EXPLORING THE INFLUENCE OF

INTERSECTIONAL STIGMA ON UPTAKE AND RETENTION IN ART PROGRAMMES FOR SELECTED YOUNG KEY POPULATIONS IN ZIMBABWE

Findings from a Mixed Methods Analysis

Report Summary

Background and Rationale

Since 2016, the national, multi-sectoral HIV/AIDS response in Zimbabwe has prioritised the inclusion of all population groups, including key populations, as essential to the country's efforts to end HIV and AIDS as public health threats by 2030. Within the country's definition of key and vulnerable populations (KVPs) are men having sex with men (MSM) and, more recently, transgender people, along with other groups. Current HIV programmes for MSM and transgender women in Zimbabwe place an emphasis on a range of tailored strategies for encouraging individuals living with HIV to come forward for diagnosis and to subsequently enrol on ART. They also contain components to strengthen retention and adherence in order 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 the uptake and retention on ART is relatively unknown, particularly for younger individuals who may face additional vulnerabilities, due to limited experience with ART, for example, or having fewer personal or social resources than their older peers to resist the influence of stigma.

This study attempted to contribute to closing these knowledge gaps. It used an exploratory, mixed-methods approach to arrive at a multi-dimensional view of the experiences of young (18-24 years), HIV-positive MSM and transgender women and their successes and challenges to sustain themselves on ART and to achieve well-being in the Zimbabwe context. 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 Zimbabwe may find themselves at the intersection of stigma related to their sexual or gender diversity and their HIV status. Understanding how these influences manifest themselves in the lives of these young people, and how they affect their health seeking behaviours, particularly retention in HIV services, is critical to designing and sustaining effective public health interventions for these priority groups.

The Zimbabwe study was part of a regional research project led by the Health Economics and HIV/AIDS Research Division at the University of KwaZulu

Natal, Durban, South Africa, The project includes similar studies in Malawi and Zambia. It is funded through the HIV Special Fund Round III initiative of the Southern African Development Community.

Study Design and Methods

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 56 young people agreed to participate and completed both the questionnaire and the in-depth interview. There were 21 from Bulawayo, 23 from Harare, 7 from Masvingo, and 5 from Mutare. 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, Shona and Ndebele). 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 c0mplementary, reflexive links between the two types of results (quantitative and qualitative).

This study was approved by the Medical Research Council of Zimbabwe and the Biomedical Health Research Ethics Committee of the University of KwaZulu-Natal.

Findings

Participant Characteristics

Of the 56 participants, approximately two thirds (63%) identified themselves as MSM; the remaining 37% identified as transgender. In terms of self-assigned gender, almost two thirds (59%) defined themselves as male, 5% as female, and 36% as transgender. The median age of the participants was 22 years. Most participants (68%) had completed secondary school as their highest educational attainment. This proportion was slightly lower for the MSM group (63%) than the transgender group (76%). Almost one third (29%) of participants had completed post-secondary level education, with this proportion being higher among MSM (31%) than transgender (24%).

With reference to employment status, 34% indicated that they were unemployed. Approximately a third (29%) of participants were self-employed (doing 'piece' work, such as selling airtime, making wigs, or hairdressing, as explained in the interviews). The remainder were either employed full-time or part-time (32%) or were students (5%). Regarding relationship status, 55% were single, and more MSM participants reported being in a relationship (43%) compared to their transgender peers (29%). Regarding other characteristics, approximately two thirds of the participants (63%) lived with their families, with the remainder living either alone or with friends.

According to the inclusion criteria for the study, all participants were HIV-positive and currently on ART. With regard to time since diagnosis, almost half (49%) of participants had been diagnosed with HIV within two or less years of the study (since 2019). Most participants (41%) had received their diagnosis through a non-governmental organisation (NGO) or a community-based organisation (CBO), perhaps reflecting how participants were recruited. Seven participants (13%) indicated that they were born with HIV. Regarding the length of time on ART, half of the participants had been on ART for two years or less prior to the study (since 2019), suggesting that most participants started ART the same year they received their HIV diagnosis. Just over half of the participants (55%) received their ART from NGO/CBO-run providers, and almost one third (31%) from public health facilities. More MSM (66% versus 42% for transgender) received services from non-governmental providers; more transgender (50% versus 34%) received services from public health facilities. Finally, a small proportion (two transgender participants) received their care from private providers.

From the data analysis, four over-arching themes emerged: 1) intersectional identities; 2) experiences and effects of intersectional stigmas; 3) coping and resilience; and 4) influences on ART adherence.

Intersectional Identities

With regard to their identities, during the interviews, *MSM participants* described their sexual orientation as natural or that they were created that way. And despite evident tensions in family settings or in communities, there was nothing that could change this core truth about themselves.

> *"Well, I understand that I am gay and I have accepted it, that I am gay man. And I am proud of it because I was born like this and nothing will change."* MSM, 20 years, Harare

Narratives from *transgender participants* mostly reflected sexual attraction to men and being 'essentially' women, regardless of their gender at birth.

> *"I will say I am a transgender woman. I like men, I am attracted to men. I am not attracted to females. I feel like I am a complete female right now that I became a transgender woman. So, my identification, that I am a woman, yes, I am a transgender woman, but I am a woman who is now attracted to men."* Transgender woman, 21 years, Bulawayo

From the questionnaire, 79% of participants agreed or strongly agreed that they were comfortable with their identities; however, a slightly lower proportion (70%) agreed or strongly agreed that they would not wish to change their identities. Transgender participants were more confident (83%) than their gay or bisexual peers (75%).

As for the proportion of participants who were less assured, the interviews indicated that these doubts largely arose from the difficulties of the social context.

> *"I am not yet that comfortable with who I am because, being who I am, it comes with a lot of baggage."* MSM, 23 years, Harare

The participants' views about being a *person living with HIV (PLHIV)* ranged from highly affirming to more doubtful.

> *"Well, at first it was difficult living with HIV. But then I heard that was now my life, it's a daily routine to keep myself going and to keep my health in check. As for me, living with HIV, I feel like it has become normal. It no longer stresses me that I'm living with HIV, no."* MSM, 22 years, Harare, Zimbabwe

From the questionnaire results, some participants found it more difficult to be so confident and assured about their HIV status compared to their sexual orientation or gender identity. For example, (40%) strongly agreed or agreed that they occasionally felt worthless because they were HIV-positive; whereas close to a third of participants (29%) strongly agreed or agreed that they were ashamed that they were HIV positive (42% for transgender compared to 18% for MSM).

> *"It's very hard because sometimes wanting to disclose that I am HIV positive is difficult. And let's say you find someone who loves you, the mere mention of being HIV positive, it can go otherwise but you will be trying to get along. Even at hospitals, you are made to queue, and they say those who have brought their green books stand this side, or a relative sees you and then she knows because of me joining the green book queue, or the viral load one. So, it's very difficult and made worse by being young. People will start talking."* MSM, 23 years, Harare

In comparison to the results for affect regarding sexual orientation or gender identity, a greater proportion of participants were struggling to find a similarly positive and accepting view of their health status.

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, for example, 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 in general.

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.

"Hearing that gays are ... it is a demon or being HIV, it is your fault. Those things, they just send you back. Hearing that a person with HIV is a moving coffin, yaa." MSM, 22 years, Bulawayo

The findings further demonstrated that, in Zimbabwe, social characteristics linked to sexual or gender diversity and HIV status were either devalued or at constant risk of such devaluation for the individuals that possessed them. For the young participants, intersectional stigma was indeed a potent force in their contexts, one that was flourishing with intricate variations in its forms, manifestations, intensities, and effects across a range of socio-ecological zones, from the private, interior world of the individual to the public and institutional, as in these examples.

"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

"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

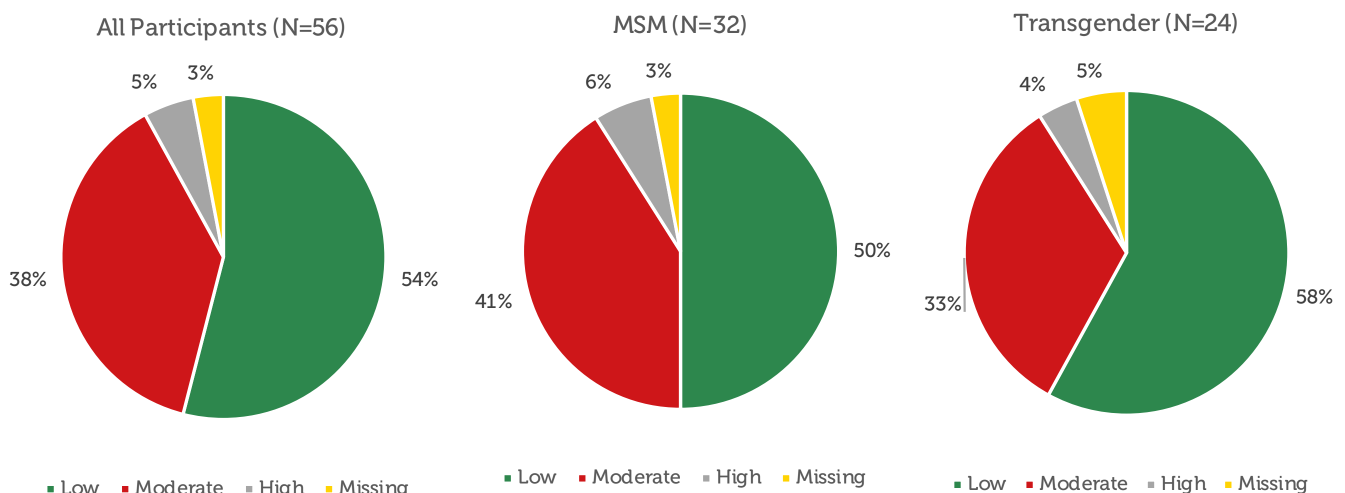
Amidst intersectional stigmas, participants revealed both vulnerabilities and remarkable strengths in the way that they found, evolved, and expressed their identities in terms of sexual or gender diversity and health status. These young people became adept at managing their outward-facing identities 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 the study participants were more able to manage their experiences and risks of 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.

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 a negative influence on mental health as well as a range of other emotional, social, or physical harms, and increasing anxiety about recurrent experiences in the future.

The study used the Centre for Epidemiological Studies Depression Scale – 10 Item Version (CES-D-10) to measure the presence of depression symptoms in participants (*Figure A*).

Figure A: CES-D-10 results



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, potentially in need of urgent clinical intervention. From the responses, over half of the participants (54%) had a score <10, indicating that they had low to minimal symptoms of depression. This proportion was slightly higher for the transgender participants (58%) as compared to the MSM participants (50%). It was also observed that a greater proportion of MSM participants had moderate to significant symptoms of depression (41%) or major depression (6%) compared to the transgender participants, at 33% and 4% respectively.

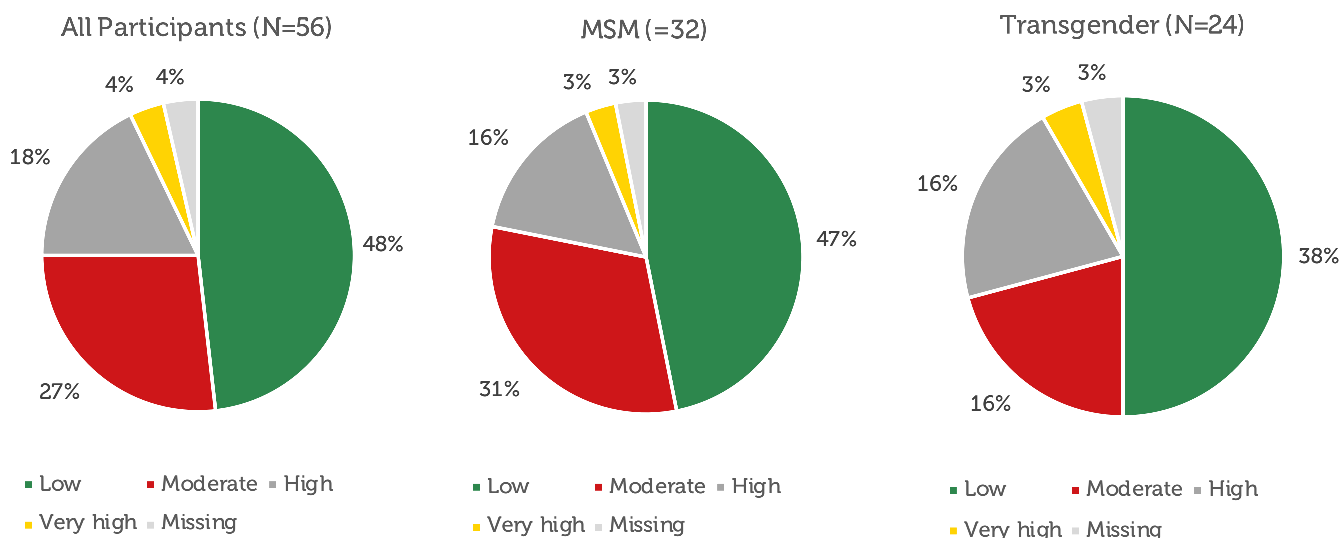
The study found that half (52%) of all participants had ever contemplated suicide. A similar proportion (50%) had done so within the past year. These results were highest for transgender participants at 71%. Few participants (20%) had told anyone about such thoughts. Finally, seven participants (13%), three MSM and four transgender, indicated that it was likely they may still attempt suicide at some point in the future.

> *"In our community, if people know that you are gay and you are taking HIV treatment it's not something easy to live with. People will be giving negative comments and discrimination towards your gender identity and HIV status. Even if you are to stay alone at times those comments make you think of even committing suicide for you won't be feeling worthy. You will be walking with a low self-esteem."* MSM, 22 years, Harare

Coping with Stigma

The study's participants had different ways that they coped with and responded to the effects of stigma, including poor mental health. These included some problematic practices, such as high levels of alcohol or drug use. The study used the Alcohol Use Disorders Identification tool (AUDIT) to examine the frequency of taking alcohol for the 79% (44/56) participants that took alcohol (*Figure B*).

Figure B: AUDIT results



More than half (59%) of participants who drank (64% for MSM and 52% for transgender) indicated a *low* level of alcohol consumption (monthly or less). Just over a third (34%) had *moderate* consumption (monthly or weekly). Only MSM participants (12%) were *high* or frequent users of alcohol, including levels symptomatic of addiction (daily use).

> *"I go to the pub, and make sure I get really, really drunk so that I forget, and I wake up feeling better the next day."* MSM, 18 years, Mutare

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, as in the examples that follow.

> *"Well, I'm a Christian, and I am a prayer warrior, by the way. So, praying is my solution. I pray and pray and pray. So, praying is the solution to everything."* MSM, 22 years, Bulawayo

> *"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

> *"I think I just, what can I say...I just try and put a better picture in my head, and just say, 'Tomorrow's just going to be better, tomorrow's going to be better, tomorrow's going to be better!' So, this has actually led me to, sort of, like, ease these suicidal thoughts as they come. Because every time when I get those thoughts, I tend to think of something that cheers me up, that actually gives me hope for a better tomorrow."* Transgender woman, 22 years, Bulawayo

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 KP-friendly health workers, and, very rarely, mental health professionals to unburden themselves and seek support.

> *"When you go to the KP-friendly units, they're very welcoming and they make you feel comfortable. You feel free to share with them and they maintain confidentiality."* MSM, 18 years, Mutare, Zimbabwe

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

Effects of Stigma on ART

Being on ART had specific meaning and significance for the participants. For some, it was empowering and life affirming, as in this example:

> *"Because for me, when you take ART, usually, it's when you go through a habit, a habit develops, after 21 days, that's what they say. So, we take our ART religiously, because it's taken at a certain time, on a daily basis, every day. So, already you are in tune, your whole body, your mind, your whole system is already in tune with you taking your ARV treatment. So, there's usually no hiccups."* MSM, 23 years, Harare

However, several 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.

One third (32%) of all participants had missed ART doses at least once (the proportions were the same for the MSM (10/32) and transgender (8/24) groups). For those who had missed doses, most indicated it was because they 'simply forgot', were avoiding being noticed or were depressed. Other reasons were being away from home or being distracted.

Some described how they had missed doses only once, while others had stopped taking their medication for many days or weeks, as in this example:

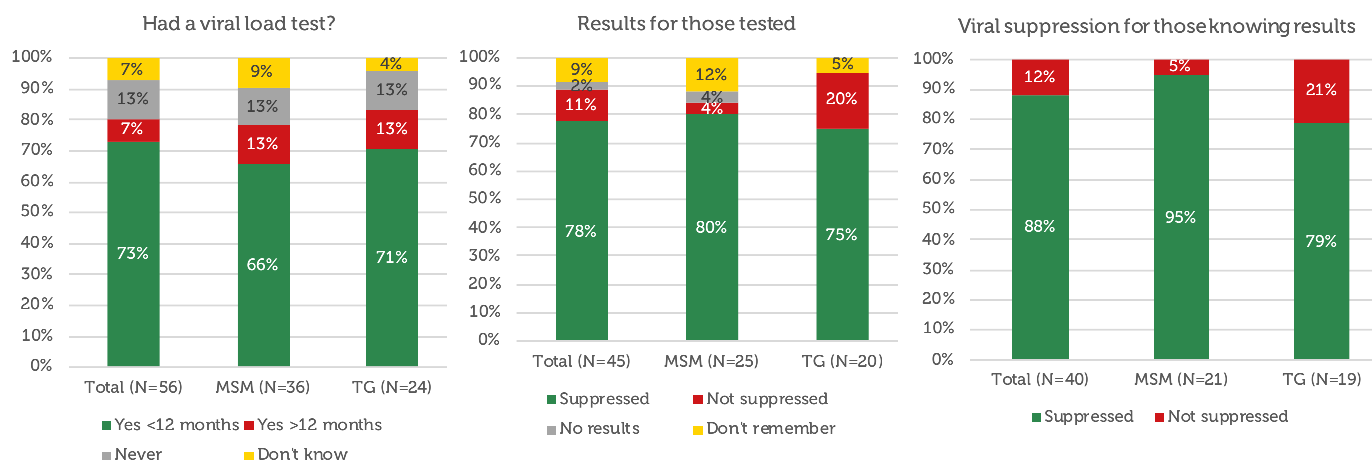
> *"I have a new boyfriend. So, whenever I go for a sleep-over or stay in for about 2-3 days, it's difficult because he's always there. You know the time that I take my tablets he will be there and I can't really change the time so in those 3 days I miss taking them then I do after when I get home. When I'm with him I don't take them so I keep wondering what if I am to move in with him? What might happen because I haven't told him. I haven't had the courage to tell him, to disclose my status."* MSM, 22 years, Bulawayo

Several factors contributed to missing doses, including simply forgetting that they were on

medication, being depressed, forgetting to carry medicines when travelling, lack of food, or consuming too much alcohol. Mental health challenges, including loneliness, depression, reacting to stigma and rejection, and suicidal thoughts could all lead to stopping ART.

Given the frequency of missed doses, it was not surprising to find that self-reported viral suppression was not optimal for all participants (*Figure C*).

Figure C: Self-reported results for viral suppression



Self-reported viral suppression was 78% for all participants who were tested, lower for transgender participants (75%) than for MSM participants (80%). Some of this is no doubt linked to missing doses; however, the study could not firmly establish these links. For those that had received a test and knew their results, the picture improved with 88% overall self-reporting viral suppression (95% for MSM and 79% for transgender).

For those participants that had stopped or interrupted treatment at some point, fortunately there were individuals or events that encouraged them to restart and to overcome whatever was influencing them in this regard.

> *"What I've taught myself when it comes to medication is that, come hail come thunder, I'm doing this for myself, even if I wake up dumped or whatsoever, medication I'll take. Unless maybe my arms are cut off."* MSM, 18 years, Mutare

Discussion

In this study, we examined how the experiences of HIV-related stigma may interact with co-occurring experiences of stigma related to sexual or gender diversity, for some and not for others. While there were instances where the participants could experience stigma for having both identities, sexual and gender minority and living with HIV, the stigma experience differed with context. For example, there are contexts were HIV-related stigma was more potent, particularly within the community of sexual and gender minorities, while diversity related stigmas were acute in other contexts. In all contexts the anticipated or enacted stigma had an effect on the mental health of the participants which affected their attitude and practices related to ART.

The findings have shown how stigma emanating from "multiple socially devalued characteristics" – being MSM or transgender, HIV-positive and on ART – are "mutually constitutive" and "synergistic" in their forcefulness. This was very evident, for example, in the many complex strategies the young participants adopted to manage disclosure (and non-disclosure) about their sexual orientation, gender identity, and their health status, depending on the social settings in which they found themselves, whether it was being amongst siblings or partners, other sexual minority peers, other friends, health workers, or members of the community at large. The opportunities or spaces where the participants did not have to feel vigilant about inadvertently revealing something about

their 'true' identity or their health status, including taking ART, were few and far between.

All of this effort was maintained, it appeared, to anticipate or avoid stigma. These efforts also had a considerable toll on the young participants in the form of mental health challenges and problematic coping behaviours, such as heavy alcohol use, that could eventually lead to missed doses of ART, or at least elevated risks of such things. Very few participants appeared to have reached a state where, through open disclosure, supportive social networks, access to counselling or mental health support, and through a highly evolved self-assurance, they appeared to have become resistant and resilient to such negative forces and were not at risk of negative consequences, including missed doses.

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 focussed approaches. It was encouraging to find that the participants in this study were not passive recipients of the intersecting stigmas, as they demonstrated personal agency and resilience to deal with this stigma, influencing better mental health outcomes and ART adherence. The significance of this is increased when the young age of the participants is taken into consideration along with the reality that they have several decades ahead of them in which to keep drawing on these resources to sustain themselves in the absence of any broader social and structural change.

Informed by the socio-ecological framework, the findings suggested multilevel interventions to address the different factors and influences that drive and shape the experiences of stigma and discrimination among young HIV-positive MSM and transgender women as well as strategies for ART adherence.

Individual interventions

- Individual affirmation counselling for young MSM and transgender women to improve self-acceptance of their sexual orientation and gender identity and to enhance their self-esteem.
- Conduct life-skills training and mentorship, support economic empowerment for example through provision of funding to empower MSM and transgender women to develop new businesses or scale up existing initiatives that can generate economic value and social impact for themselves and their communities.
- Promote positive coping behaviours in response to stigma experiences and to model accepted positive behaviours like writing poems, listening to music, or becoming social media influencers.

Relationship/interpersonal interventions

Design or strengthen mechanisms for supporting young MSM and transgender people living with HIV to manage safe disclosure of their social identities and health status and provide support to cope with rejection and other negative reactions to disclosure.

Community interventions

- Include parents, family members, friends and community members in stigma reduction initiatives that seek to address their own stigmatising attitudes, beliefs and practices regarding sexual orientation and gender identity, and HIV status.
- Scale up interventions within LGBTQI+ spaces (including DICs) to reduce and eliminate HIV-related stigma, particularly at the interpersonal and community levels.
- Equip the young MSM and transgender women with strategies for safe disclosure of their health status, including in sexual and romantic partnerships.
- Support the development of safe spaces and support groups for MSM and transgender women living with HIV.

Health systems interventions

- Scale up and strengthen LGBTQI+ sensitivity training for health workers (possibly as part of pre-service training) and provide facility level capacitation of health care workers to screen/ diagnose mental health conditions and facilitate clear referral pathways.
- Create accessible mental health services and integrate HIV and mental health services and other interventions, including linkages to social protection services, into a one-stop centre for MSM and transgender people living with HIV.
- Engage established partners who are already providing mental health services – such as the Friendship Bench initiative – and broaden

services to be inclusive of HIV-positive LGBTQI+ people on ART.

- Equip peer educators to identify mental health issues and strengthen existing support structures, such as support groups, adherence clubs, ART Champions.

Societal interventions

- Continue to engage parliamentarians, religious and cultural leaders and other opinion leaders at all levels to recognise the negative effects of current laws criminalising same sex behaviours and lobby for policies and strategies to address attitudes and practices that drive gender identity stigma, and that limit the effectiveness of the HIV response.
- Decentralise key population programmes to reach all key population groups including those in remote areas with HIV and mental health services.

Finally, the study's findings suggested some additional areas for research, including the following:

- How do HIV-positive MSM and transgender understand the manifestation of mental health and how do they cope with mental health conditions?
- What are the opportunities and challenges in conducting a study on developing a community of practice on sexual orientation and gender identity stigma and HIV stigma reduction in the SADC region?

For the full report, see: Muparamoto N, Armstrong R, Nyamaruze P, Mutenga C. Exploring the Influence of Intersectional Stigma on Uptake and Retention in ART Programmes for Selected Young Key Populations in Zimbabwe: Findings from a Mixed Methods Analysis. Durban: HEARD, University of KwaZulu-Natal; 2023. Available at: www.heard.org.za