Perceptions of HIV-Related Stigma in Portugal Among MSM With HIV Infection and an Undetectable Viral Load

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We explored perceptions of HIV-related stigma using a qualitative approach based on the findings of in-depth e-mail asynchronous interviews with 37 self-identified Portuguese men who have sex with men (MSM) with HIV infection and undetectable viral loads. Participants were asked to answer an online interview. Major findings concerned external perceptions of HIV-related stigma, HIV status disclosure, the impact of HIV on everyday life, the presence of double discrimination, and general perceptions of HIV-related stigma. Results revealed (a) stigmatizing and discriminatory behaviors and practices in psychosocial and inter-relational events, but not in accessing and receiving health care; (b) double exposure to stigma associated with being gay and having HIV; and (c) undetectability as an autonomous identity with important connections to social and interpersonal interactions. An important implication was related to multilevel risk perceptions and the psychosocial complexity and challenges of HIV infection. In Portugal, HIV is still a socially disabling disease.

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There were an estimated 54,297 HIV-infected individuals in Portugal in 2016 (Departamento de Doenças Infecciosas [DDI], 2016), and an HIV prevalence rate of 0.82% among those ages 15 to 49 years, signifying that Portugal had one of the highest HIV prevalence rates in Western Europe (Joint United Nations Programme on HIV/AIDS, 2013). In addition, 81.7% of people diagnosed with HIV were men (DDI, 2016). Historically, the most common modes of HIV transmission in Portugal have been through heterosexual unprotected sex (38%) and the use of contaminated injection equipment for intravenous drug use (44.7%; Pereira, 2014). Approximately 12.4% of all infections were transmitted via homosexual and/or bisexual unprotected sex (cumulative percentage of HIV infection transmission from 1983 to 2011; DDI, 2016). It is particularly important to mention that the rate of transmission among men who have sex with men (MSM) in Portugal has doubled since 2001, and that these estimates only included notified cases, and did not consider any unreported cases (Pereira, 2014). Therefore, MSM persist as one of the most at-risk groups for HIV transmission (Lorimer et al., 2013; Pereira, 2014), which has been exacerbated by the fact that there is a higher risk of HIV transmission during unprotected anal sex in comparison to vaginal sex given the same conditions (Hart et al., 2016). Having an HIV diagnosis impacts the emotional and sexual

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lives of MSM, whether it is via the adoption of periods of sexual abstinence following diagnosis, which many consider to be a period of adaptation to life under these new conditions, or feelings of insecurity, concerns about transmission, or the negotiation of sex and relationships as a person living with HIV (PLWH; Grace et al., 2015; Wei et al., 2014).

After an HIV diagnosis, re-engaging in sexual intercourse usually involves ensuring effective treatment, a decreased viral load, managing dating and relationships, interacting with seroconcordant/serodiscordant people, receiving support from counseling services and friends and family, and satisfying one's partner (Grace et al., 2015). The knowledge of one's viral load becomes relevant because a low viral load has been associated with a decreased risk of HIV transmission, and therefore, has a significant impact on the resumption of sex and relationships (Wu et al., 2015).

Antiretroviral therapy (ART), taken consistently, can limit and control HIV replication while reducing the viral load to undetectable levels (Wu et al., 2015), and the early and successful treatment of PLWH using ART contributes to a significant reduction in the chance of the HIV transmission (Pereira, 2015). Thus, an undetectable viral load has been seen by many MSM as a milestone for re-engaging in sex and relationships, disclosing their HIV diagnosis to sexual partners, increasing sexual freedoms, and lessening concerns about HIV transmission (Grace et al., 2015).

Furthermore, the increased use of ART has been associated with a significant decrease in HIV-related mortality, despite the fact that transmission still occurs, via undiagnosed individuals or by individuals who were treated without success (Pereira, Monteiro, Esgalhado, & Afonso, 2015). On the other hand, ART also helped to decrease HIV progression in the Western world (Herrmann et al., 2013), which led to the realization that having an undetectable viral load reduced the risk of HIV transmission (Boom et al., 2013).

More recently, ART prescribed for uninfected individuals (preexposure prophylaxis) has been shown to reduce HIV transmission in vulnerable populations, such as MSM; relevant studies concluded that risk perception played an important role in adherence to this type of treatment (Jayakumaran, Aaron, Gracely, Schriver, & Szep, 2016). The use of preexposure prophylaxis prevents new HIV infections while maintaining low or undetectable viral loads (Veloso, Mesquita, & Grinsztejn, 2015).

Lack of knowledge regarding HIV status still remains an important barrier to HIV treatment. The most common reasons for the lack of HIV testing are (a) stigma (e.g., the fear of bringing shame to one's family); (b) discrimination against MSM and PLWH; (c) the impact of relationships and characteristics of sexual partners in regard to the ease of getting tested for HIV; (d) the presence of a low perceived risk or threat; and (e) concerns related to confidentiality (Wei et al., 2014). Combating stigma and discrimination may appear to be a solitary task for many MSM, and isolation may act as a hindrance in the negotiation of safe sex practices, such as condom use (Hubach et al., 2015). Thus, risky sexual behavior by MSM living with HIV may be viewed as a coping mechanism or as a mediator of psychological stress.

In fact, the most common stigma-associated symptoms among MSM living with HIV include depression (fatigue, desperation, hopelessness, emotional withdrawal); anxiety (catastrophizing, fear of losing control, being easily frightened); interpersonal fears (difficulties seeking stable relationships and intimacy); and the fear of suffering adverse socioprofessional circumstances (anticipating unemployment or poverty; Li, Holroyd, Lau, & Li, 2015). Drug and alcohol abuse have also been prevalent, and can be seen as a coping strategy after an HIV diagnosis or as facilitators for greater social connection obtained through risky sexual behaviors by MSM (Edelman et al., 2016).

Hence, as Yuh, Ellwanger, Potts, and Ssenyonga (2014) found, HIV-related stigma can result in silence, denial, self-blame, rejection, violence, self-isolation, and serious difficulties revealing HIV status to others, in addition to exclusion and the inability to seek testing and treatment (Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008). MSM with HIV have often had to deal with several types of stigma. Internalized stigma among MSM living with HIV involves experiences and feelings of shame and fear, driven by the assumption that others will treat them negatively, and the belief that they are to blame for their health condition or for the negative