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Scoping review of HIV-related intersectional stigma among sexual and gender minorities in sub-Saharan Africa

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ABSTRACT

Objectives Sexual and gender minority (SGM) populations in sub-Saharan Africa (SSA) are disproportionately impacted by HIV and often face multiple HIV-related stigmas. Addressing these stigmas could reduce SGM HIV vulnerability but little is known about how the stigmas operate and intersect. Intersectional stigma offers a lens for understanding the experiences of stigmatised populations and refers to the synergistic negative health effects of various systems of oppression on individuals with multiple stigmatised identities, behaviours or conditions. This review aims to (1) assess how often and in what ways an intersectional lens is applied in HIV-related stigma research on SGM populations in SSA and (2) understand how intersectional stigma impacts HIV risk in these populations.

Design Scoping review following the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Reviews.

Data sources Public health and regional databases were searched in 2020 and 2022.

Eligibility criteria Articles in French and English on HIV-related stigma and HIV outcomes among men who have sex with men, women who have sex with women and/or transgender individuals in SSA.

Data extraction and synthesis Articles were screened and extracted twice and categorised by use of an intersectional approach. Study designs and stigma types were described quantitatively and findings on intersectional stigma were thematically analysed.

Results Of 173 articles on HIV-related stigma among SGM in SSA included in this review, 21 articles (12%) applied an intersectional lens. The most common intersectional stigmas investigated were HIV and same-sex attraction/behaviour stigma and HIV, same-sex attraction/behaviour and gender non-conformity stigma. Intersectional stigma drivers, facilitators and manifestations were identified across individual, interpersonal, institutional and societal socioecological levels. Intersectional stigma impacts HIV vulnerability by reducing HIV prevention and treatment service uptake, worsening mental health and increasing exposure to HIV risk factors.

Conclusion Intersectional approaches are gaining traction in stigma research among SGM in SSA. Future research should prioritise quantitative and mixed methods investigations, diverse populations and intervention evaluation.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Studies published in both English and French were included in the review.
⇒ The review was informed by the Health Stigma and Discrimination Framework.
⇒ The review was focused on sub-Saharan Africa, which restricts the generalisability of its findings.
⇒ Searching for eligible articles at multiple time points strengthens the comprehensiveness of the review.

INTRODUCTION

Sub-Saharan Africa (SSA) is home to 65% of people living with HIV despite comprising only 12% of the world's population as of 2020.[1] Around the globe, sexual and gender minorities (SGM) bear a disproportionate burden of HIV and SSA is no exception.[2–4] Sexual minorities include individuals who are attracted to or have sexual contact with people of the same gender and gender minorities include individuals whose gender identity or expression is different from their sex assigned at birth.[5] In Western and Central Africa, the HIV prevalence among men who have sex with men (MSM) and transgender women (TGW) is 11 times and 8 times that of the general adult population, respectively.[6] In Eastern and Southern Africa, the prevalence among both MSM and TGW is 2 times the general adult prevalence.[6] These statistics highlight the importance of understanding and addressing the vulnerability to HIV-related morbidity and mortality SGM in SSA face. Robust HIV prevalence estimates among women who have sex with women (WSW) and transgender men (TGM) in SSA are severely limited[6–9]; however, findings on the prevalence of HIV[10 11] and HIV risk behaviours[11 12] within these populations globally support the need for investigating the

risks of HIV infection and barriers to HIV prevention and care services among WSW and TGM as well.

Structural, social and individual factors contribute to the elevated HIV vulnerability among SGM, and stigma plays a key role.[13–18] Stigma is a social process involving labelling and stereotyping in the context of power imbalances that leads to status loss, discrimination and social inequity.[19 20] Stigmas associated with HIV, same-sex sexual attraction or behaviour (SSSAB) and/or gender non-conformity exist on every inhabited continent.[21–27] SGM in SSA in particular face heightened vulnerability to stigma and discrimination as consensual same-sex acts are criminalised in over half of SSA countries, representing nearly half of all such nations globally.[2 28–30] Stigma has been shown to reduce SGM engagement with HIV services.[31 32] Stigma is a key focus of many HIV risk-reduction interventions.[33 34]

In recent years, researchers have moved to investigate how individuals experience multiple stigmas.[35–37] Intersectionality describes how social hierarchies of oppression interconnect, creating overlapping systems of disadvantage.[38 39] This concept has been applied to the study of stigma in public health contexts and described with evolving terms including layered stigma, double stigma and others.[40–45] Intersectional stigma, a term coined by Dr. Michele Berger, denotes the synergistic and coconstitutive negative effect on well-being and health produced by overlapping systems of oppression at the intersection of multiple identities, behaviours or conditions that are stigmatised.[26 37 41 46 47] Quantitative studies have found that intersectional HIV stigma, that is, interaction effects of HIV stigma and other stigmas, predicts poorer health outcomes among MSM in Asia and North America[26 48 49] and qualitative studies have used it to understand health inequities.[46] However, there has been limited scholarly attention on SGM in SSA using an intersectional lens. It is imperative that scientific understanding of HIV-related intersectional stigma is shaped by the experiences of SGM in SSA lest externally generated knowledge be uncritically applied to them, resulting in the misinterpretation of their unique perspectives and the development of interventions poorly suited to their unique sociopolitical contexts.

Scholars have outlined a need for research on the experiences of HIV-related intersectional stigma among SGM in SSA,[13 14 50 51] particularly of transgender persons and WSW,[15 52 53] but to date there has been no review of the available literature. This review has two objectives. First, to assess how often and in what ways an intersectional lens is used in research on HIV-related stigma among SGM populations in SSA. Second, to understand how intersectional stigma is conceptualised and experienced as impacting HIV risk in these populations.

METHODS

A scoping review methodology was employed, of which full details are published elsewhere[54] but are described briefly here. This review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Reviews.[55]

Study eligibility

Records included in this review met all of the following criteria: (1) discuss or measure stigma related to HIV status or risk factors; (2) present data on HIV-related outcomes (eg. serostatus or risk factors); (3) present primary or secondary data on MSM, WSW, TGM or TGW; (4) be conducted in a United Nations-designated SSA country[56]; and (5) be published in English or French after 1991. Exclusions included review papers, conference abstracts and mixed-region data. Grey literature was considered if it presented primary or secondary data analysis. Only studies applying an intersectional approach were comprehensively reviewed, extracted and analysed. Studies were designated as intersectional if they incorporated an intersectional approach to at least some elements of the analysis or presentation of their stigma findings. Studies without an intersectional approach were included for basic review so we could calculate the proportion of research on HIV-related stigma among SGM in SSA using an intersectional approach and distinguish possible trends in the intersectional studies.

Search strategy

Yale School of Public Health librarian, author KN, searched public health databases Medline (Ovid), Global Health (Ovid), and Embase (Ovid); bibliographic databases: Scopus, Web of Science Core Collection (as licensed at Yale), and regional databases; Africa-Wide Information (EBSCOhost) and Africa Index Medicus (through Global Index Medicus) in November 2020. The searches in Medline, Global Health, Embase, Scopus, Web of Science Core Collection and Africa Index Medicus were updated in July 2022. Search strategies can be found in online supplemental file 1.

Screening, data abstraction and theoretical framework

Records were deduplicated and imported into Covidence. Four reviewers screened 50 articles, achieving high inter-rater reliability (Cohen's kappa of 0.83).[57] Titles and abstracts, and then full texts were screened by two independent reviewers; a third resolved disputes. Data were extracted in duplicate by pairs of reviewers using a standardised form and then combined by consensus.[54] For intersectional studies, we abstracted basic information (eg, setting, population), conceptualisation components (eg, theoretical framework), methods and results. Only basic information and stigma type were abstracted for non-intersectional studies.

We used thematic content analysis to categorise findings on intersectional stigma. This process was informed by the Health Stigma and Discrimination (HSD) framework, which employs constructs from

socioecological models.[58 59] Socioecological models for HIV risk purport that factors across the individual, interpersonal, institutional and societal levels shape HIV vulnerability.[59–61] HSD provides a framework for understanding what drives and facilitates stigma, how intersecting stigmas are applied to individuals, how stigma is manifested across socioecological levels (definitions provided in results), and the impacts of stigma on health.[58 59] Within HSD, stigma drivers are individually held negative beliefs, facilitators are cultural norms and laws, and manifestations include experiences of stigmatising behaviours as well as anticipated, perceived and internalised stigma.[59] Stigma marking is the process of applying stigma to individuals and resilience is the process of 'overcoming and resisting stigma'.[59] In this review, extracted data on intersectional stigma were reviewed by three authors for key findings and categorised based on HSD constructs. The authors iteratively compared their categorisations and re-read the articles as needed.

Patient and public involvement

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

RESULTS

Search results

The searches yielded a total of 6972 records, 2086 records were screened and 173 included (figure 1).[62] Of these, 21 were intersectional stigma articles, which were comprehensively reviewed.

This review classified seven records[14 50 63–67] as fully intersectional stigma articles, indicating that the study results or intervention focused predominantly on intersectional stigma. Fourteen articles[13 68–80] were partially intersectional stigma studies incorporating an intersectional approach to some elements of the analysis or presentation of their findings. We also identified 10 articles[81–90] that studied multiple stigmas in a non-intersectional manner and 142 articles[4 13 16–18 21 51 52 91–224] that studied one stigma in one population of SGM or studied one stigma in each of multiple populations (eg, SSSAB stigma only among MSM and transgender stigma only among TGW). A summary of each intersectional stigma study (n=21) appears in online supplemental file 2 and a summary of each non-intersectional stigma study (n=152) appears in online supplemental file 3. Approximately one quarter (n=5, 24%) of intersectional studies evaluated an intervention (table 1). MSM were included in over 90%

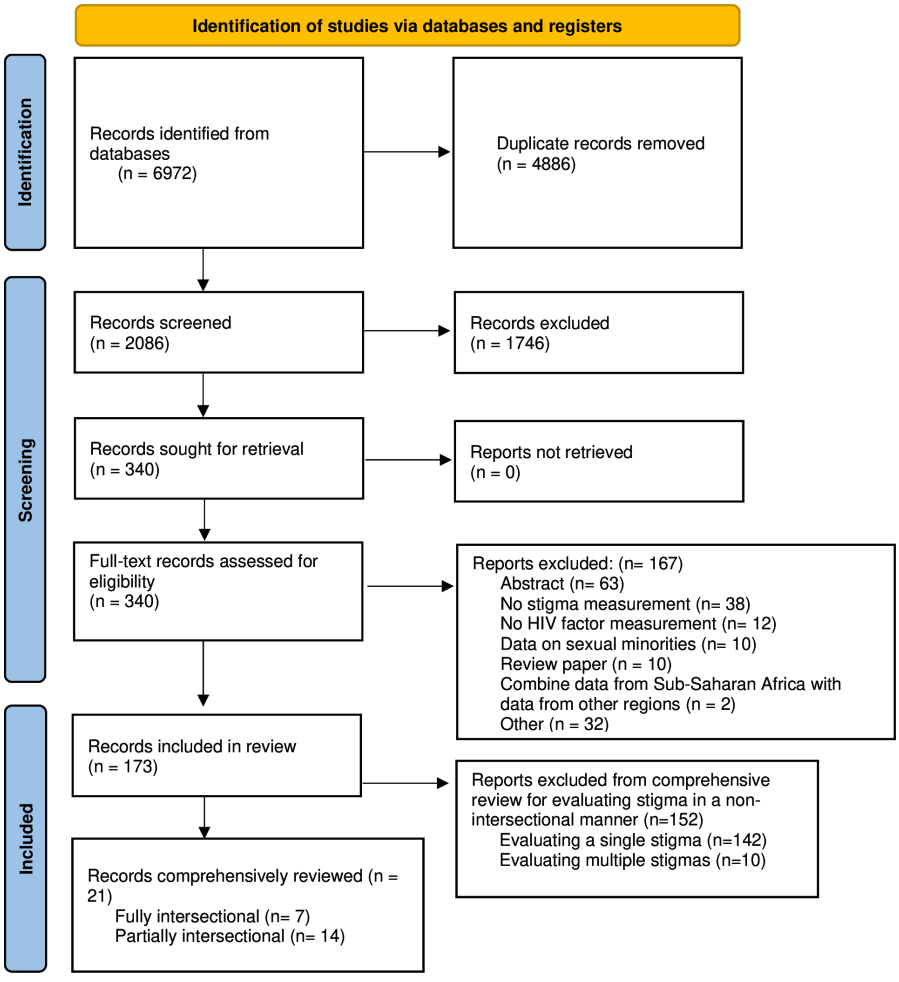

Figure 1 Flow diagram of record selection.

Table 1 Characteristics of included studies

	Intersectional stigma studies		Non-intersectional stigma studies			Intersectional stigma studies	
Study category	n=21	%	n=152	%	Study category	n=21	%
Sexual or gender minority population*					Research method		
MSM	19	90	146	96	Qualitative	13	62
WSW	1	5	14	9	Quantitative	3	14
TGM	2	10	1	1	Mixed methods	5	24
TGW	3	14	10	7	Study design*		
Other†	4	19	6	4	Cross sectional	19	90
Year					Longitudinal	2	10
1996–2000	0	0	1	1	Interventional study	4	19
2001–2005	0	0	5	3	Observational study	17	81
2006–2010	0	0	5	3	Sample size of sexual or gender minority		
2011–2015	6	29	40	26	0–50	9	43
2016–2020	7	33	77	51	51–150	4	19
2021–2022	8	38	24	16	150+	6	29
Region of sub-Saharan Africa					Unspecified	2	10
Western	11	52	47	31	HIV outcomes quantitatively assessed or qualitatively described*		
Eastern	3	14	60	39	HIV Status	15	71
Southern	7	33	48	32	Access to HIV prevention or care services	18	86
Central	0	0	7	5	Viral suppression	2	10
Setting					Condom usage	8	38
Urban	15	71	100	66	Transactional sex (provision or patronage)	4	19
Rural	0	0	9	6			
Both	3	14	21	14			
Other or unknown	3	14	22	14			

*Columns sum to greater than 100% because more than one option is possible.
†Other: unspecified or other sexual and/or gender minorities.
MSM, men who have sex with men; TGM, transgender men; TGW, transgender women; WSM, women who have sex with women.

of all studies. TGM, TGW and other SGM (eg, individuals identifying as transgender with no specific gender,[14] bisexual,[161] etc) comprised a greater proportion of the subjects of the intersectional stigma studies than non-intersectional. Intersectional studies were more likely to have been published recently with 38% published in the last 2 years alone, 2021–2022.

Most (62%, n=13) of the intersectional studies were qualitative, a quarter (24%, n=5) were mixed methods while only 14% (n=3) were quantitative. HIV outcomes investigated included HIV status[14 15 50 64 66–71 73–75 77 79] service access,[14 15 50 63–65 67–76 78 80] viral suppression,[15 66] and risk behaviour pertaining to condom usage or transactional sex.[14 50 65 66 68 73 74 79 80] Two-thirds (n=14) did not explicitly reference a theoretical framework. Of those that did, seven unique frameworks were identified. Four were epidemiological models of the relationship between individuals, their environments, and health risks: socio-ecological model,[65 67] minority stress model,[66] network-individual-resource model of HIV prevention[66] and syndemics theory.[14] Three informed intervention development and/or adaptation: Assessment, Decision, Adaptation, Production, Topical Experts, Training, Testing,[63 67] Positive Health, Dignity and Prevention Framework[50] and self-determination theory.[66 73]

There was variability in how intersectional stigmas were measured or explored in the eight quantitative or mixed methods studies. None of the studies explicitly stated they used a previously validated and published intersectional stigma measure. One study combined multiple validated scales for gender non-conformity stigma and HIV stigma.[66] Another study used a validated HIV stigma scale

Table 2 Summary of stigmas described

Study category	Intersectional stigma studies		Non-intersectional stigma studies	
	n=21	%	n=152	%
Combinations of stigmatised attributes				
HIV + same sex attraction/behaviour	7	33	8	5
HIV + same sex attraction/behaviour + gender non-conformity	7	33	2	1
Same-sex attraction/behaviour + gender non-conformity	2	10	0	0
Same-sex attraction/behaviour + transgender identity	2	10	0	0
HIV + gender non-conformity	1	5	0	0
HIV + same sex attraction/behaviour + transgender identity	1	5	0	0
HIV + same sex attraction/behaviour + transgender identity + sex work	1	5	0	0
Individual stigmatised attributes*				
Same-sex attraction/behaviour	20	95	130	86
HIV	18	86	31	20
Gender non-conformity	10	48	2	1
Transgender identity	3	14	3	2
Sex worker	1	5	0	0
Socioecological levels of stigma*†				
Individual (internalised or anticipated) ‡	20	95		
Interpersonal §	17	81		
Institutional/organizational ¶	17	81		
Societal **	16	76		

*Columns sum to greater than 100% because more than one option is possible.
†Socioecological levels were defined based on the Health Stigma and Discrimination Framework (50).
‡When an individual internalises publicly held negative beliefs about an identity, behaviour or health condition, and applies these beliefs to themself or when an individual anticipates, fears and perceives negative attitudes or discrimination will be directed at them from others in the future.
§When members of the public direct stigma towards individuals.
¶When practices in institutions actively disadvantage a stigmatised group or members of an institution actively disadvantage a stigmatised group.
**When cultural and political structures, including public policy and law, disadvantage a stigmatised group.

and investigated other stigmas qualitatively.[74] Four studies adapted or developed their own scales for measuring SSSAB and/or gender non-conformity stigma and investigated additional stigmas qualitatively.[15 67 77 79] Two mixed methods studies only investigated stigma qualitatively (and focused quantitative analyses on HIV status, risk, and behaviour).[68 76]

Types of stigmas described

Twelve per cent (n=21) of all 173 articles investigating HIV and stigma among SGM in SSA did so in an intersectional manner. Stigma associated with gender expression was categorised as transgender stigma among transgender populations and as gender non-conformity stigma among cisgender populations and populations of mixed or unknown gender identity. The most studied intersectional stigmas were HIV status and SSSAB and HIV status, SSSAB and gender non-conformity (table 2). Other intersectional stigmas investigated were SSSAB and gender non-conformity; SSSAB and transgender identity; HIV status and gender non-conformity; HIV status, SSSAB and transgender identity (and sex work). Most articles (87%, n=152) did not use an intersectional lens; of these, 94% (n=142) investigated 1 stigma and 6% (n=10) investigated 2 or more stigmas. The frequency in which different stigmas were investigated together and the number of articles investigating each stigma is represented in figure 2.[225]

The most investigated stigma was SSSAB followed by HIV status, gender non-conformity, transgender identity and sex work (figure 2). Non-intersectional studies predominantly focus on SSSAB stigma (86%), with minimal attention to others like HIV (20%) and gender non-conformity stigma (1%). Intersectional studies exhibited a broader scope, extensively investigating HIV stigma (86%), gender non-conformity (48%) and other attributes. This suggests intersectional investigations give us greater insight into how less-studied stigmas impact HIV vulnerability among SGM in SSA.

Thematic analysis of intersectional stigma studies revealed seven themes (box 1).

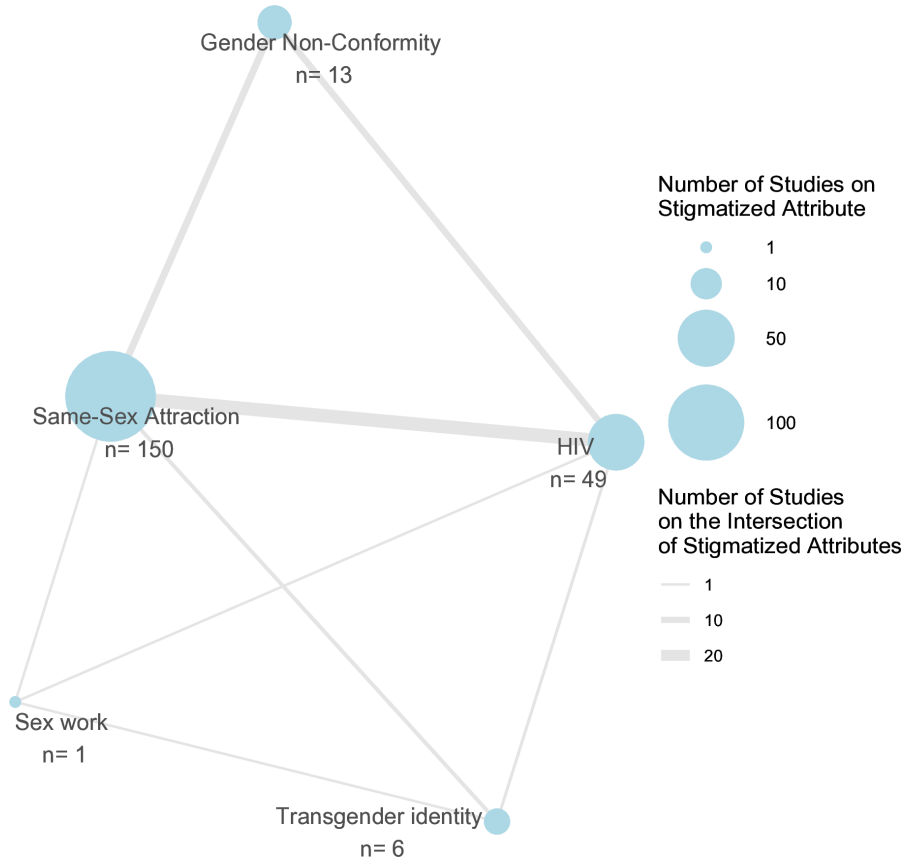

Figure 2 Network visualisation of stigmatised attributes. This illustrates the relationships between stigmas and the frequency in which their intersections are studied. The nodes in this figure represent stigmatised attributes and the size of each node represents the number of articles in the scoping review that focus on the stigmatised attribute. The width of the links represents the number of articles that analyze the intersection between the two stigmatised attributes.

Intersectional stigma drivers and facilitators

Drivers and facilitators of HIV-related intersectional stigma include cultural norms on gender and sexuality, religious beliefs, misconceptions on HIV transmission and laws, such as the criminalisation of SSSAB. Community members, including healthcare workers, and friends and family of SGM often view SGM as cultural and/or religious deviants because SSSAB, gender non-conformity and transgender identities are deemed sinful, immoral, inappropriate and/or foreign practices.[63 67 69 70 73–75 80] Many healthcare workers and members of the public perceive SSSAB and non-conforming gender expression as a choice that SGM individuals should be counselled or coerced away from making.[67 69 73 74 80] Some also believed SGM status to be psychopathology or a result of psychopathology.[63 67 80] Among community members and some healthcare workers, HIV stigma is driven by inadequate HIV knowledge and misconceptions related to its transmission and clinical progression.[50 63 67 75] A driver of combined HIV and SSSAB intersectional stigma among some health workers was the belief that SGM with HIV, particularly MSM, deserved blame for contracting and spreading HIV due to their SSSAB.[65 71 75 76] Stigma is facilitated by laws that criminalise SSSAB and institutional norms or policies that fail to protect SGM.[50 69 74 80] For example, SGM experienced harassment from law enforcement and felt unsafe reporting violence to law enforcement due to their SGM status because of the criminalisation of SSSAB.[50 69 74]

Intersectional stigma marking

Stigma marking can occur differently across intersections of stigmatised attributes. Disclosure and/or social judgement of one's gender expression are key steps in the stigma marking process for SSSAB, gender non-conformity and transgender identity stigmas. SGM reported experiencing stigma due to their SGM status either as a result of disclosing their sexual orientation or transgender identity, or as a result of their identity or orientation being assumed based on their gender expression.[14 67 70 71 74 78 80] SGM and providers explained that MSM who are gender non-conforming in their dress and mannerisms are more likely to be subject to verbal and physical harassment and abuse from community members and poor treatment from healthcare workers than MSM who are gender conforming.[67 70 78]

Intersectional stigma experiences

Intersectional stigma is manifested at all socioecological levels including from friends and family, and at healthcare facilities and it is conceptualised as synergistic. SGM experience stigma intrapersonally, within interpersonal relationships, from institutions and on the societal level.

Box 1 Key themes

Intersectional stigma drivers and facilitators

1. Drivers and facilitators of HIV-related intersectional stigma include:
   a. Cultural norms and religious beliefs on gender and sexuality that deem sexual and gender minorities (SGM) immoral or sinful and/or blame SGM for HIV
   b. Discriminatory laws and policies such as the criminalisation of same-sex sexual behaviour
   c. Misconceptions on HIV transmission

Intersectional stigma marking

2. Stigma marking can occur differently across intersections of stigmatised attributes.
   a. SGM experience stigma after their sexual orientation or transgender identity is disclosed, or after their SGM status is assumed based on their gender expression

Intersectional stigma experiences

3. Intersectional stigma is manifested at all socioecological levels including from friends and family, and at healthcare facilities and it is conceptualised as synergistic
   a. Individual: SGM internalise and anticipate maltreatment based on stigmatised identities and behaviours
   b. Interpersonal: stigma manifests interpersonally through gossip, social exclusion, family rejection, verbal harassment, sexual assault and physical violence
   c. Institutional: within healthcare institutions, SGM experience harassment, delays in care, refusal of care and religious rebukes from providers
   d. Structural: criminalisation of same-sex sexual behaviour facilitates harassment by law enforcement and community members
   e. Transgender identity stigma can intensify enacted sexual attraction/behaviour stigma among TGW, sexual behaviour stigma can intensify internalised HIV stigma among MSM living with HIV, and gender non-conformity stigma can intensify anticipated and enacted sexual behaviour stigma among MSM
   f. HIV stigma is internalised on the individual level and manifested in friend networks differently among MSM living with HIV and men who have sex with women living with HIV

Intersectional stigma outcomes on HIV and mental health

4. Anticipated stigma leads SGM to hide stigmatised identities and behaviours from healthcare workers, friends, family and the public
   a. Non-disclosure of SGM identity in fear of discrimination, breaches of confidentiality and rejection is extremely common
   b. SGM self-monitor their gender expression to be more culturally-conforming
   c. SGM with HIV hide their medication from household members, family and friends
5. Intersectional stigma poses barriers to SGM accessing and seeking HIV and sexual health-related care
   a. SGM commonly delay, avoid and/or withdraw from HIV counselling/testing services or treatment due to stigma
   b. Disclosing same-sex sexual behaviour can result in name-calling and blame for contracting HIV from providers
   c. Some SGM conceal relevant health information from providers to avoid inadvertent disclosure of their SGM status
6. Internalised intersectional stigma can lead to adverse mental health outcomes, including:
   a. Feelings of isolation, guilt, shame and disappointment
   b. Vulnerability to depression, anxiety and suicidal ideation

Continued

Box 1 Continued

Resilience in stigmatising environments

7. Social support and friendly providers help SGM cope and improve linkage with health services
   a. SGM disclose SGM status and serostatus when they anticipate a positive response
   b. Some SGM prefer non-profit-run and/or SGM-focused clinics to government facilities because providers tend to be less stigmatising
   c. Social support and access to safe spaces can mediate impact of intersectional stigma

SGM with and without HIV reported internalising negative/stigmatising views about their gender and sexual identities and anticipating maltreatment based on their seropositive status and/or SGM status. On the interpersonal level, stigma manifestations range from gossip, exclusion, verbal and physical harassment to violence and abuse.[14 50 63 66–69 71 73 74 76–80] SGM are rejected by family members and evicted from their homes.[50 63 68 73 74 77] They can experience ostracisation from friends when their SGM or seropositive status is made known.[50 63 63 65 73–75 77] SGM report experiencing physical abuse, victimisation and threats of violence from family, friends, community members and police officers due to their SGM status and are aware of other SGM experiencing physical violence up to and including murder.[50 66 69] TGM, WSW and other SGM reported being targeted for 'corrective rape' motivated by stigma, sometimes resulting in HIV infection.[14 74 77 79]

In healthcare settings, especially public and government-owned clinics, SGM face harassment, delays and refusal of care from providers.[14 66 67 70] Healthcare workers engage in medically unnecessary intrusive questioning and attempt to pressure SGM away from SSSAB using Christian or Islamic religious teachings.[67–70 73 75 80] Police have been reported to harass SGM due to SGM status as well as engagement in sex work.[14 69] SGM also described how societal-level stigmatisation including criminalisation, and discrimination (eg, in employment and housing) increased their vulnerability to economic insecurity.[50 65 74] Some SGM experiencing economic marginalisation engaged in transactional sex to meet their basic needs, which puts them at elevated risk of HIV.[14 74]

Investigations into how SGM conceptualise and report the comparative experiences of stigma between groups with a single versus multiple stigmatised attributes reveal the synergistic and co-constitutive nature of intersectional stigmas. In Southern Africa, MSM living with HIV described a HIV diagnosis as a 'double whammy', resulting in 'greater feelings of internalised AIDS stigma' as 'compared with heterosexual experiences' of the disease.[64 65 78] SSSAB stigma modified and exacerbated their experience of HIV stigma. MSM living with HIV also experienced intragroup stigmatisation within MSM peer networks.[64 65 78] They experience reduced social support

and avoid picking up antiretroviral therapy out of fear of gossip and social exclusion specifically from other MSM.[64 65 78] A study using an intercategorical approach to investigate the intersectionality of sexual behaviour stigma across trans and cisgender identities found that TGW were more likely to report exclusion, harassment, and poor treatment due to their having sex with men than cisgender MSM.[79] The presence of an additional stigmatised identity can transform the conceptualisation and experience of other stigmas such that the intensity and nature of the resultant stigma is more than the simple addition of multiple stigmas.

Intersectional stigma outcomes on HIV and mental health

Anticipated stigma leads SGM to hide stigmatised identities and behaviors from healthcare workers and community members. A prominent theme across studies was the concealment of SGM identity, HIV status and sex worker status to reduce the likelihood of encountering stigma. Many SGM prefer to conceal their SGM status and HIV status from healthcare providers due to fears of discrimination, delay/denial of care, being reported to the police and breaches of confidentiality.[50 63 65 67 69–71 74 76–78 80] SGM commonly hide their HIV status and SGM status from household members, family and friends due to fear of exclusion and maltreatment.[71 80] SGM, especially men, feel pressured to behave in ways considered consistent with cultural gender norms to be treated fairly and to protect their safety, and describe vigilant self-monitoring to adjust their gender expression based on the social context.[63 67 77 78 80] For example, MSM described feeling 'forced' to engage in concurrent sexual relationships with or marriage to women to keep their sexual orientation clandestine and/or to fulfil cultural gender expectations, which can increase their vulnerability to HIV.[14 50]

Intersectional stigma poses barriers to SGM accessing and seeking HIV and sexual health-related care. SGM commonly reported stigma as a motivation for avoiding or delaying HIV testing[14 50 65 71 73–75 78 80] and partner testing.[50] At healthcare facilities, SGM reported sometimes concealing relevant health information pertaining to stigmatised identities from healthcare workers due to fear of their SGM status being discovered.[50 65 69 74 78 80] For example, MSM did not disclose symptoms of sexually transmitted infections affecting the anus or experiences of rape to healthcare providers, hence self-medicate or avoid healthcare. SGM living with HIV hide medication or withdraw from care due to stigma.[50 65 69 71 73] They also travel long distances to seek care in areas they are not known to avoid being discovered by friends or family.[50 69 73]

Internalised intersectional stigma can lead to adverse mental health outcomes. SGM in SSA may internalise publicly held negative beliefs about their gender and/or sexual identity and develop feelings of guilt, shame, isolation and disappointment in themselves and the people around them.[14 50 63 65 70 72–74 76] This is especially true for SGM living with HIV. As a result of stigmatisation, devaluation and discrimination, many SGM in SSA experience stress, depression, anxiety and poor mental health.[50 65 77] Internalising intersectional stigma can also increase vulnerability to suicidal ideation and suicide.[14 50 73] SGM sometimes turn to behaviours that increase their vulnerability to HIV to cope with the negative impacts on mental well-being stemming from stigma such as substance abuse and transactional sex.[14 50]

Resilience in stigmatising environments

Social support and friendly providers help SGM cope with unsupportive environments and are associated with increased willingness to seek sexual health services. Despite the reported intersectional stigma, researchers also found instances where SGM have been able to confide in healthcare workers, friends and relatives concerning their gender identity, SSSAB and/or HIV status.[50 63 71 73 78 80] Disclosure is conditioned on anticipation of positive reception, support and confidentiality. Some have been able to disclose to their healthcare providers and relatives and have received affirmation and support.[50 63 66 70 71 73 78 80] A difference in comfort disclosing across facility types was also noted, with some avoiding disclosure at public facilities fearing confidentiality breaches. Instead, they prefer to disclose at non-profit facilities, particularly facilities focused on meeting the needs of SGM, because of the friendliness and non-stigmatising approach of providers, knowledgeability of SGM needs, and confidentiality.[63 69 70 73 78 80] Healthy social support and access to safe spaces were found to mediate some of the negative impacts of intersectional stigma on well-being and healthcare seeking.[66 68 70 77]

DISCUSSION

This review explored the use of an intersectional approach in HIV-related stigma research and the impact of intersectional stigma on MSM, WSW, TGM and TGW in SSA. Of all studies reviewed, relatively few employed an intersectional lens or included non-MSM SGM populations. The intersectional studies were primarily observational and qualitative and they explored stigmas less commonly studied in the non-intersectional studies, such as gender non-conformity and transgender stigma. Intersectional stigmas associated with HIV, SSSAB, gender non-conformity, transgender identity and sex work operate at individual, interpersonal, institutional and societal socioecological levels. This review provided insight into the diverse ways that HIV-related stigmas intersect in the lives of SGM in SSA. The intersectional stigmas most frequently studied were HIV and SSSAB stigma and HIV, SSSAB and gender non-conformity stigma. Stigma drivers include religious beliefs, cultural gender norms and blame for SGM living with HIV, while laws criminalising SSSAB facilitate stigma. Judgement of gender expression and disclosure of SGM status enable stigma marking. Gender non-conformity stigma increases the intensity and likelihood of experiencing SSSAB stigma, especially for MSM and in healthcare settings. Transgender identity

stigma can intensify enacted SSSAB stigma among TGW and SSSAB stigma can intensify internalised HIV stigma among MSM living with HIV. The layering of additional stigmas can decrease access to social support, which is important for coping, especially among SGM living with HIV. Anticipated stigma leads SGM to delay and avoid HIV testing and to conceal their SGM status from healthcare workers and community members . Internalised stigma worsens mental health and increases vulnerability to HIV risk factors. However, social support and friendly healthcare providers help SGM cope and improve their health-seeking behaviour. Thus, intersectional stigma among SGM in SSA forms an important area for further research and an impactful domain for intervention development.

This review highlights associations between experiencing intersectional stigma and poorer HIV-related health outcomes and behaviours (eg, HIV testing). This is consistent with the HSD framework which asserts that the process of stigma marking enables the drivers and facilitators of stigma to produce negative health outcomes among stigmatised populations. This is also in accord with findings on intersectional stigma's negative impact among MSM and women in North America, Asia and Europe.[32 226–228] This review highlighted differences in the experience of stigma and its connection to HIV outcomes across intersections of stigmatised identities and across socioecological levels, highlighting potential key areas of intervention. For example, health-seeking behaviour is poorer at clinics where SGM experience or anticipate stigma so there is a need for institutional-level interventions that address drivers and facilitators of HIV and SGM-related stigmas within health facilities. Thus, this review demonstrated the value of intersectional approaches for advancing understanding of stigma and areas in which it can be intervened upon.[35 37] We recommend that more public health stigma research among SGM in SSA use an intersectional lens because of its advantages in comprehensively illuminating their multifaceted experiences.

Most intersectional articles in this review documented intersectional stigma above just the individual socioecological level, in fact, even the least commonly studied level of societal stigma was discussed in three-quarters (n=16) of the articles. Bowleg argues that there has been a tendency in intersectional stigma public health research in the USA to privilege overly individualistic conceptualizations of intersectional stigma that focus only on individual-level stigma within populations with multiple stigmatised attributes and this obscures the role of social-structural systems in perpetuating stigma and generating health inequalities.[47] The HSD framework and the concept of intersectional stigma as put forward by Berger both emphasise how stigmatisation is a process that emerges from and is rooted in interlocking systems of oppression and therefore cannot be reduced to individual-level stigmatising experiences and behaviours.[36 47 58] In such a view, to reduce health inequalities the focus of stigma-reduction efforts must be multilevel interventions that address the social-structural forces in which stigmas are rooted.[36 47 58] By using HSD and the socioecological model, this review highlights how intersectional stigma among SGM in SSA is not conceptualised as only operating on the individual level therefore underscoring the importance of stigma reduction interventions in this context to move beyond exclusively addressing individual-level stigma.

Intersectional articles demonstrated somewhat limited variety in study populations and research methods; over half included only MSM (n=16) and were qualitative (n=13). Nonetheless, they were more likely to include WSW and transgender individuals than non-intersectional studies. Turan *et al* argue that mixed method studies are ideal for examining health-related intersectional stigma because they allow quantitative, testable measures to be well-grounded in lived experience.[35 37 229] However, there are limited quantitative measurement tools available for HIV-related intersectional stigma as reflected in their relative absence from studies included in this review. [230] Quantitative tools typically measure stigma intracategorically (experience within one multiply stigmatised group) or intercategorically (experience across multiple stigmatised groups).[226–228 231] There is a need for more tools to quantitatively measure intersectional stigma intercategorically and intracategorically that are validated in low-to-middle income countries in SSA among diverse SGM populations.[230]

This review is not without limitations. As scoping reviews typically do not assess study quality, a limitation is the inclusion of data from weak and strong studies. Our review illustrated the complex relationship between gender-expression-related and SSSAB stigmas in different SGM populations. However, there are limits to precision in categorising SGM populations across settings due to differences in language and local interpretation of commonly used terms like transgender. In some settings, sexual orientation, gender identity and sexual positioning are often conceptualised as distinct,[66 232] while in others, the boundaries are blurred or non-existent.[13 75 77] Further, our focus on SSA restricts the generalisability of findings beyond this region. Despite these limitations, the review has several strengths. We included articles in English and French, decreasing selection bias. Our search strategy was comprehensive and conducted in conjunction with an experienced public health librarian. Finally, all screening and extractions were completed by two independent reviewers.

To decrease intersectional stigma and improve HIV outcomes among SGM in SSA, there is need for well-tailored interventions, which requires accurate and comprehensive insight on how stigma is conceptualised and experienced. While intersectional perspectives in HIV stigma research have advanced, more research is needed with diverse designs and SGM populations. Applying these suggestions to future work can improve outcomes for SGM in SSA.

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