Proceedings Series on Health & Medical Sciences, Volume 8
Proceedings of the 6th International Nursing and Health Sciences Universitas Muhammadiyah Purwokerto
ISSN: 2808-1021

Barriers and Facilitators to HIV Service Access and Treatment Adherence Among Women Living with HIV in Nueva Ecija: A Mixed-Methods Study

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ARTICLE INFO

Article history:

DOI:
10.30595/pshms.v8i.2001

Submitted:
July 29, 2025

Accepted:
Sept 22, 2025

Published:
Oct 23, 2025

Keywords:

ART; health access; HIV adherence; women living with HIV; transportation barriers; stigma; self-efficacy; mixed-methods; Nueva Ecija; peer support

ABSTRACT

This mixed-methods study explored the barriers and facilitators influencing access to HIV services and treatment adherence among women living with HIV (WLHIV) in Nueva Ecija. The study integrated quantitative data from 100 survey respondents and qualitative insights from 7 in-depth interviews to provide a comprehensive understanding of logistical, systemic, and psychosocial challenges in antiretroviral therapy (ART) adherence. Quantitative results showed that transportation and healthcare costs were the most significant barriers, with 68.3% of respondents reporting difficulty affording transport to clinics (M = 4.27, SD = 0.84) and over 55% citing financial strain in paying for HIV services. Service availability was also a concern, with long wait times (M = 3.64, SD = 1.11) and inconvenient hours (M = 3.34, SD = 1.22) limiting access. Fears of stigma and breaches of confidentiality further discouraged consistent care, with 53.2% worried about being recognized at healthcare facilities (M = 3.79, SD = 1.10). Despite these challenges, self-efficacy scores were notably high. Respondents expressed strong confidence in remembering to take medication (M = 4.42), following treatment plans (M = 4.27), and managing adherence even under stress (M = 4.08). However, social support remained a moderate concern (M = 3.77), underscoring the emotional and relational dimension of adherence. Qualitative findings reinforced these patterns, revealing themes such as transportation hardship, scheduling conflicts, emotional burden, stigma, and the need for supportive, nonjudgmental care. Participants highlighted the absence of nearby clinics, fear of disclosure, and discrimination from healthcare staff as major deterrents. At the same time, many were motivated by their roles as mothers, partners, and believers, emphasizing a deep personal commitment to treatment. Suggestions included expanding peer support groups, enhancing privacy protections, and training healthcare workers in empathy and confidentiality. Overall, the study identifies key structural and psychosocial barriers while recognizing the resilience of WLHIV. It calls for integrated interventions—including logistical support, stigma reduction, and community-based care models—to strengthen ART adherence and health equity in the region.

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1. INTRODUCTION

Access to equitable, compassionate, and consistent care is a cornerstone of quality healthcare for individuals living with HIV. Despite significant advancements in antiretroviral therapy (ART) and service expansion, many women living with HIV (WLHIV) continue to face a complex array of barriers to accessing care and maintaining treatment adherence. These challenges are particularly evident in Central Luzon, Philippines, where recent epidemiological trends underscore the urgency of addressing both systemic and psychosocial impediments to HIV care.

As of December 2023, the Department of Health – Central Luzon Center for Health Development reported a total of 1,671 confirmed HIV cases in the province of Nueva Ecija, marking a considerable public health concern within the region. For perspective, neighboring provinces such as Bulacan and Pampanga reported 4,563 and 3,782 confirmed cases respectively—highlighting a growing epidemic across Central Luzon and reinforcing the need for localized, gender-responsive interventions. These numbers not only reflect the prevalence of HIV but also point to underlying disparities in awareness, access, and care delivery.

Globally, adherence to ART remains a critical factor in controlling the HIV epidemic. The World Health Organization (WHO, 2022) identifies consistent medication adherence as the cornerstone of effective HIV management—reducing viral load, preventing transmission, and improving quality of life. However, women with HIV often encounter intersecting barriers, including limited financial resources, transportation difficulties, fear of stigma, and inadequate family or social support (Marques et al., 2021). In the Philippine context, these are further compounded by gender norms, caregiving responsibilities, and gaps in healthcare worker training.

While self-efficacy—defined as one's confidence in adhering to treatment—remains a protective factor for many WLHIV, its effect is often diminished by discriminatory environments, limited clinic privacy, and negative healthcare interactions (Reyes et al., 2023). Conversely, facilitators of adherence include maternal motivation, spiritual resilience, and supportive peer or community networks. Nonetheless, these positive influences are often insufficient in overcoming structural hurdles.

Despite the availability of ART, little is known about the unique experiences of WLHIV in provinces like Nueva Ecija, where access to care may be inconsistent and tailored services for women remain limited. Current literature often falls short of capturing the dual burden of structural and psychosocial barriers, especially in localized Philippine settings. By using an explanatory sequential mixed-methods design, this study aims to bridge that gap—first quantifying barriers and adherence behaviors through tools like the Barriers to Care Scale (BSC) and HIV Adherence Self-Efficacy Scale (ASES), and then exploring lived experiences through open-ended interviews.

This study seeks to examine the barriers and facilitators that influence HIV service access and ART adherence among women living with HIV in Region 3. Through integrated data collection and analysis, the research aspires to generate localized, actionable insights that can inform regional policy, shape stigma-reduction strategies, and enhance healthcare delivery systems—ultimately empowering WLHIV to engage in lifelong, dignified, and accessible care.

Conceptual Framework

This study is anchored in the theoretical underpinnings of behavioral health access and adherence models, particularly focusing on how structural barriers and self-efficacy influence HIV treatment utilization among women living with HIV (WLHIV). The Figure 1 conceptual framework integrates two validated tools: the Barriers to Care Scale (BSC) and the HIV Adherence Self-Efficacy Scale (HIV-ASES), forming a cohesive model for examining the external and internal factors affecting ART adherence and health service access.

The Barriers to Care Scale (Wright et al., 1998) is a validated instrument that assesses external or systemic impediments to care, including domains such as transportation, cost, scheduling conflicts, provider accessibility, and perceived stigma. These structural barriers are key predictors of delayed treatment initiation and poor retention in HIV services, particularly in resource-constrained or rural settings like Region 3 in the Philippines. The BSC enables the identification of logistical and institutional factors that impact a woman's ability to consistently access HIV treatment and prevention services.

Complementing this is the HIV Adherence Self-Efficacy Scale (ASES) developed by Johnson et al. (2007), which evaluates internal, cognitive-affective constructs such as confidence in remembering to take medication, maintaining adherence under emotional distress, and communicating with healthcare providers.

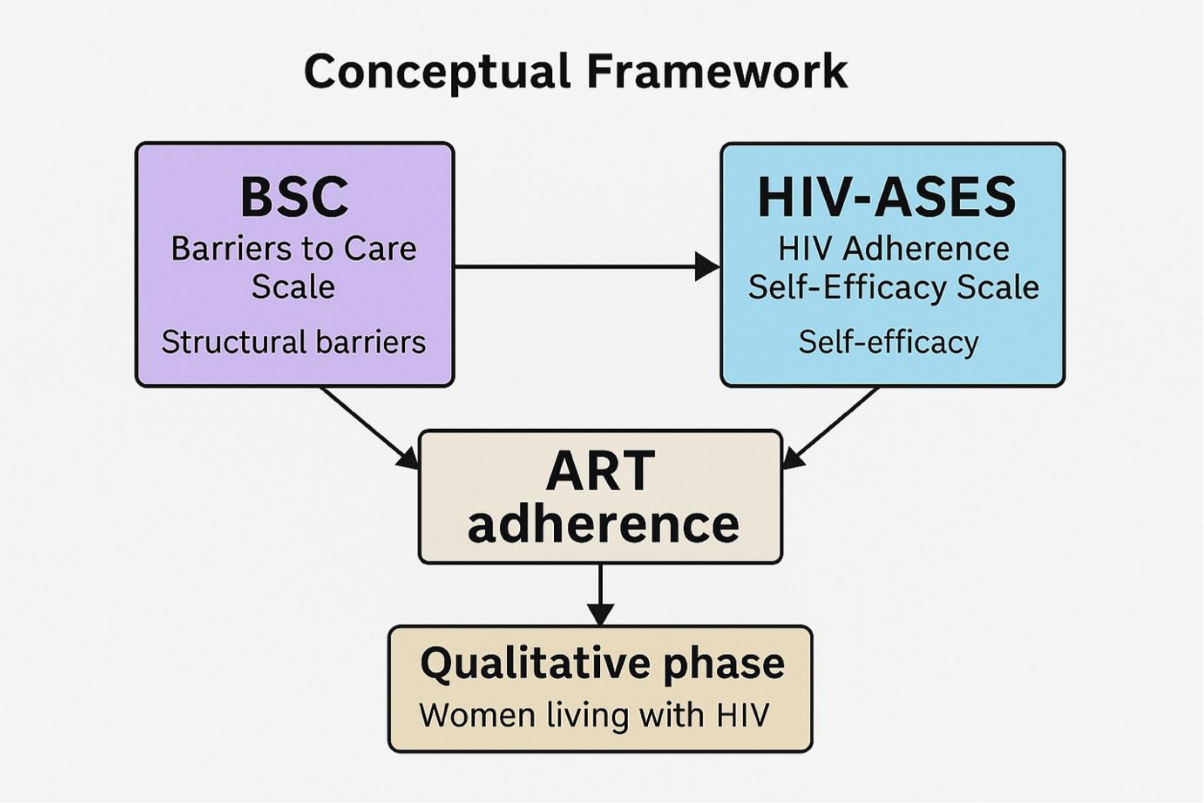
Rooted in Bandura's Social Cognitive Theory (1986), the HIV-ASES recognizes self-efficacy as a fundamental driver of health-related behaviors. High self-efficacy correlates positively with ART adherence, while diminished self-efficacy is linked to disengagement from care and viral rebound.

The conceptual model of this study posits that:

1. Structural barriers (as measured by the BSC) negatively influence ART adherence by impeding access, discouraging clinic visits, and fostering stigma-related avoidance behaviors.
2. Self-efficacy (as measured by the HIV ASES) acts as a moderating factor, where high levels can mitigate the impact of external barriers, enhancing treatment continuity and resilience.
3. Qualitative insights obtained through open-ended questions provide depth and contextual understanding of how WLHIV perceive, interpret, and respond to these barriers and facilitators in their daily lives.

This explanatory sequential mixed-methods design allows for an integrated exploration—quantitatively identifying the prevalence and severity of barriers and facilitators, followed by qualitative elaboration of lived experiences. This framework thus aligns with ecological models of health behavior, acknowledging that both individual agency and structural determinants are essential to understanding and improving HIV treatment adherence.

By utilizing validated tools such as the BSC and HIV-ASES, this study not only ensures methodological rigor but also generates evidence that is both measurable and meaningfully grounded in the social realities of WLHIV in Nueva Ecija. The results are expected to inform patient-centered interventions, strengthen service delivery, and guide future policy and program development aimed at achieving equitable, stigma-free HIV care.



2. RESEARCH METHOD

This study employed an explanatory sequential mixed-methods research design to explore the barriers and facilitators affecting HIV treatment access and antiretroviral therapy (ART) adherence among women living with HIV (WLHIV) in Nueva Ecija. The design began with a quantitative phase using validated survey instruments to identify the prevalence and intensity of barriers to care and levels of adherence self-efficacy. This was followed by a qualitative phase involving open-ended interviews to gain deeper insight into the lived experiences and contextual realities of the participants.

Mixed-methods research is particularly appropriate for complex health issues, allowing researchers to quantify trends while also capturing the nuanced, human dimensions of care experiences (Creswell & Plano Clark, 2018). The initial quantitative phase provided a structured overview of systemic and psychosocial factors, while the qualitative follow-up enriched the data by exploring how these factors are understood, navigated, or overcome by WLHIV in their day-to-day lives.

This design allowed for triangulation of data sources, enhanced validity, and the generation of practical, context-sensitive recommendations to improve HIV service delivery in Nueva Ecija.

Settings and Samples

This study focused on women living with HIV (WLHIV) residing in Nueva Ecija, a province in Region 3, Philippines. Due to the sensitive nature of the topic and the difficulty in identifying eligible participants, a non-probability sampling approach was employed to ensure both feasibility and ethical appropriateness.

Initially, quota sampling was used to guide the recruitment of survey participants, ensuring variation in participant backgrounds and service experiences. However, to reach the target number of respondents, convenience sampling was applied in coordination with local HIV treatment hubs, community-based organizations, and support groups operating within Nueva Ecija. The goal was to recruit 100 WLHIV who were willing and able to participate in the quantitative survey.

Following the survey phase, participants were asked if they would be open to a follow-up interview. From those who consented, seven respondents were purposively selected for in-depth qualitative interviews, based on the richness and relevance of their initial responses. This approach allowed for deeper exploration of their lived experiences while maintaining consistency with the quantitative data.

This dual-sampling strategy ensured a context-specific and ethically sensitive approach to data collection, providing meaningful insights into the factors influencing HIV service access and treatment adherence among WLHIV in Nueva Ecija.

Measurement and Data Collection

The primary data collection tool for this study was a structured questionnaire composed of five sections, integrating validated scales and open-ended questions to capture both quantitative and qualitative data. The tool was carefully adapted to reflect the unique social and healthcare context of women living with HIV (WLHIV) in Nueva Ecija, ensuring cultural sensitivity and relevance.

The questionnaire included the following components: (1) Demographic Profile, (2) HIV Status and Treatment History, (3) Barriers to Care Scale (BSC)-based items, (4) HIV Adherence Self-Efficacy Scale (HIV-ASES)-based items, and (5) Support and Needs. The quantitative items were assessed using a 5-point Likert scale, while qualitative insights were gathered through a set of open-ended questions offered to participants who consented to a follow-up interview.

The Barriers to Care Scale (BSC) explored logistical and systemic challenges such as transportation issues, healthcare costs, limited availability of services, and stigma-related concerns. The items were adapted from the original BSC developed by Wright et al. (1998), and aligned with Andersen’s Behavioral Model of Health Services Use (1995).

The HIV Adherence Self-Efficacy Scale (HIV-ASES) measured internal confidence and treatment management skills. Based on Bandura’s Social Cognitive Theory (1986) and the tool developed by Johnson et al. (2007), this section assessed respondents’ ability to maintain adherence despite physical, emotional, and social challenges.

Participants were also asked whether they believed adequate support systems were available in their area and what services would help them better access and adhere to HIV care. Those who expressed willingness were invited to participate in in-depth qualitative interviews, which explored themes such as personal experiences of stigma, treatment motivations, relationship impacts, and healthcare barriers.

The survey was created and administered through Google Forms to facilitate secure, accessible, and user-friendly data collection. The link was shared through community-based organizations, local HIV treatment hubs, and peer networks within Nueva Ecija. Participation was voluntary and anonymous, with clear instructions and a consent statement embedded at the beginning of the form.

Data collection occurred over a three-month period, from January 1 to March 30, 2025, immediately following approval from the Institutional Review Board (IRB). For participants who consented to the qualitative component, interviews were conducted via mobile phone or in a private, face-to-face setting, based on individual preference and availability. Conversations were audio-recorded with consent, transcribed verbatim, and thematically analyzed to complement the quantitative findings.

Data Analysis

This study employed both quantitative and qualitative approaches to analyze the experiences of women living with HIV (WLHIV) in Nueva Ecija.

Quantitative Data Analysis

Descriptive statistics, specifically frequency, percentage, mean, and standard deviation, were used to analyze the quantitative data. These measures were applied to summarize the demographic profiles of the respondents and assess their responses to Likert-scale items based on the Barriers to Care Scale (BSC) and the HIV Adherence Self-Efficacy Scale (HIV-ASES).

Mean scores and standard deviations were computed for each subdomain—such as transportation barriers, stigma, healthcare access, treatment confidence, and self-efficacy—providing insight into the central tendencies and variations in participants' perceived challenges and capabilities in managing HIV treatment.

Qualitative Data Analysis

The responses from the in-depth interviews were analyzed using thematic analysis. This method involved identifying recurring patterns and meaningful themes related to treatment access, stigma, personal motivation, emotional impact, and support systems. The thematic approach allowed for a deeper understanding of the lived experiences of WLHIV, complementing the quantitative findings with rich, contextual narratives.

This mixed-methods analysis provided a holistic perspective on the barriers and facilitators of HIV treatment and care adherence among women in Nueva Ecija.

Ethical Considerations

Ethical approval for this study was obtained from the Institutional Review Board of St. Paul University Tuguegarao prior to data collection, with approval number: SPUP_2024_0831_SR_CA. The study adheres strictly to ethical principles outlined in the Belmont Report and the framework of Beauchamp and Childress (2019), particularly focusing on respect for autonomy, beneficence, non-maleficence, and justice.

All participants were provided with a clear and detailed explanation of the study's objectives, procedures, potential risks, and benefits. Participation was strictly voluntary, and informed consent was obtained electronically prior to the administration of the survey. Participants were assured that they could decline or withdraw from the study at any point without any consequences or effect on their access to care or support services.

To protect privacy and confidentiality, all responses were anonymized. Personal identifiers were not collected, and each response was assigned a unique code. Data was extracted and securely stored in an encrypted format, accessible only to the primary investigator.

Given the sensitive nature of the topic, particularly the potential emotional impact of disclosing experiences related to HIV status, stigma, and treatment challenges, all questions were framed with empathy and care. Participants who experienced distress were referred to appropriate support services through partner health institutions and local HIV treatment hubs.

Permission to use and adapt the Barriers to Care Scale (BSC) and the HIV Adherence Self-Efficacy Scale (HIV-ASES) was obtained through appropriate citation of the original authors and adherence to usage guidelines. The study ensures that all data collected is used solely for research purposes and for informing future service delivery and support programs for women living with HIV in Nueva Ecija.

By adhering to these ethical standards, the study ensures the safety, dignity, and confidentiality of its participants, while contributing valuable insights to the field of HIV care and adherence research.

3. RESULT AND DISCUSSION

A total of 100 women living with HIV in Nueva Ecija participated in the study. Most respondents were between the ages of 26 to 35 years (38%), followed by those aged 18 to 25 (24%). The majority identified as single (54%) and had attained college or university-level education (48%). In terms of employment, more than half (52%) reported being unemployed, and 46% indicated a monthly household income below ₱10,000. Furthermore, the majority of the participants (62%) resided in urban areas. See Table 1.

Table 1. Profile of the Participants

Variable	Category	Frequency	Percentage
Age Distribution	18–25	38	38%
	26–35	34	34%
	36–45	19	19%
	46–60	9	9%
Marital Status	Single	60	60%
	Married	23	23%
	Separated/Divorced	10	10%
	Widowed	7	7%
Educational Attainment	None	5	5%
	Elementary	15	15%

Variable	Category	Frequency	Percentage
	High School	40	40%
	College/University	30	30%
	Postgraduate	10	10%
Employment Status	Employed	58	58%
	Unemployed	29	29%
	Self-employed	7	7%
	Student	6	6%
Monthly Household Income	Below ₱10,000	40	40%
	₱10,000 – ₱20,000	35	35%
	₱20,000 – ₱30,000	20	20%
	Above ₱30,000	5	5%
Type of Residence	Urban	70	70%
	Rural	30	30%

Regarding HIV status and treatment history, 72% of respondents reported that they were currently receiving antiretroviral therapy (ART), while 28% were not. Among those who were not on treatment, the primary reasons cited included stigma or fear of discrimination (18%), financial constraints (16%), and lack of awareness about available treatment (10%). Additionally, 31% of the respondents reported experiencing side effects from their HIV medication, such as fatigue or nausea. Notably, 22% acknowledged having missed at least one dose of ART in the past month, most often due to forgetfulness, emotional distress, or daily life disruptions. See Table 2.

Table 2. HIV Status and Treatment History

Variable	Category	Frequency	Percentage
When were you diagnosed with HIV?	Less than 1 year ago	30	30%
	1–2 years ago	41	41%
	3–5 years ago	19	19%
	More than 5 years ago	10	10%
Currently receiving ART?	Yes	69	69%
	No	31	31%
Reasons for not accessing ART *(n = 31)* *(multiple responses allowed)*	Lack of awareness about ART	9	29%
	Fear of side effects	13	42%
	Stigma or discrimination	10	32%
	Financial constraints	16	52%
	Access issues (e.g., clinic location)	6	19%
	Other (e.g., personal reasons)	4	13%
Experienced side effects from ART? *(n = 69)*	Yes	40	58%
	No	29	42%
Missed ART doses in the past month? *(n = 69)*	Yes	21	30%
	No	48	70%

The analysis of perceived barriers to care revealed moderate to high levels of difficulty across several domains. Transportation-related challenges received a mean score of 3.42 (SD = 0.91), while healthcare cost barriers scored a higher mean of 3.65 (SD = 0.88). Service availability challenges were also notable, with a mean score of 3.21 (SD = 0.95). The highest mean scores were observed in fear of stigma and discrimination (mean = 3.83, SD = 0.76) and health system barriers (mean = 3.58, SD = 0.84), indicating that these were the most significant obstacles reported by participants. See Table 3.

Table 3. Barriers to Care (BCS-Based Questions)

	Statement	Mean	Standard Deviation
Transportation Barriers	Difficulty accessing facility	3.8 1	1.06
	Long distance to HIV care	4.0 9	0.91
	High transportation costs	4.2 7	0.84
Healthcare Costs	HIV treatment is a financial burden	3.6 3	1.18
	Cannot afford HIV medicines	3.7 6	1.13
	Difficulty paying healthcare services	3.8 7	1.07
Availability of Services	Services not available in area	3.1 3	1.29
	Inconvenient clinic hours	3.3 4	1.22
	Long waiting times	3.6 4	1.11
Fear of Stigma or Discrimination	Fear of being judged by healthcare providers	3.4 2	1.28
	Worry about being treated differently	3.6 1	1.17
	Fear others will find out HIV status	3.7 9	1.1
Health System Barriers	Providers do not understand my needs	3.4 4	1.24
	Uncomfortable discussing treatment	3.5 8	1.19
	Worry about confidentiality	3.7 2	1.08

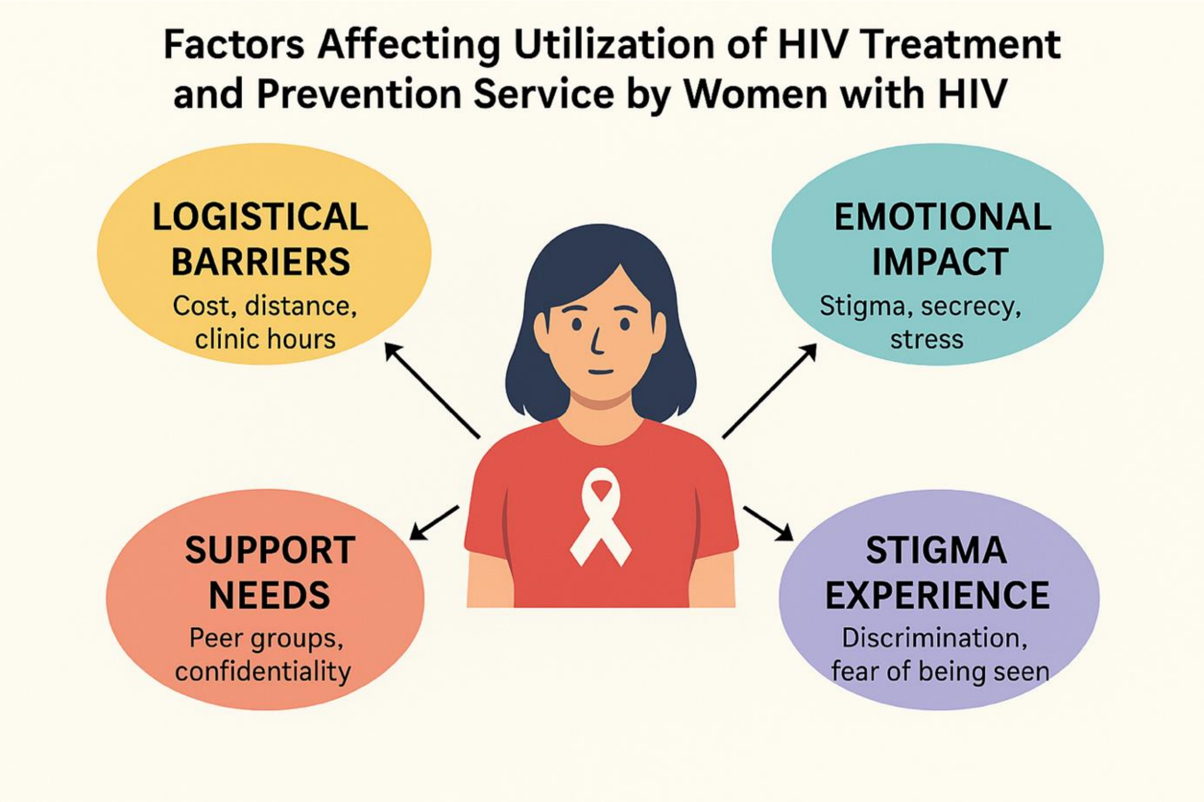
Conversely, participants demonstrated moderately high levels of self-efficacy in adhering to HIV treatment. The HIV Adherence Self-Efficacy Scale (HIV-ASES) revealed a mean score of 4.02 (SD = 0.61) for confidence in medication adherence, while overcoming personal or situational barriers had a mean score of 3.78 (SD = 0.73). Adherence to treatment routines scored a mean of 3.94 (SD = 0.69), and the ability to maintain treatment despite lack of social support or experiences of stigma had a mean score of 3.57 (SD = 0.88). These findings suggest that, while adherence confidence is generally high, social pressures and stigma continue to affect overall treatment management. See table 4.

Table 4. HIV Adherence Self-Efficacy

Category	**Items**	**Mean Score Range**	**Interpretation**
Confidence in Medication Adherence	Remember medication regularly Follow treatment plan Handle treatment when stressed	4.08 - 4.42	Very high confidence and emotional resilience

Category	Items	Mean Score Range	Interpretation
Overcoming Barriers	Take medication when tired/sick Manage when busy Stay on treatment when stressed/anxious	3.91 - 4.13	High confidence; needs minimal support
Adherence to Treatment Schedule	Remember doses when busy Keep track of schedule	3.96 - 4.21	Organized; benefits from reminders
Social Support and Stigma	Adhere without support Adhere despite stigma	3.74 - 3.81	Moderate resilience to stigma and lack of support

Qualitative data gathered from in-depth interviews with seven participants further contextualized these findings. Participants shared that stigma remains a significant deterrent to seeking treatment and disclosing their condition, particularly in rural communities. Many described a lack of peer support or safe spaces to express their struggles. Others emphasized the importance of emotional resilience, family involvement, and mental health support in continuing HIV care. Participants also voiced a collective need for more accessible, community-based education programs, outreach services, and confidential treatment facilities tailored to women's unique needs. See Figure 2.



Discussion

This study explored the barriers to HIV care and treatment adherence among women living with HIV (WLHIV) in Nueva Ecija, Philippines, utilizing both the Barriers to Care Scale (BCS) and the HIV Adherence Self-Efficacy Scale (HIV-ASES). The data revealed that only 69% of the respondents were currently on antiretroviral therapy (ART), while the remaining 31% cited various reasons for non-adherence. The most common barriers among those not receiving ART were financial constraints (52%), fear of side effects (42%), and stigma or discrimination (32%). These findings are consistent with existing literature, which has long identified economic hardship and psychosocial stigma as key deterrents to HIV treatment access (Wagner et al., 2011; UNAIDS, 2023). While access to ART is theoretically universal in the Philippines, the data suggest that structural barriers still prevail in rural areas such as Nueva Ecija.

From the Barriers to Care Scale results, transportation difficulties and healthcare costs emerged as significant challenges. Nearly half of the respondents agreed or strongly agreed that transportation costs were too high and that they had to travel long distances to access care. This aligns with WHO reports indicating that people living in rural communities face compounded disadvantages due to poor health infrastructure and geographic isolation (WHO, 2021). Additionally, many respondents (above 40%) agreed that long wait times and inconvenient clinic hours made access to HIV services even more difficult, especially for women balancing employment, household duties, or childcare.

In terms of social and emotional barriers, the fear of stigma continues to weigh heavily. Respondents indicated discomfort in seeking care due to fear of being judged by healthcare workers or being identified by others in the community. This aligns with findings by Mahajan et al. (2008), who noted that stigma remains one of the most persistent impediments to HIV care adherence worldwide. The health system itself was also identified as a barrier, with several participants expressing distrust in the confidentiality of medical providers and discomfort in discussing HIV status, especially as women.

Despite these challenges, the HIV-ASES scores showed an encouraging trend: most participants expressed high confidence in their ability to adhere to treatment, remember medication schedules, and manage their HIV care even under stress or busy circumstances. Notably, over 80% of participants expressed confidence in following their treatment plan even when tired, anxious, or unsupported by others. However, this optimism must be juxtaposed against reality—nearly 30% admitted to missing ART doses in the past month, citing issues like fatigue, emotional distress, or fear of being discovered. This gap between self-efficacy and actual adherence highlights the need for ongoing behavioral support and follow-up interventions.

Qualitative responses added depth to the quantitative findings. Respondents described concealing their medication from family members, facing subtle and overt discrimination in their communities, and struggling with isolation. Yet many also shared sources of strength: love for their children, faith in God, and peer support groups were cited as key motivators for continuing treatment. These narratives underscore the importance of integrating psychosocial and spiritual support services into HIV programs. As one respondent put it, "I continue my treatment because I want to live longer for my kids."

The findings of this study underscore the complex interplay between structural, social, and psychological factors affecting HIV treatment access and adherence among WLHIV in Nueva Ecija. While a significant proportion of participants expressed high self-efficacy regarding their treatment, practical barriers such as transportation, healthcare costs, and stigma continue to pose significant threats to consistent ART use. The discrepancy between confidence and actual adherence behavior reflects the nuanced nature of living with HIV in a rural, resource-constrained setting.

4. CONCLUSION

To improve treatment outcomes, targeted interventions must address both logistical barriers (e.g., mobile clinics, financial subsidies) and psychosocial stressors (e.g., anti-stigma education, confidential counseling). Training healthcare professionals on non-discriminatory practices and patient confidentiality could enhance patient trust and service uptake. Furthermore, integrating family and community-level support mechanisms can empower WLHIV to navigate the challenges of adherence with dignity and resilience.

This study contributes valuable insights into the lived experiences of WLHIV in Nueva Ecija and provides a foundation for localized, gender-sensitive programming. Further research with a larger and more diverse sample is recommended, as well as longitudinal studies to explore changes in treatment adherence over time. Incorporating patient voices into HIV care models will be essential in building responsive and inclusive health systems that leave no one behind.

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