Embodiment of Stigma and Resilience (Corporeality)**

In this study, the embodiment of stigma and resilience underscores the corporeal and psychological realities experienced by people living with HIV (PLHIV). Participants

conveyed how stigma was internalized and expressed physically, influencing not only how they moved through social spaces but also how they related to their own bodies. Despite these challenges, acts of resilience were reflected through sustained health-seeking behaviors and a conscious effort to preserve well-being. The participants' lived experiences reveal how the body becomes both a site of vulnerability and resistance in the context of stigma.

***Physical Responses***. As described by participants, stigma had tangible physical impacts. These physical responses included fatigue, sleep disturbances, and somatic symptoms that often coincided with social rejection or fear of disclosure. This experience is expressed when the PA stated,

> *"Oo kay nisulod man dayon akoang insomnia, ga electric fan pero gisingot japon ko."* (Interpretation: These experiences led to significant emotional distress on my part. I began to suffer from insomnia shortly afterward. Even while using an electric fan, I would continue to sweat excessively, indicating heightened anxiety and internal turmoil).

The internalization of stigma translated into behaviors such as avoiding public health centers, refraining from eye contact, and minimizing social interactions. For some, the body itself became a burden—a reminder of illness and difference-yet it was also seen as something to be strengthened through regular medication adherence, nutrition, and personal care. This experience is expressed when the PA stated,

> *"So, akong ginbuhat kay selpon lang jud ko, wala ko galantaw ug sad movies, nagsigeg kog basa sa google bahalag diko kasabot. Didto ko nakabalo nga, mabuhi pami kaya pa."* (Interpretation: Given that I only had access to a mobile

phone, I did not watch any sad movies. Instead, I continuously read information on Google, even if I did not fully understand it. Through this, I came to realize that survival was still possible and that we still had a chance).

These responses reflect how PLHIV navigate the dual burden of managing illness and countering societal judgment through bodily self-regulation.

***Emotional Responses***. Participants expressed a range of emotional responses rooted in the experience of stigmatization. Feelings of fear, shame, and isolation were frequently reported, especially in moments when disclosure was imminent or when they encountered discrimination. This experience is expressed when the PA stated,

> *"There are times nga di jud siya nimo pwede ipanabi nga huy kuan baya ko or ana baya ko, gawas nalang kung naa koy kastorya na part sa LGBTQ dayon gusto nako siya tambagan. Itago nako siya kung tan aw nakong murag wa siyay knowledge ani nga butang like di jud ni kasabot ba."* (Interpretation: There are times when you really can't just go around telling people, 'Hey, I'm like this,' or 'This is who I am,' unless I'm talking to someone who's also part of the LGBTQ community and I want to give advice. I keep it to myself if I feel like the person doesn't have any understanding of these things — like they really wouldn't get it).

These emotional responses were intensified by the anticipation of being judged or rejected, leading many to internalize negative societal perceptions. However, emotional resilience also emerged as a critical theme; some participants developed coping mechanisms, such as selective sharing, seeking support from empathetic peers, and cultivating self-acceptance. This experience is expressed when the PA stated,

*“Maabot gyud sa point na hawa diri ayaw nana siyag palaaga diri kay laagan man gud ko. Dayon aymo pakihalubilo ana kay matakdan mo ana niya even magstorya ta ana. Pero instead nga masuko ko, akong panan aw nila kay maluoy ko nga gasulti siyag negative abt HIV nya iyang topic kay puro negative puro mamatay na ana, maluoy ko kay wa siyay knowledge...”* (Interpretation: There came a point when I was told to leave and not to be entertained anymore, largely because I was perceived as someone who frequently went out. I was warned not to associate with certain individuals, with remarks such as 'Don’t interact with that person, you might get infected just by talking to them.' However, instead of feeling anger, I felt compassion. I realized that their statements about HIV were filled with negativity, often equating it with death. I felt pity, recognizing that these views stemmed from a lack of accurate knowledge and understanding).

These emotional processes highlighted the ongoing negotiation between stigma and self-worth in the lived experience of PLHIV.

**From Crisis to Acceptance (Temporality)**

In this study, the journey from crisis to acceptance is characterized by temporal shifts in the participant's emotional experience, beginning with shock, progressing through adjustment, and ultimately settling into a routine. These temporal changes illustrate how the participant's understanding and management of his HIV diagnosis evolved. This experience is clarified when Participant B expressed,

*“Actually, sa time na nagduda pa ko, so naa pa ko sa stage na kampante, pero naa gyud puy time na kanang unsa kaha no?” (interpretation: At first, when I was just suspicious, I was still at ease, but there were times I wondered, ‘what if?’)* He

further shared, *"Mura kog nakulbaan, nya naworry-nabalaka dayon ko kay what if kung positive ko, sa ako man gung mind ato na time is wala pa jud kaayo koy, wala pa jud koy idea. Once HIV, mamatay na ka, mao gyud na ang gatuyok sa akoa hunahuna that time. So mao to nga pagka-tong gihilantan ko nya nabasa na nako ang… mga giresearch nako nga possible cause [kay] HIV, so maingon kog nabalaka ko sus unsaon nalang og tinuod ni nya mamatay ko!... gagmay pa akong mga bata ba, mao toy akong mga gikabalak-an lang that time, oo."* (Interpretation: I felt nervous and worried-what if, I was positive? At that time, I had little idea about HIV. In my mind, once you have HIV, you die. That's what kept running through my head. When I had a fever and read about possible symptoms, I started to worry, thinking, 'What if it's true and I die? My children are still young.' That's what I was anxious about.)

This narrative shows the initial shock and fear that followed suspicion and diagnosis, characterized by anxiety, uncertainty, and catastrophic thinking-typical of the crisis phase after receiving a life-changing diagnosis (Breet et al., 2019).

As time passed, the participant described a shift toward adjustment:

*"Kami pa lang duha sa akong partner... So mao to siya pa lang ang nakabalo at that time nya pagkahuman… kuan man gud to kaning 2024 is grabe challenge sa akoa og sa akong pamilya, sugod sa akong pagkadiagnosed og tuig pod na na nagsakit og pag ayo akoang asawa to the point na abi namog natakdan na sya sa akoa... So mao to, nishare jud ko sailaha, tanan halos...."* (Interpretation: At first, only my partner knew. Then, 2024 became a big challenge for me and my family,

starting from my diagnosis and my wife's illness. I ended up sharing my status with others.)

Here, the participant begins to adjust by seeking support and sharing his status, reflecting a movement away from isolation and towards acceptance and adaptation. This adjustment phase is often marked by information-seeking, disclosure, and gradual acceptance (Shrestha et al., 2019).

Eventually, the participant describes the emergence of a new routine and coping strategies:

> *"To me, prayer gyud, kuan gyud ko at that time gisurrender n gyud nako tanan sa Ginoo gyud... akong pamilya akong asawa og mga anak, gipili gyud nako na magpadayon... So kuan akoa ra gyud tong gitiman an akong nabasa na drink your meds and exercise everyday, so mao to sya nagatake ko sa akoang medicine on time og naga exercise gyud ko, pasingot ba. Dayon same as usual giubanan pod nakog take og mga herbal na mga remedy na akong mga nahibaw an. Wala rman gyud pod sya nakaapekto sa akong trabaho kay na manage naman nako sa pagkakaron akong status."* (Interpretation: For me, prayer was important; I surrendered everything to God. My family, my wife, and my children motivated me to continue. I followed what I read: take your meds and exercise every day. I take my medicine on time and exercise regularly. I also use herbal remedies I know. It hasn't affected my work because I've managed my status.)

This illustrates the routine phase-where the participant incorporates health management and self-care into daily life, moving from crisis to a sense of normalcy and

control. Establishing routines is a key element of long-term acceptance and well-being among PLHIV (Rao et al., 2021).

These temporal shifts-from shock, to adjustment, to routine-demonstrate the dynamic process of coping and acceptance following an HIV diagnosis. Such transitions are well-documented in recent literature, emphasizing that acceptance is not a single event but a gradual, ongoing process shaped by personal, relational, and social factors (Pantelic et al., 2022).

**Negotiating Support and Stigma in Relationships**

Negotiating support and stigma in relationships reveals how Participant B navigated support, rejection, and disclosure after being diagnosed with HIV. These experiences highlight the complexities of relationality and personal coping strategies in the context of HIV.

Support Participant B immediately disclosed his HIV status to his partner, motivated by a sense of responsibility and care for his family:

> *"Gipahibalo jud nako sya dayon, pag uli sa balay ako dayon syang gipahibalo kay akoa is para ma prevent pod nako nga… dili sya matakdan kay uh… akong hunahuna ba kay og matakdan sya duha na mi, mamatay ko, mamatay sya, walay mabilin sa among mga anak, at least dapat unta naay isa mabilin… na at least ma aware pod sya na mudefend sa iyang kaugalingon kay kabalo naman sya na naa koy ingon ana na sakit."* (Interpretation: He disclosed his status to his wife right away to protect her and their children, showing a strong sense of responsibility and care within the relationship.)

Participant B also shared how faith and family motivated him to continue:

*"To me, prayer gyud, kuan gyud ko at that time gisurrender n gyud nako tanan sa Ginoo gyud... akong pamilya akong asawa og mga anak, gipili gyud nako na magpadayon."* (Interpretation: Prayer and family gave him strength to move forward and focus on his health.)

Family and partner support are critical for people living with HIV (PLHIV), as they foster resilience, adherence to treatment, and psychological well-being (Tshweneagae et al., 2021). Immediate disclosure to trusted partners is often motivated by a desire to protect loved ones and maintain open communication (Mabuto et al., 2020). Additionally, spirituality and faith are recognized as important coping mechanisms that help PLHIV manage distress and find hope (Adejumo et al., 2021).

Rejection although Participant B did not experience direct rejection, he described the presence of stigma and subtle social distancing:

*"Sa akoang nasabtan sa HIV man gud grabe ang stigma, si stigma sya ang gapapaspas sa pagspread sa HIV, ang mga tawo diri, wala man gud na orient kung unsa ang HIV, ang lantaw sa tawo saimoa basura o hugaw, mao man gyud na usually iingon sa tawo, kung hugaw ila panlantaw saimoha, hatred nalang man dayon sulod sa imo kasingkasing."* (Interpretation: He is aware of strong stigma in the community, where people may view those with HIV as 'dirty' or 'contaminated,' leading to feelings of exclusion.)

He also noticed subtle exclusion during social gatherings:

*"naay tapok-tapok dayon mangaon na, nakabantay ko na og aha ko mukuha og sud an, wala na dayoy musunod og kuha sa sud an, mao lang na, mao na akong*

*nabantayan."*(Interpretation: During meals, others avoided using the same serving utensils after him, reflecting subtle exclusion.)

He praticed self-isolation at home to protect his children:

*"galikay gyud gihapon ko na ipagamit ang mga akong mga gigamit na baso o kutsara sa akong mga anak, gilikayan pud gyud nako."* (Interpretation: He avoids sharing utensils with his children to prevent transmission and possibly to avoid stigma within the household.)

Stigma and discrimination against PLHIV remain prevalent and can result in social isolation, internalized stigma, and changes in daily behavior (Nyblade et al., 2019). Even subtle acts, such as avoiding shared utensils, reinforce feelings of rejection and difference (Pantelic et al., 2022). Self-isolation or altered household practices are strategies PLHIV use to protect others and manage anticipated stigma (Rao et al., 2021).

Disclosure was selective and situational for Participant B:

*"Kami pa lang duha sa akong partner... didto nuon ko ning isturya sa daghang tawo na dili suod."* (Interpretation: Initially, only his partner knew. Later, during a moment of crisis, he disclosed to a group of less familiar people rather than to close family or friends.)

He reflected on the limitations of secrecy:

*"Hiding is not protecting PLHIV, sa stigmatization dapat gyud unta na kanang dili maghide, na ma aware ang mga tawo."* (Interpretation: He believes that hiding one’s HIV status does not protect against stigma; instead, public awareness is needed to reduce it.)

Disclosure decisions are complex and influenced by anticipated stigma, need for support, and perceived safety (Maman et al., 2020). Selective disclosure can provide emotional relief and access to support but also exposes individuals to potential stigma (Bogart et al., 2021). Research suggests that increasing public awareness and normalizing HIV disclosure can reduce stigma and enhance social support for PLHIV (Dawson-Rose et al., 2020).

**Everyday Objects as Markers of Stigma and Care (Materiality)**

In this study, everyday objects such as utensils and glasses became material anchors that symbolized both stigma and care within the homes of people living with HIV (PLHIV). The way these objects are handled, separated, or shared reveals deeper meanings about protection, exclusion, and relational boundaries.

> *"Akong utensils ug plato nakasegregate tanan or kung mahimo disposable tanan kay naa man mga bata, akong mga pag-umangkon."* (Interpretation: I keep my utensils and plates separate, or if possible, use disposable ones because there are children in the house, especially my nephews.)

This participant expresses a protective instinct towards young family members, choosing to separate utensils of fear of transmitting HIV. This act is not merely a precaution but reveals underlying internalized stigma and a self-imposed distancing within their own home. It reflects both care (to protect others) and social exclusion (to isolate oneself).

> *"Galikay gyud gihapon ko na ipagamit ang akong mga gigamit na baso o kutsara sa akong mga anak, gilikayan pud gyud nako."* (Interpretation: I still avoid letting my children use the glasses or utensils I have used; I really avoid it.)

This statement illustrates how the participant continues to manage daily routines around invisible fears. Despite likely awareness that HIV cannot be transmitted this way, emotional stigma persists, prompting behaviors of avoidance and separation. The utensils and glasses take on symbolic weight — representing both anxiety over harm and a marker of difference within the household.

> *"Even akong parente di makighalubilo… akong anxiety giubanan gyud nako to, basi asa gyud ko maabot para madistract lang."* (Interpretation: Even my relatives avoided me… I struggled with anxiety and tried to keep myself busy so I wouldn't dwell on it.)

This reflects how social distancing by relatives intensifies the participant's emotional distress, contributing to anxiety and isolation. The participant copes by seeking distractions, revealing an effort to manage psychological burdens of stigma within close relationships.

These interpretations demonstrate how material objects and social interactions become symbolic carriers of both care and stigma, reinforcing internal and external boundaries in daily life.

Such behaviors echo what Pantelic et al. (2022) describe as "symbolic boundaries," material actions that manage both physical spaces and emotional realities. Even with medical facts dispelling these fears (UNAIDS, 2023), the persistence of these practices shows the depth of internalized stigma and misinformation within the household setting.

**Thematic Discussion and Return to Literature**

This section presents the discussion of the research questions. The thematic categories reflected in the five existential life world (Van Manen, 2014) are discussed in relation to the existing literature, including the assumptions and concepts of the theory Self-Care Deficit Theory and Health Belief Model. These theories offer broad concepts about caring and beliefs that can be used in a variety of situations that will facilitate an understanding of the descriptions of PLHIV's lived experiences towards their experience of stigmatizations.

**Thematic Categorization Based on Five Existential Life Worlds**

The essential themes of the study: navigating spaces of stigma and safety (spatiality), embodiment of stigma and resilience (corporeality), from crisis to acceptance (temporality), negotiating support and stigma in relationships (relationality), and everyday objects as markers of stigma and care (materiality).

Table 2. Thematic Categorization in the Lifeworlds (van Manen, 2014)

| **Essential Themes** | **Lifeworlds** |
|---|---|
| Navigating Spaces of Stigma and Safety | Spatiality |
| Embodiment of Stigma and Resilience | Corporeality |
| From Crisis to Acceptance | Temporality |
| Negotiating Support and Stigma in Relationships | Relationality |
| Everyday Objects as Markers of Stigma and Care | Materiality |

**Navigating Spaces of Stigma and Safety (Spatiality)**

PLHIV often experience stigma in spaces where they should feel safe—such as their homes, communities, workplaces, or healthcare settings. Because of this, they learn to navigate these spaces cautiously, deciding where and when to reveal their status, and to whom. For example, avoiding certain people, places, or conversations becomes a coping mechanism to reduce exposure to judgment, gossip, or rejection.

At the same time, they seek out safe spaces—like support groups, understanding family members, or empathetic healthcare workers—where they feel accepted, heard, and protected. These spaces allow them to express themselves freely, receive emotional support, and maintain their mental well-being.

This theme shows that stigma is not just a social or emotional experience—it is spatially experienced. PLHIV must constantly shift between environments of threat and environments of safety. Their daily life becomes a process of managing proximity to stigma while preserving personal dignity and emotional safety.

In summary, this theme reveals how space and place influence the lived experience of stigma, and how PLHIV develop strategies to protect themselves from harm while seeking connection and care. It's a powerful insight into the intersection of physical movement, social relationships, and emotional survival.

**Embodiment of Stigma and Resilience (Corporeality)**

For many PLHIV, stigma is not only something they hear or see—it becomes something they feel in their bodies, through stress, anxiety, shame, or even physical withdrawal. For example, when someone avoids social contact, hides physical symptoms,

or changes their posture or behavior due to fear of judgment, they are embodying the effects of stigma. As Goffman (1963) noted, stigma can result in a "spoiled identity," which is often expressed through bodily presence—how one walks, speaks, or even avoids eye contact.

However, corporeality also includes resilience. PLHIV show strength through how they care for their bodies, adhere to treatment, and continue to live and engage with others despite internal and external stigma. Resilience may be seen in the way PLHIV attend support groups, take their medications regularly, and maintain dignity even when faced with discrimination. These acts demonstrate how the body becomes not just a site of suffering but also of survival and empowerment.

As scholars like Csordas (1994) emphasize, the body is not a passive object but an active site of experience and meaning. In your study, PLHIV's stories reflect how their bodies become battlegrounds of both stigmatization and strength—where societal rejection is internalized, but also where healing, resistance, and hope are physically lived out.

**From Stigma to Acceptance (Temporality)**

It reflects the temporal journey that People Living with HIV (PLHIV) go through—from initial experiences of shock, fear, and social rejection to gradually finding self-acceptance and support. In the context of temporality, this theme emphasizes that stigma is not a static experience; instead, it evolves as individuals navigate their diagnosis, relationships, and sense of identity.

At the time of diagnosis, many PLHIV report feelings of shame, guilt, and fear of being judged. These emotions are often intensified by experiences of actual rejection,

such as being ignored by family members or avoided by peers. However, as time passes, PLHIV begin to build coping mechanisms—finding support through family, peer groups, or healthcare providers, and starting to reclaim their sense of worth. These turning points show how acceptance, both internal and external, can grow over time.

**Negotiating Support and Stigma in Relationships (Relationality)**

It highlights how the experience of living with HIV is deeply intertwined with the quality and nature of personal relationships—whether with family, friends, partners, or community members. Through the lens of relationality, this theme shows how PLHIV do not experience stigma in isolation, but rather within the dynamics of their social connections.

Many PLHIV face a conflict between fear of rejection and the need for emotional support. This reflects how PLHIV must constantly assess the trustworthiness of relationships—deciding who will respond with compassion and who might judge or abandon them.

This negotiation is a relational balancing act—one that requires PLHIV to protect themselves from potential stigma while still seeking connection, care, and understanding. This theme reveals that stigma is not just a personal burden, but a relational experience. PLHIV navigate a complex web of interactions where they must balance vulnerability with protection, silence with disclosure, and rejection with hope. Understanding stigma through the lens of relationality highlights the crucial role that supportive relationships play in mitigating the adverse effects of stigma

The theme **"Everyday Objects as Markers of Stigma and Care"** explores how ordinary, tangible items—such as medication bottles, clinic cards, or even food utensils—

can carry deep emotional and symbolic meaning for People Living with HIV. In the context of materiality, this theme reveals how stigma and care are not only experienced through words or relationships, but also through physical objects that become part of PLHIV's daily lives.

For many PLHIV, these objects serve as reminders of their condition. For instance, antiretroviral (ARV) medications can represent life and healing, but at the same time, they can trigger fear, shame, or secrecy. Taking medication in public or being seen with a prescription bottle can lead to anxiety about being "found out" or judged. This turns a life-saving object into a potential source of stigma, as it marks the body and the person as "different" or "ill" in the eyes of others.

At the same time, these same objects can also become symbols of care and resilience. For example, regularly taking medication or bringing a clinic card to appointments shows commitment to health and self-care. In supportive environments, these items may even be viewed as empowering tools—signs of survival, responsibility, and strength. The lived experience of stigma among PLHIV is not only social and emotional but also material. Everyday objects, especially those related to HIV care, carry powerful meanings that shape how individuals see themselves and how others see them. Understanding these material dimensions adds a richer layer to the narrative of stigma—showing how care and stigma are experienced through the physical world as much as through social interaction.

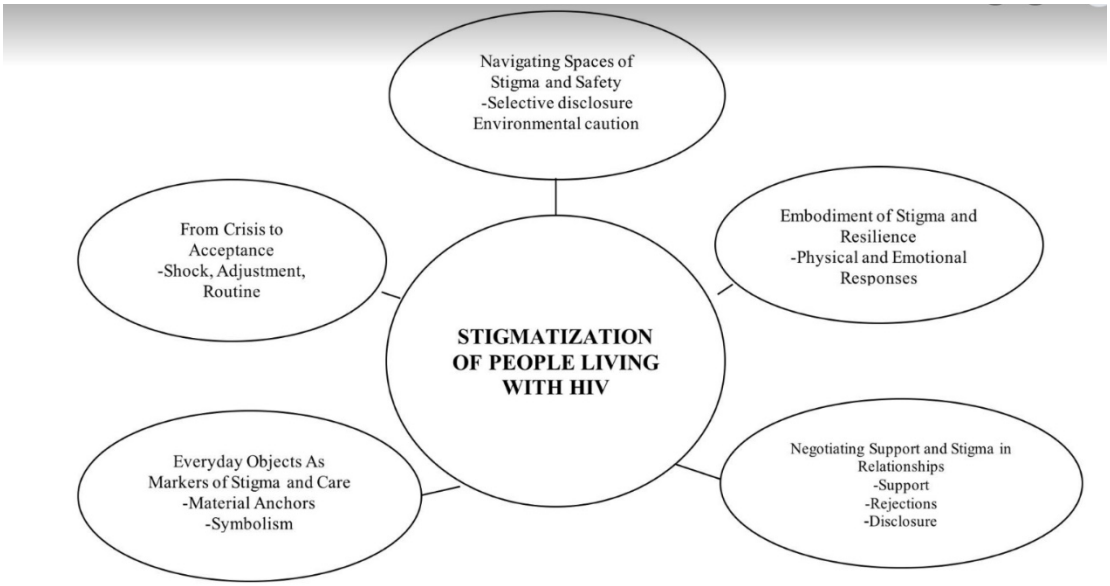


Figure 1. Essences of lived experiences of stigmatization among people living with human immunodeficiency virus. (J.A. Origenes, C.C. Peque, O. Taclob, F.F. Villar, 2025)

The lived experiences of People Living with HIV (PLHIV) revealed a complex interplay of stigma experienced through five existential dimensions: temporality, spatiality, corporeality, materiality, and relationality. Each dimension uncovered how stigma is not a singular event, but an ongoing process shaping individuals' day-to-day existence, emotions, social interactions, and coping strategies. Participants' narratives revealed that stigma is often first encountered during the moment of diagnosis, which brings an overwhelming sense of shock. This emotional upheaval gradually transitions into a period of adjustment, where individuals begin to come to terms with their condition, navigate the complexities of treatment, and reconcile their identities. Eventually, a routine is established, suggesting a movement toward acceptance and normalization of life with HIV.

These phases reflected the dynamic temporal nature of living stigma, highlighting the psychological evolution over time. PLHIV often navigate their physical and social

environments with environmental caution, carefully evaluating where it is safe to reveal their status. Selective disclosure is a common strategy used to manage potential exposure to discrimination. Participants shared experiences of altering their behavior in public, avoiding specific healthcare settings, or choosing not to disclose their status in professional environments due to fear of being stigmatized. These findings emphasize how spatiality becomes a site of both threat and protection in the daily lives of PLHIV.

The body emerged as both a bearer of illness and a symbol of social meaning. Participants described physical responses such as fatigue and illness-related changes that marked their bodies as "different," often attracting scrutiny. Additionally, emotional responses like fear, anxiety, and internalized shame appear closely to bodily experience. However, the same body was also a site of resilience, as individuals spoke about reclaiming control through medication adherence, self-care, and resistance to societal judgment. This dual experience underlines the corporeal complexity of living with HIV-related stigma. Objects associated with care, care-particularly antiretroviral medications-carried dual meanings. They functioned as material anchors, ensuring survival and stability, but also served as potential markers of illness when seen by others. Symbolism was embedded in these items; for some, they represented hope and responsibility, while for others, they were reminders of social isolation or difference. The physicality of stigma thus extended beyond the body into the objects of everyday life, reinforcing or resisting societal narratives about HIV. Stigma was deeply experienced through interpersonal relationships. Participants highlighted the fear and risk involved in disclosure, particularly to family, intimate partners, or close friends. Reactions ranged from support to rejection, with both having profound effects on emotional well-being. Many described

relational negotiations as ongoing, reflecting an effort to strike a balance between trust, vulnerability, and protection. These relational dynamics underscore the social burden that PLHIV navigate in sustaining meaningful connections while managing stigma.

The study's findings revealed that stigmatization of PLHIV is a multidimensional phenomenon that touches all aspects of lived experience. The interplay of temporal, spatial, corporeal, material, and relational domains provides a holistic understanding of how stigma operates and is managed. These insights called for more nuanced, empathetic, and person-centered approaches in healthcare, policy, and community support systems. Reducing stigma must involve addressing both societal attitudes and the structural conditions that perpetuate exclusion and marginalization.

## CONCLUSION, RECOMMENDATIONS, LINGUISTICS NARRATIVE AND AESTHETIC EXPRESSION OF FINDINGS

### CONCLUSION

The research revealed the lived experiences of HIV-diagnosed participants who constantly struggle with stigma in personal, social, and institutional contexts. Their stories uncovered silent struggles waged every day—between self-acceptance and societal judgment, between vulnerability and resilience. The patterns of navigating spaces of stigma and safety, embodiment of stigma and resilience, from crisis to acceptance, negotiating support and stigma in relationships, as well as everyday objects that serve as markers of stigma and care that comes with their condition. However, in the dungeons of oppression, acts of strength emerged—where advocacy, faith foundation, and love to keep loved ones safe became imperatives for hope and healing. Participants voiced that stigma did not just lie in the words of others, but in denied opportunities, and strained

relationships, colored by prejudice. However, they did not succumb. Instead, many redirected their stories into vehicles for awareness, opting to educate, advocate, and empower other PLHIV. The research underscores the critical need to shift HIV from its medical diagnosis and see the profoundly human and social challenges it presents.

Based on these lived experiences, the study recommends long-term psychosocial support interventions, stigma-reduction training, and community-based advocacy models to make sure that PLHIV are not just surviving—but living with dignity, visibility, and hope. In a world that still stigmatizes them, they implore not for pity—but for understanding, justice, and change.

**Recommendations of the Findings**

The findings of the PLHIV's experiences of stigmatizations paved the way for the following recommendations.

This study is crucial for **people living with HIV (PLHIV)** because based on the narratives of participants, PLHIV often carry the emotional burden of social judgment, which leads to isolation and stigma. It is recommended that PLHIV be empowered through mental health support, life skills training, and peer-led counseling programs. Participation in support groups with fellow PLHIV can help restore self-worth, provide emotional validation, and encourage treatment adherence. PLHIV must also be provided with access to leadership training so that they can be advocates and educators, speaking out against misinformation and ending the silence regarding stigma.

**In the community**, the research revealed that stigmatization often originates from societal myths, cultural prejudice, and a lack of awareness. Communities need to be

informed through inclusive, evidence-based campaigns that highlight the non-infectivity of HIV by casual contact and the progress in treatment that enables PLHIV to lead productive, whole lives. Religious leaders, teachers, and local opinion leaders need to be involved in regularizing HIV discourse to generate empathy and destroy stigmas. Schools and workplaces can also introduce anti-discrimination policies and practices that foster acceptance and support.

This research will be useful for the **Health Policy Makers (Department of Health - DOH**): as structural stigma can be addressed by the DOH strengthening policies that uphold the rights and dignity of PLHIV. This entails strict enforcement of confidentiality measures, anti-discrimination legislation, and guaranteeing non-judgmental healthcare settings. Stigma-reduction training among healthcare workers must become compulsory. Additionally, HIV education should be integrated into public health programs, with regular monitoring mechanisms to assess shifts in public opinion and access to services. Policy guidelines should be human rights and gender-sensitive, especially for marginalized groups like the LGBTQ+ community.

**For Nursing Education,** consistent with the participants' experiences of healthcare discrimination, nursing education needs to change to include in-depth content on HIV stigma, patient rights, and culturally responsive care. Curriculum developers need to incorporate case studies and PLHIV testimonies to help students develop empathy and understanding. There also needs to be a focus on ethical nursing practice, psychological first aid, and communication skills that are dignified, confidential, and inclusive. Nursing students should be required to interact with PLHIV communities during clinical exposure to gain insight into the lived experiences beyond the clinical diagnosis.

**For Nursing Research**, the study emphasized a significant research gap in knowing the complex, lived experiences of PLHIV, especially concerning stigma. Nursing researchers are motivated to conduct additional qualitative studies that examine stigma across various demographics, including age, gender identity, and rural versus urban locations. Evaluating the effectiveness of stigma-reduction in both clinical and community settings is also a research priority. Joint research involving PLHIV as co-researchers has the potential to encourage ethical participation and empower the population in the study, ensuring their voices are at the center of future HIV care and stigma control innovations.

**Reflecting the Essential Themes Through Linguistic Narrative Construction**

**Participant B's story (Spatiality)**

Participant B, a 35-year-old man living with HIV, has been silently navigating their way through the contrasting spaces of stigma and support since their diagnosis four years ago. Their story is told in cautious words, carefully chosen silences, and spatial markers that signify both danger and refuge. They often described how his movements are shaped not just by routine but by a calculated need for safety: "Nabati nako ginalayoan ko sa mga tawo sukad pagkabalo nila sa akong sakit" (I felt people started avoiding me when they found out about my illness). The language of distancing—ginalayoan (avoided), wala ko ginapansin (ignored)—points to spaces that have become emotionally and socially hostile. These phrases capture their embodied experience of exclusion, where familiar settings like their home or community transformed into sources of quiet harm.

Participant B also revealed how they learned to seek out "safe zones," especially in support groups or private settings where she could disclose without fear: "*Daghan jod naga suporta sa ako kay naa koy support groups ug pamilya*" (Many supports me because I have support groups and my family). The contrast in their narrative construction—between withdrawal and support—highlights a constant negotiation between silence and expression, risk and comfort.

Through their linguistic narrative, Partcipant B paints a spatial landscape where stigma and safety are not fixed locations but emotionally charged territories that they must navigate daily. Their story reflects the spatiality of stigma—not just experienced socially, but geographically felt through movement, presence, and absence. These lived transitions mark the terrain of their resilience, where even in spaces of rejection, they continue to find direction toward acceptance and care.

**The Embodiment of Stigma and Resilience: Participant A's Story (Corporeality)**

Participant A is a 32-year-old male who never thought will get HIV. Upon diagnosis, Participant A's life was abruptly reframed by the invisible weight of the stigma. The world around them seemed to shift; everyday interactions became fraught with the possibility of judgment. The fear of being labeled or misunderstood was ever-present, especially in social circles where knowledge about their condition was limited or, paradoxically, where awareness existed but compassion did not. In these moments, the threat of discrimination loomed largest, not only from strangers, but sometimes even from those once considered friends.

Navigating this new reality required a delicate balance. Participant A became acutely attuned to the nuances of social dynamics, learning to read the room and

anticipate reactions. They developed strategies to protect themselves emotionally, sometimes withdrawing to avoid confrontation, other times responding with subtle strength. The experience of being the subject of whispered conversations or the butt of ill-conceived jokes was painful, yet it became a crucible in which their resilience was forged.

Isolation, at first, seemed like a refuge-a way to shield themselves from the harshness of misunderstanding and prejudice. However, it also brought its own challenges: anxiety, stress, and a sense of being cut off from the world. Participant A found solace in small routines and acts of self-care. They immersed themselves in reading, cooking, and maintaining a disciplined regimen focused on health and nutrition. These daily rituals became anchors, helping them regain a sense of control and purpose.

Over time, the landscape of Participant A's relationships began to change. Initial shifts in how family and friends treated them gave way to deeper understanding and acceptance. Support became more tangible, with loved ones actively participating in their care and defending them against external negativity. The journey toward acceptance was neither immediate nor linear, but it was marked by Participant A's own willingness to educate, forgive, and lead by example.

Participant A's resilience was further strengthened through community engagement. By joining support groups and participating in advocacy, they transformed their personal challenges into opportunities for collective empowerment. They became a source of knowledge and encouragement for others facing similar struggles, helping to dispel persistent misconceptions about their condition.

Throughout this journey, Participant A's focus shifted from concerns about outward appearance or social approval to a deeper commitment to well-being and self-worth. They prioritized his health, embraced their identity, and cultivated a sense of inner peace. In doing so, they did not only survived the stigma but emerged as a resilient leader, embodying hope and strength for themselves and for others.

This narrative encapsulates the intertwined realities of stigma and resilience, illustrating how Participant A's lived experience is both shaped by external perceptions and defined by their internal capacity to adapt, endure, and ultimately thrive.

**From Crisis to Resistance: Participant B's story (Temporality)**

The clock on the wall kept ticking, but for Participant B, time had stopped.

He was 36, a salesman, a husband—two titles he had worn with pride until the day he received his HIV test results. The room had gone silent when the doctor spoke, but inside him, a storm erupted. It wasn't just the diagnosis; it was the why. He had betrayed their wife. That truth, as much as the virus in his blood, became the axis of his crisis. In that moment, the past collapsed under guilt, the present became unbearable, and the future—if it existed at all—felt like a void.

*"I remember walking out of the clinic," he said, "and feeling like I was already dead. The cars passed, people talked, life kept going. But for me, everything had frozen."*

In van Manen's terms, B's lived temporality was fractured. His inner experience of time had lost its rhythm. The days that followed blurred together. He could no longer imagine his future without shame. He feared telling his wife more than dying. "I was afraid she would leave," he admitted, "and I wouldn't blame her."

However, she did not.

Her decision to stay became the first thread of resistance in a time that had otherwise unraveled. It did not erase the betrayal or the virus, but it gave time a new shape—a path forward. With her support, B began antiretroviral therapy. The medication marked time now: morning, night, pill after pill. He came to associate time with survival, with accountability, and slowly, with healing.

He started to talk. To her. To himself. He revisited the past not to relive it, but to understand how he had arrived here. "I was never honest—not with her, not with me," he said. In naming his mistakes, B resisted their power to define him. His acceptance wasn't passive—it was active, gritty. Resistance, for him, meant facing each day with intention, showing up to his marriage, adhering to treatment, and reclaiming the future that once seemed lost.

Today, time moves again—but differently.

*"I still feel the weight of what I've done," he said, "but now I live with it, not under it. Every day is a second chance."*

In this reconstructed temporality, B lives with the virus, not as a victim of crisis, but as a man reshaping his narrative. His past no longer binds him—it informs him. His present, once saturated with regret, now pulses with effort. And the future? It's no longer blank, but unwritten.

**Negotiating Support and Stigma in Relationships (Relationality)**

Participant B, a 36-year-old man living with HIV, narrated his experiences through a language of caution, disappointment, and quiet strength. His words carried the emotional weight of relationships that changed once his status was known. He recalled, "Nabati nako ginalayoan ko sa mga tawo sukad pagkabalo nila sa akong sakit" (I felt

people started avoiding me when they found out about my illness). The phrase *"ginalayoan ko"* (they distanced themselves from me) serves as a powerful linguistic marker of social withdrawal, reflecting how relational ties were disrupted by stigma. This distancing—both physical and emotional—reshaped his sense of belonging and trust.

Yet amid rejection, He remained intentional in managing relationships. He stated, *"Mamili jod ko kinsa ko muistorya bahin sa akong sakit kay malahi ug sabot" (I really choose who to talk to about my illness because people may misunderstand). His use of "mamili"* (to choose) signals agency, a conscious filtering of his social world in response to stigma. This reveals that relationships for him were not static but negotiated spaces, requiring careful balancing between the need for emotional support and the risk of being judged or alienated.

Despite facing rejection from extended relatives and some friends, He found solace in his small circle of trusted individuals. He spoke with quiet gratitude about a sibling and an old friend who remained by his side. His language softened when mentioning them, describing their presence as *"akong saligan ug kasandigan"* (my trusted and dependable ones). Through this contrast in tone and expression, He constructed a relational narrative that showed both fracture and resilience—a life shaped by selective disclosure and guarded connection but also marked by enduring loyalty and care.

Participant B's story captures the core of relationality—how identity and emotional well-being are interwoven with the responses of others. His linguistic narrative reflects a deeply lived tension between support and stigma, and how every relationship becomes a space that must be interpreted, tested, and sometimes mourned. In this

narrative space, stigma is not only a social label but a personal reality that is navigated moment by moment, word by word.

**Everyday Objects as Markers of Stigma and Care: Participant C's story (Materiality)**

Participant C is a 42-year-old transwoman living with HIV. She received her diagnosis later after getting tattooed with a needle she later suspected had been reused. She had been sexually active and expressive in her identity, and tattoos were one of the ways she affirmed who she was. For her, they had always been personal statements—forms of resistance, identity, and empowerment etched into her skin. But after her diagnosis, those same tattoos took on a different weight.

She described how people's glances shifted when they saw her ink. "It's like they don't see a person anymore," she said. "They see the tattoos and assume everything about me—how I live, how I got infected." What had once been her armor now made her feel exposed. The tattoos, as objects embedded in her body, became symbols not just of self-expression but also of judgment and perceived deviance in the eyes of others.

Van Manen's concept of lived materiality helps us understand how the objects in Participant C's everyday life were not neutral but deeply entangled in how she experienced stigma and care. The mirror in her apartment, for instance, became something she avoided. Looking at herself reminded her not just of her illness, but of the social weight it carried. "I used to love putting on makeup and looking at myself before heading out. Now I rush past it. I feel like I'm being watched, even alone."

Amid these markers of shame and discomfort, there was one object she never let go of—her cellphone. It was through that phone that she first started searching for

information after her diagnosis. “I Googled everything. What is HIV? Can I die from it? Can I still live normally?” Her phone became her primary source of education, reassurance, and connection. She found forums, support groups, and online communities where other trans women living with HIV shared their experiences. It was also the way she stayed in touch with her chosen family—close friends and community members who checked on her regularly and reminded her that she was not alone.

She spoke about the comfort she found in small, everyday objects that had slowly regained their place in her routine. A tube of lipstick she had stopped using found its way back into her handbag. At first, it had seemed frivolous, even inappropriate—like trying to claim beauty while carrying the burden of a disease. But over time, she began to see it differently. “Putting it on in the morning,” she said, “became part of feeling like myself again. Like I still had a place in the world.”

Her antiretroviral medication—once a source of dread—also became a part of her material world that symbolized care rather than crisis. She kept the bottle on her nightstand, not hidden away, as a reminder of her commitment to her health. “It was scary at first. It meant facing the reality of it every day. But now it’s just part of me taking care of me.”

For participant C, these everyday things—tattoos, mirrors, phones, lipstick, pill bottles—became more than just objects. They were markers of how she moved through stigma and toward self-acceptance. Through them, she experienced her diagnosis not just as a medical event, but as something deeply woven into the material fabric of her daily life. In this way, her story offers a powerful lens on how the lived world of things, as van Manen describes shapes how people experience illness, identity, and resilience.

**Aesthetic Expression of the Findings:**

**Not just a Diagnosis: The Silent Struggles of the Stigmatized**

**(O. Taclob, C.C, Peque, F.F, Villar, J.A, Origenes, 2025)**

It began not with a symptom, but with a silence.
A pause in the breath.
A quiet in the soul.
The introduction of the word HIV was not alone.
It arrived carrying shame, judgment, and fear—
not from the virus itself,
but from the world that turned its gaze away.

We became the whispers in crowded rooms,
the glances passed like shadows on our skin.
No longer just people—we were reduced to a condition,
an assumption, a warning.
Not just a diagnosis—but a verdict.

Guilty in the court of misunderstanding.
In that silence, we wrestled.
Some in hidden corners, pills tucked into drawers.
Some in rooms echoing only our own breath.
We spoke to few.
We trusted fewer.
And still, we endure.

One found strength in his children's eyes.
One who's silenced by stigma- now stood and spoke.
One in karenderia selling meals with smile.
But all turned to faith, to prayer, to God.
All found family in those who understood—
fellow warriors bound not by blood,
but by shared scars and the need to be seen.

Our bodies became battlegrounds—
fighting not just for health,
but for dignity.
For the right to love, and to live.
For the right to be more than a just diagnosis.

That stigma is louder than the virus.
That healing is more than medicine.
That in the silence of the stigmatized,
there is a story worth hearing.

At every quiet breath we take we do not ask for pity.
but we plead for understanding, for dignity,
and to be simply seen as human once more.

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**Appendix A:**

**RESEARCH QUESTIONNAIRE**
**Lived experiences of Stigmatization among Persons Living with Human Immunodeficiency Virus**

The researchers will ask opening questions to the interviewees to get to know the respondents in terms of personal information. These questions serve as demographic queries.

**Interview Protocol**

**Introduction**

The researchers first and foremost will make sure that the tools are set, and participants are ready for the interview and are comfortable enough to speak. This will be the researcher's chance to show positivity, politeness, and persuasion.

- Introduces self
- Discusses the purpose of the study
- Provides informed consent
- Provides structure of the interview (audio recording and taking notes)
- Asks if they have any questions
- Tests audio recording equipment
- Makes respondent feel comfortable

**Opening Questions**

1. Ask about her/his profile as to biological sex, gender, age, civil status, educational attainment, and nature of work.

2. Ask about how long have they been diagnosed with HIV?

3. Ask about how did you get the disease?

**Core Questions**
These core questions are useful in gaining answers to the current research problem.

1. How does the fear of stigma influence your decisions about who to trust or open to?

2. Do you feel that hiding your status protects you from stigmatization, why or why not?

3. How did you feel upon knowing about being HIV positive?

4. How are your support systems in managing HIV?

5. How do you combat social stigma and discrimination?

6. What are your ways in overcoming isolation and stigma of an HIV diagnosis?

7. How are your relationship towards your family and friends knowing that you have HIV?

8. How do you handle concerns about your personal appearance, and does it affect your participation in any activities that you have at present?

9. What are some of the misconceptions about living with HIV as perceived?

10. What are the tools and strategies that have helped you in managing HIV over many years?

## Appendix B: Letter of Request and Endorsements

**MISAMIS UNIVERSITY**
Ozamiz City 7200, Philippines
College of Nursing, Midwifery and Radiologic Technology
Tel No. +63 88 521-0367 / Telefax No. +63 88 521-2917
E-mail Address: mu@mu.edu.ph

**CERTIFIED:** ISO 21001:2018 Educational Organizations Management System by DNV
**ACCREDITED:** Philippine Association of Colleges and Universities Commission on Accreditation (PACUCOA)
**GRANTED:** AUTONOMOUS STATUS by the Commission on Higher Education (CHED)

March 24, 2025

**DR. MARIA NIÑA F. BANQUE, MD, FPPS**
Research Chairperson
Mayor Hilarion A. Ramiro Sr. Medical Center
Ozamiz City

Dear Dr. Banque,

Good day!

We are 3rd year students from Misamis University, Ozamiz City taking up Bachelor of Science in Nursing and are currently working on our research study titled "LIVED EXPERIENCES OF STIGMATIZATION AMONG PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (PLHIV)." This study will elucidate in-depth how people living with HIV feel in daily situations through the process of qualitative methods of research. Analyzing these lived experiences gives our study the objective of identifying the deep psyche and emotional burden that stigma imposed on indidviduals in their self- esteem, mental well-being and overall living. With this, we would like to ask for an approval from your good office to allow us to conduct the study and to access relevant data of HIV patients from your hub on March until April 2025.

Rest assured that all information derived herein will be treated with utmost confidentiality and will be used solely for research purposes in accordance to ethical guidelines. We would greatly appreciate your support in facilitating this request and are willing to comply for necessary protocols.

Thank you very much and God bless.

Sincerely yours,

**ORIGENES, JAN ANTHONY R.**

**PEQUE, CECILLE CHANTAL A.**

**TACLOB, OMAR P.**

Researchers

Noted by:

**DR. SAMMY B. TAGHOY**
College Dean

Approved by:

**DR. MARIA NIÑA F. BANQUE, MD, FPPS**
Research Chairperson
Mayor Hilarion A. Ramiro Sr. Medical Center

# Misamis University

**H. T. Feliciano St., Ozamiz City, 7200 Philippines**

**MISAMIS UNIVERSITY RESEARCH ETHICS COMMITTEE**

Phone: +6388 521 0367 | Fax: +6388 521 2917

Email: muresearchethics@mu.edu.ph


MU-REB-001/03 March 2022

April 23, 2025

**MR. JAN ANTHONY R. ORIGENES, MS. CECILLE CHANTAL A. PEQUE**
**MR. OMAR P. TACLOB, MS. FRANZLYN FEBY O. VILLAR**
Principal Investigators

**MUREC Code 2025-110**

**LIVED EXPERIENCES OF STIGMATIZATION AMONG PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (PLHIV)**

Dear Investigators:

The MU Research Ethics Committee (MUREC), upon review of your research protocol, found no risk to the research participants, hence recommending **APPROVAL**. You may proceed with gathering data for your study.

Sincerely yours,

**HAYDEE D. VILLANUEVA, PhD**
Chair, MUREC

Republic Of the Philippines
Department of Health
**MAYOR HILARION A. RAMIRO SR. MEDICAL CENTER**
Ozamiz City

**PROFESSIONAL EDUCATION TRAINING AND RESEARCH UNIT**

May 5, 2025

**CHILO E. CEBEDO, RN, MN**
Nurse VII/ Chief Nurse
Mayor Hilarion A. Ramiro Sr. Medical Center

Thru: **JERICKSON AROBO, RN**
Nurse VI

Dear Mrs. Cebedo,

Greetings!

Endorsing to your good office a group of students from Misamis University, Ozamiz City who will be conducting a research titled "Lived Experiences of Stigmatization Among People Living with Human Immunodeficiency Virus (PLHIV)" here in our institution.

Your support to their endeavor is highly appreciated.

Thank you very much.

Respectfully yours,

**ROVI CONCEPCION R. LARANJO, MD, FPOGS**
Medical Specialist II/ Chief Training Officer

**Appendix C: Informed Consent Form**

**Title**

Lived Experiences of Stigmatization Among People Living with Human Immunodeficiency Virus (PLHIV)

**Principal Investigator**

CECILLE CHANTAL A. PEQUE

Misamis University

+639816099889

**Introduction**

You are invited to participate in a research study exploring the lived experiences of stigmatization among people living with HIV (PLHIV). This study aims to understand how stigma affects individuals' daily lives, emotions, and well-being. Your participation is voluntary, and you have the right to withdraw at any time without consequences.

**Purpose of the Study**

The purpose of this study is to explore and document the personal experiences of PLHIV in relation to stigma, discrimination, and social challenges. The findings will contribute to a better understanding of stigma's impact and inform future interventions to support PLHIV.

**Procedures**

If you agree to participate, you will take part in an in-depth interview that will last approximately 45-60 minutes. The interview will be conducted in person/virtually/via phone at a mutually agreed time and location. With your permission, the interview will be audio-recorded for accuracy.

Your responses will be anonymized to protect your identity.

**Potential Risk and Discomforts**

Discussing your experiences may bring emotional distress. If you feel uncomfortable, you may take a break or stop the interview at any time. You will be provided with support resources if needed.

**Potential Benefits**

Your participation will help raise awareness about the stigma faced by PLHIV.

The research findings may contribute to advocacy efforts and improved support services for PLHIV.

**Confidentiality**

Your identity and responses will be kept confidential.

Any identifying information will be removed from the research data. The data will be stored securely and accessible only to the research team. Your participation is entirely voluntary. You may refuse to answer any question or withdraw from the study at any time without any negative consequences.

**Contact Information:**

If you have any questions or concerns about the study, you may contact:

CECILLE CHANTAL A. PEQUE

Misamis University

+639816099889

**Consent Statement:**

I have read and understood the information provided in this consent form. I voluntarily agree to participate in this study. I understand that my participation is confidential, and I may withdraw at any time without consequences.

**Participant's Name:**

**Participant's Signature:**

**Date:**

**Researcher's Name:**
**ORIGENES, JAN ANTHONY R.**
**PEQUE, CECILLE CHANTAL A.**
**TACLOB, OMAR P.**
**VILLAR, FRANZLYN FEBY O.**

## Appendix D: Tables For Uncovering the Themes and Essences and Table Reflecting the Themes, Cluster, And Essences Within the Five Lifeworlds

### TABLES FOR UNCOVERING THE THEMES AND ESSENCES

**(PARTICIPANT A)**

| SIGNIFICANT THEMES | FORMULATED MEANINGS | THEMATIC CATEGORY | THEME CLUSTER | LIFE WORLDS |
|---|---|---|---|---|
| 1. There are times nga di jud siya nimo pwede ipanabi… Itago nako siya kung tan aw nakong murag wa syay knowledge ani nga butang… | Selective disclosure of HIV status, based on perceived understanding and safety. | Selective Disclosure | Disclosure and Stigma Management | Relationality, Spatiality |
| 2. Akong utensils ug plato nakasegregate tanan or kung mahimo disposable tanan kay nay mga bata, akong mga pag umangkon. | Experience of enacted stigma and discrimination in daily life, especially through material things. | Enacted Stigma | Stigma and Discriminatio n | Materiality, Spatiality |
| 3. Even akong parente di makighalubilo… Akong anxiety gilabanan gyud nako to, basig asa gyud ko maabot para madistract lang. | Diagnosis leads to social withdrawal, anxiety, and seeking distraction. | Social Withdrawal & Anxiety | Emotional Response | Spatiality, Temporality, Corporeality |
| 4. Nisulod man dayon akoang insomnia… Nagsige kog basa sa google… Didto ko nakabalo nga mabuhi pa mi, kaya pa. | Initial shock and stress, but information seeking leads to hope and adaptation. | Information Seeking & Adaptation | Coping & Self-Management | Temporality, Corporeality |
| 5. Katong nahibaw an nako, nahadlok jud kayko… Nangayo kog pasaylo kay mamatay na lage ko, mao akong thinking… | Initial diagnosis triggers fear of death and need for closure with loved ones. | Fear of Mortality | Emotional Response | Temporality, Relationality |
| 6. Right that day na nigawas ang result, nakabalo pud sila tanan. Akong gideretsog post sa | Public disclosure as a way to control narrative and seek support. | Public Disclosure | Disclosure and Stigma Management | Relationality, Spatiality |

| | | | | |
|---|---|---|---|---|
| facebook. | | | | |
| 7. Everyday naa koy bisita… Halos everyday gacash out kog Php 5,000-10,000 | Community and social support manifest in tangible and emotional ways. | Social Support | Social Relationships | Relationality, Materiality |
| 8. Wala ko kafeel og discrimination sa mga nurses, mutabang gyud sila. | Positive healthcare experiences can counteract social stigma. | Positive Healthcare Experience | Coping and Self-Management | Relationality |
| 9. Ang importante kay naa kay ulian na balay, naa kay initiative, makasurvive ra jud ka. | Personal agency and initiative are key to survival and well-being. | Resilience & Agency | Coping and Self-Management | Corporeality, Temporality |
| 10. Kung feeling nako maapiki ko diha, madiscriminate, naa koy true friends na saligan. | True friendships provide a safety net against discrimination. | True Friendship | Social Relationships | Relationality |
| 11. Naka encounter gyud ko ana na gijudge ko mismo sa akong atubangan while gatapok mi gainom. | Direct experience of judgement and discrimination in social settings. | Experienced Discrimination | Stigma and Discriminatio n | Spatiality, Relationality |
| 12. Geunhan nako sila di ko pabisita, taman sila sa gawas og nay ihatag, butang sa gawas… | Setting boundaries in relationships as a form of self-care and agency. | Boundary Setting | Coping and Self-Management | Spatiality, Relationality |
| 13. Karon kay fully accepted ko nila… Og nay mangaway nako sila nay moatubang… | Full acceptance by family and friends leads to well-being and happiness. | Acceptance & Belonging | Social Relationships | Relationality |
| 14. Nisulod kog support groups para naa koy idea and makatabangay… | Support groups are a resource of learning and emotional support. | Seeking Support | Coping and Self-Management | Relationality |
| 15. Dili lang jud padala sa anxiety, di padala sa problema… | Active effort to manage anxiety and maintain mental health. | Mental Health Management | Coping and Self-Management | Corporeality, Temporality |
| 16. Ako sa akong kaugalingon naga disiplina gyud ko na | Discipline and routine as self-protection and self- | Discipline & Routine | Coping and Self-Management | Corporeality, Materiality |

| | | | | |
|---|---|---|---|---|
| kung unsa akong gigamit, diha ra na, ako ray hugas ana, ilain na tanan akoang gigamit. | care. | | | |
| 17. Mao tong gipasabot pud nako sa akong mama, nay mga nega na response? Di jud ko mutubay nga masuko pod ka, imo jud silng pasabton taman sa makasabot gyud sila. | Patiently educating others to address misconceptions and stigma. | Education & Advocacy | Disclosure and Stigma Management | Relationality |
| 18. Pero karon kay fully accepted ko nila tanan even my friends | Achieving acceptance and reintegration into social circles. | Social Reintegration | Social Relationships | Relationality |

**(PARTICIPANT B)**

| Significant Statements | Formulated Meanings | Thematic Categories | Theme Clusters | Life Worlds |
|---|---|---|---|---|
| 1.Pagkahibalo nako... kami pa lang duha sa akong partner ang nakabalo. | Disclosure was limited to spouse for protection and support. | Disclosure and Support | Managing Disclosure | Temporality |
| 2. Nabasa nako... possible cause kay HIV... nabalaka ko... mamatay ko! | Fear and anxiety upon learning about possible symptoms and consequences. | Fear and Anxiety | Facing Mortality | Corporeality |
| 3. Gipaak sa lips pag kiss and ningdugo to... possible didto nahitabo ang pagtakod. | Reflecting on possible transmission event; concern about cause. | Searching for Cause | Understanding Transmission | Corporeality |
| 4. Grabe ang stigma... ang mga tawo diri, wala man gud na orient kung unsa ang HIV... lantaw sa tawo saimoa basura o hugaw... | Experiences and perceptions of stigma and misunderstanding. | Stigma and Social Perception | Social Stigma | Relationality |
| 5. Nishare jud ko sailaha, tanan halos... sayop kaayo kay wala | Regret over disclosure to strangers rather than | Disclosure Regret | Navigating Disclosure | Relationality |

| | | | | |
|---|---|---|---|---|
| gani ko nag tell-sturya sa akong parents or igsuon... | trusted family/friends. | | | |
| 6. God will make a way nalang siguro! Wa ra gyud pod nako hunahunaa man gyud. | Reliance on faith to cope with negative perceptions. | Coping Mechanisms | Faith and Resilience | Materiality |
| 7. Gapatest gyud ko sa mga transmittable na mga sakit... galikay gyud gihapon ko na ipagamit ang mga akong mga gigamit na baso o kutsara sa akong mga anak... | Practicing precautionary measures to protect family. | Responsibility and Precaution | Protecting Loved Ones | Materiality |
| 8. Prayer gyud... gisurrender na gyud nako tanan sa Ginoo... akong pamilya akong asawa og mga anak, gipili gyud nako na magpadayon. | Faith, family, and self-care as sources of strength. | Sources of Strength | Coping and Resilience | Materiality, Relationality |
| 9. Mamili ra gyud kog tawo na mutrust ko... mas komportable ko. | Selective trust and preference for solitude. | Trust and Isolation | Social Withdrawal | Spatial |
| 10. Drink your meds and exercise everyday... nagatake ko sa akoang medicine on time og naga exercise gyud ko... | Adherence to medication and healthy lifestyle. | Self-care and Health Management | Health Maintenance | Corporeality |
| 11. Usually, ang mga pangutana halos kay, di ba pre na og naa ka ana kay patay o dapat magdaot na ka ana? | Misconceptions and myths about HIV persist. | Misconceptio ns and Myths | Public Perceptions | Relationality |
| 12. Open mind lang dayon prayer... healthy diet... exercise everyday... nagasulat pud ko sa akoang mga experience... | Openness, healthy habits, and journaling as coping strategies. | Coping Strategies | Self-empowerment | Materiality, Corporeality and Relationality |
| 13. Wala, hiding is not protecting plhiv, sa stigmatization dapat | Belief that openness, not hiding, helps | Openness vs. Hiding | Advocacy and Awareness | Relationality |

| | | | | |
|---|---|---|---|---|
| gyud unta na kanang dili maghide, na ma aware ang mga tawo. | combat stigma. | | | |

**(PARTICIPANT C)**

| Significant Statements | Formulated Meanings | Thematic Category | Theme Cluster | Life World |
|---|---|---|---|---|
| 1. Naa juy times nga maulaw ko…hala yucks ayawg dool ana kay makatakod ana. | Feels shame and anticipates rejection due to HIV stigma. | Fear and Stigma | Internalized Stigma and Social Fear | Corporeality, Relationality |
| 2. Wala... except rajud sa parehas lang nako nga part sa LGBTQ…didto rako masabtan. | Discloses status only to those who understand (LGBTQ peers). | Selective Disclosure | Disclosure in Safe Spaces | Spatial, Relationality |
| 3. Daghan kaayo mitabang nako from the LGBTQ. | Receives practical and emotional support from LGBTQ community. | Social Support | Community Support | Relationality |
| 4. Wala rapud baya ko nakafeel ug diskriminasyon gikan sa mga gatrabaho sa hospital. | Experiences acceptance and non-discrimination from healthcare staff. | Professional Acceptance | Positive Healthcare Experience | Relationality |
| 5. Naa koy friend…mugreet saako ug Hi Aida! Like Aids ba. So mura kog matandog… | Hurt by insensitive jokes, feels misunderstood even by friends. | Social Stigma | Negative Social Interactions | Relationality, Corporeality |
| 6. At first oo kay nag hunahuna pako unsaon nako kay wala sad koy hanaw. | Initial diagnosis brought fear, confusion, and uncertainty. | Emotional Crisis | Shock and Fear | Temporality |
| 7. Nagpasalamat gyud kos ginoo getagaam gyud niya ug kanang kusog. | Finds strength and hope through faith/spirituality. | Coping and Resilience | Spiritual Coping | Corporeality, Temporality |
| 8. Nagkamang nako…dli na kaau ko mokaon…dli nako kalakaw. | Experienced severe physical weakness and deterioration. | Physical Suffering | Bodily Decline and Vulnerability | Corporeality |
| 9. Ako raman sad pud | Lives mostly in | Social Isolation | Physical and | Spatial, |

| | | | | |
|---|---|---|---|---|
| diri sa balay. | isolation, limited social interaction. | | Social Isolation | Relationality |
| 10. Wala man nakaapekto sa akoa pero makita nako sa akong lawas na okay gyud cya. | Maintains daily activities, physical health currently stable. | Physical Well-being | Adaptation and Stability | Corporeality, Temporality |
| 11. Moingon ang barkada nako na dli ta magpatakakuan…dagh an na kaau anang ana hiv. | Aware of misinformation and changing social perceptions about HIV. | Social Perceptions | Community Awareness and Misconceptions | Relationality |
| 12. Kanang kuan pagkalat sa hiv sa pag istorya sa lain tawo… | Worries about gossip and rumors regarding HIV status. | Stigma and Gossip | Fear of Social Exposure and Rumors | Relationality, Spatial |
| 13. Gedawat gyud nako…karon na realize na nako dli najud lalim… | Accepts diagnosis, reflects on personal responsibility and change. | Acceptance and Responsibility | Self-Acceptance and Accountability | Corporeality |
| 14. Nikalit daw kono kog kagamay…daghan kaau kog rashes…akong dila nag puti na. | Physical symptoms prompted HIV testing and diagnosis. | Bodily Awareness | Physical Signs Leading to Diagnosis | Corporeality |

**TABLE REFLECTING THE THEMES, CLUSTER, AND ESSENCES WITHIN THE FIVE LIFEWORLDS**

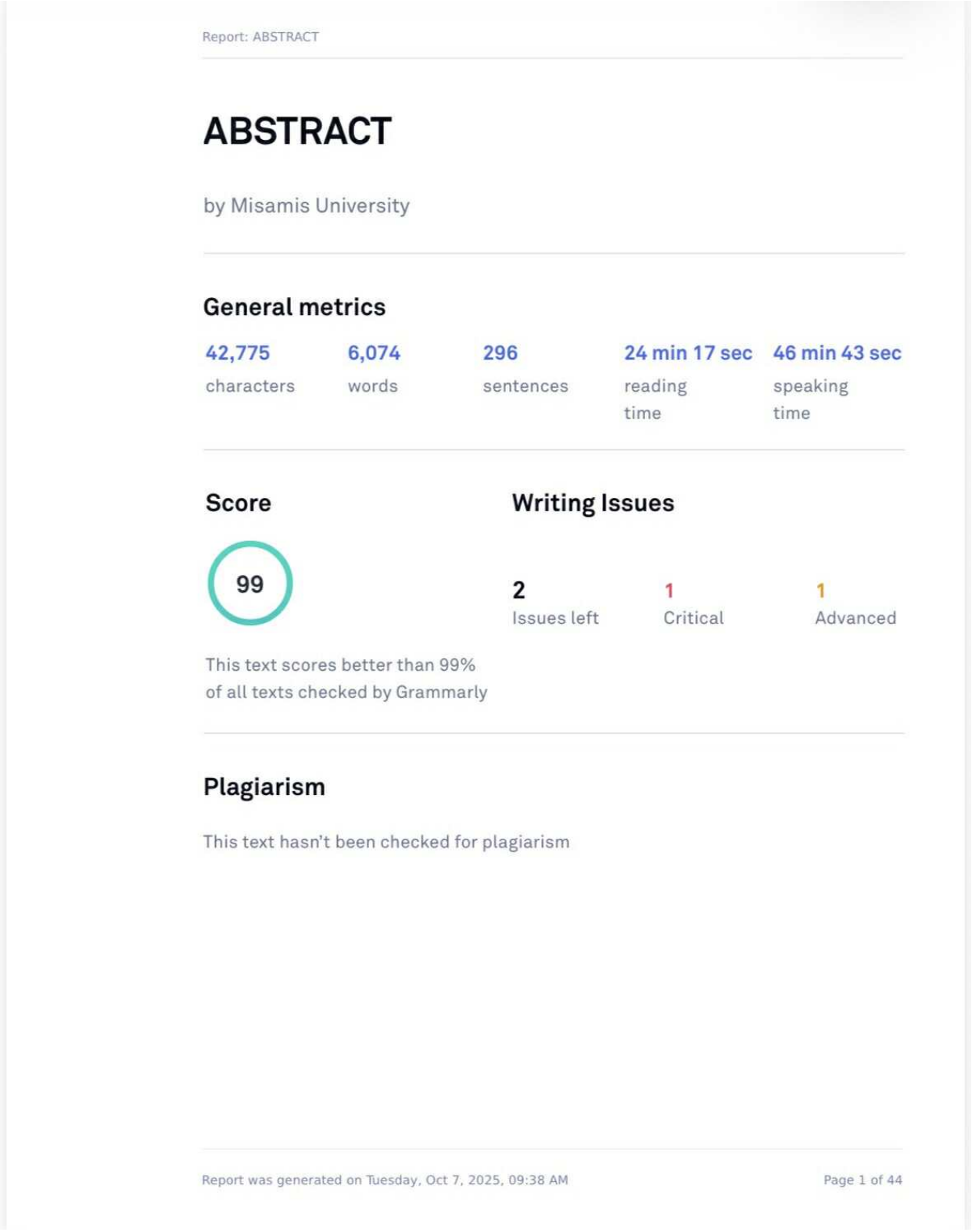
| Formulated Meanings (FM) | Themes | Theme Clusters |
|---|---|---|
| **Corporeality:** | | |
| **PB** (FM 22: Reflecting on possible transmission event; concern about cause) | Mode of transmission | Acquisition & awareness |
| **PC** (FM 46: Physical symptoms prompted HIV testing and diagnosis)<br>**PC** (FM 40: Experienced severe physical weakness and deterioration) | Symptoms recognition | |
| **PA** (FM3: Diagnosis leads to social withdrawal, anxiety, and seeking distraction) | Mental Health Struggle | Emotional reactions |
| **PB** (FM 29: Adherence to medication and healthy lifestyle) | Medication &health practices | Health & Daily life |
| **PA** (FM 15: Active effort to manage anxiety and maintain mental health)<br>**PC** (FM 42: Maintains daily activities; physical health currently stable) | Impact on work and functioning | Resilience & self-reflection |
| **PA** (FM 4: Initial shock and stress, but information seeking leads to hope and adaptation; FM 9 Personal agency and initiative are key to survival and well-being.)<br>**PC** (FM 39: Finds strength and hope through faith/spirituality) | Overcoming downfall | |
| **PA** (FM 16: Discipline and routine as self-protection and self-care)<br>**PB** (FM 31: Openness, healthy habits, and journaling as coping strategies)<br>**PC** (FM 45: Accepts diagnosis, reflects on personal responsibility and change.) | Personal growth & expression | |
| **Spatiality:** | | |
| **PA** (FM1:<br>Selective disclosure of HIV status, based on perceived understanding and safety) | Selective Disclosure | Disclosure and Stigma |
| **PA** (FM3:<br>Diagnosis leads to social withdrawal, anxiety, and seeking distraction. | Social Withdrawal & Anxiety | Emotional Response |

| | | |
|---|---|---|
| **PA** (FM11:<br>Direct experience of judgement and discrimination in social settings) | Experienced Discrimination | Stigma and Discrimination |
| **PA** (FM12:<br>Setting boundaries in relationships as a form of self-care and agency) | Boundary Setting | Coping and Self-Management |
| **PB** (FM28: Selective trust and preference for solitude) | Trust and Isolation | Social Withdrawal |
| **PC** [(FM34: Discloses only to those who understand) LGBTQ peers] | Selective Disclosure | Disclosure in Safe Spaces |
| **PC** (FM41: Lives mostly in isolation, limited social interaction) | Social Isolation | Physical and Social Isolation |
| **Temporality** | | |
| **PA** (FM5:<br>Initial diagnosis<br>triggers fear of death and need for closure<br>with loved ones. | Fear of Mortality | Emotional Response |
| **PB** (FM19: Initial suspicion and uncertainty led to proactive testing) | Uncertain and Curiosity | The Journey to Diagnosis |
| **PC** (FM38: Initial diagnosis brought fear, confusion, and uncertainty) | Emotional Crisis | Shock and Fear |
| **PC** (FM38: Initial diagnosis brought fear, confusion, and uncertainty) | Emotional Crisis | Shock and Fear |

| | | |
|---|---|---|
| **Relationality** | | |
| **PA** (FM6: Public disclosure as a way to control narrative and seek support) | Public Disclosure | Disclosure and Stigma Management |
| **PA** (FM8: Positive healthcare experiences can counteract social stigma) | Positive Healthcare Experience | Coping and Self-Management |
| **PA** (FM10: True friendship provides a safety net against discrimination | True Friendship | Social Relationships |
| **PA** (FM13: Full acceptance by family and friends) | Acceptance and Belonging | |
| **PA** (FM14: Support groups are a resource of learning and emotional support) | Seeking Support | Coping and Self-Management |
| **PA** (FM17: Patiently educating others to address misconceptions and stigma) | Education and Advocacy | Disclosure and Stigma Management |
| **PA** (FM18: Achieving acceptance and reintegration into social circles) | Social Reintegration | Social Relationships |
| **PB** (FM20: Disclosure was limited to spouse for | Disclosure and | Managing Disclosure |

| | | |
|---|---|---|
| protection and support) | Support | |
| **PB** (FM23: Experiences and perceptions of stigma and misunderstanding) | Stigma and Social Perception | Social Stigma |
| **PB** (FM24: Regret over disclosure to strangers rather than trusted family/friends) | Disclosure Regret | Navigating Disclosure |
| **PB** (FM30: Misconceptions and myths about HIV persist) | Misconceptions and Myths | Public Perceptions |
| **PB** (FM32: Belief that openness, not hiding, helps combat stigma) | Openness vs. Hiding | Advocacy and Awareness |
| **PC** (FM33: Feels shame and anticipates rejection due to HIV stigma) | Fear and Stigma | Internalized Stigma and Social Fear |
| **PC** (FM35: Receives practical and emotional support from LGBTQ community) | Social Support | Community Support |
| **PC** (FM36: Experiences acceptance and non-discrimination from healthcare staff | Professional Acceptance | Positive Healthcare Experience |
| **PC** (FM37: Hurt by insensitive jokes, feels misunderstood even by friends) | Social Stigma | Negative Social Interactions |
| **PC** (FM43: Aware of misinformation and changing social perceptions about HIV) | Social Perceptions | Community Awareness and Misconceptions |
| **PC** (FM44: Worries about gossips and rumors regarding HIV status | Stigma and Gossip | Fear of Social Exposure and Rumors |
| **Materiality**: | | |
| **PA** (FM 2: Experience of enacted stigma and discrimination in daily life, especially through material things)<br>**PB** (FM26: Practicing precautionary measures to protect family.) | Hygiene and Family | Health and Daily Life |
| **PA** (FM 7: Community and social support manifest in Tangible and emotional ways) | Support System | Disclosure and Support |
| **PA** (FM 16: Discipline and routine as self-protection and self-care)<br>**PB** (FM 25: Reliance on faith to cope with negative perceptions; FM 27: Faith, family, and self-care as sources of strength) | Coping Mechanism | Emotional Reactions |

## Appendix E: Grammarly and Turnitin Result



Report: ABSTRACT

# ABSTRACT

by Misamis University

### General metrics

| 42,775 | 6,074 | 296 | 24 min 17 sec | 46 min 43 sec |
|---|---|---|---|---|
| characters | words | sentences | reading time | speaking time |

### Score

99

This text scores better than 99% of all texts checked by Grammarly

### Writing Issues

| 2 | 1 | 1 |
|---|---|---|
| Issues left | Critical | Advanced |

### Plagiarism

This text hasn't been checked for plagiarism

Report was generated on Tuesday, Oct 7, 2025, 09:38 AM

Page 1 of 44

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## Exclusions

- 1 Excluded Source

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  Matches with neither in-text citation nor quotation marks
- **22** Missing Quotations 1%
  Matches that are still very similar to source material
- **4** Missing Citation 0%
  Matches that have quotation marks, but no in-text citation
- **0** Cited and Quoted 0%
  Matches with in-text citation present, but no quotation marks

## Top Sources

2% Internet sources
1% Publications
6% Submitted works (Student Papers)

## Integrity Flags

**0 Integrity Flags for Review**

No suspicious text manipulations found.

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A Flag is not necessarily an indicator of a problem. However, we'd recommend you focus your attention there for further review.

# CURRICULUM VITAE

JAN ANTHONY R. ORIGENES
Maningcol, Misamis Occidental

PERSONAL INFORMATION

| | | | |
|---|---|---|---|
| Date of Birth | : January 17, 2004 | Place of Birth | : Ozamiz City |
| Sex | : Male | Civil Status | : Single |
| Nationality | : Filipino | Religion | : Roman Catholic |
| Language/s Spoken | : English/Filipino/Bisaya | | |

EDUCATIONAL BACKGROUND

| | |
|---|---|
| College Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Course and Year | : Bachelor of Science in Nursing – 3rd year |
| Estimated Year of Graduation | : 2026 |
| | |
| Senior High School Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Year | : 2020-2022 |
| | |
| Junior High School Education | : Ozamiz City School of Arts and Trades |
| Address | : Maningcol, Ozamiz City |
| Year | : 2016-2020 |
| | |
| Intermediate Education | : Ozamiz City Central School (SPED Center) |
| Address | : Tinago, Ozamiz City |
| Year | : 2015-2016 |

CECILLE CHANTAL A. PEQUE
Brgy. Napolan, Pagadian City, Misamis Occidental

PERSONAL INFORMATION

| | | | |
|---|---|---|---|
| Date of Birth | : Novermeber 21, 2003 | Place of Birth | : Pagadian City |
| Sex | : Female | Civil Status | : Single |
| Nationality | : Filipino | Religion | : Roman Catholic |
| Language/s Spoken | : English/Filipino/Bisaya | | |

EDUCATIONAL BACKGROUND

| | |
|---|---|
| College Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Course and Year | : Bachelor of Science in Nursing – 3rd year |
| Estimated Year of Graduation | : 2026 |
| | |
| Senior High School Education | : Saint Columban College |
| Address | : Sagun St., Pagadian City |
| Year | : 2020-2022 |
| | |
| Junior High School Education | : Holy Child's Academy |
| Address | : Brgy. San Jose, Pagadian City |
| Year | : 2016-2020 |
| | |
| Intermediate Education | : Pagadian City Pilot School |
| Address | : San Jose Heights, Pagadian City |
| Year | : 2015-2016 |

OMAR P. TACLOB
San Apilinario, Tangub City

PERSONAL INFORMATION

| | | | |
|---|---|---|---|
| Date of Birth | : Sept. 05, 2004 | Place of Birth | : Tangub City |
| Sex | : Male | Civil Status | : Single |
| Nationality | : Filipino | Religion | : Roman Catholic |
| Language/s Spoken | : English/Filipino/Bisaya | | |

EDUCATIONAL BACKGROUND

| | |
|---|---|
| College Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Course and Year | : Bachelor of Science in Nursing – 3rd year |
| Estimated Year of Graduation | : 2026 |
| | |
| Senior High School Education | : Tangub City National High School |
| Address | : Brgy. Mantic, Tangub City |
| Year | : 2020-2022 |
| | |
| Junior High School Education | : Tangub City National High School |
| Address | : Brgy. Mantic, Tangub City |
| Year | : 2016-2020 |
| | |
| Intermediate Education | : San Apolinario Elementary School |
| Address | : San Apolinario, Tangub City |
| Year | : 2015-2016 |

FRANZLYN FEBY O. VILLAR
Brgy. Bacolod, Ozamiz City, Misamis Occidental

PERSONAL INFORMATION

| | | | |
|---|---|---|---|
| Date of Birth | : February 12, 2004 | Place of Birth | : Davao del Sur |
| Sex | : Female | Civil Status | : Single |
| Nationality | : Filipino | Religion | : Roman Catholic |
| Language/s Spoken | : English/Filipino/Bisaya | | |

EDUCATIONAL BACKGROUND

| | |
|---|---|
| College Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Course and Year | : Bachelor of Science in Nursing – 3rd year |
| Estimated Year of Graduation | : 2026 |
| | |
| Senior High School Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Year | : 2020-2022 |
| | |
| Junior High School Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Year | : 2016-2020 |
| | |
| Intermediate Education | : Misamis University |
| Address | : H.T. Feliciano St., Ozamiz City |
| Year | : 2015-2016 |