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Pandemics have psychosocial and sociocultural burdens



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Living with HIV has changed substantially across the HIV pandemic. Some people would say that in many countries, treatment as prevention (ie, the use of antiretrovirals for treatment and prevention of HIV) has democratised the management of HIV across communities of gay, bisexual, and other men who have sex with men (GBMSM) and the undetectable=untransmittable concept reduces the need for HIV status disclosure. At this level, it appears that everything is changing for the better and the global community could hope that the psychosocial burden of living with HIV is dissipating. However, in *The Lancet HIV*, Ward van Bilsen and colleagues¹ show this expectation is not the case and the negative psychosocial sequelae of HIV sadly endure. Should we really be surprised?

Drawing on questionnaires completed by 438 men who have sex with men who were diagnosed with HIV between 1984 and 2018, van Bilsen and colleagues show how the psychosocial and sociocultural burden of HIV infection reverberates long after the urgency of the biomedical crisis has passed. Almost a third of participants reported that living with HIV was burdensome. The burden was associated with the experience of other chronic conditions, recent diagnosis, and isolation from others living with HIV. A quarter of participants reported experience of discrimination.

Although the data from van Bilsen and colleagues relate to the individual participants, the felt stigma that the participants report firmly relates to the complex interrelated social, environmental, and structural factors that shape the systems in which the participants live. Early commentators on HIV highlighted the centrality of the social world in which HIV gains meaning,² and van Bilsen and colleagues' analysis of data gathered between 2018 and 2019 shows how the negative psychosocial and sociocultural dimensions of HIV have not yet diminished. The laudable goals concerning testing and treatment reflected within the UNAIDS 90-90-90 strategy provide strategic direction and focus for bringing an end to AIDS in relation to its biomedical aspects, and do acknowledge the need for reducing stigma and discrimination.³ Efforts are being made to challenge stigma, yet it remains pervasive across contexts, cultures, and continents.⁴ There appears

to be a notable lag, and a growing gap, between intervention success in relation to biomedicine and intervention success in relation to psychosocial and sociocultural aspects.

van Bilsen and colleagues' study is cross-sectional and cannot provide insight into whether these experiences are changing over time. Yet the high level of burden associated with recent diagnosis does not bode well for considering the easing of psychosocial burden. These findings beg questions of how the global community is considering psychosocial and sociocultural interventions to improve the lives of GBMSM living with HIV. Addressing the proximal determinants of their distress could put a plaster on the wound but does not address the root cause of their burdens. van Bilsen and colleagues' finding relating to the relatively high level of burden associated with not knowing other individuals with HIV is depressing. Perhaps this association is a result of HIV becoming less visible through the reduced need for disclosure that treatment as prevention enacts. This reduced need for disclosure might reduce peer-to-peer social support, and might be related to the loss of wider HIV-related supportive infrastructure and organisations that facilitate opportunities for peer learning.

So what can the global community do differently? The future goal has to move beyond the idea of HIV as a burden, and should be to support men to live long, healthy, happy, and good lives, with and without HIV. Health is more than the absence of disease and there is a clear need to support the health and wellbeing of gay and bisexual men in its broadest sense. van Bilsen and colleagues do not mention the social patterning of HIV-related burden across the typical fault lines of inequalities (eg, ethnicity, class). COVID-19 shows that most pandemics tend to illuminate who is served, and who is not, by the current social system. Perhaps what the global community can learn from HIV/AIDS is the need to move beyond biomedicine and ensure that psychosocial and sociocultural burdens are at the heart of the response.⁵ This response would include situating health in the broader context of everyday lives, addressing the structural determinants of health inequalities, building on the strengths and assets of the whole community, capitalising on the support

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of salutogenic social networks within these communities to increase community assets, and focusing on the individual to build sustainable resilience, coping, and wellbeing among the most susceptible people.⁶

We declare no competing interests.

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