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From Diagnosis to Hemodialysis Initiation: Lived Experiences of Patients with Chronic Kidney Disease in Bulacan, Philippines

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Abstract

Introduction: Chronic kidney disease is characterized by an irreversible and progressive decline in kidney function and remains a major global public health concern. Its increasing prevalence in the Philippines is concerning; however, few studies have examined patients' lived experiences within the country's cultural and healthcare context. Objective: This study aimed to describe Filipino patients' transition from chronic kidney disease diagnosis to hemodialysis initiation in Bulacan, Philippines. Methods: This descriptive phenomenological study used purposive sampling to recruit six participants who met the inclusion and exclusion criteria. Data were collected through in-depth, semi-structured interviews and analyzed using Colaizzi's seven-step method. Results: The findings indicated that most participants experienced fear, anxiety, denial, abrupt lifestyle changes, and physical discomfort during the initial stages of treatment. As they continued their treatment journey, they gradually became more accepting and adjusted to their new reality despite experiencing considerable physical, emotional, and financial difficulties. This process was supported by their families, healthcare providers, peers, and spirituality. Conclusion: The participants' experiences underscore the importance of providing holistic, patient-centered care, greater emotional support, and structured education to improve the overall health and quality of life of patients undergoing hemodialysis.

Keywords:
Chronic Kidney Disease, Hemodialysis Initiation, Lived Experience, Patient Support

INTRODUCTION

Chronic kidney disease (CKD) is a progressive condition characterized by abnormalities in kidney structure or function that persist for at least three months and have implications for health. These abnormalities may include an estimated glomerular filtration rate (eGFR) below 60 mL/min/1.73 m², with or without other markers of kidney damage (Kidney Disease: Improving Global Outcomes [KDIGO] CKD Work Group, 2024). As CKD progresses, kidney function may gradually decline until kidney failure occurs, at which point renal replacement therapy (RRT), such as dialysis or kidney transplantation, may be required to sustain life (Elias et al., 2025; KDIGO CKD Work Group, 2024). When patients are diagnosed with advanced CKD, conservative management may no longer be sufficient to maintain kidney function, requiring preparation for RRT. In resource-constrained settings, however, access to RRT may be limited by financial barriers, geographic challenges, shortages of specialists and equipment, and inadequate knowledge of available treatment options (Shumbusho et al., 2025).

The burden of kidney disease in the Philippines continues to increase. Citing data from the National Kidney and Transplant Institute, the Philippine Society of Nephrology estimated that approximately one Filipino develops chronic renal failure every hour, equivalent to about 120 cases per million population annually (Philippine Society of Nephrology [PSN], 2024). Among Filipino patients with end-stage renal disease, approximately 94% receive center-based hemodialysis, whereas only 4% undergo peritoneal dialysis and 2% receive kidney transplantation (Pajimna et al., 2023). Kidney disease therefore remains a major contributor to morbidity and mortality in the country. Delayed clinical presentation, geographic disparities, financial constraints, and suboptimal access to healthcare services continue to hinder timely diagnosis and treatment (Pajimna et al., 2023; PSN, 2024). These conditions emphasize the need to understand the experiences of patients undergoing the difficult transition from CKD diagnosis to hemodialysis initiation.

Patients with pre-dialysis CKD may experience physical, psychological, social, economic, and spiritual difficulties (Agustiyowati et al., 2018). The initiation of hemodialysis introduces additional demands and is often accompanied by a complex and evolving process of adjustment. Patients must adapt not only to the physical effects of treatment but also to changes in their independence, daily routines, social roles, and perceptions of life's meaning (Alsing et al., 2022; Li et al., 2025; Mehta et al., 2024). Consequently, dialysis care should extend beyond the management of clinical symptoms and adopt a holistic, accessible, and person-centered approach that addresses patients' emotional, social, economic, and spiritual needs (Elias et al., 2025).

Although the long-term clinical outcomes and experiences of patients receiving maintenance hemodialysis have been extensively investigated, less attention has been given to the specific transition from CKD diagnosis to the first few months of treatment, particularly in low- and middle-income countries (Alsing et al., 2022; Mehta et al., 2024; Uwiragiye et al., 2025). In the Philippines, this transition may represent an abrupt shift from independence to technology dependence, accompanied by physical discomfort, acute emotional distress, and substantial financial strain. Filipino patients may navigate these challenges through culturally contextualized coping strategies, particularly close family involvement and spiritual faith (de Guzman et al., 2009). Because healthcare infrastructure, access to treatment, and cultural dynamics vary across settings, examining this critical transition within the local context is necessary. The present study addresses this gap by exploring how patients newly initiated on hemodialysis adapt to treatment, thereby providing an empirical basis for culturally appropriate, patient-centered care and targeted psychosocial nursing interventions.

The relationship between the physical disruption caused by chronic illness and patients' psychological adaptation is interpreted through Michael Bury's Theory of Biographical Disruption and Albert Bandura's Social Cognitive Theory. Bury (1982) proposed that chronic illness constitutes a major disruption to an individual's daily structures, social roles, and sense of identity. This perspective provides a basis for understanding the anxiety, disbelief, loss of autonomy, and identity disruption that may occur during the early transition to hemodialysis (Mehta et al., 2024; Uwiragiye et al., 2025). Bandura's (1986) theory explains how individuals' cognitive beliefs and behaviors interact dynamically with their social and environmental circumstances. Within the context of hemodialysis initiation, external influences such as family involvement and support from healthcare professionals may interact with internal coping resources, including self-efficacy and spiritual faith. These interactions may help patients manage emotional distress, strengthen psychological resilience, and maintain treatment adherence despite continuing physical symptoms and financial difficulties (de Guzman et al., 2009; Saedi et al., 2024).

This study is grounded in Husserlian descriptive phenomenology, which seeks to describe the essence of participants' lived experiences through the bracketing of researchers' preconceived assumptions. Bury's Theory of Biographical Disruption and Bandura's Social Cognitive Theory are used only as interpretive frameworks for understanding the findings rather than as predetermined categories for data collection or analysis. Bury's theory helps explain how CKD and hemodialysis disrupt patients' lives and identities, whereas Bandura's theory provides insight into how self-efficacy, coping resources, and environmental support influence adaptation during hemodialysis initiation.

The primary aim of this study is to explore and describe the lived experiences of Filipino patients in

Bulacan as they transition from CKD diagnosis to the initiation of hemodialysis. Specifically, the study aims to describe patients' emotional reactions to the diagnosis, identify challenges experienced before dialysis, explore their initial treatment experiences, examine the effects of hemodialysis on daily life and quality of life, and identify culturally relevant coping mechanisms and support systems. The analysis attends to two interrelated processes: the profound biographical disruption associated with emotional distress and loss of personal autonomy, and the behavioral adaptation facilitated by family support, spiritual engagement, and interactions with healthcare professionals.

Unlike previous qualitative studies that have primarily examined patients already receiving maintenance hemodialysis, this study focuses on the frequently overlooked transition from CKD diagnosis to hemodialysis initiation. By examining patients' experiences before and during the decision to begin dialysis, the study captures the emotional, cognitive, social, and practical adjustments that precede long-term treatment. Conducted within the Philippine healthcare context, it also provides culturally relevant insights into how family involvement, financial concerns, spiritual beliefs, and access to healthcare shape this transition. The findings are expected to validate patients' psychological struggles, enhance nephrology nurses' understanding of holistic care, and provide healthcare policymakers with context-specific evidence for strengthening educational programs, psychosocial support, financial safety nets, and transition-focused healthcare interventions. Ultimately, the study seeks to establish an empirical foundation for culturally adapted and patient-centered care strategies for Filipino patients beginning hemodialysis.

METHODS

1. Design

This descriptive phenomenological study explored the lived experiences of patients with chronic kidney disease during their transition from diagnosis to the initiation of hemodialysis. Husserlian descriptive phenomenology was used to describe the essential structure of the participants' experiences while minimizing the influence of the researchers' prior assumptions. Data were analyzed using Colaizzi's seven-step phenomenological method (Colaizzi, 1978). The reporting of this study was guided by the 32-item Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007).

2. Study Setting and Participants

The study was conducted at a selected hemodialysis center in Bulacan, Philippines, between February and March 2026. The target population consisted of adults who had recently initiated maintenance hemodialysis and resided in selected municipalities in Bulacan.

Six participants were recruited through purposive sampling to obtain information-rich accounts of the phenomenon under investigation. The inclusion criteria were patients who: (1) were at least 18 years old; (2) resided in Bulacan; (3) could communicate verbally in Tagalog or English; and (4) had been receiving maintenance hemodialysis for 1–3 months before their participation in the study.

Patients were excluded if they exhibited signs of acute medical or psychological distress during screening, including drowsiness, agitation, or dangerously elevated blood pressure that could prevent them from safely completing the interview. Patients experiencing delirium, those unable to communicate verbally, and those admitted to an intensive care unit because of critical illness were also excluded.

Data saturation was achieved when successive interviews produced no new meanings, categories, or themes relevant to the phenomenon. After the sixth interview, the participants' accounts reflected previously identified patterns, and no additional information emerged that substantially expanded or modified the thematic structure. The research team subsequently agreed that the data were sufficiently rich to describe the participants' lived experiences.

3. Semi-Structured Interview Guide

Data were collected using a semi-structured interview guide developed by the research team based on the study objectives, a review of relevant literature, and the theoretical perspectives underpinning the study. The interview questions were designed to explore participants' experiences from CKD diagnosis to hemodialysis initiation, including their emotional and psychological responses, physical difficulties before and after dialysis initiation, functional limitations, financial challenges, coping practices, and perceived support from family members, friends, community networks, and healthcare providers.

The interview guide underwent content validation by a panel of three experts comprising a nephrology nurse specialist, a qualitative research expert, and a senior nursing academic. All three experts held doctoral degrees and had experience in nephrology care, qualitative research, nursing education, or instrument development. Based on their recommendations, the wording and sequence of the interview questions were revised to improve clarity, relevance, cultural appropriateness, and alignment with the study objectives and descriptive phenomenological approach. Ambiguous wording and technical terminology were simplified to promote an empathetic and conversational interview process.

4. Data Collection Process

The interviews were conducted by M.C.A., N.C.B., J.L.B., I.F.B., and P.L.M., who served as the primary instruments for data collection. Before each interview, participants received information about the

purpose of the study, the open-ended interview format, the voluntary nature of participation, and the potential emotional sensitivity of recounting their diagnosis and early treatment experiences.

Individual, in-depth, semi-structured interviews lasting approximately 15–30 minutes were conducted in a quiet, private, and comfortable location selected in consultation with each participant. The interviews were scheduled outside active hemodialysis sessions and critical rest periods to minimize fatigue and physical discomfort. Participants were permitted to pause, reschedule, or discontinue the interview if they experienced fatigue or distress.

The interviews were conducted in Tagalog or English according to each participant's preferred language. All interviews were audio-recorded with the participants' permission and transcribed verbatim. The transcripts preserved the participants' expressions, emotional pauses, and culturally relevant language as accurately as possible. Tagalog quotations selected for inclusion in the manuscript were translated into English by a bilingual member of the research team. The translations were independently checked against the original Tagalog transcripts by another bilingual researcher, and any discrepancies were resolved through discussion until agreement was reached.

5. Data Analysis

The interview transcripts were analyzed using Colaizzi's seven-step phenomenological method (Colaizzi, 1978). The analysis involved the following steps: (1) Familiarization. The researchers repeatedly read the interview transcripts to obtain a comprehensive understanding of the participants' accounts; (2) Identification of significant statements. Statements directly related to the transition from CKD diagnosis to hemodialysis initiation were extracted from the transcripts; (3) Formulation of meanings. The researchers interpreted the meanings underlying each significant statement while remaining close to the participants' original accounts; (4) Clustering of themes. Related formulated meanings were organized into theme clusters, themes, and subthemes; (5) Development of an exhaustive description. The researchers developed a comprehensive description that integrated the identified themes and represented the participants' lived experiences; (6) Identification of the fundamental structure. The exhaustive description was condensed into a concise statement representing the essential structure of the phenomenon; and (7) Participant validation. The fundamental structure and principal findings were returned to the participants for confirmation that the interpretation accurately reflected their experiences. All six participants reviewed the summary of the findings and confirmed that it adequately reflected their experiences. No substantive changes to the thematic structure were requested.

The researchers reviewed the emerging codes, formulated meanings, themes, and subthemes throughout the analysis. Differences in interpretation were discussed among the research team until consensus was reached.

6. Rigor and Trustworthiness

The rigor of the study was established according to Lincoln and Guba's criteria of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was supported through participant validation, peer debriefing, and continued engagement with the interview data. Transferability was facilitated by providing descriptions of the participants, study context, and phenomenon. Dependability was supported through an audit trail documenting the data collection and analytical decisions. Confirmability was maintained through researcher bracketing, reflexive journaling, research team discussions, and independent review of the coding and thematic analysis.

As the primary instruments of qualitative data collection, the researchers practiced reflexivity throughout the study. Bracketing was undertaken before and during data collection and analysis to minimize the influence of personal assumptions and previous clinical experiences. Reflexive journals and research team discussions were used to ensure that the findings remained grounded in the participants' accounts rather than the researchers' prior perspectives.

7. Research Ethics

Ethical approval was obtained from the Center for Research Excellence and Development Office of Dr. Yanga's Colleges, Inc., Philippines (Reference No. CREDO-EC-CHS-002/02/2026). Administrative permission was also obtained from the participating hemodialysis facility and relevant local authorities before data collection.

All participants received written information about the study and provided written informed consent before participation. They were informed of their right to decline to answer any question, pause or discontinue the interview, and withdraw from the study at any time without penalty. Separate permission was obtained for audio recording.

The study complied with the Philippine Data Privacy Act of 2012 (Republic Act No. 10173). Personal identifiers were removed from the transcripts, and each participant was assigned an alphanumeric code, such as "HD Pt1." Digital audio recordings and interview transcripts were stored on encrypted, password-protected devices accessible only to authorized members of the research team. A referral plan was established to provide appropriate psychosocial support if a participant experienced significant emotional distress during or following the interview.

RESULTS

Six adults receiving maintenance hemodialysis in Bulacan, Philippines, participated in the study. The

participants comprised three men and three women. Five participants were married, and one was single. At the time of data collection, their duration of hemodialysis ranged from 30 to 90 days, representing the early transition period following hemodialysis initiation. The participants' characteristics are presented in Table 1.

Analysis of the participants' accounts generated four themes and 13 subthemes describing their experiences from CKD diagnosis to hemodialysis initiation. The themes and sub-themes are presented in Table 2.

Table 1. Participant Characteristics (*N* = 6)

Patient Code	Gender	Educational Attainment	Marital Status	Duration of Hemodialysis (Days)	Comorbidities
HD Pt1	Male	Primary	Married	45	Hypertension, diabetes
HD Pt2	Male	College	Married	30	Hypertension, diabetes
HD Pt3	Female	College	Married	30	Hypertension, diabetes
HD Pt4	Female	Primary	Married	60	Hypertension, diabetes
HD Pt5	Female	College	Married	90	Hypertension, diabetes
HD Pt6	Male	College	Single	60	Hypertension

Table 2. Themes and Sub-themes

Theme	Sub-themes
Theme 1: Lived Emotional and Psychological Responses to Chronic Illness	1.1 Denial and Eventual Acceptance of Dialysis 1.2 Emotional and Psychological Impact of Chronic Illness 1.3 Spiritual Beliefs and Faith
Theme 2: Deterioration in Physical Health and Functional Ability	2.1 Clinical Deterioration and Symptom Progression Before Dialysis 2.2 Physiological and Bodily Changes Following Dialysis 2.3 Functional Limitations and Social Withdrawal 2.4 Treatment-Related Complications and Adaptation
Theme 3: Self-Management and Health Regulation	3.1 Reliance on Alternative and Self-Management Practices 3.2 Delayed Health-Seeking Behavior 3.3 Improved Adherence and Health Awareness
Theme 4: Social Support Networks	4.1 Family Support 4.2 Community Support 4.3 Healthcare Provider Support

1. Theme 1: Lived Emotional and Psychological Responses to Chronic Illness

This theme describes the participants' emotional and psychological responses to CKD diagnosis and hemodialysis initiation. Their accounts reflected initial fear and denial, emotional distress associated with chronic illness, gradual acceptance of dialysis, and the importance of spiritual beliefs in coping with their condition.

1.1 Sub-theme 1: Denial and Eventual Acceptance of Dialysis

Participants initially expressed resistance to hemodialysis and difficulty accepting that they required long-term treatment. Some viewed dialysis with fear and attempted to reject the recommendation. Over time, however, they began to recognize hemodialysis as necessary to relieve their symptoms and sustain their lives.

> *"I did not want dialysis; I really did not want it. However, later, I no longer regretted it because without dialysis, I would continue to suffer from the illness." (HD Pt2)*
>
> *"At first, I said that I did not want it. I did not like the idea of dialysis, but the doctor said it was necessary and that I really needed it." (HD Pt5)*

1.2 Sub-theme 2: Emotional and Psychological Impact of Chronic Illness

CKD diagnosis and the need for hemodialysis caused considerable emotional distress. Participants described sadness, discouragement, and questions about why the illness had happened to them. The loss of employment, independence, and their previous way of life further intensified these emotional responses.

> *"It hurts emotionally, and I even asked why it happened to me when I was not a bad person." (HD Pt4)*
>
> *"I am sad because I no longer have a job, and then I also became ill." (HD Pt1)*
>
> *"I felt discouraged because there was another problem." (HD Pt3)*

1.3 Sub-theme 3: Spiritual Beliefs and Faith

Spiritual beliefs helped participants interpret and cope with their illness. Some viewed their condition as a test from God and believed that they had been given the strength to endure it. Prayer, church attendance, and trust in God provided comfort and supported their gradual acceptance of treatment.

> *"It is okay. I accept it because I know that I will not be given a test that I cannot handle. I just*

have to hold on. The Lord will not give me a test that I cannot handle, so I accept it." (HD Pt3)
"This is from God. Of course, it was given to me, so I must face it. I am not afraid." (HD Pt4)
"I am thankful that I can still go to church; it is a source of strength for me." (HD Pt1)

2. Theme 2: Deterioration in Physical Health and Functional Ability

This theme describes the physical symptoms and functional changes experienced before and after hemodialysis initiation. Participants reported worsening symptoms before treatment, changes in their bodies following dialysis, limitations in daily and social activities, and treatment-related complications that required continued adaptation.

2.1 Sub-theme 1: Clinical Deterioration and Symptom Progression Before Dialysis

Before initiating hemodialysis, participants experienced worsening physical symptoms that eventually required medical attention or hospitalization. These symptoms included breathlessness, fluid accumulation, skin rashes, changes in urination, and increasing creatinine levels. For some participants, the severity of these symptoms contributed to their realization that treatment could no longer be postponed.

"My creatinine level increased from 6 to 10 mg/dL. I had severe fluid accumulation in my lungs, which made it difficult for me to breathe and caused complete exhaustion." (HD Pt2)
"I developed rashes on my legs that were very itchy. I also urinated frequently, four or five times, and experienced breathlessness." (HD Pt5)
"I only found out when I had pneumonia and could not breathe, so I had to be taken to the hospital." (HD Pt6)

2.2 Sub-theme 2: Physiological and Bodily Changes Following Dialysis

Following hemodialysis initiation, participants became increasingly aware of changes in their bodies. They described weight loss, darkening of the skin, and reduced or absent urine output. For one participant, the inability to urinate reinforced the perceived necessity of continuing hemodialysis.

"I lost weight. I used to be heavier than you. My body lost so much weight, and my skin started to darken." (HD Pt5)
"Now, I undergo dialysis because I no longer urinate. If I could still urinate, I would not undergo dialysis." (HD Pt6)

2.3 Sub-theme 3: Functional Limitations and Social Withdrawal

Participants described fatigue, reduced physical strength, and restrictions on strenuous activities following hemodialysis initiation. These limitations affected their independence and participation in social activities. Some participants remained at home more frequently or stopped attending community gatherings.

"I no longer attend gatherings because there is really nothing I can do there." (HD Pt6)
"I stopped my physical activities for now. I mostly stay at home, although I can still go out sometimes." (HD Pt3)

2.4 Sub-theme 4: Treatment-Related Complications and Adaptation

Participants experienced treatment-related complications, including muscle cramps and concerns about catheter-related infection. Those using temporary central venous catheters described taking additional precautions to protect the catheter. A previous catheter infection also caused anxiety and led one participant to avoid crowded places.

"Initially, when I started dialysis, I experienced leg cramps, but I no longer have them and am generally stable during treatment." (HD Pt1)
"I need to protect it, so I cover this [referring to the central venous catheter] in case it gets dusty." (HD Pt2)
"I had a catheter infection before, so now I avoid crowds as much as possible because I am worried about getting another infection." (HD Pt5)

3. Theme 3: Self-Management and Health Regulation

This theme describes how participants managed their health before and after hemodialysis initiation. Their accounts reflected the use of alternative practices, delayed professional care, and increased awareness of the need to follow dietary, physical activity, and treatment recommendations.

3.1 Sub-theme 1: Reliance on Alternative and Self-Management Practices

Before recognizing the severity of CKD, some participants attempted to manage their symptoms through home remedies, particular foods, or other self-directed practices. These approaches were influenced by limited awareness of CKD and the belief that their symptoms were caused by less serious conditions, such as kidney stones.

"I thought that eating apples would get rid of my kidney stones and that kidney stones were what was wrong with me. I did not realize how serious my condition was." (HD Pt4)
"I took something—what I called my 'sucking stuff'—whenever I felt pain, until the pain subsided." (HD Pt2)

3.2 Sub-theme 2: Delayed Health-Seeking Behavior

Fear of dialysis and reluctance to accept the diagnosis contributed to delays in seeking or following recommended treatment. Some participants continued to hope that their laboratory results would improve and initially declined preparations for dialysis. Medical emergencies eventually led them to recognize the seriousness of their condition.

"The doctor insisted that I should have a fistula because my creatinine was high. However, I refused because I was still hoping that my creatinine level would decrease." (HD Pt3)
"Initially, I did not follow the doctor's advice because I did not want to undergo dialysis. I waited until it was really necessary, and I eventually required emergency hospitalization." (HD Pt2)

3.3 Sub-theme 3: Improved Adherence and Health Awareness

After initiating hemodialysis, participants described becoming more aware of the importance of following treatment recommendations. They reported changes in their diets, fluid intake, and physical activities. These changes reflected an increased effort to regulate their health and avoid behaviors that could worsen their condition.

"I avoid the foods that I should not eat. I am always mindful now—no red meat, limited vegetables, and fruit." (HD Pt1)
"I need to be more careful and avoid risky or strenuous movements." (HD Pt3)

4. Theme 4: Social Support Networks

This theme describes the emotional, practical, financial, and informational support that participants received during the early period of hemodialysis. Family members, community organizations, local government units, and healthcare providers contributed in different ways to helping participants manage treatment-related challenges.

4.1 Sub-theme 1: Family Support

Family members provided emotional encouragement, practical assistance, and financial support. They also helped participants coordinate medications, prepare appropriate meals, and travel to treatment sessions. Participants described family support as an important source of strength and motivation.

"My sister always tells me that I am going to make it. My friends are always there to support me, and my children always say, 'Mama, you will make it.'" (HD Pt4)
"It is the support and prayers of my family that really help." (HD Pt1)
"They are always there, providing encouragement and financial support." (HD Pt3)
"I feel blessed because I have support. My friends and family do not neglect me." (HD Pt5)

4.2 Sub-theme 2: Community Support

Community organizations and local government units provided logistical and financial assistance. Participants described receiving support from neighbors, tricycle driver associations, and local government services, including transportation and emergency assistance.

"Our tricycle association, or TODA, also gave me assistance because I am a member. My neighbors also gave me something." (HD Pt2)
"The local government unit provided financial assistance and an ambulance when I needed to be taken to the hospital." (HD Pt4)

4.3 Sub-theme 3: Healthcare Provider Support

Healthcare providers supported participants by explaining their condition, providing treatment-related education, offering emotional reassurance, and helping them make decisions about their care. Clear communication with nurses and physicians helped participants better understand their illness and treatment requirements.

"The nurses were helpful and provided important education about my illness." (HD Pt2)
"My doctor was very good. He explained my illness in detail and taught me which foods I could eat." (HD Pt1)

DISCUSSION

This study explored the lived experiences of adults during the first 30–90 days of hemodialysis in Bulacan, Philippines. The findings indicate that the transition from CKD diagnosis to hemodialysis initiation involved a multidimensional disruption affecting the participants' emotional well-being, physical functioning, health behaviors, and social relationships. Participants initially experienced fear, anxiety, denial, sadness, and uncertainty. Over time, however, they gradually accepted their condition and adjusted to the demands of treatment. These experiences are consistent with Bury's (1982) concept of biographical disruption, which explains how chronic illness may interrupt daily routines, future expectations, social roles, and an individual's sense of identity. The emotional and existential adjustment described by the participants is also consistent with previous studies of patients initiating or receiving hemodialysis (Alsing et al., 2022; Elias et al., 2025; Li et al., 2025; Mehta et al., 2024; Uwiragiye et al., 2025).

Another important finding concerned how participants recognized the seriousness of their illness. For several participants, abnormal laboratory findings alone did not immediately lead to acceptance of their condition or the need for hemodialysis. Instead, the severity of CKD became more apparent when symptoms such as difficulty breathing, fatigue, sleep disturbances, reduced functional capacity, and decreased or absent urine output began to interfere with their daily activities. Some participants delayed seeking professional care or initially relied on home remedies until their symptoms became difficult to manage. Reduced or absent urine output was interpreted by some participants as a tangible indication that their kidneys were no longer functioning adequately and that hemodialysis had

become necessary. These findings illustrate how patients may understand illness not only through clinical information but also through direct and observable bodily experiences.

After hemodialysis was initiated, participants frequently evaluated the effectiveness of treatment according to improvements they could personally observe, particularly relief from breathing difficulties and other distressing symptoms. Their understanding of treatment was therefore grounded partly in their immediate bodily experiences rather than laboratory findings alone. This interpretation is consistent with previous studies showing that patients' perceptions of CKD and hemodialysis are shaped by symptom burden, functional limitations, and their direct experiences of treatment outcomes (Fletcher et al., 2022; Mehta et al., 2024; Pollock et al., 2024). The participants' accounts of fatigue, physical discomfort, emotional distress, and limited daily functioning are also consistent with qualitative evidence demonstrating that symptom burden among patients receiving hemodialysis may reduce independence and adversely affect emotional well-being (Akhtar et al., 2025). The prominence of these symptoms further reinforces the importance of systematic nurse-led symptom identification, monitoring, and management throughout dialysis care (Bennett et al., 2025).

The findings also demonstrate a gradual change in the participants' health-related behaviors. Before initiating hemodialysis, some participants reported delaying medical consultation, minimizing their symptoms, or relying on alternative and self-management practices. After treatment began, they became more attentive to dietary restrictions, fluid intake, medication use, treatment schedules, and changes in their physical condition. This transition should be understood as an adaptive process rather than simply as a change from nonadherence to adherence. Bandura's (1986) Social Cognitive Theory suggests that health behavior is shaped by reciprocal interactions among personal beliefs, previous experiences, behavior, and environmental influences. In this study, symptom relief, improved understanding of the illness, guidance from healthcare providers, and encouragement from family members appeared to support the participants' growing capacity to manage their condition.

The relationship between illness acceptance and changes in health behavior is supported by Hreńczuk et al. (2024), who identified a positive association between illness acceptance and engagement in health-related behaviors among patients receiving hemodialysis. Although their quantitative study did not specifically examine how severe symptoms affected denial, its findings support the interpretation that greater acceptance may be associated with improved engagement in self-care and treatment recommendations. Previous qualitative studies have similarly shown that psychological adjustment, health knowledge, and supportive relationships influence self-care behaviors among patients with advanced CKD or those receiving hemodialysis (Kim & Lee, 2023; Nair et al., 2021). The behavioral changes reported in the present study therefore represent an evolving process of learning, acceptance, and adaptation to the demands of long-term treatment.

Spirituality was another important component of the participants' adjustment. Prayer and faith helped them manage uncertainty, maintain hope, and interpret their illness within a broader spiritual context. Faith did not eliminate their physical or emotional difficulties; rather, it provided an emotional and spiritual resource that helped them continue treatment and gradually accept their condition. This finding is consistent with previous research indicating that spirituality and religious faith are important coping resources among Filipino patients receiving hemodialysis (de Guzman et al., 2009). The importance of faith described in the present study also demonstrates how adaptation to hemodialysis is influenced by the cultural and spiritual context in which patients understand illness, suffering, treatment, and recovery.

Adaptation was further supported by relationships with family members, community members, and healthcare providers. Family members provided emotional encouragement, financial assistance, transportation, and practical support with treatment-related needs. Healthcare providers contributed through clinical information, reassurance, and guidance concerning treatment and self-care. Previous research has similarly demonstrated the importance of supportive healthcare relationships and family involvement in helping patients manage the demands of hemodialysis (Reid et al., 2016; Shahgholian & Yousefi, 2018). Comparable findings were reported by Gebrie et al. (2023), whose participants described faith, family and social support, supportive healthcare relationships, financial constraints, and transportation difficulties as important aspects of living with hemodialysis.

In addition to family and healthcare support, participants described assistance from members of their local communities. This assistance included financial contributions and, in some cases, free transportation provided by associations of tricycle drivers. These experiences reflect the Filipino cultural value of *bayanihan*, or collective community support, in responding to illness-related difficulties. Community assistance helped participants address transportation and other treatment-related needs that might otherwise have interfered with their ability to continue hemodialysis. The findings therefore indicate that adaptation to hemodialysis was not solely an individual process but was facilitated by a multidimensional support network involving family members, healthcare providers, peers, and the broader community.

Taken together, the findings suggest that behaviors sometimes perceived as nonadherence during the early stages of hemodialysis may occur in the context of fear, denial, uncertainty, limited understanding of the illness, reliance on familiar home remedies, financial difficulties, and symptom-based interpretations of health. These behaviors

should therefore not automatically be interpreted as deliberate refusal or unwillingness to follow medical recommendations. Recognizing the circumstances surrounding patients' decisions may help healthcare providers understand the challenges experienced during the transition to hemodialysis and respond in a supportive and nonjudgmental manner. The findings also demonstrate that adaptation was not a linear process. Emotional distress, physical changes, treatment-related difficulties, increasing health awareness, and acceptance frequently occurred simultaneously and changed over time.

This study contributes context-specific evidence concerning the early transition to hemodialysis among patients in Bulacan. Examining this transition within the Philippine context is particularly important given the substantial national burden of CKD. A national report indicated that at least 7 million Filipinos were living with CKD in 2021 and that the actual burden may have been underestimated because only a relatively small proportion of affected individuals had been diagnosed (Montemayor, 2023). The particular contribution of the present study lies in describing how emotional, physical, behavioral, spiritual, familial, and community factors interact during the first 30–90 days of treatment. The application of Colaizzi's seven-step analytical method and participant validation supported the credibility of the findings and maintained a close connection between the identified themes and the participants' accounts. By focusing on an early and particularly vulnerable treatment period, this study provides relevant insights for developing culturally responsive, holistic, and transition-focused nursing care for Filipino patients beginning hemodialysis.

Implications for Practice and Future Research

The findings underscore the need for person-centered and culturally responsive care during the transition from CKD diagnosis to hemodialysis initiation. Nurses should provide clear, gradual, and nonjudgmental education concerning treatment procedures, symptom monitoring, medication use, dietary and fluid restrictions, and vascular access care. Psychological and spiritual needs should also be assessed, particularly during the first 90 days of treatment. With the patient's consent, family members and primary caregivers should be involved in education and individualized care planning. Healthcare institutions should also recognize the contribution of community support and improve access to practical and financial assistance for transportation, laboratory examinations, medications, and other treatment-related needs.

Future research should include participants from multiple hemodialysis centers and different regions of the Philippines to examine how cultural, socioeconomic, and urban–rural differences influence patients' experiences. Longitudinal, mixed-methods, and intervention studies are also recommended to evaluate changes in adjustment over time and strategies for improving symptom management, treatment adherence, psychological well-being, and quality of life.

Limitations

This study involved six participants recruited through purposive sampling from a single hemodialysis center in Bulacan; therefore, the findings may not represent the experiences of patients in other settings or geographical regions. The interviews lasted approximately 15–30 minutes to accommodate participants' physical condition and possible post-treatment fatigue, which may have limited the depth of some accounts. In addition, the findings relied on participants' recollections and interpretations, which may have been influenced by recall limitations and their emotional state at the time of the interviews. As a qualitative study, the findings are not intended to be statistically generalized but may be transferable to similar populations and healthcare contexts. Despite these limitations, the systematic application of Colaizzi's seven-step method, participant validation, and trustworthiness procedures supported the credibility of the findings.

CONCLUSION

This study described the lived experiences of adults during the first 30–90 days of hemodialysis in Bulacan, Philippines. The transition from CKD diagnosis to hemodialysis initiation involved substantial emotional, physical, behavioral, functional, and relational changes. Participants initially experienced fear, anxiety, denial, sadness, physical discomfort, and uncertainty. For some participants, the seriousness of their condition became more apparent through worsening bodily symptoms than through laboratory findings alone. These experiences influenced their decisions to seek professional care and accept the need for hemodialysis.

Following treatment initiation, participants gradually developed greater acceptance and awareness of their health needs. They became more attentive to dietary and fluid restrictions, medications, treatment schedules, and changes in their physical condition. This adjustment was not linear but evolved through ongoing interactions among symptom experiences, treatment outcomes, personal beliefs, healthcare guidance, and environmental support. Spiritual faith helped participants maintain hope and cope with uncertainty, while family members, healthcare providers, and community networks provided emotional, practical, and financial assistance.

The findings demonstrate that adaptation to hemodialysis is not solely an individual process. It is shaped by culturally meaningful relationships, spirituality, family involvement, healthcare support,

and the Filipino value of bayanihan. By describing these experiences during the early treatment period, this study provides context-specific insights that may inform holistic, culturally responsive, and transition-focused nursing care for Filipino patients beginning hemodialysis.

Author Contributions

Conceptualization: Marissa Advincula, Neriza Bacus, Jannah Bautista, Ireneo Buenaflor, Princess Lean Marte, and Glenn Ford D. Valdez; Methodology: Marissa Advincula, Neriza Bacus, Jannah Bautista, Ireneo Buenaflor, Princess Lean Marte, and Glenn Ford D. Valdez; Data Collection: Marissa Advincula, Neriza Bacus, Jannah Bautista, Ireneo Buenaflor, and Princess Lean Marte; Analysis: Marissa Advincula, Neriza Bacus, Jannah Bautista, Ireneo Buenaflor, and Princess Lean Marte; Writing – Original Draft: Marissa Advincula, Neriza Bacus, Jannah Bautista, Ireneo Buenaflor, Princess Lean Marte, Glenn Ford D. Valdez, Regie De Jesus, and Teodora M. Delos Reyes; Writing – Review & Editing: Marissa Advincula, Neriza Bacus, Jannah Bautista, Ireneo Buenaflor, Princess Lean Marte, Glenn Ford D. Valdez, Regie De Jesus, and Teodora M. Delos Reyes.

Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Conflict of Interest

Glenn Ford D. Valdez serves as a member of the International Editorial Board of the Celebes Nursing Journal. He was not involved in the editorial assessment, reviewer selection, peer-review process, or decision-making concerning this manuscript. The manuscript was handled independently by editors with no conflicts of interest. The remaining authors declare no conflicts of interest.

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Declaration of Use of AI in Scientific Writing

The authors declare that artificial intelligence (AI)-assisted tools were used solely to support language refinement, grammar correction (Grammarly and Microsoft Copilot), and improvements in manuscript clarity and readability during the preparation of this manuscript. All study conception, research design, data collection, data analysis, interpretation of findings, and final scientific content were completed by the authors. The authors critically reviewed, verified, and approved all AI-assisted outputs and accept full responsibility for the accuracy, integrity, and originality of the manuscript. No AI tool was used to generate, manipulate, or interpret research data or to formulate scientific conclusions.

REFERENCES

Agustiyowati, T. H. R., Sitorus, R., Waluyo, A., & Besral, B. (2018). The lived experience of patients with pre-dialysis chronic kidney disease: A qualitative study. *Belitung Nursing Journal, 4*(2), 263–270. https://doi.org/10.33546/bnj.409

Akhtar, T., Pienaar, A. J., Asmat, K., & Sikander, S. (2025). Lived realities of symptom burden among haemodialysis patients: A phenomenological study from rural Pakistan. *BMJ Open, 15*(11), Article e106937. https://doi.org/10.1136/bmjopen-2025-106937

Alsing, J. F. L., Hayes Bauer, E., Brandt, F., & Kampmann, J. D. (2022). Expectations and experiences of patients recently initiated to centre-based dialysis treatment. *Healthcare, 10*(5), Article 897. https://doi.org/10.3390/healthcare10050897

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice Hall.

Bennett, P., Warren, M., Aydin, Z., Beige, J., Bowes, E., Cheung, M., Finderup, J., Gallego, D., Hecking, M., Hurst, H., King, J. M., Kleophas, W., Liossatou, A., Martins, P., Masià-Plana, A., Meuleman, Y., Neri, L., Noruišienė, E., Ortiz, J., . . . Tsukamoto, Y. (2025). Kidney Disease: Improving Global Outcomes (KDIGO) workshop on the nurse's role in managing the symptoms of people receiving dialysis. *Kidney International Reports, 10*(2), 313–320. https://doi.org/10.1016/j.ekir.2024.11.029

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness, 4*(2), 167–182. https://doi.org/10.1111/1467-9566.ep11339939

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48–71). Oxford University Press.

de Guzman, A. B., Chy, M. A. S., Concepcion, A. F. P., Conferido, A. J. C., & Coretico, K. I. (2009). The language of coping: Understanding Filipino geriatric patients' hemodialysis lived experiences. *Educational Gerontology, 35*(9), 769–783. https://doi.org/10.1080/03601270802708384

Elias, M. A., Van Damme, W., Ku, G. M. V., Kadammanavar, M., & Wouters, E. (2025). Lived experiences of people with chronic kidney disease on maintenance dialysis: A systematic review and thematic synthesis of qualitative studies. *BMC Nephrology, 26*, Article 22. https://doi.org/10.1186/s12882-025-03952-4

Fletcher, B. R., Damery, S., Aiyegbusi, O. L., Anderson, N., Calvert, M., Cockwell, P., Ferguson, J., Horton, M., Paap, M. C. S., Sidey-Gibbons, C., Slade, A., Turner, N., & Kyte, D. (2022). Symptom burden and health-related quality of life in chronic kidney disease: A global systematic review and meta-analysis. *PLOS Medicine, 19*(4), Article e1003954. https://doi.org/10.1371/journal.pmed.1003954

Gebrie, M. H., Asfaw, H. M., Bilchut, W. H., Lindgren, H., & Wettergren, L. (2023). Patients' experience of undergoing maintenance hemodialysis: An interview study from Ethiopia. *PLOS ONE, 18*(5), Article e0284422. https://doi.org/10.1371/journal.pone.0284422

Hreńczuk, M. K., Rudnicka, W., Piątek, T. D., & Małkowski, P. (2024). Acceptance of illness and health behaviours of patients with end-stage renal disease treated with haemodialysis: A single-centre study. *Healthcare, 12*(24), Article 2562. https://doi.org/10.3390/healthcare12242562

Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. (2024). KDIGO 2024 clinical practice guideline for the evaluation and management of chronic kidney disease. *Kidney International, 105*(4S), S117–S314. https://doi.org/10.1016/j.kint.2023.10.018

Kim, S., & Lee, H. Z. (2023). The lived self-care experiences of patients undergoing long-term haemodialysis: A phenomenological study. *International Journal of Environmental Research and Public Health, 20*(6), Article 4690. https://doi.org/10.3390/ijerph20064690

Li, C., Shan, Y., Yan, X., & Wang, Z. (2025). Qualitative study on the sense of meaning in life in uremic patients undergoing initial hemodialysis. *International Journal of Qualitative Studies on Health and Well-Being, 20*(1), Article 2545262. https://doi.org/10.1080/17482631.2025.2545262

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.

Mehta, K., Hussein, W. F., Leuther, K. K., Fegler, A., Schiller, B., & Bennett, P. N. (2024). The experiences of people starting haemodialysis: A qualitative study. *Journal of Renal Care, 50*(4), 365–375. https://doi.org/10.1111/jorc.12496

Montemayor, M. T. (2023, June 2). *7M Filipinos have chronic kidney disease as of 2021*. Philippine News Agency. https://www.pna.gov.ph/articles/1202791

Nair, D., Bonnet, K., Wild, M. G., Umeukeje, E. M., Fissell, R. B., Faulkner, M. L., Bahri, N. S., Bruce, M. A., Schlundt, D. G., Wallston, K. A., & Cavanaugh, K. L. (2021). Psychological adaptation to serious illness: A qualitative study of culturally diverse patients with advanced chronic kidney disease. *Journal of Pain and Symptom Management, 61*(1), 32–41.e2. https://doi.org/10.1016/j.jpainsymman.2020.07.014

Pajimna, J. A. T., Orpilla, G. A. L., Milan, M. J. D. C., Virtucio, C. T. S., & Pamatian, J. V. M. (2023). Gaps and challenges in the provision of treatment for patients with end-stage renal disease: Perspectives from the Philippines. *The Lancet Regional Health–Western Pacific, 38*, Article 100889. https://doi.org/10.1016/j.lanwpc.2023.100889

Philippine Society of Nephrology. (2024, March 1). *Rising incidence of chronic kidney disease in the Philippines sparks call for kidney health awareness: The Philippine Society of Nephrology urges Filipinos to take proactive measures*. https://psn.org.ph/2024/03/01/rising-incidence-of-chronic-kidney-disease-in-the-philippines-sparks-call-for-kidney-health-awareness-subtitle-the-philippine-society-of-nephrology-urges-filipinos-to-take-proactive-measures/

Pollock, C., Carrero, J.-J., Kanda, E., Ofori-Asenso, R., Palmer, E., Niklasson, A., Linder, A., Woodward, H., Pentakota, S., Garcia Sanchez, J. J., Kashihara, N., Fishbane, S., Pecoits-Filho, R., & Wheeler, D. C. (2024). The lived experience of patients with chronic kidney disease: Insights from DISCOVER CKD. *American Journal of Nephrology, 55*(6), 618–628. https://doi.org/10.1159/000541064

Reid, C., Seymour, J., & Jones, C. (2016). A thematic synthesis of the experiences of adults living with hemodialysis. *Clinical Journal of the American Society of Nephrology, 11*(7), 1206–1218. https://doi.org/10.2215/CJN.10561015

Saedi, F., Dehghan, M., Mohammadrafie, N., Xu, X., Hermis, A. H., & Zakeri, M. A. (2024). Predictive role of spiritual health, resilience, and mental well-being in treatment adherence among hemodialysis patients. *BMC Nephrology, 25*, Article 326. https://doi.org/10.1186/s12882-024-03768-8

Shahgholian, N., & Yousefi, H. (2018). The lived experiences of patients undergoing hemodialysis with the concept of care: A phenomenological study. *BMC Nephrology, 19*, Article 338. https://doi.org/10.1186/s12882-018-1138-4

Shumbusho, G., Nyenyeri, D. L., Kabahizi, J., Uwiragiye, D., Habyarimana, O., Binayisa, G., Nyirangirimana, A., Twagirumukiza, E., Neil, K. L., Deyessa, N., Leichtman, A., Murayire, J., Dufatanye, E., Nkundimana, G., Sebera, E., & Elbasha, A. M. (2025). Perspectives of adult advanced pre-dialysis chronic kidney disease patients about kidney replacement therapy in three referral hospitals in Rwanda. *BMC Nephrology, 26*, Article 347. https://doi.org/10.1186/s12882-025-04310-0

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Uwiragiye, D., Nkuranyabahizi, M., & Alagbonsi, A. I. (2025). Lived experiences of patients undergoing hemodialysis in selected teaching hospitals in Rwanda. *Rwanda Journal of Medicine and Health Sciences, 8*(2), 246–261. https://doi.org/10.4314/rjmhs.v8i2.7