In Guatemala, a concentrated epidemic within a highly stigmatized social context creates an environment fraught with challenges for reaching, and linking vulnerable men who have sex with men (MSM) and transgender women (TW) with HIV testing and care.

As part of USAID’s Combination Prevention Program in Guatemala, the Pan American Social Marketing commissioned an ethnographic study in 2016-2017 to understand the sexuality, identity construction, health care seeking behaviors, and MSM/TW-health provider relationships to design consumer-focused strategies to facilitate access to HIV services.

“It is illogical that I die of a flu that turns into pneumonia just because I do not have the money to go to a private doctor, because in health centers and organizations they only treat me if I go for sexually transmitted infections checkups. So we are not going to die of HIV instead of a lung infection, or diabetes or a poorly treated cut, that shouldn't happen. We are people like everyone, but they treat us poorly in the undifferentiated services and deny us attention, or they tell us things like ‘take those pills and I leave immediately’, but those pills are aspirin, that is only to get rid of me, but they don't give me a real diagnosis.”

HIV CARE IS FINE BUT WHAT IF I GET THE FLU?

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This ethnographic study was conducted in the two Guatemalan Departments with the highest HIV prevalence (Guatemala and Escuintla) among a sample of 24 MSM and 26 TW. The study included in-depth interviews that integrated complementary data collection instruments. Results were validated in a focus group with the target population.

This study highlights the need to have general health services for MSM and TW. Informants raised the issue that there is a large investment in HIV tests and treatment as well as in STI’s but they feel they are “subjects of interest” for the health sector only because of their gender identity and sexual orientation.

This objectification of the individuals as they expressed is due to the need of organization to meet the goals of HIV programs. Therefore, informants feel that these specialized organizations do not contribute to achieve their rights for holistic health services. This also includes mental health, which is a key factor in the overall health condition of individuals. They feel that organizations are only interested in the sexually transmitted infections neglecting other health conditions.

In contrast, MSM/TW lack a place to go where they can receive appropriate, integrated and gender-friendly health services, for general and daily health issues such as the ‘flu’. This leaves them with little alternatives that results in a lack of service or self-medication.

For MSM/TW from 30 consultations were not associated with HIV or STI’s. In the case of TW 16 from 27 consultations were not associated with HIV or STI’s. In those cases individuals had to seek health services from the private sector, pharmacies, and public hospitals or public health services. In these last two instances, they report being mistreated, and in the private sector, the economic factor is a big barrier. That is why MSM and TW, will end up at the pharmacy and self-medicating.

The MSM/TW populations recognized many advances in the provision of gender-friendly HIV services, but these are not reflected in the provision of integrated health care. Vulnerable populations are reliant on the specialized HIV services provided by NGOs or HIV clinics, but have no appropriate options for primary care and mental health, and so there is need for synergy and appropriateness of healthcare services for MSM/TW.

Additionally, participants emphasized the need for including mental health as part of the HIV services for a more holistic and human approach.

While there are criticisms of public health services and some organizations, the quality of HIV services available is generally considered satisfactory more so for MSM than TW, mostly because the last suffer from higher stigma and discrimination in the public sector.