











A “What Matters Most” approach to investigating intersectional stigma toward HIV and cancer in Hanoi, Vietnam

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Abstract

Background: Vietnam is experiencing a growing burden of cancer, including among people living with HIV. Stigma acts as a sociocultural barrier to the prevention and treatment of both conditions. This study investigates how cultural notions of “respected personhood” (or “what matters most”) influence manifestations of HIV-related stigma and cancer stigma in Hanoi, Vietnam.

Methods: Thirty in-depth interviews were conducted with people living with HIV in Hanoi, Vietnam. Transcripts were thematically coded via a directed content analysis using the What Matters Most conceptual framework. Coding was done individually and discussed in pairs, and any discrepancies were reconciled in full-team meetings.

Results: Analyses elucidated that having *chủ tin*—a value reflecting social involvement, conscientiousness, and trustworthiness—and being successful (eg, in career, academics, or one’s personal life) are characteristics of respected people in this local cultural context. Living with HIV and having cancer were seen as stigmatized and interfering with these values and capabilities. Intersectional stigma toward having both conditions was seen to interplay with these values in some ways that had distinctions compared with stigma toward either condition alone. Participants also articulated how cultural values like *chủ tin* are broadly protective against stigmatization and how getting treatment and maintaining employment can help individuals resist stigmatization’s most acute impacts.

Conclusions: HIV-related and cancer stigma each interfere with important cultural values and capabilities in Vietnam. Understanding these cultural manifestations of these stigmas separately and intersectionally can allow for greater ability to measure and respond to these stigmas through culturally tailored intervention.

HIV and cancer are public health concerns in Vietnam, and cancer among people living with HIV is of growing concern. As of 2021, Vietnam has an estimated 250 000 people living with HIV (1) and approximately 165 000 new cancer cases and 115 000 cancer-related deaths annually (2). The country has expanded its efforts to address HIV, including the provision of free antiretroviral therapy through their national health-care system (3–6). Meanwhile, the array of cancer care services—encompassing interventions such as biomarker testing, chemotherapy, radiation therapy, and surgery (7)—can be challenging to access at a desired level of quality within Vietnam (8). Moreover, challenges in accessing care result in a substantial proportion of the

country’s cancer cases being diagnosed at an advanced stage, further exacerbating cancer-related morbidity and mortality (9,10). Relatively little is known about the epidemiology of cancer among people living with HIV in Vietnam; however, it is known that globally, people living with HIV have increased susceptibility to various cancers (eg, Kaposi’s sarcoma, non-Hodgkin’s lymphoma, and cervical cancer) (11–13), yet often exhibit low rates of engagement in the cancer care continuum (14). The rising burdens of HIV and cancer in Vietnam and the known heightened risk of cancer among people living with HIV necessitate implementation of strategies to raise awareness, establish preventive measures, enhance access to early detection, and further

increase access to appropriate HIV care and cancer treatment services throughout the country and especially for groups most at risk (3,8,15).

Despite improvements in public knowledge and development and expansion of health systems, stigma continues to be a socio-cultural obstacle to addressing the disease burdens of HIV and cancer (16–19). Globally, HIV-related stigma has been linked to lower self-efficacy, higher depressive symptoms, increased substance use, and lower rates of HIV-related health behaviors (eg, testing, taking treatment) (18–20). In Vietnam, HIV-related stigma is known to negatively affect public health initiatives and the well-being of people living with HIV by discouraging testing, engendering isolation and despair, worsening mental health, and limiting prospects for employment and higher education (21,22). Cancer stigma has been linked to delayed diagnosis, difficulty in obtaining treatment, and worse mental health (16,23–29). To date, however, much of the research on cancer stigma has occurred in high-income countries (17,25,30), and only 1 known study has investigated cancer stigma in Vietnam (31). This study found a high prevalence of perceived stigma and self-blame among people with stage IV cancer and statistically significant associations with depression, emotional well-being, and social well-being (31). Further, although people living with HIV are known to be at elevated risk of cancer (11–13) and less engaged in the cancer care continuum (14), how cancer stigma manifests among people living with HIV warrants further investigation in general, including in Vietnam.

Even though stigma is a sociocultural barrier to the prevention, care, and treatment of HIV and cancer, these stigmas' cultural manifestations have yet to be fully understood. What Matters Most is one theoretical framework that has been used to investigate the cultural aspects of stigma. What Matters Most enables a demarcation of core values and capabilities that matter most in a specific local cultural context (32,33). What Matters Most then posits that 1) stigma is experienced most acutely when it threatens the achievement of these values and capabilities, and 2) the achievement of these values and capabilities, when possible, can help mitigate the negative effects of stigma (32,33). Much of the research that uses What Matters Most has primarily focused on singular stigmas, yet it has also investigated these stigmas among populations that hold additional social positionings [eg, stigma toward mental illness among primarily undocumented Chinese immigrants in the United States (34), stigma toward HIV among women living in Botswana (35)]. Recent work that used What Matters Most to develop an intersectional stigma intervention for pregnant women living with HIV in Botswana (36) has illustrated how What Matters Most could be extended for formally investigating intersectional stigma. The concept of intersectional stigma names the interplay of stigmas toward various identities, attributes, and health conditions that intersect to shape individuals' lived experience at the nexus of multiple systems of oppression (37–39). Bringing these 2 concepts (ie, What Matters Most and intersectional stigma) together points toward a possibility that the stigmas related to these conditions may be uniquely and acutely felt when they intersect in ways to pose further threats to culturally salient capabilities. Understanding these interplays could, in turn, aid in the understanding of how to address cancer stigma and its harms among groups at higher risk for cancer who also face other stigmas, such as people living with HIV.

This qualitative study investigates perceived and experienced HIV-related stigma and perceived cancer stigma among people living with HIV. In particular, this study aims to use the concepts

of What Matters Most and intersectional stigma to advance the understanding of how these stigmas separately and intersectionally interplay with cultural notions of respected personhood in Hanoi, Vietnam.

Methods

Study setting and participants

Participants ($n = 30$) were recruited from an ongoing tobacco cessation randomized controlled trial among people living with HIV in Hanoi, Vietnam (40). Because smoking is disproportionately prevalent among people living with HIV in Vietnam—with estimates as high as 60% among men living with HIV (41,42)—and is a well-documented cancer risk factor, sampling from a tobacco cessation randomized controlled trial allowed for potential exploration of perceived cancer stigma among groups of people living with HIV with different levels of cancer risk (ie, those who smoke and those who do not smoke). All participants were living with HIV, and data on participants' cancer status and personal experiences with cancer (eg, knowing friends or family with cancer) were not collected. The sample majority was men ($n = 21$, 70%), the average age of participants was 43.5 years (8.8, range = 29–61 years), and half ($n = 15$, 50%) of the participants reported smoking.

Data collection and procedures

Following consent, participants were asked to complete semi-structured in-depth interviews with a trained Vietnamese-speaking interviewer. The interview guide began with questions on what it means to be a respected person in Vietnam. Then, to elicit participants' reactions and thoughts about negative social attitudes related to HIV and cancer, participants were presented with a series of statements engaging with stereotypes identified in peer-reviewed literature on HIV-related and cancer stigma (eg, “Most people believe that someone who has HIV brought it on themselves,” “Most people treat people with cancer like outcasts”); for each statement, participants were asked to what extent they agreed and why. A similar process was also conducted with stereotypes around people living with both HIV and cancer to explore the intersectional stigma that may be faced by people living with both conditions. This method of prompting participant discussion of stigma by using statements engaging with possible stereotypes was adapted from prior studies using the What Matters Most theoretical framework to understand stigma toward various conditions in other contexts (35,43).

In-depth interviews were conducted in Vietnamese by 4 trained research associates in a private room. All 30 in-depth interviews were audio recorded and transcribed in Vietnamese, then the first 18 in-depth interviews conducted were translated into English. The 12 in-depth interviews not translated into English were still used to inform the results, described further below. There were no statistical differences in the gender or age of the 18 participants whose transcripts were translated vs the 12 participants whose transcripts were not translated (13 men and 5 women vs 8 men and 4 women, respectively; average age 43.4 [9.8] vs 43.7 [7.4] years, respectively). Translations were checked by research associates and then by a principal investigator of the study (NTN).

Data analysis

The 18 in-depth interview transcripts translated into English that were primarily used for coding were deductively and inductively coded using a directed content analysis (44). Based on the What

Matters Most framework and prior work, 3 a priori thematic domains were defined: 1) salient cultural capabilities that are most at stake (ie, “what matters most” among people living in Hanoi, Vietnam), 2) how stigma is shaped by “what matters most” (ie, how salient cultural capabilities are threatened by stigma), and 3) how “what matters most” protects against stigma (ie, how achieving salient cultural capabilities can protect against the harms of stigma). Codes within these domains were then inductively identified via an initial review of 4 transcripts by pairs of masters-level research assistants. This preliminary codebook was then iteratively refined as coding progressed with the remaining transcripts. No new codes were added following the coding of the 11th of 18 English-translated transcripts, suggesting thematic saturation was being reached. Throughout this process, each research assistant independently coded their assigned transcript then met with the other research assistant in their coding pair to review their coding. In this step, coding pairs could identify questions or points needing clarification from the larger team (eg, unknown idioms, acronyms, or abbreviations) and resolve any discrepancies with each other, if possible. The full research team met every other week (ie, for a total of 10 full-team meetings, approximately 15 hours) to review the pairs’ coding, answer questions and provide clarification, and resolve any remaining outstanding discrepancies. Few outstanding discrepancies were brought to the full-team meetings; although metrics on interrater reliability were not used, the ability of coding pairs to reconcile almost all discrepancies between themselves suggests consistent interpretation and application of the codebook.

Because the analysis approached thematic saturation during coding of the 18 English-translated transcripts, and because of considerations around the time-intensive nature of translation, the remaining 12 in-depth interview transcripts were not translated into English. Instead, as a saturation check and to use these data to inform the analysis, these 12 transcripts were reviewed by a Vietnamese native-speaking research assistant (DH) who had coded the English-translated transcripts to see if there were any novel emergent themes in the remaining transcripts; none were identified. The descriptors used throughout the results (eg, some participants, most participants) specifically reference the group of 18 English-translated transcripts, though the presented themes are consistent across all 30 transcripts.

Ethical approval

Written informed consent was obtained from all participants. Participants were compensated approximately US\$6.50 for their participation in the study. Ethical approval for this study was granted by the institutional review boards of New York University and the Institute of Social and Medical Studies.

Results

“What matters most” among people living in Hanoi, Vietnam

Among study participants living with HIV in Hanoi, Vietnam, primary cultural considerations for “what matters most” to be a respected person centered on the interconnected attributes of having *chũ tìn* (ie, a moral concept of being credible and trustworthy) and being successful (eg, in career, academics, or one’s personal life). These capabilities are interrelated in that participants saw having *chũ tìn* as a precondition for meaningful relationships that, in turn, facilitate one’s success.

Having *chũ tìn*

Having *chũ tìn* means having good virtue and morality as well as being trustworthy, conscious, and credible. Participants saw having *chũ tìn* as a foundation for establishing and maintaining meaningful relationships and a core capability for one to be a respected person in this cultural context. Participants mentioned having *chũ tìn* as manifesting through harmonious social interactions and communication with others. In particular, participants described how one needs to initiate respectful behaviors, respectful attitudes, and good deeds to gain their interlocutor’s respect.

Well, you just need to live in harmony with the community, then people will respect you. Otherwise, as I said, people come to visit you but you have bad behaviors and attitude, then no one respects you. First of all, you should behave in a certain way to make people respect you first. (Man, aged 56 years)

Make merit, do good deeds to bring blessings to yourself and also to make others see you with a different way. (Man, aged 30 years)

In addition to one’s attitude and manners, participants saw effective communication as depending on one’s words and the ability to follow through on those words with corresponding actions. To maintain credibility and have *chũ tìn*, one is expected to speak with integrity, committing only to statements or promises that one is capable and willing to fulfill.

For example, let’s say, if I made a promise, I would make it. If I said something, it had to be precise. For example, if I made a promise with other people and I did not do it, they would no longer respect me. (Man, aged 40 years)

Participants also articulated how the moral basis for whether one’s words and actions reflect having *chũ tìn* is derived from both one’s personal virtues and morals as well as the law.

A person who is respected must first of all have the morality. (Man, aged 52 years)

To be respected in Vietnam, a person must comply with social norms... It’s complying with the constitution and law of the government. If you don’t violate the law, people will look at you respectfully. (Man, aged 47 years)

Being successful

In addition to having *chũ tìn*, participants also saw having achieved success—whether in career, academics, or personal life—as a core attribute of a respected person. Being successful was seen to further solidify one’s standing and respect within the community. Some participants acknowledged that success could be found in a broad set of different domains, whereas a few participants stated that financial success was primary.

They are particularly good at professional skills or qualified things such as being smarter than others, or to be more talented in their own fields such as academics and ... sports, or in ... things that they are better at than others, more specifically, they will be more respected. (Man, aged 44 years)

Economic condition, well, for example, if you do a certain position, you will be respected by more people and for example, comparing two people going together on the same way and foothold, others will respect those people with economic condition more. (Man, aged 52 years)

Further, some participants articulated that respect based on being successful operated in a more binary fashion (ie, one is

either successful enough to have respect and therefore achieve full personhood, or is not); on the other hand, some participants saw respect as increasing alongside perceptions of success.

Man or woman, as I said, just like what I said before, it is also especially based on their income as well as their level of education. The richer you are, the more so-called talented you are, the more respected people will be, it goes on increasing gradually. (Man, aged 44 years)

There were also ways that these core capabilities were interconnected. In this context, facets of success were seen as not only material wealth but also social capital and contributions to the community. For example, one participant noted how values similar to having *chũ tìn* (ie, sharing and being helpful) allowed for greater success in one's family life, which in turn can garner increased community respect.

If you are a man, of course, in life nowadays, both wives and husbands have to take care of the family, finances and children, but need to know how to share and help each other. I think so, once he respects his family, he can do great things in society, and he will be respected. (Woman, aged 44 years)

Stigma is shaped by “what matters most”

Using their experiences and perceptions of HIV-related stigma and perceptions of cancer stigma, participants discussed how living with HIV, having cancer, and living with both HIV and cancer could threaten one's ability to achieve cultural capabilities that matter most. Table 1 presents illustrative quotes related to stigma being shaped by “what matters most” arranged by subtheme, health condition, and whether the subtheme is more closely related to having *chũ tìn* or being successful.

Participants detailed how people known to be living with HIV can face difficulties in achieving cultural capabilities because of aspects of HIV-related stigma. Notably, stereotypes of infectiousness and immorality were seen as a barrier to forming and maintaining closeness with others—socially and physically—which threatens one's ability to have *chũ tìn*. Participants also mentioned ways HIV-related stigma inhibits success in core interpersonal relationships—especially achieving marriage—and negatively impacts employability, which limits one's ability to be successful in work and financial standing.

Looking thematically across transcripts, having cancer was generally viewed as relatively less stigmatized compared with living with HIV. However, participants did anticipate that misperceptions of infectiousness and how some cancers are tied to certain behaviors (eg, lung cancer being tied to smoking) may result in people with cancer being blamed for their condition, which could in turn inhibit social connectedness with others. Smoking status possibly leading to blame being attributed to people with lung cancer was the only way that smoking's relationship with cancer stigma appeared as thematically salient in this analysis. Having cancer was also perceived to have the real possibility of damaging or burdening prospective and existing relationship bonds—limiting especially one's success in spousal and family connections—as well as one's employability.

Intersectionally, participants articulated ways that the stigmas related to both health conditions operating together could threaten “what matters most” in ways that had some distinctions compared with the threat posed by the stigma of either condition alone. Whereas participants noted specific stereotypes being enacted to inhibit social integration for people living with HIV or cancer, they most often cited a general lack of sufficient

knowledge about both conditions as a key factor limiting the social connectedness of people living with HIV and cancer. Further, beliefs around those living with both conditions as having a “death sentence” was seen as damaging one's ability to be successful in an all-encompassing sense.

“What matters most” protects against stigma

Cultural considerations appeared to largely have protective effects against HIV-related and cancer stigma. Relative to the ways “what matters most” was seen to shape how stigma was experienced, there were many more ways that participants saw achieving or having “what matters most” could temper some of the harms of stigma (Table 2). The ways “what matters most” could protect against stigma was also relatively more consistent across conditions. For example, perceptions of either or both conditions being seen as not one's fault or unlucky were seen to alleviate blame and allow for one's moral standing to be upheld. Participants often emphasized how the high value placed on having *chũ tìn* promotes a general baseline respect for anyone in one's community, including people with potentially stigmatizing health conditions. This deeply rooted value was described as broadly protective against stigmatization. There were also ways that certain achievements related to *chũ tìn* (eg, being able to contribute to society and work, being able to take care of one's family) allowed for individuals to maintain respect; for people with cancer or living with both HIV and cancer, there also appeared to be modulation of what is expected within the physical bounds of their condition. Additionally, it was common for participants to articulate that whether individuals could be successful depended on whether they were getting treatment.

Discussion

Overall, this analysis highlighted 2 salient cultural capabilities that “matter most” in this local context (ie, having *chũ tìn* and being successful) that shape and protect against stigma toward HIV and cancer. Historically, Vietnamese cultural and societal norms are known to emphasize family cohesion, community involvement, educational attainment, professional success, mastery of an art or skill, and especially moral integrity (45,46). Many of these values were also perceived and articulated by participants to be core aspects of what it means to be a respected person in this context. Further, the use of the What Matters Most framework to look at these capabilities helped reveal ways HIV-related and cancer stigma become especially salient when they obstruct the realization of these essential cultural values and capabilities. Using What Matters Most also allowed insight into how the attainment or preservation of these capabilities might act as a buffer against the most extreme impacts of stigma.

This study adds to the cancer stigma literature by explicitly considering and investigating cultural aspects of stigma toward cancer. Research on cultural aspects of cancer stigma is extremely scarce (17,30), yet these findings also speak to the importance of such research. The comparatively low amounts of stigma toward cancer (ie, compared with HIV-related stigma) were still seen to feed into major consequences for individuals' health and well-being. Even though the level of stigmatizing attitudes toward cancer reported by participants was comparatively low, an understanding of what is most at stake was able to reveal key ways by which stigma can transform the realities of living with cancer into also negatively affecting one's social standing. In other words, examining stigma from a cultural lens helped elucidate how a more objective reality (eg, cancer treatment

Table 1. Illustrative quotes and brief summaries of ways stigma is shaped by “what matters most” by health condition(s)

Subtheme	Living with HIV	Having cancer	Both living with HIV and having cancer
Subthemes more related to having <i>chū tīn</i>			
Stigmatizing stereotypes inhibits social integration and connectedness.	Stereotypes of infectiousness “Because people don’t know much about it, they think it brings infection to other people, and they will not respect it.” (Man, aged 56 years)	Stereotypes of infectiousness and dirtiness “When people have lung cancer, people will cough and spit out a lot of sputum.... People around will then feel disgusted and won’t come near, and lung cancer is highly infectious diseases, so people will stay away from those having lung cancer, so I think it’s because of lung cancer, they are dirty.” (Man, aged 44 years)	General lack of comprehensive knowledge about both conditions “Because not everyone is knowledgeable enough and can understand much and to respect people with HIV and people with cancer ... they only know a little bit and shun. Also, be afraid of [the person with both conditions] transmitting the disease[s] to them.” (Man, aged 30 years)
Moral standing is diminished by perceptions of immorality, fault, or blame.	Transmission of HIV perceived as immoral. “There are also people who say they play around, and they are dirty or something, and such people usually sleep around together, and they inject and throw the syringes here and there, that’s dirty, they find it terrifying, they disgust them.” (Woman, aged 50 years)	Certain types of cancer (eg, lung cancer) viewed as one’s fault. “For some, it’s because they smoke a lot, like they eat and drink not really well, like it has toxic chemicals, so they got sick.” (Woman, aged 50 years)	Not applicable
Subthemes more related to being successful			
Living with the condition negatively impacts success in specific core interpersonal relationships.	HIV status negatively impacts marriageability. “Because when knowing someone with such a disease, who would want to get married to that one? About marrying, commonly people don’t want to marry someone with the disease. Only people with the same disease, luckily would empathize with each other and find themselves acceptable.” (Man, aged 45 years)	Cancer negatively impacts marriageability. “Uh if that person hasn’t had a family then definitely will have people around them, it will be harder to get married to healthy normal people. Because everyone wants their husband or wife when getting married to be healthy ones because healthy people give birth to healthy children.” (Man, aged 29 years)	Not applicable
Assumption of inability to make contributions to society	HIV status negatively affects employability. “They will lose all their health, people will not want to let them work.” (Man, aged 32 years) “And if HIV causes them to lose their jobs and their families may be ruined or something like that, they won’t be valued as they were in the beginning.” (Man, aged 30 years)	Cancer status negatively affects employability. “People with cancer ... the employers find out that they have cancer then they must definitely stop working. Because the disease makes them unable to work, for example, so they cannot do hard work, for example, or cannot meet the assigned quota or target. They are fired.” (Man, aged 40 years)	Living with both cancer and HIV is seen as a death sentence. “Because when they have it, they are sure that they will die. Those are two death sentences on them, right?” (Man, aged 56 years)

being costly) becomes a driver of social devaluation (eg, by impairing one’s ability to be perceived as successful in being able to provide for one’s family or community). Studies that examine cancer stigma in a way that is divorced from specific cultural contexts may miss key cultural mechanisms and consequences of cancer stigma.

Further, these findings demonstrated how What Matters Most helps identify ways that cultural considerations interplay with the intersectional stigma toward both conditions (ie, HIV and cancer). Pinpointing the systems of oppression that marginalize people with cancer can be challenging; however, recognizing how cultural dynamics can function oppressively and protectively in relation to stigma is crucial. Understanding the role of culture in

shaping and protecting against stigma toward cancer helps elucidate how people with, at risk for, or thought to have cancer can experience marginalization and how these experiences can vary across groups and settings, including among people with another stigmatized status like people living with HIV. Beyond solely the intersection of HIV-related stigma and cancer stigma, What Matters Most may be a helpful framework to understand the ways in which culture patterns individuals’ experiences of many types of intersectional stigma and associated harms.

A better understanding of how cancer stigma operates in a specific context can then allow the development of culturally informed interventions to reduce cancer stigma and promote psychosocial well-being (36,47). Moreover, because cancer is

Table 2. Illustrative quotes and brief summaries of ways “what matters most” protects against stigma by health condition(s)

Subtheme	Living with HIV	Having cancer	Both living with HIV and having cancer
Subthemes more related to having <i>chū' tīn</i>			
Health condition not perceived as one's fault allows for maintenance of moral standing.	HIV can be considered as not one's fault. “But there are people who did not play around, they got infected, they don't, they do not want to get that.” (Woman, aged 50 years)	Getting cancer is seen as not one's fault and/or unlucky. “Because as I said in the beginning, people unfortunately have such incurable diseases, they don't do anything to suddenly be forced or shunned.” (Man, aged 56 years)	Getting both HIV and cancer is considered one's misfortune. “Because they unfortunately have such diseases, they are likely to have one foot in the grave, they will not live long, we should not hold grudges against them, we should encourage them to have a better mood so that they can live a healthier life.” (Woman, aged 54 years)
<i>Chū' tīn</i> encourages a baseline of respect toward others regardless of health conditions.	People with faith and being positive will still be respected. “... those cases are people with HIV but they are not depressed because of that, they still rise up ... then those are the people who still are respected, except for people having HIV who depress and take revenge on society, those are not worthy of respect.” (Man, aged 44 years)	Everyone should be respected as a human. “They still have to be respected, because they are also human, they only live for 3 months, even if they can live just a day, they are still human.” (Man, aged 32 years)	People should respect and be kind to individuals with both HIV and cancer. “Yes, right, respected ... As long as they stay alive, we should live well with them, considering it as kindness to that person, to the living people.” (Woman, aged 54 years)
Ability to continue contributing to society	Being able to support the community. “Because people with HIV are not dead yet, they can still help the community and society. And when they do those actions, the community will definitely respect them, and need them.” (Man, aged 56 years)	Health conditions do not affect individuals' ability to work. “Because when we first get sick, we are still healthy enough to work and live normally until the illness gets so worse that we can't work or act anymore.” (Man, aged 30 years)	Remaining capable to contribute to the community. “Because they already know that they will not live for long, but luckily, they find good medicine and doctors, they are still alive. They still have a little health to support the community and society as much as they can, then the community and society will never abandon those people.” (Man, aged 56 years)
Subthemes more related to being successful			
Pursuing treatment allows for employment and career success.	Treatment allows ability to work. “People with effective treatment still work, just like normal people. They have no problem at all, still healthy....” (Woman, aged 50 years)	Treatment allows ability to work and being part of the community. “It's ... if they take medicine to stop symptoms, they will be healthy, they still go to work with the community, live with the community, do business with brothers, people still respect them.” (Man, aged 46 years)	Treatment manages symptoms and allows employment and contribution to society. “They still work, they are still normal, their family is still healthy, they are treated with this anti-medicine [antiretroviral therapy] and that cancer medicine. Some people last a long time. They still work as normal, just like everyone else, there's nothing to stigmatize and discriminate against them.” (Woman, aged 50 years)
Maintaining the ability to support family and society can lead to continued perception of success.	Ability to work and contribute to the family. “They still go to work, still take care of their families, society, and community.” (Woman, aged 50 years)	Ability to work and take care of the family “I disagree with this [idea that people with cancer cannot contribute to society]. Because a person with cancer still contributes normally to society, still has to take care of their family, or still has to contribute to society. They still have the right to work, it is not that they don't have the right to work.” (Man, aged 32 years)	Patients with both cancer and HIV work to support their family “People who have both HIV or cancer, they live for 1 day, they work, unfortunately they get it ... unfortunately one of their hands gets it, or something like that ... they still must be respected. They work to support their families ... it's not that they don't work and neglect their families.” (Man, aged 32 years)

more prevalent in some groups of individuals with additional marginalized statuses (eg, people living with HIV), it is important to be able to investigate these cultural manifestations of stigma toward cancer intersectionally, as well as apply these findings to interventions for these groups (48). For example, this study's intersectional findings can help inform efforts to mitigate cancer stigma as a barrier to engagement in the cancer care continuum among people living with HIV in Hanoi. These efforts could provide general knowledge about both conditions (as opposed to being highly targeted toward specific negative stereotypes), dispel the idea of having both conditions as being a "death sentence," and further leverage the capabilities of having *chủ tín* and being successful by emphasizing that people with both conditions can still give and receive community support and be successful in their own right, especially if supported in getting treatment.

Study results should be considered in light of potential limitations. All participants were living in or near Hanoi at the time of the interviews, meaning that these findings may not be transferable to other local contexts in Vietnam. Further, even though many of the questions asked about general community perceptions of "what matters most" and perceived stigma, the sample was of individuals who had one of the stigmatized statuses being investigated (ie, living with HIV), none of whom mentioned having cancer. Participants could thus speak to their personal experiences of HIV-related stigma as well as their perceptions, while their discussions of cancer stigma and intersectional stigma toward HIV and cancer were limited to perceived cancer stigma only; this means their responses were likely largely hypothetical and based on their perceptions of community attitudes. It is possible that some participants may have been speaking from personal experience as a cancer patient or knowing a friend or family member with cancer; however, how often this happened is unknown because sociodemographic data were not collected on cancer-related experiences. Further, because of their lived experience of HIV, participants may also have had conceptions of HIV-related stigma and intersectional stigma toward HIV and cancer that may differ from those held by people living in Hanoi who are not living with HIV. Also, many other forces known to shape respected personhood as well as HIV-related stigma in other contexts (eg, gender, heterosexism, stigma toward drug use) were not investigated in this study design or emerged as themes in the data elicited yet may deserve further exploration (35,43,49–51). Smoking status was one factor thought to potentially shape perceived cancer stigma in this context; although the influence of smoking status on cancer stigma was not thematically salient in this analysis, it may deserve further exploration in additional qualitative studies on cancer stigma, particularly those that focus on stigma toward lung cancer. Lastly, cancer was asked about only generally in these interviews, and future efforts could investigate how stigma toward specific cancers (eg, breast cancer, lung cancer, cervical cancer) and cancer at different stages of the life course may have distinctions in specific cultural manifestations (17,30).

As cancer and the HIV epidemic continue to contribute greatly to global disease burden, it becomes increasingly crucial to understand how stigma impedes the control and prevention of these conditions; is detrimental to the health and well-being of people who have or are at risk for HIV and cancer; and intersects with additional stigmas toward other attributes, identities, and health conditions. Although HIV-related stigma and cancer stigma vary across cultures, frameworks like What Matters Most can assist researchers in identifying culturally relevant aspects

of stigma and offer indispensable insight into how and why these health conditions are damaging to personhood. This in turn facilitates steps toward reducing the burden of these health conditions, such as the development and tailoring of stigma measures and antistigma interventions for specific contexts and priority groups.

Data availability

The data underlying this article cannot be shared due to the privacy of individuals who participated in the study.

Author contributions

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Conflicts of interest

The authors declare no conflicts of interest.

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