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Self-Isolation Tendencies among People Living with HIV Due to Fear of Job Loss in Makassar City

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Abstract

HIV and AIDS are not only health issues but also social problems marked by stigma and discrimination. One of the social impacts experienced by people living with HIV (ODHIV) is the fear of losing their jobs due to the disclosure of their HIV status, which encourages them to withdraw from their social environment. This study aims to understand the tendency of ODHIV to engage in self-isolation as a response to social tension, particularly in the workplace context in Makassar City. This research employed a qualitative method with a phenomenological approach to explore the lived experiences of ODHIV. Data were collected through in-depth interviews and observations involving six informants, with two key informants showing a strong tendency to conceal their HIV status. The findings indicate that although informants perceived a decline in discrimination against ODHIV over the past 10–15 years, fear of stigma and potential job loss remains significant. This fear drives ODHIV to limit identity disclosure as a self-protective strategy. These findings confirm that stigma and discrimination against ODHIV have not been fully eliminated and continue to influence their social behavior. This study recommends strengthening employment protection policies and public education as efforts to reduce social tension and improve the quality of life of ODHIV.

Keywords: *Fear of Job Loss, ODHIV, Self-Isolation, Stigma.*

INTRODUCTION

To date, HIV and AIDS are understood not only as public health issues but also as complex and multidimensional social phenomena. Numerous studies indicate that the impact of HIV does not end at the biological level but extends into the psychological, social, economic, and cultural domains of the lives of those affected (Herek, Capitanio, & Widaman, 2002; Parker & Aggleton, 2003; Lasiu et l., 2024). People living with HIV (ODHIV) frequently face persistent stigma, discrimination, and social exclusion, which affect their quality of life and participation in social life.

Social tension is one of the consequences of unequal social relations between dominant groups and stigmatized groups. This tension refers to conditions of latent or manifest conflict that arise from differences in values, norms, interests, and the distribution of power within society (Coser, 1956). In the context of HIV, social tension is often triggered by social constructions that position ODHIV as a "high-risk" group and as "deviant" from prevailing moral norms. Such perceptions contribute to the emergence of social distance between ODHIV and the broader community, ultimately reinforcing patterns of discrimination and marginalization.

From a micro-sociological perspective, Randall Collins, through his theory of interaction ritual chains, explains that social tension is formed and reproduced through everyday interactions imbued with symbolic domination. According to Collins (2004), language, symbols, and social rituals function to affirm social hierarchies and reinforce stratification between dominant and subordinate groups. In the lives of ODHIV, social labels attached to HIV serve as symbols that produce symbolic violence, creating feelings of shame, fear, and insecurity in social interactions, particularly in public spaces such as the workplace.

In line with this, the theory of symbolic interactionism proposed by George Herbert Mead emphasizes that individual identity is formed through processes of social interaction and the exchange of symbolic meanings (Mead, 1934). The identity of people living with HIV (ODHIV) is not naturally given but is socially constructed through societal perceptions and reactions to HIV status. Stigma toward HIV can be understood as a process of social labeling that produces negative stereotypes and influences how ODHIV perceive themselves. Goffman (1963) describes stigma as a discrediting attribute that causes individuals to lose social acceptance and experience a decline in social status within social interactions.

One of the social arenas most vulnerable to practices of stigma and discrimination against ODHIV is the workplace. Numerous studies indicate that ODHIV often face barriers in obtaining and maintaining employment due to employers' fears of HIV transmission and the moral stigma attached to the disease (Herek et al., 2002; Earnshaw & Chaudoir, 2009). Workplace discrimination may take the form of recruitment rejection, restricted promotion opportunities, unfair treatment, or covert termination of employment. These conditions create significant economic insecurity for ODHIV.

Fear of job loss encourages many ODHIV to develop coping strategies by concealing their HIV status from social and professional environments. This tendency toward self-concealment does not merely reflect a personal choice but represents a rational response to social structures that are not yet fully safe and inclusive. Parker and Aggleton (2003) emphasize that HIV-related stigma functions as a mechanism of social control that sustains social inequality. Disclosing HIV status is frequently perceived as a high social risk.

Globally, UNAIDS reported that by the end of 2023, approximately 39.9 million people were living with HIV, with around 77% having accessed antiretroviral therapy (UNAIDS, 2024). Despite significant progress in medical treatment, stigma and discrimination remain major challenges in the HIV response. This indicates that the success of biomedical interventions does not always align with changes in societal attitudes toward people living with HIV (ODHIV).

In Indonesia, stigma and discrimination against ODHIV remain critical issues. Indonesia ranks 14th globally in the number of ODHIV and 9th in new HIV infections. In 2025, it is estimated that there are approximately 564,000 ODHIV; however, only 63% are aware of their HIV status, and around 55% have achieved viral load suppression (Aji, 2025). The low level of HIV status disclosure is closely linked to fear of social stigma, including discrimination in the workplace.

At the regional level, South Sulawesi Province shows relatively high HIV case numbers, with Makassar City reporting the highest number of cases—563 cases during the period of January to August 2025 (Adhe, 2025). These high figures not only reflect epidemiological concerns but also indicate the complexity of social problems faced by ODHIV in urban settings. As a center of economic and social activity, Makassar City presents both opportunities and risks for ODHIV, particularly in relation to job security and social acceptance.

The constructivist paradigm views social reality as a shared construction shaped through interaction, experience, and individual interpretation. Within this framework, the experience of self-withdrawal among ODHIV is understood as a subjective reality arising from their interactions with socially tense structures. Knowledge of this phenomenon is obtained through an in-depth understanding of the lived experiences of ODHIV, as emphasized in the phenomenological approach, which places subjective meaning at the center of analysis (Creswell, 2013).

This study is grounded in the awareness that stigma and discrimination against ODHIV do not originate solely from the general public but, in some cases, are also found among healthcare workers and formal institutions (Ardani & Handayani, 2017). This condition further reinforces ODHIV's fear of disclosing their HIV status. Therefore, examining the tendency of people living with HIV to withdraw due to fear of job loss in Makassar City is crucial for understanding how social tension operates in the daily lives of ODHIV and how it affects their quality of life.

METHODS

This study employed a qualitative research method with a phenomenological approach. A qualitative approach was chosen because this study seeks to understand the meanings, experiences, and social processes experienced by people living with HIV (ODHIV) in the context of everyday life. According to Denzin and Lincoln (2008), qualitative research emphasizes socially constructed realities, close relationships between researchers and research participants, and value-laden inquiry to understand how social experiences are created and interpreted. This approach differs from quantitative research, which relies on mathematical logic and statistical measurement, as qualitative research focuses more on an in-depth understanding of the quality of human behavior and experiences (Mulyana, 2013).

The phenomenological approach was used to explore the lived experiences of ODHIV related to their tendency toward self-withdrawal due to fear of job loss. Phenomenology seeks to understand phenomena as they are consciously experienced by individuals

through personal perception and reflection (Schwandt, 2001). This approach allows researchers to enter the experiential world of participants and view reality from a first-person perspective. Daymon and Holloway (2008) explain that phenomenology helps researchers understand the meaning frameworks constructed by individuals in responding to events and social experiences throughout their lives. Thus, phenomenology is particularly relevant for uncovering the subjective meanings underlying self-concealment strategies adopted by ODHIV in response to stigma and social insecurity.

This study is grounded in the constructivist paradigm, which views social reality as a constructed outcome that is relative, contextual, and dependent on individual experiences and interpretations. Within this paradigm, social truth is not regarded as singular and objective but is formed through social interaction and meaning-making processes (Denzin & Lincoln, 2008). The constructivist paradigm is rooted in the interpretivist tradition, which positions research participants as active agents in constructing the meaning of their social reality and rejects a strict separation between subject and object of research (Ardianto & Q-Anees, 2009). Accordingly, the experiences of ODHIV related to fear of job loss are understood as socially constructed realities shaped through interaction and lived experience.

The data sources in this study consisted of primary data obtained through direct observation and in-depth interviews with research informants. The primary informants were ODHIV who had direct experiences with social stigma and fear of job loss in Makassar City. In addition, the data were strengthened through source triangulation to enhance the credibility and trustworthiness of the research findings. The focus of the study was directed toward the subjective experiences of ODHIV in confronting social stigma, particularly in relation to the workplace, and how these experiences shaped their tendency to withdraw and conceal their HIV status from their social environment.

The main instrument in this study was the researcher, as emphasized by Sugiyono (2015), who states that in qualitative research, the researcher serves as the key instrument. The researcher was directly involved in the data collection process through interviews and observation. To support this process, auxiliary instruments were used, including interview guides, stationery, field notes, and audio recording devices to ensure that the data were systematically and accurately documented (Hikmawati, 2017).

Data collection techniques included in-depth interviews and participant observation. In-depth interviews were conducted to comprehensively explore the experiences, perceptions, and meanings constructed by ODHIV regarding fear of job loss and self-withdrawal strategies. Observation was carried out by entering the informants' social environments to understand the interactional contexts and social situations surrounding their lives. During the observation process, the researcher adopted the role of a participant observer without intervention, allowing informants to freely express their views and experiences (Creswell, 2002; Kuswarno, 2009).

Data analysis was conducted simultaneously with data collection and continued iteratively until data saturation was achieved. The data analysis technique followed the interactive analysis model proposed by Miles and Huberman, which includes the stages of data reduction, data display, and conclusion drawing and verification (Sugiyono, 2017). Data reduction involved summarizing and selecting data relevant to the research focus. The data were then presented in descriptive narrative form to illustrate the informants' experiences and subjective meanings. The final stage involved concluding ongoing verification of findings based on data consistency and depth, resulting in a credible understanding of the tendency toward self-withdrawal among ODHIV due to fear of job loss.

RESULTS AND DISCUSSION

This study aims to understand the lived experiences of people living with HIV in relation to their tendency toward self-withdrawal due to fear of job loss in Makassar City. By employing a phenomenological approach, this study does not position the experiences of people living with HIV merely as responses to objective conditions, but rather as subjective realities that are interpreted, reflected upon, and internalized within everyday consciousness. The primary focus of the analysis is directed toward how people living with HIV make sense of discrimination, social change, and feelings of security within the employment context.

The phenomenological approach enables researchers to explore experiences as they are lived by research participants, including the emotions, anxieties, and adaptive strategies that emerge in response to

social realities (Creswell, 2013). In this context, fear of job loss is not understood solely as a rational response to tangible threats, but as an existential experience that shapes self-withdrawal as part of a survival strategy.

Of the six primary respondents involved in this study, two respondents—Ruth and RM—demonstrated the strongest tendency toward self-withdrawal by choosing not to disclose their HIV status in the workplace. The decision to focus on these two respondents was based on the depth of reflection and consistency of the experiences they articulated, which phenomenologically represent meaningful patterns relevant to the aims of the study. In phenomenological qualitative research, in-depth engagement with meaning-rich cases is prioritized over quantitative representation (Smith, Flowers, & Larkin, 2009).

The tendency toward self-withdrawal exhibited by Ruth and RM did not emerge by chance but was the result of a prolonged reflective process shaped by lived experiences, observations of the social environment, and an awareness of the potential social and economic consequences should their HIV status become known to others. In the subjective experiences of both respondents, disclosure of HIV status was perceived as a high-risk action, particularly in relation to the risk of job loss or changes in treatment within the workplace.

For Ruth, HIV status was understood as a condition that placed her in a vulnerable position within the social structure, particularly in the world of work. The workplace was perceived as not yet fully a safe space for people living with HIV. Ruth expressed concern that disclosing her HIV status could trigger changes in attitudes among supervisors and colleagues, which could ultimately threaten her job security. This concern aligns with previous research findings indicating that HIV-related stigma in the workplace often manifests in subtle forms, such as social exclusion, role restriction, or moral prejudice, all of which undermine the sense of security of workers living with HIV (Herek, Capitanio, & Widaman, 2002).

Interestingly, Ruth's fear did not originate entirely from direct experiences of discrimination, but rather from indirect experiences acquired through stories, information, and observations of how society treats people living with HIV (ODHIV). From a phenomenological perspective, such indirect experiences still possess the power to shape individual consciousness and behavior, because social reality is constructed not only from what is factually experienced, but also from what is imagined and perceived as possible (Schutz, 1967).

In Ruth's experience, HIV-related stigma operates as a latent concern that persists within consciousness, even when it does not always manifest in overt discriminatory actions. Goffman (1963) explains that stigma does not always appear in the form of explicit acts, but also in the anticipation of social rejection. It is this anticipation that drives individuals to develop identity management strategies, one of which is concealing attributes considered stigmatizing.

Within this context, self-withdrawal is understood by Ruth as the most rational form of self-protection to maintain life stability, particularly in preserving employment as a primary source of livelihood. Her reserved attitude is not interpreted as a rejection of her identity as a person living with HIV, but rather as an effort to manage social and economic risks that are perceived to remain high.

Meanwhile, RM interprets the decision to withdraw as a survival strategy that affects not only himself but also the family members who depend on him. In RM's subjective experience, employment holds profound meaning as a foundation of livelihood, a moral responsibility, and a source of social identity. Consequently, HIV status is perceived as highly sensitive information that could pose substantial risks if disclosed in the workplace.

Although RM reported never having experienced direct discrimination at work, the possibility of unfair treatment remains a persistent fear within his consciousness. This finding suggests that discrimination does not need to be directly experienced to produce social and psychological effects. The perception of potential discrimination alone is sufficient to shape self-withdrawal behavior, as also documented in other studies on HIV-related stigma in the workplace (UNAIDS, 2020).

Both Ruth and RM demonstrated reflective awareness of social changes that have occurred over the past 10–15 years. They agreed that discrimination against people living with HIV (ODHIV) is currently less severe than in the past, particularly compared to one to one-and-a-half decades ago. Increased public knowledge about HIV, advances in healthcare services, and the growing openness of public discourse were perceived as contributing to a general decline in stigma. This finding is consistent with UNAIDS (2024), which reports a reduction in discriminatory

attitudes toward ODHIV in various countries, although such attitudes have not been entirely eliminated.

Nevertheless, in the subjective experiences of Ruth and RM, this decline in discrimination has not been fully internalized as a sense of security. From a phenomenological perspective, this condition indicates a gap between objective social change and individual subjective experience. Although structural progress has occurred, the lived experiences of people living with HIV remain overshadowed by uncertainty and fear of discriminatory treatment, particularly in the employment context.

Awareness of the possibility of discrimination, even when it is not directly experienced, is sufficient to shape self-withdrawal behavior. Thus, the reality lived by people living with HIV is shaped not only by what actually happens, but also by what might happen. Within the framework of symbolic interactionism, social meaning is constructed through interpretive processes involving symbols, actions, and the reactions of others, including anticipated reactions (Mead, 1934).

The tendency toward self-withdrawal experienced by Ruth and RM can be understood as an adaptive strategy in response to a social reality that is not yet fully inclusive. Self-withdrawal is not interpreted as passivity or a form of powerlessness, but rather as an expression of individual agency in managing risk and maintaining control over one's life. In the context of the workplace, where legal and social protections for ODHIV remain uncertain, a reserved stance is perceived as the safest option.

These findings also demonstrate that HIV-related stigma operates not only at the level of overt social interaction, but also at psychological and existential levels. Fear of job loss becomes an enduring emotional experience that shapes how people living with HIV perceive themselves and their environment. From a phenomenological perspective, such emotional experiences are an integral part of lived reality and cannot be separated from the social context in which individuals exist (van Manen, 2014).

Furthermore, the experiences of Ruth and RM indicate that employment is understood not merely as an economic resource but also as a component of social identity and self-worth. Threats to employment are perceived as threats to overall life continuity. Consequently, the decision to withdraw is regarded as the most logical and secure choice in the face of social uncertainty. This phenomenon underscores that discrimination against people living with HIV cannot be understood simply in binary terms of presence or absence, but rather as a complex and layered spectrum of experiences.

In the context of Makassar City, these findings indicate that although progress has been made in efforts to reduce stigma against ODHIV, substantial work remains in creating a sense of security that is tangibly experienced by people living with HIV. Protections for ODHIV in the workplace are not yet fully perceived as reliable, reinforcing the tendency for people living with HIV to adopt self-withdrawal as a self-protective strategy.

Thus, the results of this study affirm that the tendency toward self-withdrawal among people living with HIV cannot be separated from lived experiences and subjective meaning-making processes in relation to social reality. The reduction of discrimination over the past 10–15 years represents an important advancement; however, it has not been sufficient to eliminate the fear of job loss. From a phenomenological perspective, social change must not only be structurally visible but also felt and internalized as a sense of security at the individual level.

CONCLUSION

This study demonstrates that the tendency toward self-withdrawal among people living with HIV in Makassar City constitutes an adaptive strategy arising from uncertainty in social and employment protection, even though stigma and discrimination against people living with HIV have generally declined over the past one to one-and-a-half decades. Fear of job loss is not solely triggered by direct experiences of discrimination, but also by awareness of the potential for unfair treatment in the workplace. These findings underscore a gap between structural social change and the subjective experiences of people living with HIV, in which advancements in regulation, public knowledge, and healthcare services have not yet been fully translated into a tangible sense of security at the individual level.

Based on these findings, efforts to reduce stigma against people living with HIV should be directed toward strengthening employment policies that guarantee protection against health status–based discrimination, accompanied by clear mechanisms for workplace monitoring and legal enforcement. In addition, sustained educational strategies are needed

for employers and employees to foster inclusive, safe, and nondiscriminatory work environments. Policies that are sensitive to the lived experiences of people living with HIV, along with adequate psychosocial support, are essential prerequisites for ensuring that HIV status disclosure is no longer perceived as a risk, but rather as a protected right within social and economic life.

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