

ORIGINAL RESEARCH

illuminating the Experience of Stigma among Persons Living with HIV using Participative Drawing Method



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Abstract

Background: Arts-based techniques such as drawing is a helpful means in research because of its potential to capture taboo, culturally sensitive issues, and other critical health experiences. However, very few studies integrate the use of drawing as a qualitative method in HIV research.

Purpose: This study aims to explore the experience of stigma among persons living with HIV using the drawing method.

Methods: The study utilized a participative qualitative approach. There were eleven (11) participants who were recruited through snowballing and were asked to draw their experience of stigma as a Person Living with HIV/AIDS (PLHA). The participants were men who-have-sex with men (MSM) who have been diagnosed for at least one year, and are active members of a support group. This preliminary study was conducted in Central Philippines from November-December 2019. The narrative explanations were recorded, transcribed, and analyzed using thematic analysis.

Findings: Results revealed three themes: (1) Psycho-socio-emotional needs which illuminated their need for love and acceptance; (2) Profound feelings which reflected a plethora of negative towards positive convergence of emotions, and (3) Coping with HIV stigma which presented the three-pronged anchor to move forward and sustain a hopeful living.

Conclusion: A stigmatized PLHIV needs intimacy, interconnectedness, and inclusiveness in society. Likewise, they feel a plethora of feelings that transcend negative to positive emotions depending on their coping. A PLHIV copes with stigma and discrimination through the aid of their social circle, spirituality, and self-love. Future researchers may consider the use of participative drawing to explore HIV stigma apart from the conventional interview, as it is found to be a valuable method of facilitating the expression of emotions and experiences.

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1. Introduction

Stigma is an experience of negativity that may be self-internalized, community induced, or socially inflicted, such as deprivation of human rights (van der Kooij et al., 2021; Ibrahim et al., 2019). Organizations and advocates have shown efforts to mitigate the incidence of HIV stigma by implementing stigma reduction activities. A breadth of literature discussed a variety of modalities and approaches, and this includes emotional regulation (Wei et al., 2016), anticipated discrimination and self-disclosure (Olley et al., 2016), socio-ecological integration in information dissemination (Du et al., 2018) and stigma reduction training programs such as Acceptance Commitment Therapy (ACT) Training and Social Justice Capacity Building (SJCBC) (Li et al., 2018), and measuring and improving health worker's behaviors towards high risk groups (De los Santos et al., 2022a). Remarkably a reduction of incidence of HIV stigma in health facilities was found when interventions were focused on the health care providers (Nyblade et al., 2020; De los Santos, 2020). However, despite these endeavors, the stigma in HIV continues to exist and has been linked to the problems of patients' health-seeking behaviors, compliance, and adherence to treatment and rehabilitation (De los Santos et al., 2022b).

Although the literature discussed the genuineness of stigma experience, it revealed that there are no concrete stigma reduction activities and effective assessment modalities existing at present (Andersson et al., 2020). Notably, there is a scarcity of studies discussing how stigma is assessed.

The literature only presented the use of face-to-face interviews and Focus Group Discussion (FGD) in assessing HIV-related stigma and discrimination as an effective means of eliciting qualitative responses among its participants (Mahamboro et al., 2020; Reinius et al., 2021).

Scholars have suggested utilizing arts-based techniques such as drawing as a qualitative method in research because of its potential to capture taboo, culturally sensitive issues, and other critical health experiences (Gameiro et al., 2018; Literat, 2013). However, very few studies integrate the use of drawing as a qualitative methodology in HIV research. The existing studies are focused more on their capacity for knowledge generation. An example of this is a study by Mutonyi & Kendrick, 2011), who found drawing as an effective method to understand culturally sensitive topics such as sexual health and HIV/AIDS among the youth. The strategy was found to help construct a persons' understanding of HIV and helped the participants to arrive at a conclusion based on their personal experiences. Another is combining art into the patients' medical regimen, which has shown improvements in their physical and mental health and general quality of life (Tolleson & Zeligman, 2019). Drawing as a methodology fosters an in-depth expression of perception, thoughts, and views on a particular concept, which may be difficult when expressed through words, such as the experience of HIV stigma and discrimination.

With the seeming lack of literature focusing on exploring HIV stigma experience through the application of visual arts in health research, this paper intends to bridge this gap by qualitatively exploring the lived experience of stigma using the drawing method among men-having-sex with-men (MSM) PLHA.

2. Methods

2.1 Research design

This study utilized a participative, exploratory, descriptive qualitative design. Descriptive qualitative is considered an appropriate method to assess an experience to explicate the essence and peculiarity in the eyes of those who experienced it firsthand.

2.2 Setting and participants

This study was conducted in the Central Philippines between November-December 2019. The snowball method of member participation was employed to gather the target participants for this project. Inclusion criteria were MSM PLHA diagnosed for at least one year and an active HIV social support group member. Excluded were those with debilitating health conditions and new members with less than six months from the diagnosis. The researcher coordinated with the support group leaders of active HIV support groups regarding the study's intention. The leaders cascaded the recruitment intention to potential participants coming from their groups. A total of fifteen (15) participants agreed to participate in the drawing session. Data saturation was met at the eleventh participant which prompted decision to cease further data gathering.

2.3 Data collection

Prior to data gathering, the author did bracketing written in a separate journal to identify existing biases and assumptions to assure that data interpretation, is pure and grounded only on the gathered participants' responses.

The participants were gathered in a private room to hold the activity. Informed consent was sought before commencement, wherein only voluntarily agreeing participants signing the form were included in the sessions. The session observed a draw-and-talk sequence. The participants were provided with art materials (A4 paper, pencil, crayons, and colored pens). They were instructed to illustrate their lived experience of how they felt as a person living with HIV. They were also asked to prepare an explanation of their drawings and illustrations. The drawing session lasted 60-90 minutes, which was subsequently followed by group sharing. The participants were allowed to explain the details of their creative outputs central to their experience living with HIV. The participants were allowed to freely discuss using their native language to exhaust rich sharing of experience (Braun & Clarke, 2006). A voice recorder was utilized to record the sharing session facilitated by the researcher. The sharing session lasted for 10-15 minutes per participant.

2.4 Data analysis

The recording was transcribed and analyzed using inductive thematic analysis following Braun and Clarks' (Braun & Clarke, 2006) framework. The transcripts were initially transcribed

verbatim and later translated into English. A professor with an English major verified the translated transcripts to ensure the accuracy and coherence of the translation.

Data immersion was done through transcription reading and rereading process to identify embossed patterns that emerged from the data. Two inter-raters then coded the transcripts following the procedure of eclectic coding with a repertoire of values and emotions codes. The codes were grouped and clustered into one, along with the other narratives sharing the same thought or meaning. A review of the similarities and dissimilarities of codes/transcripts was done followed by the selection of highly relevant codes. Categorization into sections or themes was done thereafter. An expert reviewed the final codes and themes in qualitative research to guarantee the reliability of the data. Qualitative content and thematic analysis were the appropriate approaches in analyzing the qualitative data that were gathered in this study because it used a systematic process of coding, finding meaning, and thematization to describe a concept in a social context (Braun & Clarke, 2020; Byrne, 2021).

2.5 Trustworthiness/rigor

The qualitative rigor of this study was achieved by following the criteria of Qualitative Framework (Creswell & Miller, 2010). To gain the credibility of this study, the researchers performed members checking where the participants were invited to read, comment, change when necessary, and finally, agree on the derived findings of the study. The use of bracketing and journal writing likewise enhances the credibility and authenticity of the results of this investigation. The researchers followed an intercoder reliability check to minimize and avoid biases in the data analysis. This study's dependability and confirmability criteria were achieved through meticulous documentation and audit trail done by an external evaluator, and facilitating two data collection methods. The comprehensive description of the participant's background, experience, and quotes reinforced the transferability of this study.

2.6 Ethical consideration

This study observed proper ethical procedures and was cleared by the Ethics Review Committee of the St. Paul University Philippines with the code: 2018-01-PhDNS-11. The multilevel approach to the recruitment of participants ensured that the participant's participation in this study was voluntary. This was further strengthened by securing a signed informed consent form. The participants were assured of their confidentiality and anonymity in the outputs of the study. The researcher provided utmost privacy by organizing the session in a private facility. To secure the participant's safety, the researcher prepared a standby crisis management plan.

3. Results

3.1 Profile of participants

The majority of the participants were aged between 31-40 years old and were gays. There were 46% of the participants who claimed to be on the tertiary level of education. Most of the participants (55%) were diagnosed with HIV within the last two years (Table 1).

Three themes emerged after the textural analysis of the narratives derived from the sharing session. The themes were: (1) Psycho-socio-emotional longingness; (2) Profound feelings and; (3) Coping and holding on (Figure 1).

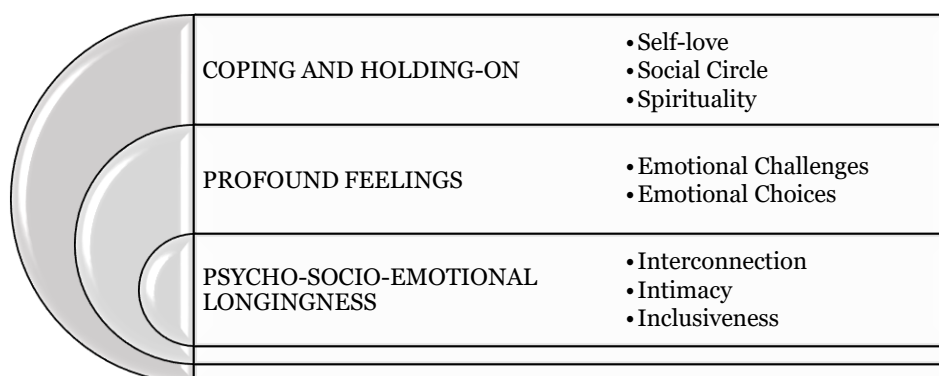


Figure 1. Themes and categories extracted from the experiences of a person living with HIV

Table 1. Profile of the participants

Demographics	Frequency	Percentage
Age (year)		
20-30	3	27
31-40	6	55
41-50	1	9
51-60	1	9
Gender		
Gay	8	73
Bisexual	2	18
Transgender	1	9
Educational Attainment		
High School graduate	2	18
College level	5	46
College graduate	4	36
Number of years diagnosed with HIV		
1-2	6	55
3-4	2	18
4-5	1	9
>5	2	18

3.2 Theme 1: Psycho-socio-emotional longingness

The session was able to extract a variety of longingness experienced by a person living with HIV. Most of the participants expressed literally and figuratively their need for love and acceptance. They yearned for a sense of belongingness, a nonjudgmental and nondiscriminatory treatment, respect, equality, unity, the open-mindedness of other people, and the protection of their human rights.

3.2.1 Longingness for interconnection

A participant expressed his dismay when his family ostracized him and told him to leave the house and how much he wished to be understood:

My mom did not make a fuss about it (my HIV diagnosis), maybe because she did not understand what it was about. That was what I thought until my brother learned about it. He told me to look for another place to stay. He sent me out of the house [...] For two weeks, I was roaming here and there. I went to some of my friends and rested there for a while, and sometimes I would sleep anywhere there was even a time I slept in the park [...]. It gave me some time to think. Sort of like a soul-searching. Nobody owns me anymore. I am all alone. I realized that even your own family would not be able to understand. (PL 07)

Despite being physically beaten by his mother because of his HIV diagnosis, like any child, he still longs for a motherly love:

My mother got mad at me. She became physical. I accepted all the slaps, blows, and kicks she did to me. I understand her because it is all my fault anyway. I was not careful. I did not take care of myself. I miss my mother; I miss being with her. (PLO8)

Typical to the participants is their disconnection with their peers. One participant expressed missing his friends.

I feel so alone now that my friends left me because they do not want to be associated with me. They do not want gossips that they, too, have HIV. Before I had this HIV, I had a lot of friends. I am easy to befriend with anyone. But now, I have no one. (PLO3)

3.2.2 Longing for intimacy

Being diagnosed with HIV is considered as a dead-end by a participant to forming romantic relationships. They believe they are unlovable because of their disease condition.

I fear that my boyfriend will break up with me if he finds out I am HIV+... If I lose this relationship, I know I won't be able to find another one knowing I am HIV+ [...], and I know I should tell him as it is my obligation. However, I am afraid he will break up with me once he finds out. (PL 02)

3.2.3 Longing for inclusiveness

The participants expressed being deliberately discriminated against because of their HIV status experienced by them and their family members. These experiences are common in their school, place of work, neighborhood, and even in healthcare facilities.

Going to school is a struggle because they feel that people there are discussing their HIV status. They prefer not to go to school out of fear of being judged. One participant became frustrated when his classmate, who is a close friend, told him that their schoolteacher asked the whole class if HIV was the reason why he was absent; at that time, he was admitted to the hospital. He said: *I felt humiliated, and I didn't want to go to school anymore. I don't want to face them after what they have done to me. I feel like going to school is stressful and useless. (PL 07)*

Another participant expressed how he was felt deprived of his right to education because he was HIV positive. He narrated: *It is too personal for me, mainly because I experienced discrimination when I was declined to study on my preferred degree program [...] They required blood screening tests as a requirement for enrollment, I know I have no chance. (PL01).*

Looking for a job is wearying for a person with HIV because some institutions require HIV screening for employment. The participants find this as discriminating and personally invasive. One participant was disheartened when applying for a part-time job to support his expenses for education:

I was disappointed to know when we were asked for an additional requirement of HIV screening test results from us applicants; I should not have applied in the first place had I learned about it earlier, so I will not be wasting my time, money, and effort. (PLO9)

Similarly, a participant experienced the same experience of discrimination when his supervisor told him that he would not be renewed of his contract because of his HIV status:

I was scared when my boss started to doubt my health, especially when I was admitted to the hospital and was diagnosed positive (of HIV). He said that I could not renew my expiring contract next month because I have this disease. (PL10)

Even in health facilities, participants felt stigmatized and discriminated against:

They placed me in a room where patients with rabies. They suspect me with a mental problem; that's why they put me there. Also, I felt they placed me there because I have HIV[...] I went to a hospital to have myself checked. I was bothered by my cough, which was two months already. The doctor prescribed a medicine for TB (Tuberculosis), and I felt they were already suspecting me as an HIV case as well. The doctor ordered the nurse to put a face mask on me while they all wore the same. I was offended because right in front of me. In my presence, they would spray a disinfectant in the room. I was hurt that that was how they treated me. They were disgusted with me. The wearing of a mask is fine, but the spraying of disinfectant is a different story. After all, they don't have a hold of my lab results yet. (PLO4)

The participants unanimously felt that they had been robbed of their right to liberty after being known as HIV positive. They receive this kind of treatment from their family members, neighbors, other people, and their community. He said: *Ever since I got diagnosed with HIV, I felt boxed. My brother would not allow me to be with my friends. I don't know; maybe he is just overly protective of me, but I think it is too much (PLO2)*

Another participant shared his painful experience being declined to commute on a vehicle for public use. He narrated: *I cannot go out to places where I want to go. The drivers of public utility*

vehicles would not allow me to ride, saying that I would spread HIV to the other passengers. (PL03)

There were stories that it is not only them who experience this discrimination but also include their other family members. One participant shared how he worries and feels sorry because their whole family is gossiped about. In verbatim, he said: *Ever since I got sick, my mother would always defend against anyone who would raise malicious issues about me, even her friends. I feel sorry for my mother. She lost her friends because of me.* (PL06)

3.3 Theme 2: Profound feelings

The results also revealed a breadth of emotions experienced by a person living with HIV. This includes a surge of positive and negative feelings. Remarkably, their feelings evolve from a negative towards a positive change.

3.3.1 Emotional challenges

Initially, there is denial, fear, self-blame, isolation, self-stigma, and perceived or actual discrimination. Two participants expressed their feelings of resignation:

I just let it be. I leave it as it is. I let myself fight on the worst disease ever experienced in my life until such time my body cannot take it anymore. I prefer to wait until I am in my worst, in my death bed, because I fear being stigmatized. It all boils down to my fear of rejection and shame. (PL 02)

I felt I was hopeless and had no chance in life, and I didn't want to fight anymore and see my parents suffer [...] I wanted to give up already. I even told my parents just to bring me home. I wanted to give up already and prayed for Him to take my life. (PL 04)

3.3.2 Emotional choices

Most of the participants go through the process of denial to depression until they can realize resilience, as displayed by their willingness to live and let go. Examples are the narration of PL01 and PL 10:

The tree that stands alone on this island represents me. I keep myself in isolation because that is how I feel as of now. I am hiding and not able to express myself freely. On the right side is the mainland, which represents my diagnosis of HIV and fears. I am far from accepting the real me, and I am far from letting people know what I am hiding; that is why I have to be away with it. What divides us is the wind and wave. The wind and wave represent the stigma and discrimination. The sun represents my ARV, which is my ticket to living a longer life. It tells me I have a future to look forward to every day. (PL 10)

My life is like a P100 bill, it may have been crumpled, stepped on, but its worth remains; it still can be used to buy from its value. Like me, I can be crushed, tumbled as a person because of what happened to me and my diagnosis, but yes, I am still the same me. That's why when I talk to a person now, I don't feel inferior anymore. I will not let myself feel down. I do not see myself as a dirty person nor a wrong person just because I have the virus. (PL 01)

3.4 Theme 3: Coping and holding-on

Most PLHIV have a good sense of self and spirituality. Their coping is anchored on different sources stemming from themselves, significant others, and their relationship with their God.

3.4.1 Spirituality

The participants draw strength in their belief in a spiritual being. In the absence of their family, the participants consider God as their ultimate source of hope and strength. One participant believed what saved him ultimately was a miracle from the Lord. He claimed: *Prayers were the key, and I believe it was a miracle. I relied on the Lord, and prayers became my weapon to fight my ordeals every day.* (PL 12)

PL 07 expressed how his need for love and acceptance from people around him and his spirituality inspired him to move on and live life despite the stigma he feels in dealing with other people and within himself.

In this drawing, I illustrated a drop of blood where God is found in the center. Because he is the center of my life now, with the help of my family, friends, and support groups, and my co-PL, I realized I should fight back, not lose hope and never give up on my dreams. My life is anchored on this bible verse from Proverbs: "I love those who love me and those who love me seek me. (PL 07)

3.4.2 Self-love

The participants consider themselves as a source of strength in coping with their illnesses and everyday challenges. The participants best explicate self-love through genuine efforts of staying healthy:

I may have encountered problems, but I don't make it a point to mess my life. As much as possible, I solve it myself. What matters to me is I am healthy, and I will not get any OIs (opportunistic infections). I always take care of myself and get fit as much as possible. I focused on myself, and I am always careful [...] I don't let gossip affect me because if I did, I might get stressed, and my body would be affected. (PL 09)

Another participant described his way of coping through self-empowerment, which helped him personally:

A time came when I had an opportunity to attend a Learning Group Session (LGS) with a psychiatrist as the speaker. I was enlightened. It was a wake-up call for me to get up and put my pieces together. I helped myself and applied everything I learned from the LGS. I forgave and accepted myself. I was able to remove the heavy chain in my chest, and I could unlock myself out of depression. (PL 02)

I am thankful for my strength. If not, it would have broken me down into pieces. Now I do not think about them too much, as long as I know that I am strong and capable and can support myself with whatever small things I have. Though deep inside, I would still feel hurt every time I felt they were gossiping about me. (PL 05)

3.4.3 Social circle

The participants also consider their family as their source of strength and motivation to fight their illness and move on with their lives.

I pretend to be strong, and I pretend that it does not affect me. As soon as I got home, I would cry to my mom, and she would console me. My mom's words are my anchor to make myself strong. She would always tell me to let it pass, that I just need to consider this a 'trend,' but time will come, and people will forget it... I held on to that until I was able to reach my graduation. (PL 02)

One participant expressed how disclosing his HIV status came to be one of the best decisions he made. This improved his coping and strengthened family relationship:

After I disclosed, I felt my burdened chest became a lot lighter. I felt free because I had a family to share it with. When I revealed my status to my family, they were able to help me more. Now, I feel closer to them. (PL 11)

Likewise, rebuilding relationships with peers helped participants cope with their illness and have a positive outlook in life:

I had a bad case of lung problems before, but now, I started to go out with my friends and have conversations with them. I feel I'm okay now that I have recovered and regained my

health. I feel I do not have the stigma anymore. What made me lose it was when my friends started to accept me and involve me back. (PL 03)

I tried before to open myself and tell everything to a trusted friend gradually. I told him about my situation and what this disease is all about. Thank God he understood me[...] I was expecting him to despise me, and yet it did not happen. He was able to have an open mind to accept me and to understand this disease. There I lost my stigma. (PL 1)

The participants expressed how being with their support group helped them understand their situation more and gave them a sense of purpose.

LGS (Learning Group Sessions) helped me. The members were my source of strength and determination to live. They convinced me to save myself by taking my medicines. It was so hard, but I endured all the itch and allergic reactions just to survive. When I attended the LGS, the group was able to convince me to take my meds. I started with my anti-TB drugs, then ARV after two weeks. (PL 05)

That is why when I hear the sad stories of a new co-PL, I can get strength from it to move forward. I feel inspired when I can save people. I convince them to be aware of their HIV status to get into treatment in the hub. I am happy to see them alive. It gives my life meaning and purpose. I can cope with my problems when I can relate it with people who also need help. (PL 01)

4. Discussion

The results revealed that HIV stigma is an experience that is real to a person living with HIV. The experience of stigma sheds light on the corporeal response of a person going through the process of emotional lability to stability. The derived themes were compared to existing studies.

4.1 Psycho-socio-emotional longingness of a stigmatized PLHIV

The majority of the longingness of a PLHIV were psycho-social and psycho-emotive in nature. The tripartite psycho-socio-emotional longing is most dominant primarily because stigma is an experience rooted in a person's social circle, which also explains their need for emotional safety as explained by their desire for acceptance and protection of their human rights. The need for love and acceptance is anchored in three dimensions. First is the longing for *intimacy*, or the desire to have or maintain a partner who will accept them despite being diagnosed with HIV. As the participants in this study, most PLHIVs are scared of the inability to form love and sexual relationship with a partner out of fear of rejection, devaluation, and abuse (Durbin et al., 2017; Handlovsky et al., 2022). The need for love and acceptance also roots in their tendency to remain socially and emotionally connected with their family and friends. This pertains to the need for *interconnection*. The family's primary function is to accept its members regardless of oddities and uncertainties challenged in the presence of HIV. Unfortunately, HIV stigma is not exempted even in the family. Although there are reports of untoward reactions of the family, the perceived stigma of the PLHIV himself remains as the main ingredient for nondisclosure of HIV status towards family and friends out of fear of rejection, ostracization, and maltreatment (Shrestha et al., 2019). At present, researchers are still trying to understand the complexity of HIV stigma. HIV stigma and discrimination as a phenomenon is too convoluted to decipher linearly because of its multiple socio-cultural issues and intersectionalities (Andrasik et al., 2020). Perhaps this explains why the need for *inclusiveness* has long been felt, yet a concrete approach and resolution have not been attained. The experience of discrimination and stigmatization by the participants of this study is similar to existing literature (Beck et al., 2017) which found that issues such as gender insensitivity, homophobia, prejudiced social classifications, and the blunt deprivation of human rights due to HIV diagnosis discriminatory experiences of a person living with HIV/AIDS. Based on these experiences are their need for love and acceptance, which is mainly resonated in their hope to be accepted equally in a society without prejudice and discrimination.

4.2 Feelings of a stigmatized PLHIV

A PLHIV experiences a collection of feelings that usually initiates denial, along with complex and perplexing negative emotions. The surge of feelings tests the sensibility threshold of a person, hence the term *emotional challenges*. Our results are similar to those found by several scholars who have contextualized the negativity felt by a person experiencing stigma, which affects the physical and emotional well-being (Andersson et al., 2020; Stockton et al., 2018). The negative feelings may include fear, self-pity, loneliness, desolation, depression, self, or enacted stigma, which leads to emotional changes in the life of a stigmatized PLHIV. The feelings of shame and guilt take over and are carried daily, which may afford no resolution, especially when the person remains closeted and lacks a support system (Cantisano et al., 2015; Heggeness et al., 2017). Mao et al. (2018) stressed the importance of having adequate support systems such as family, friends, and social services catering to the needs of a PLHIV to augment their general well-being. A healthy perception of social support makes them more adaptive to the challenges and changes they are experiencing. The stigma in a person with HIV harbors negative feelings longer because of the emotional tension, as they hurdle the physical and psychological burden of the disease.

Through the course of the denial to acceptance, a PLHIV is tasked to make life-changing decisions, and it is at this stage, he has to appraise his emotional competence, hence the term *emotional choices*. This is the period when a budding feeling of motivation starts to set in. A signal that the need for resolution is emergent, either to build resilience or to quit. There is a conflicting tug of war of feelings of holding on and letting go that they need to settle to move forward. Wei et al., (2016) suggested that recognizing and identifying these feelings will facilitate emotional understanding and, consequently, better coping skills. This is similar to the findings of Tuppal et al. (2019) explaining how a person living with HIV/AIDS goes through life stages, where choices are to be made to destroy and remain stigmatized or ascend the self from the emotional and life challenging consequences of HIV. This is the period of emotional chances. Emotional changes refer to the opportunity to live again, tainted but not destroyed, restructured, renewed, but remain as the same person through coping.

4.3 Coping with HIV stigma

A PLHIVs effective coping mechanism is lifted from their 3 S's of coping: Social Circle, Spirituality, and Self-love. A PLHIV copes with stigma through the help of his *Social Circle*. The social circle includes family and friends who can be sources of holistic coping and recovery. Maintaining a sound support system is vital to make a PLHIV more interactive, adaptive and cope effectively with his disease and stigma elimination. The involvement of family members in the course of therapy is proven to be effective in stigma reduction and enhancement of supportive relationships with a sick family member (Harrison & Li, 2019; Huang et al., 2019). Friends are necessary for positively influencing a person with an incurable illness (Doherty et al., 2019). Friends help provide ill persons' practical and psychosocial support, which is beneficial to the process of coping among those suffering from serious conditions such as HIV.

On the other hand, *Spirituality*, as a coping mechanism, involves a connection or a relationship with an eternal being much greater than the self. A PLHIV copes with his stigma by creating a solid spiritual foundation with God and enriching it through prayers. Studies have supported the essentiality of spirituality in reducing anxiety and the development of hope and well-being of a person undergoing a challenging time (DiPierro et al., 2018; Philip et al., 2019). Fundamentally, coping through his religion and having a sense of spirituality is beneficial to a person living with stigma because it aids in their psychosocial and cognitive functioning.

The essential coping, which is considered the key to unlocking and releasing the tension of stigma, is *Self-love*. Self-forgiveness is a form of self-love that entails emotional freedom. For a PLHIV to be genuinely free, is to focus on the self and disregard what other people say and think. To self-love is to be at peace with the self, which is attained through self-acceptance, self-forgiveness, and self-efficacy. Forgiving of self is necessary to relieve the psycho-emotional stress resulting from the stigma and, at the same time, has been proven to improve health and well-being (Sezgin & Erdoğan, 2018). This indicates that persons who have forgiven themselves have improved their self-efficacy, primarily because of their willingness to perform tasks to uplift their morale out of their motivation. It indicates effective coping when a PLHIV considers compliance and adherence to his ART an essential responsibility.

5. Implications and limitations

Participatory drawing techniques may be integrated by health practitioners in their care for clients with HIV, especially the newly diagnosed and are in the process of adjusting to their disease condition. The enjoyable and entertaining character of the participative drawing-sharing session facilitated the voicing and articulation of rich qualitative information of PLHIVs' life experiences on HIV stigma. The sharing session allows fluidity of expressing their deepest emotions, and to share more of their experiences knowing that their peers share the same feelings of stigma experience. The use of art in HIV research and its integration in the care of PLHIVs is an authentic and ethically sound method because of its inherent potential to legitimately illuminate the personal and lived realities as they become engaged and engrossed to produce a visual craft from their creativity. Participative drawing as a qualitative method in assessing HIV stigma is adequate to illuminate an in-depth expression of the participants' lived experiences, emphasizing their perceptions, thoughts, views, and feelings. The illuminated experiences of stigma in this study provide a lens to practitioners on how to assist PLHIV clients in their needs effectively, coping with their disease, selecting healthier options, and living a meaningful life.

This study is limited to only a specific group of MSMs who were members of a support group. Considering the closeted nature of PLHA, the researchers opted to seek the aid of support groups leaders to ensure recruitment of participants. Future researchers are encouraged to assess other groups to determine the usability of drawing to determine a PLHIVs lived experience of stigma. Second, the data collection was lifted only from the different experiences of the available participants, future researchers may do participant triangulation involving various PLHA coming from different groups such as commercial sex workers, sea farers and others on high-risk groups. Given the limitations, the findings of this study may be considered preliminary.

6. Conclusion

The study adds to the body of knowledge on the usefulness of applying a participatory approach and visual art in health, particularly in HIV/AIDS research. For a stigmatized PLHIV, they yearn the sense of belongingness, respect, and nondiscriminatory treatment to practice their rights as persons. The experience of stigma results in feelings and responses that evolve from negative towards positive adaptation through self-help and coping with spiritual and support systems. This study acquired the usability and facility of drawing to facilitate the expression of PLHIVs' experiences and thoughts on stigma. Future researchers may consider integrating participative drawing method to explore intensively and expound participants narratives in explicating their lived experiences.

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Conflict of interest

The author declares no conflicts of interest relative to the release and publication of this manuscript.

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