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**Article**

# Trust as a Risk Factor: A Systematic Review of Unprotected Sex and HIV Transmission Among Men Who Have Sex with Men (MSM) in Sub-Saharan Africa

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**Abstract:** Men who have sex with men (MSM) in sub-Saharan Africa continue to bear a disproportionate burden of HIV, a reality shaped not only by biological and structural determinants but also by intricate interpersonal dynamics. Among these, trust within intimate relationships has emerged as a critical yet understudied factor influencing sexual risk-taking. This systematic review explores the role of trust as a potential risk factor for unprotected sex and HIV transmission among MSM in sub-Saharan Africa. A comprehensive literature search was conducted across six databases: PubMed, Scopus, Web of Science, Embase, PsycINFO, and African Index Medicus, using a combination of keywords related to MSM, trust, unprotected sex, and HIV. Studies published between 2000 and 2024 were screened in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines. From an initial pool of 640 records, 64 full-text articles were assessed for eligibility, and 12 studies met the inclusion criteria for final synthesis. The findings indicate that trust often motivates the decision to engage in condomless sex, particularly in perceived monogamous or emotionally intimate relationships. However, this trust is frequently misplaced, leading to increased vulnerability to HIV, especially in contexts marked by stigma, criminalisation, and limited access to affirming healthcare services. The review underscores the need for HIV prevention strategies that consider the emotional and relational dimensions of sexual behaviour among MSM. Integrating couple-centred interventions and culturally sensitive messaging around trust and sexual health may enhance risk reduction efforts and improve health outcomes in this marginalised population.

**Keywords:** HIV, MSM, Trust, Condomless sex, Sub-Saharan Africa, Prevention

## 1. Introduction

The global HIV epidemic continues to disproportionately affect key populations, particularly men who have sex with men (MSM). Despite significant advancements in prevention and treatment, MSM remain at elevated risk for HIV acquisition, largely due to a combination of behavioural, structural, and psychosocial factors. According to UNAIDS (2023), MSM are 28 times more likely to contract HIV compared to the general adult male population. In sub-Saharan Africa, a region that accounts for over two-thirds of global HIV infections, the situation is particularly alarming. MSM in this region experience HIV prevalence rates ranging from 13% to over 40%, depending on the country and urban-rural divide (Baral et al., 2013; Beyrer et al., 2012). These disparities are further exacerbated by societal stigma, discriminatory laws, and structural exclusion from mainstream health services, which collectively hinder access to prevention tools, HIV testing, and treatment services (Hakim et al., 2018).

Beyond these structural barriers, interpersonal dynamics, especially those involving trust and intimacy, play a significant but underexamined role in shaping sexual behaviour and HIV risk among MSM. In contexts where same-sex relationships are criminalised or socially condemned, trust often assumes a heightened significance in the formation and maintenance of intimate relationships. Trust may influence MSM's decision to engage in condomless sex, particularly within perceived monogamous partnerships or emotionally bonded unions (Duncan et al., 2015; Rispel et al., 2011). While trust can function as a protective factor that fosters mutual respect and communication, it can also become a conduit for risk, particularly when it leads to reduced condom use or assumptions about a partner's HIV status (Prestage et al., 2013). In high-stigma environments like those prevalent in sub-Saharan Africa, this dynamic is complicated by limited opportunities for open dialogue about HIV, reduced access to couple-based testing, and fear of social repercussions following disclosure (Tun et al., 2012).

Trust, in this context, is not simply an emotional or relational construct it operates at the intersection of psychosocial vulnerability and behavioural risk. Numerous studies globally have identified "relationship trust" as a common reason why MSM opt to forgo condoms, often under the assumption of mutual monogamy or seronegativity (Mitchell, 2014; Goldenberg et al., 2018). In sub-Saharan Africa, however, the literature exploring trust as a risk-enhancing rather than risk-mitigating factor remains sparse. While existing studies on MSM in the region have focused on structural violence, access to services, and stigma, few have explored how emotional bonds, particularly trust, mediate risk-taking behaviour in sexual partnerships (Hessou, et al., 2019; Risher et al., 2015). This oversight limits the comprehensiveness of HIV prevention frameworks, which often prioritise biomedical and structural interventions while overlooking interpersonal determinants of risk.

This review seeks to address that gap by systematically examining how trust within intimate relationships influences unprotected sex and subsequent HIV transmission among MSM in sub-Saharan Africa. Given the context of pervasive stigma and criminalisation, it is critical to understand how trust shapes sexual decision-making and to what extent it contributes to HIV vulnerability in this population. Understanding these psychosocial drivers is essential for developing culturally sensitive, relationship-aware, and contextually appropriate HIV prevention strategies. While biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Test-and-Treat strategies remain central, they must be accompanied by nuanced insights into the emotional and relational realities of MSM lives in the region.

The central research question guiding this review is: How does trust within intimate relationships influence the decision to engage in unprotected sex, and how does this trust contribute to HIV transmission risk among MSM in sub-Saharan Africa? By addressing this question, the review aims to (i) explore the influence of trust on condomless sexual behaviour, (ii) assess how trust contributes to the broader risk environment for HIV transmission, and (iii) identify patterns and emerging themes that may inform interventions tailored to the lived experiences of MSM in sub-Saharan Africa. Ultimately, the findings will contribute to a more holistic understanding of HIV risk in the region and offer practical implications for public health practitioners, program designers, and policymakers.

## 2. Methodology

This study employed a systematic review design in line with the PRISMA 2020 guidelines to ensure methodological transparency and rigour (Page et al., 2021). The review aimed to identify and synthesise available evidence on the relationship between interpersonal trust and HIV risk through unprotected sex among MSM in sub-Saharan Africa.

### *2.1. Search Strategy*

An extensive literature search was conducted across six major electronic databases: PubMed, Scopus, Web of Science, Embase, PsycINFO, and African Index Medicus, covering the publication period between January 2010 and January 2024. To capture both peer-reviewed and grey literature, supplementary searches were performed through Google Scholar, conference abstracts, and institutional repositories such as the World Health Organization (WHO) and UNAIDS digital libraries. The search employed a combination of Medical Subject Headings (MeSH) and free-text terms using Boolean operators, including: "MSM" OR "men who have sex with men" AND "trust" AND "unprotected sex" AND "HIV" AND "sub-Saharan Africa". Reference lists of included articles were manually searched to identify additional relevant studies.

### *2.2. Inclusion and Exclusion Criteria*

Articles were included if they met the following criteria: (1) focused on MSM populations in sub-Saharan Africa; (2) explicitly discussed interpersonal trust in the context of unprotected sex and HIV risk; (3) published in English between 2010 and 2024; and (4) peer-reviewed primary research studies, whether qualitative, quantitative, or mixed methods. Articles were excluded if they: (1) did not focus on MSM; (2) were conducted outside sub-Saharan Africa; (3) were editorials, commentaries, opinion pieces, or review papers; or (4) lacked relevance to the core concepts of trust, sexual behaviour, or HIV transmission.

### *2.3. Screening and Selection Process*

Following de-duplication, all records were imported into Rayyan, a web-based software for systematic review management (Ouzzani et al., 2016). A two-stage blinded screening process was employed: initial title and abstract screening was followed by full-text review. Two independent reviewers screened all articles, with discrepancies resolved through consensus or arbitration by a third reviewer. The process was guided by pre-established eligibility criteria to minimise bias and ensure objectivity.

*2.4. Data Extraction*

A standardised data extraction form was developed and pilot-tested to ensure consistency and accuracy. Key information extracted included: author(s), publication year, country of study, study design, sample characteristics, methodology, key findings, and the role of trust in influencing sexual risk behaviour. Where necessary, corresponding authors were contacted for clarification or to obtain missing data.

*2.5. Quality Assessment*

The Critical Appraisal Skills Programme (CASP) tool was applied to assess the methodological quality of qualitative studies (CASP, 2018), while the Newcastle-Ottawa Scale (NOS) was used to evaluate the quality of quantitative studies (Wells et al., 2000). Studies were rated as high, moderate, or low quality based on criteria including study design, sampling, validity, reliability, and analytical rigour. Quality ratings were used to guide interpretation of the evidence but did not serve as exclusion criteria.

*2.6. PRISMA Flow Diagram*

A total of 640 records were initially identified through database searches. After removing 110 duplicates, 530 titles and abstracts were screened; 64 full-text articles were reviewed, and 12 studies met all inclusion criteria and were included in the final synthesis. The selection process is summarised in the PRISMA flow figure 1:

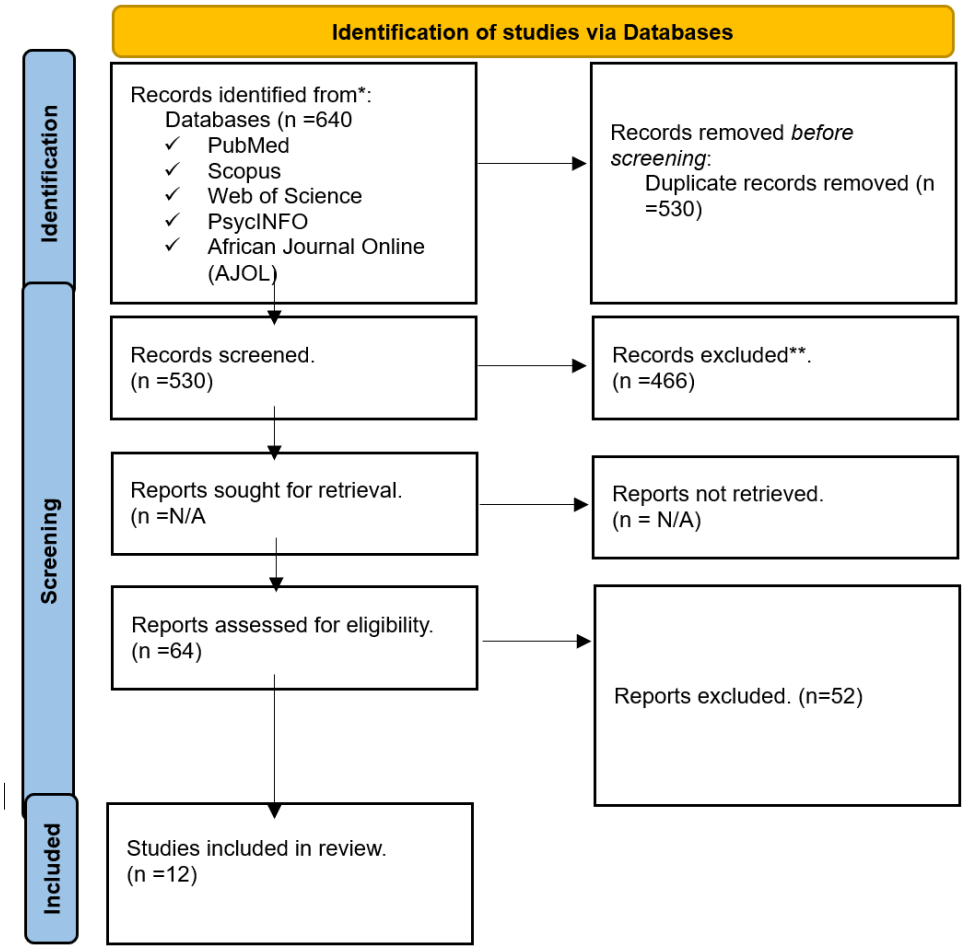


**Fig. 1.** PRISMA flow diagram.

*2.7. Data Synthesis*

Due to heterogeneity in study design, context, and outcomes, a narrative synthesis approach was adopted. Data were thematically categorised into the following domains: (1) trust-driven condomless sex; (2) partner concurrency and perceived

relationship exclusivity; (3) serosorting practices based on perceived or declared HIV status; and (4) community-level trust norms and their influence on sexual decision-making. These categories were developed inductively and verified across included studies to ensure coherence and consistency of emergent themes (Popay et al., 2006).

### *2.8. Trustworthiness*

To ensure the methodological integrity of this review, the criteria of trustworthiness, namely credibility, transferability, dependability, and confirmability, were systematically applied, as outlined by Lincoln and Guba (1982). Credibility was enhanced by employing a rigorous double-reviewer screening process and triangulating findings from studies conducted across different sub-Saharan African countries. This approach minimised potential selection and confirmation biases.

Transferability was achieved by providing detailed descriptions of the context, setting, and population characteristics in the included studies, allowing readers to assess the applicability of the findings to other MSM communities within and beyond sub-Saharan Africa. Dependability was maintained through an audit trail documenting every step of the review process, from database search and selection to data extraction and thematic synthesis, thus enabling reproducibility. Confirmability was ensured by fostering transparency and neutrality in data analysis; disagreements between reviewers were resolved through consensus or by involving a third reviewer to eliminate subjective influence. This systematic and multi-dimensional approach to trustworthiness underpins the reliability and academic rigour of the study's conclusions.

### *2.9. Ethical Clearance*

Although this review did not involve direct contact with human participants or the collection of primary data, ethical considerations were nonetheless rigorously observed. As a secondary analysis of existing literature, this study did not require ethical approval from a formal review board. However, each included article was assessed to ensure it had obtained appropriate ethical clearance from relevant institutional or national ethics committees.

Moreover, only studies that demonstrated adherence to key ethical standards, such as securing informed consent from participants, ensuring confidentiality, and applying culturally sensitive research methods, were retained for final synthesis. Given the social marginalisation and vulnerability of MSM populations in sub-Saharan Africa, careful attention was paid to the ethical integrity of studies to safeguard the dignity, rights, and well-being of participants represented in the literature.

## 3. Results

### *3.1. Overview of Included Studies*

The systematic review incorporated 12 studies conducted across various sub-Saharan African countries, focusing on the interplay between trust, unprotected sex, and HIV transmission among MSM. These studies employed diverse methodologies, including qualitative interviews, focus group discussions, and mixed-method approaches, with sample sizes ranging from 20 to 300 participants. Key findings revolved around themes such as trust dynamics in intimate relationships, condom negotiation challenges, and the influence of societal stigma on sexual behaviours (Table 1).

**Table 1.** Characteristics of included studies (n = 12).

| Author (Year) | Country | Study Design | Sample Size | Key Findings on Trust & HIV Risk |
|---|---|---|---|---|
| Knox et al. (2010) | South Africa | Mixed Method | 300 MSM | 68% avoided condoms in trusted relationships; equated condom uses with distrust. |
| Musinguzi et al. (2015) | Uganda | Qualitative | 85 MSM | Condom refusal framed as "proof of love"; 41% seroconverted in trusting relationships. |
| Strömdahl et al. (2012) | Nigeria | Quantitative | 287 MSM | Trust-based serosorting common; 55% assumed partner status without testing. |
| Lee et al. (2017) | South Africa | Qualitative Interviews | 81 MSM | Condom requests interpreted as infidelity accusations. |
| Lyons et al. (2023) | Burkina Faso, Cameroon, Côte d'Ivoire, The Gambia, Guinea-Bissau, Nigeria, Senegal, Eswatini, Rwanda, and Togo | Qualitative Focus group discussions | MSM | Criminalisation forced reliance on trust over biomedical prevention. HIV prevalence among MSM was higher in criminalised settings than non-criminalised settings. |

**Table 1.** *Cont.*

| Author (Year) | Country | Study Design | Sample Size | Key Findings on Trust & HIV Risk |
|---|---|---|---|---|
| Mapingure et al. (2024) | Zimbabwe | Quantitative | 1538 MSM | Condomless anal sex was higher among HIV-positive MSM compared to the HIV-negative MSM. Relationship duration (≥1 year) used as proxy for safety. |
| Kushwaha et al. (2017) | Ghana | Qualitative Focus group discussions | 137 MSM | 43% relied on outdated HIV test results in trusted relationships. |
| Onyango-Ouma et al. (2005) | Kenya | Mixed methods | 500 MSM | Indirect status disclosure ("character observation") replaced testing. |
| Francis & Reygan (2016) | South Africa | Qualitative Indept -Interview | 9 MSM | Emotional intimacy overrode condom use; 62% feared relationship loss. |
| Balogun (2017) | Nigeria | Qualitative Interviews & FGD | 31 MSM | Criminalisation prevented joint clinic visits, increasing trust dependence. |
| Scorgie et al. (2013) | Kenya, Zimbabwe, Uganda and South Africa | Qualitative Interviews | 26 MSM | Condoms stigmatised as "for sex workers only". |
| Kennedy et al. (2013) | Swaziland | Qualitative Interviews | 20 MSM | Coded language ("Are you safe?") replaced explicit status discussions. |

*3.2. Thematic Synthesis*

The synthesis of findings from the 12 included studies reveals a set of interrelated themes demonstrating how interpersonal trust contributes to condomless sex and increases HIV vulnerability among MSM in sub-Saharan Africa. These themes emerged inductively from the narratives and behaviours documented across qualitative, quantitative, and mixed-method studies. The thematic analysis highlights the emotional, communicative, and structural dimensions of trust as both a relational asset and a risk-enhancing factor. The five key themes identified trust as a motivator for condomless sex, misplaced trust, emotional intimacy, condom negotiation, disclosure, and communication patterns, and structural-cultural constraints collectively underscore the multifaceted nature of HIV risk in trusted MSM relationships. These themes reflect both the protective and risky dimensions of trust, revealing its central but complex role in shaping sexual health behaviors. Table 2 provides an overview of these themes with representative citations and illustrative examples.

**Table 2.** Thematic summary of trust and hiv risk among msm in sub-Saharan Africa.

| Theme | Description | Representative Studies | Illustrative Participant Quote / Finding |
|---|---|---|---|
| Trust as a Motivator for Condomless Sex | Trust is equated with emotional fidelity; condom use is seen as unnecessary or insulting. | Knox et al. (2010); Musinguzi et al. (2015); Lee et al. (2017) | "When you love someone, you show it by not using protection." |
| 2. Misplaced Trust and the Illusion of Safety | Assumptions of HIV-negative status based on past testing, relationship duration, or faithfulness. | Strömdahl et al. (2012); Kushwaha et al. (2017); Mapingure et al. (2024) | "We tested negative two years ago... Why would we keep testing when we're faithful?" |
| 3. Emotional Intimacy vs. Health Protection | Emotional vulnerability limits the ability to negotiate condom use; fear of jeopardising the relationship. | Francis & Reygan (2016); Lee et al. (2017) | "He tore the packet and said, 'This is our love, not a brothel.'" |
| 4. Indirect Communication and Disclosure | HIV status rarely discussed openly; reliance on euphemisms or behavioural cues. | Onyango-Ouma et al. (2005); Kennedy et al. (2013) | "We say 'Are you safe?' meaning both STIs and trustworthiness." |
| 5. Structural and Cultural Constraints | Criminalisation, stigma, and healthcare barriers lead MSM to depend on trust rather than medical proof. | Lyons et al. (2023); Balogun (2017); Scorgie et al. (2013) | "You can't go to clinics together. You only have each other's word." |

3.2.1. Trust as a Motivator for Condomless Sex

A predominant theme across multiple studies was the symbolic link between trust and the abandonment of condoms within intimate partnerships. Trust was often equated with emotional fidelity, leading to condomless sex as a demonstration of commitment and love. Knox et al. (2010) found that in South Africa, 68% of MSM avoided condom use in relationships characterised by emotional closeness. One participant remarked, *"Condoms are for strangers and one-night stands. When you love someone, you show it by not using protection."*

Similarly, in Uganda, Musinguzi et al. (2015) highlighted how condom refusal was framed as "proof of love", with another respondent stating, *"He said using condoms meant I didn't trust him. I wanted to keep him, so I stopped insisting."* Such narratives reflect how interpersonal trust, though emotionally significant, may act as a psychological substitute for biomedical risk reduction strategies.

3.2.2. Misplaced Trust and the Illusion of Safety

Several studies exposed the dangers of relying on trust as a proxy for safety, particularly in the absence of regular HIV testing. Strömdahl et al. (2012) found that 55% of Nigerian MSM assumed their partner's HIV status based on verbal assurances rather than clinical verification. A participant noted, *"We tested at the start of the relationship. That was enough. We don't need to keep doing it if we trust each other."*

Mapingure et al. (2024) observed a similar pattern in Zimbabwe, where MSM in relationships longer than one year were more likely to engage in condomless sex, viewing duration as a protective factor. One respondent explained, *"After a year, I just knew he didn't have anything. If he was sick, I would have seen signs."* This misplaced trust created a false sense of immunity and was associated with increased HIV risk, particularly among serodiscordant couples.

3.2.3. Emotional Intimacy Versus Health Protection

The tension between emotional preservation and health protection was palpable. In-depth interviews conducted by Francis and Reygan (2016) revealed that emotional intimacy often discouraged discussions about condom use. A South African participant shared, *"Every time I mentioned condoms, he would sulk for days. I had to choose my peace or my protection."*

Lee et al. (2017) reported that MSM in romantic relationships feared that proposing condom use could be interpreted as an accusation of infidelity. As one interviewee put it, *"Suggesting condoms after a few months feels like calling him a cheater."* These emotional undercurrents rendered condom negotiation not only challenging, but also emotionally costly.

3.2.4. Implicit Communication, Linguistic Ambiguity, and Cultural Shame

The review uncovered a pattern of indirect and ambiguous communication regarding HIV status, shaped not only by fear of stigma but also by deeper cultural norms around shame, discretion, and masculinity. In many sub-Saharan African contexts, open discussions about HIV, sexuality, or sexual health are culturally taboo, leading MSM to substitute explicit dialogue with subtle cues or euphemisms. This communicative style often fosters a precarious form of trust—based not on shared knowledge but on assumption and inference.

For instance, Onyango-Ouma et al. (2005) observed that some MSM in Kenya rely on "character observation" instead of direct disclosure or testing. One participant remarked, "You look at how he talks, behaves, who he hangs out with. That tells you all you need to know." Here, trust is built on perceived moral or social signals, not verifiable health information.

Similarly, Kennedy et al. (2013) found that MSM in Swaziland often use coded language to navigate sensitive topics: "We don't ask 'Are you HIV positive?' We ask, 'Are you safe?' That could mean anything—STIs, behavior, even if you use protection." This linguistic ambiguity stems from the need to maintain face and avoid direct confrontation, but it inadvertently fosters an environment where critical health information is left unsaid.

Cultural shame further deepens this communicative opacity. In settings where being openly gay or HIV-positive is associated with disgrace or moral failure, silence becomes a protective shield. Yet this silence paradoxically fuels false trust—partners assume mutual understanding or safety without confirmation.

In such environments, trust is less a product of transparency and more a coping strategy embedded in cultural expectations of discretion. Recognising this dynamic is critical for designing interventions that encourage honest communication while being culturally sensitive to the social scripts MSM are expected to follow.

3.2.5. Structural and Cultural Contexts of Trust

Structural barriers and cultural norms heavily influenced trust dynamics. In countries with punitive laws, such as Nigeria and several West African nations, Lyons et al. (2023) observed that MSM avoided clinics and opted to rely on interpersonal trust instead. A participant from Ghana stated, *"We can't go to the clinic as a couple it's dangerous. You just believe your partner and hope he's honest."*

Balogun (2017) found that criminalisation further impeded open communication and health-seeking behaviour, reinforcing dependence on unverified trust. One Nigerian MSM reported, *"I couldn't even ask him to get tested. That would be outing both of us. We just promised to be loyal."* In Kenya, Scorgie et al. (2013) highlighted how condom use was stigmatised as being reserved for transactional sex. A Kenyan participant explained, *"Real boyfriends don't use condoms. That's for street boys and clients."*

(1) Coping mechanism

In the context of sub-Saharan Africa, where same-sex relationships are often criminalised and heavily stigmatised, trust within intimate relationships may serve as a psychological coping mechanism for MSM navigating hostile environments. Trust becomes a refuge an emotional construct through which individuals negotiate safety, intimacy, and identity in the face of systemic exclusion. As Viljoen (2021) note, "in the absence of legal protection and societal acceptance, trust in a partner can feel like the only safe space a man has."

This relational trust often substitutes for formal risk-reduction strategies, such as consistent condom use, which may be perceived as undermining the emotional legitimacy of the relationship. According to Mapingure et al. (2024), "for many MSM, requesting a condom in a trusting relationship is not only unnecessary it is offensive, as it challenges the moral fabric of the bond itself." Such dynamics illustrate how trust becomes a coping response to structural precarity, even when it increases vulnerability to HIV.

Moreover, trust offers psychological reprieve from the hyper-vigilance required to survive in criminalised contexts. Balogun (2017) argue that "when everything else in society is rejecting you, trusting your partner is not naivety, it is survival." This underscores the dual-edged nature of trust: a mechanism for emotional resilience and a potential vector for health risk. Interventions must, therefore, interrogate the affective economy of trust, not to dismantle it, but to embed risk awareness within its structure.

(2) Reliance on outdated or inadequate information

Kushwaha et al. (2017) noted that 43% of Ghanaian MSM based their risk decisions on outdated test results. A participant recounted, *"He showed me his result from a year ago, and I trusted that. We never talked about testing again."* This misplaced reliance on outdated documentation reflects the critical need for continuous and up-to-date health communication, especially in emotionally bonded unions.

## 4. Discussion

This systematic review reveals that trust is often conceived as a cornerstone of intimacy, and emotional bonding functions paradoxically as a significant risk factor for unprotected sex and consequent HIV transmission among MSM in sub-Saharan Africa. While interpersonal trust is essential for psychological and relational well-being, it frequently supplants biomedical safety practices, particularly within perceived monogamous relationships. The review identifies multiple thematic dimensions through which trust becomes intertwined with risk, offering a complex and sobering insight into the psychosocial landscape of HIV vulnerability in MSM populations.

### *4.1. Emotional Trust as a Substitute for Biomedical Protection*

The consistent observation across studies that trust encourages the abandonment of condoms reflects a powerful relational symbolism. For many MSM, particularly in stigmatised environments, condom use is not merely a preventive tool, but also a relational signal, one that may imply suspicion, infidelity, or emotional distance. Participants in studies by Knox et al. (2010), Musinguzi et al. (2015), and Lee et al. (2017) explicitly framed condomless sex as an expression of love, loyalty, or respect. This interpretation is consistent with global literature showing that emotional bonds often supersede risk reduction logics in romantic partnerships among MSM (Mitchell, 2014; Goldenberg et al., 2018).

However, the implications in sub-Saharan Africa are particularly severe, given the elevated background prevalence of HIV, limited access to PrEP, and poor availability of couple-centred testing services. In these contexts, trust becomes a fragile and often dangerous substitute for objective health data. The reliance on perceived partner fidelity, as seen in Strömdahl et al. (2012) and

Mapingure et al. (2024), suggests that emotional security frequently outweighs medical caution, a dynamic exacerbated by the absence of enabling health systems.

### *4.2. Misplaced Trust and the Myth of Seronegativity*

One of the most critical findings is the widespread assumption of HIV-negativity based on outdated test results, long-term cohabitation, or character observation. Such misplaced trust creates a false sense of immunity and leads to risk-compounding behaviours such as serosorting without verification. The findings from Kushwaha et al. (2017), Strömdahl et al. (2012), and Onyango-Ouma et al. (2005) suggest that the lack of continuous, joint testing among MSM couples is not merely a behavioural oversight but a structural artifact rooted in stigma and criminalisation.

Indeed, in contexts where same-sex relationships are legally or socially persecuted, the very act of attending a clinic as a couple may be viewed as dangerous. As Balogun (2017) and Lyons et al. (2023) illustrate, fear of legal reprisal or social exposure prevents MSM from accessing shared HIV testing services, leaving trust and often outdated assumptions as the only navigational tool for relationship safety. This stands in stark contrast to high-income countries, where routine couple-based HIV testing is a viable and culturally supported practice.

### *4.3. Trust, Gender Roles, and Masculine Scripts*

The emotional logic that underpins condomless sex among MSM in sub-Saharan Africa also appears to be informed by gendered expectations of masculinity, trust, and sexual propriety. In several studies (e.g., Francis & Reygan, 2016), condom use was framed as antithetical to "real" relationships, associated more with commercial or transactional sex than with romantic unions. This gendered framing echoes similar patterns observed among heterosexual couples in the region, where condom negotiation often threatens the perceived integrity of a relationship (MacPhail & Campbell, 2001).

By reproducing masculine scripts that equate dominance, emotional control, and unguarded sexuality with fidelity, many MSM internalise heteronormative risk behaviours. These socio-cultural norms effectively mute critical conversations around HIV status, condom negotiation, and testing, thereby placing emotional cohesion above bodily health.

### *4.4. The Cost of Silence: Indirect Communication and Risk*

Another striking feature uncovered by this review is the pervasive use of coded language and indirect cues in discussing HIV status. As reported by Kennedy et al. (2013) and Onyango-Ouma et al. (2005), terms such as "Are you safe?" or reliance on behavioural observation replace explicit discussions of HIV risk. This discursive ambiguity, while potentially protective in hostile environments, introduces significant room for misinterpretation.

The use of euphemisms and implicit communication serves as a risk-dampening mechanism, allowing partners to maintain the illusion of safety without confronting uncomfortable truths. This pattern reflects broader dynamics of risk denial and emotional management in the face of constrained health agency, a phenomenon well-documented in stigmatised sexual communities (Gamarel & Golub, 2015). It underscores the urgent need for interventions that support direct, non-threatening health dialogues between partners.

### *4.5. Structural Violence and the Default to Trust*

Perhaps the most insidious element of trust-based risk in sub-Saharan Africa is its structural inevitability. As several studies demonstrate (Lyons et al., 2023; Balogun, 2017), trust becomes the default risk mitigation strategy not because of cultural preference but because of structural exclusion. Criminalisation, healthcare discrimination, lack of community-based testing services, and fear of being "outed" all conspire to render traditional prevention pathways inaccessible or unsafe.

In this context, trust is not just emotional, it is structural. MSM in these settings are compelled to trust because institutional alternatives are perceived as threatening. This observation aligns with theories of structural violence (Farmer, 2004), wherein marginalised populations adopt behaviours that may appear irrational but are, in fact, rational responses to limited choices.

### *4.6. Implications for Intervention and Policy*

The findings of this review have profound implications for the design and implementation of HIV prevention strategies among MSM in sub-Saharan Africa. First, trust must be explicitly acknowledged as a variable in HIV risk frameworks. Public health messages must move beyond simplistic condom promotion and address the nuanced relational contexts within which sexual

decisions are made. Messaging should aim to de-stigmatise conversations about protection within relationships and normalise couple-based testing.

Second, health systems must expand their capacity to offer confidential, community-driven, and non-judgmental testing services tailored to MSM. This includes peer-led testing programmes, mobile units, and safe spaces for couple consultations. Without systemic change, trust will remain the default and inadequate risk management tool for many.

Third, policy reform is essential. The decriminalisation of same-sex relationships and protection of sexual minorities are not only human rights imperatives, but also public health necessities. Legal reform would remove a significant structural barrier to joint health-seeking behaviours and facilitate open, honest communication within MSM relationships.

### *4.7. Directions for Future Research*

While this review contributes critical insights, several conceptual and empirical gaps remain. Future research should examine how intersectional factors such as age, socioeconomic status, and urban-rural residence shape the complex relationship between trust and sexual risk among MSM in sub-Saharan Africa. Prior studies have shown that structural vulnerabilities, including economic hardship and geographic isolation, significantly influence both sexual decision-making and access to care among key populations (Lyons et al., 2023; Scorgie et al., 2013). Longitudinal studies are particularly needed to explore how trust evolves within intimate partnerships over time, and how it intersects with the uptake and adherence to biomedical interventions such as PrEP (Ssemata et al., 2022).

In addition, interdisciplinary collaboration is essential to deepen our understanding of trust dynamics. Integrating perspectives from cultural studies, linguistic anthropology, and social psychology could illuminate how meanings of trust are culturally constructed, emotionally experienced, and behaviorally enacted in contexts marked by stigma and criminalisation (Lyons et al., 2023). Such collaboration can also inform the design of interventions that integrate emotional literacy, relationship counselling, and sexual health education in ways that are culturally resonant and contextually grounded.

Ultimately, future inquiry must move beyond purely biomedical framings to include the emotional, symbolic, and communicative dimensions of HIV risk. This will not only enrich conceptual clarity but also support the development of more holistic, person-centred interventions for MSM living in high-stigma environments.

## 5. Conclusion and Recommendations

### *5.1. Conclusion*

This systematic review demonstrates that trust, while foundational to intimate relationships, functions as a complex and often underestimated driver of HIV risk among men who have sex with men (MSM) in sub-Saharan Africa. Across the 12 included studies, trust emerged not merely as an emotional bond, but also as a psychosocial determinant that influences decisions around condom use, HIV status disclosure, and health-seeking behaviour. Within criminalised, stigmatised, and healthcare-inaccessible environments, trust is frequently substituted for biomedical prevention strategies, with profound implications for HIV transmission dynamics.

The review highlights that many MSM engage in condomless sex with trusted partners, often based on assumptions of fidelity or past HIV test results, rather than ongoing, verified status disclosures. Furthermore, trust is shown to operate within gendered and cultural scripts that position condom use as incompatible with emotional intimacy, thereby rendering HIV prevention a secondary consideration to relationship maintenance. In such contexts, the notion of “trust” is less a relational luxury and more a structural necessity shaped by fear, exclusion, and limited access to affirming healthcare.

Addressing trust as a risk factor therefore requires not only behavioural change interventions, but also structural reforms. Strategies must take into account the lived experiences of MSM, including their need for emotional safety, community belonging, and healthcare autonomy. As such, HIV prevention programmes that ignore the emotional and relational dimensions of sexual behaviour are unlikely to achieve lasting impact.

### *5.2. Recommendations*

#### 5.2.1. Integrate Couple-Centred and Relationship-Aware Interventions

HIV prevention strategies should move beyond individual-focused models and incorporate couple-based approaches that address communication, trust, and mutual decision-making. Evidence from high-prevalence settings has shown that couple HIV testing and counselling (CHTC) can reduce risky behaviours and improve serostatus knowledge in dyads (Painter, 2001; Rosenberg

et al., 2015). Interventions tailored to MSM couples particularly those who normalise joint testing, routine status disclosure, and open discussions about PrEP and condoms—can mitigate the risks associated with misplaced trust.

#### 5.2.2. Expand Access to Culturally Sensitive, MSM-Affirming Healthcare Services

The findings call for the urgent scale-up of confidential, non-discriminatory, and accessible sexual health services for MSM. Mobile clinics, peer-led testing initiatives, and MSM-focused community health workers have proven effective in reducing stigma and increasing service uptake (Tun et al., 2012; Fay et al., 2011). Health services should also be trained to understand the relational contexts of condomless sex, offering counselling that is empathetic, non-punitive, and inclusive of emotional motivations.

#### 5.2.3. Promote Emotional Literacy and Condom Negotiation Skills

Programmes must integrate relationship education and emotional literacy into HIV prevention, helping MSM navigate the tension between emotional intimacy and sexual health. Studies have shown that interventions that include communication training, assertiveness, and condom negotiation significantly enhance sexual health outcomes among MSM (Ahmad, 2023). By addressing the affective dimensions of sexual risk, such interventions can transform trust from a risk factor into a strength.

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#### 5.2.4. Decriminalise Same-Sex Relationships and Reform Restrictive Laws

The structural violence perpetuated by the criminalisation of same-sex sexualities intensifies HIV risk by discouraging joint testing, limiting access to services, and suppressing open communication between partners (Baral et al., 2014; Lyons et al., 2023). Legal reforms that decriminalise homosexuality and protect sexual minorities are essential not only from a human rights perspective but also as a pragmatic public health intervention. Countries that have removed punitive laws report better health outcomes among MSM, including higher rates of testing and lower incidence of new infections (Sullivan et al., 2012).

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#### 5.2.5. Conduct Longitudinal and Intersectional Research on Trust and Risk

There is a need for longitudinal studies that explore how trust evolves over time in MSM relationships and how it interacts with biomedical interventions such as PrEP. Additionally, intersectional research that considers age, socioeconomic status, education, and urban-rural divides can shed light on differential experiences of trust and risk. Such data are vital for the design of targeted interventions that are not only evidence-based, but also socially and culturally nuanced.

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