ADVANCING PARTNERS & COMMUNITIES

ADDRESSING STIGMA AND GENDER-BASED VIOLENCE TO IMPROVE HIV SERVICE DELIVERY TO KEY POPULATIONS: FINDINGS FROM A RAPID ASSESSMENT

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Advancing Partners & Communities

Advancing Partners & Communities (APC) is a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID), under agreement no. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc., in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

International Center for Research on Women

The International Center for Research on Women (ICRW) is a global research institute with headquarters in Washington, DC, and regional offices in Nairobi, Kenya, and New Delhi, India. Our research evidence identifies women's contributions as well as the obstacles that prevent them from being economically strong and able to fully participate in society. ICRW translates these insights into a path of action that honors women's human rights, ensures gender equality, and creates the conditions in which all women can thrive. ICRW's mission is to empower women, advance gender equality, and fight poverty in the developing world.

Recommended Citation

CONTENTS

ABBREVIATIONS AND ACRONYMS

AIDS	acquired immune deficiency syndrome
amfAR	The Foundation for AIDS Research
APC	Advancing Partners & Communities
CSW	commercial sex worker
DPP	director of public prosecution
FACT	Family Awareness Consciousness Togetherness
FGD	focus group discussion
FSW	female sex worker
G+	The Network of Guyanese Living With and Affected By HIV/AIDS
GBV	gender-based violence
GOG	Government of Guyana
HIV	human immunodeficiency virus
ICRW	International Center for Research on Women
IPV	intimate partner violence
KP	key population
LGBT	lesbian, gay, bisexual, and transgender
LGBTI	lesbian, gay, bisexual, transgender, and intersex
M&E	monitoring and evaluation
MOH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Committee
NAPS	National AIDS Programme Secretariat
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
S&D	stigma and discrimination
SASOD	Society Against Sexual Orientation Discrimination
STI	sexually transmitted infection
SW	sex worker
TG	transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's' Emergency Fund
USAID	U.S. Agency for International Development

EXECUTIVE SUMMARY

"Often there are reports of violence but there is no support; the major issue is [a lack of] shelter for [women] and children, school and economic support during the transition period. As a result, persons don't have an alternative option and are forced to endure punishment." **(Dr. Ruth Ramos, National Care and Treatment Centre, Ministry of Public Health)**

Around the world, there is growing recognition that ending the AIDS epidemic will depend largely on reaching key populations (KPs) with HIV prevention, care, and treatment services (UNAIDS 2014). Yet stigma, discrimination, and violence remain formidable obstacles to achieving this goal and must be effectively addressed by national AIDS programs in order to expand access to and uptake of these services (UNAIDS 2014; Israel, Laudari, and Simonetti 2008; amfAR 2010). In Guyana, there is concern that KPs are not being adequately reached with services and that insufficient frameworks, policies, and regulations are contributing to the marginalization of those at greater risk of HIV infection.

The Advancing Partners & Communities (APC) initiative, supported by the U.S. Agency for International Development (USAID) and implemented by JSI Research & Training Institute, Inc., in partnership with FHI 360 and the International Center for Research on Women (ICRW), seeks to strengthen the capacity of local nongovernmental organizations (NGOs) in Guyana to provide HIV prevention, care, and treatment services to KPs at heightened risk of HIV infection—men who have sex with men (MSM), transgender (TG) individuals, and sex workers (SWs)—and women. The rapid assessment presented in this report was conducted to gather information on the programmatic and capacity needs of the NGOs supported through the APC to implement services for KPs as well as the structural challenges faced by these NGOs.

The following findings were synthesized from interviews and focus group discussions (FGDs) with staff from thirteen NGOs and nine key stakeholders from the Government of Guyana (GOG) and development agencies.

KEY FINDINGS

Context

- Despite growing acceptance of people living with HIV (PLHIV) by the general population, members of KPs living with HIV are still subjected to high amounts of shaming and blaming in their communities.
- In institutional settings, attitudes and behaviors of staff toward PLHIV, MSM, and SWs have improved—but more programmatic efforts are needed to sustain these gains. High rates of staff turnover, particularly among police and health care workers, impede progress in stigma reduction.
- Homophobia and the illegal status of same-sex sexual behavior seriously impede progress in reaching MSM with life-saving services. Many, if not most, MSM live on the "down-low," maintaining marriages and families while having sex with men in secret. In addition, homophobia and harmful gender norms inhibit help-seeking for intimate partner violence (IPV) among MSM.
- Sex workers continue to face stigma and discrimination (S&D) in health care facilities and from police, which significantly reduces their willingness to engage with HIV prevention, care, and treatment services or seek help from the police when needed.
- Transgender individuals are subject to extremely high levels of violence. In the past year, one organization reported that six of its members were murdered. While data on the size of the TG population and HIV prevalence among TG individuals are lacking in Guyana, HIV prevalence is quite high among members of Trans United Guyana, with an estimated 50 out of 100 members living with HIV. Women in Guyana face high levels of violence, particularly IPV, which increases their vulnerability to HIV infection. NGOs are struggling to meet the needs of clients experiencing violence and have requested training, tools, and resources.

Recommendations for New Structural Directions

- *Institutionalize rigorous training in professional schools on S&D pertaining to HIV and KPs.* Given the high turnover of staff in many institutional settings and the limited resources available to support NGO-run trainings of new staff, trainings on HIV, S&D among KPs, and harmful gender norms that perpetuate gender-based violence (GBV) should be integrated into the curriculum of professional training programs for doctors, nurses, social workers, police, and teachers.
- *Train police officers for more appropriate and effective GBV response and violence prevention.* There is an acute need for police to be more responsive when women, men, TG individuals, and MSM report partner violence, sexual assault, and hate-based violence/harassment. Police abuse of SWs, TG individuals, and MSM must also end.
- *Expand shelter and economic empowerment opportunities for survivors of violence.* Given the high levels of IPV in Guyana, limited availability of shelter, and the fact that economically self-sufficient individuals are more likely to exit abusive relationships, there is a clear need for more GBV shelters and related economic empowerment efforts for GBV survivors throughout the country.

Recommendations for New Programmatic Directions

- *Shift norms among the general population.* Several NGOs noted that given the high prevalence of harmful gender norms, violence, and negative attitudes toward KPs, they want support in developing media campaigns and edutainment initiatives to foster community and national dialogue and change. There was also strong interest in working specifically with men for violence prevention, stigma reduction, and the promotion of healthy masculinities.
- *Expand educational sessions with youth in schools.* Several NGOs expressed a desire to be able to do more with youth in schools to promote sexual health and reduce harmful gender norms and stigmatizing attitudes.
- *Expand and enrich support groups for KPs.* Given the importance of support group sessions for helping clients overcome internalized stigma and engage in health-protective behavior, many NGOs were eager to increase the frequency of these group sessions and expand the range of topics addressed during the sessions.
- *Empower survivors of violence to facilitate exiting a relationship.* Several organizations noted that economic empowerment helps women exit violent relationships, and they expressed interest in expanding efforts to empower survivors of violence.

Capacity Needs

NGOs expressed the following capacity-strengthening needs:

- Training in basics of GBV (including IPV, non-partner sexual assault, and hate-based violence and harassment)
- A GBV screening tool and training on how to use it
- Refresher training on stigma, with a focus on KPs
- Support to monitor and evaluate their efforts to reduce stigma and GBV
- Support to expand and develop new edutainment strategies to reach the general population

The findings of this rapid assessment will inform the development of a training course and ongoing technical assistance to enhance the capacity of local organizations to integrate stigma and GBV prevention and response activities into their work and expand their HIV-related services to better meet the needs of KPs and women.

INTRODUCTION

Around the world, there is growing recognition that ending the AIDS epidemic will depend largely on our collective ability to reach key and vulnerable populations with HIV prevention, care, and treatment services (UNAIDS 2014). Yet these populations face a number of challenges, including stigma, discrimination, and violence, which must be effectively addressed by national AIDS programs to expand access to and uptake of available services (UNAIDS 2014; Israel, Laudari, and Simonetti 2008; amfAR 2010).

In Guyana, adult HIV prevalence is relatively low. According to the *Global AIDS Response Progress Report*, the prevalence is 1.4 percent (Presidential Commission on HIV and AIDS 2014). However, prevalence among KPs is much higher, with reports of 19.4 percent among MSM and 16.6 percent among female sex workers (FSWs) (Presidential Commission on HIV and AIDS 2014). While data are limited in Guyana, other groups, also referred to as priority populations, such as migrants, mobile populations, and survivors of violence, are considered more vulnerable to HIV infection. Over the past six years, Guyana has seen a decline in HIV prevalence among adults in general and in KPs (Presidential Commission on HIV and AIDS 2014). While these trends are encouraging, HIV remains the sixth leading cause of death among people ages 25–44 in Guyana, and there is an increasing feminization of the epidemic, with more women affected than men (Guyana Ministry of Health 2006).

There is concern that KPs are not being adequately reached with services and that insufficient frameworks, policies, and regulations are contributing to the marginalization of those most at risk of HIV infection. In addition, while Guyana has achieved universal coverage of antiretroviral therapy, reaching populations in the hinterland regions with HIV testing, care, and treatment services remains a challenge (Guyana Ministry of Health 2006). Consequently, the GOG has prioritized reaching those most at risk, and USAID's strategy reflects this shared commitment.

The *Guyana National HIV/AIDS Strategic Plan, 2007–2011*, indicates overlapping individual and societal factors driving the epidemic. These include multiple concurrent partners, inconsistent condom use, low perception of risk, substance abuse, myths about transmission, poverty, population mobility, violence, and gender inequity (Guyana Ministry of Health 2006). It is also well established that HIV S&D fuel HIV transmission and impede access to services. Stigmatizing attitudes in the general population and discriminatory treatment by actors ranging from health care providers to policymakers intensify the marginalization of vulnerable groups. This reality, along with mounting evidence on effective stigma-reduction strategies, highlights the need for bolstering the multisectoral national response.

GBVis another notable risk factor for HIV, as well as a barrier to preventing and treating HIV. Global evidence indicates that GBV is both a cause and consequence of HIV. For example, individuals with abusive partners are less able to negotiate condom use with their partners, and PLHIV are at elevated risk of partner violence and victimization as a result of disclosing their HIV status (Klot and Ngueyn 2009; Gupta 2000a, 2000b; Maman et al. 1999, 2002; Jewkes, Levin, and Penn-Kekana 2003). In Guyana, few data exist on GBV; however, available resources (PEPFAR 2011) indicate that it is very common, with "research on sub-populations [suggesting] that as many as two-thirds of all women will face abuse at some time.… Furthermore, the crimes are under-reported and victims often do not seek assistance."

Violence toward MSM and TG individuals is also a common occurrence (Equal Rights Trust and Society Against Sexual Orientation Discrimination [SASOD] 2012). Homophobia, transphobia, and violence toward these populations heighten their risk of HIV infection. These attitudes are enshrined in the legal framework of Guyana, which criminalizes homosexuality, thus perpetuating a climate conducive to violence and mistreatment of these groups (Jeffries et al. 2013; Adebajo et al. 2012; Laws of Guyana; Huebner et al. 2002).

Efforts to reduce GBV and S&D directed at KPs are critical to a successful national response to HIV. The APC initiative, supported by USAID and implemented by JSI Research & Training Institute, Inc., in partnership with FHI 360 and the ICRW, seeks to strengthen the capacity of NGOs in Guyana to provide HIV prevention, care, and treatment services to KPs at heightened risk of HIV infection—MSM, TG individuals, and SWs—and women.

The purpose of this rapid assessment was to gather information on the programmatic and capacity needs of and the structural challenges facing the NGOs supported through the APC in their work with KPs. The findings will inform the development of a training course and ongoing technical assistance to enhance the capacity of local organizations to integrate stigma and GBV prevention activities into their work and expand their HIV-related services to better meet the needs of key and priority populations.

METHODOLOGY

The rapid assessment was conducted with representatives from fifteen NGOs, as well as nine key informants: five members of the Ministry of Health (MOH), two members of other governmental institutions, and two members of development partner organizations (see appendices 1 and 2 for a list of participating organizations).
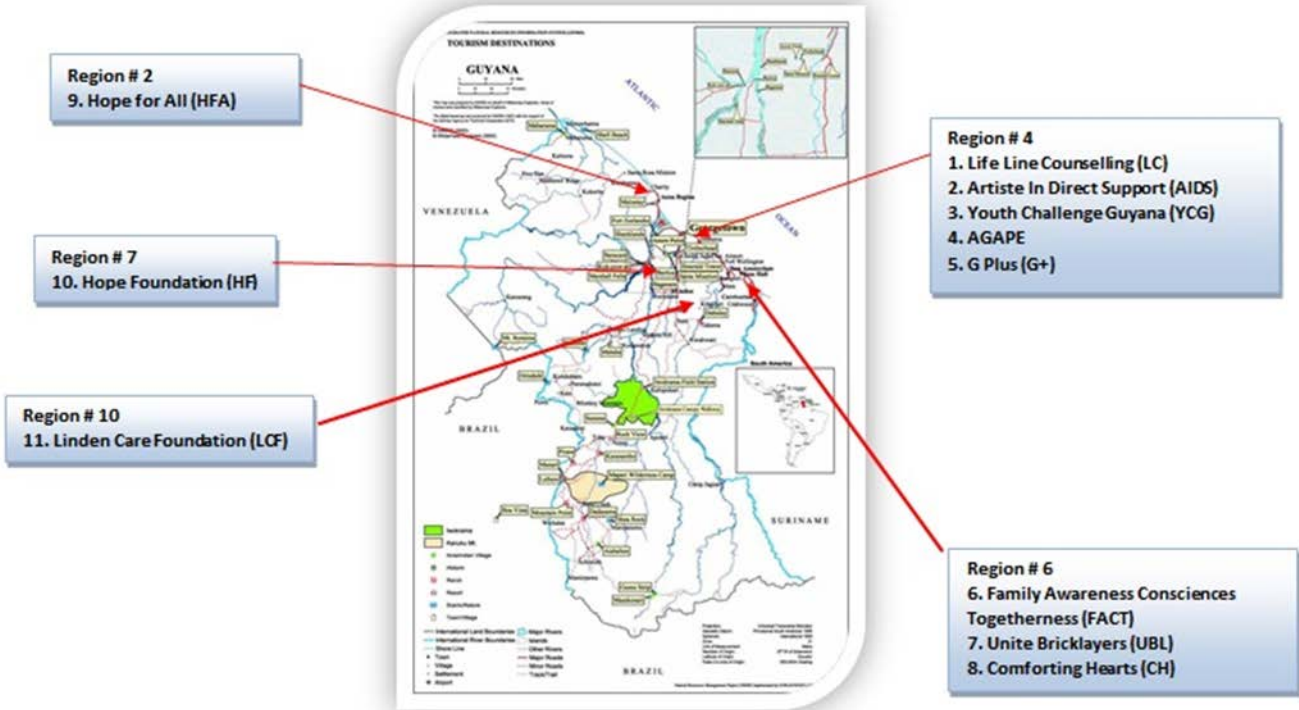

Figure 1: Diagram showing the map of Guyana and Advancing Partners and Communities (APC) supported Non-Governmental Organisation

Figure 1 depicts the regions of Guyana in which the various NGOs work. Participants consisted of (a) frontline staff or administrators within NGOs implementing HIV and GBV services across Regions 1–7 and 10 and (b) policymakers or program managers within governmental institutions addressing HIV, gender, and/or GBV. Participants were recruited on the basis of their involvement in HIV or GBV service delivery within NGOs or their involvement in policy development and strategic planning within governmental and development agencies.

Interviews took approximately 90 minutes and were conducted between June and July 2014. Two additional NGO interviews, with SASOD and Trans United Guyana, were conducted in October 2014, following feedback from stakeholders who reviewed the draft rapid assessment report in October, to better capture the experiences of the TG community with regard to stigma and GBV. Data were collected using a semi-structured interview guide (see appendices 3 and 4). No personal information was requested in this rapid assessment. All interviews were conducted in English, recorded, and transcribed. The investigators analyzed the transcripts to identify key themes and other salient findings.

Prior to the initiation of fieldwork, the rapid assessment received a non-research determination from the Institutional Review Board of ICRW and was approved by the ethics committee of the Guyana MOH.

LIMITATIONS

It is relevant to note that our findings are synthesized from interviews with NGO staff and key informants, but we were not able to directly interview clients of the services discussed, police, or health care providers. However, several of the NGO respondents were also KP members (MSM, PLHIV, TG individuals, and SWs). Our findings are based on a relatively small number of qualitative interviews. However, the sample size was suited to the objective of this assessment, which was to identify gaps in current capacity among APC-supported NGOs to develop training materials and tools to support the NGOs in their stigma- and GBV-reduction work.

With these limitations in mind, our findings do provide a current window into the experience and perspectives of key organizations and practitioners in the country. The findings will inform the development of a training course and ongoing technical assistance to enhance the capacity of these organizations to integrate stigma and GBV prevention and response activities into their work and enrich their HIV-related services to better meet the needs of KPs throughout the country.

FINDINGS AND DISCUSSION

In seeking to understand challenges and successes experienced in delivering HIV prevention, care, and treatment services to key and priority populations, we explored perceptions about the level of and current responses to HIV and KP S&D and GBV in Guyana. We also discussed new directions for programmatic work and the capacity needs of organizations to enhance efforts to address stigma and violence. These themes were discussed with NGO staff, government officials, and development partners.

PERCEPTIONS ABOUT STIGMA AND DISCRIMINATION

Both NGO staff and key stakeholders noted that S&D toward PLHIV have diminished in severity over the past decade, but negative and judgmental attitudes persist.

> *Persons are seeing the benefits of treatment, they are able to live healthy lives, and HIV is no longer a death sentence. This has contributed to a decrease in S&D since there is no way persons can classify or identify anyone with HIV.* **(Dr. Ruth Ramos, National Care and Treatment Centre, MOH)**

> *Over the years I've seen a lot that has been done … to reduce stigma and discrimination, but I still feel there are pockets of it.* **(Agape Network)**

> *With all the work we've done in this area, I still find people stigmatize and discriminate against [women living with HIV]. They keep away from them, they don't want anything to do with them. People talk.…* **(Help and Shelter)**

While increased knowledge about HIV transmission and the availability of antiretroviral therapy seem to have contributed to greater tolerance toward PLHIV among the general population, shame and blame are still prevalent—particularly toward KPs such as MSM and SWs.

> *I don't think we have a lot of stigma leveled against people who live with HIV. That was in the early days. But I think now people are not fearful of getting tested … and people are dealing better with people living with HIV, I guess because of the medication and because you can look so well—it is not a scary, sick-looking person, it is not a death sentence. So I think there is less stigma and discrimination against those with HIV. But if you are a gay man and you have HIV, it is your lifestyle. Gay men—they already have the stigma attached to them that they are the ones who brought it to our country. There is still that stigma, more for men than women.* **(Artistes in Direct Support)**

> *Societal views have given rise to prejudice and discriminatory practices towards MSM and SWs, including PLHIV, but to lesser extent for PLHIV.* **(Dr. Shanti Singh, National AIDS Programme Secretariat [NAPS])**

Stigma also seems to vary by geographic location. In remote areas, where education levels and awareness of HIV are low and the reach of NGOs and government services is particularly limited, stigma toward PLHIV is reported to be still common and often severe.

> *Most people who find out they are living with HIV leave the [hinterland] region because of the stigma. Especially among Amerindians, they kick [PLHIV] out. There was one girl who found out she was HIV-positive. She didn't know what to do so she told her cousin. The cousin told her mother and the mother told the chief, and [the girl with HIV] had to move. She was kicked out of the community. And another thing we have found out when we go into these areas is that if someone finds out you have HIV, nobody will accept food or drink from you.* **(Youth Challenge)**

> *When we were in Moruca [Region 1] the last time, one of the community leaders said that if he knew someone in the community who was living with HIV, he would "treat them with a long spoon." And he*

said that in his community there is a lot of stigma. That doesn't mean we aren't working with the community, but in those communities there is a lot of work to be focused. **(Hope for All)**

Likewise, in some urban areas with high rates of poverty and illiteracy, HIV-related stigma seems to persist.

…we have the information and the knowledge, but there are still instances where people will say "Oh, I have HIV," and not everyone is going to be out there with open arms and love you.… I think that is specific to this area because of the demographics of this area. Sophia is known as one of those places with high marginalization, high poverty, high illiteracy. You name it, we have it. I think those demographics play into the reactions people have to being [HIV-] positive. **(Agape)**

Stigmatizing attitudes can also vary greatly between towns in the same region. For example, NGO staff of Family Awareness Consciousness Togetherness (FACT) in Skeldon noted that people in the community were open to change and were more tolerant toward PLHIV and KPs. Conversely, one hour's drive away in New Amsterdam, NGO staff from Comforting Hearts and United Bricklayers noted high levels of intolerance toward these populations, which fostered non-disclosure of HIV status and fears of going to the main hospital for HIV care and treatment services.

Now that persons are more knowledgeable, they will tend to act better towards people. The sessions at the hospital and at the police are helpful initiatives in that it reduced a lot of stigma in accessing services. **(FACT)**

The [negative] attitude of the general community and health care workers affects services. In terms of the general community there is an STI [sexually transmitted infection] testing site. As soon as somebody will see you going there, you are HIV-positive. **(United Bricklayers)**

INTERNALIZED STIGMA

Internalized stigma, also called "self-stigma," comprises three steps: awareness of stigmatizing public attitudes, agreement with it, and applying it to oneself. Self-stigma within KPs prevents individuals from pursuing opportunities fundamental to their best interest—like accessing and using evidence-based practices that prevent HIV infection. Internalized stigma is a well-established barrier to medication adherence among PLHIV and can inhibit uptake of HIV-related services. According to both NGO staff and government stakeholders interviewed, internalized stigma remains a problem among PLHIV and KPs and merits further attention and programmatic response.

Members of key populations harbor a lot of self-stigma. **(Mr. Nazim Hussain, NAPS Coordinator)**

In terms of stigma in the community, it's very sad. You used to hear about people being stigmatized and discriminated against, they got called names, were attacked, whatever. We are not getting that complaint as much now, not even in the workplace, because most people are saying they have HIV-in-the-workplace policies and they have manuals too. So people are getting more comfortable. What I think is the most challenging is self-stigma. So I think the individuals in the population need a lot more sensitization in terms of dealing with themselves. **(Hope for All)**

Several NGO staff described the importance of support groups for helping PLHIV and members of KPs, such as MSM and SWs, to address and overcome self-stigma. The key challenge these NGOs face is the lack of financial resources to continue hosting support groups, which has led to reductions in the frequency of support group sessions or inability to hold the sessions at all. In addition, several NGOs requested capacity-strengthening to expand the content of support group sessions to better address issues of stigma and violence toward KPs.

With some of our MSM, when we have [a] support group it was really good for them because some were HIV-positive, they have to deal with the lifestyle in the community and with their family. And then too they have to deal with their status, being HIV-positive, which is difficult for them because they have no one to talk to. So now when they come to the support sessions, they can express themselves and how

they feel. And the support sessions help to build their self- esteem. And it helps for them to see themselves as a normal person and not somebody that should be cast away from society. So the support sessions that we used to host were very good for the MSM and the SWs. **(Linden Care Foundation)**

While individual-level interventions such as support groups are important for helping PLHIV and KPs overcome internalized stigma, it should be noted that internalized stigma is driven in large part by harmful societal level norms and discriminatory attitudes. Therefore, community-level interventions that aim to reduce discriminatory attitudes and increase support of PLHIV and KPs will also be needed to reduce internalized stigma significantly.

STIGMA IN INSTITUTIONAL SETTINGS

Several NGOs have been conducting stigma reduction trainings in the health care sector, with police, in schools, and with employers over the past few years. While the impacts of these efforts have not been formally assessed, the NGO respondents thought the trainings had done a lot to reduce stigmatizing attitudes and behaviors in these settings, based on changes they observed following the trainings. For example, FACT staff described how using contact strategies, in which members of KPs present or co-facilitate a training, helps to break stereotypes and negative attitudes held by participants about certain groups, namely because they have never had contact with a member of this group.

> *There have been changes—because when we start to conduct the session we invite the FSW, we invite the MSM to be part of the training, part of the workshop. So doctors, nurses, sisters, nobody would even know that there are MSM and FSWs there. You know, so everybody gives their view to respect each other's values, everybody said how they feel about this person, everybody is able to share and at the end come to one common goal that you are not only treating these persons because they are MSM or FSWs or they are having a same-sex relationship but you are treating them as a human.* **(FACT)**

> *We used to see a lot of stigma from the police, especially with sex workers, so … we had a session about this … and once the new police officers have been trained we will go to the training site and do follow-up sessions with them so they are aware of the issues [SWs] have faced.* **(United Bricklayers)**

> *My responsibility was training the workers at the Ministry of Labour. Then they would go on to do training at the workplaces.* **(Artistes in Direct Support)**

Some organizations also noted that structural changes had occurred following stigma-reduction trainings, which ultimately increased access to services for KPs.

> *[Now a] person can eas[il]y access service at the hospital without any barrier because first, if a FSW were to walk through the hospital with [a strapless top], they would be turned away. They would be told to go home. But that is what they wear.… [This was] against the policy of the health system. You [would] have to be well-covered before you [could] see a doctor. But that stopped over a period of time [during the training]. Because [the health workers] would get to realize that this person, this is how they make a living, and these are the only kind of skimpy clothes that they would have, so they should not be hindered from getting patient care and treatment.… [Now] you come in how you are, how you dress, and you can access your care and treatment.* **(FACT)**

The main challenge reported was that the trainings had short-lived effects due to high rates of staff turnover— particularly among health care workers and police.

> *We do not see 100-percent changes [among health care workers and police] because every now and then the shift change[s], police come and go, nurses and doctors, that is why [training] has been an ongoing thing for us all the time.* **(FACT)**

> *The only time you would have difficulty when it comes to stigma and discrimination, when it comes to the treatment site, is when you have a change in staff and the person has to get acquainted and sensitized.* **(Comforting Hearts)**

To address the high turnover rates, some NGOs have strengthened relationships with local health care providers and police to do ongoing sensitizations for new workers and specifically-scheduled trainings as needed. For example, the local hospital in New Amsterdam now calls United Bricklayers for sensitization training when they have new staff.

> *The hospital is now calling us when they have new staff, and now somebody goes every Friday to do this. What they will also do is they will call us to meet with them for specific appointments and to perform [sensitization trainings].* **(United Bricklayers)**

> *We have an ongoing stigma and discrimination session normally held at a hospital and that usually with the police force and the police organization in the community.* **(FACT)**

Despite the improvements reported and the strategies NGOs are adopting to try to maintain stigma reduction in institutional settings, it appears that more programmatic efforts are needed. For example, many incidents of inappropriate behavior by the police—ranging from name-calling and refusal to follow up on crimes reported to actual physical and sexual assault of PLHIV, MSM, and SWs—were noted by the NGO staff interviewed.

> *There is no justice from the police force, so SWs don't report violence that they experience. Officers sexually assault SWs; they don't address violence.* **(The Network of Guyanese Living with and Affected by HIV/AIDS [G+])**

> *Because of how these [hinterland] regions are structured, the only people you can rely on are the police. And sometimes the police become violent, and what we have to do is to try and identify an organization that can intervene on behalf of a client.* **(Youth Challenge)**

> *I don't think that the laws are enforced. I think the laws are there and can be used if people feel like using them because the police will use it if they want. A lot of times they want to have sex with those MSM.… So they do use the law for that.* **(Artistes in Direct Support)**

In the health sector, it appears that stigma can vary by health facility as well as by provider, with some hospitals and private clinics refusing to treat PLHIV or treating PLHIV poorly.
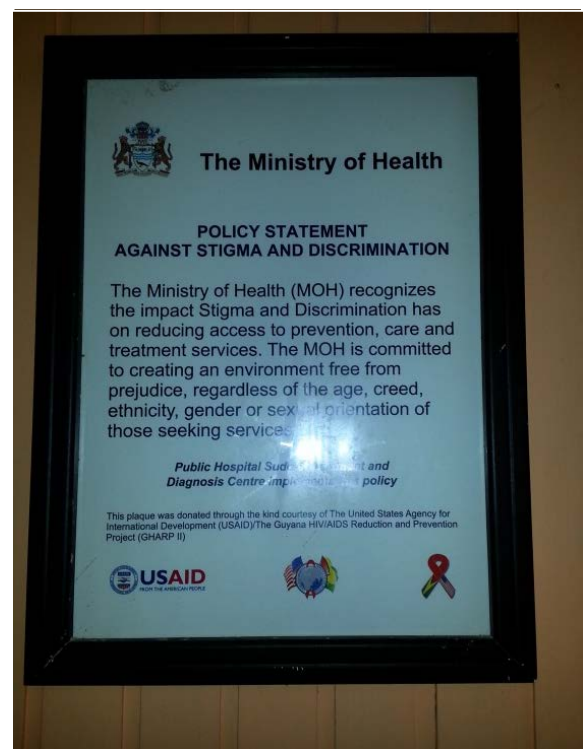
> *We've had a client who explained to me that he has visited the Diamond Diagnostic Centre, a health facility on the East island.… He was supposed to have surgery.… He said he was going through all the tests they need to have done, the last thing they were supposed to have done was for him to have an HIV test, and they say they checked his hemoglobin and stuff like that. And he said he volunteer[ed] the information. He said to the nurse, "I am HIV-positive. I am on treatment." And the doctor said, "OK, well, we can't do your surgery."* **(Lifeline)**

When clients reported experiences of health facility S&D to NGO staff, NGO staff often contacted the health facility to report these experiences, with varying degrees of success.

Figure 2. Non-Discrimination Policy Statement

> *We file complaints about stigma and discrimination that PLHIV experience at treatment and care facilities, and the management of these facilities tends to be responsive. They may reassign that worker to a different area, but it's hard to fire them.* **(G+)**

In addition, almost all of the NGO respondents noted that they accompany their new clients to the health facility to help them feel safe and comfortable navigating HIV-related services and ensure that they go. Some also noted that accompaniment is often only necessary for the first few visits, and then most clients become comfortable going to the clinic on their own.

Since 2012, all public and private health facilities have been required to post the non-discrimination policy shown in Figure 2. The MOH also now requires that anonymous suggestion boxes be placed in health facility waiting areas so clients can report bad experiences or abuse; some clients are uncomfortable using these boxes, however, because they are typically placed right at the receptionist's or nurse's desk.

> …all health care settings were required to have these two plaques placed in their setting where the public can see it. And they are also given a suggestion box and so if people thought they were discriminated against and they didn't want to go complain they will just write it and drop it into the box. And the head of the health center is responsible for opening that box and addressing whatever situation it is. **(Artistes in Direct Support)**

> …nobody wants to go to the suggestion box because the suggestion box was placed right by the nurses. **(Youth Challenge)**

Stigma, homophobia, and harmful gender norms in secondary schools, among both administrators and students, were noted as a concern by NGO staff and government stakeholders alike.

> Sometimes [lesbian, gay, bisexual, and transgender (LGBT) youth] are expelled because of their [flamboyant] behavior in the schools.… The parents don't know that you cannot expel children because of this, so when the headmaster says that the child is expelled they will take the child with them.… **(United Bricklayers)**

> We have found that school teachers are very insensitive and irresponsible when dealing with [an] issue of this nature; there are reports of them breaching children's confidentiality and telling the child's peers not to play with the child since they are HIV-positive. **(Dr. Ruth Ramos, National Care and Treatment Centre, MOH)**

To address these issues at the request of the MOH, some NGOs have conducted sessions on HIV, sexuality, and violence in the classroom setting or through afterschool sports-based programs. Other organizations try to assist informally in the schools when invited by school administrators.

> [Our peer educators] are required to do sessions in the schools to support the Ministry of Education's Health and Family Life program. So they do awareness of HIV, STIs, and sexuality with the students in the schools. **(Youth Challenge)**

> We do work with youth in school. We work in schools even though it's not funded because we have a relationship. They call us in, and we try to do stigma and discrimination work. **(Artistes in Direct Support)**

> UNICEF [(United Nations International Children's Emergency Fund) supports us to implement] a program with a cultural aspect and a sporting aspect, where there are training portions developed by a committee and you work with students teaching them sports. You realize that apart from being in school and learning, they are more informal methods of learning taking place when they are active and participating in sports. **(FACT)**

The two main obstacles NGOs are facing in this work are (a) "limitations on what they are able to discuss with school children in the classroom, given current laws in Guyana and the need to follow the Health and Family Life Education Programme,[1] and (b) the recent shift to having teachers leading these sessions instead of NGO staff".

> [Criminalization of same-sex relationships and prostitution] does affect the organization, because when we go out there to educate [children], there is a limit to how much we can educate them. We have to know our limits because Guyana is governed by a constitution that says these things [are illegal]. **(United Bricklayers)**

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[1] The Health and Family Life Education Programme is a comprehensive life skill program. Its primary focus is to teach students "critical life skills that are necessary for applying values, becoming independent thinkers, actively participating responsible citizens and to increase the awareness of children and youth, in formal and non-formal sectors, of the fact that the choices they make daily will profoundly influence their health and personal development. The areas addressed are sexuality and sexual health, self and interpersonal relationships, appropriate eating and fitness, and managing the environment.

Addressing Stigma and Gender-based Violence

…there is not a whole lot of NGO involvement like it used to be in the initial stages.… The students don't feel comfortable discussing it with the teachers.… While the teachers were there doing a session, the children weren't willing to discuss certain things … and when the teachers were excused out of the session, [the students] were very vocal. **(FACT)**

We need to start introducing them to the issues of GBV and STIs, because since we've started working with the Ministry of Education we've found that kids are more comfortable talking about these issues to social workers rather than teachers. **(United Bricklayers)**

In workplaces, NGOs have worked at both the structural and organizational levels to reduce HIV-related S&D.

For example, Artistes in Direct Support trained Ministry of Labour staff on how to guide workplaces in the development of policies to prevent HIV-related S&D at their sites, and Comforting Hearts conducted workplace trainings directly with employers and employees. While the general sense is that these trainings went well, again, there are no evaluation data regarding the impacts on attitudes and behaviors.

[The organizations we trained] had services brought to the workplace. So you would have a counseling and testing day where all the staff would get counseling [and] testing. Or they would send outside and ask someone to do a session on whatever issue they had. A lot of times it was stigma and discrimination. **(Artistes in Direct Support)**

We would also do training in the workplaces, train peer educators, and we would hope that after training those in workplaces and in faith-based and other groups that they would continue to distribute this information to staff and others. **(Comforting Hearts)**

Workplace discrimination seems to depend on the employer, with some businesses open to employing PLHIV and others enacting subtle forms of discrimination, such as having PLHIV work in the back of the store, away from the public.

Stigma is still there in the workplace. Gossip, ostracization. People stop sitting with them for lunch, won't use the same bathroom. Employers also decrease the workload of PLHIV so they'll leave the job. **(G+)**

There is still some stigma leveled against people with HIV in the workplace, but they never say they are sending them off because of HIV—it is always because of something else. But there are more workplaces embracing people with HIV than before. **(Artistes in Direct Support)**

There were also some reports of employers requesting to see the HIV test results of employees.

[A client] had palliative care for over three months, then she had some challenges where she had to have certain tests done, like she had tuberculosis, and then had to have … those tests done all over again and so on and [her employer] wanted to have a report. I knew that for a fact. It was an environment like that where I saw some of the requests that were made [by her boss], and I'm like, these results should not be going to a boss. **(Lifeline)**

STIGMA AS A BARRIER TO HIV SERVICES

Both NGO staff and government stakeholders expressed that S&D continue to impede access to and uptake of HIV care and treatment services for both PLHIV and KPs.

[Stigma] is directly preventing persons from accessing HIV services. They are not enrolling, or if they do, it is late, their viral load is high and CD4 is low. The fear of discrimination from clinic staff, family, and supportive friends contribute to the reluctance. **(Dr. Rosalind Hernandez, Pan American Health Organization/World Health Organization)**

When PLHIV perceive stigma at a treatment facility, like negative body language, they're less likely to return. We work with clients, provide psychosocial support in dealing with stigma, and encourage them to return to care regardless of it. **(G+)**

I think stigma and discrimination is the main driver. Because once people have become stigmatized, they become closeted. People don't want to go to uptake services, even though you plan to navigate them. I remember waiting all day for a woman because she didn't even want to be seen. So stigma and discrimination is still the main driver and a violation of human rights. And it prevents our clients from uptaking their services. (Linden Care Foundation)

Opinions about the influence of stigma on HIV testing were mixed. Youth Challenge staff members said they do not think HIV stigma is a barrier to people in the general community getting tested; they suggested that the primary barrier is the cost of getting to the service—but that "once people know the service is available, they will come, and there is no stigma surrounding testing."

On the other hand, United Bricklayers noted that HIV stigma may indeed inhibit HIV testing in New Amsterdam.

There is an STI testing site. As soon as somebody will see you going there, you are HIV-positive. The site is also a clinic for mothers and babies, but if they don't see that you're pregnant they will think you are HIV-positive. (United Bricklayers)

For KPs, many of the NGO and government stakeholders interviewed thought that stigma inhibits testing.

I think the MSM are at risk because they won't be able to access the services they need because of the stigma that exists towards MSM. (Youth Challenge)

If [members of KPs] can't come to us for tests we take the test to them. Especially for MSM—they don't want to come into New Amsterdam. So we will tell them to go to a certain place and we will go to them. (United Bricklayers)

According to some NGO staff, fear of public outing is a major concern among many PLHIV and can keep people from accessing treatment and care at their local health clinic in a timely manner.

Now the treatment site is based in the public health sector, and much of the staff knows or are related to people in the area. So chances are that when somebody is diagnosed with HIV, they already know a staff member at the clinic.… So it's one of the hardest transitions, from positive diagnosis to accessing care … because [the health care provider] might be the type to stigmatize against PLHIV. (Comforting Hearts)

ANTICIPATED STIGMA AND VIOLENCE

The anticipation or fear of experiencing S&D if one's HIV-positive status becomes known appears to be a major challenge. Several NGOs linked clients' non-disclosure to fear of experiencing stigma. They noted that this resistance to disclosure was impeding adherence to treatment and also acceptance of the social support services offered by the NGOs and government ministries.

I don't think there is as much of that shunning and putting aside people but there is still that "I'm not that open to talk about it." That's just generally. In Sophia specifically we have had cases where people and disclosure is a big issue with clients, and we are really looking at how to address that. People are afraid to disclose, because they don't know what is going to happen. (Agape Network)

Clients…feel that they do not want to disclose and they do not want our people to come and visit them. And that is one of the difficult things because then we cannot form a proper support system for our clients. We can't work with family members, and considering the place we work in it is hard to get resources. We want that support network so if someone does get sick someone can take them to the doctor, make sure they take their meds, and it's difficult to do that if they don't disclose. (Agape Network)

Anticipated stigma seems to be informed by reality in many communities. For example, Comforting Hearts noted that it has seen many negative reactions to sero-status disclosure, ranging from family break-ups to clients

being shunned by family members to clients having no one to take them to the hospital when they are sick. Several NGOs noted that families often view HIV as something immoral and shameful that negatively affects the family's reputation.

> *I think it's a reflection of how the epidemic has developed over the years. Say, if my friend is dying of cancer, I want to be there for my friend until the end. But if I hear that a friend or family member is dying from AIDS, I will tend to be more withdrawn and stay away, because they got that through immoral means. So with that, it's just not associating with that person and staying away from them as long as possible.* **(Comforting Hearts)**

In addition, disclosure of HIV status is also inhibited by fear of experiencing partner violence. Help and Shelter noted that women who disclose their HIV-positive status to a partner are at higher risk of violence. Fear of violence or being put out of the home leads women living with HIV to continue having unprotected sex with their partners, without disclosure of their status.

> *The threat of violence presents a major restriction for accessing care. This has resulted in many women missing clinical appointments, not adhering to medication and not practicing healthy behaviors.* **(Dr. Ruth Ramos, National Care and Treatment Centre, MOH)**

> *There was one client we were working with that didn't want to disclose [to her spouse] because "If I tell him, he is going to kill me." I feel that the disclosure issues that we face could be connected in one instance to the violence that happens. Sophia generally has an issue with violence. Violence in terms of children, violence in terms of GBV, violence in terms of people just fighting.* **(Agape Network)**

INTERSECTIONS OF STIGMA, DISCRIMINATION, AND VIOLENCE

Key and vulnerable populations often face stigma on multiple fronts, which can manifest in discrimination and violence. In this section, we examine the stigma, discrimination, and violence experiences of MSM, lesbians, TG individuals, SWs, and women in more detail and discuss how these experiences can hinder utilization of HIV prevention, care, and treatment services.

Men Who Have Sex with Men

Homophobia and Cultural Geography

Both NGO staff and government stakeholders noted high levels of homophobia in Guyanese society overall. Help and Shelter noted that "in general, people in communities don't accept" MSM and that homosexuality is viewed "as a wicked act, an abomination." Respondents stated that homophobia is particularly pronounced in urban areas, Afro-Guyanese communities (which have a higher proportion of Christians), and among men—and that there is less homophobia in indigenous, East Indian, and rural communities. United Bricklayers also noted high levels of internalized homophobia among MSM. Stigma toward MSM is also very prevalent in mining communities.

> *Let me tell you something about the mining camps. These people are very superstitious. They live by the code of the mining camps which say[s] it's an abomination—we went in there last month to talk about having sex with men and using condoms and you should have been hearing what they said. Talking about lighting them on fire and everything.… In the interior mining communities we don't get many reports of there being MSM.* **(Youth Challenge)**

Sophia and New Amsterdam were also highlighted as areas with particularly high levels of homophobia and social value given to "bad men" (i.e., men who embody dominant masculine ideals such as strength, toughness, and having lots of women). United Bricklayers suggested that homophobia in New Amsterdam is driven in part by illiteracy and masculinity norms, which dictate that men should be "macho." Hence the common vernacular term for MSM in Guyana is "anti-man."

Homophobia and the illegal status of same-sex sexual behavior have fostered a substantial reality of men living on the down-low, maintaining marriages and families and having sex with men in secret. Artistes in Direct Support thinks that "the majority" of MSM in Guyana are on the down-low or closeted.

> So for MSM, because society is not open to that population, MSM are more closeted. So they are not coming out to access the services. We currently do not have an MSM program at our organization but that does not mean we don't have MSM in our region. We do, but they are not coming out to access the services, and a lot of that has to do with self-stigma and their perceptions of how people will treat them. *(Hope for All)*

> The men who have sex with both men and women, they have an issue with S&D since it's frowned upon in Guyanese society to be bisexual. This is the driving force behind the epidemic, they are closeted and don't consider themselves as MSM. *(Ms. Deborah Success, NAPS Coordinator)*

At the same time, there are events where the LGBT community is highly visible and people are willing to openly participate, such as the Mashramani float parade that occurs in all regions of Guyana, and the Ms. Gay Glory Pageant which is held in Georgetown.

Forms of Violence Experienced by Men Who Have Sex with Men

Help and Shelter suggested that the physical violence experienced by MSM is "mostly partner violence." Respondents also noted that homophobia fosters verbal harassment and physical and sexual violence against MSM by community members and police. United Bricklayers noted that outside New Amsterdam, where MSM are more likely to cross-dress, "a lot of them … are being targeted in the community by police officers."

Artistes in Direct Support noted that Guyana's prostitution and sodomy laws tend to be inconsistently enforced, that police often have sex with MSM, and that MSM have been physically and sexually assaulted by police. Also, MSM are robbed and killed by clients in the course of sex work. Physical violence between MSM occurs, including a recent murder/suicide when one man wanted the other to stay away from his partner, stabbed the partner and the rival, and then killed himself. Artistes in Direct Support also noted that MSM sometimes engage in harassment, catcalling at seemingly straight men on the street.

Homophobic violence by community members usually takes the form of multiple people attacking one person. For example, a boy was murdered a few years ago by a group of people; less severe examples of violence by community members include throwing bottles at MSM at a nightclub in response to homophobic lyrics in a song. Artistes in Direct Support noted that "most of the discrimination" against MSM comes from other men.

Homophobia and Harmful Gender Norms Diminish Gender-based Violence Help-seeking and Response

United Bricklayers noted that homophobia and the illegal status of same-sex sexual behavior inhibit MSM from pressing charges for hate-based violence or partner violence.

> They'll tell us [about the violence they experienced], but they won't go to the station to press charges.… They are afraid that they will go to jail. And some of these partners are married, or community leaders. *(United Bricklayers)*

The police are not sufficiently sensitized to work with MSM who are dealing with IPV. In addition to the illegality of same-sex relationships, few MSM experiencing IPV go to the police because they don't feel the police will do anything for them.

> Most of [the MSM who wish to report violence] will just be laughed at, at the police station. It is very difficult for a man to go to the police to say that another man just assaulted you. Right? And a lot of times when MSM fear assaults, sexual or whatever the case may be, it won't be reported because they already know what to expect. *(FACT)*

> [MSM] feel that the police will not do anything for them. Some of them will make noise on the issue, but for most they won't go. I think they would prefer to raise the matter with SASOD because they will do a much better job of reporting and setting it up. *(Help and Shelter)*

The consensus among respondents was that given these challenges, most MSM who experience IPV simply bear it quietly and don't tell anyone about it. Those MSM who experience IPV sometimes call the Help and Shelter hotline and are referred there to SASOD, but few go to Help and Shelter in person. Having an IPV support group specifically for MSM could be helpful in increasing help-seeking and improving support for MSM who experience IPV.

Sex Workers

Given the large mining industry in Guyana, sex work is quite common—particularly in the hinterland regions. Many women travel to the hinterland areas for a few months at a time and then return to their home area in Georgetown or along the coast. It also appears common for women to come from other countries, such as Suriname, Brazil, and Venezuela, to engage in sex work in the hinterland areas. While these women sometimes come of their own free will, trafficking of girls into these areas was raised as a concern by several NGOs. Apparently, girls as young as 12 years of age are being brought in with the promise of "a job."

> We have had a lot of stories in the news about women who have been trafficked to go to the mines as sex workers—girls who have been tricked into becoming employed in the interior and then discovering that they will be doing sex work and are held against their will. They cannot leave because it is very expensive, and they have been tricked into using all of their money to get to an advertised job that turns out to be trafficking. **(Youth Challenge)**

These trafficked women and girls can also be sent to urban areas like Georgetown.

United Bricklayers noted that school youth are also engaging in sex work at high rates in New Amsterdam and Georgetown—to the point that it is viewed as "normal"—with fellow students, teachers, and other clients they pick up on the streets during school hours. They engage in sex work for money, clothes, and cell phones. Many live on their own, since their parents have gone to seek opportunities in the hinterland areas.

Sex Worker Clientele

In the hinterland areas, the primary clients of SWs are the approximately 20,000 gold and diamond miners. Youth Challenge suggested that the vast majority of miners visit sex workers. Staff of NGOs working in the hinterland areas noted that loggers engage SWs substantially less, because they are working deep in the jungles and are not near the areas where sex work is common. The NGO staff also noted that loggers are also more likely to be indigenous and are paid less than miners, so may have less disposable income to pay for sex. However, they may sometimes buy sex when traveling from town to town.

Risk for HIV and Sexually Transmitted Infections

Some NGO respondents noted that clients' negative attitudes and lack of education regarding condom use may heighten SWs' risk for HIV and STIs.

> We also tell them to keep the lights on and to check the condoms, because at this stage men don't give them condoms, we give condoms to them. We've had girls find holes in the condom or old condoms. We had a girl come in to one of our sessions and say a man refused to pay her because she was making him use a condom, and he didn't want to. And some men will pay less because the girls made them use a condom. **(Youth Challenge)**

On the other hand, it also appears that many clients are indeed willing to use condoms. Violence is another factor that may put SWs at risk for HIV and STIs; IPV seems to be a more pronounced problem than violence from clients.

Experiences of Violence

According to the NGOs working with SW populations, most of the physical violence experienced by SWs appears to come from their partners, rather than their clients.

> Most of our domestic and gender violence [work] we have done with education is really with the sex workers, because most of the sex workers' regular partners abuse them … not so much the clients. And

*sometimes [partners] will take their money. Sometimes they didn't make any money and so they can't cook no food [so the partner beats them]. **(Artistes in Direct Support)***

*[SWs experience violence from] partners, yes. I don't know how serious it is with other people, but I do know at the community level it could happen too. **(Help and Shelter)***

Respondents suggested that the main forms of abuse experienced from clients include theft, non-payment, and, until recently, false payment (e.g., fake gold from miners). Youth Challenge stated that the level of physical violence against SW in the hinterlands is "not very heavy" and that the main clients who perpetrate such violence are new to the region and want more services than what they are paying for. If men own a brothel, they may also use violence if a SW has not paid her rent on time.

*What we have noticed is that the violence is coming from people who are new to the region and feel they can exercise power because they are new or want to pay for one thing but want extra services. **(Youth Challenge)***

Some NGOs have also been working with SWs to provide training on safety precautions they can take to protect themselves from violence perpetrated by clients. These strategies appear to be working well.

*We have encouraged [SWs] to be [their] brother's or [their] sister's keeper and to look out for them when they are with a client. In Region 1 we have established this phone/text message to keep them safe.… [W]hat we have told them is to tell other people where they are going. We also told them not to go too far from the brothel. And it's working. **(Youth Challenge)***

*Violence against SWs is not that common. They've learned self-protective measures, such as stashing payment in a separate place before going off with the customer. Pimps also protect them. **(G+)***

Stigma and Discrimination from Police and Health Care Workers

The level of S&D faced by SWs seems to vary by geographic area and whether sensitization programs have been conducted with police and health care staff—institutions with which SWs must frequently engage.

Youth Challenge noted that SWs experience S&D related to sex work in the hinterland areas—from staff at health care settings as well as community members more broadly. In these areas, religious mores contribute to S&D.

*There are many parts of the communities which are very religious and they believe sex work is a sin. So they won't give the same treatment to sex workers that they would give to other people who are going to the clinics.… I think the people in the interior, because they are so isolated, they might not have as much access to education or news about what is changing, so their behavior is shaped in a vacuum. **(Youth Challenge)***

Sex workers also face stigma and abusive behavior in the interior from miners, who are their main clients. Behaviors range from calling them names because they are exchanging sex for money to stealing their money or not paying for services already provided.

*For the SWs we don't have a lot of issues for them on the coast, but for those in the interior they face a lot of stigma and discrimination coming from the miners. And that has to do more with the location and the fact that the persons working there are from all parts of Guyana. **(Hope for All)***

United Bricklayers noted that stigma is "very high" toward sex workers in New Amsterdam, but that police response to violence against SWs has improved since United Bricklayers started doing related sensitizations with them.

*Before, when we used to take them to the police, they would laugh us off because prostitution is illegal, but since we started working with the police the case is different. They follow up. **(United Bricklayers)***

Youth Challenge stated that there is a good overall relationship between SWs and the police in the regions in which they work and a less-good relationship between SWs and hospital staff—even after Youth Challenge did a

three-day session with the latter group. Given this, they expressed the need for more training with health care workers in the hinterland areas.

> So for example, we have sex workers that have gone to the hospital with a complaint and the nurses do not treat their complaint as urgent. Or, say, they go and tell the nurses they think they have an STI, so the nurses will ask "Do you have XYZ symptoms?" The patient will say no, and the nurse will say that they don't have an STI … because they are a known sex worker. **(Youth Challenge)**

Transgender Individuals

Lack of Awareness

Among most of the NGOs interviewed, there appeared to be a lack of knowledge and awareness of the TG community. Most organizations were unable to give any concrete comments and insights into the challenges and needs of this community apart from Guyana Trans United, SASOD, and G+. Indeed, SASOD upheld this observation, noting that "most organizations within the country don't understand transgender issues." Furthermore, SASOD stated that there is a definite "need for NGOs to be more aware of LGBTI [LGBT and intersex] issues and how to address them, [and SASOD is] more than willing to assist with that role."

> If they do exist in this region, they are not coming out.… And they are not coming out for good reason. **(Hope for All)**

> I think people find it funny and laugh, but I don't know that there is a lot of violence because of how they dress. **(Artistes in Direct Support)**

Stigma and Discrimination

According to Guyana Trans United and SASOD, the level and frequency of S&D reportedly experienced by TG individuals is significant. This S&D was described as negatively impacting every sphere of their lives and was made further evident from the subsequent examples shared. From accessing basic services to trying to earn a living, the TG community faces notable challenges as the result of S&D.

> The bus driver won't stop for me, some taxi would say plainly we don't take anti-man or they would increase the taxi fare because you are trans. Banks don't provide services and educational institutions [do] the same thing.… The landlord would charge you more rent if you were a trans, sometimes nobody wants to rent to trans. **(Guyana Trans United)**

> [Despite receiving skills-building trainings], there is no one to employ us, so we have no other option than sex work. **(Guyana Trans United)**

Stigma and discrimination considerably deter TG individuals from accessing and utilizing health services, as oftentimes they are harassed by patients and staff or discriminated against for their attire. Furthermore, as a result of S&D, many TG individuals are too poor to access health services. Fortunately, there are a few programs and facilities that work to meet the needs of TG individuals and encourage use of health services.

> Sometimes when they go to the hospital, [people] who are waiting to see the doctor taunt and trouble [them] and a confrontation would occur. This would cause them to not want to return, plus sometimes the health staff side with the people who are making the trouble. **(Guyana Trans United)**

> The National Care and Treatment Centre [is] offering services at non-traditional hours. [Transgender individuals can access services without] having John Public noticing and collecting their medication and then go out on the road to work. **(SASOD)**

Transgender individuals were observed to face more S&D when it comes to HIV. Guyana Trans United estimated that 50 percent of the TG population that it works with (about 100 individuals) are living with HIV. Guyana Trans United described it as a double burden to be infected with HIV and be transgender.

> [Transgender individuals] are presumed HIV-positive. Even if they are not positive [it is assumed] eventually they would acquire it. **(SASOD)**

*Men who have sex with men are most at risk for HIV and AIDS, [but] it is not the other men who you have sex with, but trans [who] face more stigma. **(Guyana Trans United)***

*[The level of discrimination is] greater for HIV-positive LGBTI [people] compared to a[n] HIV-positive heterosexual. **(SASOD)***

*There seems to be a reduction of stigma towards PLHIV, while SWs, TG individuals, and MSM face more challenges than others. **(SASOD)***

With regard to geographic location, S&D faced by TG individuals were reported to be greater in Afro-Guyanese communities than in Indian communities where "third sex" is a mainstream social construct. While stigma toward MSM and TG populations was noted to be commonplace throughout Guyana, it appears to be more pronounced in some areas, such as Essequibo and New Amsterdam, according to the NGO staff interviewed.

Experiences of Violence

Guyana Trans United and SASOD reported extremely high levels of violence experienced among the TG community; Guyana Trans United noted that six of its members were murdered in the past year alone. The spectrum of violence against the TG community varied from "corrective" measures to the result of power dynamics on the part of intimate partners or sex work clients.

*A lot of times we were verbally abused. Sometimes they attacked you to rape you.… They believed if you [were] raped you [would] somehow be changed. **(Guyana Trans United)***

*[The reason for violence among the TG community] is the same as the general population but 10 times worse. [It is] gender inequality across the board. If you are the masculine partner in the relationship, you feel you are the dominant within the relationship and take on the macho patriarchal role. **(SASOD)***

*[Dominant male partners] feel they are doing you a favor and can tell you anything and beat you any time since you are not a real woman and you need them more than they need you. **(Guyana Trans United)***

With regard to violence, there is a sense of hopelessness among TG individuals, as they feel reaching out to authorities is a futile effort.

*Police are reluctant to take reports or complaints from sex workers. **(SASOD)***

*If I am living with a partner and he is beating me, I can't go to the police. I am a trans, not much place we can go to report the case, so I stay within the relationship until I can find a support group for someone to help. **(Guyana Trans United)***

Women

Both NGO staff and government stakeholders agreed that women in Guyana face high levels of violence, particularly IPV, which increases their vulnerability to HIV infection. Some respondents noted high rates of femicide in the country. Others noted emerging trends in violence, such as forced anal sex.

*So there is a lot of violence going around with sex, anal sex, where men are forcing women.… It's a recent thing. I don't know where it came from. **(Artistes in Direct Support)***

Several respondents noted that social norms often support IPV and that these norms are reinforced over generations.

*I grew up in the country, and from a young age, girls are taught to accept this as normal behavior—the violence and the beatings. Even if a woman escapes and goes to her family, they will send her back to her husband. **(United Bricklayers)***

Pop culture and external influences contribute to social norms that support GBV.

*I think with all the influence of the Jamaican music we get in Guyana, there's a lot of violence talking against women, calling women's body parts fun names and calling the penis a "plank"—and all of it speaks to violence. It refers to sex as "slam." So sex is a "slam." **(United Bricklayers)***

Comforting Hearts noted that about once a month a client would report experiencing violence. Comforting Hearts went on to discuss how the community has become desensitized to violence and noted the need for programs to address this.

> The sad thing is that even though there is supposed to be zero tolerance when it comes to violence, there is a lot more tolerance. We had a nurse come in with her partner to be tested, and the marks were there. So we separated them and she started crying because she didn't know what to do. We asked if she had gone to the police and she said six times, so she has just given up, and he is just so controlling so she can't leave. *(Comforting Hearts)*

The NGO staff noted that the legal organizations they work with to address GBV are very responsive and responsible. Yet fears surrounding disclosure of IPV and hesitancy to leave the partner were also commonly mentioned by NGO staff as barriers to being able to follow up with clients and help them use legal services and social support.

Obstacles to Leaving the Abusive Partner

Several factors were noted to stand in the way of women's leaving abusive partners, including economic dependence on the partner, not defining what they are experiencing as "abuse," viewing violence against them as normal or justifiable, loving and not wanting to leave the partner, and lack of options with regard to alternative shelter. For women living with HIV, there is an additional fear of being "left alone" and heightened concern about finances and shelter. United Bricklayers noted that there are cases of family violence, including child sexual abuse, where "the family protects the abuser—even wives will take their savings to go bail out their husbands. And this thing is starting the cycle anew."

> Other [obstacles to leaving the partner] are culture—their marriage, religion, and if the person is a good provider and they didn't grow up in that type of home they prefer to stay. One woman said that she doesn't want to leave because he is a good provider, but he is accusing her of having an affair while he is drinking. *(Help and Shelter)*

> I think the other thing is economic situation … I will say sometimes you have a certain amount (of money) and he give it to you. Right and then that (the sum of money) might not be enough for you, you might not be able to leave. *(Red Thread Foundation)*

Police Response to Intimate Partner Violence

Several NGOs noted areas of need with regard to police and legal response to IPV, including effective enforcement of restraining orders and better response to reports of IPV. Police do not always arrest partners who have violated restraining orders; this inconsistent response may be due to factors including insufficient understanding of the law and lack of infrastructure such as an available vehicle or officer.

> Most times when women take out protection orders and their partner is still looking for them, they go into hiding, either with family or somewhere out of town. *(Help and Shelter)*

Help and Shelter noted that female IPV survivors often choose not to press charges against their partners. In cases where a woman has gone repeatedly to a police station to report violence but has not left the abuser, the police may "get fed up" and "disgusted with her" and cease responding to her reports—unless the NGO gets involved and talks with the police commander or other authority figure about the case.

> What they are doing now is, the magistrate is implementing a fine—if the victim comes around and asks to drop the charges, they have to pay $1,000 for wasting the court's time. And sometimes the police stop wanting to help them, because they keep coming back and complaining about being abused, but the police tells them to stop coming because it's clear they aren't going to leave the abuser—and it becomes fatal. *(United Bricklayers)*

Corruption in the system was also noted as a barrier to legal redress for victims of violence.

> A juvie [juvenile corrections] officer—she is based right here in New Amsterdam … is now accusing the girls we send to her of enjoying rape and doesn't send the files along to [the] director of public

prosecution [DPP]. She'll take bribes but even then they don't get sent. So we have to go to the police commander to get stuff done because we can't trust her.… We had a case of two kids coming in from the New Opportunity Corps and they told us, in detail, how the officers from there were having all types of sex with them. And then it hurts because the government officials will go on TV and say nothing is wrong with the New Opportunity Corps—yet we have these victims telling us their stories right here. And the thing is, this is the only place that is helping them because nobody else believes them. **(United Bricklayers)**

Overall, with regard to IPV, several organizations mentioned that they lack the resources and training to offer appropriate services to support survivors of violence.

ADDITIONAL CHALLENGES

Men as Victims of Intimate Partner Violence

Help and Shelter noted that while it most often sees opposite-sex partnerships where the man is violent toward the woman, men are increasingly contacting the organization about violence they are experiencing from a female partner. Some men are coming in for in-person counseling with regard to IPV victimization and expressing interest in having a shelter where they can go. United Bricklayers noted that there is stigma surrounding men's reporting that they are victims of IPV. Help and Shelter also noted that physical IPV is often bi-directional (i.e., two-way, not a dynamic of self-defense) and that couples sometimes view mutual abuse as "normal behavior."

Suicide

Several organizations expressed concern over what they perceived to be a high incidence of suicide in Guyana, particularly among youth in East Indian communities. Suicide was thought to stem from factors including bullying, child abuse, and pressures placed on East Indian youth.

I'm from the country area where there are a lot of East Indians. And there if something happens, like a child is raped or sexual abuse happens, it is considered shameful and it's not reported. And most of the time you'll find out the child was raped or abused and that's why the child committed suicide. **(United Bricklayers)**

There are different factors, persons have different theories. The pressure to be perfect—if you listen to schoolchildren the pressure in the Indian community is for them to be perfect and for them to get everything right, and just last year we had a girl commit suicide in my community because she was tired of her parents quarrelling and she wanted her siblings to have a better life. **(Hope for All)**

NEW STRUCTURAL DIRECTIONS

Institutionalizing Rigorous Training in Professional Schools on Stigma and Discrimination Pertaining to HIV and Key Populations

Given the high turnover of staff in many institutional settings and the diminishing resources available to support NGO-run trainings of new staff, several organizations suggested that training on HIV and KP S&D should be integrated into the curricula of professional training programs for doctors, nurses, social workers, police, and teachers. This education should occur as a standard part of the curriculum and should engage students in examination of their own beliefs and prejudices (including their religious-based beliefs)—rather than only focus on conceptual learning about S&D. Curricula should also address how to work sensitively and effectively with KPs. The educators leading these courses should be well trained and vetted. As an example, a curriculum for

medical students developed in Puerto Rico has been shown to significantly reduce stigmatizing attitudes among students; such curricula could be adapted for use in Guyana (Varas-Diaz et al. 2013).

It should be noted that there would still be a need for some on-the-job trainings in institutional settings, particularly for other workers who come into contact with KPs, such as receptionists and janitorial staff.

Training Police Officers for More Appropriate and Effective Gender-based Violence Response

Several respondents noted an acute need for police to be more responsive when women, men, and TG individuals report partner violence, sexual assault, and hate-based violence/harassment. Several respondents also expressed the need for police abuse (including sexual assault) of SWs, MSM, and TG individuals to end, as well as the need for police not to accept bribes to disclose shelter locations.

> We can build more shelters, but the men who are violent to the women will pay the police to find out where they are. **(Youth Challenge)**

> [The key] is working with police officers. Once a person knows that the police would listen and deal with the case, they will make the report. **(SASOD)**

Establishing penalties for those who do disclose locations may help deter such behavior.

Expanding Shelters for Victims of Violence

Both NGO staff and government stakeholders expressed a need for more GBV shelters in the country. At present, the shelter run by Help and Shelter in Georgetown is "the only one of its kind"—a shelter of undisclosed location for women who are survivors of trafficking and other GBV, women living with HIV, and their children (under age 13). Women and their children can stay for up to six months, and some have stayed longer when needed. However, boys over 13 years of age cannot stay in the shelter, which sometimes deters women with older children from seeking shelter.

> Often there are reports of violence but there is no support; the major issue is [a lack of] shelter for [women] and children, school, and economic support during the transition period. As a result, persons don't have an alternative option and are forced to endure punishment. **(Dr. Ruth Ramos, National Care and Treatment Centre, MOH)**

There are currently no shelters for male survivors of violence in Guyana. Due to the increase in men seeking shelter and the stigma surrounding men who report IPV, some NGOs also expressed a desire to establish an IPV shelter for men.

Improving Response Time of the Child Protection Agency

A few organizations expressed frustration with the slow response times when they refer clients to the Child Protection Agency in cases of child abuse. These NGOs expressed a desire for more funding for this agency to enable them to both improve their response and the speed with which they are able to respond.

> When we report cases—especially child sexual abuse cases—I hate the fact that we have to report it to [the] DPP and it takes a very long time to process. The police only keep the abuser for 72 hours, then he's out on bail and he either returns to the victim or attacks another victim, and the family gets the charges dropped.… Some of our cases haven't been responded to in months. **(United Bricklayers)**

Expanding Services in the Hinterland/Hard-to-reach Areas

Organizations working with populations in the hinterland areas expressed a strong need for more health care professionals and services, such as social workers, in these hard-to-reach areas. Given the difficulties of living in these areas, incentives could be considered to get qualified candidates interested in these positions. Currently, it is challenging to implement HIV prevention, care, and treatment services in these areas, which is problematic given the key and vulnerable populations that live in these areas for mining and sex work. In the past, there was an initiative where HIV testing was supported through Guyana Geology and Mines Commission at the mining

camps; however, these services are now provided by NGOs working within these areas, which has limited uptake of HIV care and treatment despite the availability of test kits supplied by the NAPS.

> *I think the scale of testing that we are doing can be scaled up to reach a greater number of populations and a greater number of locations. Because even though we know that sex workers might be a valuable group to reach, the issue is if we don't meet the people who are on the outskirts of sex work, or if we don't meet the indigenous people who have lots of stigma in their communities, then you might not have that impact in the long-run if people become HIV-positive.* **(Youth Challenge)**

NEW PROGRAMMATIC DIRECTIONS

Shifting Norms in the General Population

Several NGO staff interviewed stressed the importance of ensuring that awareness campaigns targeted to the general population are central to the activities supported by the APC, even though the focus of the funding is KPs. Given the pervasiveness of harmful gender norms and stigmatizing attitudes toward KPs, NGOs expressed interest in mounting media campaigns and edutainment initiatives to reach mass audiences and foster community and national dialogue and change. In addition, NGOs expressed strong interest in working specifically with men for stigma reduction, violence prevention, and the promotion of healthy masculinities.

> *The problem is the general population—not MSM or PLHIV. Men are a problem—and husbands, like those who are having sex on the down-low with men.* **(G+)**

> *I think being in a position to work in a general population would be the best thing.… [I]t might be kind of stigmatizing to a point if we just have a session for men who beat women and they walk around and say they're going to this meeting. So we're going to need to be broad with this and just do general men. Because many times the perpetrators might be like, a big council man, who then if you go around and beat women and think it's okay.* **(Comforting Hearts)**

> *All this money that is going to the key populations—we are going to have some terrible issues if we don't do programs targeting men. Generally, men go with sex workers and men go with men who have sex with men. So if you do a program for sex workers and you don't do a program for men, that is not a balanced program. So … that is one thing we have issues with because we cannot be looking for partners. In meeting men generally, we are going to meet the partners, the ones who are in the closet, when we meet with men generally.* **(Artistes in Direct Support)**

> *It is now politically incorrect to stigmatize a person who is HIV-positive, due to politicians and other prominent individuals advocating against HIV stigma and discrimination, but there is not that level of political support for sex workers and LGBTI people.* **(SASOD)**

To this end, a few NGOs have or are currently implementing television or radio programs that have the potential to be updated and expanded throughout the country to increase awareness of stigma experienced by KPs and foster changes in the harmful cultural norms that pervade Guyanese society. In interviews, NGO staff thought these programs could address HIV and KP stigma, as well as GBV.

> *Banks Ltd. [initially] did this as part of a way to promote their products, but they saw that they could get advocacy messages out with it too because they saw a lot of young people were talking about the program. So they came up with the curriculum and we do call-in sessions about MSM or SWs and stigma. And we brought Alexandra on to the show because she is transgender, so she can talk about those issues.… I know [people in the region] have become more tolerant through knowledge. Because a lot of people might not know what transgender means, so I would educate them if they asked … and what I found is with education there is more tolerance. And with the television program I found a lot of people have started contacting me through Facebook. Most of them are MSM that we never even reached and we're now having Facebook discussions with them. Some of them are even transgender, so I am able to talk to them more about that.* **(United Bricklayers)**

[W]e provide messages at events. So if you have a concert or if you have a pageant or whatever and people need an HIV message or a message on a social issue they would call us, and our actors would perform.… [We give] messages on domestic violence, a lot of people have been asking for that. Messages on stigma and discrimination. Messages on relationships, especially gay relationships if you have someone who you find out that they are gay, what do you do? Messages on child abuse. And general HIV education. (Artistes in Direct Support)

We did a program on television at one time called Help Watch, but we were not able to maintain it because of transportation difficulties. But it made an impact because people would ask us why we were not doing the program anymore, and we would find people would access services more after watching the program, and we would give information about things like GBV, suicide, and other things that weren't HIV. So to me, that was a very good program, and if we could continue that, people would be able to learn from that. (Hope for All)

Expanding Educational Efforts with Youth in Schools

Several NGOs expressed a desire to be able to do more work with youth in schools to promote HIV prevention and reduce harmful gender norms and stigmatizing attitudes.

One area we can look at is the high schools. Because once we could implement a program by going in once or twice a week and we do an hour session or half-an-hour session and we reach them from far away because what we find [is] they are coming from different communities there. So you are finding every community, they go back with what they discovered and share what they learned in the session and hopefully somewhere down the line there will be a change to watch in gender-based violence. Because most of the time it happens in high school with students … but you know with these types of things you could change it. (FACT)

Educating the General Public and Relevant Organizations/Practitioners about Existing Laws

Several NGOs and government stakeholders highlighted a need to increase public awareness about the existing laws in place to protect against violence and child abuse. They indicated that many individuals and organizations are unaware of the laws and policies in place, such as those put forward by the Child Protection Agency in 2009, and expressed interest in conducting trainings and mounting communication campaigns to this end.

I would suspect that in Guyana there is not a lot of awareness about domestic violence laws, so I think training on laws would be good. The Child Protection Agency has several laws from 2009 that a lot of people are not aware of, so those should be brought up. I don't know how we will deal with the HIV S&D, because it is not policy, so it is good for us to explore that area because I know some organizations have written policy on it but the government hasn't accepted it, especially when it comes to willful infection of people. (Help and Shelter)

A lot [of] person[s] are not aware of the anti-discrimination legislat[ion]; additionally enforcement of the same is another challenge that would have to be address[ed]. (Mr. Dereck Springer, Pan Caribbean Partnership Against HIV & AIDS Coordinating Unit)

Expanding and Enriching Support Groups for Key Populations

Many of the NGO staff interviewed had experience leading support groups for PLHIV and in some cases for members of KP groups. Given the importance of support group sessions for helping clients overcome internalized stigma, feelings of shame, and lack of self-worth, many NGOs were eager to increase the frequency of these group sessions and expand the topics covered during the support groups. However, there is currently a lack of materials and tools to address KP S&D and GBV.

A structured tool in how to approach S&D in the MSM and SW community, maybe have a focus group for them so they know what sorts of stigma they experience, because right now we don't have a

complete tool. We'd like for tools to teach them how to deal with stigma from the community, HIV stigma, and self-stigma. **(United Bricklayers)**

Some organizations also expressed interest in starting support groups for male victims of IPV and for MSM who experience violence.

Empowering Survivors of Violence to Exit Relationships

Several NGO respondents expressed a need for more shelters throughout the country and also noted the importance of accompanying activities to economically empower survivors of violence. Help and Shelter members noted that it has cases "all the time" of women who successfully leave their abusive partners; most women who live temporarily in their shelter and concurrently receive help in finding work do not return to their partners. Help and Shelter linked relationship exit with the economic empowerment it fosters by referring shelter residents for computer and other skills training and assisting them in finding work and a place to live.

> *Once women find financial independence, they move on. Very rarely will you find them returning.… And for these women, it's the best thing that's ever happened to them.* **(Help and Shelter)**

> *We need to focus on empowering persons. Because even when you put them in the shelter, when they come out, what are they going to do?* **(Youth Challenge)**

Developing Entrepreneurial/Occupational Skills among Sex Workers and Transgender Individuals

Many SWs working in the hinterlands come from around the country to serve the miners. With regard to pursuit of alternative occupations, Youth Challenge noted that while sex work is "very lucrative—especially in the interior," SWs with whom Youth Challenge works with have expressed interest in alternative occupations. Some have "used money from sex work as capital for other business ventures—and they don't want credit." Some don't want to live in the bush, have goals other than sex work, want to be with their families, and value hard work. Likewise, Guyana Trans United aims to create opportunities for income among TG individuals so they do not have to turn to sex work.

CAPACITY NEEDS IDENTIFIED BY NGOS

Training in Basics of Gender-based Violence

Most organizations expressed a need for further training on the topic of GBV—including IPV, non-partner sexual assault, and hate-based violence/harassment. Some organizations noted that they did not have a strong understanding of the subject and related terminology. Several organizations wished to serve as educators for the general population on the subject of GBV and help them to become allies and empowered bystanders. One organization wished to be trained to provide basic counseling and support to survivors of GBV and to have materials it could share with staff and clients.

Gender-based Violence Screening Tool

Most organizations expressed interest in having a GBV screening tool to use with clients. Several of these organizations noted that they do not currently have a tool or format for screening. Previously, they have attempted to screen for GBV through a simple conversation. On a related note, Youth Challenge specifically mentioned a need to screen for individuals who are being trafficked; several organizations indicated that this is a serious and under-addressed problem in Guyana. They informed us that each year in the U.S. State Department's Trafficking in Persons Report, Guyana is among the countries with the highest incidence of human trafficking.

Refresher Training on Stigma with a Focus on Key Populations

The need for training on S&D was also identified. One organization noted that it would be beneficial for such a training to highlight ways in which S&D and GBV interact and mutually reinforce each other. Another organization noted that having a specific module on supporting clients in dealing with internalized stigma and homophobia would be valuable. There were several requests for new and updated curriculum materials, as well as new ideas for engaging with the general population on HIV and KP stigma. While past efforts appear to have successfully reduced the level of S&D experienced by PLHIV, it is clear that similar efforts are now necessary to spur reductions in KP stigma.

Support to Monitor and Evaluate Efforts to Reduce Stigma and Gender-based Violence

Currently, there is a paucity of data at the programmatic level with regard to the effectiveness of current programs and strategies for reducing S&D and GBV. In addition, national data on stigma are limited to a single domain of stigma—discriminatory attitudes—and thus do not provide a complete picture of the prevalence or dynamics of S&D. There are currently no data available at the national level regarding the prevalence of GBV. Given this, several NGO respondents expressed a desire for training on monitoring and evaluation (M&E) of S&D and GBV programs.

Support to Develop and Expand Edutainment Strategies

Several NGOs expressed interest in gaining skills to develop mass media and edutainment strategies to address stigma, GBV, and gender norms with the general public. There was also interest in learning from international efforts that have used artistic mediums such as theatre and dance to engage populations on difficult issues and foster dialogue. Lastly, some organizations expressed an interest in linking with other NGOs in Guyana that already have experience in media and edutainment to join forces and more efficiently tackle some of these issues.

CONCLUSION

Significant efforts have been made over the past decade in Guyana to reduce HIV-related S&D and increase access to HIV prevention, care, and treatment services. These efforts have laid the groundwork for expanding the accessibility of HIV services for key and vulnerable populations and enabling Guyana to reach its goals of reducing the social and economic impact of HIV and AIDS on individuals, communities, and the country as a whole. The findings from this rapid assessment highlight structural and programmatic areas where efforts can be focused in the coming years to realize these goals.

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Organization	Region	Persons Living with HIV	OVC	Men who have Sex with Men	Sex Workers	Adjacent Population	Loggers	Miners	Care & Support Adults (HBHC)	Care & Support Children (HKID)	Positive Health & Dignity Prevention (PHDP)	HIV & Other Prevention (HVOP)	HIV Testing & Counseling (HTC)	Gender Based Violence (GBV)
		Population Targeted							HIV Services Offered					
Guyana Trans United	4			✓	✓							✓	✓	✓
SASOD	4			✓								✓		✓
Agape	4	✓	✓						✓	✓	✓			
Artiste in Direct Support	3,4			✓	✓							✓	✓	
Comforting Hearts	5,6	✓	✓						✓	✓	✓			
FACT	6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
G+	3,4	✓									✓			
Help & Shelter	All Regions	✓	✓	✓	✓	✓	✓	✓						✓
Hope for All	1,2	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	
Hope Foundation	7	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Red Thread Foundation	All Regions	✓	✓	✓	✓	✓	✓	✓						✓
Lifeline Counseling Services	4	✓	✓						✓	✓	✓			
Linden Care Foundation	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
United Bricklayers	5,6			✓	✓							✓	✓	
Youth Challenge	1,8				✓	✓	✓	✓				✓	✓	

APPENDIX 2. KEY INFORMANTS

Name	Organization	Position	Contact Information
Ms. Jennifer Ganesh	National AIDS Programme Secretariat	National Behaviour Change Communication Coordinator	jganesh@health.gov.gy
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Ms. Hemwattie Lagan	Ministry of Human Services and Social Security	Administrator, Women's Affairs Bureau	Hlagan13@gmail.com
Dr. Ruth Ramos	National Care and Treatment Centre, MOH	Director	Ruthramos64@gmail.com
Dr. Shanti Singh	National AIDS Programme Secretariat	Programme Manager	fsjaanthony@gmail.com
Mr. Dereck Springer	Pan Caribbean Partnership Against HIV & AIDS Coordinating Unit	Director	Dereck.springer@caricom.org
Ms. Deborah Success	National AIDS Programme Secretariat	National Voluntary Counselling and Testing Coordinator	dsuccess@health.gov.gy
Mr. Wenthworth Tanner	Ministry of Human Services and Social Security	Director, Social Services	dssmhss@gmail.com

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APPENDIX 3. RAPID ASSESSMENT: IN-DEPTH INTERVIEW GUIDE FOR NGO PROGRAM STAFF

Rapport Building

- Climate setting, greetings
- Introduce purpose of the visit; <u>seek oral consent for interview</u>; discuss taking notes.

INTERVIEWER CAN CHOOSE ADDITIONAL QUESTIONS TO ASK TO FURTHER BUILD RAPPORT IF NECESSARY.

Theme 1: Sociodemographic and Interview Information

- Record date, location, start and end time of interview, gender, organization, position, time at current post.
- Describe the respondent and interview setting.

Can you briefly tell me about your role at (fill in name of organization)? (Probe: What are your main activities/responsibilities?)

Theme 2: Social Context

1. What HIV services does your organization provide?

- Where do the projects take place?
- Who are the target audiences?
- How long have the projects been going on? (Probe: When did the project start?)
- Are there existing M&E systems in place to monitor and evaluate your project activities?

2. Please tell me about the HIV projects or programs that you are involved with. (Probe: What projects do you oversee/work on?)
3. How do HIV-related stigma and discrimination affect the general population here? How does it affect your target populations (MSM, TG individuals, sex workers, OVC)? In general, how are PLHIV viewed and treated here? Are people in the community willing to talk openly about HIV? Please provide some examples.
4. How are LGBT people viewed and treated here? How do homophobia and transphobia manifest themselves, and what are the effects for LGBT youth and adults? (E.g., is it common for health workers and members of the police and legal system to be homo/transphobic?)
5. What are the social attitudes here toward CSW? OVC? How do these social attitudes manifest, and what are the impacts for CSW? OVC?
6. Have you noticed any changes in attitudes towards PLHIV or key populations in recent years? What do you think influenced these changes?
7. How do stigma and discrimination hinder implementation of HIV prevention, care and treatment services in Guyana? *(Probe: How do stigma and discrimination influence key populations' (including MSM and sex workers) willingness to enroll and adhere in HIV care and treatment services?)*

Theme 3: Stigma-Reduction Programming

1. How do HIV-related stigma and discrimination affect your organization's ability to implement projects or programs? (Probe: How does stigma affect your organization's ability to meet its objectives in relation to HIV prevention, treatment and care?)

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2. How do societal views toward MSM and sex workers affect your organization's ability to reach these populations with HIV programming? (Probe: Does your organization find it is difficult to reach MSM with HIV prevention or treatment programs? *Sex workers? How so?*)
3. How do governmental policies towards PLHIV, sex workers, and MSM affect your organization's ability to reach these populations with HIV programming? (Probe: Does your organization find it is difficult to reach MSM populations with HIV programming? Sex workers? How so?)
4. How is HIV-related stigma and discrimination addressed within these projects or programs? Note: If interviewee indicates that stigma and discrimination are not addressed within their organizations' projects or programs, skip to question 12. (Probe: How does the project/program seek to reduce stigma? Is stigma reduction the main goal of the project? How is stigma reduction integrated within project activities?)

   - What models did your organization use to address stigma? (Probe: Stand-alone models? Models that combine stigma reduction with ongoing project activities? Referrals? Linking with other organizations working with target populations?)
   - What worked well? (Probe: Which activities would you recommend to others seeking to reduce stigma and discrimination?)
   - Is there anything you would have liked to do to reduce stigma that you were not able to? (Probe: Activities you think would be really helpful that you may have not had the funding, resources, time, etc. to implement?)
   - Please describe any challenges your organization faced in implementing stigma reduction activities. (Probe: Have you had any difficulties implementing stigma-reduction activities among MSM? Sex workers? Community members? Other relevant key population?)
   - What strategies has your organization used to address these challenges?
   - Please describe any changes that have occurred in community attitudes towards persons living with HIV or their families *as a result of your project activities*.
   - Is there any evidence that stigma and discrimination has changed? Please describe.
     - Please describe any evaluation data that were collected about stigma-reduction activities. (Probe: What indicators were collected to assess stigma and discrimination over time? Please describe the outcomes of these evaluations.)
   - In your view, what were the benefits of including stigma reduction in project activities?
   - How feasible would it be to scale up the stigma-reduction activities you are currently conducting? (Probe: What would it take to scale up stigma reduction activities within your organization's existing HIV programming efforts?)

5. *If stigma is not addressed*: How could stigma reduction be addressed within project activities?

   - What models would be most appropriate for addressing stigma in your organization's projects or programs? (Probe: Stand-alone models? Models that combine stigma reduction with ongoing project activities? Linking with other organizations working with target populations?)
   - In your opinion, what would be the benefits of including stigma reduction in project activities?
   - What would be the challenges of including stigma reduction in project activities?
   - How feasible would it be to include stigma-reduction efforts within ongoing prevention, care, and treatment activities? (Probe: What would it take to scale up stigma-reduction activities within your organization's existing HIV programming efforts?)
   - What challenges do you foresee in scaling up stigma-reduction activities within your organization's ongoing HIV programming efforts? (Probe: Please describe any barriers to scaling up stigma reduction activities, e.g., funding, human resources, lack of stigma-reduction models).
     - What support might be useful for overcoming these challenges? (Probe: Training? Models? Tools? Strategies? Support from particular government offices?)

6. In your opinion, which kinds of HIV programs (prevention, care, treatment, etc.) would benefit most from the addition of stigma-reduction activities in Guyana? (Probe: All programs? Only some? Which ones? How would adding stigma reduction to these programs be helpful?)

- What type of support would be required to successfully include stigma-reduction activities in these program areas (fill in areas)?
  - What type of technical support would be required?
  - What type of resources would be required (e.g., funding, human resources, tools, stigma-reduction models, guidelines)?

Theme 4: Stigma Reduction—Starting at Home

7. How have HIV and key population stigma been addressed within your own organization?

- Is there an organizational policy or guidelines relating to stigma and discrimination? Please describe.
- Is there a workplace policy regarding stigma and discrimination?
  - If yes, what is stated in this policy?
- Please describe any training you received about HIV stigma and discrimination.
  - Who conducted the training?
  - Who at your organization participated in the training? (Probe: All staff? Staff involved in HIV-related projects?)
  - Were persons living with HIV involved in the training? If yes, how so?
  - What topics were covered in the training? Were the needs of key populations, including MSM and sex workers, covered in the training?
- If no training, would training about HIV stigma and discrimination be helpful? (Probe: How so? What are key topics that you would like covered?)
- How did this training influence your work? How did it influence your organization's HIV programming activities?

8. How are HIV and key population stigma typically included in the project proposals your organization submits? (Probe: How does stigma influence the development of project objectives and activities?)

  - Is stigma reduction thought of as a primary or secondary objective? (Probe: What influences this decision (e.g., the request for proposals? U.S. government guidance? Technical capacity?)
  - Is addressing stigma typically planned from the start or does it occur organically as the need arises during the life of a project?
  - What would enable your organization to include stigma and discrimination in project planning stages? (Probe: Training? Guidelines? Tools? Stigma-reduction models?)

Theme 5: Gender-based Violence Screening and Training

1. When news client come to your organization, do you do an intake session with them?

- If yes: what kind of information do you gather from them? Do you ask them about whether they have experienced, or are currently experiencing, any form of violence? If yes, do you use a specific screening tool for asking about violence? What forms of violence do you ask about? *Note: Request to see screening tools, if any.*

2. What are the key forms of violence experienced by your clients? What are the social attitudes that foster these forms of violence?
3. Based on what your clients have told you, in your estimation, what proportion of your clients have experienced intimate partner violence? Sexual assault in adolescence or adulthood? Violence because they are gay or transgender?
4. In your estimation, what proportion of your sex worker clients have experienced sexual assault or other violence in the course of their work (e.g., with clients, their bosses, or while on the street seeking customers)?
5. Are there staff at your organization who have received training on how to support survivors of partner violence and sexual assault? On how to support a survivor of LGBT hate crimes? What kind of training have they received, and when? Are there areas in which additional training would be helpful?

6. If a client tells you that they have experienced (or are currently experiencing) partner violence, sexual assault, an LGBT hate crime, or violence related to sex work, how does your organization respond? Is this disclosure confidential? How would you like for your organization to be able to respond?
7. If a client shares that they have perpetrated intimate partner violence, sexual assault, or other violence, how does your organization respond? How would you like to be able to respond?

Theme 6: Gender-based Violence-related Referrals

1. Is there a referral network in place in this local area? Are there clinics, hospitals, crisis centres, and other organizations nearby to which you can refer a violence survivor for medical care, legal assistance, counseling services, and safety/shelter?
2. Have you experienced any barriers to referral or ways in which the referral system needs to be strengthened? (If you refer clients, do they actually go?)
3. Are there organizations and institutions that refer clients to you? For what reasons do they refer clients to you? (Overall, how do you get your clients?) Do they refer as much as they should, or are there missed opportunities?

Theme 7: Client's Engagement in Gender-based Violence-related Services

1. For your clients who experience partner violence or sexual assault, how common is it for them to seek health care or counseling? Safety/shelter? How common is it for them to report it to the police? What are key barriers to survivors' seeking care? To reporting? How can these barriers be addressed? Where/with whom do survivors most often seek support?
2. For your clients who experience LGBT hate crimes or harassment, how common is it for them to seek health care or counseling? How common is it for them to report it to the police? What are key barriers to seeking care? To reporting? How can these barriers be addressed? Where do survivors most often seek support?
3. For your sex worker clients who experience violence, how common is it for them to seek health care or counseling? How common is it for them to report it to the police? What are key barriers to seeking care? To reporting? How can these barriers be addressed? Where do survivors most often seek support?
4. For your HIV+ clients who experience GBV, how common is it for them to seek health care or counseling? Safety/shelter? How common is it for them to report it to the police? What are key barriers to seeking care? To reporting? How can these barriers be addressed? Where do survivors most often seek support?
5. Is there stigma associated with being a survivor of partner violence or sexual assault in Guyana? To what extent might this be a barrier to help-seeking and reporting?
6. Having asked you several questions, do you have any for me? *Note: Answer any questions as applicable.*

Thank you for your time. I really appreciate your willingness to talk with me today.

END OF INTERVIEW

Note to interviewer: Please ask respondents if they have any documents to share relating to their stigma-reduction or GBV-reduction efforts or HIV awareness campaigns (e.g., survey instruments, evaluation reports, media messages [brochures, posters, etc.]).

APPENDIX 4. RAPID ASSESSMENT: IN-DEPTH INTERVIEW GUIDE FOR GOVERNMENT STAKEHOLDERS

INTERVIEWER: Record date, location, start and end time of interview, gender, organization, position, time at post. Describe the respondent and interview setting.

Theme 1: Respondent's Roles and Responsibilities

1. Can you briefly tell me about your role at (the ministry of __ or relevant organization)? (Probe: What are your main activities/responsibilities?)
2. What are the goals and objectives of the ministry of __ as a whole in relation to HIV programming? What are the roles and functions of the ministry of __/NAC/NAP in relation to HIV prevention, treatment and care?
3. Please tell me about HIV policy development efforts that you are involved with.
4. Please tell me about the HIV projects or programs that you support or are involved with at (the ministry of ___).

   - Who are the target audiences?
   - Where do the projects take place?
   - What do the projects consist of?
   - How long have the projects been going on? (Probe: When did the projects start?)
   - Are there existing M&E systems in place to monitor and evaluate the project activities?
   - Are there programs that specifically aim to reach MSM, CSWs, and OVC?

Theme 2: Stigma-reduction Policy and Programming

1. How do HIV-related stigma and discrimination affect the general population in Guyana? How does it affect key populations, including MSM, sex workers, and transgender individuals? In general, how are PLHIV and key populations viewed and treated here? Are people in the community willing to talk openly about HIV? Please provide some examples.
2. How do HIV-related stigma and discrimination influence/shape the implementation of HIV prevention, care, and treatment services in Guyana?
3. How do HIV-related stigma and discrimination influence people's risk of infection in Guyana?

   - How do stigma and discrimination influence key populations' (including men who have sex with men and sex workers) decisions to enroll and adhere in HIV care and treatment services?

4. Does the national AIDS policy/plan include sections on reducing stigma and discrimination? If so, how is HIV-related stigma and discrimination addressed?
5. How are HIV-related stigma and discrimination addressed within the HIV projects or programs you support/are involved with? *Note: If interviewee indicates that stigma and discrimination are not addressed within projects or programs they're involved with, skip to question 10.* (Probe: How does the project/program seek to reduce stigma? Is stigma reduction the main goal of the project? How is stigma reduction integrated within project activities?)

   - What models were used to address stigma? (Probe: Stand-alone models? Models that combine stigma reduction with ongoing project activities? Referrals? Linking with other organizations working with target populations?)
   - From your perspective, what has worked well? (Probe: Which activities would you recommend to others seeking to reduce stigma and discrimination?)

- Please describe any challenges faced in implementing stigma reduction activities. (Probe: Have you had any difficulties implementing stigma-reduction activities among MSM? Sex workers? Community members?)
- What strategies were used to address these challenges?
- Is there any evidence that stigma and discrimination have changed? Please describe.
- Please describe any evaluation data that were collected about stigma-reduction activities. (Probe: What indicators were collected to assess stigma and discrimination over time? Please describe the outcomes of these evaluations.)
- In your view, what were the benefits of including stigma reduction in project activities?
- How feasible would it be to scale up these stigma-reduction activities? (Probe: What would it take to scale up stigma-reduction activities within existing HIV programming efforts?)

6. *If stigma is not addressed*: How could stigma reduction be addressed within the HIV studies, projects, or programs that you support or are involved with?

- What models would be most appropriate for addressing stigma in the projects or programs your ministry/organization supports? (Probe: Stand-alone models? Models that combine stigma reduction with ongoing project activities? Linking with other organizations working with target populations?)
- In your opinion, what would be the benefits of incorporating stigma reduction into HIV project activities?
- What would be the challenges of including stigma reduction in project activities?
- How feasible would it be to include stigma-reduction activities within ongoing prevention, care, and treatment activities? (Probe: What would it take to scale up stigma-reduction activities within the ministry's existing HIV programming efforts?)
- What challenges do you foresee in scaling up stigma reduction activities within the ministry's ongoing HIV programming efforts? (Probe: Please describe any barriers to scaling up stigma-reduction activities, e.g., funding, human resources, lack of stigma-reduction models).
  - What support might be useful for overcoming these challenges? (Probe: Training? Models? Tools? Strategies?)

7. How do societal views towards MSM and sex workers affect the ministry's ability to reach these populations for HIV prevention, treatment, and care? (Probe: Is it difficult to reach MSM with HIV programming? Sex workers? Transgender individuals? How so and why?)
8. How do governmental policies towards sex workers and MSM affect the ability to reach these populations with HIV programming?
9. In your opinion, what kinds of HIV programs (prevention, care, treatment, etc.) would benefit most from the addition of stigma-reduction activities in Guyana? (Probe: All programs? Only some? Which ones? How would adding stigma reduction to these programs be helpful?)

- What type of support would be required to successfully include stigma-reduction activities in these program areas (fill in areas)?
  - What type of technical support would be required?
  - What type of resources would be required (e.g., funding, human resources, tools, stigma-reduction models)?
  - What about additional guidelines or policies?

10. How is HIV stigma and discrimination typically included in:

- Ministry planning and budgeting efforts? (Probe: Are stigma and discrimination included directly or indirectly? Please explain.)
- Reporting requirements?
  - If stigma is not typically included, how could stigma be included in these processes?

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- o Please describe the benefits and challenges of including stigma and discrimination in the ministry planning processes.
- o What would be required to get stigma and discrimination included in ministry planning and budgeting efforts?

Theme 3: Stigma Reduction—Starting at Home

1. Please describe any training you have received about stigma and discrimination.

- Who conducted the training?
- Who participated in the training? (Probe: All staff? Staff involved in HIV-related projects?)
- Were persons living with HIV involved in the training? If yes, how so?
- What topics were covered in the training? Were the needs of key populations, including MSM and sex workers, addressed in the training?
- Were there any key topics that were not discussed that you would like to be able to discuss with your colleagues?

  - o *If no training was received*: Do you think that training about stigma and discrimination would be helpful? (Probe: How so? What are key topics that you would like covered?)
  - o *If training was received*: How did this training influence your perspectives and work? How did it influence the ministry's HIV policies and programming?

Theme 4: Gender-based Violence Context

1. In your view, how big of a problem is intimate partner violence in Guyana? What about sexual assault? Hate crimes against members of LGBT groups? (Probe: Please tell me more about how IPV, sexual assault, and hate crimes are a problem in Guyana.)
2. What are the key programs being funded or implemented by government bodies in Guyana to prevent each type of violence?

- In schools?
- In community-based contexts?
- In health care settings?
- With a focus on engaging men and boys?
- Do these programs also address HIV and STI prevention issues? Stigma-related issues pertaining to GBV survivorship? Gender-inequitable norms?

3. Are there additional key GBV prevention programs that are led by NGOs? If yes, what are they? Whom do they serve? Do these programs also address HIV and STI prevention issues? Stigma-related issues pertaining to GBV survivorship? Gender-inequitable norms?
4. Have any of these key government or NGO programs been evaluated? If yes, what were the evaluation methodologies, and what have the findings been?
5. What gaps in services exist for GBV prevention efforts? In schools? In community-based contexts? With boys and men?
6. What efforts exist in Guyana to identify cases of GBV? Are there screening tools currently in use, as standard practice, by primary care providers? Mental health care providers? Emergency health services? LGBT resource centres? Sex worker support services? HIV and STI clinicians? Social service providers? *Note: If yes, request copies.*
7. Is there training (institutionalized or otherwise) regarding GBV screening and referral for primary care providers? Mental health care providers? Emergency health services? LGBT resource centres? Sex worker support services? HIV and STI clinicians? Social service providers?
8. If GBV screening and referral is not a standard practice for the aforementioned sorts of service providers, why not? Are there barriers that you foresee to having GBV screening and referral become a standard part of care for these providers?
9. What resources and programs exist in the country to respond to IPV? Sexual assault? Violence experienced by sex workers? LGBT hate crimes? (Probe: Examples are batterer intervention programs, safe spaces and

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shelters, counseling for survivors, police training, legal services, and, more holistically, vocational training, financial literacy for survivors, etc.)

10. What gaps in services exist for GBV response efforts? In medical settings? In other settings (e.g., counseling, legal system, safety and shelter, vocational training)?
11. Is there integration of HIV and GBV services in public health care settings and public social service settings? For example, if someone tests positive for HIV or STIs, is that person screened for GBV and given appropriate referrals (and the other way around)?
12. Do PLHIV experience higher rates of violence due to HIV-related stigma?
13. If there is not an integration of HIV and GBV services as of yet, what would be needed to help programs move in this direction? What barriers might exist, and how can they be addressed?
14. Having asked you several questions, do you have any for me? *Note: Answer any questions as applicable.*

Thank you for your time. I really appreciate your willingness to talk with me today.

END OF INTERVIEW

Note to interviewer: Please ask respondents if they have any documents to share relating to stigma reduction efforts they are involved with or support (e.g., survey instruments, evaluation reports, media messages [brochures, posters, etc.]).

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