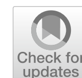
AIDS and Behavior (2020) 24:3462–3472
https://doi.org/10.1007/s10461-020-02917-y

ORIGINAL PAPER



Conceptualizing LGBT Stigma and Associated HIV Vulnerabilities Among LGBT Persons in Lesotho

Carmen H. Logie[1,2] · Amaya Perez-Brumer[3] · Tampose Mothopeng[4] · Maya Latif[1] · Amelia Ranotsi[5] · Stefan D. Baral[6]

Published online: 11 May 2020
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Abstract

Social marginalization harms lesbian, gay, bisexual, and transgender (LGBT) persons' wellbeing in Lesotho. Socio-cultural mechanisms linking LGBT stigma, depression, substance use, and HIV among LGBT persons in Lesotho are understudied. We explore associations between LGBT stigma, mental health stressors, and HIV vulnerabilities among LGBT persons in Lesotho. We conducted in-depth, semi-structured interviews with 46 LGBT persons and six key informants (e.g. healthcare providers). Participants described depression, substance use, and HIV as mutually reinforcing and situated in larger social contexts of stigma. Alcohol use was a stigma coping strategy and a way to build LGBT connections. At the same time, alcohol use elevated HIV vulnerabilities by lowering condom use uptake. Pervasive stigma reinforced barriers to healthcare engagement. Community-led support and services were leveraged to navigate stigma, reduce HIV vulnerabilities, and ultimately improve health. Findings emphasize the key role contexts play in shaping sexual and mental health among LGBT persons in Lesotho.

Keywords Syndemics · Stigma · LGBT · Mental health · HIV · Lesotho · Violence

Introduction

Lesotho has among the highest HIV prevalence in the world, with an estimated 23.6% of Basotho (people from Lesotho) adults estimated to be living with HIV [1]. However, disparities in the burden of HIV do exist and are evidenced among gay, bisexual and other men who have sex with men (MSM) and among transgender (trans) women, with HIV prevalence estimated to be 32.9% and 59.2%, respectively [2]. Emergent literature highlights co-morbidity between HIV and adverse mental health conditions among lesbian, gay, bisexual and transgender (LGBT) Basotho adults [3–5].

Social marginalization and violence dynamically impact the adverse health of LGBT Basotho adults. LGBT stigma refers to the intertwined processes of social exclusion, devaluation, reduced access to opportunities, and power inequities disproportionately impacting gender and sexual minorities [6]. Same-sex practices in Lesotho were decriminalized less than a decade ago [7]. Despite policy change, LGBT stigma remains pervasive, including targeted violence, familial rejection, health care service denial, and other human rights violations [8, 9]. However, in 2020, there is a dearth of knowledge regarding health needs including HIV-related needs and broader health care needs among LGBT persons in Lesotho [10–12].

Examining health disparities among LGBT Basotho people necessitates a biosocial perspective. A syndemics framework deepens our understanding of the mechanisms by which social disparities, such as stigma and discrimination targeting LGBT persons in Lesotho, contribute to multiple interacting health epidemics [13]. Applying a syndemics

✉ Carmen H. Logie
carmen.logie@utoronto.ca

1 Factor-Inwentash Faculty of Social Work, University of Toronto, 246 Bloor Street West, Toronto M5S 1V4, ON, Canada

2 Women's College Research Institute, Women's College Hospital, Toronto, Canada

3 Dalla Lana School of Public Health, University of Toronto, Toronto, Canada

4 Matrix Support Services, Maseru, Lesotho

5 Maluti College of Nursing, Mapoteng, Lesotho

6 Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, USA

approach has the potential to identify the roles that social environments, including poverty, stigma and violence, play in shaping interrelated health problems [13]. This approach is particularly salient for advancing health among LGBT persons who experience a greater global disease burden for HIV and mental health challenges [2, 14, 15]. As first proposed by Singer to describe interacting epidemics of substance use, violence and HIV [16], syndemics theory refers to "a set of closely intertwined and mutual enhancing health problems that significantly affect the overall health status of a population within the context of a perpetuating configuration of noxious social conditions" (p. 99). Scholars have extended this conceptual framework to LGBT health, particularly due to associations between HIV vulnerabilities and mental health [17, 18], problematic substance use [13], and interpersonal victimisation [19]. LGBT health literature more broadly has evidenced the relationship between social stigmatization and disease [20], yet, there has been limited study of LGBT stigma as a fundamental cause of multiple, interacting diseases [21] across low and middle-income contexts (LMIC). This may be particularly important to examine in socio-political contexts without LGBT human rights protection, including Lesotho. Moreover, the lack of human rights protection can also be understood as *structural violence* directed toward LGBT persons [22].

The assessment of stigma related to sexuality and gender non-conformity and syndemics is a burgeoning field [14, 23–25]. For example, a 2019 study with transgender women in India reported that transgender identity stigma was associated with sexual risk and the clustering of depression, substance use, and HIV. Separately, a study with sexual minority women in Canada reported that harmful social conditions including low social support and economic insecurity mediated the pathway from sexual stigma to depression [26]. A large study with MSM across 151 countries found associations between social conditions including sexual stigma, violence, mental health challenges such as depression and substance use, and HIV vulnerabilities [27]. Taken together, these findings suggest that LGBT communities across global contexts experience harmful social conditions and mental health challenges that elevate HIV vulnerabilities.

Yet, limited scholarship has explored LGBT stigma specifically in LMIC within a syndemic framework, and this direction is relevant to understanding health disparities among LGBT Basotho adults. Evidence from Lesotho suggest that LGBT stigma is associated with increased HIV vulnerabilities and mental health problems [5, 28]. Among Basotho MSM social mistreatment [28] and healthcare stigma were associated with depression and alcohol use, and substance use including alcohol and non-injection illicit drugs was associated with HIV vulnerabilities measured as higher numbers of sex partners [5]. Another study with MSM in Lesotho reported associations between social stigma, depression, and reporting an HIV positive serostatus [4]. Among Basotho lesbian, bisexual and sexually diverse women, stigma and human rights abuses including blackmail, losing employment, and healthcare denial were associated with being diagnosed with HIV and other STIs [12]. Another study with MSM reported that widespread community-level verbal abuse targeting MSM, and secrecy surrounding same-sex relationships, were associated with sexual practices that elevated HIV vulnerabilities [28]. There is limited research among all LGBT communities beyond MSM in Lesotho that explores the social production of LGBT stigma and pathways to interacting health epidemics.

There are also knowledge gaps regarding protective factors that can mitigate the effects of harmful social conditions on health outcomes. A study with LGBT persons in Jamaica reported that social support and resilient coping partially mediated pathways from a latent construct of syndemics that included violence and substance use to sexual risk [29]. Furthermore, a study with MSM in Mexico reported that 'outness' about same sex sexual practices moderated pathways between syndemic factors, including substance use, depression, and internalized stigma, to sexual risks [30]. A systematic review of protective factors among cisgender MSM with interacting HIV risk factors identified structural (socio-economic), interpersonal (relationships), and intrapersonal (coping strategies, cognitions and emotions) factors [31] associated with lower HIV risks. Notably all studies included in this systematic review were in high income countries. A qualitative study with Black MSM in the US [32] found that persons without interacting psychosocial health conditions (depression, substance use, sexual abuse) reported having supportive relationships that fostered a positive sense of identity and health in comparison with those experiencing multiple conditions. Modifiable social factors that can mitigate the effects of harmful social conditions and interacting health issues are understudied in LMIC at large [30]. Identifying these protective factors can inform contextually tailored interventions.

LGBT stigma, while a global phenomenon, is socially organized and thus is shaped by contextual differences in history, geography, political economy, and culture [33]. This suggests that LGBT stigma will manifest differently across contexts, leading to systematic differences in the ways that syndemics are produced and experienced. Campbell and Cornish [34] theorize that enabling social environments for HIV prevention include the interacting dimensions of *symbolic context*, such as cultural perspectives, values and ideologies, *material and political context,* including access to resources and opportunities, and *relational context* focused on social capital and relationships with institutional and state actors. Ultimately, characterizing how LGBT stigma (symbolic context) contributes to social isolation and exclusion (relational context) that in turn leads to interacting health

epidemics among LGBT communities in Lesotho is critical to informing evidence-based and rights-affirming interventions. In response, the goals of this manuscript are to address knowledge gaps regarding socio-cultural mechanisms that link LGBT stigma, depression, substance use, and HIV among the LGBT community in Lesotho. We explore the role of stigma in producing and perpetuating the risk of interacting health challenges among LGBT persons in Lesotho.

Methods

Study Design and Data Collection

We conducted a community-based research project in Maseru, Lesotho between January 2015–April 2015. The study was a partnership between academic researchers and Matrix Support Group, a LGBT community-based organization. Matrix Support Group, led by co-author TP, provides advocacy, outreach and support programs for LGBT persons across Lesotho with the goal of stigma reduction and advancing human rights. We hired six LGBT persons and facilitated training peer researchers in research ethics and research methods. Peer researchers and TP provided feedback and guidance throughout the research process, including planning, designing the questions, coordinating and facilitating participant recruitment and data collection, and interpreting the findings.

A total of 52 in-depth interviews were conducted (LGBT persons = 46 and key informants = 6). We used an open-ended interview approach that allowed unanticipated themes to arise. Interview questions largely focused on stigma among LGBT persons in Lesotho, including: experiences and sources of stigma; health and social issues and concerns; recommendations for social and health services to support LGBT persons; and coping strategies for LGBT persons in Lesotho. Key informants (n = 6) included persons with experience working with LGBT persons in Lesotho, including in health clinics, government and non-governmental agencies, and in human rights and advocacy. We applied a purposive sampling approach to include LGBT persons with varying experiences and perspectives on stigma, specifically including lesbian, bisexual, gay, and transgender persons, to provide a rich understanding of social processes of stigma [35]. LGBT peer researchers recruited all participants via convenience recruitment methods, whereby participants were informed they could invite other participants. To ensure the study team had the same baseline understanding of LGBT health and rights, researchers at the Maluti College of Nursing were trained in LGBT issues and research methods, and conducted in-depth individual interviews in a private room at Matrix Support Group or a location of their choice (e.g. coffee shop, other community agency). Research ethics approval was obtained by the University of Toronto and the Lesotho Ministry of Health.

Data Analysis

Interviewers were approximately 60-min in length, conducted in Sesotho, and each interview was digitally recorded, transcribed verbatim, and then translated into English. Data were entered into QSR NVivo 11 (Burlington, MA, USA). We conducted thematic analysis, a theoretically flexible approach that includes inductive and deductive exploration of themes. Analytic techniques included constant comparative analysis of transcripts and examining deductive (e.g. stigma) as well as inductive (e.g. sexual power dynamics) themes [36, 37]. Specifically, authors (CHL, ML) followed Braun & Clarke's [37] thematic analysis guidance, including first reading transcripts and noting emerging ideas followed by using QSR NVivo 11 (Burlington, MA, US) to systematically generate initial codes across all transcripts.

The team subsequently collapsed codes into broader conceptual themes (e.g. mental health, including depression and substance use), followed by developing a thematic map (e.g. substance use and depression as related to LGBT stigma). Following this, the team further examined the data to understand the relationship between themes in the data (e.g. clustering of HIV and mental health). Guided by a syndemics conceptual framework, as a final step, we selected examples of each theme and contextualized the themes and their interrelationships. Data were coded by two separate coders (CHL, ML), and APB provided theoretical guidance and input regarding the thematic map and theoretical positioning. Transcripts were coded separately and coders met on multiple occasions to compare representative extracts to refine codes. CHL conducted member checking with the Basotho research team, including co-authors from the Matrix Support Group and the Maluti College of Nursing.

Results

Findings are drawn from in-depth conversations with 46 LGBT people of diverse sexualities and fluid gender identities (mean age: 28 years old), including gay cisgender men (n = 12), lesbian cisgender women (n = 15), bisexual cisgender men (n = 2) and a bisexual cisgender woman (n = 1). Persons who identified as transgender (trans) included trans men (n = 3), trans women (n = 2), and trans persons with no gender specified (we refer to as non-binary in the findings) (n = 11). While participants were asked both their gender identity and sexual orientation, persons discussed one or the other. In consultation with Basotho team members, including co-author TP, this finding reflects larger experiences in

Lesotho whereby it can be challenging to separate concepts of gender and sexuality. This phenomenon has been reported in prior research with LGBT persons in Lesotho [11] as well as in other global contexts such as Thailand, where gender and sexuality are often intertwined concepts [38]. We also conducted in-depth interviews with six key informants (mean age: 34 years old) who included 2 cisgender men (one heterosexual, one gay), 3 cisgender women (1 lesbian, 2 heterosexual), and 1 heterosexual trans (non-binary) person.

Findings are presented in three core, interwoven groupings. We first discuss the clustering of depression, substance use, and HIV. Second, we explore large-scale social forces that precipitate disease clustering among Basotho LGBT people. These include four ways of understanding LGBT stigma's relevance to the production of disease among LGBT persons in Lesotho: (a) intersecting LGBT and HIV stigma, (b) sexual and gender-based violence targeting LGBT persons, (c) LGBT stigma and exclusion in healthcare and HIV prevention, and (d) sexual power dynamics and HIV. Third, we describe the ways in which community expertise can be leveraged to navigate harmful social conditions. This includes ways that LGBT persons are connected with tailored information and services, as well as LGBT community solidarity that can facilitate HIV care cascade engagement.

Clustering of Depression, Substance Use, and HIV

Participant narratives described depression, substance use, and HIV as mutually reinforcing epidemics. Participants detailed how social contexts of stigma, encompassing social, familial and religious processes of exclusion, contributed to depression and its sequalae that included hopelessness and at times suicidality. In turn, participants described substance use as a way to cope with stigma, and to build connections with other LGBT persons in a context of social exclusion. Participants portrayed substance use as a barrier to condom use, in turn increasing HIV vulnerabilities. For example, one trans man situated his depression as a response to familial exclusion:

> I became emotional and lost weight; I took it as my fault that my parents are being stigmatized and that affects my emotions. You become lonely if you are not staying with them. You become depressed and your mind doesn't work effectively because it is upset when you know that you born with this sexual orientation, and you become lonely and you will be expecting support in the family, and as a person you are expecting peace, but when you get into the house it is as if you are a leprosy patient who is being discriminated. (participant identification #1, trans man)

The preceding narrative also signals the importance of considering loneliness from familial and social exclusion and its role in exacerbating depression. Another participant shared the processes by which a lack of social acceptance elevated fears of disclosing one's LGBT identity, in turn contributing to depression:

> Some of them [LGBT persons] may commit suicide because they cannot accept themselves; I have seen that happen. Some of them are afraid to come out, and that makes their lives difficult; especially women who feel like men. They may feel pressure to date a lot of men, in trying to prove they are not transgender or lesbian. They may also even get married and have kids. By the time they are ready to come out, they would have done so many things that would confuse society about their sexuality because the person was so afraid to come out for so long. Looking at that person's results of not having come out soon enough—such as the long list of ex-boyfriends, the marriage, the children, the society who is supposed to accept them—they will be depressed instead. (#2, lesbian woman)

This narrative also reveals emotional (fear, social pressure, depression) and physical (suicide, condomless sex) sequalae of adverse social conditions (stigma), and the ways that society's lack of acceptance of LGBT persons played a role in reducing self-acceptance. Finally, this narrative suggests that there may be pressure to conform to heteronormative standards of engaging in opposite-gender marriage and having children due to fear of disclosure. Other participants discussed suicide as a response to social and religious exclusion: "That is why some people end up choosing to commit suicide, feeling that there is no use in living, because they feel that not only are they not accepted in society, but they are also not accepted in the church." (#3, gay man) Another participant discussed that experiencing violence could result in suicidality among LGBT persons: "maybe if I could look deeper, I would find incidences of violence in Lesotho, but we just choose to keep quiet and let it be. That's when we come across homosexual people who commit suicide because maybe something happened and they didn't say it." (#4, lesbian woman) Taken together, depression and suicide were noted as prevalent psychological responses to social exclusion.

Drug and alcohol use were another epidemic discussed by participants as a stigma coping strategy. For instance, a participant articulated how drug and alcohol use were common ways to cope among LGBT persons: "with outright abuse and discrimination, they resort to turning to drugs and alcohol in order to numb emotional pain. In fact, people in this group [LGBT] take drugs, a lot." (#5, lesbian woman) Yet participants also discussed that using alcohol as a coping strategy might not always be effective at reducing stress: "once they are being ill-treated they end up abusing alcohol to reduce the stress. I don't think

alcohol can help me to de-stress; once I drink, I will sleep and tomorrow morning I will still think about what has happened." (#6, gay man) Drug use among LGBT persons was also attributed to religious exclusion and subsequent low self-acceptance:

> When you exclude them [LGBT persons] in the church and spirituality, they turn to alcohol. Perhaps it makes them feel better to smoke marijuana and use some other kinds of drugs. When you have not accepted yourself and you meet people who do not accept you, you'll end up even committing suicide, or doing drugs in order to feel accepted. The main thing is for you to accept all areas of your life. (#7, gay man)

Social exclusion resulted in limited spaces for LGBT persons to socialize. Alcohol and drug use were connected with bars being a common place to meet other LGBT persons, including sex partners. When the interviewer asked a participant "Why do you think LGBT people like to go drinking?", a respondent described: "often that is where we meet men, more than anywhere else." (#8, gay man) When persons meet sex partners in bars, alcohol use might reduce the likelihood of condom use, that in turn could elevate HIV exposure. A participant articulated how social exclusion could result in alcohol use and subsequent HIV vulnerabilities: "I realize that since we are unaccepted we tend to have partners from the shebeens [bars]; we get drunk and things that we do when we are drunk makes people not to protect themselves during sex. This inevitably increases our chances of contracting HIV." (#9, gay man) Another participant reinforced the idea that drinking to reduce stigma related stress may also lower the likelihood of condom use: "I think they find comfort in booze, because of criticism and all these negative things around them. Yes. I think when they are out drinking they get to relax and forget their problems for a while, I think they end up engaging in unprotected sex." (#10, lesbian woman) In this way we see that not only is there interaction between health epidemics (depression and suicide, substance use, HIV), but that each health issue is discussed in relation to harmful conditions of social exclusion and its psychological impacts, namely a lack of self-acceptance.

LGBT Stigma and Disease Clustering

Participants described interactions between LGBT stigma and disease clustering. Stigma attributed to LGBT identities and HIV created the backdrop whereby LGBT persons in Lesotho experienced social exclusion, violence, and healthcare barriers. Sexual power dynamics were also linked to HIV vulnerabilities, revealing the importance of considering the experiences of young LGBT persons.

Intersecting LGBT and HIV Stigma

Many narratives described the perception that people were disgusted by LGBT persons. A bisexual man (#11) explained that this disgust often resulted in mistreatment and subsequent feelings of fear:

> Often times you will see people peeping through their windows at us like we are criminals or something. Although we try to mind our own business, this behaviour is very uncomfortable; to stay around people who gossip about us makes us not feel safe. And it makes us uneasy, as if we have done something wrong, that they may harm us at some point. Sometimes you find out that a person may spit; and you will realize later that they did that because you're gay, so like they were showing their disgust.

Participants also discussed negative perceptions towards HIV. A key informant (A) described that this fear of experiencing stigma and rejection following an HIV positive diagnosis may reduce HIV testing:

> People are afraid of getting tested because there is a stigma which goes with being HIV positive. So, in that way there is that fear of them being HIV positive and then whether you'll be accepted by your family, friends. Is your whole life going to change, your own health, and what that means. I think these groups would face those challenges and have the fear of actually getting tested.

Stigma toward HIV was also rooted in misconceptions that HIV was associated with 'promiscuity'. A lesbian participant (#5) articulated: "What gives people fear is that they believe once they have been infected with HIV, then it means they are labelled as promiscuous people. That is what makes people afraid of it. They innocently wonder, 'I didn't have it, where could I have gotten it from?'" Stigma toward LGBT persons intersected with HIV stigma through narratives whereby LGBT persons were constructed as 'promiscuous' and in turn blamed for HIV. A trans (non-binary) participant (#12) explained: "People even say that we are the ones who spread HIV, so most people see dirt when they look at us, you know what I mean?"

Sexual and Gender-Based Violence Targeting LGBT Persons

Community-based and institutionalized power inequities often resulted in physical and sexual violence targeting LGBT persons. Participants explained that violence targeting LGBT persons was largely unprovoked: "some will get beaten just for being gay, lesbian or transgender. That is the only thing they get fought about." (#13; trans non-binary) Others described that violence commonly targeted

gay men: "I have heard that gay guy was beaten for being gay. That happens quite a lot and I have a gay friend who has experienced that." (#14; lesbian woman) Violence was also discussed in relation to gender non-conformity: "There is much abuse. You find that some just get beaten on the basis of being accused of making themselves into men, yet they are women." (#15; trans non-binary)

This violence directed toward LGBT persons was sometimes fatal: "Indeed many deaths occur. If a person passes away and it was not because they were sick, or of natural causes, then you can bet that person was perhaps stabbed with a knife, or something horrific was done to them." (#5; lesbian woman) Participants discussed that fear of violence resulted in safety concerns: "They advise us not to walk during the night because we may get assaulted. Many people have been assaulted and some have died; there are people who hate LGBT to an extent that they can just beat you up when they see you." (#16; lesbian woman)

Participants also discussed sexual violence, particularly directed toward lesbian and bisexual women and transgender persons. As a participant noted: "rape, especially to the lesbians and transgender, they do that to prove they are girls." (#17, trans non-binary) A key informant also described rape targeting gender non-conforming persons: "What I have realized is that the masculine women get raped, because men want to prove a point that they are still women, with vaginas, who still go on their periods." (Key informant E)

Sexual violence was also explicitly homophobic, framed as a 'corrective' practice, and an HIV risk factor: "lesbians get raped; they call it 'corrective rape', to 'correct' them. They say, 'that's the woman who sleeps with another woman.' During that rape, there is not protection being used most of the time." (#18, trans non-binary) Another participant described becoming HIV infected through 'corrective' rape:

> When I got raped for the first time, I got raped by seven men. I am HIV positive because of that experience. I have fallen pregnant from that experience. Then I had a miscarriage at 5 months. That thing still bothers me even now: I am living with HIV, I once got pregnant. (#19, lesbian woman)

The above narrative articulates both the risks for HIV during sexual violence within high prevalence contexts, and the psychological and physical sequalae of sexual and gender-based violence. While described as pervasive and at times fatal, violence against LGBT persons occurred in socio-political landscapes where they had little to no recourse to justice. For instance, a participant reported that persons who experienced violence in the workplace due to their sexual orientation felt it was fruitless to try to seek justice:

> …one person got raped at work and this made them resign from work, especially when they were not able to do anything about the rape even though they knew who had raped them. They never did anything about it as people had realized they were different [gay], they just thought it would be useless to make an issue out of it, so they just left. (#20; trans non-binary)

This hesitance to report violence to police was largely due to concerns of being blamed for victimization. A participant explained: "it becomes a heavy load, because if you go to the police, they literally laugh at you there. When you tell them that someone has hit you, they snap and say, 'What was the problem which caused them to hit you?'" (#7; gay man) Blaming survivors of violence for their victimization was described as part of a larger pattern of inequitable gender norms that also influenced heterosexual women who reported rape to police:

> It is also the same for straight women who have been raped. For when they go and report it they might get asked, 'But what were you wearing?' or 'You! You see now we are no longer sure of whether you are a man?' so they feel that going to report the matter is only going to cause more pain. (Key informant B)

This physical and structural violence was fostered in larger conditions of pervasive LGBT stigma and produced profound barriers to reporting violence and seeking support.

LGBT Stigma and Exclusion in Healthcare and HIV Prevention

LGBT persons' mistreatment and exclusion in healthcare, including HIV prevention, were significant barriers to accessing healthcare, in turn exacerbating HIV vulnerabilities. A participant described a healthcare experience where they perceived receiving poor treatment:

> For example, there was a time I visited a healthcare centre in need of help. There was a lady who was to help me. She did not service me well. I think maybe it is because she noticed what type of person I am, because there are people who just look at you and notice who you are then they approach you with a different attitude from that which they approach others with. We really have a problem at healthcare institution when we seek help there. (#15; trans non-binary)

Another participant identified healthcare mistreatment as a deterrent from accessing future healthcare: "people like ourselves, we are not able to go to and get healthcare services and talk about those things [sexual identity] because there we get abused, and you will not go to a place where you get abused every time." (#21; lesbian woman)

Participants also discussed the perception that LGBT persons were largely excluded from HIV prevention campaigns: "People who provide HIV education on the radio usually talk about men and women—not considering that there are the gays and the lesbians. There is no specific education that is targeted for LGBT. There needs to be a balance to include both gay and straight groups of people in order to reduce the chances of STI transmission." (#22; trans non-binary) A key informant described service providers' lack of knowledge regarding trans persons' HIV prevention needs:

> For transgender people it is a bit tricky. This is because one of the things we have learned is that as a society, we wrongly give them standards and say that they will only have anal sex if they are gay; and that is not the case. They have sexual intercourse in different ways. (Key informant C)

In addition to a lack of tailored information, participants reported constrained access to prevention resources. At times stigma was a barrier to accessing resources, such as the case with lubricant due to its associations with LGBT persons: "when you put them [lubricant] in the general public they will fear to take them, because once he takes lubricant people will be suspicious that he is a LGBT member." (Key informant F) Participants reported a dearth of prevention resources for women engaged in same-gender sexual practices: "We need to protect ourselves but there are no methods of protection for lesbians. They are not available at all." (#21; lesbian woman) Others illustrated a lack of HIV prevention resources for sexually diverse women and transgender persons. A key informant described that HIV programs in Lesotho:

> are focusing more to men having sex with other men than LGBT. Every time when they present their issue they say MSM—and I like fighting for LGBT to be presented because transgender [people] need services or if lesbians practice unprotected sex. We're saying we want to reduce the spread of HIV in a country although other people are excluded, and that is a very big challenge. (Key informant D)

A key informant articulated that mistreatment and exclusion of LGBT persons in healthcare settings contributes to the HIV epidemic: "we are the ones who may influence the infection rate to be high amongst them, given the way we treat them—by not supporting them, and by not giving them the right information." (Key informant B) This insufficient healthcare, including HIV prevention, provided for LGBT persons aggravated HIV vulnerabilities.

Sexual Power Dynamics and HIV

Sexual power dynamics elevated HIV vulnerabilities, particularly among younger LGBT persons. To illustrate, a participant described that he was at risk for HIV as he had less power to enforce condom use due to his younger age: "Yes, I am at risk because I sometimes meet older men who do not believe that there is HIV in the anus and refuse to use protection. Since they are older than me I can't argue much; we just continue having unprotected sex because of fear. So, it is easy to get infected." (#11, bisexual man) This narrative also shows sexual relationship power dynamics that shape condom use. Another participant described that LGBT youth were less likely to use condoms: "As youth we mostly do not use protection when we have sex; we ignore such things though we know what we are supposed to do. We just regret afterwards—what if that could have left me infected?" (#23, bisexual woman)

Sexual power dynamics also emerged as an important consideration for shaping HIV vulnerabilities linked with multiple sex partners. For instance, having sex partners who had other sex partners was considered an HIV risk factor. A participant described how men in a heterosexual marriage may also engage in same sex practices:

> If I am in love with a married person who is still hiding his status there will be high risk, by having sex with his wife and me too, and once he is not available I will also find someone who has time. There is a sexual network in this situation. Again, it is about the use of condoms, but that is beyond an individual's discretion. (#24, gay man)

This narrative also notes that in a heterosexual relationship condom use is controlled by men and reduces women's power to enforce condom use, even if her male partner has other partners. Others discussed discovering their partners had other sex partners and being concerned about their HIV risk: "I think I am at a high risk because recently I discovered that my partner is involved with so many people. Furthermore, I have found out that it has been happening for a long time, yet I am only finding out now. I fear that I may be infected with HIV, so much that I am afraid to know my status." (#25, lesbian woman) In this account, two social factors emerge as increasing HIV vulnerabilities: first, power dynamics whereby a woman found out her partner has other sex partners, and second, HIV-related stigma that produces fear of testing.

Leveraging Community Expertise to Navigate Syndemics

To address the ways in which social forces influence health outcomes, participants identified community level strategies.

This included leveraging community expertise regarding mitigating HIV vulnerabilities. Notably participants did not discuss strategies to promote mental health, such as reducing depression or substance use. Participants also described solidarity among LGBT persons as a social enabler of HIV cascade engagement.

Engaging LGBT Communities with Tailored Information and Services

Narratives pointed to the need for LGBT specific HIV information and services. A key informant described the need for LGBT programs at the national level: "I think in Lesotho as a whole we need to work a lot more on that programming, and to make sure that these key affected populations such as transgender and MSM are actually targeted and that they have the education so that they know where and what service they can access." (Key informant A) Participants specifically recommended community workshops for LGBT persons that provide condoms and lubricant: "There is an organization that we work with where they do workshops at the communities within Maseru district; there is high HIV prevalence in Maseru. They hold workshops and provide condoms and the lubricants so that they can have protected sex." (#26, trans man)

Others discussed institutional changes to increase access to safer sex resources and clinical care. For instance, a participant discussed providing access to condoms and lubricants in public institutions nationally: "it [condoms and lubricant] should be accessible. One should know where they can find them; they should not just be available at Matrix Support Services, because there are many districts. They should be accessible, just as those who are said to be 'normal' find condoms all over the place. At the hospitals they are there, at schools you find them in the toilets, you find them everywhere." (#15; trans non-binary) Another suggested change to clinical care included hiring LGBT persons as service providers to reduce LGBT stigma when accessing healthcare:

> If there could be a member of LGBT [communities] who can work at the clinic; the person who knows about people like me so that he can accept me. That will make LGBT members to be free when they go to the clinic, and in every clinic I should know there is LGBT member who can provide a service without stigmatizing. (#1, trans man)

Leveraging Solidarity Among LGBT Persons

LGBT participant narratives discussed the ways that LGBT communities supported one another to engage in HIV testing and care. One approach included raising HIV awareness within LGBT communities: "We can't say we are 'Mr. know all', there are other LGBT members that are illiterate, and they don't have enough information on how they can protect themselves. I think it could be better if there is a group that will mentor them on how to care for themselves." (#18, trans man) Many of the other narratives from within LGBT communities centred on how persons supported one another to be tested for HIV and, when living with HIV, to take antiretroviral therapy. Narratives around partner testing were common. For instance, a lesbian (#27) described: "I am not going to deny the fact that I was promiscuous, but I was using protection. I now have only one partner and I told her that I see a future for us and that I wanted no mistakes. So, I asked that 'we go and get tested together, in order for us to know each other's status, and then everything will be well, when I am always aware of your status'." Another participant discussed how partner support for testing was health promoting and an important part of sexual intimacy:

> I used to encourage the person that I engage into love with to go for an HIV test, if not obviously we won't be in love or do unprotected sex. Truly in our community [LGBT] we do protected sex not that we can't be pregnant, but the main reason is that we are avoiding sexual illnesses. Personally, I do care for myself and I make sure that I test after every three months. I don't want to stop testing because I know when my window period finishes. (#28, gay man)

The above example also illustrates the connection between self-care and care for sexual partners. Others discussed that LGBT persons living with HIV often adhered to anti-retroviral therapy (ARV) to maintain their health, and in turn avoid community-level stigma:

> Most of them are self-accepting, even though I do not want them to mention how they got it, and under what circumstances. You will even find one saying that they would rather start taking ARVs straight away, whilst their CD4 count is still okay, so that they do not find themselves harassed in the public. They really like to insist to take ARVs well in time before their CD4 count drops." (#12, trans man)

Others discussed being in relationships and supporting one another to take ARV. This was illustrated in the following example of a relationship where both persons were living with HIV: "I take care of myself; I make sure that my partner and I take care of ourselves. I disclose myself to my lady partner and I live with my partner who is HIV positive. We work in such a way that we do not increase the virus, but rather keep it on the level that it is at. We both take ARVs and we remind each other at 8 o'clock." (#29, trans women) Another participant discussed the perspective that HIV was a manageable disease in a serodiscordant relationship:

> These days, I see it is a manageable disease, as compared to TB and diabetes. Right now, you cannot tell if I am infected with HIV…HIV infection is not obvious. You and your partner can work it out, as long as you are taking good care of yourself according to the instructions given to you, which are to take your pills and eat vegetables. (#3, gay man)

Discussion

Our study provides evidence of LGBT stigma as a harmful social condition that operates across institutional, community, interpersonal, and intrapersonal dimensions to reproduce the risk of interacting mental health and sexual health epidemics among LGBT persons in Lesotho. Participant narratives reveal the ways that symbolic contexts that devalue both LGBT persons and people living with HIV produced community level stigma. LGBT stigma fostered a climate where violence targeting LGBT persons was pervasive and at times fatal. LGBT persons experienced constrained access to justice and healthcare. LGBT stigma strained relational contexts, including in intimate partnerships, whereby inequitable sexual power dynamics reduced sexual agency for enforcing condom use. Using alcohol helped LGBT persons to cope with depression resulting from stigmatizing social contexts and was a tool to connect with other LGBT persons. Substance use, sexual violence, inadequate HIV prevention resources, and inequitable sexual relationship power converged to increase HIV vulnerabilities. Harmful social contexts emerged as the key factor contributing to the interacting issues of mental health challenges and HIV vulnerabilities.

These findings align with prior research that revealed widespread stigma, including violence and health care mistreatment, among MSM and sexually diverse women in Lesotho [8–10]. Narratives also corroborate research in Lesotho that highlights associations between stigma and sexual and mental health disparities among MSM [5, 28] and sexual health disparities among sexually diverse women [12]. Our findings suggest that stigma, and connected mental and sexual health sequalae, are shared experiences among LGBT communities at large in Lesotho. Participant narratives also point to the larger hegemonic gender norms underpinning violence targeting gender nonconformity, including homo/transphobic 'corrective' rape similarly reported in LGBT research in Eswatini [39, 40]. Compulsory heterosexuality is enforced through punishments including documented lack of human rights, violence, and social exclusion [41, 42]—reflecting sexual rights constraints among LGBT persons in Lesotho. Participants discussed how structural violence also impacted heterosexual, cisgender women in Lesotho who are blamed for sexual victimization when seeking justice, signalling larger symbolic contexts where women's sexuality is stigmatized and their sexual agency constrained.

Findings contribute to the nascent literature regarding how LGBT persons in LMIC—particularly with no LGBT human rights protection—can leverage community expertise to navigate stigma and reduce HIV vulnerabilities. Access to HIV prevention resources tailored for LGBT persons was identified as salient to advancing LGBT health. LGBT solidarity was another theme that arose as central to HIV care engagement, suggestive of bridging social capital. Similar to other research with sexually diverse women in Sub-Saharan Africa [38, 39], participants called for HIV education to include sexually and gender diverse women—rather than solely focus on MSM. This tension is longstanding: money flows to HIV programs and can exclude persons (e.g. lesbians) with less clearly delineated HIV-related risks [43–45]. HIV funds are often the most stable funding source for LGBT agencies in LMIC, hence excluding sexually diverse women from LGBT programs could limit opportunities for them to build connections and relationships with other LGBT persons. The syndemic framework indicates that while we need funding to address HIV risks, we also need to address harmful social conditions such as sexual violence and comorbid health issues, including depression and substance use, that exacerbate HIV exposure among LGBT persons.

The importance of solidarity in reducing HIV vulnerabilities among LGBT persons was a core finding. This aligns with other scholarship, namely in the US, that highlights the potential for LGBT connectedness to mitigate the impacts of stigma on HIV risks [30, 32]. Research can further explore ways that building LGBT leadership and advocacy, bonding social capital with ties between LGBT persons, and bridging social capital comprising ties between LGBT persons and others with socio-political power, can engage LGBT persons in transforming harmful social conditions while navigating interacting health conditions [25].

These findings should be understood in relation to study limitations. This study was originally designed to explore stigma among LGBT persons in Lesotho, hence there is not a focus on overlapping health issues central to most syndemics research. There was also not an explicit focus on mental health; while participants discussed strategies to manage HIV risks there was not a similar discussion on navigating mental health issues. There were not enough interviews conducted with lesbian and bisexual women, MSM, and transgender persons to define differential needs and experiences within the LGBT community. For that reason, there is a need for future studies to explore shared and different experiences of stigma and interacting health issues among LGBT persons in Lesotho.

Despite these limitations, this paper underscores LGBT stigma as a harmful social condition that contributes to the syndemic of interacting sexual and mental health disparities among LGBT persons in Lesotho. We identified complex pathways from stigma to: violence and exclusion, mental and sexual health outcomes, and sexual relationship dynamics. The growing literature on syndemics and protective factors underscores the need to consider the ways that affected communities navigate inequitable contexts. By exploring violence targeting LGBT communities and its sequalae, we signal the importance of considering the persistent and damaging influence of compulsory heterosexuality. We emphasize the interconnectedness and interplay of contextual dimensions that shape the production of LGBT stigma.

Community narratives showcase that multi-level approaches are required to reduce LGBT stigma in Lesotho. Investing in LGBT community structures, including LGBT community-based agencies, can enhance social capital, foster social advocacy, and grow grassroots initiatives such as Lesotho Pride. Addressing structural violence requires advancing national LGBT human rights protection, as well as providing healthcare training and standards for LGBT affirmative care. These advocacy and institutional tactics can in turn transform social norms. Culturally tailored LGBT affirmative community-based mental health and substance use programs can be developed with LGBT persons in Lesotho to integrate local understandings of mental wellbeing and contextually appropriate adaptive coping strategies. There is an urgency to tackle LGBT mental health in Sub-Saharan Africa, where there is a dearth of research and efficacious interventions among general populations [46]. Even less is known about what works to promote mental health among LGBT persons. Taken together, these data suggest that interventions informed by a syndemics framework developed with and for LGBT persons in Lesotho have great potential in advancing social transformation, health and realization of human rights.

Acknowledgements We acknowledge the important contributions of The Matrix Support Group, the Maluti School of Nursing, and the Ministry of Health Scientific and Ethics Committee in Lesotho, and research assistants and participants. We dedicate this paper to the memory of Xolile Mabuza—our study co-investigator, dear friend, colleague and devoted activist for the rights of sexual and gender minorities worldwide.

Funding This study was funded by a Social Sciences and Humanities Research Council of Canada (SSRHC) Partnership Development Grant (PI: Logie). CHL's efforts were also supported by the Canada Foundation for Innovation, Canada Research Chairs Program, and an Ontario Ministry of Research & Innovation's Early Researcher Award. SB's contribution to this publication were supported by US National Institutes of Mental Health and the Office of AIDS Research of the US National Institutes of Health under award number R01MH110358. The content is solely the responsibility of the authors and does not necessarily represent the official views of the US National Institutes of Health.

Compliance with Ethical Standards

Conflict of interest The authors have no conflicts of interest to declare.

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