Exploring the Influence of Intersectional Stigma on Uptake and Retention in Art Programmes for Selected Key Population Groups in Three SADC Countries — Malawi, Zambia and Zimbabwe

Regional Symposium Report: April 2023
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1. INTRODUCTION

In 2020, the Health Economics and AIDS Research Division (HEARD) of the University of KwaZulu Natal, along with the Kamuzu University of Health Sciences (Blantyre, Malawi), the University of Zambia, and the University of Zimbabwe, partnered in a research project entitled: Exploring the influence of intersectional stigma on uptake and retention in ART programmes for selected key population groups in three SADC countries – Malawi, Zambia and Zimbabwe. The project is funded through the Southern African Development Community’s (SADC) HIV/AIDS Fund III opportunity and is a multi-phase, three-year applied research initiative examining the influence of intersectional stigma for young HIV-positive men-having-sex-with-men and transgender individuals on uptake and retention on anti-retroviral treatment (ART).

The research examines the extent to which experiences of stigma and discrimination, based on sexual orientation or gender identity and HIV-status may interfere with retention or adherence. The three-year initiative is designed around four main objectives or phases: 1) exploratory research examining experiences of intersectional stigma; 2) development of a conceptual model or theory of change; 3) design of an intervention based on the conceptual model in order to mitigate stigma effects and improve ART uptake and adherence; and 4) documentation of project results in the form of guidelines for improved intervention design and quality of care across the SADC region. The project is implemented on a collaborative basis with participation from organisations and networks of key populations in each country.

By December, 2022, the project had completed its first objective, exploratory research, and was moving forward on the second objective, development of the conceptual model. As part of the research plan, a regional symposium was convened in Durban from April 3-5, 2023. This short report summarises the discussions and outputs of the symposium.

2. PROGRESS UPDATE

While the project was initially expected to commence in October 2020 upon approval by SADC, some unexpected delays arose meaning that the effective start date was October-November 2021 for the exploratory research component. As at June 30, 2022, all three project partners had submitted initial research reports and HEARD had prepared a draft multi-country analysis. In addition, for the quantitative component of the mix-methods design, the HEARD team had undertaken some exploratory analysis towards the development of the conceptual model. In total, 156 young people participated from different locations in each of the three countries, sharing their experiences as part of in-depth interviews and a quantitative questionnaire. Their participation has created a unique and rich data set regarding the phenomenon of intersectional stigma in the southern African context and its influence on health and well-being for this group of young people living with HIV. The research reports are expected to be revised and finalised shortly and drafts of manuscripts prepared for peer-reviewed publication.

3. PURPOSE AND OBJECTIVES OF THE SYMPOSIUM

The overall purpose of the symposium was to consolidate and validate the results of the exploratory research phase and to reach consensus on the design and approach for subsequent phases based on these results.

The specific objectives of the meeting were:

a) To review and reach consensus on the country level results and the multi-country synthesis arising from the completion of the exploratory research phase.

b) To review, further develop, and reach consensus on a conceptual model to guide intervention selection/development for the subsequent phases of the project.

C) To undertake a review and preliminary selection of intervention models.

d) To discuss and agree on implementation modalities and implementation timelines for subsequent phases of the project.

e) To discuss and agree on strategies to further engage and share ownership of the project with key populations constituencies as we move forward.

f) To discuss and agree on a plan for additional scientific outputs based on the exploratory research results.

g) To share experiences arising from the implementation of the project to date and to discuss and agree on strategies for improvement.

4. SYMPOSIUM PARTICIPANTS

A full list of the participants and their respective organisations is included at Annex A.

5. SYMPOSIUM AGENDA

The agenda for the meeting is included at Annex B.

6. SUMMARY OF PROCEEDINGS

On the first day of the symposium, following participant introductions, opening remarks, and a review of the
objectives and the agenda for the symposium, research teams presented a summary of the main findings from each county. These were followed by a presentation of a multi-country synthesis of results from the HEARD research team.

6.1 Presentation and Discussion of Research Results

Zambia Results – The presentation by the Zambia team highlighted how, although many participants were comfortable or confident about their sexual orientation or gender identity, this changed when becoming HIV-positive. Being gay or transgender worsened HIV stigma for many, making it difficult to disclose their HIV status to others, including to potential romantic or sexual partners. Participants could also be hesitant to disclose their status to family members or friends for fear it would be assumed that they were gay or transgender and that this was the reason they were HIV positive.

“As I said to you, being gay is not easy. And being gay plus being HIV positive is something that makes you crazy because people will just say, ‘Whatever they were doing, it caught them in their act!’ ...So, it’s something that is so difficult to keep up with.” – MSM, 24 years, Chipata

The burden of not being able to disclose their identities or their HIV status in order to avoid stigma lead to mental health challenges for many, including depression, anxiety and thoughts of suicide. It also led to coping behaviours that were problematic for some, such as heavy alcohol consumption. Overall, 50% of participants had missed taking their HIV medication at least once in the recent past. A number of participants spoke about the challenges that they encountered which contributed to missed doses, such as fear of rejection by significant others, fear of being gossiped about and food insecurity.

“It affects me sometimes because, if people reject you, you feel like stopping to take the medication. ‘Maybe am just wasting my time, let me just die.’ It affects me a lot.” – MSM, 19 years, Lusaka

“Things like 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.” – Transgender, 23 years, Lusaka

“Sometimes the challenges I face are those of diet. Sometimes you might find that I do not have food. The medication requires one to eat.” – MSM, 24 years, Lusaka

These challenges aside, there were also a number of positive findings, with participants showing resilience and many positive ways to cope with the stress of stigma, including self-care, playing sports, listening to music, spending time with friends, or benefiting from the (limited) number of key population (KP)-focused services designed to support them.

The team concluded that reducing intersectional stigma and improving adherence would require adopting a socio-ecological approach with interventions targeting multiple levels, including the personal environment, interpersonal settings, family and community settings, health service delivery environments, and the broader institutional environment, particularly for changing laws and policies.

Zimbabwe Results – The Zimbabwe team began their presentation by noting the diversity amongst respondents in terms of age, socio-economic characteristics, etc. Although most were confident about their sexual orientation or gender identity, some still experienced challenges making them more ambivalent or even regretful, particularly given the social context.

“I am very much comfortable. I have no problem with my gender identity. I just feel alright about it. What the next person thinks about me and for what, it’s their problem. I do what pleases me... All this never affected me because I always tell people that you know what, if you can’t sit next to me and you feel uncomfortable around me, you must just stay away from me. Don’t interfere with my life or my space as I will also do the same and will stay away from you.” – Transgender, 24 years, Bulawayo

“It depends. Some days, I just wake up and say, ‘Woo... Jesus Christ, why me?’ And then sometimes, I even go, ‘YES!! I’m proud of myself. I’m proud of who I am!’ and all that. Then life keeps going. But then, but then, I’m just saying it’s 50/50.” – MSM, 18 years, Mutare

There was a similar range of views regarding HIV status, but with more participants indicating that it was slightly easier to be a person living with HIV (some participants still had more difficulties with their HIV status, however).

“At first it was very difficult for me. It took me time to accept my status but as time goes, meeting other new people telling me that they are HIV positive as well, it changed me to an extent that I can now stand before people and tell that I am HIV positive. I can advocate for HIV positive people because I am also HIV positive. So now, I am fine, even proud of it.” – MSM, 22 years, Harare

The experiences of stigma related to sexual orientation,
gender identity and HIV status were equally varied. Experiences of stigma and discrimination related to sexual orientation and gender identity appeared to be more intense for participants than experiences related to HIV status.

“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... Sometimes, I can say I prefer to live with HIV than being a trans.” – Transgender, 19 years, Bulawayo

The team highlighted how HIV stigma from other members of the LGBTIQ+ community in Zimbabwe was particularly difficult for the participants, particularly in the way that it affected their ability to find partners.

“I've told a lot of people, but most people, especially in relationships, if I tell them about my status they leave me because to them I am a ticking bomb, but not realizing that we deserve love like any other person because we are all humans, except that I'm living with HIV.” – MSM, 20 years, Harare

The mental health effects of stigma were evident in the number of participants showing symptoms of depression, anxiety and thoughts of suicide. Elevated levels of alcohol and drug use were also noted as a coping mechanism. A number of positive coping behaviours were also identified, including self-care, pursuing sports or hobbies, confiding in friends or family members, or benefiting from some of the KP-led services, including drop in centres and psychosocial support.

“I think I just, what can I say, every day is it comes right? 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, 22 years, Bulawayo

The influence of stigma on ART adherence was evident in the number of participants who had missed ART doses, but also in the attempts to keep their HIV status a secret. Individuals had to keep their ART hidden and to be very selective in terms of who they disclosed taking medication to and who they hid it from.

“Yes, sometimes I miss ART doses because now 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 and 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

The team concluded that the influence of intersectional stigma is very apparent in the lives of the young participants, and that it poses important risks to their health in terms of ART adherence and other factors. The results also showed how it was rare that the participants found social spaces that allowed them to be at once a member of a sexual minority and a person living with HIV, and where they could feel safe and accepted, even by their LGBTQI+ peers. The experiences of the participants demonstrated how the gaps were significant, within the services available, that addressed the specific health and social needs of these young people.

Malawi Results – The Malawi team highlighted some of the diversity of the respondents, particularly differences between MSM and transgender participants, and the fluidity between these identities for some (identifying as both transgender and MSM, for example).

"In gay life, I act as a man because I take some other friends as women, but I take myself as a man." – MSM, 18 years, Lilongwe

"I am a man, a Malawian man. I am 19 right now. I was born in 2001. Currently, right now, I am residing in Lilongwe. I was born a man but as I know myself, I am a transwoman, transgender." – Transgender, 19 years, Lilongwe

They also noted how a large proportion (90%+) were confident about their identities.

"I am comfortable [being transgender] because I am the image of God. It's the reason I am comfortable. Because if I am not comfortable with the way I was born, it's like I am against with God." – Transgender, 24 years, Blantyre

More than half of participants (56%) in Malawi had been on ART for five years or more (Malawi has the longest experience with KP programming compared to Zambia and Zimbabwe, for example). While there was some evidence that the social context for sexual and gender diversity may be a little more accepting in Malawi, participants were still experiencing the effects of stigma, particularly with regard to who they chose to disclose to about their social identities or their health status. One third of participants had not disclosed their sexual orientation or gender identities to their HIV care providers, for example. Additionally, one third of participants (more transgender than MSM) still reported experiencing stigma related to their identities, either in the form of gossip or verbal harassment, or blackmail. There was also elevated anxiety about the possibility of experiencing stigma in the future.

"Okay, it depends where you are. Let's say you are all gays, there is no need to hide to your friends that you are also a gay. Why would you hide? And what your friends are doing, you will also do the same. But when you are with straight men and chatting with them, like friends from church, work, or from the hood where I stay, there is no need to come and explain to them that I am gay. No, you need to keep your privacy so that people should respect you." – MSM, 24 years, Blantyre

Actual experiences of HIV stigma were less frequent, with gossip or exclusion in family and community settings, and having someone disclose one's HIV status without consent, as the more common experiences. Participants generally found more difficulties regarding their sexual orientation or gender identity than their HIV status.

"More challenge it's about my sexual orientation and gender, that's where the main challenge is. As I told you because the public cannot accept who I am [a transgender person]. But being with, living with HIV/AIDS, people they now, the community accepts people like us, we can live. People, they can know about us and no one can come to judge us, or talk something bad about us." – Transgender, 19 years, Lilongwe

"It is very difficult because, one, we are already MSM being discriminated in communities and, two, if you are also positive, you are also to be discriminated, so a lot of discrimination! So, I feel like I am nothing." – MSM, 23 years, Blantyre

Regardless, one third of participants had missed ART doses at least once. Some of this was due to the burden of stigma and its mental health effects, including depression, anxiety and suicidal thoughts.

"In the community, I can say I am affected mentally, because I do isolate myself. On the issue concerning HIV positive and the way I look, being a gay, I just feel guilty because when say I am a gay and at the same time I am a homosexual, so people do laugh at me saying it's a punishment from God. And when I combine all these things, I don't feel good because the community judges me, with the condition I am in, the way I do things. So, I don't feel comfortable, and mentally I am disturbed a lot." – MSM, 18 years, Lilongwe
“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

Alcohol use was a common coping mechanism but there were other more positive coping mechanisms, including self-care, social support from friends and family, or utilising tailored services for KPs, such as peer navigators linked to drop-in centres.

“There are a lot of things that I do in order to pull out from bad mental health. For instance, I share my situations with my friends. I tell them that, gentlemen, this is what I am facing, and they advise me, like, ‘Man, don’t worry do this!’ and that life goes on....Sometimes I go to the counsellors and they are helping a lot. They will talk to me, advise me, saying, ‘Remember your drugs! Don’t forget about social gatherings! Don’t forget to share your stories with others!’ So, those things, and sometimes I choose to be quiet, listening to music, and sometimes going to parties, festivals, or DICs, because there we get good and right information about ourselves.” – MSM, 21 years, Lilongwe

However, there appeared to still be a significant level of unmet need regarding mental health challenges. Any improvements being planned to address the results of the research much prioritise mental health according to the Malawi team (‘mental health, mental health, mental health’).

**Multi-country synthesis** – Following the presentation and discussion of the results for each country, HEARD presented a cross-county synthesis. Overall, there were more similarities than differences among the countries. There was a clear convergence of results that, in Malawi, Zambia and 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. The findings demonstrated that intersectional stigma was indeed a potent force in the young participants’ lives, one that remained flourishing but with intricate variations in its forms, manifestations, intensities and effects across a range of socio-ecological zones. In the midst of this, the participants revealed both vulnerabilities and remarkable strengths in the way that they found, evolved and expressed their identities, in terms of both their sexual or gender diversity, and their health status.

“Music, I am a fan of music. I have about a zillion tracks in my phone so I will just listen to music, nothing depressing especially not Adele – currently, sweetheart, she is very depressing! So I just listen to Ariana Grande, maybe, yeah, and I try by all means to twerk whilst I am working!” – MSM, 21 years, Bulawayo, Zimbabwe

Mental health challenges were common along with frequent alcohol use, for example. The study used the Centre for Epidemiological Studies Depression Scale 10 Item Version (CES-D 10) to measure signs of depression symptoms in participants (Figure 1).
Just over half of all participants (51%) had low to minimal signs of depression, and 38% had moderate to severe symptoms. A further 5% were highly symptomatic with more serious challenges. Participants from Zimbabwe and transgender participants had more overall challenges with depression than other participants. The study questionnaire also asked about suicide risk. Overall 42% of participants had contemplated suicide at least once in their young lives, 36% in the past year. Very few (17%) had disclosed these thoughts to anyone. The proportions of participants contemplating suicide were highest in Zimbabwe (52% and 50%) and lowest in Malawi (35% and 28%).

With regard to use of alcohol, the study used the Alcohol Use Disorders Identification tool (AUDIT). The results are shown in Figure 2. Overall, 63% of participants used alcohol. The proportion reached 79% for Zimbabwe.
With regards to frequency of drinking, of those who took alcohol, 44% had low to minimal alcohol use (monthly or less), 38% had moderate to frequent use (monthly or weekly), and 15% had serious use verging on addiction (weekly to daily). Participants from Zambia were heavier alcohol users than others. Similarly, transgender participants use alcohol more frequently than their MSM peers. Both mental health and alcohol use posed significant risks to ART adhere for many participants.

Despite these challenges and risks of stigma and its effects, the young participants 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 were more able to cope with their experiences and risks of HIV-related stigma, they retained 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 the risk of stigma through 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, frequent alcohol use, or using sleep to escape stress.

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, 24 years, Blantyre, Malawi

As shown in Figure 4, between 36% (Malawi) to 50% (Zimbabwe) of participants had missed doses of ART at least once. For Malawi, 33% of those missing doses had done so in the past week (see Figure 5).

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 required more specifically focussed approaches.

6.2 Reflections and Experiences of Peer Researchers

On the second day of the symposium, the peer researchers had an opportunity to report on their experiences during the data collection process as well as with the other aspects of the project. Each team commented on the most significant findings for them, the experience of the research process, areas for improvement, and next steps.

Malawi – The Malawi peer researchers found that lack of knowledge regarding mental health, the heavy use of alcohol, and inconsistencies in ART adherence were the most significant findings. The absence of sufficient mental health support was also important and a critical gap to be addressed moving forward. Their experience of the research process was largely positive. The use of DICs as the entry point for finding participants ensured that there would be a sufficient number of individuals who would participate, and that they could do so in a safe and confidential manner. For the peer researchers, the project was an opportunity to learn more about community members’ experiences.
on ART and some of the important variations in urban and rural experiences. The team felt that the age restriction was sometimes a challenge with more individuals wanting to participate than were eligible according to the study criteria. Overall, the experience was positive with good opportunities for personal growth and for networking, including at the regional symposium itself.

Zambia – The Zambia peer researchers had all participated in previous projects with HEARD, including a project on mental health and young MSM that had a similar research design. What they found significant about this project was the high level of need regarding mental health support, and the need to address some of the problematic coping strategies in the absence of such support, particularly the high levels of alcohol and other substance use. There was also a need to work on empowerment interventions for the young participants to build more socio-economic independence and resilience. The peer researchers all felt that they gained additional skills and experience in research, and that this was leading to other opportunities to be part of other projects. They deepened their knowledge regarding HIV in the LGBTIQ+ community in Zambia, particular regarding urban and rural differences. They appreciated the incentives participants received which ensured good engagement and respected their contributions. Some of the challenges included the low literacy levels of some participants (particularly in remote areas) and the difficult of administering the questionnaire. In addition, researchers felt pressured sometimes to find immediate solutions to some of the challenges faced by the young participants. They also found some of the interviews quite draining on a personal level. Regardless, they felt the project was very important and that the findings should be shared as soon as possible, particularly within the LGBTIQ+ community in Zambia.

Zimbabwe – The Zimbabwe team had generally positive experiences and all highly appreciated the opportunity to be involved in the project. Prioritising community members as researchers was a main strength of the approach in their view. They also appreciated the support of NAC and MOH to endorse the project. As key takeaways from the results, the team spoke about the challenges young people face around disclosure and safety, the challenges of daily medication regimens, the significant need regarding mental health and some of the problematic responses, including high levels of alcohol use. While Zimbabwe has some opportunities for KPs to seek mental health support, these are clearly not reaching enough young people. The team noted the differences between the different locations where the study took place, where Bulawayo and Harare had more to offer the participants than other locations. Finally, the team appreciated developing their skills as researchers and being part of an important project. They were concerned that the results be shared soon amongst community members so that there could be more collective action to address the needs of the young participants.

During discussion, some additional reflections were made. Generally, across all countries, the peer researchers noted that there was a lack of knowledge and understanding of mental health issues by the participants. Whilst the participants may have identified that they were distressed,
they did not have the appropriate words to explain their mental health challenges. In all the countries, peer researchers noted that DICs were considered to be very important, as they provided access to basic health and psycho-social services within their communities in a friendly manner. The peer researchers believed that involvement in the project had resulted in capacity development. They had received training before the start of the data collection process and also ongoing support throughout the data collection process. The peer researchers had developed research-related abilities and skills through participation in the study, which they could apply to other projects.

The process of data collection was sometimes overwhelming for the peer researchers as they identified with some of the painful and traumatic content emerging from the in-depth interviews. They desired more opportunities to share and offload some of the troubling thoughts that may have emerged from the data collection process. This suggested a need for more counselling and debriefing services for peer researchers. Whilst the peer researchers had collaborated fairly well with the universities in their respective countries, there was room for improvement. They indicated a need for better communication between them and the country leads regarding the project, particularly the next steps of the project.

### 6.3 Opportunities and Risks of Using Peer Researchers

The reflections by the peer researchers prompted a wider discussion on the opportunities and potential risks of this approach. As examples of potential risks, one symposium participant noted how using peer researchers may attract bias in that research participants might not be willing to give full disclosure to someone ‘from the community.’ In addition, peer researchers may not probe comprehensively during in-depth interviews. Individuals less connected to the research topic or research participant may be better positioned to generate quality data. There was some acknowledgement and debate on these issues. There was strong support amongst symposium participants for using peer researchers, particularly for this particular study where there was uncertainty regarding whether there would be enough interest and support in the community to reach the study’s enrolment targets. Being able to empathise with and share some of the participant’s struggles and experiences was also seen as a strength of the peer researcher approach which helped to keep interviews going and to ensure that there was a rich body of data that resulted. Concepts of bias and how to address it are changing in qualitative research, particularly for research involving vulnerable or marginalised populations. Using peer researchers helps to build commitment and solidarity to address the research results, for example, as there is more ownership and engagement throughout the research process. This did no mean that non-peer researchers could not perform well, however. The discussion concluded that, for this project, using peer researchers was the preferred approach and resulted in clear advantages.

### 6.4 Progress to Develop a Conceptual Model

Emma Lansdell, a member of the HEARD research team, presented preliminary work on the quantitative results and the development of a conceptual model of the effects of intersectional stigma on ART adherence. She has been exploring various ways of analysing the data in order to bring forward the multi-dimensional nature of stigma and its effects. She has been using logistic regression analysis to explore interactions between different experiences of stigma related to sexual orientation and gender identity, HIV status, and the influence of these on ART adherence. She presented six examples of these interaction analyses. So far, the results have suggested that when experience of HIV stigma is low, the probability of non-adherence increases as experiences with sexual orientation/gender identity stigma increases. When experience of HIV stigma is high, the probability of non-adherence is relatively unaffected by experience of sexual orientation of gender identity stigma at any level. She emphasised that these findings were still provisional and subject to additional analysis. The next steps will involve exploring intermediary variables that may mediate or moderate these relationships. She expected to have more detailed results in the coming weeks.

### 6.5 Review of Intervention Models

Researches from HEARD presented the results of a literature review on stigma interventions within the broader fields of HIV and sexual orientation and gender identity broadly, and on intersectional stigma more specifically. It was clear that there was some preliminary work that had been done on intersectional stigma interventions, mostly in the European and North American contexts (there were also some examples from Asia). It was possible that there were opportunities to adapt some of these approaches to the Southern African context. In the discussion following the presentation, there was consensus on the need to incorporate the perceptions and experiences of front-line service providers, and to prioritise community ownership, engagement, and connectedness, which were considered to be critical to the successful of stigma reduction interventions. Importantly, the team noted the need to use validated measures to assess the outcomes and impact of whichever interventions were finally proposed and implemented.
6.6 Country Reflections and Next Steps

As a small group exercise, country teams met to consider the following items: 1) the ‘top five’ take-aways or most important findings for each country; 2) any proposed actions/interventions to respond to the research findings; 3) how the actions/interventions should be designed and implemented (roles and responsibilities for the next phase of the research); 4) any additional research questions that should be included in subsequent phases; 5) ways to share the research findings so that they bring about change (who, how, when, etc.); and 6) any recommendations for strengthening/improving the project moving forward.

In their presentations of the results of the small group discussion, the country teams emphasised the following key points:

**Most significant findings**

- Transgender women and MSM living with HIV experience high levels of stigma and discrimination which has an impact on access to care and ART adherence.
- The young participants (and the LGBTQI+ community more broadly) faces a higher risk of mental health challenges such as depression and anxiety due to lack of support, discrimination, isolation, and other factors.
- In addition to stigma and discrimination, many young people have other challenges, including economic struggles, that result in poor nutrition and other negative effects on ART adherence.
- Many participants have had their status disclosed by LGBTQI+ peers without their consent. HIV-related stigma is still highly prevalent with the LGBTQI+ community and has many negative impacts.
- High levels of alcohol and substance use reflect both the burden of stigma and discrimination, and the inadequate levels of support for young MSM and transgender women living with HIV.
- Participants continue to experience or fear stigma at health facilities related to their sexual orientation and gender identity, which affects their access and retention in HIV care, including ART adherence.
- Tailored HIV services for key populations, including young MSM and transgender women, are not reaching everyone, with rural areas being the least included.
- Addressing structural and societal factors such as homophobia, transphobia, discrimination, and marginalization is vital in improving the health of MSM and transgender women living with HIV.

**Actions/interventions to respond to research findings**

- The teams highlighted opportunities within current interventions to address the research findings as well as proposals for new interventions to address current gaps.

**Opportunities within current interventions**

- Scale up the mental health services in DICs, KP-friendly health facilities and through KP-led organizations.
- Undertake awareness campaigns within the LGBTQI+ community for individuals to be able to recognize and seek to address mental health issues.
- Equip peer educators, peer navigators, and other cadres of health care workers to identify and address mental health issues.
- Strengthen existing support structures, such as support groups, adherence clubs, etc., to identify and address mental health challenges (including through referral).
- Propose integrating the needs of KP in the national mental health training curricula.
- Scale up/intensify interventions addressing values clarification and capacity building for health care workers, particularly regarding medical and human rights (especially confidentiality and privacy).
- Continue to advocate for more progress and inclusion of diversity within comprehensive sexuality education.
- Scale up interventions to prevent and respond to sexual and gender-based violence, including intimate partner violence, amongst MSM and transgender women.
- Seek more allies working on sexual and reproductive health and rights to support more inclusive and comprehensive programming for MSM and transgender women living with HIV.
- Scale up lobbying and advocacy for comprehensive law and policy change.

**New interventions**

- Conduct support groups focusing specifically on alcohol and substance use.
- Conduct mental health support groups.
- Introduce mobile and/or virtual modalities for mental health support.
- Improve the quality and comprehensiveness of services for transgender people, including transgender women living with HIV.
- Identify and support more champions who are MSM or transgender women openly living with HIV and taking ART

**Ways to share research findings**

- Utilise current platforms, including Technical Working Groups, to share and promote findings.
- Engage key stakeholders such as National AIDS Commissions/Councils, Ministries of Health to adopt findings and to promote action.
• Promote research findings through KP networks and coordination platforms.
• Engage SADC mechanisms, including Council of Ministers of Health, Parliamentary Forum and others.
• Produce research findings in a variety of accessible and engaging formats.
• Publish findings in reputable journals to emphasise the legitimacy of the project and the findings.
• Support country teams to promote the research findings, particularly in non-urban areas.

**Additional research questions or areas for further inquiry**

• How do intersectional identities or characteristics, such as gender identity, religion and social economic status, influence the experiences of stigma in relation to ART and HIV care among MSM and transgender women living with HIV?
• What are the most effective strategies for addressing mental health and substance use challenges among MSM and transgender women living with HIV?
• What are the best practices for developing culturally sensitive and responsive interventions to reduce stigma and improve retention and care among MSM and transgender women living with HIV?
• Conduct a focused HIV stigma index with in the LGBTIQ+ community.
• Undertake a feasibility study on developing a community of practice on intersectional stigma reduction (SOGIE & HIV) in the three SADC countries (or a broader selection of SADC countries).
• Undertake further research exploring understandings of mental health amongst LGBTIQ+ communities in SADC.
• Undertake more in-depth research on physical and sexual violence, especially intimate partner violence.
• Undertake more in-depth research on the drivers of problematic alcohol and substance use.
• Continue to investigate factors affecting access to mental health services and mental-health-seeking behaviour amongst LGBTIQ+ communities.
• Explore intersectional stigma and HIV care for other individuals, especially lesbian, bisexual, queer (LBQ) women and transgender men.
• Explore the influence of economic empowerment/economic inclusion on ART adherence and overall health for LGBTIQ+ communities.

**Improvements**

• Develop and share a clear roadmap for the remaining phases of the project.
• Carefully monitor the implementation of ‘improvements’ particularly from the perspective of the LGBTIQ+ community.
• Convene more learning and sharing opportunities, including through virtual modalities.
• Make better efforts to promote the project and its findings, particular amongst the different SADC mechanisms and constituencies.
• Develop a resource mobilisation plan to continue the project beyond the life of the current SADC grant.
• Be more inclusive of other identities moving forward, particularly LBQ women and transgender men.

**Next Steps**

The HEARD team presented the following provisional timeline for next steps following the workshop:

**April-June 2023**

• Finalise and release research reports
• Develop and finalise Phase 2 plan
• Prepare/share workshop report and Phase 2 plan
• Develop research briefs highlighting key results
• Support in-country/regional results sharing activities
• Draft and submit manuscripts for publication
• Move forward on conceptual model
• Finalise design(s) of intervention phase
• Conduct regular information sharing sessions with teams
• Issue new contracts
• Renew ethics clearances
• Prepare for baseline data collection

**July-December 2023**

• Launch intervention phase
• Undertake baseline data collection
• Continue to share results
• Draft and submit additional publications
• Write-up and share results of conceptual model development
• Organise side event for ICASA
• Prepare for mid-term data collection (January)
• Identify additional funding opportunities to support further phases of research/action

**January-June 2024**

• Undertake mid-term data collection
• Secure additional grants
• Complete intervention pilots
• Undertake end-term data collection
• Analyse results (regional workshop)
• Produce and share research report
• Draft programmatic guidance
• Transition to subsequent phases
7. CONCLUDING REMARKS

In the final session of the symposium, participants reflected on the range of stakeholders that were represented, including those from academic institutions, National AIDS Councils/Commissions, Ministries of Health, KP networks, other service providers, donors and community activists. All of these individuals were influential in their various fields and each had opportunities moving forward for further disseminating the research findings and for galvanising action. There was a strong consensus on the need to get the findings of the research to the people who can make use of them in order to maximise the benefits of the research without delay. There was a particular emphasis on this point by the SADC representative, who congratulated all of the participants on the uniqueness and the strategic importance of the research project. All participants were encouraged to consider their country context in choosing the target audiences and the settings in which research findings were to be promoted, with the aim to influence policy makers and health service providers in ways that will facilitate uptake of the study’s recommendations, as well as overall improvements to the way the HIV-positive MSM and transgender women are encouraged and empowered to live open and positive lives.

ANNEX A: LIST OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Participant</th>
<th>Organization</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td><strong>ZIMBABWE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nelson Muparamoto</td>
<td>Research Team</td>
<td>Lead researcher</td>
</tr>
<tr>
<td>Gracious Jamali</td>
<td>CeSHHAR</td>
<td>Service provider</td>
</tr>
<tr>
<td>Mojalifa Mokoele Ndlovu</td>
<td>Sexual Rights Centre</td>
<td>KP organization/service provider</td>
</tr>
<tr>
<td>Edgar Muzulu</td>
<td>NAC</td>
<td>Provincial manager</td>
</tr>
<tr>
<td>Takunda Adonis Sola</td>
<td>Ministry of Health and Child Care</td>
<td>HIV prevention and key populations medical officer</td>
</tr>
<tr>
<td>Michelle Chipo Ruhonde</td>
<td>GALZ</td>
<td>LGBTI+ CSO/service provider</td>
</tr>
<tr>
<td>Brighton Meki</td>
<td>Research Team</td>
<td>Peer researcher</td>
</tr>
<tr>
<td>Vusizwiwe Khumalo</td>
<td>Research Team</td>
<td>Peer researcher</td>
</tr>
<tr>
<td>Learnmore Chikwewe</td>
<td>Research Team</td>
<td>Peer researcher</td>
</tr>
<tr>
<td>Clyte Mutenga</td>
<td>Research Team</td>
<td>Research officer</td>
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<tr>
<td><strong>ZAMBIA</strong></td>
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</tr>
<tr>
<td>Joseph Mumba Zulu</td>
<td>Lead Investigator</td>
<td>Lead researcher</td>
</tr>
<tr>
<td>McLean Kabwe</td>
<td>The Lotus Identity</td>
<td>KP organization/service provider</td>
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<tr>
<td>Mwale Banda</td>
<td>Women’s Alliance for Equality</td>
<td>KP organization/service provider</td>
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<tr>
<td>Daliso Mumba</td>
<td>NAC</td>
<td>CSO coordinator</td>
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<td>Mirriam Zulu</td>
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<td>Musa Bwalya</td>
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<td>Tamika Chanda</td>
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</tr>
<tr>
<td>Ngamanya Nkunika</td>
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<tr>
<td>Wezi Chisulo</td>
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<tr>
<td><strong>MALAWI</strong></td>
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<tr>
<td>Adamson Muula</td>
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<td>Lead researcher</td>
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<tr>
<td>Zikani Garvey Mafunga</td>
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<td>Executive director for gender collective(peer researcher)</td>
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<tr>
<td>Nyirenda</td>
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<td>Hans Robert Katengeza</td>
<td>Ministry of Health</td>
<td>National program coordinator for adolescents &amp; youth SRHR program</td>
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<td>Dunker Kamba</td>
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<td>Patrick Mbulaje</td>
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<td>Beatrice Chasowa</td>
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<tr>
<td>Mphangera Mbeya</td>
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<tr>
<td>Kaymarlin Govender</td>
<td>HEARD</td>
<td>Principal investigator</td>
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<tr>
<td>Russell Armstrong</td>
<td>HEARD</td>
<td>Study manager</td>
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<td>Patrick Nyamaruze</td>
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<td>Researcher</td>
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<tr>
<td>Emma Lansdell</td>
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<td>Researcher</td>
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<tr>
<td>Stella Mlombe</td>
<td>SADC</td>
<td>SADC secretariat representative</td>
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# Annex B: Workshop Agenda

## Day 1: Monday, April 3

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<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tr>
<td>08h30</td>
<td>Participant registration</td>
<td>HEARD</td>
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<tr>
<td>09h00</td>
<td>Official welcome and opening remarks</td>
<td>HEARD, SADC</td>
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<tr>
<td>09h20</td>
<td>Participant introduction Overview of workshop objectives and agenda</td>
<td>HEARD</td>
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<tr>
<td>09h30</td>
<td>Brief overview of project and progress to-date</td>
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<tr>
<td>10h00</td>
<td>Session 1: Research results for Malawi Presentation and discussion</td>
<td>Malawi team</td>
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<tr>
<td>11h00</td>
<td><strong>Tea break</strong></td>
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<tr>
<td>11h30</td>
<td>Session 2: Research results for Zambia Presentation and discussion</td>
<td>Zambia team</td>
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<tr>
<td>12h30</td>
<td>Session 3: Research results for Zimbabwe Presentation and discussion</td>
<td>Zimbabwe team</td>
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<td>13h30</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>14h30</td>
<td>Session 4: Cross-country synthesis Presentation and discussion</td>
<td>HEARD team</td>
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<tr>
<td>15h30</td>
<td>Plenary exchange: what have we learned?</td>
<td>All participants</td>
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<td>16h30</td>
<td>Recap and close of Day 1</td>
<td>HEARD</td>
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## Day 2: Tuesday, April 4

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<tr>
<td>09h00</td>
<td>Session 4: Cross-country synthesis Presentation and discussion</td>
<td>Russell</td>
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<tr>
<td>09h30</td>
<td>Session 5: Views of Peer Researchers Panel discussion</td>
<td>Peer researchers</td>
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<tr>
<td>11h00</td>
<td><strong>Tea break</strong></td>
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<tr>
<td>11h30</td>
<td>Session 6: Progress on conceptual model Presentation and discussion</td>
<td>Emma (HEARD)</td>
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<tr>
<td>12h30</td>
<td>Session 7: Overview of interventions &amp; opportunities Presentation and discussion</td>
<td>Patrick (HEARD)</td>
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<tr>
<td>13h00</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>14h00</td>
<td>Session 8: Small group work Participant break into country teams Country teams discuss next steps</td>
<td>All participants</td>
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<tr>
<td>15h00</td>
<td>Session 9: Report back on country strategies Country teams share results of discussions</td>
<td>All participants</td>
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<tr>
<td>16h30</td>
<td>Recap of Day 2</td>
<td>HEARD</td>
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<tr>
<td>17h00</td>
<td><strong>Day 2 ends</strong></td>
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## Day 3: Wednesday, April 5

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<tr>
<td>09h00</td>
<td>Recap of Day 2 and overview of Day 3</td>
<td>HEARD</td>
</tr>
<tr>
<td>09h30</td>
<td>Session 7: Overview of interventions &amp; opportunities Presentation and discussion</td>
<td>Patrick</td>
</tr>
<tr>
<td>10h00</td>
<td>Session 9: Report back on country strategies Country teams share results of discussions</td>
<td>Research teams</td>
</tr>
<tr>
<td>11h00</td>
<td><strong>Tea break</strong></td>
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<tr>
<td>11h30</td>
<td>Session 10: Next steps Presentation and discussion</td>
<td>Russell</td>
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<tr>
<td>12h00</td>
<td>Session 11: Discussion of research dissemination strategies Facilitated discussion</td>
<td>HEARD and Country Teams</td>
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<td>12h30</td>
<td>Wrap up and workshop close</td>
<td>HEARD</td>
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<tr>
<td>13h00</td>
<td><strong>Lunch and departure</strong></td>
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The regional symposium was funded by SADC through an HIV/AIDS Special Fund Round III grant.