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Negotiating and Struggling for a New Life: Stigma, Spirituality, and Coping Strategies of People Living with HIV in Myanmar

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Abstract

Although enacted and internalized stigma is a continuing problem for people living with HIV (PLWH) in Southeast Asia, there is little understanding of how PLWH cope with discrimination, exclusion, and other negative outcomes caused by HIV-related stigmatization. This article aims to bridge this gap by analyzing the lived experiences of HIV-related stigmatization and coping strategies among 30 people with HIV in Myanmar, a country heavily influenced by religion, especially Buddhism. Among the 30 study participants, 20 were female and 10 were male, with ages ranging from 18 to 50 years. Through the lens of Bourdieu's concepts of habitus, field, and capital, this article first elucidates the various forms of stigmatization in family, work, social, and other settings as symbolic violence on people with HIV. The present article shows that spirituality serves as a perceptual and action framework for people with HIV to generate reflexivity toward their HIV infection and related stigmatization and to further engage in agentic responses. More importantly, this article demonstrates how people with HIV draw on spirituality to support peers in reclaiming control over their lives and how they are perceived by society. The findings indicate that the local context, especially cultural and religious resources, should be considered when developing interventions to mitigate HIV-related stigmatization in Southeast Asia.

Keywords: people with HIV, stigmatization, spirituality, agentic responses, Myanmar, Southeast Asia

Introduction

Myanmar, with a population of 54 million, is located where South Asia, East Asia, and Southeast Asia converge. Given its critical location, Myanmar has long served as a cultural crossroads.[1,2] Endowed with an abundance of natural resources, Myanmar was once called *Suvarnabhumi*, or the "Land of Gold," in Sanskrit.[3] Over the past two centuries, however, Myanmar has been highly politically unstable and has experienced a series of collective traumas, including British colonization, military rule, and civil wars.[3,4] As a result, Myanmar remains one of the poorest countries in Southeast Asia In 2021, Myanmar had a gross domestic product (GDP) per capita of $1,149.2, which decreased to 22.33% compared with 2020.[5] The country's poverty rate increased from 24.8% in 2017 to 46.3% in

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2022.[6] Myanmar has also been among the countries that spends the least GDP on health care worldwide, resulting in a severely inadequate health care infrastructure, a shortage of health services, and low life expectancy.[7] The life expectancy in Myanmar is 66.8 years,[7] which is much lower than the world average of 72.27 years.[7]

Experiences of people living with HIV in Myanmar

After the first case of HIV was diagnosed in 1988, the HIV epidemic rapidly escalated over the next decade, particularly among stigmatized populations, such as substance users and sex workers. This resulted in Myanmar having the third largest population of people living with HIV (PLWH) in Southeast Asia.[8] Owing to intensive interventions by international nongovernmental organizations (NGOs), the HIV infection rate leveled off during the early 2000s. However, the findings from the recent global IeDEA survey show that the lowest level of retention in care for PLWH is in the Asia-Pacific region (53.8%) compared with other parts of the world, that is, East Africa (82.7%).[9] Similar to their counterparts in the Asia-Pacific region, PLWH in Myanmar suffer from high attrition rates from the HIV care continuum[10–12] and low treatment coverage rates. As a consequence, HIV remains among the top 10 causes of death in Myanmar.[7] Adding to these challenges, large NGOs withdrew from Myanmar in 2020 as well as after the recent military coup, rendering many without vital support. Owing to necessity, PLWH returned to the local health care system;[13] however, many facilities were no longer providing HIV care because of resource limitations. Hence, there is an urgent need to optimize HIV care and to scale up treatment coverage in Myanmar.[14,15] However, evidence regarding HIV care remains extremely limited, and few studies have explored how to manage potential barriers to care, such as HIV stigma, in PLWH in Myanmar.

HIV-related stigma has been defined both as a social determinant that limits access to health resources, social support, and other connections and as a social process that contributes to producing and reproducing a cycle of power and control. Stigma causes people with HIV to be devalued and perceived to be inferior to other people.[16] Although research into HIV stigma in Myanmar is severely limited, a few existing studies hint at its detrimental effects on Myanmar PLWH and those vulnerable to HIV, particularly women living with HIV. According to a 2010 UNAIDS report, out of 324 surveyed PLWH in Myanmar, more than one-third reported being excluded from social activities because of their HIV status, while $\sim$60% experienced negative self-perceptions such as shame or feeling deserving of punishment.[17] These distressing encounters contributed to a quarter of the respondents experiencing suicidal thoughts. Another study revealed that more than two-thirds of 172 HIV-positive women in Myanmar experienced some form of HIV stigma, which significantly impacted their quality of life, as did factors such as age and household income.[18] In addition, HIV stigma was linked to reduced utilization of HIV preventive care services among HIV-negative men who have sex with men (MSM)[19] and transgender women in Myanmar, as well as among Myanmar female sex workers along the Myanmar-China border.[20] Among HIV-positive Myanmar migrant workers in Thailand, HIV stigma acted as a barrier to accessing necessary HIV care.[21] However, a gap remains in published studies that explore the experiences of PLWH in Myanmar with HIV stigma beyond the UNAIDS report, particularly concerning how PLWH navigate stigma when engaging in their care and how local culture influences the experiences of HIV stigma. This dearth of evidence significantly impedes the development of culturally sensitive interventions to support PLWH in coping with HIV stigma and promoting healthy behaviors, including engagement in HIV care.

In Myanmar, Buddhism has a profound influence on culture, much similar to the neighboring countries such as Cambodia, Laos, and Thailand. Buddhism forms the bedrock of Myanmar culture, serving as an overarching ideology and civic religion that offers a unified symbolic framework for interpreting and organizing daily life.[22] Approximately 90% of Myanmar's population are identified as Buddhists, and Buddhist principles permeate nearly all aspects of social existence.[23] To fully understand stigma among PLWH in Myanmar and to design effective interventions for stigma reduction, it is crucial to contextualize HIV stigma within the local Buddhist Myanmar culture. This involves examining cultural perceptions of health, illness, and HIV stigma, as well as actions taken to combat HIV stigma.

Central to the Buddhist philosophy is the concept of karma, which provides a guiding principle for understanding the causes and effects of both the material and the metaphysical realms that include health and illness. Karma represents the cumulative effect of an individual's past choices and actions, extending across previous lifetimes. Consequently, illness is often viewed as a manifestation of past poor choices, or "bad karma."[24,25] This may include failing to acknowledge and relinquish strong emotions (*vedana*), leading to craving and attachment to certain ideas (*drsti*) or material things (*kama*), resulting in suffering (*dukkha*).[26,27] To alleviate suffering, individuals are encouraged to both gain insight into the impermanent nature of the material world, including notions of "face" and social status, and to follow the Noble Eightfold Path, which includes practices such as meditation and mindfulness, to attain enlightenment.[26,27] Through this journey, individuals may gradually reduce their attachment to desires while cultivating compassion and acceptance toward themselves and others.[24] In addition, accruing merit through virtuous actions, such as self-discipline and aiding those in need, can mitigate bad karma and suffering in future lives.[28,29]

The objective of this article is to explore how Buddhism impacts stigma and coping with HIV-related mental stress in the context of the Buddhist Myanmar culture. These findings will inform the development of culturally sensitive interventions to reduce stigma and, ultimately, assist PLWH in finding inner peace and harmony by gradually relinquishing the desire for social status that contributes to their suffering from HIV stigma.

Theoretical perspective on HIV-related stigmatization

Much work on stigma related to HIV and AIDS in Southeast Asia has countered the prevalent misinformation on HIV infection and the misrepresentation of HIV as a "social evil" and explored its negative consequences for PLWH.[14,15] However, previous works have overlooked how stigma against PLWH is constructed in relation to broader social inequalities and the exercise of power. HIV-related stigmatization and discrimination are not uncontested by those subjected to them. Instead, PLWH have the potential to generate a reflexive understanding

of their infection and "agentic practice" to challenge prevalent HIV-related stigmatization and discrimination experiences.[30,31] Reflexive understanding and agentic practice among PLWH may be rooted in Bourdieu's concepts of habitus, capital, and field.[32–34] Together, these concepts urge us to think both socially and relationally but with a focus on the immediate lived experiences of PLWH and their responses to HIV-related stigmatization and discrimination.

Habitus can be understood as "a system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations, and actions and makes possible the achievement of infinitely diversified tasks."[32] Created by cumulative engagement with particular social conditions, habitus structures people's understandings of their "fit" within society, as well as associated practices and actions within particular social relations or settings. Inspired by previous religion studies based on the Bourdieusian framework, this study deploys the concept of habitus to investigate a set of frameworks of perceptions and actions that study participants generated from the pan-Buddhist spirituality, which is deeply rooted in their family, community, and broader Myanmar society.

For Bourdieu, society is best understood as an ensemble of fields, or settings, each of which is bestowed with particular values, hierarchies, regulatory principles, and power relations.[34] One's position in the field is determined by one's possession of different types of capital, including economic capital, social capital, and cultural capital. This study uses the concept of cultural capital to investigate the Buddhist practices and doctrines that study participants mobilize to change how they are perceived and reclaim control over their lives. The lens of social capital is also used to investigate social networks and support embedded within the PLWH community, including NGOs that work for better health care, HIV infection and prevention education, and other collective activities to resist HIV-related stigmatization and discrimination.

Symbolic violence refers to the process through which symbolic systems (words, images, and practices) promote the interests of dominant groups as well as the distinctions and hierarchies of ranking between them while legitimating that ranking by convincing the dominated to accept existing hierarchies through processes of hegemony. In this study, we focus on the symbolic violence to which PLWH may be subjected, and the ways in which HIV-related stigma may be used as a resource to keep PLWH "down" (where one group is inferior to another) or "away" (where one group excludes another from particular settings).[31]

Habitus is both creative and inventive, making space for improvisation by agents in response to the stimuli and structure of particular settings and circumstances.[34] At times of crisis, where "the routine adjustment of subjective and objective structures" may be "brutally disrupted," a heightened level of reflexivity may be triggered—enabling the development of a new sense of self and one's position in society. This, in turn, may support the creation of new ways of acting and new forms of habitus. Reflexive and agentic practices may be especially evident in the creative and positive responses of affected individuals living with HIV who seek to redefine what it means to live with a serious life-threatening condition.[35,36] In this study, HIV infection and the stigma that follows not only rapidly worsened the physical and mental health of its sufferers, but also deteriorated social status across settings. After experiencing the rapid, damaging effects of HIV-related stigma, study participants draw on their pan-Buddhism, a spiritual habitus to redefine their HIV infection and, following stigmatization, mobilize different resource networks to receive medical care and therapy, and, most importantly, engage in collective action to challenge HIV-related stigma.

Methods

Study design

This study uses a qualitative research design involving 30 individuals who are living with HIV and who reside in Myanmar. One-on-one, in-person, in-depth, semi-structured interviews were used to gather insights into the influence of social capital, stigma, and spirituality on the coping strategies used by PLWH in Myanmar. The study inclusion criteria were as follows: (1) aged 18 years or older; (2) confirmed HIV-positive status; (3) resides in Myanmar; and (4) willingness to participate in an in-depth interview that lasted approximately 1 h. To analyze the data generated by the in-depth interviews, a content analysis approach was used.

All interviews were conducted in Burmese. The interviewers followed an interview guide to facilitate discussions with the participants regarding their personal experiences with HIV, their spiritual practices both before and after their HIV diagnosis, and their coping mechanisms. Specific questions included the following: "Could you share with me how and when you became aware of your HIV status?" "Are you affiliated with any religious faith? If so, which one?" "Could you describe your religious practices and how they have evolved, especially since receiving your HIV diagnosis?" "How has spirituality played a role in your life, and have there been any changes in this aspect since your HIV diagnosis?" "Could you elaborate on your relationship with your family before and after your HIV diagnosis?" In addition, interviewers asked participants to describe a particular experience where they used spirituality as a means of coping with a stressful situation—this experience might involve moments such as feeling a direct connection with higher power or experiencing a profound sense of well-being. Typically, the participants took the lead in these discussions, with interviewers providing guidance and prompts as necessary.

Setting and participants

In this study, we recruited all potential study participants from the membership list of the Myanmar Positive Group (MPG). The MPG is a national network of PLWH in Myanmar and is the largest NGO that provides direct psychosocial services to, and advocates for, PLWH in Myanmar. Supported by the United Nations Development Programme and the International HIV/AIDS Alliance, the MPG started with 49 self-help groups in 2005. The mission of the MPG is to network and build capacity among PLWH, reduce HIV stigma in the PLWH community, represent PLWH in the national policy arena in Myanmar, and advocate for greater access to treatment and services, including training peer counselors and establishing self-help groups. Currently, the MPG has more than 180 self-help groups operated by peer support case managers throughout the country and has a membership of more than 9000 PLWH. The MPG staff distributed recruitment invitations to its 80 chapters across Myanmar. Prospective participants throughout Myanmar then contacted the central MPG office in Yangon and arranged for an in-person visit to Yangon's office for the purposes of data collection. In this article, we focused on how coping strategies have been impacted by spirituality, stigma, and cultural and social capital among PLWH in Myanmar.

Ethical considerations and recruitment

This study was approved by the involved institutional ethical review boards, and the research was completed in accordance with the Declaration of Helsinki as revised in 2013. Potential PLWH participants were identified with assistance from staff at the MPG, including peer counselors and administrators. An information sheet explaining the study was disseminated to all PLWH clients who met the study's eligibility criteria. The MPG staff referred prospective participants to the study staff, who described the purpose and procedures of the study in detail, answered questions, and assessed eligibility and willingness to volunteer. Participants provided consent, were told that they did not have to participate or answer any question(s) they did not want to, and that services would not be withheld if they chose not to participate. After providing consent, participants completed an in-depth interview in Burmese. Upon completion of the study activities, all participants were compensated for their time.

Data analysis

In our qualitative data analysis, MAXQDA 2020 software[37] was used to facilitate coding and conduct the content analysis, following the approach outlined by Hsieh and Shannon.[38] The process involved the following several key steps: (1) Translation and Back Translation: Initially, all in-depth transcripts were translated from Burmese into English by two professional translators. Subsequently, these translations were back-translated to ensure accuracy. To further enhance precision, two bilingual researchers proficient in both English and Burmese languages performed additional back-translation into Burmese, striving to maintain content fidelity. (2) Code Generation and Categorization: After linguistic congruity was achieved, the authors coded the English data into broad topic categories, with a specific focus on spirituality, cultural and social capital, and stigma. The objective was to summarize the range of responses obtained from the participants. (3) Individual Examination of English Transcripts: The English transcripts were independently scrutinized by the researchers. Codes were assigned to correspond with emerging themes present in the narratives. (4) Collaborative Coding Discussion: The authors engaged in discussions regarding the coding process to address any disparities in code interpretation and assignment, and to identify overarching patterns observed within the data. (5) Quotation Selection: Finally, relevant quotations related to spirituality, cultural and social capital, and stigma were chosen for publication. This rigorous approach to data analysis ensured the accuracy, consistency, and depth of our qualitative findings, shedding light on the intricate relationship between these factors and the coping strategies used by individuals living with HIV in Myanmar.

Results

Two times as many HIV-infected women as men participated in the study (20 females and 10 males), and the participant ages' ranged from 18 to 50 years. Most male participants (90%) were MSM. Half of the study participants ($n = 15$) were not working at the time of the interviews. In terms of marital status, 40% ($n = 12$) were married and two participants were widowed.

Three distinctive themes emerged from the participant narratives. These themes were (1) how people were impacted by discrimination and stigma, (2) how they used cultural spirituality to cope with HIV, and (3) how spirituality fueled reflective practices to ameliorate HIV-related stigma in Myanmar. These three themes were synthesized from participants' coping strategies and experiences with spirituality. In this article, participants displayed various points of reconciliation with their current situation with HIV. Each participant's story serves to remind us of how stigma in Myanmar has impacted PLWH and influenced their spirituality.

Theme one—"I was ashamed to death at that moment": HIV-related stigmatization as symbolic violence

There was a general consensus among the study participants that HIV-related stigmatization was a common experience. In line with the findings of other studies in Southeast Asia,[39,40] HIV-related stigmatization occurred within families, neighborhoods, workplaces, and health care settings. False HIV-related perceptions, that is, exaggerated fears of HIV infection and misperceptions about HIV transmission, were seen to be the main causes of the discrimination and stigmatization experienced by the study participants. A middle-aged gay man reported how the misperception of HIV transmission led to the HIV-related discrimination he experienced in the workplace.

> My friend saw me taking medication and told colleagues. And then the other colleagues asked me. I tried to deny it but they believed in my friend's words and discriminated against me. They didn't want to stay close to me although we worked together in the same shop. And they told other people in the shop. Then the other people also discriminate against me. They said, "Don't stay close to him. You'll also get infected."

A gay sex worker who was also a dancer at nightclubs admitted that the misperception of HIV transmission resulted in the discrimination she experienced within her own family.

> My sisters do not allow me to kiss my nephews and nieces on the mouth and to be cautious about my behavior when playing with them. They were concerned about the possibility of transmitting to the kids.

A 43-year-old widow and housewife experienced misinformation about HIV infection and mortality, which led to discrimination and isolation in daily interactions with her sister-in-law and other family members.

> Even my sister-in-law discriminated against me. During the hot summer months, I would go into their room to apply thanakha after showering. However, my sister-in-law would always wash the flat stone used for grinding thanakha with warm water after I used it, making me feel bad. This was just one example of the domestic discrimination we faced. People didn't speak to us directly, but rather talked behind our backs and looked down on us as if my husband had died from AIDS and we were going to die soon too.[1]

Moreover, participants' accounts echoed the findings of recent studies and indicated that HIV-related stigmatization and discrimination operate as symbolic violence to keep PLWH "down" and "away" in different social settings.[30,31] In

[1]Thanakha (သနပခါး) is a paste made from ground bark. It is a distinctive feature of the culture of Myanmar, seen commonly applied to the face and sometimes the arms of women and girls, and is used to a lesser extent by men and boys.

Myanmar, a country dominated by ideologies of masculinity and patriarchy,[41] HIV-related stigmatization intertwines with these dominant ideologies to intensify and reproduce the disadvantaged positions of PLWH, especially females and homosexuals, in different social settings. A young gay man described how HIV-related stigmatization made him morally inferior and drove him to hide his gay identity at home.

> Yes, I got blamed. I could not show my true identity at first. I had to hide it. When I went out with my gay friends but [sic] I had to cover my identity. I dressed as a lady outside but had to remove it when I was back home.

A 47-year-old widow, who was homosexual and worked as a delivery person, shared how HIV-related discrimination connected her HIV infection with sexual misbehavior and caused her blame and doubt from others.

> They looked down on me. They looked at me like I was a slut. I was ashamed to death at that moment.

Moreover, participants reported that HIV-related discrimination was prevalent among employers and that HIV screening is quasi-compulsory when applying for most jobs. This context undermines the possibility for PLWH to obtain a formal, permanent occupation and secure economic independence. One participant shared his experience as follows:

> The requirement of undergoing infection screening had negative consequences on my professional opportunities. I was rejected by Dagon Center and had to decline multiple restaurant job offers. This resulted in a significant loss of potential employment prospects.

Although some participants had obtained permanent occupations and provided financial support to their families, they suffered from discrimination and exclusion from family members. One participant, as the primary breadwinner in his family, complained about his inferior position to his siblings owing to the misperception in his family of the relationship between gay identity and HIV infection.

> Yes. I felt a bit discriminated. Even though I could support my family, I felt a bit inferior for being a gay. I was not treated as equal as my siblings.

As reflected in the participant excerpts, HIV-related discrimination functioned as symbolic violence in different social settings to marginalize PLWH, especially infected females and homosexuals, and further forced PLWH to bear negative critiques from others. Some participants internalized HIV-related stigma and blamed themselves for being infected. One single, homosexual male who worked in a restaurant shared his sense of guilt during the interview.

> I felt I was very unlucky to get this infection. I was very cautious. I lived a normal life with my boyfriend. I just don't know from where I got this infection. I started to feel very guilty and blame myself.

Some participants reported self-isolation behaviors within family, health care institutions, and other social settings in response to discrimination. Rather than criticizing others for discriminating, they isolated themselves from others first. One participant shared,

> I isolate myself from others. I don't want others to get infected from me. I don't want my son to get infected too. So, I isolate myself.

A 38-year-old wife who was running a family business said,

> I did not even want to go out such as going to pagodas and hanging out. I did not go to other people's donation ceremony even I was invited. I became isolated and enclosed. I tried to stay away from the other people. I did not even face my siblings . . . I did not join the family meals as I felt inferior.

A few participants endured suicidal intentions after experiencing discrimination and a rapid decline in social status across social settings. As one middle-aged, married woman, said,

> At that time, I generated the commitment to suicide. Sometimes I wanted to jump off the building without telling my family. Sometimes I wanted to run straight in front of running car and be crushed.

Theme two—"It gives me power to carry on": Spirituality as habitus to redefine HIV infection

Participants' narratives documented their negative reactions, that is, self-isolation and suicidality, after experiencing HIV-related stigmatization and discrimination as a form of symbolic violence across different social settings. Rather than being affected by the damaging consequences of HIV-related stigmatization over the long term, study participants generated a more positive reinterpretation of their HIV infection and a reflective understanding of stigmatization in reference to their spiritual beliefs and practices. In Myanmar, Buddhism has permeated and exerted a strong influence across social settings, which range from the family to its ruling party.[42,43] Most study participants endorsed Buddhist doctrines, that is, rebirth and achieving liberation from *dukkha* or suffering, and conducted spiritual practices such as meditation, whether they were Buddhist or not. Some participants relayed that they had endorsed pan-Buddhist spirituality since early childhood. One participant shared that he inherited the pan-Buddhism spirituality from his parents. When prompted to share how he understood religion and traditions, he replied,

> The way I understand is that traditions are related to my parents. We do tradition as usual. But I give priority to it. Because I believe that there's nothing comparable to Buddha.

Some participants admitted that family and community influences persuaded them to embrace pan-Buddhism spirituality and practices. A middle-aged, unemployed woman shared her experience as follows:

> We have believed in Buddhism since we were young, so we don't need special teaching. Since we were young, we always went to the temple to do good deeds with our sisters, to help others. The monks in the community temple like our sisters. One of my uncles is a big monk in a temple of our community, so we were asked to help when holding religious activities and opening classes or going to worship. So, everything about Buddhism is quite natural for us. I believe that good deeds will be rewarded, and I will do so if I do more good deeds. I always put my spiritual beliefs in my heart when I am in a bad mood, when I have time, and in my ordinary life. There is no set time to do what must be done, from the beginning to think and accept that good deeds will be rewarded. We should also think positively about people and have fewer negative views. It is best to believe in Buddhism without having bad and negative emotions and moods.

As explained by one participant, upbringing in Myanmar provided social environments that ingrained pan-Buddhism spirituality and created durable dispositions to understand encountered challenges and generated spiritual practices. More specifically, participants' narratives revealed that their pan-Buddhism spirituality served as a habitus to generate a more positive attitude toward accepting the changes in themselves and their lives that resulted from HIV infection. A young, unemployed woman explained how she reinterpreted her infection as the *dukkha* in accordance with Buddhism's doctrine of rebirth.

> I believe it's dukkha I have to face for the fault I made in previous life. I feel that I have insulted others in my previous life. And in my current life, I have to experience this challenge and do something good to pay for the fault I made in previous life.

As indicated in the excerpt above, the pan-Buddhist spiritual habitus provided this participant with an alternative framework to reject moral condemnation, which presents PLWH as "social evils" imposed by others. It also has the capacity to redefine her HIV infection as a challenge that she must overcome for a better life.

In addition to being the framework for participants to redefine their HIV infection status, pan-Buddhism spirituality encouraged study participants to have more positive attitudes toward receiving medical treatment. A middle-aged married woman, who worked as a caregiver in a health care institution, conveyed her optimism based on her pan-Buddhism spirituality.

> If we are infected with HIV, as long as we have good thoughts, use the right way to take medical treatment and the right mentality, do good deeds, the Buddha will surely give us with power to carry on.

The narratives of the study participants also documented their more positive HIV symptom management after redefining their HIV infection in reference to their pan-Buddhist spirituality. The positive influences on HIV symptoms are reflected in the answers of two participants.

> [After regularly mediating, praying to God and doing good deeds], I am also taking medication regularly for one year. I hadn't taken medication for 10 years. I just started taking medication only for one year. But up to now I have no signs and symptoms HIV positive. (A single gay middle-aged male who is unemployed)
>
> [Besides accepting the changes in myself after infection], I think it is also important to take medicine regularly. (A young gay male who is employed)

In addition to regularly taking medication such as other PLWH, some participants took further steps and turned to NGOs, including the MPG, for daily life support, medical care, and knowledge of symptom management. They admitted,

> I got support from NGOs. I connected with some organizations which will support me if I am admitted. (A young, single, gay, adult male who is unemployed)
>
> Yes, I did. Sometimes I turn to NGO for help. NGO gives us food. (A single, gay, middle-aged male who is unemployed)

As an embodied set of durable yet flexible dispositions that influence perception and practice, study participants' spiritual habitus further guided them to mobilize different forms of capital to reclaim control over their lives and how they are perceived in different social settings. Buddhist beliefs and practices are dominant in Myanmar and the study participants strictly followed and practiced doctrine, that is, doing good deeds and being kind to others, to reestablish their reputation in social surroundings. A middle-aged unemployed woman explained why she decided to voluntarily help her peers.

> At the beginning, all surrounding people condemned this disease and refused to accept me. Even nurses at hospital looked at me with pity in their eyes . . . Later I decided to do good deeds and help others. I provided assistance to a sister, who was a sex worker and married to a non-infected person. She, like me, was infected when her little girl was very young. So, at that time there was no one to accompany her and take care of her. Her husband needed to work in order to cover her medical expenses, so he could not accompany her. The first two days they gave me money, but on the third day I did not take money as I heard from hospital staffs that the sister's medical expenses were very high and she had two children to raise. So, I decided to take care of her for free. I accompanied her until she died . . . Gradually I found more and more people trusted me and were open to listen to me for suggestions.

As indicated in this narrative, doing good deeds is highly valued in the Myanmar society and used as cultural capital. By actively providing voluntary support to an HIV-infected peer, this participant successfully mobilized cultural capital to construct a new, positive sense of self and voluntarily undertook a social responsibility to support other PLWH.

Theme three—"We should take actions to challenge the stereotype ideology": Spirituality as a source for reflective practices to ameliorate HIV-related stigma in Myanmar

More importantly, the research findings indicate that study participants' pan-Buddhism spirituality as habitus further guided them to generate a reflexive understanding of the position of PLWH in Myanmar society and of the need for collective actions to resist the negative representation of PLWH as "social devils." One participant shared his positive transformation as follows:

> I encouraged them by using my experience as an example. I said to them that this disease became worse if you felt depressed. So don't be depressed. You and I were in the same situation. Look at me, I stayed alive by taking ART. I did good deeds and took medicine regularly. I didn't blame others no matter what they say. I kept my mind clean and good. By doing so, you will feel the benefits of these. Now you become bedridden patient only because you suffered from TB. Don't worry. You will feel better after your TB has been treated. You should do good deeds. Now he is healthy like me by taking ART regularly and I feel pleased to see him getting better.

After experiencing HIV-related stigma and drawing on pan-Buddhism spirituality to accept the changes in themselves and their social surroundings, the study participants generated a more critical, reflexive understanding of HIV-related stigma. Instead of blaming people who stigmatized them, study participants reflexively perceived HIV-related stigma and discrimination as the result of misinformation on HIV infection and prevention, which is common in Southeast Asian countries. Therefore, study participants proactively engaged in public education activities to ameliorate the HIV-related stigma that

is so prevalent in Myanmar society. One devoted Buddhist shared her experience of engaging in public education:

> I have my own experiences [of living with HIV]. I have my own knowledge. I can give training. I can establish organizations. As I am overcoming this by myself, I can help people like me. I can share them as we have [the] same feelings.

Some participants chose to be volunteers for caring for PLWH in health care settings. A middle-aged Buddhist shared the decision-making process for becoming a volunteer in the hospital.

> I had experience in taking care of people like me at a hospital. First was my husband. He was bed-bound for 2 years and I had to take care of him. After that, I can help and support people like me. I empathized on [sic] [with] them because I felt the same. At that time, I did know what to do and where to go. I had to stay away from people even when I went to hospitals. Bearing that in mind, I help other people so that they don't feel bad like me.

One participant shared a similar consideration:

> As I am working in an organization, people in need contacted me. I also do a lot of interviews and share my HIV experiences. People reach out to me. I help people a lot. I tried to send patients to get ART and I sent patients to hospital, too. I helped people to get tested and get treatment. I helped people to get admitted and to get donation. I tried to calm HIV positive boys every year. I organized events and raised funds for HIV positive funeral services. I can help establish HIV support organizations.

Discussion

In this article, we delve into the harmful impact of stigma on PLWH in Myanmar and examine the pivotal role of spirituality and religion in shaping their coping mechanisms in daily life. In this study, participants shared their experiences of discrimination, viewing it as a symbolic form of violence that deeply affected their ability to cope. As symbolic violence further compounded its impact, many individuals turned to religion as a source of solace and peace of mind. Their experiences not only undermined their sense of dignity and self-worth but also posed significant challenges to their psychological well-being and overall quality of life. The stigma they faced was not merely a reflection of societal attitudes but also served as a potent symbol of the violence enacted upon them, both emotionally and psychologically.

Engaging in religious practices, such as prayer, meditation, and religious gatherings, offered refuge from the harsh realities of stigma and discrimination. In moments of despair and hopelessness, turning to religious beliefs provided participants with a renewed sense of purpose and meaning in life. After learning to cope effectively with discrimination, PLWH in Myanmar were willing to lend their empathy and support to their PLWH peers. Through embracing spiritual principles such as compassion, forgiveness, and acceptance, they found the strength to confront stigma and discrimination with dignity and resilience.[44] Rather than succumbing to feelings of bitterness or resentment, many individuals choose to respond to stigma with grace and understanding, drawing inspiration from their religious teachings.

In essence, our study sheds light on the interplay between stigma, spirituality, and coping among PLWH in Myanmar. By elucidating the role of religion as a source of resilience and healing,[45,46] we hope to underscore the importance of holistic approaches to addressing the psychosocial challenges faced by PLWH in Myanmar. Moreover, by sharing the voices of PLWH and acknowledging the significance of spirituality as a coping strategy, we aim to foster greater empathy, understanding, and support from within the health care system and from the broader community.

This article explores how spirituality serves as a source of empowerment for PLWH in Myanmar to modify their relationships with HIV, resist stigmatization, and actively participate in developing peer support networks. Spirituality is deeply rooted in Myanmar's rich religious traditions and is further underscored by the inadequacy of systematic HIV treatment in the region, especially after the recent coup that has left the health care system almost destroyed.[47,48] Moreover, under current Myanmar law, homosexual sex remains criminalized. Legal circumstances further complicate the delivery of prevention services and medical care to MSM by blocking community-based organizations from official state registration and by creating an unfavorable environment for MSM in government-based medical institutions.[49]

Limited access to health care resources, as well as cultural and legal barriers, prevented PLWH from accessing essential medical care and psychosocial support. Especially in this context, spirituality has emerged as a crucial coping mechanism, offering a holistic approach to healing that addresses the spiritual, emotional, and social dimensions of living with HIV.[14]

In Myanmar, spirituality holds cultural and social significance; it is intertwined with daily life and provides a framework for understanding and navigating adversity. For PLWH, embracing spirituality offered a transformative means of reframing their HIV status, moving beyond mere illness to view it as a part of their broader spiritual journey and a path to future reincarnation in the next life.[50] Through spiritual practices such as meditation, prayer, and reflection, individuals are able to find solace and strength in their faith, cultivating a sense of inner peace and acceptance amid the challenges posed by HIV.

Moreover, spirituality served as a powerful tool for resisting HIV-related stigmatization. By grounding themselves in their spiritual beliefs and values, PLWH are empowered to challenge negative stereotypes and misconceptions surrounding HIV/AIDS patients. Rather than internalizing societal prejudices, they draw upon their spiritual resilience to confront stigma with dignity and compassion, fostering a sense of solidarity and belonging within their communities.

In addition, spirituality plays a pivotal role in the development of peer support networks among PLWH in Myanmar. Through shared religious practices and beliefs, individuals are able to forge deep connections and bonds of solidarity with others facing similar challenges. These peer support networks provide a vital source of emotional support, practical guidance, and encouragement, enabling people to navigate the complexities of living with HIV with greater resilience and hope. A recent study on PLWH in resource-rich countries highlighted that resilience and optimism function as buffers against the harmful effects of stigma experienced in health care settings, further lowering PLWH's depression symptoms while increasing their trust in service providers. Therefore, the resilience and hope generated from mutual supportive networks and bonds may be valuable change objectives to target through interventions that aim to reduce depression symptoms or improve engagement in health care systems among people who experience HIV-related stigma in Myanmar.

Limitations

This study has several limitations. First, in-depth interviews were conducted in Myanmar from the summer of 2020 to the winter of 2021. Because of the COVID-19 pandemic and the Myanmar coup on February 1, 2021, participants were limited to those who were able to travel to the study site in Yangon, Myanmar. Therefore, generalizing the findings to every region in Myanmar is not possible. Second, although most of the study participants were Buddhists, several different religions are practiced in Myanmar. Thus, future research focused on spirituality should also consider how other religions impact PLWH in Myanmar. Third, 20 research participants were female, whereas the remaining 10 were male. The unequal gender distribution of the sample undermines its representativeness, although it enables more focus on the specific HIV-related stigma that is faced by females. Fourth, the study was susceptible to researcher bias. Given that translation was dependent solely on a small number of bilingual researchers (Burmese and English), biases could be present in the transcriptions. Finally, this study recruited 30 PLWH in Myanmar, with most residing in Yangon and its vicinity. Therefore, future studies should also include PLWH who live in suburban and rural areas to understand more completely how spirituality and religion have impacted perceptions of HIV-related stigma. However, there is a dearth of research on how Myanmar PLWH internalize and apply these cultural interpretations of illness, suffering, and HIV stigma. This study may serve as one of the first to explore how religion and spirituality impact HIV-related stigma in PLWH in Myanmar.

Despite these limitations, our findings highlight the role of spirituality in empowering PLWH in Myanmar to resist stigmatization and develop peer support networks that can enhance their ability to cope with HIV. By relying on the power of spirituality, health care providers, policymakers, and community leaders can foster greater resilience, solidarity, and well-being among PLWH, ultimately contributing to more inclusive and compassionate approaches to HIV/AIDS care and support in Myanmar.

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Authors' Contributions

H.X.: Writing—original draft (lead); data curation; and visualization. T.W.: Data curation and writing—reviewing and editing. W.H.: Data curation and writing—reviewing and editing. C.S.: Methodology; project administration; and funding acquisition. T.N.N.A.: Investigation and resources. S.M.: Investigation. M.A.: Investigation and resources. M.T.: Investigation; resources; and project administration. S.H.L.: Investigation; resources; and project administration. K.M.M.: Investigation and resources. K.M.O.: Investigation and resources. R.A.: Writing—reviewing and editing. W.C.: Conceptualization; funding acquisition; supervision; writing—reviewing and editing; visualization; and project administration.

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