

EXPLORING THE INFLUENCE OF

INTERSECTIONAL STIGMA ON UPTAKE AND RETENTION IN ART PROGRAMMES

FOR SELECTED YOUNG KEY POPULATIONS IN MALAWI, ZAMBIA, AND ZIMBABWE

Findings from a Mixed Methods Analysis



Report Summary

Background and rationale

HIV programmes for men-who-have-sex-with-men (MSM) and transgender women in Malawi, Zambia and Zimbabwe place an emphasis on a variety of strategies for encouraging individuals living with HIV to come forward for diagnosis and to subsequently enrol on anti-retroviral treatment (ART). For those on ART, they include components to encourage retention and adherence, and to achieve and maintain viral suppression. All of this occurs in a challenging social context for these individuals that is characterised by a high risk of stigma, discrimination and violence as well as other forms of marginalisation and exclusion across personal, social, economic, cultural and professional domains. The extent to which these risks affect uptake and retention on ART is relatively unknown, particularly in any systematic depth or detail.

Research from other settings, including a small but growing number of efforts from across the African continent, has begun to illuminate these risks, including for the youngest members of these populations (between the ages of 18 and 24 years). For MSM and transgender young people,

specifically, varieties of forms of stigma and discrimination (including physical and sexual violence) interact with important HIV-related health outcomes including intentions regarding safer-sexual practices, disclosure, uptake and retention in HIV care, medication adherence, and achieving and sustaining viral suppression. However, understanding these interactions in the African context is in its infancy with current knowledge largely relying on survey-based, cross-sectional research. Theoretical approaches also vary with only limited consideration of concepts such as intersectional stigma, as well as aspects of coping, positive health and resilience.

This study attempted to contribute to resolving these gaps. It used a mixed-methods approach to arrive at an intersectional view of the experiences of young, HIV-positive sexual minorities and their successes and challenges to sustain themselves on ART and to achieve well-being in three settings that are broadly characteristic of the Southern African Development Community (SADC) region as a whole. The conceptual framework for the research drew on emerging trends in theory and practice for research on stigma, including the concepts of minority stress, intersectionality and intersectional stigma. Young HIV-positive MSM and transgender women in



Malawi, Zambia or Zimbabwe may find themselves at the intersection of stigma and exclusion related to their sexual or gender diversity and their HIV status. Understanding how these influences manifest themselves in the lives of these young people (including in the context of power relations driving or reenforcing historic marginalisation and exclusion), and how they affect their health seeking behaviours, particularly retention in HIV services, may be critical to designing and sustaining effective public health interventions.

The study was designed and lead by the Health Economics and HIV/AIDS Research Division (HEARD) of the University of KwaZulu-Natal in Durban, South Africa. The study partners included the Kamuzu University of Health Sciences (Malawi), the University of Zambia, the University of Zimbabwe, and SADC. Study partners also included non-governmental and community-based organisations led by or working with members of the study population in each country. The study was funded through the HIV Special Fund Round III mechanism administered by SADC.

Research objectives

The study had the following objectives:

- a) To describe the experiences of young, HIV-positive MSM and transgender women with stigma and discrimination linked to their sexual orientation, gender identity and health status in the three settings (Malawi, Zambia and Zimbabwe).
- b) To explore the effects of stigma experiences on their general well-being and, specifically their experiences and attitudes towards ART.
- c) To identify opportunities and enablers for improving ART adherence and reducing the negative effects of stigma.
- d) To propose recommendations for strengthening programmatic responses for young HIV-positive MSM and transgender women on ART.

The research findings will be used to develop and pilot interventions to improve the health and well-being of the study population. Based on these further results, regional programmatic guidance will be developed to improve the quality and comprehensiveness of programmes across the SADC region for young key populations on ART.

Study design and methodology

The study followed a mixed-methods, parallel design with simultaneous collection of qualitative and quantitative data from the same study sample. The qualitative component involved semi-structured, in-depth interviews; the quantitative component involved a self-administered, confidential questionnaire. The study population included young (18-24 years) gay, bisexual or other men who have sex with men, and young transgender women, self-disclosed as HIV-positive and currently on ART. Data was collected in secure, confidential settings by trained peer research assistants, some of whom were themselves members of the study population.

A total of 158 young people agreed to participate and completed both the questionnaire and the in-depth interview. There were 46 from Malawi, and 56 from Zambia and Zimbabwe, respectively. All participants were offered US\$10 at the end of the session to support transport costs. Interviews were recorded and subsequently transcribed and translated by trained transcribers (participants spoke a mix of English and local languages). Questionnaire results were loaded to Kobo Connect and transcripts to Nvivo 12 pro. Data analysis used both qualitative and quantitative techniques and relied on a flexible, dialogic approach to triangulation to build complementary, reflexive links between the two types of results (quantitative and qualitative).

This study was approved by the Biomedical Research Ethics Committee of the University of Kwa-Zulu Natal, the research ethics committees of the Kamuzu University of Health Sciences (formerly the College of Medicine, University of Malawi) and the University of Zambia. and the Medical Research Council of Zimbabwe.

Findings

The multi-country findings, as presented in this report, identified five over-arching themes related to intersectional stigma and its influence on ART and other health outcomes for the young participants: 1) intersectional identities (sexual orientation, gender identity and health status); 2) experiences of and anxieties about intersectional stigmas; 3) effects of stigma on mental health; 4) coping and resilience; and 5) influences of stigma on ART adherence and retention. The analysis of these themes laid out the range and complexity of the drivers, experiences, effects and the intersectional nature of the stigma-



related risks these young people fear and endure, arising from either their sexual orientation or gender identity, their health status or both. Such risks appear to have consequences for the participants of varying duration and intensity, physical, emotional, psychosocial and spiritual. Whether or not these risks can be managed or mitigated (through different personal characteristics, strategies or coping mechanisms) appears to influence beliefs and practices about health and well-being, including the commitment to HIV treatment and regular adherence to ART.

Intersectional identities

Amongst the 158 participants, the average age ranged from 21-23 in each country, indicating that there were fewer participants in the 18-19-year age group than their older peers. With regard to gender identity, from half (52%) to two thirds (66%) identified their gender as male regardless of their gender at birth. The remainder were female (12% in Zambia) or transgender (37% in Malawi). With regard to sexual orientation, overall, two-thirds (66%) indicated they were gay or bisexual. The remainder identified as transgender women with males being their primary sexual partners.

According to the inclusion criteria for the study, all participants self-reported as being HIV-positive and currently on ART. With regard to time since diagnosis, overall, approximately half (51%) of participants had been diagnosed with HIV within two or less years of the study (since 2019). However, among the countries there were differences. For Malawi, the largest proportion (43%) had been diagnosed five or more years prior to the study, whereas for Zambia two-thirds (69%) had been diagnosed within two years or less (since 2019). For Zimbabwe, participants were fairly evenly distributed across time periods.

With regard to length of time on ART, there were similar proportions and variations between countries with, at the overall level, approximately half of participants having been on ART for two years or less prior to the study (since 2019). Again, Malawi had the highest proportion of participants (46%) having been on ART for five years or more prior to the study (67% of participants from Malawi were between 22-24 years old). Across all countries, participants were evenly distributed between receiving their ART in government-run facilities or those run by non-governmental organisations

(NGOs). Malawi was highest for government-run facilities (59%) and Zimbabwe for NGO-run facilities (54%).¹ A small proportion received their care at church-run health facilities (3% in Malawi and Zambia only) or from private providers (9% in total).

During the interviews, participants expanded on their identities and their health status, using a variety of terms and expressions. Many of these young people experienced their identities along a spectrum from being “two people in one” – a sexual minority in one context and a person living with HIV (PLHIV) in another – to fully integrating the different components of their identities into something new: “I am a queer man living with HIV.” Individuals were generally confident about the sexual orientation and gender identities, as in these examples:

“For me, it [sexual orientation] makes me unique and special. It’s not something I chose or bought. It’s who I am and I can’t change it.” MSM, 18 years, Mutare, Zimbabwe

“Being a TG, it is not something that you just wake up today and just say, ‘I am a TG.’ No, it is about the way you feel yourself. The way I feel myself it is important. I feel like a woman; I see the woman in me. So, it is very important to me.” Transgender woman, 22 years, Lusaka, Zambia

Through the questionnaire, across all countries, 82% agreed or strongly agreed that they were ‘very comfortable’ with their identities, and 81% would not change these enduring aspects of themselves. Malawi had noticeably higher results (96% and 89% respectively) and Zambia the lowest (75% for both, respectively). Between groups, transgender participants had a higher level of confidence than their gay or bisexual peers (86% versus 79% on comfort with SOGI) in spite of the more difficult social journeys for many of these individuals.

With regard to HIV status, participants had a similar range of views, although these were weighted more on the negative side. For example, across countries, between one-quarter and one-third of participants (29%, 39% and 25%, respectively) agreed or strongly agreed with negative statements in the questionnaire, such as ‘I am ashamed that I am HIV positive’ or ‘I think less of myself because of my HIV status’. This reached 45% for periodic feelings of

¹ This variation may arise due to national policy as much as preference, when, for example, government policy restricts where ART can be provided (only in government settings, for example).



worthlessness in Zambia, for example, meaning that only as much as 55% of participants did not have such negative feelings (recall that 80% or more of participants held their sexual orientation or gender identity in a highly positive light).

This ambivalence was explored through the interviews, with some participants still being periodically uncertain about their confidence or worth as a PLHIV, as in this example:

"In general, this HIV that I am living with, it is a talk of the community. It is type of a disease or an illness that is painted with a lot of backlash on it because people feel that these people who have HIV have been doing bad things, and involving themselves into sexual activities. Yeah, they have been doing immoral activities. That is the reason why they are living with HIV. So, I feel it's not something that is really straight sitting with me because of that." Transgender woman, 23 years, Solwezi, Zambia

Experiences and fears of intersectional stigma

The presence of stigma and its influence became more evident as participants interacted with their social environment through processes of disclosure of their sexual orientation and gender identity, or their health status, and what may or may not have transpired when such information began to circulate in social settings, whether within families, among sexual minority peers and other friends, or in the community more generally. Encounters with stigma soon intensified beyond disclosure to influence most aspects of daily social interaction.

There were numerous interrelationships between stigma related to sexual orientation, gender identity, and health status, that manifested themselves on a frequent basis, either as things to be endured and recovered from, with or without the assistance of others, or as experiences to be feared and avoided, sometimes at a significant cost to self-confidence and self-esteem. These examples are illustrative:

"The moment I disclosed it [sexual orientation] to my parents, my friends, at first they were running away from me, failing to chat with me, meaning I was staying alone. Even my parents were saying I am not a human. Even

my brother said that this is a bad choice, you are not suppose to be my friend, my relative, whatever. So, it was such a bad thing to me because I was feeling alone. Nobody was there to help me to overcome the situation." MSM, 18 years, Lilongwe, Malawi

"Actually, my parents, what can I say? They are very strict. They're very, very strict. Because my dad is actually a pastor, a part-time pastor. So, him hearing that I'm homosexual, that was a straight 'No!' from him. And maybe if I can get much into detail to when they found out, actually found out, right. So, they actually said, 'Do you know that the Bible says people like that, they're like dogs!'" Transgender woman, 19 years, Bulawayo, Zimbabwe

"You know how these people are. Sometimes they try you. 'Are you positive? But why as cute as you are, you are positive? What happened?' You know? Then they will be taking me back, 'But why are these guys saying such things?' You feel pain in you. 'Where did I go wrong?' You start questioning God. 'Where did I go wrong? Among all the people in Zambia, you have just decided to have me infected?'" Transgender woman, 23 years, Chipata, Zambia

In the midst of such tensions, participants revealed both vulnerabilities and remarkable strengths in the way that they found, evolved and expressed their identities, in terms of sexual or gender diversity and health status. These young people became adept at managing their outward-facing identities through various strategies for disclosure and concealment, being a person living with HIV in some contexts, being a member of the sexual minority community in others, but rarely being both at once.

While it would appear that the study participants were more able to manage their experiences and fears regarding HIV-related stigma, they had a stronger vulnerability to stigma related to their sexual orientation or gender identity, particularly if their HIV status was also used to devalue them, as in these examples:

"It is difficult to live as a trans. It is difficult because everyone sees it. It's physical and everyone sees it. But with HIV, I can take my pills and look strong and beautiful and people will say, 'Look at that one, they are God sent.'

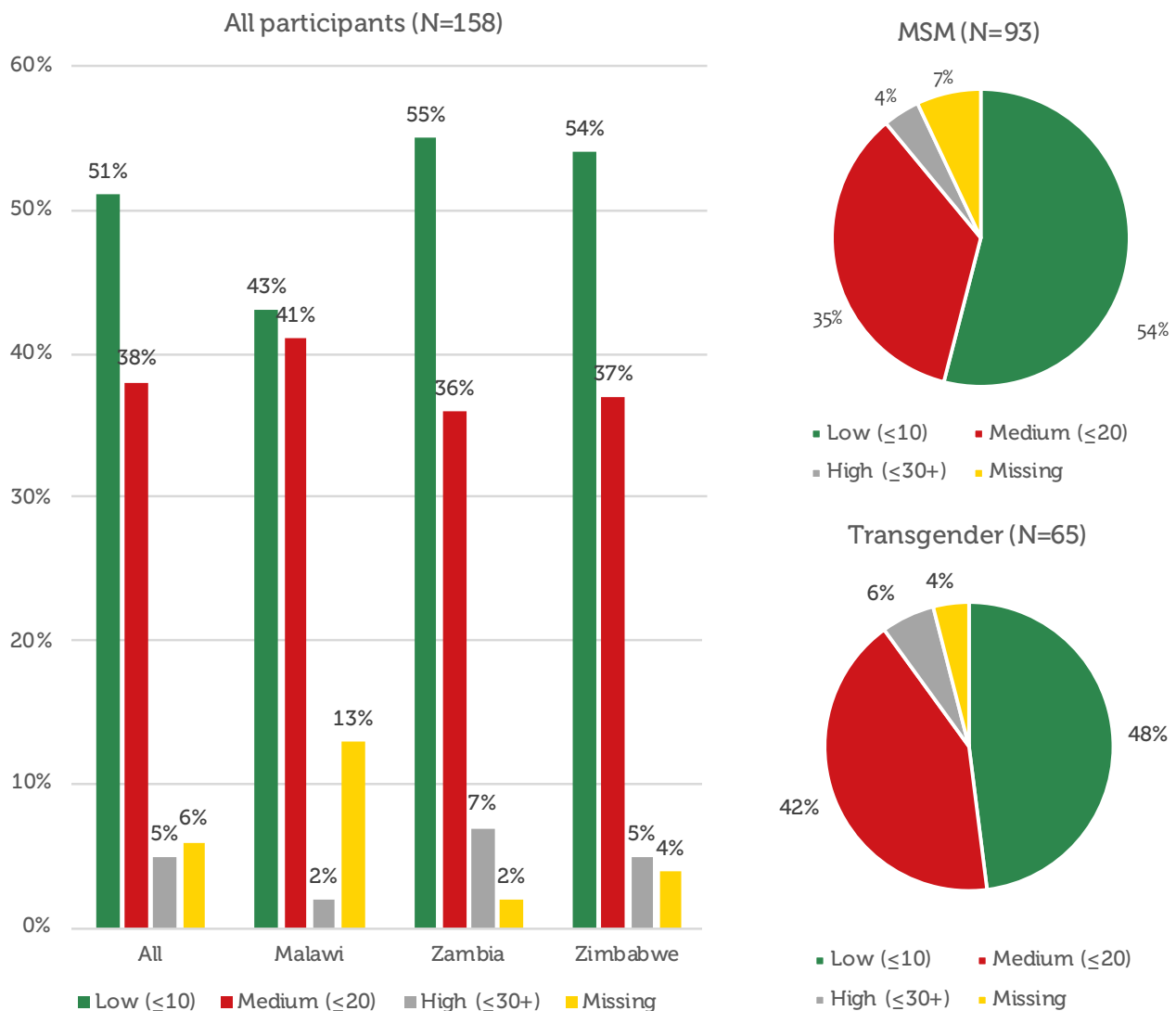
But just be a trans and everyone will be looking at you ,and you will be judged and everything. They will pour water on you as you walk along the road. Sometimes, I can say I prefer to live with HIV than being a trans.” Transgender woman, 19 years, Bulawayo, Zimbabwe

“Being HIV positive, being gay, there’s a lot that even if you walk, you’re just feeling that maybe people are talking about, how I have HIV, or maybe they’re talking about me being gay. So, it gives you so much stress. You stay so suspicious that you’re gay and HIV positive.” MSM, 18 years, Mutare, Zimbabwe

Effects of Stigma

There were a range of stigma-related effects on the participants, arising from actual experiences or fears and anxieties about stigma and discrimination, whatever their source or object. These effects included being a negative influence on mental health as well as causing a range of other emotional, social, or physical harms, and increasing one’s anxiety about recurrent experiences in the future. The study used the Center for Epidemiological Studies Depression Scale 10 Item Version (CES-D-10) to measure the presence of depressive symptoms in participants (Figure A).

Figure A: CES-D-10 results by country and group





According to the CESD-10 methodology, a score of <10 indicates *low* to minimal symptoms of depression, a score from 10-20 indicates *moderate* to significant symptoms of depression, whereas a *high* score from 20-30 is symptomatic of major depression. Overall, almost half of participants (38%+5%=43%) scored above 10 with 5% in the highest band (≤ 30). The results were similar across countries and groups indicating the potential for a significant mental health burden among the young participants. Transgender participants had a higher burden (42%+6%=48%) than their MSM peers (35%+4%=39%).

The study results also revealed that 41% of participants had contemplated suicide at least once in their young lives, 32% in the past year. Very few (17%) had disclosed these thoughts to anyone. The proportions of participants ever contemplating suicide were higher in Zimbabwe (52%) and lower in Zambia (36%). A higher proportion of transgender participants had ever contemplated suicide (54%) than their gay or bisexual peers (33%), and more transgender women had disclosed these thoughts to someone (26% versus 11%). Finally, 11% of all participants indicated it was likely or somewhat likely that they would contemplate suicide in the future. These proportions were equal in Malawi and Zimbabwe (13%) and higher among transgender

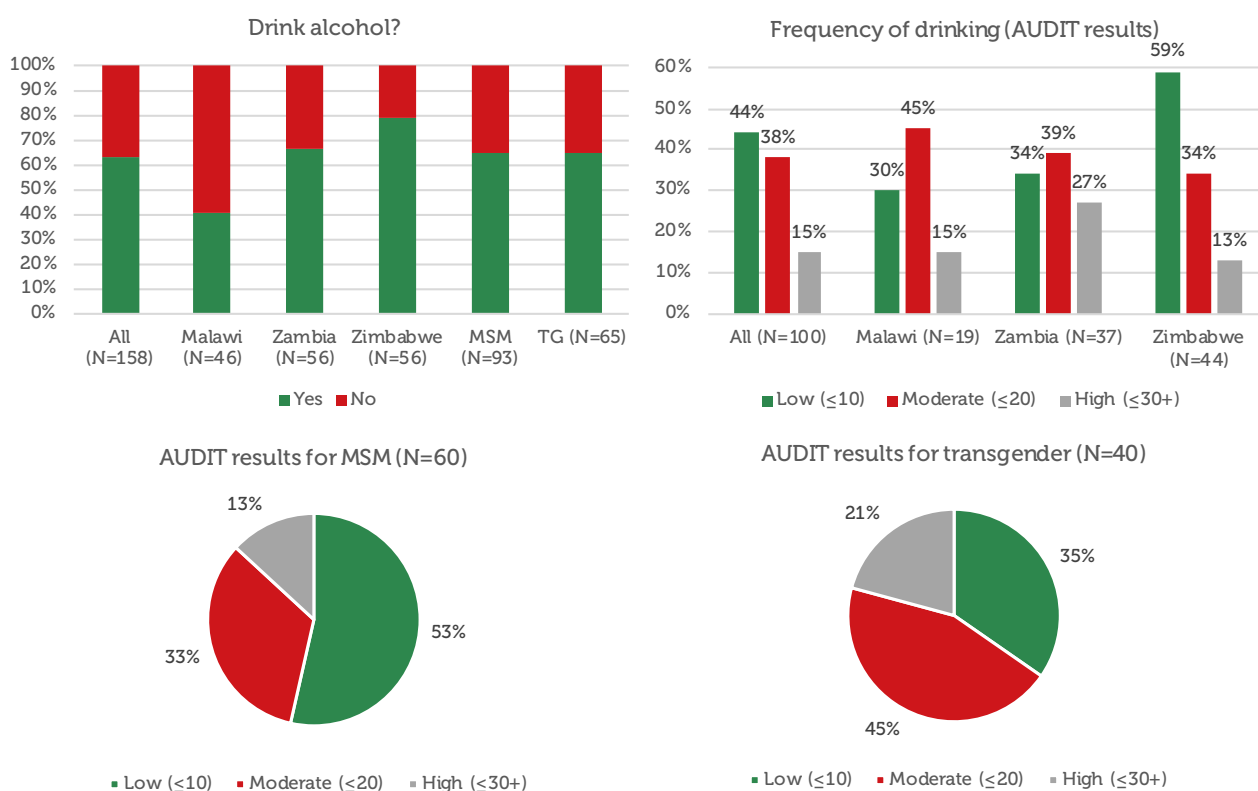
participants (14%). This is an example of how one participant contemplated suicide:

"Yeah when I am in bad mental health, I don't take food, and even I would decide not to take any medication, because I feel like I am nothing, I am useless. In the community, looking at HIV, I am a gay, people they isolate me. So I don't feel comfortable, even failing to go to work and finding some money, whatever. And, sometimes, I decide if I can die today, I can rest. So, a lot of things come into my mind when I am disturbed.... Sometimes my parents try to comfort me but, internally, I am really disturbed." MSM, 18 years, Lilongwe, Malawi

Coping and resilience

The study's participants had different ways in which they coped with and responded to the effects of stigma, including poor mental health. These ranged from some more problematic practices, such as high levels of alcohol or drug use, to more positive and affirming strategies, such as self-care, prayer, or seeking help from peer counsellors or health care workers. The study used the Alcohol Use Disorders Identification tool (AUDIT) to examine the frequency of consuming alcohol (Figure B).

Figure B: AUDIT results by country and group





Two thirds of all participants (63%) indicated that they consumed alcohol, regardless of frequency. The proportion of participants consuming alcohol was highest in Zimbabwe (79%) and lowest in Malawi (41%). The proportions were equal between both groups of participants. According to the AUDIT methodology, a score of ≤ 10 indicates occasional or very limited drinking; ≤ 20 indicates moderate to high alcohol use; above that score, individuals are considered to have potential markers of alcohol addiction, possibly requiring clinical intervention. Overall, of the number that use alcohol, slightly less than half (44%) scored ≤ 10 , meaning they drank irregularly and in limited quantities. The proportion was highest in Zimbabwe (59%) and lowest for Malawi (44%). Gay and bisexual participants consumed alcohol less frequently than their transgender peers (53% versus 35%). Of the remaining participants, 38% drank frequently, sometimes in high quantities. Malawi had the highest proportion in this group (45%), Zimbabwe the lowest (34%). Transgender participants consumed alcohol more frequently and in larger amounts than their gay or bisexual peers. Finally, 16% of participants indicated heavy alcohol use, with the possibility of addiction. Zambia had the most participants in this group (24% or 10 participants); as did transgender individuals (21% or eight participants).

"Yeah, when I have bad mental health, I will just go somewhere, like you have a small liquor shop there, you just take liquor and sleep. That's the only problem that I face when something is stressing me, I need to go and drink so heavy."
MSM, 23 years, Chipata, Zambia

Aside from alcohol or drug use, the young participants had other ways of coping with the effects of stigma. These included exercise (sports, walking, swimming), meditation and prayer, reading, having sex, or just keeping busy. Focussing on positive or purposeful activities relieved stress or lifted the burden of poor mental health for these young people. This participant used a range of strategies:

"At times, when I walk, people might call me names, 'Chichiman, chichiman!'; and I can take three days and think if I should pass through that place again, or I decide to avoid that road. So, if I have something mentally troubling me, usually I just write it down. I just write, like, a poem or a song. Then I feel

relieved; it would have passed. Then I listen to music. Sometimes I go to music sessions and I keep around my friends who make me smile. So, I think that's what gives me good mental health." MSM, 22 years, Harare, Zimbabwe

In addition to their own strategies for coping with the stress of stigma or poor mental health, participants had relied on peer counsellors, or peer promoters or navigators, and health workers trained in KP-related health needs, and (rarely) mental health professionals in order to unburden themselves and to seek support, as in this example:

"The moment I go to the hospital to get medication, they counsel me on how I can handle myself, how to avoid stress. So, when I go there, those people do help me, saying this is not the end of life, you can do everything, anything you can do. So, that kind of encouragement makes me to feel comfortable, saying I am a human and I can do everything as a person." MSM, 18 years, Lilongwe

Those young participants that could access these services reported that they benefited from them. Participants also relied on family members, friends or romantic partners when they felt overwhelmed.

Links to ART

Being on ART had specific meanings and significances for the participants. For some it was empowering and life affirming:

"I have accepted it [being on ART] and the fact that I am HIV positive, it's now another chapter. So, I decided to live as normal. The other side is taking my treatment as a daily hope." MSM, 22 years, Lilongwe

However, a number of participants had mixed views about taking ART, much of it linked to fears or experiences of stigma. This fuelled an additional layer of risk that led some individuals to prefer missing doses, occasionally or over more prolonged periods, rather than endure actual or feared social, emotional, or physical harms linked to being 'found out' as someone living with HIV and taking ART.

As shown in Figures C and D, overall, more than one third of participants (37%) had missed at least one dose of their HIV medication.

Figure C: Missed doses

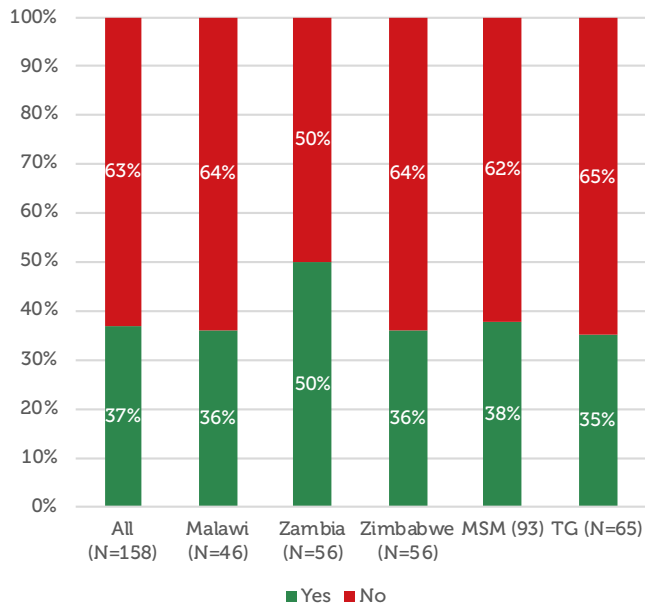
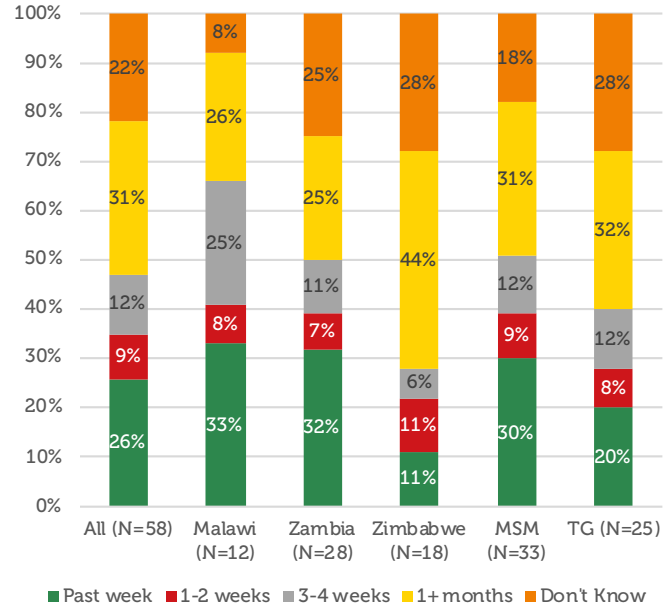


Figure D: Frequency of missed doses



The proportions were highest for Zambia (50%). Almost the same proportions of gay or bisexual (38%) and transgender participants (35%) had missed doses, irrespective of countries. One quarter (26%) of participants having missed doses had done so within the past week; the proportions were highest for Malawi, Zambia, and for gay or bisexual participants. Overall, of those who had missed doses, almost half (26%+9%+12%=47%) had done so within the past month. The proportion was highest for Malawi (33%+8%+25%=66%). Adjusting for participants who couldn't remember, the proportion for all participants rises to 60%. More gay or bisexual participants had missed doses in the past month than their transgender peers.

These examples illustrate the range of situations and experiences that led to missing doses.

"Sometimes I feel as if I'm just wasting my time, and sometimes it feels, it's time for me to go because I can't take it anymore. This is too much for me, taking tablets constantly. Imagine if I am to go to a gathering, then my time is going to be there. I'm going to have to move away from people. I'm going to have to do my separate thing. When I come back, people ask me what I was doing. It's hard for me to explain to them because they don't understand me. So, it's just a thing that

disturbs me constantly. And it's hard." MSM, 18 years, Mutare, Zimbabwe

"What made me to delay in taking medication [to miss doses] is when my partner wants me to visit his home because he stays in Zomba, and I haven't disclosed my HIV status to my partner yet, and I can't take the ARVs with me there. As a result, I go there without the ARVs." Transgender woman, 24 years, Blantyre, Malawi

"Yes, because the moment I am in a bad situation, I decide not to take drugs because I feel like taking drugs, it's nothing. And I don't see any importance of taking drugs at that moment because I decide that I am useless, I am nothing. So, when I am disturbed, I feel like I am nothing, I don't even recall that I should take the drugs at this time. As you know, we are told to have a specific time of taking the drug." MSM, 18 years, Lilongwe, Malawi

"When I am walking in the road and people start talking about me, that I walk like a girl and I am gay, that hurts and gets to me. I end up sleeping and forgetting to take my medication." MSM, 22 years, Lusaka, Zambia

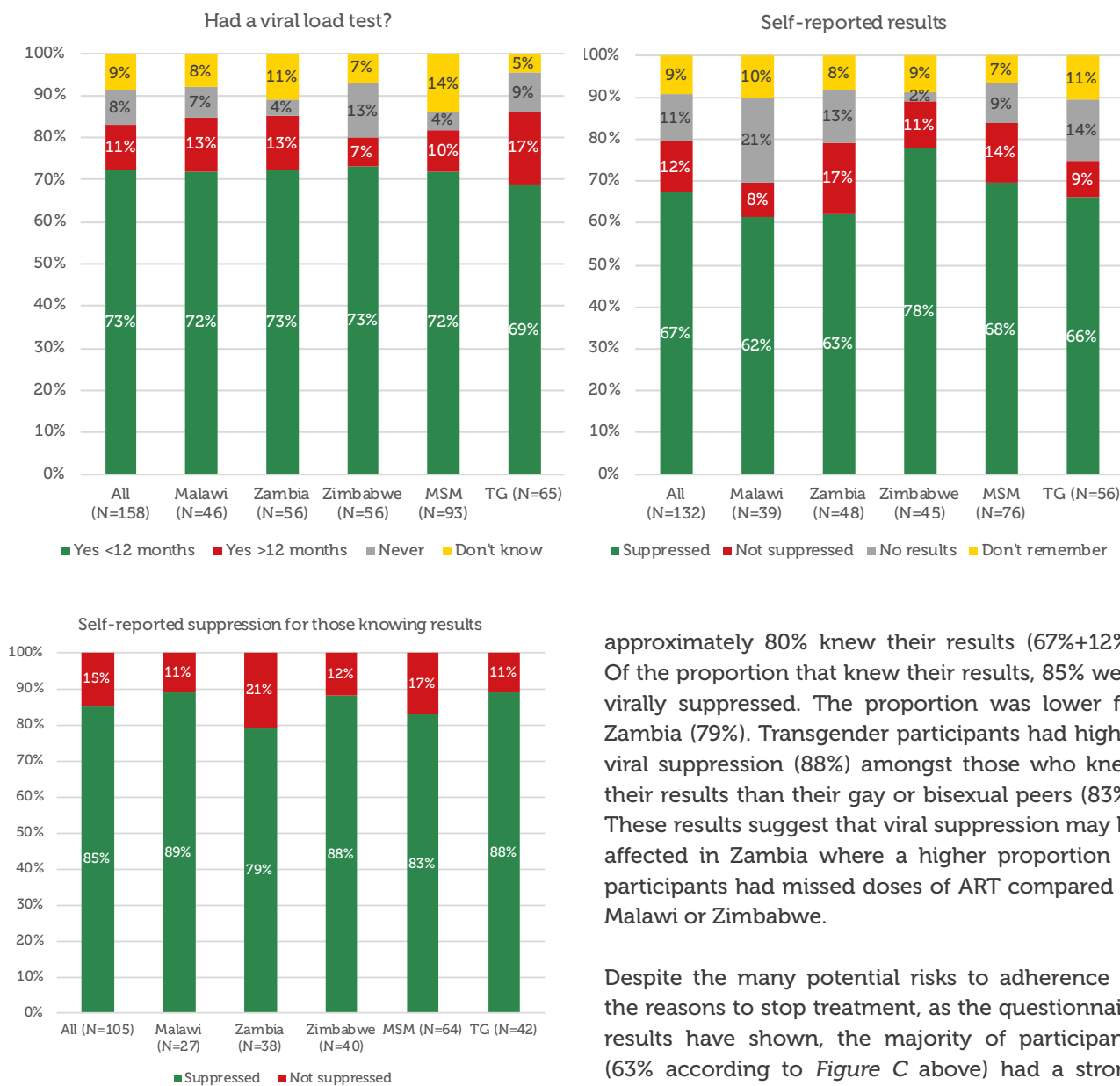
Simply forgetting, being depressed, forgetting to carry medicines when travelling, lack of food,



taking too much alcohol, mental health challenges, including loneliness, depression, reacting to stigma and rejection, and suicidal thoughts could all lead to stopping to take ART.

Given the frequency of missed doses, the study asked participants about their viral load (Figure E).

Figure E: Self-reported viral load results




approximately 80% knew their results (67%+12%). Of the proportion that knew their results, 85% were virally suppressed. The proportion was lower for Zambia (79%). Transgender participants had higher viral suppression (88%) amongst those who knew their results than their gay or bisexual peers (83%). These results suggest that viral suppression may be affected in Zambia where a higher proportion of participants had missed doses of ART compared to Malawi or Zimbabwe.

Despite the many potential risks to adherence or the reasons to stop treatment, as the questionnaire results have shown, the majority of participants (63% according to Figure C above) had a strong commitment to treatment. These participants found enablers within themselves or in their environments to maintain this commitment and to avoid missed doses. For some, this commitment centred around personal agency and a positive outlook:

“There is the realisation that if the treatment is what is giving you life, what is supporting your health, this realisation is the one that moves you, encourages you not to stop taking

Overall, 84% of participants self-reported that they taken a viral load test at least once since they started treatment, 73% within the past 12 months. The results were consistent across countries and relatively similar between groups (as many as 86% of transgender participants had ever taken a viral load test). Of the number of participants tested,



treatment whatever the situation. That is, if you are depressed, stressed or what not, you just have to take the treatment.” – Transgender woman, 21 years, Lilongwe, Malawi

The findings illustrated that there were a range of risks to starting and continuing ART, arising from fears and anxieties about stigma, personal meanings and significances associated with being on ART in the first place, and the different choices and arrangements individuals made regarding who could know or not know that they take medication. Fortunately, these risks were mitigated by numerous positive sources of meaning which supported that idea that taking ART was life affirming. While there were participants who missed doses or even stopped treatment for a time, they eventually encountered these positive resources that encouraged them to resume treatment, and that healed and restored their commitment to their own positive health and dignity.

Discussion

As an exploratory venture, the findings of the study were expansive and have shed light on a constellation of stigma-related possibilities and effects for the participants. Intersectional stigma was indeed a potent force in their contexts with intricate variations in its forms, manifestations, intensities and effects. These stigmas flourished across a range of socio-ecological zones, from the private, interior world of the individual, to the public and institutional. The accounts of the participants have shown how the roots of intersectional stigma are structural. Criminal laws and strongly negative socio-cultural and religious attitudes, practices, and beliefs compound each other and manifest themselves in a deeply rooted intolerance and heightened suspicion around sexual or gender diversity that runs across social contexts. Such forces and effects can be compounded by stigma linked to their HIV-status. As a result, the young participants find themselves either experiencing, or fearing to experience, stigma and discrimination in multiple forms and modalities, from subtle microaggressions, including gossip or indirect threats, to more overt forms of exclusion, such as verbal harassment, and physical or sexual violence.

In the midst of this nexus of powerful, marginalising forces and effects, the participants revealed both vulnerabilities and remarkable strengths in the way that they find, evolve, and express their identities, in terms of sexual or gender diversity and health status.

These young people become adept at managing their outward-facing identities through various strategies for disclosure and concealment, being a person living with HIV in some contexts, being a member of the sexual minority community in others, but rarely being both at once. While it would appear that the study participants are more able to parry their experiences and risks of HIV-related stigma, they retain a stronger vulnerability to stigma related to their sexual orientation or gender identity.

Being on ART had specific meanings and significances for the participants, much of it linked to stigma arising from being seen to take the medication or having it found in one's possession. This fuelled an additional layer of risk that led some individuals to prefer missing doses, occasionally or over more prolonged periods, rather than endure actual or feared social, emotional, or physical harms linked to being 'found out' as someone living with HIV and taking ART. Other risks stemmed from coping mechanisms, such as frequent alcohol use, or using sleep to escape stress.

Conclusion and recommendations

The study findings were proof enough that more needs to be done on multiple fronts and levels. Long-term ART adherence remains a global challenge for all groups and requires layered, multi-pronged interventions at multiple levels, from the individual to the structural. Older adolescents and young people on ART, including those who are members of sexual minority populations, may require more specifically focused approaches.

The findings suggest the following areas for further action, in terms of further research as well as for the strengthening of programming to protect and sustain important public health goals for young sexual minority individuals on ART:

Research

This study data should be used for additional sub-analyses on key mediator/moderator relationships between different experiences and effects of stigma, coping and resilience mechanisms, and ways to insulate and protect the commitment to ART. The focus could initially be on data from those participants who succeed in this respect.

Based on these additional sub-analyses, a conceptual model should be proposed for further



inquiry, where feasible, or for consensus-building through a Delphi process, for example.

The conceptual model should be used to either develop new pilot interventions or to select from and adapt existing interventions that aim to significantly mitigate the effects of intersectional stigma on those individual and collective factors that enable and strengthen ART adherence independent of features and experiences of the social context. The participants themselves in this study give some clues as to what this might entail. Additional conceptual and empirical work is needed, however, to make 'what works' clearer.

Once identified and designed, such interventions should be piloted in order to generate further tools and resources for mitigating and resisting the influence of intersectional stigma for the young participants.

As with this study, individuals living with HIV from sexual minority communities should be engaged in these efforts and offered more substantive and central roles, building on the achievements of this effort.

Programmes

- Scale up 'friendly' and secure interventions specifically developed to address the comprehensive needs of sexual minorities living with HIV.
- Design and implement comprehensive approaches to address intra-community stigma against HIV-positive sexual minorities.
- Expand the range of safe and healing spaces that HIV-positive sexual minorities can have access to and where they can express and celebrate their integrated identities without fear of stigma and its consequences.
- Enhance the component of mental health support through flexible, innovative means (lay counsellors or through social media, for example), including urgent support for individuals in crisis.
- Explore emerging interventions using positive psychology, mindfulness and affirmation and commitment therapies, which show some positive influence in other settings, in addressing and resolving risks and vulnerabilities to stigma.

Enabling environment

On a more general level, work should intensify and accelerate to create more enabling environments for access and uptake in HIV services for sexual minorities in the SADC region, through law and policy reform, stronger protections and protective mechanisms, interventions to empower sexual minorities.



For the full report, see: Armstrong R, Zulu JM, Muparamoto N, Jumbe V, Muula A, Nyamaruze P, Govender K. Exploring the Influence of Intersectional Stigma on Uptake and Retention in ART Programmes for Selected Young Key Populations in Malawi, Zambia and Zimbabwe: A Mixed Methods Analysis. Multi-Country Findings Report. Available at: www.heard.org.za

