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Article

Invisible violence among individuals living with HIV/AIDS in Nampula – Mozambique

Violência invisível em indivíduos vivendo com HIV/SIDA em Nampula – Moçambique

Violencia invisible en individuos que viven con VIH/SIDA en Nampula – Mozambique

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Abstract

Objective: To analyze experiences of invisible violence, stigma, and discrimination among individuals living with HIV/AIDS in the province of Nampula, Mozambique, in order to understand how such experiences influence treatment adherence, quality of life, and access to social protection networks. **Methodology**: This is an exploratory case study with a quantitative approach to data analysis. Field research was conducted with 100 participants aged between 18 and 60 years, monitored by health services and social organizations. Data were collected through a structured questionnaire and analyzed using descriptive statistics and thematic analysis. **Results**: The sample was predominantly young, with a mean age of 32 years, and showed high adherence to antiretroviral therapy. High social vulnerability was observed, associated with the persistence of barriers such as stigma, violence, and control of resources. Fear of disclosing the diagnosis and discrimination in the labour market contribute to social isolation and economic insecurity, negatively affecting physical and emotional health, as well as quality of life. Social and institutional support proved to be limited, also affecting continuity in treatment adherence. **Conclusion**: Living with HIV/AIDS involves vulnerabilities that go beyond the biomedical sphere, including discrimination, stigmatization, and violence in different social contexts. Integrated public policies are needed to articulate health, social protection, and human rights, aiming to reduce inequalities and improve quality of life through the strengthening of integrated care actions, with emphasis on continuous psychosocial support, prevention of treatment abandonment, and community awareness. It is also essential to train health and education professionals, as well as community leaders, in order to promote practices based on confidentiality, respect, and equity.

Keywords: HIV/AIDS; Vulnerability; Quality of Life; Social Stigma; Mozambique.

Resumo

Objetivo: analisar as experiências de violência invisível, estigma e discriminação em indivíduos vivendo com HIV/SIDA, na província de Nampula, Moçambique, a fim de compreender como tais experiências influenciam a adesão ao tratamento, a qualidade de vida e o acesso às redes de proteção social. **Metodologia:** estudo de caso, de caráter exploratório, com abordagem quantitativa dos dados. Foi realizada pesquisa de campo com 100 participantes com idades entre 18 e 60 anos, acompanhados por serviços de saúde e organizações sociais. Os dados foram recolhidos por meio de questionário estruturado e analisados por estatística descritiva e análise temática. **Resultados:** a amostra foi predominantemente jovem, com média de 32 anos, e apresentou elevada adesão à terapia

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antirretroviral. Observou-se elevada vulnerabilidade social, associada à persistência de barreiras como estigma, violência e controle de recursos. O medo da revelação do diagnóstico e a discriminação no mercado de trabalho contribuem para o isolamento social e a insegurança económica, com impactos negativos na saúde física, emocional e na qualidade de vida. O suporte social e institucional mostrou-se limitado, afetando também a continuidade da adesão ao tratamento. **Conclusão:** o viver com HIV/SIDA implica vulnerabilidades que vão além do âmbito biomédico, incluindo discriminação, estigmatização e violência em diferentes contextos sociais. São necessárias políticas públicas integradas que articulem saúde, proteção social e direitos humanos, com vista à redução das desigualdades e à melhoria da qualidade de vida, com o fortalecimento de ações integradas de cuidado, ênfase no acompanhamento psicossocial contínuo, na prevenção do abandono terapêutico e na sensibilização comunitária. É igualmente fundamental capacitar profissionais de saúde, educação e líderes comunitários, de modo a promover práticas baseadas na confidencialidade, no respeito e na equidade.
Palavras-chave: HIV/SIDA; Vulnerabilidade; Qualidade de Vida; Estigma Social; Moçambique.

Resumen

Objetivo: Analizar las experiencias de violencia invisible, estigma y discriminación en personas que viven con VIH/SIDA en la provincia de Nampula, Mozambique, con el fin de comprender cómo dichas experiencias influyen en la adherencia al tratamiento, la calidad de vida y el acceso a las redes de protección social. **Metodología**: Estudio de caso, de carácter exploratorio, con enfoque cuantitativo de los datos. Se realizó una investigación de campo con 100 participantes de entre 18 y 60 años, acompañados por servicios de salud y organizaciones sociales. Los datos fueron re colectados mediante un cuestionario estructurado y analizados a través de estadística descriptiva y análisis temático. **Resultados**: La muestra fue predominantemente joven, con una media de edad de 32 años, y presentó una elevada adherencia a la terapia antirretroviral. Se observó una alta vulnerabilidad social, asociada a la persistencia de barreras como el estigma, la violencia y el control de recursos. El miedo a revelar el diagnóstico y la discriminación en el mercado laboral contribuyen al aislamiento social y a la inseguridad económica, con impactos negativos en la salud física y emocional, así como en localidad de vida. El apoyo social e institucional resultó limitado, afectando también la continuidad de la ad herencia al tratamiento. **Conclusión**: Vivir con VIH/SIDA implica vulnerabilidades que van más allá del ámbito biomédico, incluyendo discriminación, estigmatización y violencia en diferentes contextos sociales. Se requieren políticas públicas integradas que articulen salud, protección social y derechos humanos, con el objetivo de reducirlas desigualdades y mejorar la calidad de vida mediante el fortalecimiento de acciones integradas de cuidado, con énfasis en el acompañamiento psicosocial continuo, la prevención del abandono terapéutico y la sensibilización comunitaria. También es fundamental capacitar a profesionales de la salud y la educación, así como a líderes comunitarios, para promover prácticas basadas en la confidencialidad, el respeto y la equidad.
Palabras clave: VIH/SIDA; Vulnerabilidad; Calidad de Vida; Estigma Social; Mozambique.

Introduction

The Human Immunodeficiency Virus (HIV/AIDS) is one of the main public health challenges in Mozambique, with approximately 2.3 to 2.6 million people living with the virus and an estimated prevalence of approximately 12% in the adult population[1,2]. In recent years, between 80,000 and 90,000 new annual infections have been recorded, affecting primarily women and young people, which keeps the epidemic a significant concern in the country[1].

In this context, HIV/AIDS must be understood not only as a biomedical condition but also as a social phenomenon deeply marked by invisible violence, manifested through discrimination, stigma,

intimidation and control resources, which constitutes a central element in increasing the vulnerability of these individuals[3,4,5,6,7,8].

The stigma associated with HIV/AIDS has been identified as one of the main factors that exacerbate this vulnerability [4,9]. The virus is frequently associated with processes of criminalization and social exclusion, in which legal norms and social practices reinforce forms of institutional and symbolic violence[4,10]. Furthermore, recent studies demonstrate that stigma directly impacts psychological well-being, contributing to social isolation and hindering treatment adherence [4,11], thus constituting a social determinant of health that manifests through discrimination, exclusion, and limited accesses to health services[12,13].

In Mozambique, the HIV/AIDS epidemic remains one of the main public health challenges, and the social stigma associated with HIV/AIDS continues to be a major barrier, leading some people to avoid testing or to discontinue treatment[14]. National data indicate that treatment discontinuation remains a significant challenge: in 2024, the country had approximately 2.48 million people living with HIV/AIDS, with notable progress in antiretroviral treatment coverage, but with significant losses in the care cascade exacerbated by recent changes in the external financing landscape, requiring sustained and integrated responses[15].

Women and girls are disproportionately affected by HIV/AIDS, not only in epidemiological terms but also with regard to exposure to gender-based violence[10]. The established link between HIV/AIDS, power inequalities in marital relationships, and intimate partner violence supports analyses that view violence against women as an integral part of patriarchal systems that regulate bodies, sexualities, and behaviours[16]. The disclosure of HIV status, often followed by abandonment, physical abuse, or moral blame, highlight show HIV/AIDS can act as a trigger for the intensification of violence already latent in gender relations[11].

Difficulties in accessing health services, the interruption of antiretroviral treatment in contexts of armed conflict – especially in the north of the country – and the scar city of human and material resources constitute forms of indirect yet continuous aggression against the lives of people living with HIV/AIDS[2,15]. These factors reveal that vulnerability to HIV is not the result isolated individual choices, but of historical, political, and economic conditions that limit opportunities for care and survival[12,17].

Conceptually, invisible violence can be understood as a set of subtle, indirect, and often normalized practices that do not necessarily manifest as physical aggression but produce significant psychological, social, and emotional harm[3,7]. Complementarily, symbolic violence is characterized by mechanisms of domination exercised in subtle ways and frequently internalized by the victims themselves, there by becoming socially legitimized[5,18]. On the other hand, structural violence high light show social, economic, and institutional qualities create conditions that perpetuate the suffering and exclusion of vulnerable groups, including people living with HIV/AIDS[6].

Thus, it is observed that stigma and violence, in their multiple dimensions - symbolic, structural, and institutional - are interconnected and directly influence quality of life, mental health, and treatment adherence. Thus, the literature highlights the need for integrated approaches that consider not only clinical treatment but also the social determinants of health, psychosocial support, and the guarantee of human rights[19].

From this perspective, this study aims to analyze experiences of invisible violence, stigma, and discrimination among individuals living with HIV/AIDS in Nampula Province, Mozambique, in

order to understand how such experiences influence treatment adherence, quality of life and access to social protection networks.

Methodology

This research adopted an exploratory case study methodlogy with a quantitative data approach[20,21,22]. The case study allowed for the exploration, description, and understanding of specific situations related to the topic under analysis, as well as the identification and explanation of the variables involved, enabling the researcher to adopt a critical stance toward the observed evidence. In turn, the exploratory nature of the research aimed to generate initial information about the phenomenon under study, contributing to the delimitation of the field of research and providing a foundation for future explanatory studies[21]. The quantitative approach was used to quantify the collected data, allowing for statistical analyses and the formulation of inferences[21,22].

The study was conducted in Nampula Province because it plays a central role in this epidemiological context. Nampula is Mozambique's most populous province, combining densely populated urban areas with vast rural zones that are difficult to access. This territorial diversity contributes to wine qualities in access to healthcare, with rural communities facing greater difficulties in undergoing regular testing and initiating early treatment.

A literature review was conducted to provide a theoretical foundation for the topic. Subsequently, data were collected using a structured questionnaire comprising five thematic groups, organized into two main sections: invisible violence among individuals living with HIV/AIDS and motivation, as proposed by Creswell[21]. Before administer in gather questionnaire, participants were fully informed about the objectives and purpose of the study, and were assured of their right to with draw at any time without any penalty.

Data collection took place in Nampula Province between June and September 2025, at associations of individuals living with HIV/AIDS, private residences, and workplaces, always with prior consentandensuringtheconfidentialityanddiscretionoftheparticipants. Data collection sessions were schedule according to participants' availability, and all were fully informed about the study's objectives and any questions they might have. Throughout the entire process, the voluntary nature of participation was ensured, as well as the right to with draw at any stage of the research without any consequences. The target population consisted of individuals diagnosed with HIV/AIDS, aged between 18 and 60 years. The sample, whose characteristics are shown in Table 1, was non-probabilistic and purposive in nature.

Considering that not all participants were literate, convenience sampling was chosen. After the questionnaires were administered, the data were checked for eligibility, tabulated using SPHINX software, and subsequently analyzed using the Statistical Package for the Social Sciences (SPSS), version 25.0, for Windows.

In the first phase, an exploratory analysis of the data was conducted using descriptive statistics. Categorical variables were analyzed based on absolute frequencies and percentages, while continuous variables were described using measures of central tendency and dispersion, namely mean, standard deviation, median, mode, minimum and maximum values, as well as indices of skewness and kurtosis. Subsequently, canonical correlation and Pearson correlation analyses were performed to examine the relationships among the variables understudy.

From an ethical standpoint, the study was previously submitted for review and approved by the Institutional Ethics Committee for Health Research (CEIIS), under opinion No. 023/CEIIS/2025, ensuring compliance with the fundamental principles of research involving human subjects, namely respect for dignity, informed consent, confidentiality, and the anonymity of participants. The study also followed the principles established in the Declaration of Helsinki and the Oviedo Convention[23,24].

Results and Discussion

The study group consisted of 100 participants, with unequal distribution between men (50%) and women (50%). The estimated mean age was 32 years, ranging from 18 to 60 years, indicating a predominantly young adult group (Table 1).

Table 1. Sociodemographic data of individuals with HIV/AIDS in the Nampula region, Mozambique, 2025

Variable	Category	Percentage/value
Total Participants		100%
Gender	Men	50%
	Women	50%
Age group	18 to 60	Average age of 32
Marital status	single	42
	married /civil union	38
	separated/divorced	20
Occupation	Services	40
	Education	15
	Health	10
	Self-employed	20
	Other	15
Types of institution	Public	55
	Private	35
	Self-employed	10

Source: Prepared by the author.

Regarding marital status, there is a balanced distribution between single (42%) and married/in a stable relationship (38%), with 20% separated/divorced, which may reflect potential social and emotional impacts related to living with HIV/AIDS, but also common profiles within the age group presented.

In terms of employment, the service sector predominates (40%). The education (15%) and health (10%) sectors account for a smaller but still significant share. The majority are currently employed in public institutions (55%), which may influence perceptions of job stability and access to health care. The fact that participants work in public institutions may influence this perception because, in general, the public sector in Mozambique is associated with greater job stability (even if with salary limitations), greater social protection, and more structured access to health services. Public sector works tend to have easier access to health facilities through institutional referral

systems, insurance or occupational health programs. Additionally, these institutions frequently promote health and information campaigns, which may increase the perception of safety and support in HIV/AIDS care. Never the less, this advantage may vary depending on the type of institution and the region.

Overall, the profile indicates a relatively young group, heterogeneous in terms of occupations and with broad participation in the labour market, which is consistent with Mozambique's demographic structure, characterized by a predominantly young population of working age. According to Mozambique's National Institute of Statistics (INE), the country has a high proportion of young people, which is directly reflected in the composition of the work force and the occupational profiles observed, especially in provinces such as Nampula, where activities in the service and informal sectors predominate.

The data show that sociodemographic characteristics do not act in isolation but interact with social and structural factors, directly influencing experiences of violence, vulnerability, social support, and access to care. The relationship between sociodemographic characteristics, vulnerability, violence, and stigma among people living with HIV/AIDS must be understood through the lens of the social determinants of health. Evidence shows that factors such as gender, age, educational level, and socioeconomic status influence both exposure to HIV/AIDS and experiences following diagnosis.

Stigma related to HIV/AIDS manifests itself in different dimensions — experienced, anticipated, and internalized — and is strongly associated with social inequalities, potentially leading to social isolation, discrimination, and difficulties in accessing and adhering to treatment[9]. Vulnerability to HIV/AIDS and its impacts are exacerbated by contexts of violence, especially gender-based violence, and by structural conditions such as poverty and low educational attainment. These factors interact at multiple levels — individual, social, and programmatic — increasing exposure to risk and hindering continuity of health care. Thus, stigma and violence cannot be analyzed in isolation but rather as part of a broader system of social in equalities that affects the health and well-being of people living with HIV/AIDS[11].

According to the data in Table 2, the time since diagnosis reveals that nearly half (47%) have been living with HIV/AIDS for between 1 and 5 years, while 35% have been diagnosed for more than 5 years and 18% were diagnosed recently (< 1 year). This scenario indicates a group composed of both individuals newly entering care and those with extensive experience in HIV care.

Table 2. Experience of individuals with HIV/AIDS in the Nampula region. Mozambique, 2025

Variable	Category	Percentage
Time since diagnosis	<1 year	18%
Time of diagnosis	1–5 years	47%
Time of diagnosis	5+	35%
Regular treatment	Yes	92%
Regular treatment	No	8%
Main challenges	Balancing with work	46%
Main challenges	Professional stigma	21%
Main challenges	Side effects	28%
Main challenges	Lack of family support	33%

Source: prepared by the author.

Furthermore, treatment adherence is high, with 92% regularly using antiretroviral therapy, which is a positive indicator of care and follow-up. Thus, consistent adherence to international guidelines was observed, which identify therapy as the central pillar in the control of HIV/AIDS[25].

However, there ported challenges - such as the difficulty of balancing treatment with work activities, side effects, and lack of family support – demonstrate that adherence depends not only on access to health services but also on favourable social conditions[1,26]. Stigma in the workplace, although mentioned by a smaller proportion of participants, contributes to silence and the concealment of the diagnosis, increasing psychological distress and social isolation.

Specifically, the main difficulties cited include balancing treatment and work (46%), followed by a lack of family support (33%), side effects (28%), and workplace stigma (21%). This context demonstrates that, although the majority are undergoing treatment, social, family, and occupation al factors continue to pose significant barriers.

In this regard, the data in Table 2 indicate that individuals living with HIV/AIDS face significant challenges in balancing their health condition with the workplace, often being exposed to situations of stigma and vulnerability. Stigma can be understood as a socially devalued attribute that leads to exclusion and discrimination, manifesting itself in these individuals' work context[27]. Furthermore, it involves processes of labelling, stereotyping, and loss of status, evident in managers' negative perceptions of absences related to health relapses[9].

On the other hand, it is important to highlight that the vulnerability associated with HIV/AIDS is not limited to the individual level, but also encompasses social and institutional dimensions, such as weak family support and inequalities between the public and private sectors[11,12].

It is also observed that difficulties in balancing treatment with work activities tend to intensify processes of mistrust and speculation in the workplace, constituting forms of symbolic and invisible violence that exacerbate the vulnerability of these individuals. In summary, it is concluded that, despite advances in treatment adherence, structural and social challenges persist that require greater attention and intervention.

Table 3 presents the section with the highest expression of vulnerability. More than half of the participants have felt threatened or intimidated (61%) and 54% reported emotional or verbal violence in the family environment. Control over resources, including money and even medications, was reported by 37%, indicating unequal power dynamics in close relationships. Additionally, 29% stopped seeking treatment out of fear of family or social repercussions, a concerning finding, as interrupting care directly impacts health. In the workplace, 48% perceived an impact of the diagnosis on professional dynamics, and 32% reported discrimination. The majority (73%) do not feel safe discus sing health issues, highlighting an environment marked by secrecy and fear.

Table 3. Violance and social vulnerability reported by individuals with HIV/AIDS in Nampula, Mozambique, 2025

Variable	Category	Percentage
Felt threatened/intimidated	Yes	61%
Emotional/verbal abuse	Yes	54%
Control of resources (money/medication)	Yes	37%

Avoided treatment out of fear	Yes	29%
Impact of HIV on work	Yes	48%
Discrimination at work	Yes	32%
Do you feel safe talking about health?	No	73%

Source: Prepared by the author.

The data in Table 3 indicate that a significant number of individuals living with HIV/AIDS face threats and intimidation, reaching 61% of the sample studied. It is also noted that third-party control of financial resources is a cause for concern, given that these individuals depend on these resources to meet basic needs and essential expenses. When such resources are restricted, the situation becomes even more vulnerable, increasing the risk of treatment discontinuation and a consequent worsening of health status.

These results can be understood in light of the concept of vulnerability, which considers the interaction of individual, social, and institutional factors in risk exposure[12,17]. At the same time, the perspective of stigma highlight show social devaluation and prejudice can manifest through forms of symbolic violence, such as intimidation, financial control, and social exclusion, directly affecting access to healthcare and adherence to treatment[5,18].

In contexts of greater social vulnerability, invisible violence can be intensified by intersectional factors such as gender, race, sexual orientation, and socioeconomic status. Women living with HIV/AIDS, for example, face a higher risk of domestic violence, emotional abandonment, and blame following disclosure of their diagnosis, highlighting the overlap of social and health inequalities[19].

In this scenario, situations of violence, intimidation, and control over resources do not occur in isolation but are embedded in social contexts marked by power inequalities and stigmatization. These factors contribute to the perpetuation of unsafe environments, in which individuals feel prevented from disclosing their health status and seeking adequate support.

They canal so be understood in light of the concept of structural violence, which describes how social structures produce and reproduce inequalities that limit equitable access tore sources and rights[6,13]. Complementarily, the concept of symbolic power helps to understand how subtle forms of domination, such as financial control and intimidation, are normalized in social relationships, fostering the internalization of subordination by the affected individuals[5,18].

The presence of fear, secrecy, and discrimination, both in the family and professional environments, reinforces structural barriers that hinder access to healthcare and the continuity of treatment, further exacerbating the vulnerability of these individuals. The results indicate that physical and psychological violence, even when subtle or indirect, reinforces patterns of discrimination that compromise the autonomy, well-being, and continuity of care for individuals living with HIV/AIDS.

Perceptions of quality of life vary, with “fair” (38%) and “good” (33%) being the most common ratings, while 17% consider their quality of life to be “poor.” Only 12% rate it as “excellent.” More than half (58%) state that domestic emotional violence directly affects their health, indicating a strong link between abuse and a decline in physical and psychological well-being. Furthermore, 46% say that their health condition interferes with their social and professional lives, reinforcing the emotional and social burden of living with HIV/AIDS (Table 4).

Table 4. Quality of life of individuals with HIV/AIDS in the Nampula region, Mozambique, 2025.

Variable	Category	Percentage
Quality of life	Excellent	12
Quality of life	Good	33
Quality of life	Fair	38
Quality of life	Poor	17
Violence affects health	Yes	58
Health affects social/professional life	Yes	46

Source: prepared by the author.

It is evident that, for a significant portion of the sample, exposure to violence, stigma, and discrimination compromises not only physical health but also psychological and social well-being, directly impacting the perception of quality of life (QOL). The predominance of ratings ranging from fair to good, rather than higher levels of satisfaction, suggests that, although many individuals manage to maintain some balance in their lives, structural and relation al factors persist that limit a more positive perception of quality of life.

The high proportion of participants reporting a direct impact of violence on health (58%) demonstrates that experiences of aggression are not isolated events, but rather ongoing factors that negatively influence overall health status. This scenario is exacerbated by the interference of health status in social and professional spheres (46%), indicating that HIV/AIDS associated with stigma extends beyond the clinical realm and affects social integration, productivity, and interpersonal relationships.

Furthermore, the interconnection between violence, stigma, and discrimination creates a cycle of vulnerability, in which psychological distress can lead to social isolation, decreased self-esteem, and, consequently, reduced adherence to treatment and self-care. Thus, quality of life must be under stood in a multidimensional way, involving not only biomedical aspects but also social and emotional determinants. Furthermore, the interconnection between violence, stigma, and discrimination creates a cycle of vulnerability, in which psychological distress can lead to social isolation, decreased self-esteem, and, consequently, reduced adherence to treatment and self-care. Thus, quality of life must be under stood in a multidimensional way, involving not only biomedical aspects but also social and emotional determinants.

The World Health Organization highlights that social determinants of health, such as violence, discrimination, and social exclusion, exert a direct influence on the living conditions and health of populations, especially in contexts of vulnerability such as HIV/AIDS[12]. Furthermore, recent studies on quality of life among people living with HIV/AIDS reinforce that well-being is strongly associated with social support, mental health, and the absence of stigma, these factors being determinants of treatment adherence and self-care[9,28].

The theory of social stigma[4] holds that the labelling and exclusion of individuals with stigmatized characteristics, such as HIV-positive status, reduce opportunities for social participation and increase psychological vulnerabilities. In light of this theoretical approach, the observed results indicated at stigma acts not only as a symbolic phenomenon but as a concrete mechanism of exclusion that directly affects individuals' living conditions.

In this sense, the stigma associated with HIV/AIDS can intensify experiences of discrimination and violence, contributing to the internalization of feelings of inferiority, shame, and fear. These factors tend to limit the search for social support and health services, further exacerbating the situation of vulnerability. The opinion, the fore, points to the need for interventions that are not limited to clinical treatment but also address the social, cultural and institutional dimensions of the problem.

Additionally, it is essential to promote community awareness strategies and strengthen support networks in order to reduce the impact of stigma and foster social inclusion, there by contributing to improved quality of life for these populations.

The data in Table 5 show that less than half of the participants are aware of support services (44%), which highlights the need for greater dissemination and facilitation of access. Social support is limited, with 36% of participants reporting family support, 28% support from friends or other members of their social network, and 22% support from their employer. These results suggest a fragile support network, which contributes other emotional and social vulnerabilities of individuals living with HIV/AIDS.

Table 5. Support and recommendations for individuals with HIV/AIDS in the Nampula region, Mozambique, 2025.

Variable	Category	Percentage
Aware of support services	Yes	44
Family support	Yes	36
Support from colleagues	Yes	28
Support from management	Yes	22
Recommendations	Support group	52
Recommendations	Stigma policies	47
Recommendations	Legal/social assistance	39
Recommendations	Training for family members	28

Source: Prepared by the author.

Regarding recommendations, participants highlight the importance of emotional support groups (52%), policies to combat stigma (47%), legal and social assistance (39%) and family training (28%). The qualitative comments reinforce the fear of disclosing the diagnosis, experiences of discrimination and violence, difficulties in accessing and maintaining treatment, as well as strong social stigma, highlighting a lack of adequate psychological and social support.

The data in Table 5 point to the importance of support groups in improving the health and well-being of people living with HIV/AIDS. The social support provided by these groups contribute story educing stigma, emotional strengthening, and improved adherence to antiretroviral treatment - essential elements for these individuals' quality of life[9]. Participation in support networks offers a welcoming space for sharing experiences and psychological strengthening, promoting mental and social health[9].

Studies indicate that consistent social support is directly associated with greater treatment adherence and increased engagement in self-care practices[9]. However, the data presented highlight

significant weaknesses in the support network, which may compromise treatment continuity and the emotional well - being of individuals[26]. Limited family, community, and institutional support reinforce social isolation and can exacerbate existing situations of vulnerability.

Despite the existence of public policies aimed at people living with HIV/AIDS, it is observed that many individuals in vulnerable situations face significant gaps, such as discrimination in the workplace, constituting a significant barrier to the full exercise of their rights[29]. Although protective mechanisms exist, their effectiveness remains limited, especially in contexts of greater socioeconomic vulnerability [15].

There is a clear need for integrated policies that consider not only the biomedical dimension of the disease but also the human rights and social protection of individuals[26]. In addition to social support and public policies, legal reinforce mentis an essential component for guaranteeing the rights of people living with HIV/AIDS. Legal protection ensures confidentiality, combats discrimination, and facilitates access to social and labour benefits[30]. Legislation constitutes a fundamental instrument for promoting the right to health[31], while effective legal policies have a positive impact on public health and the quality of life of affected populations[32].

Final Considerations

The findings show that the study group is relatively young, with a mean age of 32 years, and heterogeneous in terms of occupation and marital status. Furthermore, the results indicate that living with HIV/AIDS entails vulnerabilities that extend beyond the biomedical realm, including discrimination, stigmatization, and violence in various social contexts. Although adherence or therapy is high, the persistence of stigma contributes to social isolation and, in some cases, treatment discontinuation.

There is high exposure to violence, intimidation, and control of basic resources by third parties, indicating forms of domestic and workplace violence that also include psychological and symbolic violence, understood as forms of social domination that produce silence, submission, and exclusion. These factors extend beyond the family context and are equally evident in the workplace, with a direct impact on the continuity of care and quality of life.

Most participants report a fair or good quality of life, although about 60% acknowledge the negative impacts of stigma and violence on their physical and emotional health. Social and institutional supports insufficient, as less than half of the participants are aware of support services, and only a portion report effective support from family, the professional environment, or formal institutions.

A relationship also observed between social support and treatment adherence, highlighting that psychosocial support and safety nets play a central role in maintaining treatment and reducing vulnerability. This underscores the need for support and counselling for participants who have interrupted treatment, reinforcing the fragility of care continuity.

In the workplace, the fear of disclosing the diagnosis confirms the persistence of institutional stigma, even among individuals in the formal labour market. This reality highlights the need for coordinated interventions among health, social assistance, education, and community services, with a focus on protecting human rights and reducing discrimination.

Given this scenario, it is recommended to strengthen integrated care initiatives for people living with HIV/AIDS, with an emphasis on continuous psychosocial support, the prevention of

treatment discontinuation, and community awareness. It is equally essential to train health and education professionals and community leaders to promote practices based on confidentiality, respect, and equity.

A limitation of the study is the use of convenience sampling and the small sample size, which limits the generalize ability of the results, as well as the possibility of under reporting of experiences of violence duet the stigma associated with HIV. It is recommended that future research employ mixed-methods approaches and expand the sample size, allowing for a deeper understanding of vulnerability dynamics and supporting the development of more effective public policies.

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