Stigma Kills

Stigma due to an HIV diagnosis is a well-known phenomenon and is a major barrier to accessing care.[1] Over the last forty years, HIV has been transformed from a fatal disease to a manageable one, thanks to the remarkable success of antiretroviral (ARV) medication.[2] When people living with HIV (PLHIV) start ARV treatment early, their life expectancy is almost completely restored. Moreover, a suppressed viral load means that PLHIV are no longer able to infect other people.[3] They can have children naturally without risk to their seronegative partner or their child. PLHIV nowadays are more likely to die with HIV, not of HIV. While a cure remains elusive, the successful global rollout of ARVs means that there is no good reason for a PLHIV to die of AIDS and its complications due to lack of access to proper treatment.

The Philippine AIDS Law Republic Act 8504 and its successor, Republic Act 11116 explicitly states that the State should "ensure access to HIV and AIDS-related services by eliminating the climate of stigma and discrimination that surrounds the country's HIV and AIDS situation, and the people directly and indirectly affected by it." Unfortunately, despite this admonition, stigma remains a significant cause of delayed HIV testing and of not seeking treatment in our country.

In this issue of the journal, Dr. De Los Santos and her colleagues examine the effect of healthcare facility stigma on PLHIV accessing care in the Philippines.[4] They report that 81% of their Filipino PLHIV respondents experienced stigma, which is an unacceptably high number. They identify which facilities are more likely to be correlated with stigma and make suggestions on how to address this problem. This study is very timely and comes at a time when the Department of Health is shifting first line antiretrovirals to dolutegravir-based regimens.[5] Dolutegravir-based treatment is associated with fewer side effects than efavirenz-based regimens and is much more durable against resistance.[6] With an HIV transmitted-drug resistance rate of 11.7%, it is imperative that PLHIV are started on more durable regimens which they are less likely to discontinue.[7] Properly addressing stigma means that more people will access care. Better regimens will ensure that people stay in care. This will go a long way towards minimizing the impact of HIV and AIDS on Filipino PLHIV.

Stigma among PLHIV is a complicated subject matter. Aside from the stigma associated with diagnosis, there is also stigma associated with the mode of acquisition of the disease. The most-at-risk populations are highly stigmatized. Men who have sex with men, people who inject drugs, and female sex workers experience additional stigma on top of the stigma from an HIV diagnosis.[8] Aside from societal stigma, PLHIV are also prone to self-stigma.[9] This phenomenon occurs when PLHIV believe they no longer deserve to live since they contracted the disease from deviant or sinful behavior. High rates of depression are found among these self-stigma sufferers. This significantly impacts the entire HIV healthcare cascade, starting from early diagnosis, to accessing treatment, and staying in care.

The finding that Public Rural Health Units are the most stigmatizing healthcare facilities is very concerning since these are usually the only facilities available to PLHIV in far-flung areas. This needs to be addressed with better sensitivity training as well as concrete guidelines on avoiding stigma. It is very troubling that facilities that are supposed to cater to vulnerable populations inadvertently make it difficult for them to access care.[10] Unfortunately, even facilities in urban areas are not immune to discrimination and stigmatizing behavior.

I recall the experience of one of my early PLHIV patients who developed and eventually succumbed to a disseminated fungal infection.[11] He told me that he had tried getting tested several years earlier but he had a traumatic experience in the government health facility that he accessed. He made a wrong turn and entered a different clinic in that hospital and when he asked for an HIV test, people recoiled from him in horror. Because of that terrible experience, he put off getting his HIV test for years until he started developing the fungal infection that eventually killed him. Had he been started on proper treatment earlier, he could have been saved. For me, it wasn't just the fungus that killed him but it was the delay in diagnosis and care as a direct result of stigma.

Addressing HIV-related stigma in our country entails a whole-of-society and a whole-of-nation approach. Mental health services to address self-stigma and depression should be standard of care not just among confirmed PLHIV but among the most-at-risk populations. Proactive education of all members of society, especially healthcare workers in facilities that diagnose and care for PLHIV is essential for ensuring sustained linkage to care. Ensuring that the majority of the PLHIV population are properly diagnosed, enrolled in treatment hubs, and have suppressed viral loads will ultimately lead to fewer transmissions and less AIDS-related deaths.

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