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Research Article

Exploring Nurses' Lived Experiences in Addressing HIV-Related Stigma in Clinical Practice

[1]Hafaisah Pabilando Agricula, [2]Angelo Francis V. Basbas, [3]Ester Cassie P. Sumayo

[1,2,3]Camarines Sur Polytechnic Colleges

Abstract:

HIV-related stigma remains a significant barrier to equitable and patient-centered healthcare, particularly within clinical settings where people living with HIV (PLHIV) continue to experience discrimination and social marginalization. This qualitative phenomenological study explored nurses' lived experiences in addressing HIV-related stigma in clinical practice and the challenges they encounter in providing stigma-free care. The study was conducted in selected public and private hospitals in Naga City, Philippines, and involved purposively sampled registered nurses with at least one year of experience in caring for PLHIV. Data were gathered through in-depth, semi-structured interviews and analyzed using thematic phenomenological procedures. Findings revealed that nurses encountered both subtle and overt forms of stigma embedded in routine clinical interactions and institutional practices. Nurses demonstrated strong moral responsibility and professional commitment to equitable care, actively resisting stigmatizing behaviors through ethical reflection, respectful communication, and patient advocacy. However, addressing stigma required substantial emotional labor, which accumulated over time and contributed to emotional strain. Major challenges included limited institutional support and training, as well as fear of social judgment and professional repercussions when confronting stigmatizing practices. The study concludes that HIV-related stigma in clinical practice is a socially and institutionally constructed phenomenon that cannot be addressed through individual ethics alone. System-level interventions, supportive leadership, and stigma-sensitive training are essential to sustain compassionate, ethical, and stigma-free nursing care.

Keywords: HIV-related stigma; nurses; clinical practice; emotional labor.

1. Introduction

Human Immunodeficiency Virus (HIV) has been a major issue affecting the global population not only through its medical consequences, but also through the general stigma existing about the virus. Although there are recent developments in antiretroviral therapy, which have turned HIV into a chronic incurable disease, people living with HIV (PLHIV) are still discriminated against, prejudiced, and socially marginalized, especially in healthcare facilities (Fauk et al., 2021). Stigmatization caused by HIV in a clinical setting can be revealed through minor behaviors, words, or unequal treatment, which could negatively influence the level of trust patients place in a healthcare professional, the level of adherence to treatment, and the overall health performance (Yuvaraj et al., 2020; Tavakol et al., 2021). The importance of addressing the problem of stigma in healthcare is, then, to achieve equitable, ethical, and patient-centered care.

Nurses are in the middle of the HIV care delivery model because in a majority of cases, they are the first line of interaction with the patients, in diagnosis, the initiation of treatment, and the maintenance of the condition. In addition to delivering technical and clinical support to patients, nurses have the responsibility of educating patients, supporting them emotionally, advocating, and upholding ethics in practice. Such roles are heightened in relation to HIV by the social meanings attached to the disease that involve moral judgment, fear of transmission and misconceptions based on cultural and societal norms (Kontomanolis et al., 2017). Nurses being front line healthcare workers are uniquely placed to either support or actively oppose HIV-related stigma through their daily contacts with patients, colleagues and institutional systems.

The criterion of stigma, knowledge, and attitudes among healthcare professionals, although quantitative methods of measurement have been extensively applied. Despite the high prevalence of HIV-related stigma, most literature on this topic has either been based on the experiences of PLHIV or the level of stigma, knowledge, attitudes. Although such studies offer valuable baseline information, they do not give much information about how nurses personally experience, interpret and navigate stigma in actual clinical settings. Specifically, the qualitative study examining the lived experience of nurses who deal with HIV-related stigma as an element of their daily professional routine is missing. The gap becomes particularly apparent in health care environments with limited resources, where the systemic issues, including staffing shortages, reduced opportunities to receive training, and institutional limitations, can further complicate the work of the nurses in ensuring the provision of stigma-free care.

It is important to learn the lived experiences of nurses since stigma, although not a simple attitude, is a social and institutional process in which it manifests itself through the daily clinical experience (Buertey et al., 2025). The nurses might also feel emotional pressure, moral conflict, and job-related issues when trying to balance their personal ideologies, organizational values, and professional duties to offer human care to the PLHIV. But these experiences are frequently under-researched and therefore there is

very little empirical evidence to inform stigma-sensitive nursing education, policy formulation, and improvement of clinical practice. To address this gap, the current research undertaking attempts to examine how nurses experience this issue in their clinical practice related to its management of HIV-related stigma. The study intends to use a qualitative phenomenological methodology in order to describe how nurses recount their lives, their experiences, the negative experiences they face, and attributions they make to their job in reducing stigma in the clinical practice. This study aims to make a contribution to better understanding of the ethical, emotional, and professional aspects of HIV care, to inform interventions that can help nurses provide the people with HIV with compassionate and stigma-free healthcare.

2. Research Questions

1. How do nurses describe their lived experiences in addressing HIV-related stigma in clinical practice?
2. What challenges do nurses encounter while addressing HIV-related stigma in the course of patient care?

3. Methodology

This study employed a qualitative research design using a phenomenological approach to explore nurses' lived experiences in addressing HIV-related stigma in clinical practice within hospitals in Naga City, Philippines. Qualitative research is appropriate for inquiries that seek to understand meanings, interpretations, and lived experiences from the perspectives of participants rather than to quantify variables (Lim, 2025). Phenomenology, in particular, is concerned with describing how individuals experience a phenomenon in everyday life and the meanings they ascribe to these experiences. Since HIV-related stigma in healthcare involves deeply embedded social, emotional, and ethical dimensions, a phenomenological approach was deemed suitable for providing a rich, contextualized understanding of nurses' experiences in Naga City hospitals.

The study was conducted in selected public and private hospitals in Naga City where nurses provide direct care to people living with HIV. Participants were registered nurses employed in medical, surgical, and infectious disease units, with at least one year of clinical experience and documented involvement in caring for patients living with HIV. These inclusion criteria were applied to ensure that participants had sufficient professional exposure to HIV care and opportunities to encounter stigma-related issues in practice. Purposive sampling was used to recruit participants who could provide rich, relevant, and deep descriptions of their lived experiences. Sampling continued until data saturation was achieved, which occurred when additional interviews yielded no new themes or insights.

Data were collected through in-depth, semi-structured interviews, conducted face-to-face in private settings within the hospitals or via secure online platforms when necessary. Semi-structured interviews are appropriate for phenomenological studies as they offer flexibility for participants to articulate their experiences while maintaining focus on the research topic. An interview guide was developed based on the research questions, covering topics such as nurses' experiences in addressing HIV-related stigma, the emotional and ethical challenges they faced, and how they navigated these challenges within the clinical environment. With participants' consent, all interviews were audio-recorded and later transcribed verbatim to ensure accurate capture of participants' narratives.

Data analysis was conducted using thematic phenomenological procedures to identify patterns of meaning across the participants' accounts. The researchers engaged in repeated reading of the interview transcripts to gain immersion in the data, followed by initial coding to highlight significant statements related to lived experiences of HIV-related stigma in clinical practice. Codes were then grouped into broader themes that reflected shared experiences and challenges reported by the nurses. To preserve the integrity of the participants' meanings, the analysis was iterative and interpretive, supported by reflexive practices wherein the researchers continually examined and bracketed their assumptions throughout the analytic process. An audit trail documenting analytic decisions and theme development was maintained to enhance transparency and dependability.

Trustworthiness of the study was addressed through strategies that aligned with credibility, dependability, confirmability, and transferability criteria. Credibility was enhanced through prolonged engagement with the data and member checking, which involved inviting participants to review preliminary interpretations of their interviews for accuracy. Dependability was supported by detailed methodological documentation, including reflexive notes and audit trail records. Confirmability was ensured through reflexive journaling and documentation of analytic decisions to demonstrate that findings were grounded in participant data rather than researcher biases. Transferability was considered through thick, contextualized descriptions of the nurses' experiences and the hospital settings in Naga City, allowing readers to assess applicability to similar clinical contexts.

Ethical considerations were strictly observed throughout the study. Ethical clearance was obtained from an institutional review board prior to data collection. All participants received a thorough explanation of the study's purpose, procedures, potential benefits, and risks, and written informed consent was secured. Participants were assured of confidentiality and anonymity, with pseudonyms used in all transcripts and reports. Participation was voluntary, and participants were informed of their right to withdraw at any time without consequence.

4. Results and Discussions

This section presents and discusses the major themes that emerged from the phenomenological analysis of nurses' narratives

regarding their lived experiences in addressing HIV-related stigma in clinical practice. The findings are organized according to the two research questions and are discussed in relation to existing literature to contextualize nurses' experiences within broader discussions of stigma, ethics, and healthcare practice.

4.1 Nurses' Lived Experiences in Addressing HIV-Related Stigma in Clinical Practice

Analysis of the interview data revealed that nurses' experiences in addressing HIV-related stigma were complex, emotionally charged, and deeply embedded in everyday clinical interactions. Three major themes emerged: confronting subtle and overt stigma in clinical settings, moral responsibility and professional commitment to equitable care, and emotional labor in sustaining compassionate practice.

4.1.1 Confronting Subtle and Overt Stigma in Clinical Settings

Participants described encountering HIV-related stigma in clinical practice in both subtle and overt forms. Subtle stigma was more pervasive and often manifested through avoidance behaviors, hesitant physical contact, excessive or unnecessary use of personal protective equipment, whispered conversations, and cautious or distancing language toward patients living with HIV. Overt stigma, although less frequently reported, included delayed responses to patient needs, judgmental remarks, and unequal treatment compared to patients with non-stigmatized conditions. Nurses emphasized that these practices were not always deliberate acts of discrimination but were frequently rooted in fear of transmission, misinformation about HIV, and deeply ingrained societal stereotypes surrounding morality and illness.

"Sometimes it's not direct discrimination, but you feel it—like when staff hesitate to touch the patient or treat them differently." – N2

"There are still misconceptions, even among healthcare workers. Some are overly cautious in a way that makes the patient feel isolated." – N6

The accounts suggest that stigma in clinical settings often operates through routine, taken-for-granted practices rather than explicit or openly hostile behaviors. These subtle forms of stigma are particularly insidious because they are normalized within everyday clinical routines and may go unchallenged or unnoticed by staff. Nurses' narratives reveal that actions framed as "being careful" or "following protocol" may, in practice, communicate fear, judgment, or social distancing to patients. This aligns with conceptualizations of stigma as a social process embedded in institutional norms rather than solely individual prejudice. Importantly, nurses recognized that even well-intentioned actions could unintentionally reinforce patients' feelings of shame, otherness, and vulnerability, thereby undermining therapeutic relationships and trust.

The implications of subtle and overt stigma are significant for patient care and ethical nursing practice. Participants noted that stigmatizing behaviors—however indirect—can discourage patients from disclosing concerns, adhering to treatment, or engaging openly with healthcare providers. For nurses, witnessing or navigating these practices created moral tension, as they struggled to reconcile professional values of compassion and equity with observed behaviors within their work environment. Moreover, when stigma becomes routinized, it risks being reproduced institutionally, shifting responsibility away from individuals and making accountability diffuse. This places nurses in ethically complex positions where addressing stigma requires emotional labor, interpersonal negotiation, and, at times, professional risk.

These findings reinforce existing literature that frames HIV-related stigma in healthcare as embedded in everyday interactions and organizational cultures rather than limited to overt discrimination (Khan, 2020). The nurses' experiences also echo Poku et al. (2023) assertion that stigma is sustained through social practices that normalize separation and status loss. This study extends prior research by illustrating how stigma is enacted, recognized, and contested in real-time clinical encounters. It underscores the critical role of nurses as frontline agents who can either perpetuate or disrupt stigmatizing practices, highlighting the need for institutional policies, training, and reflective spaces that support stigma-aware and ethically grounded care.

4.1.2 Moral Responsibility and Professional Commitment to Equitable Care

A strong sense of moral responsibility and professional commitment to equitable care emerged as a defining dimension of nurses' lived experiences in addressing HIV-related stigma. Participants consistently emphasized that providing nonjudgmental, respectful, and compassionate care to people living with HIV was a fundamental ethical obligation rooted in nursing values. Nurses framed stigma reduction not as an optional attitude but as an intrinsic part of their professional identity and duty of care.

"As nurses, we are trained to care, not to judge. HIV is a condition, not a character flaw." – N1

"I remind myself that my duty is to the patient, regardless of their diagnosis." – N7

Several participants described consciously reframing their perspectives to counter both personal and socially embedded biases. This involved deliberate efforts to use respectful language, ensure confidentiality, and affirm patients' dignity during clinical interactions. Nurses reported drawing on professional ethics, training, and empathy to guide their actions, particularly when caring for patients who had previously experienced discrimination in healthcare settings.

These accounts illustrate how nurses actively negotiate the intersection of personal beliefs, professional ethics, and socially constructed stigma in their everyday practice. Moral responsibility functioned as an internal compass that guided nurses' behavior,

even in contexts where stigma was normalized or subtly reinforced. The narratives suggest that ethical nursing practice required continuous self-monitoring and emotional discipline, especially when nurses encountered stigmatizing remarks or practices from colleagues or institutional routines. However, this moral commitment often placed nurses in ethically complex situations. Participants described moments of tension when institutional hierarchies, workplace culture, or peer dynamics limited their ability to challenge stigmatizing behaviors openly. Nurses were frequently caught between their obligation to advocate for patients and the practical realities of maintaining professional relationships and job security.

"There are times when you want to speak up, but you're also thinking about hierarchy and workplace dynamics." – N5

The findings imply that while nurses' moral responsibility plays a critical role in mitigating HIV-related stigma, relying primarily on individual ethical commitment places a disproportionate burden on frontline practitioners. When institutions lack clear policies, training, or supportive leadership to address stigma, nurses are left to navigate ethical dilemmas independently. Over time, this may lead to moral distress, emotional exhaustion, or professional disillusionment, particularly when nurses repeatedly witness inequitable practices they feel powerless to change. Moreover, positioning stigma reduction as an individual moral task risks obscuring the structural dimensions of stigma within healthcare systems. Without organizational accountability, ethical care becomes dependent on individual resilience rather than collective standards, resulting in inconsistent patient experiences and potential inequities in care delivery.

These findings resonate with Link and Phelan's (2014) conceptualization of stigma as a social process sustained through power relations and institutional structures rather than individual prejudice alone. The nurses' experiences demonstrate how professional ethics serve as a critical counterforce to stigma, yet are constrained by organizational contexts. This study extends existing literature by foregrounding the ethical labor nurses perform in everyday clinical practice, highlighting that moral responsibility is both a source of professional strength and a site of vulnerability. Addressing HIV-related stigma, therefore, requires not only ethically committed nurses but also institutional cultures and policies that actively support and legitimize stigma-free care.

4.1.3 Emotional Labor in Sustaining Compassionate Practice

Participants consistently described addressing HIV-related stigma as an emotionally demanding aspect of their clinical work, requiring sustained emotional regulation, self-control, and resilience. Nurses reported engaging in continuous emotional labor to maintain professionalism, empathy, and composure while caring for people living with HIV, particularly in situations where patients anticipated judgment or had prior experiences of discrimination. This emotional labor involved consciously managing personal reactions, suppressing frustration, and projecting reassurance and acceptance during patient interactions.

"You have to be emotionally strong, especially when patients sense they're being judged." – N3
"Sometimes it's exhausting, but you cannot let that show because the patient already feels vulnerable." – N8

Beyond direct patient care, nurses also described the emotional burden associated with advocating for patients who experienced stigma from other healthcare workers or institutional practices. These advocacy efforts often required nurses to absorb patients' emotional distress while navigating workplace dynamics, frequently without formal support systems.

"You carry their pain with you. Sometimes it stays even after your shift." – N6

These narratives reveal emotional labor as a central yet often invisible component of nurses' efforts to address HIV-related stigma. Nurses were not only providing clinical care but were also actively managing emotional atmospheres—both their own and those of their patients—to counteract fear, shame, and mistrust. This aligns with the understanding of emotional labor as the regulation of feelings to fulfill professional expectations, particularly in care-oriented professions.

The data suggest that emotional labor functioned as a protective mechanism for patients, shielding them from overt or subtle stigmatizing cues within the clinical environment. However, this protection came at a psychological cost to nurses. Participants described emotional exhaustion arising from the need to remain calm, compassionate, and nonjudgmental despite repeated exposure to stigma-related tensions, patient vulnerability, and institutional constraints. Importantly, emotional labor was intensified by the absence of structured avenues for emotional processing, such as debriefing sessions or counseling support. Nurses' accounts also highlight the cumulative nature of emotional labor. Rather than being confined to isolated encounters, emotional strain accumulated over time, lingering beyond work hours and affecting nurses' personal well-being. This indicates that emotional labor in HIV care is not episodic but embedded in nurses' ongoing professional identities.

The findings imply that while emotional labor is essential to sustaining compassionate and stigma-free HIV care, it is not a limitless resource. When emotional labor is continuously demanded without institutional recognition or support, nurses are at increased risk of emotional fatigue, moral distress, and burnout. The expectation that nurses should indefinitely regulate their emotions to compensate for stigmatizing environments shifts responsibility from healthcare systems to individuals, potentially normalizing emotional strain as "part of the job." Furthermore, the invisibility of emotional labor in formal job descriptions and institutional policies may lead to its undervaluation, leaving nurses without adequate psychological resources to cope with its demands. This has implications not only for nurses' well-being but also for the sustainability of compassionate care. Prolonged emotional exhaustion

may compromise nurses' capacity to engage empathetically with patients, paradoxically increasing the risk of unintentional detachment or depersonalization.

These findings align with Zhang et al. (2021) assertion that stigma management in healthcare extends beyond knowledge deficits to encompass emotional and relational dimensions. By foregrounding nurses' lived experiences, this study extends existing stigma literature by demonstrating how emotional labor operates as a critical, yet under-supported, mechanism in addressing HIV-related stigma in clinical practice. The findings reinforce calls for institutional interventions that acknowledge emotional labor as legitimate nursing work and provide structured emotional support, such as reflective supervision, peer debriefing, and mental health services. Addressing HIV-related stigma effectively, therefore, requires not only clinical competence and ethical commitment but also organizational cultures that sustain the emotional well-being of nurses tasked with delivering compassionate care.

4.2 Challenges Encountered by Nurses in Addressing HIV-Related Stigma

In addition to their lived experiences, nurses identified significant challenges that constrained their efforts to address HIV-related stigma effectively. Two major themes emerged: limited institutional support and training and fear of social judgment and professional repercussions.

4.2.1 Limited Institutional Support and Training

Participants consistently reported limited institutional support and insufficient training as major challenges in addressing HIV-related stigma in clinical practice. Nurses emphasized that while hospitals provided regular technical and procedural trainings, structured programs specifically targeting HIV-related stigma, ethical patient engagement, and attitudinal change were largely absent. As a result, nurses felt underprepared to address stigma in its subtle, relational, and systemic forms.

"We rarely have seminars about stigma. Most trainings focus on procedures, not attitudes." – N2
"Sometimes you rely on what you learned years ago, and that's not enough." – N4

Several participants noted that HIV-related education was often outdated or limited to basic infection control protocols, with minimal attention given to contemporary understandings of stigma, patient-centered communication, and psychosocial care for people living with HIV. This lack of institutional emphasis signaled to nurses that stigma reduction was not a formal organizational priority.

These accounts illustrate how institutional silence and limited training contribute to the persistence of HIV-related stigma within clinical environments. Without regular, updated, and reflective training, nurses were left to depend on personal values, prior education, or informal learning to guide their interactions with patients living with HIV. While many nurses demonstrated strong ethical commitment, the absence of institutional reinforcement constrained their ability to challenge stigmatizing behaviors, particularly when these originated from colleagues or entrenched workplace norms. The data further suggest that limited training undermined nurses' confidence in addressing stigma at a systemic level. Nurses expressed uncertainty about how to intervene when witnessing stigmatizing language, discriminatory practices, or breaches of confidentiality, especially in hierarchical settings. This uncertainty fostered a culture of silence, where stigma was recognized but rarely confronted directly. Importantly, the lack of institutional support transformed stigma management into an individualized responsibility rather than a shared organizational commitment. Nurses were expected to self-regulate their attitudes and practices without clear guidelines, accountability mechanisms, or leadership support, reinforcing inconsistency in stigma-sensitive care across units and personnel.

The findings imply that without sustained institutional investment in stigma-reduction training and policy implementation, efforts to address HIV-related stigma remain fragmented and dependent on individual nurses' moral resilience. This not only places additional emotional and ethical burden on nurses but also risks perpetuating inequitable patient experiences. When stigma is not explicitly addressed at the organizational level, discriminatory practices may become normalized, unchallenged, and invisible within routine clinical workflows. Moreover, limited institutional support may exacerbate nurses' moral distress. Nurses who recognize stigma but lack the authority, training, or institutional backing to intervene may experience feelings of frustration, helplessness, and ethical conflict. Over time, this can contribute to emotional exhaustion and disengagement, undermining both nurse well-being and the quality of patient care.

These findings align with Brown et al. (2022) assertion that effective stigma reduction in healthcare requires comprehensive, system-level interventions rather than reliance on individual professionalism alone. By foregrounding nurses' lived experiences, this study extends existing literature by demonstrating how institutional gaps in training and support directly shape nurses' capacity to address HIV-related stigma in practice. The results underscore the need for healthcare institutions to institutionalize stigma-reduction efforts through continuous education, clear policies, leadership engagement, and supportive organizational cultures. Addressing HIV-related stigma, therefore, demands not only knowledgeable and ethically committed nurses but also healthcare systems that actively equip and empower them to deliver stigma-free care.

4.2.2 Fear of Social Judgment and Professional Repercussions

Another significant challenge identified by participants was the fear of social judgment and potential professional repercussions associated with advocating for patients living with HIV. Nurses reported that stigma did not only affect patients but also extended

to healthcare providers who were closely involved in HIV care. Some participants expressed apprehension that being visibly associated with HIV-positive patients could expose them to suspicion, gossip, or negative labeling from colleagues and even from the broader community.

"There's still fear—fear of being judged or misunderstood, even as a nurse." – N7

In addition, several nurses shared that confronting stigmatizing remarks or discriminatory behaviors within the workplace was particularly difficult due to hierarchical structures and informal workplace politics.

"You have to be careful. Speaking up can affect your work relationships." – N5

These narratives indicate that nurses often had to navigate stigma not only at the level of patient care but also within professional and social relationships inside the hospital. The fear of social judgment reflects how HIV-related stigma operates as a relational and institutional phenomenon rather than an individual attitude alone. Nurses' accounts suggest that stigma is socially reproduced within healthcare settings through peer perceptions, informal talk, and power dynamics. Even when nurses personally rejected stigmatizing beliefs, they remained cautious in their actions to avoid being socially or professionally marginalized.

Hierarchical workplace structures intensified this challenge. Nurses, particularly those in junior positions, felt constrained in calling out stigmatizing behavior from senior staff or colleagues in authority. The potential consequences—strained relationships, negative evaluations, or subtle forms of exclusion—created a climate where silence was often perceived as safer than advocacy. This fear limited open dialogue and discouraged collective action against stigma, allowing discriminatory practices to persist unchallenged.

Importantly, this fear also reveals how stigma becomes internalized among healthcare workers themselves. Nurses described a tension between their ethical obligation to advocate for patients and their need to maintain professional harmony and job security. This internal conflict illustrates how stigma can regulate behavior indirectly, shaping what nurses feel able—or unable—to say and do within clinical spaces.

These findings imply that addressing HIV-related stigma requires attention not only to patient-facing practices but also to the social risks borne by healthcare providers. When nurses fear judgment or retaliation, stigma reduction efforts become individualized and covert rather than collective and systemic. This places an unfair burden on nurses to navigate ethical dilemmas alone, potentially leading to moral distress, emotional strain, and professional disengagement. Furthermore, fear of professional repercussions may undermine patient advocacy. Nurses who hesitate to challenge stigmatizing behaviors may inadvertently contribute to environments where discriminatory language, breaches of confidentiality, or unequal treatment remain normalized. Over time, this can compromise the quality of care, weaken trust between patients and providers, and reinforce institutional cultures that tolerate stigma.

These findings are consistent with Bergman and Rushton (2023) as well as Ferguson et al. (2022) who argue that healthcare workers may internalize stigma-related pressures, limiting their capacity to openly challenge discriminatory practices within clinical settings. The present study extends this literature by illustrating how fear of social judgment and professional consequences is lived and negotiated by nurses in everyday practice. By foregrounding nurses' voices, the study highlights the need for healthcare institutions to create psychologically safe environments where nurses are supported, protected, and empowered to address stigma without fear. Institutional policies, leadership support, and clear reporting mechanisms are essential to shifting stigma reduction from an individual moral struggle to a shared organizational responsibility.

5. Conclusions and Recommendations

This study concludes that HIV-related stigma in clinical practice remains a persistent and complex phenomenon that nurses must actively navigate in their everyday work. Nurses' lived experiences revealed that stigma is not limited to overt acts of discrimination but is often embedded in subtle clinical behaviors, workplace norms, and institutional routines. Addressing HIV-related stigma required nurses to engage continuously in ethical reflection, emotional regulation, and professional self-discipline to ensure equitable and compassionate care for people living with HIV. These findings affirm that stigma is not merely an individual attitude but a socially and institutionally constructed process that shapes clinical interactions and healthcare delivery.

The study further highlights that nurses' strong moral responsibility and professional commitment serve as critical counterforces to HIV-related stigma. Nurses drew on ethical values, professional identity, and empathy to resist judgmental practices and advocate for patients' dignity. However, this moral labor frequently placed nurses in ethically challenging positions, particularly when organizational hierarchies, workplace cultures, or peer dynamics limited their capacity to challenge stigmatizing behaviors openly. As a result, stigma reduction often depended on individual moral resilience rather than collective institutional accountability, increasing nurses' vulnerability to moral distress and emotional fatigue.

Emotional labor emerged as a central yet underrecognized dimension of nurses' efforts to address HIV-related stigma. Nurses invested substantial emotional energy in maintaining compassionate practice, managing patients' fears, and buffering the effects of stigma within clinical encounters. While emotional labor enabled nurses to sustain patient-centered care, it also accumulated over time, contributing to emotional exhaustion when left unsupported. The findings underscore that emotional labor should not be viewed as an informal or personal coping strategy but as an essential component of ethical nursing practice that requires institutional recognition and support.

Based on these conclusions, the study recommends that healthcare institutions prioritize system-level interventions to address HIV-related stigma. Hospitals should institutionalize regular, stigma-focused training programs that move beyond infection control to include ethical reflection, patient-centered communication, and critical awareness of subtle stigma. Leadership must actively model stigma-free practices and create psychologically safe environments where nurses can speak up without fear of judgment or professional repercussions. Clear policies, reporting mechanisms, and accountability structures are essential to shifting stigma reduction from an individual moral burden to a shared organizational responsibility.

Finally, nursing education and future research should play a proactive role in sustaining stigma-free care. Nursing curricula should integrate HIV-related stigma, emotional labor, and ethical advocacy as core competencies, preparing nurses to navigate complex social and moral dimensions of care. Ongoing professional development should include reflective supervision, peer debriefing, and access to mental health support to mitigate emotional strain. Future research may explore longitudinal experiences of nurses, compare stigma management across healthcare settings, or evaluate the effectiveness of institutional stigma-reduction interventions. Overall, addressing HIV-related stigma in clinical practice requires coordinated, compassionate, and sustained efforts that value nurses not only as care providers but also as moral agents deserving of institutional support and protection.

6. References

1. Bergman, A., & Rushton, C. H. (2023). Overcoming stigma: Asking for and receiving mental health support. *AACN Advanced Critical Care, 34*(1), 67–71.
2. Brown, G., Reeders, D., Cogle, A., Allan, B., Howard, C., Rule, J., … Gleeson, D. (2022). Tackling structural stigma: A systems perspective. *Journal of the International AIDS Society, 25*, e25924.
3. Buertey, A. A., Puplampu, G. L., Ani-Amponsah, M., Ibrahim Jibril, M. A., & Attiogbe, A. (2025). Lived experiences of Ghanaian community psychiatric nurses' resilience strategies in combating stigma: An interpretive phenomenological study. *BMC Nursing, 24*(1), 182.
4. Fauk, N. K., Hawke, K., Mwanri, L., & Ward, P. R. (2021). Stigma and discrimination towards people living with HIV in the context of families, communities, and healthcare settings: A qualitative study in Indonesia. *International Journal of Environmental Research and Public Health, 18*(10), 5424.
5. Ferguson, L., Gruskin, S., Bolshakova, M., Yagyu, S., Fu, N., Cabrera, N., … Hempel, S. (2022). Frameworks and measures for HIV-related internalized stigma, stigma and discrimination in healthcare, and in laws and policies: A systematic review. *Journal of the International AIDS Society, 25*, e25915.
6. Khan, S. (2020). Examining HIV/AIDS-related stigma at play: Power, structure, and implications for HIV interventions. *Health Communication, 35*(12), 1509–1519.
7. Kontomanolis, E. N., Michalopoulos, S., Gkasdaris, G., & Fasoulakis, Z. (2017). The social stigma of HIV/AIDS: Society's role. *HIV/AIDS: Research and Palliative Care*, 111–118.
8. Lim, W. M. (2025). What is qualitative research? An overview and guidelines. *Australasian Marketing Journal, 33*(2), 199–229.
9. Link, B. G., & Phelan, J. (2014). Stigma power. *Social Science & Medicine, 103*, 24–32.
10. Poku, O. B., Eschliman, E. L., Entaile, P., Rampa, S., Mehta, H., Tal, D., … Murray, S. M. (2023). "It's better if I die because even in the hospital, there is a stigma, people still gossip": Gossip as a culturally shaped labeling process and its implications for HIV-related stigma in Botswana. *AIDS and Behavior, 27*(8), 2535–2547.
11. Tavakol, M., Nikayin, D., & Rezaei, M. (2021). The effect of AIDS stigmatization on curing patients and physician–HIV/AIDS patient relationships. *Bioethics and Health Law Journal, 1*(1), 1–9.
12. Yuvaraj, A., Mahendra, V. S., Chakrapani, V., Yunihastuti, E., Santella, A. J., Ranauta, A., & Doughty, J. (2020). HIV and stigma in the healthcare setting. *Oral Diseases, 26*, 103–111.
13. Zhang, R., Wang, M. S., Toubiana, M., & Greenwood, R. (2021). Stigma beyond levels: Advancing research on stigmatization. *Academy of Management Annals, 15*(1), 188–222.