

# Guyana LGBTQ+ COVID-19 Survey

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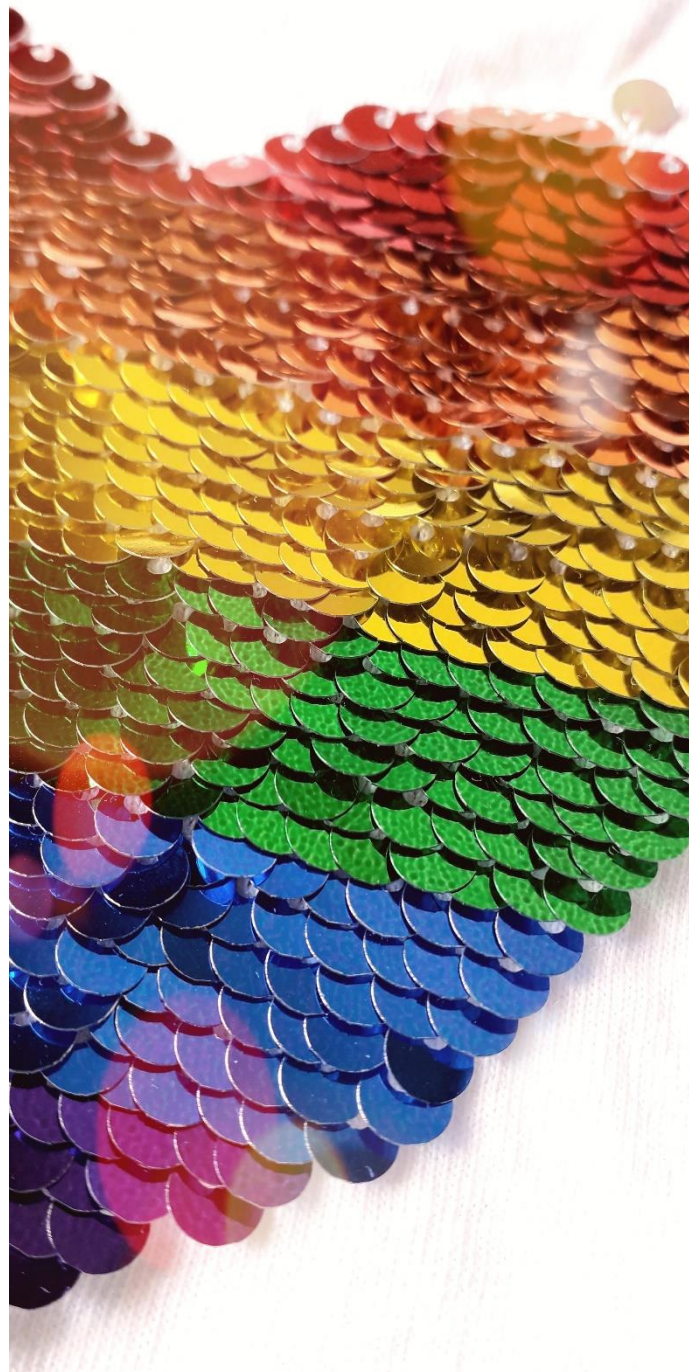
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# Background

Coronavirus disease (COVID-19) caused by the newly discovered Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2) <sup>1</sup> was declared a global pandemic by the World Health Organization (WHO) in March 2020 <sup>2</sup>. The effects of this pandemic are continuously evolving, wide-reaching and unpredictable, but similar to conflict situations, women, children, people with disabilities, the marginalized and the displaced, are considered most at risk for devastating losses from COVID-19 <sup>3</sup>. Lesbian, gay, bisexual, transgender and queer plus (LGBTQ+) persons are marginalised persons and there is reason to suspect that this population may be disproportionately impacted due to several factors tied to their vulnerability. These include pre-existing health disparities such as higher rates of smoking and its sequelae; higher rates of HIV and cancer, and discrimination and stigma in accessing healthcare <sup>4</sup>.

One of the main public health actions taken against the spread of COVID-19 has been the introduction of 'shelter in place' and/or 24-hour curfew for populations. As LGBTQ+ people currently experience disproportionate levels of domestic and family violence and scapegoating, with the pandemic cutting off access to community centres and events that help to sustain resilience <sup>5</sup>, domestic violence could be escalated. It has also been noted that LGBTQ+ people are more likely to work in jobs affected by the national shutdowns, such as retail businesses and hospitality services, or in "front-line" jobs like food services or healthcare which make social distancing difficult <sup>6</sup>. Trans women and sexual minority women are also likely to experience further disparities since pandemic mitigation factors such as school closures, limited economic opportunities, the involvement of women in domestic sectors and differential quarantine needs contribute to a gendered impact of the disease <sup>7</sup>.

In the Caribbean, the United Caribbean Trans Network (UCTRANS) released a statement highlighting that existing socio-economic marginalization of transgender people forms a barrier to many services, and in Belize and Guyana, the pandemic has displaced persons who couldn't pay rent or were discriminated against by landlords <sup>8</sup>. However, much of the current impact of the COVID-19 pandemic on LGBTQ+ persons in the region remains anecdotal. This

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<sup>1</sup> European centre for disease prevention and control. 2020. Q & A on COVID-19. Available from: <https://www.ecdc.europa.eu/en/covid-19/questions-answers>

<sup>2</sup> Cucinotta, D & Vanelli, M. 2020. WHO declares COVID-19 a pandemic. *Acta Biomed*, 91(1):157-160

<sup>3</sup> The United Nations Department of Global Communications. UN working to ensure vulnerable groups not left behind in COVID-19 response. Available from: <https://www.un.org/en/un-coronavirus-communications-team/un-working-ensure-vulnerable-groups-not-left-behind-covid-19>

<sup>4</sup> Marr, R. 2020. LGBTQ people are 'particularly vulnerable' to coronavirus effects, advocacy groups warn. Available from: <https://www.metroweekly.com/2020/03/lgbtq-people-are-particularly-vulnerable-to-coronavirus-effects-coalition-of-organizations-warn/>

<sup>5</sup> Outright Action International. 2020. OutRight Launches COVID-19 LGBTIQ Global Emergency Fund. Available from: <https://outrightinternational.org/content/outright-launches-covid-19-lgbtqi-global-emergency-fund>

<sup>6</sup> Riley, J. 2020. HRC warns of COVID-19 pandemic's impact on black and LGBTQ communities. Available from: <https://www.metroweekly.com/2020/04/hrc-warns-of-covid-19-pandemics-impact-on-black-and-lgbtq-communities/>

<sup>7</sup> Wenham, C., et al. COVID-19: the gendered impacts of the outbreak. *The Lancet*, Volume 395, Issue 10227, 846 – 848

<sup>8</sup> United trans Caribbean network. 2020. Statement to regional governments on social security during COVID-19. Available from:

<https://www.facebook.com/uctransnetwork/photos/a.507053599779465/862871900864298/?type=3&theater>

study sought to provide the evidence for how COVID-19 has affected the LGBTQ+ communities in four (4) Caribbean countries – Barbados, Grenada, Guyana and St Lucia, with a specific focus on socio-economic disparities, sexual practices and mental health burdens. It is the result of a collaboration between the University of the West Indies (UWI) Cave Hill Campus and four LGBTQ+ organizations in each of the countries under consideration – Equals Inc (Barbados), GrenChap (Grenada), SASOD (Guyana) and United and Strong (St Lucia). Funding for parts of the research was provided by the United Nations Development Program (UNDP) Being LGBTI In the Caribbean (BLiC). The results of this study will be useful to not only guide immediate programmatic activities for addressing the needs of the LGBTQ+ populations in these four countries and the wider Caribbean but could also serve as a baseline assessment as the pandemic unfolds.

## Country Context

Guyana lies on the Northern coast of South America and is the only English-speaking country on the continent. Historically and culturally part of the Caribbean, the nation has a population of around 800,000 mostly living on the coastal area and concentrated around the capital city, Georgetown.

The first case of COVID-19 in Guyana was announced on March 11, 2020, and was diagnosed in a woman who had recently returned from New York City. She subsequently died<sup>9</sup>. On March 18<sup>th</sup> Guyana closed its borders to all incoming air traffic, and this directive will last until July 31, 2020<sup>10</sup>. In early April a nightly curfew and the closure of non-essential businesses was instituted and remains in place<sup>11</sup>. To date (June 14, 2020), the country has recorded 159 cases, 12 deaths<sup>12</sup>, and region 4, which is the most populous region, has accounted for the majority of cases<sup>13</sup>.

LGBTQ+ organizations, such as SASOD Guyana, GuyBow and Guyana Trans United (GTU) have executed ongoing hamper distribution events for LGBTQ+ persons living mostly around Georgetown, since the end of March. There are also efforts being made by the government and international donor agencies to provide more aid to this population, and especially persons living with HIV.

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<sup>9</sup> Kaieteur News. 2020. Breaking News! Guyana records first coronavirus-related death. Available from: <https://www.kaieteurnews.com/2020/03/11/breaking-news-guyana-records-first-coronavirus-related-death/>

<sup>10</sup> GCAA. 2020. Directive: Restriction of Flight Within Georgetown FIR. Available from: <https://www.gcaa-gy.org/airport-closure-2020.html>

<sup>11</sup> iNewsGuyana. 2020. President announces closure of bars, restaurants from 6 pm daily. Available from: <https://www.inewsguyana.com/president-announces-closure-of-bars-restaurants-from-6-pm-daily/>

<sup>12</sup> Ministry of Public Health. 2020. Guyana COVID-19 Dashboard. Available from: <https://health.gov.gy/index.php/component/k2/item/184-guyana-covid-19-dashboard>

<sup>13</sup> Guyana Chronicle. 2020. Region 4 accounts for 86% of COVID-19 cases. Available from: <http://guyanachronicle.com/2020/04/15/region-4-accounts-for-86-of-covid-19-cases>

# Study Methodology

This study employed a cross-sectional quantitative methodology utilizing an online survey hosted on SurveyMonkey. The self-administered questionnaire elicited information on demographics, health status, and access to healthcare and other services during the COVID-19 lockdown period, as well as perspectives and experiences related to the adoption of non-pharmaceutical intervention measures.

The sampling strategy used convenience and snowball sampling, whereby persons in the researchers' personal and professional networks were sent a link to the survey (via online messaging, WhatsApp, Facebook messenger etc.) with persons who were sent this link being able to forward it to other persons in their networks. The survey was also advertised on the social media platforms of LGBTQ+ organizations in Barbados (Equals Barbados, SHE Barbados etc), Grenada (GrenCHAP), Guyana (SASOD Guyana, Guyana Trans United etc.) and St Lucia (United and Strong, ECADE) and boosted through payment for advertising on these platforms so that potential respondents who had no affiliation or interaction with these organizations' social media pages could still see the advertisement for the survey on their feeds. The survey link was launched on May 20, 2020, and remained active for 11 days.

To participate in the study, individuals had to self-identify as lesbian, gay, bisexual, transgender, queer or other sexual and gender minorities; aged 18 years and older; resident in the participating site (Barbados, Grenada, Guyana or St Lucia) for 3 months or more; and able to complete the survey in English. Participants gave electronic informed consent and self-completed the survey. At the end of the survey, respondents were given the option to enter their cell phone number on an external website for receipt of USD \$10 cell phone credit as a token for their time. Only the first 350 respondents were given this cell phone credit. Data analysis utilized SPSS v26 and consists of descriptive analyses as well as analytic statistics (Cronbach's alpha, ANOVA and chi-square calculations) applied to the scaled items and used to determine differences in practices and impacts by demographic category. P-values are considered statistically significant at  $<0.05$ .

This study was approved by the UWI/ Barbados Ministry of Health Research Ethics Committee/Institutional Review Board (IRB No. 200409-B).

## Results

## Demographics

Analysis for the Guyana dataset involved removing a total of 13 persons who identified as cisgender and heterosexual from further analysis, for a total of 265 respondents who met the inclusion criteria. The average age of respondents was 27.2 years with 38.6% assigned female at birth and 60.6% assigned male. In terms of gender identity, the largest number identified as **males (45.5%)**, followed by **females (30.5%)**, **trans women (8.2%)**, **trans men (5.2%)** and **non-binary/gender fluid (4.7%)**. Seven (7) respondents indicated a different gender identity from the sex assigned at birth but did not select the trans option. Three (3) of these persons were female-to-male and 4 were male-to-female. In determining associations between gender and different variables these persons were recoded to the trans category of gender identity. The majority of the respondents were from **Georgetown (40%)** or outside the capital in region 4 (19.6%). Regions 3 (17%), 6 (10.6%), and 5 (4.9%) also had some representation, followed by region 10 (4.2%) and each of the remaining regions where less than 2% of the respondents resided. Other demographic characteristics are presented in Table 1.

**Table 1:** Demographic characteristics of the respondents (n = 265)

	Number	Percentage
<b>Sexual Orientation</b>		
Asexual	7	3.0
Bisexual	70	29.9
<b>Gay</b>	<b>83</b>	<b>35.5</b>
Lesbian	44	18.8
Pansexual	12	5.1
Queer	13	5.6
Other (no label, transgender)	5	2.1
<b>Ethnicity</b>		
Indigenous	10	4.3
<b>Black/African</b>	<b>96</b>	<b>41.2</b>
Indian descent	52	22.3
Multiracial/Multiethnic	66	28.3
Other (Chinese, White)	5	2.2
<b>Religion</b>		
<b>Christianity</b>	<b>160</b>	<b>68.1</b>
Hinduism	22	9.4
Islam	13	5.5
Other (non-religious, atheist, Rastafarian)	17	7.2
<b>Education</b>		
Completed primary school	9	3.8
<b>Completed secondary school</b>	<b>94</b>	<b>39.8</b>
Did not complete primary school	3	1.3
Some secondary school	27	11.4
University	93	39.4
Other	6	2.5

## Socio-Economic Disparities

In the months before COVID-19 most respondents were working full-time (62.1%) or part-time (14.9%), with 6.4% being full-time students and 8.1% unemployed. At the time of surveying, **45% reported they had lost their job or had their business closed** because of COVID-19, with another 26.5% having reduced hours or being temporarily laid off, leaving 28.5% of the respondents who were still employed. Only 12.3% of persons had more than 2 months' worth of savings, the rest having either less than 1 month of savings (38.7%) or 1 to 2 months' (36.6%). A majority of persons also reported that they were the main breadwinners in their household (57.1%) which contained an average of 4.2 persons. Table 2 shows the other socio-economic characteristics of the respondents.

**Table 2:** Socio-economic characteristics of the Guyana respondents (n = 265)

	Number	Percentage
<b>Able to work from home</b>		
<b>No</b>	141	<b>53.6</b>
Yes	67	25.5
Not applicable	48	18.2
Other (internet and equipment issues)	8	3.0
<b>Able to study from home</b>		
No	76	28.9
<b>Yes</b>	87	<b>33.1</b>
Not applicable	100	38.0
<b>Own or rent home</b>		
Living rent-free	52	22.0
Own outright	32	13.6
Own with a mortgage	18	7.6
<b>Rent</b>	126	<b>53.4</b>
Other (living with parents, roommates)	8	3.4
<b>Healthcare worker</b>		
<b>No</b>	237	<b>92.2</b>
Yes	20	7.8
<b>Non-healthcare essential worker (grocery, police, military etc)</b>		
<b>No</b>	177	<b>69.7</b>
Yes	77	30.3
<b>Caring for children or dependents</b>		
<b>Yes</b>	142	<b>54.4</b>
No	100	38.3
Not applicable	6	2.3
<b>Able to secure care in the last 3 weeks</b>		
Yes	31	21.8
<b>No</b>	82	<b>57.7</b>
Not needed	29	20.4

## General Health and Support Services

There were 34 persons living with HIV (PLHIV) (12.8%), 30 sex workers (11.3%), 13 persons with disabilities (4.9%) and 10 persons who were homeless (3.7%). Other vulnerable categories identified by respondents included having respiratory illnesses, diabetes, living with HPV and living with relatives.

The state of general health was reported to be fairly good (43.5%) or very good (21.2%), followed by neither good nor poor (20.8%), and fairly poor (6.9%) to very poor (4.6%). When asked about health-related support and access to services prior to COVID-19, 47.7% of those who completed the question indicated no, that they did not require any services. For those who indicated yes to accessing at least one support/service option, Table 3 shows the breakdown of their answers.

**Table 3:** Access to health-related services and support pre-COVID-19

	Number	Percentage (from persons who indicated accessing services)
<b>Health-related service/support</b>		
Referrals to access health and social services	28	10.8
Help with reporting harassment and discrimination	19	7.3
Legal and paralegal services	8	3.0
<b>Counselling</b>	38	<b>14.6</b>
HIV treatment and care	33	12.7
Hormones	4	1.5
Hypertension/blood pressure	24	9.2
Diabetes Mellitus (Type 1 or Type 2.	11	4.2
Depression, Anxiety, Schizophrenia	29	11.1
PrEP medications	5	1.9
Condoms /dental dams and such	24	9.2
Prefer not to say	36	13.8

The most common reason for not accessing a service was being in isolation/quarantine (34.3%), followed by the support agency being closed (29.3%), and the pharmacy or clinic being closed (13.6%). Other reasons included, mostly, being unable to afford the service or transport to the service, along with fear of visiting the hospital for fear of contracting COVID-19, and the agency not allowing in-person visits. Persons most frequently indicated that they needed support at present with food/water (28.2%), help to cope/emotional or stress support (18.4%), someone to talk to (14.7%), a place to live or assistance with rent (14.7%), transportation (12.7%), and medication/access to medication (11%). Money for unspecified purposes was the main support needed by those who selected 'other' forms of support.

Participants were asked how LGBTQ+ organizations could better support them during this period, and whilst some had no definite suggestions or couldn't think of anything in particular, many others had several suggestions. Support in the form of food hampers, health care supplies, groceries, cash, assistance with rent and utilities, as well as provision of cleaning supplies, sanitizers and masks was commonly mentioned. Others thought that these organizations should be regularly checking in on the community via telephone calls and texts or a social worker, and conducting outreach to evaluate community needs and mental health needs. Mental health issues could then be addressed via free virtual counselling sessions, along with the provision of other medical and social services as needed. Another popular

suggestion was support groups (Zoom rooms, WhatsApp/Facebook groups for interaction) and virtual group chats where moral encouragement, support and empowerment could take place. Outside of these chats and groups, there were also suggestions to support, encourage and empower the community, along with disseminating information on the pandemic. Novel suggestions included the provision of a safe haven or shelter for LGBTQ+ persons, support resources for persons trapped in unsupportive homes, cell phone credit so persons could stay in touch with loved ones and posting more inspirational and motivational messages online.

## Mental Health

Mental health was assessed through the Patient Health Questionnaire-4 (PHQ-4) which is an ultra-brief screener for anxiety and depression that combines the Patient Health Questionnaire-2 (PHQ-2) and the Generalized Anxiety Disorder-2 (GAD-2), utilizing 4 questions with responses provided on a Likert scale<sup>14</sup>. The sub-scales assess anxiety and depression, while the combined score indicates psychological distress<sup>15</sup>. The PHQ-4 has been used extensively in research and clinical settings, with a range of populations, but has not been previously validated for use in the Caribbean or with Caribbean LGBTQ+ populations, to our knowledge. Cronbach's alpha was 0.84 which indicates a high level of internal consistency for this scale with this specific sample.

The sum of questions 1 and 2 gives the anxiety sub-scale (score range, 0 to 6), while the sum of items 3 and 4 gives the depression sub-scale (score range, 0 to 6). On each sub-scale, a score of 3 or greater is considered positive for screening purposes. Total score ranges from 0 to 12, with categories of psychological distress being: none 0-2, mild 3-5, moderate 6-8, severe 9-12<sup>ibid</sup>. Applying these scoring criteria gave a **median anxiety score of 3** (n = 248, mean = 3.1, SD = 2.0), with 53.2% screening positive for anxiety. The **median depression score was 2** (n = 250, mean = 3.0, SD = 1.9), with 50.4% screening negative for depression. Overall, the total score median score was 6 (n = 248, mean = 6.1, SD = 3.6) which correlates to **moderate levels of psychological distress**.

Additionally, many reported **very worried (75.2%)** or fairly worried (18.4%) about COVID-19.

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<sup>14</sup> Stanhope, J. 2016. Patient Health Questionnaire-4. *Occupational Medicine* 2016; 66:760–761

<sup>15</sup> Utah Med. PHQ-4. Available from: [https://www.utahmed.org/docs/CS\\_Resources/PHQ-4%20Patient%20Health%20Questionnaire.pdf](https://www.utahmed.org/docs/CS_Resources/PHQ-4%20Patient%20Health%20Questionnaire.pdf)



## COVID-19 Related Practices and Beliefs

Understandably, most persons had not been tested for the infection (88.5%), since these tests were not readily available during the early stages of the epidemic. However, 9.9% reported testing negative, and 1.6% testing positive or unsure of results. Roughly a third of the total respondents (28.6%) knew someone who had been diagnosed with COVID-19. The responses for what persons had done to protect themselves from COVID-19 are shown in Table 4.

**Table 4:** Non-pharmaceutical interventions and other actions against COVID-19

	Yes (%)	No (%)
<b>Worn a facemask</b>	250 ( <b>99.2</b> )	1 (0.4)
<b>Washed hands more frequently with soap and water</b>	250 ( <b>99.2</b> )	2 (0.8)
Used hand sanitizer more regularly	242 (96.4)	9 (3.6)
Covered nose and mouth with a tissue or sleeve when sneezing and coughing	239 (95.2)	8 (3.2)
Avoided crowded areas	243 (96.4)	9 (3.6)
Avoided meeting new sex partners	214 (84.9)	22 (8.7)
Avoided going to a hospital and other healthcare settings	229 (90.9)	15 (6)
Gargle with saltwater	90 (36.1)	153 (61.4)
Bathe in the sea	22 (8.9)	219 (88.3)
Drink herbal /ginger/bush tea	195 (77.4)	55 (21.8)

For those who reported on their activities in preparation for lockdown or curfew, the most common preparation was stocking up on food supplies (63.5%), followed by stocking up on prescription meds (45.4%), stocking condoms and safe sex supplies (32.3%) and finding alternative childcare (16.9%). The most frequently reported source of COVID-19 information was social media, with Table 5 showing the breakdown according to the reported source. Respondents were asked whether the new coronavirus is a bio-weapon developed by a government or terrorist organization, and many thought this conspiracy was likely (60.4%).

**Table 5:** Sources of COVID-19 information

	Number	Percentage (of total respondents)
Newspapers or magazines	121	45.6
Radio	95	35.8
Cable television / Satellite	99	37.3
Official websites (e.g. government, Ministry of Health)	148	55.8
<b>Social media (e.g. WhatsApp, Twitter, Facebook)</b>	189	<b>71.3</b>
My doctor or other healthcare professionals	42	25.4
My family or friends	98	36.9
Not applicable-I am not getting any information about corona-virus	2	0.7
Other (independent research, GTU)	3	1.1

## Sexual Activity and Substance Use

Most people reported being unable to meet people who did not live with them for sex (67.1%). For those who met persons, they had connected mostly through online chats (dating apps, WhatsApp, etc.) (54.4%) or at residences (20.5%). Frequency of substance use is shown in Table 6.

**Table 6:** Substance use in the 3 months prior to lockdown/curfew

	Alcohol N (%)	Drugs other than marijuana N (%)	Marijuana N (%)
Never (or I stopped more than 3 months ago)	52 (21.2)	<b>196 (82.4)</b>	<b>169 (70.7)</b>
Occasionally (less than once a month)	<b>74 (30.2)</b>	19 (8)	31 (13)
Once or twice a week	64 (26.1)	12 (5)	11 (4.6)
1 - 3 times a month	36 (14.7)	7 (2.9)	14 (5.9)
Every day or nearly every day	19 (7.8)	4 (1.7)	14 (5.9)
Total	245 (100)	238 (100)	239 (100)

Among persons who used alcohol, the respondents most commonly drank 3 to 5 (33.5%) or more than 5 drinks at a time (33%). However, during the last 2 weeks of the lockdown / curfew period, most alcohol users reported they did not use the substance more than usual (66.5%). Persons who used drugs other than marijuana also did not report an increased usage during the 2 weeks of lockdown/curfew (74.5%). Marijuana users had a closer division in increased use, with 58.3% reporting no more than usual use in the last 2 weeks, but 41.7% using more.

## Reports of Violence

Less than a third of the total respondents answered the question on whether they had experienced any physical, sexual or emotional abuse during lockdown; among those who did answer, 20% reported experiencing abuse. Table 7 illustrates the responses to the questions on specific violence situations in the household during the last 2 weeks.

**Table 7:** Situations of violence

	Yes N (%)	No N (%)	Total N (%)
Touched, kissed or hugged in a sexual way that was unwanted	15 (8.2)	168 (91.8)	183 (100)
Forced into something sexual that found degrading or humiliating	8 (4.4)	174 (95.6)	182 (100)
Forced into sexual intercourse (oral, anal, vaginal)	5 (2.7)	177 (97.3)	182 (100)
Shouted, belittled, made feel bad, threatened to hurt you or loved ones	<b>42 (23.2)</b>	139 (76.8)	181 (100)
Slapped, threw something, pushed or shoved, pulled hair, hit with a fist, kick, drag or beat	16 (8.9)	164 (19.1)	180 (100)

For the most commonly reported type of violence – verbal – the perpetrator was another/sister (33.3%), followed by husband/boyfriend (26.1%). The perpetrators of forced sexual activity were most commonly reported as husband/boyfriend (66.6%).

For persons who experienced forced sex, emotional or physical abuse, the largest percentage did not call anyone (39%), whilst others called the police (19.5%), family or friends not living in the same household (12.1%) or their mothers (12.1%).

## Demographic associations and inferential analyses

Table 8 shows a breakdown of age by the sex assigned at birth, gender and sexual orientation, while Table 9 illustrates how sources of information on COVID-19 varied by age groups.

Performing chi-square tests for association between age and the PHQ-4 screening for anxiety and depression revealed no statistically significant results. Similar analysis on age and gargling with saltwater, drinking herbal teas, stocking up on food/medications/safe sex supplies, use of substances and whether COVID-19 is a bioweapon also revealed no statistically significant findings.

**Table 8:** Age by sex, gender and sexual orientation

	AGE				
	18-24 N (%)	25-34 N (%)	35-44 N (%)	45-54 N (%)	55-64 N (%)
<b>Sex assigned at birth</b>					
Female	36 (38.3)	36 (37.1)	17 (48.6)	1 (16.7)	1 (50)
Male	58 (61.7)	61 (62.9)	18 (51.4)	5 (83.3)	1 (50)
Total	94	97	35	6	2
<b>Gender</b>					
Female (Woman)	29 (32.9)	24 (25.8)	12 (38.7)	1 (16.6)	1 (50)
Male (Man)	42 (47.7)	49 (52.6)	10 (32.2)	2 (33.3)	0
Trans woman	6 (6.8)	9 (9.6)	4 (12.9)	3 (50)	1 (50)
Trans man	5 (5.6)	6 (6.4)	4 (12.9)	0	0
Non-binary/gender fluid	6 (6.8)	4 (4.3)	1 (3.2)	0	0
Other	0	1 (1)	0	0	0
Total	88	93	31	6	2
<b>Sexual orientation</b>					
Asexual	3 (3.2)	1 (1)	3 (8.6)	0	0
Bisexual	36 (38.3)	22 (22.9)	11 (31.4)	0	1 (50)
Gay	32 (34)	35 (36.5)	10 (28.6)	5 (71.4)	1 (50)
Lesbian	12 (12.8)	21 (21.9)	10 (28.6)	1 (14.3)	0
Pansexual	6 (6.4)	6 (6.3)	0	0	0
Queer	5 (5.3)	8 (8.3)	0	0	0
Other	0	3 (3.1)	1 (2.9)	1 (14.3)	0
Total	94	95	35	7	2

**Table 9:** Age by sources of information on COVID-19

	AGE				
	18-24 N (%)	25-34 N (%)	35-44 N (%)	45-54 N (%)	55-64 N (%)
Newspapers or magazines	50 (41.3)	52 (43)	15 (12.4)	3 (2.5)	1 (0.8)
Radio	39 (41.1)	39 (41.1)	13 (13.7)	2 (2.1)	2 (2.1)
Cable television / Satellite	38 (38.4)	39 (39.4)	18 (18.2)	3 (3)	1 (1)
Official websites (e.g. government, Ministry of Health)	56 (37.8)	62 (41.9)	25 (16.9)	4 (2.7)	1 (0.7)
Social media (e.g. WhatsApp, Twitter, Facebook)	75 (39.7)	85 (45)	23 (12.2)	5 (2.6)	1 (0.5)
My doctor or other healthcare professional	21 (50)	17 (40.5)	3 (7.1)	1 (2.4)	0
My family or friends	41 (41.8)	44 (44.9)	9 (9.2)	3 (3.1)	1 (1)

Table 10 shows how sources of COVID-19 information varied by gender.

Testing for an association between age and having been shouted at/belittled/made to feel bad, more persons aged 18-24 reported experiencing this violence (35.7%) compared to the other age groups (all <20%), and this was statistically significant with  $p < 0.05$ . The age group that most reported physical violence (slapped/pushed/shoved) was 25-34, but there was no statistically significant difference compared to the other age groups.

Performing chi-square tests for association between gender and the PHQ-4 screening for anxiety, depression and overall score revealed no statistically significant results. Similar analysis on sex and current savings, being able to study/work from home, being worried about COVID-19, use of substances, drinking herbal teas, stocking food/medications/finding alternative childcare, experiencing verbal and physical abuse, and whether COVID-19 is a bioweapon also revealed no statistically significant findings. With regards to caring responsibilities, men were more likely to report no care responsibilities (59.6%), compared to women (36.5%), trans women (19%), trans men (20%) and other/non-binary identities (27.3%) ( $p < 0.05$ ). Gargling with saltwater was also done significantly less by men (22%) as compared to women (44.4%), trans women (47.8%) and trans men (66.7%) ( $p < 0.05$ ). Finally, trans women were more likely to stock up on condoms and safe sex supplies (70%) compared to cis women (26%) and men (30.8%).

**Table 10:** Gender by sources of COVID-19 information

	GENDER		Other/Non-binary N (%)	Trans women N (%)	Trans men N (%)
	Female N (%)	Male N (%)			
Newspapers or magazines	34 (30.1)	59 (52.2)	7 (6.2)	8 (7.1)	5 (4.4)
Radio	27 (30.7)	45 (51.1)	4 (4.5)	10 (11.4)	2 (2.3)
Cable television / Satellite	28 (30.8)	44 (48.4)	4 (4.4)	10 (11)	5 (5.5)
Official websites (e.g. government, Ministry of Health)	36 (26.9)	69 (51.5)	10 (7.5)	12 (9)	7 (5.2)
Social media (e.g. WhatsApp, Twitter, Facebook)	49 (28.7)	85 (49.7)	9 (5.3)	17 (9.9)	11 (6.4)
My doctor or other healthcare professional	9 (23.7)	24 (63.2)	1 (2.6)	3 (7.8)	1 (2.6)
My family or friends	19 (21.6)	53 (60.2)	6 (6.8)	6 (6.8)	4 (4.5)

There were no significant associations between educational level and drinking herbal teas or thinking COVID-19 is likely a bioweapon, however, persons who attended university were less likely to gargle with salt water (21.3%) compared to persons with other schooling levels ( $p < 0.05$ ).

# Key Findings

Within the limitations of this study and the sampling methodology, the following points are notable:

- A little over 70% of persons had lost their job or experienced reduced working hours due to COVID-19; most persons had very little current savings.
- Fifty-four per cent (54%) of the respondents reported having caring responsibilities and many were unable to secure care in the past 3 weeks.
- Counselling was the most frequently utilized support service pre-COVID-19 and persons most desired support with food/water and help to cope with emotions and stress. This was also reflected in the open-ended question on how LGBTQ+ organizations could best support the community.
- The analysis revealed moderate levels of psychological distress in the sample population overall.
- Most persons were worried about COVID-19 and used the preventative measures advocated by public health authorities. Drinking herbal teas was also widely practiced.
- The most commonly reported source of information on COVID-19 was social media.
- Many persons did not meet persons outside their homes for sex, and there was some increase in more than usual substance use during the lockdown.
- Although less than a third of respondents answered the general question on experiencing abuse, over 65% of the respondents answered the individual questions on various types of household violence. Sexual and physical abuse in the household within the last 2 weeks was fairly uncommon, and verbal abuse was the most commonly reported form of abuse.