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Exploring the potential of participatory theatre to reduce stigma and promote health equity for lesbian, gay, bisexual and transgender (LGBT) people in Swaziland and Lesotho

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Abstract

Stigma and discrimination affecting lesbian, gay, bisexual and transgender (LGBT) people compromise health and human rights, and exacerbate the HIV epidemic. Scant research has explored effective LGBT stigma reduction strategies in low and middle-income countries. We developed and pilot-tested a participatory theatre intervention (PTI) to reduce LGBT stigma in Swaziland and Lesotho, countries with the world's highest HIV prevalence. We collected preliminary data from in-depth interviews with LGBT people in Lesotho and Swaziland to enhance understanding of LGBT stigma. Local LGBT and theatre groups worked with this data to create a 2-hour PTI comprised of 3 skits on LGBT stigma in healthcare, family, and community settings in Swaziland (Manzini) and Lesotho (Maseru, Mapoteng). Participants (n=106) (nursing students, healthcare providers, educators, community members) completed 12 focus groups following the PTI. We conducted thematic analysis to understand reactions to the PTI. Focus groups revealed the PTI increased understanding of LGBT persons and issues, increased empathy, and fostered self-reflection of personal biases. Increased understanding included enhanced awareness of the negative impacts of LGBT stigma, and of LGBT people's lived experiences and issues. Participants discussed changes in attitude and perspective through self-reflection and learning. The format of the theatre performance was described as conducive to learning and preferred over more conventional educational methods. Findings indicate changed attitudes and awareness towards LGBT persons and issues following a PTI in Swaziland and Lesotho. Stigma reduction interventions may help to mitigate barriers to HIV prevention, treatment and care in these settings with a high burden of HIV.

Keywords

LGBT; HIV; stigma; participatory theatre; Swaziland; Lesotho

Introduction

Stigma, discrimination and violence targeting lesbian, gay, bisexual and transgender (LGBT) people compromise health and human rights (Baral, Sifakis, Cleghorn & Beyrer, 2007; Frisell, Lichenstein, Rahman & Langstrom, 2010; Logie, 2012; Meyer, 2003). Stigma is widely acknowledged as a key social driver of the HIV epidemic as it limits access to prevention, testing, support, and treatment (Lyons et al., 2017; Ogden & Nyblade, 2005). Stigma refers to social processes of labeling and stereotyping that result in loss of status, power, mistreatment, discrimination and violence; stigma is reproduced in social and institutionalized exclusion (Herek, 2007; Parker & Aggleton, 2003).

Same sex practices are criminalized in 33 countries across Africa (Carroll, 2016), underscoring the impact of socio-political factors on the lives and wellbeing of LGBT people. The Kingdoms of Swaziland and Lesotho are both small, lower middle-income landlocked countries in Southern Africa. They have among the world's highest national HIV prevalence: 23% in Lesotho (Lesotho Ministry of Health, 2014) and 29% in Swaziland (The Kingdom of Swaziland Ministry of Health, 2014). Lesotho decriminalized same-sex practices between consenting adult males in 2012. In Swaziland, the practice of sodomy remains illegal. In Swaziland and Lesotho, same-sex sexual activity between women has never been outlawed. Despite changes to Lesotho's criminal law, there are reports of pervasive stigma and discrimination targeting LGBT persons in Swaziland and Lesotho (Mayer, Bekker, Grulich, Colfax & Lama, 2012; Human Rights Watch, 2011). For example, findings suggest that LGBT people in Swaziland (Baral et al., 2011) and Lesotho (Baral, Grosso, Adams, Kennedy & Hurley, 2012) experience high levels of targeted violence, harassment, stigma, rejection from family and friends, eviction from homes, healthcare and police services discrimination, religious discrimination, and human rights violations.

Participatory theatre has been used in low and middle-income countries (LMICs) as an intervention to combat stigma. Participatory theatre in these contexts has predominantly focused on reducing HIV stigma towards persons living with HIV in response to the global HIV pandemic (Bagamoyo College of Arts, Tanzania Theatre Centre, Mabalac & Allend, 2002; Carlson, Brennan & Earls, 2012; Kamo, Carlson, Brennan & Earls, 2008; Stangl, Carr, Brady, Eckhaus, Claeson & Nyblade, 2010). Less research has explored the potential of participatory theatre in reducing LGBT stigma in LMIC.

The research objective was to understand the potential of participatory theatre as a mechanism to change stigmatizing attitudes towards LGBT people in Swaziland and Lesotho. In this paper we present findings from focus groups conducted with nursing students, LGBT community members, healthcare providers, and educators in Swaziland and Lesotho who participated in a participatory theatre intervention aimed at changing stigmatizing attitudes and increasing awareness towards LGBT persons and issues.

Methodology

This study is guided by community-based research (CBR). CBR is a transformative framework for conducting research with communities that incorporates community voices,

knowledge and theories within the research process (Wallerstein and Duran, 2010). This CBR study involved partnerships between academic researchers and community-based LGBT organizations in Swaziland (The Rock of Hope) and Lesotho (Matrix Support Group). The Rock of Hope and Matrix Support Group aim to improve the wellbeing of LGBT individuals and communities through providing support, advocacy and training strategies. The Rock of Hope and Matrix Support Group participated in all phases of study planning and implementation, including developing the participatory theatre vignettes, conducting data collection, and helping with data interpretation. We hired LGBT identified peer research assistants (PRAs) based at The Rock of Hope (n=3) and Matrix Support Group (n=3) to facilitate LGBT community engagement and the PTI.

Methods

Participatory Theatre—Interventions to reduce the general public's stigma towards LGBT people have been predominantly school-based and conducted in North America (D'Augelli, 2006; Fuoss, Kistenberg & Rosenfeld 1992; Goodman, 2005; Rye & Meaney, 2009; Wernick, Dessel, Kulick & Graham 2013). Participatory research approaches, focused on empowerment, social change and partnership with local communities (Cook, 2005), hold promise for addressing stigma and discrimination in Southern Africa and are congruent with a CBR framework. Participatory approaches recognize that stigma reduction initiatives should build on community understanding of forms and causes of stigma, and that persons who are targets of stigma should be actively engaged to develop solutions (Campbell, 2005; Freire, 1973).

Participatory theatre has its roots in Theatre of the Oppressed, a critical pedagogical tool developed by Augusto Boal (1974) in 1960s and 1970s Brazil. Boal utilized theatre as a communicative tool for engaging with marginalized populations in Brazil to generate empowerment, leading to critical consciousness (understanding of one's oppression), in turn promoting individual and social transformation. While marginalized persons have often been the foci of change in theatre interventions, Boal argued that it was also necessary for the entire community to participate to foster social change (Boal, 1974).

Performance ethnography refers to performances such as participatory theatre that are based on scripts developed from qualitative interviews (Goldstein, 2012; Lea 2012). This method has been used in North America to educate teachers (Goldstein, 2004; Goldstein, 2008; Skyes & Goldstein, 2004) and students (Gallagher, 2006) about LGBT issues. Participatory theatre aims to create new knowledge generated through community problem solving (Quinlan, 2009). This approach offers the potential to engage LGBT people in producing and mobilizing knowledge, and community members in envisioning and practicing solutions to stigma.

Developing the Participatory Theatre Intervention

We developed a participatory theatre intervention (PTI) working with preliminary data (not presented) from in-depth interviews our team conducted with LGBT individuals from Swaziland (n=49) and Lesotho (n=57); these interviews explored experiences of LGBT stigma. Local theatre groups in Swaziland and Lesotho worked with the academic research

team and Rock of Hope and Matrix Support Group, respectively, to create three short (3–4 minute) skits. While skits were developed separately with Swaziland and Lesotho teams to ensure cultural and contextual relevance and community engagement, each country included skits that demonstrated an example of stigma experienced by: a gay, bisexual or other man who has sex with men; a lesbian, bisexual, or woman who has sex with women; and a transgender person. Skits in each context also provided examples of stigma in healthcare, family, and community settings. Contents of skits were developed through performance ethnography techniques (Sloman, 2012) including presenting theatre specialists and researchers with a summary of qualitative data findings and selected examples of stigma across different LGBT populations and settings. Theatre specialists, researchers and PRAs from Rock of Hope and Matrix then worked together to highlight narratives, themes, and visual images from the data to create scripts for PTI performances. The skits were pilot tested with academic team members and The Rock of Hope and Matrix Support Services members before being finalized.

The PTI involved two components. First, community animators from the theatre groups enacted the skits to audiences of approximately 25 persons. Community animators performed each play once to illustrate the situation and a particular experience of stigma. This initial enactment of the vignettes culminated in a crisis with no solution offered. Each play was performed a second time, and one of the co-facilitators stopped the play at a key point where there was a challenge and invited one or more of the intervention participants to portray a more positive and supportive solution. The participants, representing community stakeholders, then came to the stage to replace the character and acted out a possible solution. In line with a CBR approach, this technique directly involved community stakeholders in brainstorming solutions to the challenges LGBT people experience, as presented in the plays (Chambers, 1994). Swaziland skits included: a mother walking in on her son kissing another man; an employer firing a transgender women after she transitioned; and a nurse mistreating a lesbian patient. Lesotho skits included: a gay man being mistreated by a nurse; a lesbian being forced to marry a man by her family; and a transgender man being harassed while trying to use a public toilet.

Study Design

Qualitative methods were used to understand experiences of participating in the PTI as well as the immediate sense making that may occur following PTI participation (Creswell, 2003). Specifically, we employed purposive sampling (Palys, 2008) methods with PRAs, academic and community partners who used word-of-mouth and snowball sampling methods to recruit nursing students, LGBT community members, healthcare providers, and educators in Swaziland and Lesotho to participate in the PTI. Participant recruitment aimed to include persons who worked in institutional, healthcare, government and non-government organizational settings where they are likely to interact with LGBT people, as well as LGBT persons. Additional inclusion criteria were: adults aged 18 years and older, able to provide informed consent, interested in attending a workshop on LGBT stigma, and willing to complete a 1-hour focus group. Participants were invited to the 2-hour PTI, followed by a semi-structured focus group to explore their experiences of the PTI. Participants received

refreshments, a meal and a small monetary incentive for participation in the 2-hour PTI and focus group.

In total, four PTI (2 in Swaziland [Manzini], 2 in Lesotho [1 in Maseru, 1 in Mapoteng]) were conducted with a total of 106 research participants (Lesotho n=57, Swaziland n=49). All focus groups were conducted at one point in time, immediately following the PTI, to explore the immediate reactions and sense making of the PTI. Focus groups were facilitated by peer research assistants (PRAs) in either Sesotho (Lesotho) or SiSwati (Swaziland). We divided participants in each PTI into 3 smaller groups for focus group discussions, conducting 6 focus groups in Swaziland and 6 in Lesotho with 6–10 participants per group. LGBT members of Rock of Hope attended 1 PTI in Manzini, and Matrix Support Services members attended 1 PTI in Maseru: we conducted a separate focus group with these LGBT community members in each context.

Ethics Approval and Funding

Research ethics approval was attained from the Office of Research Ethics at the University of Toronto; the Lesotho Ministry of Health; and the Swaziland Ministry of Health.

Data Analysis

Focus groups were audio-recorded, transcribed verbatim and then translated into English by bilingual native Sesotho or SiSwati speakers who were research team members. Once transcribed and translated, transcripts were uploaded to qualitative data management and coding software, Nvivo 10 (Doncaster, Australia). Focus group transcripts were analyzed using a thematic analysis approach (Attride-Stirling, 2001; Braun & Clarke, 2006) that involved multiple readings and coding of the data. An initial reading of the transcripts involved producing descriptive codes that identified key features of the data. This initial reading entailed staying close to the data and developing codes based on the language prevalent in the transcripts. A second reading entailed identifying emerging patterns in the data and beginning to group the codes. CL and LD met to discuss these descriptive codes and worked to refine these codes while developing initial themes. Subsequent readings of the data involved grouping the coded data according to themes (Attride-Stirling, 2001; Braun & Clarke, 2006) with a focus on participant experiences of, and immediate reactions to, the intervention.

Throughout the coding and data analysis process, analytic memos were produced describing the codes and initial themes. Memoing is a practice of reflective writing that facilitates data analysis (Bailey 2007). LD recorded thoughts on connecting codes and concepts, and reflected on how they were thinking about the data. Memoing was especially useful for moving the analysis from initial descriptive coding into thematic analysis and also left a trail of decisions made about codes and themes. After data were organized by initial themes, CL and LD met to discuss, refine and reconceptualise the themes where necessary. These refined themes were discussed with academic and community team members in Lesotho, Swaziland, Canada and the United States, and subsequently we created a list of final themes presented in this paper.

Results

Thematic analyses from Swaziland and Lesotho focus groups garnered similar results regarding immediate reactions to the PTI, therefore we present combined findings for Swaziland and Lesotho. Throughout our discussion of the themes, where applicable, we highlight any differences in responses between participants based on country or other characteristics. Participant demographics are presented in Table 1, a notable difference is there was a higher proportion of nursing students in Lesotho than Swaziland.

Increased Understanding and Exposure

Participants discussed both increased knowledge of the negative impacts of stigma as well as new exposure to LGBT persons and issues.

Understanding Perceptions of Negative Impacts of LGBT Stigma.—It was common for focus group participants to discuss an increased understanding of the problems and negative impacts of stigma and discrimination against LGBT people. For instance, one participant communicated that prior to watching the plays, they lacked understanding of what it means to feel attraction to the same gender:

> I didn't understand how a girl could feel attracted to another girl. But now what I have realized is that these people need our support. I especially realized this when I saw the scene where the lady was being forced into marriage and that really hit me deep inside. I believe that each and every person who does something does it because they believe in it; you know, you do something because you like it. So I don't like it when their feelings get oppressed when we want them to do what we want. (Lesotho, Mapoteng 3).

In this instance, this participant expressed understanding of the harmful implications of expecting LGBT people to follow heteronormative expectations such as marriage. This participant identified the format of the PTI as enabling a shift in their awareness of issues—such as forced marriage—that may impact LGBT communities and this awareness contributed to a shift in perspective.

The PT intervention also provided an avenue for participants to expand their understanding of gender identity and sexuality. As a participant in Swaziland communicated:

> I personally got clarity on transgender people. I really did not have a proper definition of what a transgender person really was. I now have a clear understanding and now that I have a clear understanding, and for me it is now ok, people should be treated in the same manner. (Swaziland, Manzini 1)

Participants also articulated increased awareness of LGBT people's feelings. In speaking on how their understanding has improved, it was common for participants to discuss their perception of how LGBT people might feel. Participants seemed to want to relate to and/or understand the feelings of LGBT people, communicating that they appreciated "really seeing them [LGBT people], how they feel about not being able to express themselves, like how it's like they are living in a prison they can't be free to enjoy life like we do—I really felt bad" (Swaziland, Manzini 4). Another participant similarly reflected that: "the theatre group

brought out how they feel when they are treated that way. It boils down to the fact that they are human just like the rest of us and we should care how the next person feels" (Lesotho, Mapoteng 2). The participants' responses to how LGBT people feel suggests that invoking emotions through drama can foster understanding and empathy. The way in which the PTI enacted typical, everyday relational situations, such as familial interactions or encounters in a healthcare setting, offers a starting place for the participating audience to understand and empathize with LGBT persons.

The PTI also appeared to increase understanding among LGBT participants. Some participants from the LGBT focus groups articulated how the intervention created awareness of the diversity of experiences within the LGBT communities. As one participant from the Swaziland LGBT focus group stated:

> It's like as a lesbian I can't really relate to gay troubles and as a gay I can't really relate to lesbians and when you see it, it's like honestly it doesn't really matter. It's frustrating: the problems are the same in a way, so I think it builds solidarity and it opens even our eyes to each other struggles, let alone the general population, but it helps us relate with each other in our community so I think I really like that (Swaziland, Manzini 6 LGBT group).

These findings suggest that PTI has the potential for LGBT-identified individuals to begin to gain insight into the problems affecting other LGBT community members and to foster a sense of unity among communities with similar and different needs and issues.

Exposure to LGBT People and Issues.—One of the most significant PTI benefits that participants voiced was that of exposure to LGBT people and issues. Exposure is discussed as a subtheme because it was a feature of the PTI that participants often discussed as facilitating increased understanding of LGBT experiences. LGBT participants discussed the importance of the PTI as an important and accessible forum for introducing community members to the lived experiences of LGBT peoples:

> I think if they see things like this drama they will start to be aware that this things are taking place. How can we help them stop discriminating? So, first is that they have to be aware and be educated. (Swaziland, Manzini 6 LGBT group).

For community stakeholder participants, exposure through the play created a space for participants to reflect on their own understanding of the issues:

> That is why we need these first encounter experiences from those who have gone through this to know that this is what they have had to deal with. The skits really show what is happening in the communities and how long we have to go in terms of education (Swaziland, Manzini 1).

Service providers also discussed the importance of exposure in understanding how to provide services to LGBT persons:

> It provides exposure and we now know that such things happen and we now know how to approach the LGBT people. It helps us know how to provide the best possible care to all people (Lesotho, Maseru 1).

This participant acknowledged how the PTI not only created exposure to issues that LGBT individuals might face in their daily encounters, it also offered an opportunity for audience participants to intervene and change the outcome of the enacted scenario. This allowed participants to perhaps consider new attitudes and behaviors.

In some cases, participants acknowledge the intervention as their first known encounter with LGBT people or issues. One participant in the Swaziland intervention described their surprise, as the PTI was their first *known* engagement with LGBT people: "this was my first encounter with LGBT folk. I am still in shock. I am still wondering if this is real. I think with time I will adjust" (Swaziland, Manzini 1). A strength of this PTI is that it not only promoted understanding about LGBT stigma, it also engaged participants in dialogue with LGBT-identified people, dialogue that participants perceived never having had the opportunity to experience.

In addition to participants discussing how the intervention created a space for exposure, they also communicated a desire to decrease distance between themselves and LGBT people. Decreasing distance was often discussed in terms of creating friendships with LGBT people, friendships that were perhaps never contemplated prior to the intervention:

> Ok now I feel more relieved. I even feel like I could make friends with them. Truly speaking since I was born I have never had a friend in this life of such sexuality. I've never had one. But now it feels like I can have one so I can get closer (Swaziland, Manzini 5).

And,

> Facilitator: Some of us have expressed that they like them from a distance. How many of us feel that way?
>
> Respondent: That is how I felt, way back, but now after watching the skits I somehow wish to have friends who are LGBT so I can learn what they are all about (Swaziland, Manzini 1).

As this last example illustrates, the desire to create friendships with LGBT people was also tied to wanting to foster and deepen understanding of LGBT people and communities. The desire to decrease distance speaks to the impact of exposure as having the capacity to broaden the realm of possibilities for the participants, where prior to the intervention they may have not thought it possible or even conceived of forming relationship with LGBT people.

Changes in Attitude or Perspective.

Participants communicated a change in attitude or perspective that came about through practices of introspection and self-reflection, or through a focus on what knowledge was learned. Participants also discussed the theatre format of the intervention was conducive to changing one's perspective. While many participants communicated a change in attitude, some participants also communicated ambivalence in changing attitude.

Change in Attitude or Perspective through Self-Reflection.—Participants shared how the intervention created a space for them to reflect on themselves. This reflection allowed participants to have more awareness and knowledge of their own attitudes and perspectives, and in some instances, participants voiced a desire to change those attitudes and desires. Some participants also articulated a desire to share new knowledge with others with the aim of expanding awareness within their own communities.

As one participant explains, they had reservations about participating in the PT intervention, but after having done so they feel like they are experiencing a shift in their attitude:

> When I was initially asked to be part of this study, I was so reserved, in fact you do not want associations that will make people think like are you confused. I think coming here, especially after watching the performance, I feel like I am changing my attitude (Swaziland, Manzini 4).

Another participant characterizes their attitude towards LGBT people as a negative one, and reflects on how the play brings up personal feelings of guilt and shame for harboring such an attitude towards LGBT people:

> I felt a guilty conscience because most of the time I treat LGBT people decently whilst I have a very negative attitude about them, deep down inside. Now, after watching the play, I felt very ashamed, because truly they are people, and they have rights (Lesotho, Mapoteng 2).

In reading the participants reactions, it is worth noting how in reflecting on their personal shifts in attitude or perspective participants often discussed their own feelings. Often these feelings were difficult, such as feeling “bad”,“guilty”, or “shame”. Connecting one’s feelings to changes in one’s attitudes relates to the process of increased understanding and empathy that was discussed in the previous thematic section.

Change in Attitude or Perspective through Learning.—In discussing their attitudes and perspective, participants reflected on change with a focus on what was learned through the PT intervention. Rather than articulating changes by explicitly engaging self-reflection, some participants talked more about *what* they learned. For instance, one participant from a Lesotho focus group reflects on several things they learned by taking part in the intervention:

> I am happy and satisfied because this was a great learning experience. I learnt how a person feels is how they really feel and there is nothing we can do about it. I also learnt that we need to take a step back and really analyze whether the way in which we treat these people is okay, and perhaps make some changes. I realized that we have to respect them, in order for them to also respect us (Lesotho, Mapoteng 3).

Another participant reflected on how they learned that discrimination is problematic and that there is a need to change negative attitudes:

> I have learned that discriminating against these people is not right at all; that they are a part of us and that we should commit to changing the negative perceptions of others. It is not always that we will all be the same (Lesotho, Maseru 2).

While participants did not always explicitly communicate changes in their personal attitude, they did communicate learning the need to change the attitudes or perspectives of others.

Participatory Theatre Format as Supporting Change.—In discussing changes in attitude or perspective, participants also explained how the theatre format of the intervention helped in supporting change. Participants communicated how theatre provided an avenue for learning that is distinct from other forms of learning and more interesting. A participant from Swaziland articulated:

> I feel like the way you are bringing the sensitization through the performances is louder, clearer, and it is better than having to sit through a power point presentation. It changes your attitude even better than having to buy a book, because even if there was a book about it, I do not think I would even buy it. But the performance make me more interested, I even want to take the initiative to make this known to my institution (Swaziland, Manzini 4).

As this participant communicated, the theatre performance offers a type of sensitization to LGBT issues that is different from more conventional learning tools. This highlights the appeal of visual and interactive forms of learning that is unique to PTI. Another participant similarly communicated the importance of the visual and interactive aspects of participatory theatre:

> I felt happy that finally someone is actually trying to draw a real picture of what actually happens because all along I have had people talk about the situation, and trying to describe them and not actually trying to portray the real case scenario… Because sometimes you might describe and explain to people and people won't see, but through action drama that we have seen out there it actually shows in reality what is going on out there (Swaziland, Manzini 3).

Participants discussing the significance of the visual and interactive elements of the PT intervention to their learning and change processes is worth highlighting because it speaks to some of the benefits of this kind of intervention.

Ambivalence in Changing Attitude or Perspective.—While many focus group participants described that they experienced a change in attitude towards LGBT people, other participants shared that they felt ambivalent or uncertain about how or whether they ought to change their attitude or perspective. One participant in particular communicated their continued hesitation around accepting LGBT people stating: "I don't want to lie. There is still a long way to go, so I am not totally convinced that they should really be allowed to express themselves. I'm in a dilemma" (Swaziland, Manzini 1). Communicating reservations about moving towards change in attitude or perspective was not unique to this participant. Other participants communicated similar confusion and at times invoked references to religious scripture as a basis for their position:

> I am now confused, after watching this play. Yes, humanity plays a role, everyone should feel free. However, the Bible says it is wrong; yes the person is to be free to be themselves, but then the Bible says it's wrong. So I have a problem; because of

> what the Word of God says. At the same time, when they're happy, I'm happy for everyone to do what they like (Lesotho, Mapoteng 2).

This also highlights tensions between wanting all persons to be happy, and following religious teachings that do not support LGBT persons. The role that religion figures in shaping cultural attitudes towards LGBT is further reinforced by participants' recommendations discussed below that future PTI include religious leaders to foster community change.

Recommendations for Participatory Theatre Interventions.—Focus group participants offered several recommendations for future interventions aimed at reducing stigma towards LGBT people in Swaziland and Lesotho. These recommendations, detailed in Table 2, include expanding intervention to other targeted groups (e.g. school children, heterosexual men, religious leaders) and to rural villages and other regions. Another suggestion was to expand and further develop storylines to focus on forced marriages and the family.

Contextual Differences—Data elicited cultural similarities regarding the influence of factors that shape stigmatizing norms regarding LGBT persons. In both countries participants discussed generational differences in acceptance, with the views and influence of elders perceived as particularly stigmatizing: "The elderly in Lesotho could not talk about LGBT things because they would be regarded as perverts, or Satanists if they did." (Lesotho – Mapoteng 3). Living in rural areas was also discussed as exacerbating stigma for LGBT populations, as expressed by this participant in Swaziland: "In my community I'm from a rural area this thing is totally wrong, it's totally out such that if one realised they will move from the rural to urban areas so that they fit. If you stay there with these habits it's really a taboo." Gender norms were also cited in both countries as sources of stigma. This included *familial expectations of having children* ("I think the stigma there is with them not being able to start a family," Swaziland 3) and *normative gender roles* ("It is expected that when one is male, he shall do everything that is done by male people and similarly, if a person is female then they will do everything which is done my female people. So that has made LGBT people to be shocking to society", Lesotho – Mapoteng 2).

Some cultural differences were noted between the two country contexts. Swazi cultural traditions were discussed as accepting of non-heteronormativity. For instance, in Swaziland participants explained that herbalists often challenged conventional understandings of gender: "When you are training to be a herbalist you can be a female and have male spirits and do manly roles, and that's culture, that is traditional and you can be female and have a spirit that doesn't want anything to do with males but it's ok" (Swaziland 5). Participants also highlighted the impact of organized religion on traditional gender norms: "when religion came it changed a lot of things, culture was rewritten altogether, when before we would have chief having a boy wife whenever they go attack another kingdom they bring their boy wives" (Swaziland 6-LGBT). Lesotho participants suggested the integration of PTI in local community 'Pitsos', traditional tribal meetings in local villages: "we should try to hold some Pitsos in our neighborhoods and villages to shed light on these issues, for some of them are our siblings and colleagues" (Lesotho, Mapoteng 2), and: "things such as holding

Pitsos, creating awareness and going back to the basics of teaching parents and giving them a foundation." (Lesotho, Mapoteng 1 – LGBT). These cultural traditions can be considered as resources for future PTI.

Discussion

Findings suggest that participatory theatre has the potential to promote positive change in attitudes towards LGBT individuals. Qualitative data provided insight into immediate change processes of increased knowledge, empathy, self-reflection, as well as barriers to change. Moreover, these data suggest that increased knowledge can increase understanding of LGBT persons and foster greater acceptance. For instance, participants described no longer having issues with transgender people after they had a clear definition of transgender identity. These results aligns with prior research; for instance, in a U.S. study LGBT youth used PTI to demonstrate typical experiences of stigma to their teachers in order to make the school safer and more inclusive (Wernick, Woodford, & Kulick 2014). As data was collected at one time-point directly following the PTI, they should be considered as immediate reactions to a PTI that can inform strategies for continued engagement on learning and growth regarding LGBT issues.

Participatory theatre generated empathy among participants, corroborating prior research (Etherton & Prentki 2006). Some participants described that the PTI was their first known interaction with LGBT persons. Participants wanted to transfer the empathy they felt for these fictional characters to people they meet in person. Storytelling can depict daily routines participants experience, yet highlight differences due to stigma—this can reach participants on empathetic levels. By connecting to familiar occurrences, stories can create a deeper connection with the shared human experience (Day, 2002). Winston (1999) articulated that emotional feelings, combined with reason, can influence moral action.

Exposure to the vignettes appeared to provide the participants with space to self-reflect, and often for the first time to question thoughts and beliefs regarding LGBT persons. Not all participants, however, changed their attitudes towards LGBT persons. Several participants expressed continued hesitation around accepting LGBT individuals. These results point to a need to explore sustained dialogue and other strategies that address root causes as a barrier to LGBT acceptance, particularly to change long held perspectives.

The study has limitations. Conducting focus groups at only one point in time limits understanding of the durability of PTI effects. It is possible that persons with less LGBT stigma would be more likely to participate in the study, therefore we may overestimate the effectiveness of PTI for persons with more negative attitudes towards LGBT persons. While additional socio-demographic information could deepen understanding of differential PTI experiences across social identities, community-based collaborators requested that we not collect participant sexual orientation in order to promote participant confidentiality and safety. The focus group format could have contributed to social desirability bias, whereby participants may have felt pressure to frame their sense making of the PTI in a more positive light. Despite these limitations, this multi-site qualitative study is unique in LMIC contexts

to demonstrate the potential of participatory theatre methods to increase awareness and positive attitudes toward LGBT persons.

Implications for theory, policy and practice.

Participatory theatre approaches are congruent with an integrated approach to mitigating stigma by addressing social and individual contexts of stigma (Ogden & Nyblade, 2005; Campbell, 2007; Crawford, 2005). Our study suggests that PTI holds promise in Swaziland and Lesotho, but there is the possibility that attitudinal changes may be short-lived. Prior research on PTI to address mental illness stigma demonstrated that immediate attitudinal changes were not sustained (Michalak, Livingston, Maxwell, Hole, Hawke & Parikh, 2014). Structural changes at institutional levels (e.g. hospital, police) may create contexts that support continual self-reflection, learning and non-discriminatory policies to sustain attitudinal changes (Quinlan, 2009). Future PTI research should consider mechanisms to address policy and community level changes in stigma to foster lasting attitudinal changes. Moreover, participants recommended expansion of the PTI to other community members and events. Social ecological approaches to PTI could help broaden the focus to have participants identify individual, community and structural level barriers and facilitators to attitudinal change.

The findings reported here can inform practices to promote health equity with LGBT persons, particularly regarding HIV prevention, treatment and care in these high HIV prevalence countries. Pilot study findings could be expanded to nursing and medical education, as well as national HIV prevention strategies to foster increased awareness of HIV prevention needs of LGBT persons and to improve quality of care for LGBT persons. Stangl et al.'s (2010) study of HIV stigma reduction strategies highlighted PTI was culturally appropriate and effective in promoting understanding of challenges experienced by persons living with HIV, and helped people to recognize their own role in generating HIV stigma. Lyons et al. (2017) reported that a multi-level integrated stigma mitigation intervention in Senegal that targeted men who have sex with men (community level) as well as healthcare workers (structural level) reduced fear of seeking healthcare services. Social justice is required to realize health equity (Braveman, 2014): PTI strategies should address how social injustices among LGBT persons elevate HIV vulnerabilities. Multi-level strategies can use participatory theatre to foster social justice for LGBT persons through raising awareness of LGBT social and health disparities, supporting self-reflection and advocating for changes in policy and practice.

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Table 1,

Overview of Participant Characteristics

	Lesotho n=57	**Swaziland n=49**	**Total N=106**
Gender	**n=57**	**n=48**	**n=105**
Man	19 (33.3)	19 (39.6)	38 (36.2)
Woman	36 (63.2)	27 (56.3)	63 (60.0)
Transgender	2 (3.5)	2 (4.2)	4 (3.8)
Living Area	**n=51**	**n=46**	**n=97**
Rural	10 (19.6)	10 (21.7)	20 (20.6)
Suburban	25 (49.0)	18 (39.1)	43 (44.3)
Urban	16 (31.4)	18 (39.1)	34 (35.1)
Marital Status	**n=57**	**n=49**	**N=106**
Single	38 (66.7)	39 (79.6)	77 (72.6)
Married	16 (28.1)	7 (14.3)	23 (21.7)
Living with Partner	1 (1.8)	3 (6.1)	4 (3.8)
Other	2 (3.5)	0 (0.0)	2 (1.9)
Working Field	**n=50**	**n=37**	**n=87**
Nursing Student	25 (50.0)	6 (16.2)	31 (35.6)
Nurse	2 (4.0)	4 (10.8)	6 (6.9)
Educator	2 (4.0)	6 (16.2)	8 (9.2)
Community Leader	4 (8.0)	4 (10.8)	8 (9.2)
Police	2 (4.0)	3 (8.1)	5 (5.7)
Self-Employed	3 (6.0)	2 (5.4)	5 (5.7)
Not Currently Employed	1 (2.0)	2 (5.4)	3 (3.4)
Other	11 (22%)	10 (27.0)	21 (24.1)

Table 2,

Recommendations for Participatory Theatre Interventions

1. EXPANDING INTERVENTION TO TARGETED GROUPS	
Focus Group	**Quote**
Lesotho, Mapoteng 2	As we are gathered here, so ***heterosexual men*** should also gather and become educated.
	I think education about LGBT people can also ***be given to children at schools because schools form the foundation of our learning***. This is so that when they grow up, they have a full understanding of the gay and lesbian sexuality.
	Heterosexual men are the ones who have the biggest problem with MSM. It would help them to grow up with an understanding. Also, a ***parent who helps their child with homework will benefit in such a way that they will see that LGBTI people exist*** and perhaps they may even have the desire to learn more about it.
	Perhaps there can be a ***workshop held for priests***, by people such as you.
Lesotho, Maseru 1	I think just as we are having this kind of a meeting, ***there should also be similar meetings held for LGBT people alone, and for the parents of LGBT people, where they will also be alone***. I say this because I feel that an LGBT person really needs support from their family, and when they have support, they can be able to cope better.
Swaziland, Manzini 3	I think it might be more effective to ***target more intimate groups*** than large crowds. Like after the skits you look for smaller groups like four or five people and get their reactions. So that people get more real because in a large crowd people would be like oh no, we cannot accept that.
Swaziland, Manzini 1	So there is that need of education around these issues and I think the ***target should be the young people because the older generation is too conservative***, but if we take this kind of drama (skits) to schools and universities, at least people will be enlightened to know that this is real.
2. INTEGRATING INTERVENTIONS INTO EXISTING COMMUNITY EVENTS	
Focus Group	**Quote**
Lesotho, Mapoteng 2	It should be in this interactive format and not in teacher style, if say, it were in the ***form of a Pitso***.
	Yes. I agree with her and I would like to add that we should try to hold ***some Pitsos held in our neighborhoods and villages*** to shed light on these issues, for some of them are our siblings and colleagues.
Lesotho, Mapoteng 1 (LGBT)	In terms of suggesting what should be done in order to make things right; I don't know anymore***. Maybe what is being done; things such as holding Pitsos,*** creating awareness and going back to the basics of teaching parents and giving them a foundation, for I think most of our lives are complicated by parents.
3. FOCUSING INTERVENTION IN RURAL COMMUNITIES	
Focus Group	**Quote**
Lesotho, Mapoteng 2	Drama is an effective form of communication ***and I wish this drama could be mobile and go to the villages where I come from*** so that people can see that it is a mistake to discriminate against others.
Lesotho, Maseru 2	***May the plays please also be shown in the villages***, so that whilst we are educating, we may have the support of these plays, because that is where this type of education is mostly needed.
Swaziland, Manzini 1	Personally because from the cultural point of view I saw while they were playing and for me what they were playing signals what is actually happening in the communities and for me ***I wish they could be expanded into the communities***, so that people would see this in a different light.
Lesotho, Maseru 1	To add, some education about LGBT people and LGBT issues should also ***be passed on in the villages and neighborhoods.***