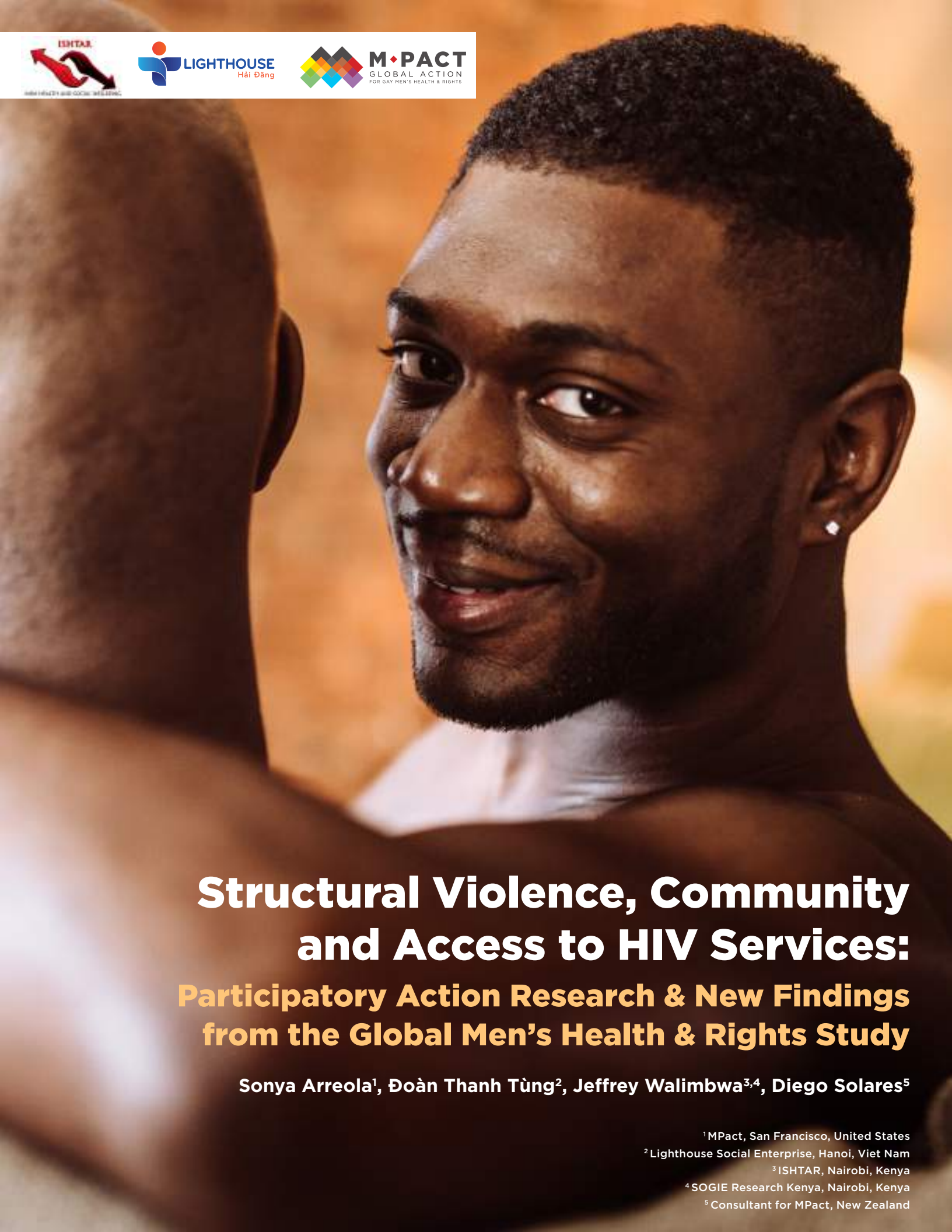




Structural Violence, Community and Access to HIV Services: Participatory Action Research & New Findings from the Global Men's Health & Rights Study

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INTRODUCTION

Gay and bisexual men and other men who have sex with men (hereafter referred to as gay and bisexual men)¹ are 22 times more likely to acquire HIV than other adult men.² In 2019 gay and bisexual men represented nearly 1 out of 4 new HIV infections worldwide.^{2,3} Ecological factors such as criminalization of sex between men; structural barriers such as sexual stigma; and individual level factors such as psychological distress impede access to health services that are essential along the HIV care continuum.^{4,5,6} Conversely, community level factors such as community engagement enable health services access among gay and bisexual men.⁷ These associations are significant because having access to HIV services is critical to deterring new infections as well as to the health of people living with HIV. Therefore, examining the barriers and enablers of access to HIV and other support services is essential for guiding programming, informing policy and increasing advocacy of gay and bisexual men's health and rights.

This report presents global and country-level (Kenya and Viet Nam) research findings from the Action for Access! and Global Men's Health and Rights (GMHR-4) studies. Using a community based participatory action research approach (CBPAR) and mixed methods design our specific aims were to:

1. Build community-based organization research capacity;
2. Identify and explore indicators of access to HIV prevention and care, and support services for gay and bisexual men in Kenya and Viet Nam; and
3. Identify and explore indicators of access to HIV prevention and care, and support services for gay and bisexual men globally.

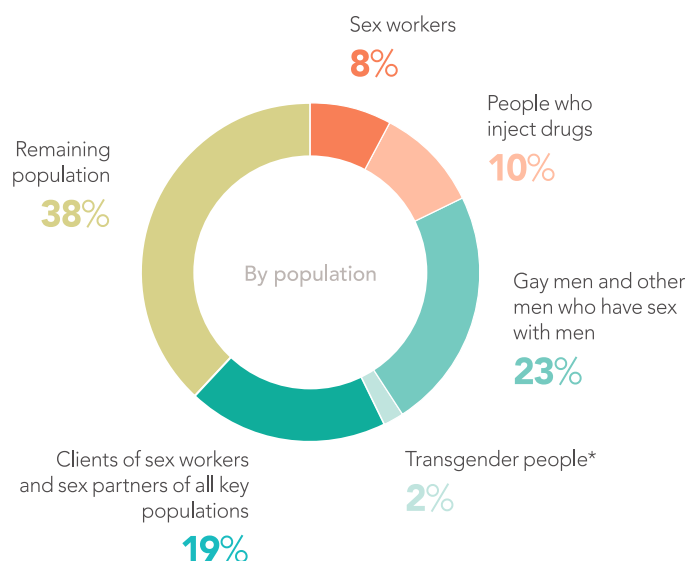
This report describes the research approach and design, followed by the methods and results. These sections are followed by a discussion section that explores the significant indicators revealed by qualitative and quantitative data and their implications.

Global Background

In 2019, 60% of all new HIV infections were among key populations and their partners, including: sex workers, people who use drugs, transgender people, prisoners, and gay and bisexual men.^{2,8} Although there is significant overlap among these intersecting populations, available data from 2018 suggest that the risk of HIV acquisition among gay and bisexual men was 22 times higher than it was among all adult men.

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FIGURE 1. **Distribution of new HIV infections by population, global, 2019**



Gay and bisexual men specifically accounted for an estimated 17% of new HIV infections globally (see Figure 1), including more than half of new HIV infections in western and central Europe and North America, 40% in Latin America and 30% in Asia and the Pacific.² Available data among gay and bisexual men from selected countries indicate that HIV prevalence and incidence are even higher among younger men.²

While there have been successes in reducing HIV infections and AIDS-related deaths among gay and bisexual men in some cities, many communities of gay and bisexual men still have limited access to HIV services, due in large measure to structural barriers such as criminalization, sexual stigma and health provider discrimination. For example, in many cities and countries globally, gay and bisexual men are still treated as criminals and denied access to the health and HIV services they need. Laws that criminalize sex between men undermine their basic human rights, and expose them to hate speech, violence, forced anal examinations and forced heterosexual marriage.⁹ As of March 2019, there were 70 UN Member States (35%) that criminalize consensual same-sex sexual acts. In addition, other jurisdictions which are not UN Member States also criminalize such acts (e.g., Cook Islands and certain provinces in Indonesia).¹⁰

*Data only included from Asia and the Pacific, the Caribbean, eastern Europe and central Asia, Latin America, and western and central Europe and North America.

Source: UNAIDS epidemiological estimates, 2020 (see <https://aidsinfo.unaids.org/>); UNAIDS special analysis, 2020 (see methods annex).

Note: Epidemiologic data from transgender populations are available primarily from the Asia and the Pacific, Caribbean and Latin America regions.

Sparser data are available from the western and central Europe and North America region. Limited programme data are available from western and central Africa and eastern and southern Africa. Furthermore, data are primarily from transwomen, and among those transwomen, data are frequently from people who sell sex. Only a few data points were available from transmen. Nonetheless, the transgender population and their risks for acquiring HIV should not be fully ignored in UNAIDS analyses.

Previous research with global populations of gay and bisexual men has shown that ecological factors such as being from a country that criminalizes sex between men; and structural factors such as sexual stigma and provider discrimination hinder, whereas community factors such as community engagement enable, access to HIV-prevention services.^{4-6, 11-20}

Although not as extensive, country-level studies reveal similar patterns as those found globally. Below are summaries of findings from Kenya and Viet Nam.

Kenya Background

Kenya has an average HIV prevalence of 4.9% among adults with about 1.3 million people living with HIV infection.^{21, 22} Among gay and bisexual youth (aged 15 – 24) HIV prevalence was higher at 20% (PBS report, 2018). Regional differences indicate that Nairobi has the highest HIV prevalence (27%), followed by Kiambu (23%), Mombasa (19%), Kisumu (13%), Kilifi (12%) and Nakuru (9%). According to the 2018 UNAIDS Gap Report, HIV prevalence is estimated to be 19 times higher among gay and bisexual men than among the rest of the adult population, globally.²² Finally, preliminary 2020 data the Kenya Modes of Transmission (MOT)²³ study estimates that HIV incidence among gay and bisexual men is 15.2 per 1000 population, which is one of the highest compared to other populations.

In a 2018 behavioral survey in Kenya, 32% of gay and bisexual men reported having unprotected sex at least once in the last month due to various reasons including lack of condom availability.²⁴ The same study also showed that 79% of gay and bisexual men reported condom use and 76% reported using water-based lubricant at last sex during last anal sex experience, which is lower than the global standard of 90%. From 2018-2019, Kenya experienced a shortage of lubricants, which was associated with a reduction in water-based lubricant use during that year.



Community and friendship in Kenya. Photo credit: ISHTAR

Average HIV prevalence in Kenya:

- **Adult 4.9%**
- **Gay & bisexual youth 20%**

Program data collected by NASCOP every quarter, indicated that only 59% of the estimated HIV positive gay and bisexual men in the country know their HIV status (Quarterly data, Jan - March 2020, NASCOP). In a study conducted in three counties (Mombasa, Kiambu and Kisumu), 38% of gay and bisexual men reported being aware that they are living with HIV.²⁵

Consensual same-sex relations and practices are illegal in Kenya and punishable by a prison sentence of up to 14 years (Kenyan Penal Code sections 162 [a] and [c] and 165). Criminalization of sex between men coupled with entrenched social attitudes, contributes to high levels of stigma and discrimination towards gay and bisexual men, making them targets for violence and deterring many of them from seeking the HIV services they need. In the survey in 2017, 14% of gay and bisexual men reported experiencing sexual and physical violence, 20% reported experiencing police violence and 39% of those who experienced violence reported getting support at the time.²⁴

Criminalization, violence and stigma cause anxiety, fear, depression and other mental health issues among gay and bisexual men. There are several studies that point towards the need for mental health interventions among gay and bisexual men. Findings from a study of gay and bisexual men led intervention in Nairobi showed that 30% of the respondents had moderate to severe symptoms of depression, 36.8% had a hazardous alcohol use problem, and 60.8% of gay and bisexual men respondents reported experiencing childhood abuse.²⁶

Viet Nam Background

It is estimated that there are 230,000 people living with HIV in Viet Nam, among whom 280 were new HIV infections within the first ten months of 2018. HIV prevalence among gay and bisexual men has increased from 2.3% in 2012 to 10.8% in 2018. In 2019 HIV prevalence continued to increase in all age groups among gay and bisexual men.²⁷

Although National Strategy to End the AIDS Epidemic in Viet Nam set a goal of making PrEP available to 30% of all gay and bisexual men, PrEP coverage nationally is still quite low. The initial findings of the first chemsex research in Viet Nam conducted with 293 gay and bisexual men engaging chemsex showed that 67% had never used PrEP, and 11% had ever used PrEP but not at the time of the study (Lighthouse Social Enterprise, 2020). Among 408 gay and bisexual men and TGW, 38.3% have never heard about PrEP before.²⁸ Among gay and bisexual men living with HIV, 23% received Antiretroviral therapy (ART).²⁷



Caring for each other in Viet Nam. Photo credit: Lighthouse

The percentage of young gay and bisexual men (<age 25) who had been on ART in the past 12 months (25.8%) was lower for older gay and bisexual men group, (20.5%).

Despite lack of fully published data on the prevalence of STIs in Viet Nam, previous research indicates a high rate of STI infections among gay and bisexual men. In Hanoi and Ho Chi Minh City, 312 out of 995 young male sex workers tested positive for at least one STI, namely syphilis (16.7%), gonorrhea (10.5%), and Chlamydia (11.5%).²⁹ The phase 1 VHATTC-UMP report also found a high STI prevalence among gay and bisexual men (64.5%) and transgender women (73.3%).³⁰

There is a clear need for sexual health services for gay and bisexual men in Viet Nam. However, they encounter many barriers to accessing health services such as HIV prevention services that include HIV education. Recent data show that only 26.8% of young key populations (YKPs) were comprehensively knowledgeable about HIV and only 46.21% of young people correctly identified ways to engage in protected sex.^{31,30} Additionally, some gay and bisexual men have been confronted with policies and regulations that prevent them from accessing services.^{32,33} Stigma and discrimination have been found to be important factors contributing to higher HIV risk for gay and bisexual men.^{34,35}

Although sex between men is not criminalized in Viet Nam, gay and bisexual men face severe stigma and discrimination from society in many public and private environments, such as family, schools, work environments, and health facilities. These factors negatively affect their lives, and contribute to inequality, violence, and poor mental health outcomes. 'Coming out' experiences reveal a stark situation. For example, 62.9% of LGBT reported that they were forced to change appearance and gestures; in addition to other forms of violence, such as verbal pressure (60.2%); being held at home (13.3%); and assaults (12.7%).³⁶

Regarding mental health, the WHO estimates there to be a 4% prevalence of depression and 2.2% prevalence of anxiety disorders in Viet Nam.³⁷ The percentage of gay and bisexual men in Hanoi with significant psychological distress has been estimated to be as high as 61%.³⁸ Stigma and discrimination are believed to negatively impact mental health outcomes of Vietnamese gay and bisexual men.³⁹ Nevertheless, mental health services are lacking in Viet Nam, with only one mental health practitioner per 100,000 people.⁴⁰

Taken together, the available global, Kenyan and Vietnamese findings indicate significant HIV prevalence and incidence among gay and bisexual men as well as a critical need for HIV prevention, care and support services. Research that examines the specific factors contributing to access to health services is warranted. The following sections present the Action for Access! and GMHR-4 studies that were designed to address this.

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Action for Access! Study

Action for Access! began as a CBPAR collaboration among three community-based organizations. Supported by a research grant from the Ministry of the Netherlands' Bridging the Gaps initiative, MPact (global), ISHTAR (Kenya) and Lighthouse (Viet Nam) organized in response to their expressed desire to learn how to conduct research that informs programing, policy and advocacy on behalf of their respective organizations. As a result, Action for Access! became a CBPAR project whose aims were to 1) increase capacity of lead investigators and other staff of community-based organizations to lead their own research endeavors, and 2) investigate the unique forces that shape access to sexual health services among gay and bisexual men and transgender women who have sex with men.

Community Based Participatory Action Research (CBPAR)

Community members who have contributed to research in their local communities often complain that researchers arrive, use community members to collect data, only to disappear and disseminate findings elsewhere. This approach leaves community members suspicious of professional researchers' intentions and creates two additional problems: Firstly, questions are not directly relevant to communities when researchers fail to investigate questions that advance understanding of community needs, and instead, investigate questions that are important solely to other researchers. Secondly, researchers often fail to disseminate findings among community members who are best positioned to use them to improve evidence-based advocacy and to strengthen programs. It is with this in mind that the Action for Access! study choose to use a participatory action approach.



Action for Access! Principal Investigators presenting at AIDS 2018: From left, Jeffrey Walimbwa, Sonya Arreola and Đoàn Thanh Tung

**CBPAR is
a research
framework for
collaborative
systematic
data collection
& analysis to
generate practical
knowledge for
action & change.**



Community engagement in Viet Nam. Photo credit: Lighthouse

While definitions vary, for the purposes of this report, CBPAR is a research framework for collaborative systematic data collection & analysis to generate practical knowledge for action & change. In this way, members of the community being studied are engaged as full partners with deliberately shared power across all aspects of research endeavor.

Using a CBPAR approach, Action for Access! set out to investigate the unique forces that shape access to services among gay and bisexual men, and trans women who have sex with men. CBPAR is an approach that places community members in the driver's seat of the research project, where they set the research questions and strategies, and collect and analyze data, ensuring the results have the potential to directly influence programs and advocacy among participating communities. To do this, the team rigorously explored the needs of LGBT communities in their respective countries (see Kenya and Viet Nam background sections above) and participated in ongoing methods training to meet the research goals they identified

Learn more about this process and Action for Access! here:

<https://mpactglobal.org/global-mens-health-and-rights-survey-2019/>

RESEARCH CAPACITY

From October 2015 through December 2020, the A4A! team met weekly online, twice a year for three-day face to face intensive training and planning meetings; and at conferences and workshops where they presented study process or study findings, as well as engaging in further training. Ongoing training centered on study design, qualitative and quantitative methods and analyses, institutional review board protocol development, writing and presentations skills, dissemination of findings, sharing lessons learned with local teams, writing research grant proposals, applying



Research team after long day learning about odds ratios. Photo credit: Lighthouse

implications of findings to community organizational programming, policy and advocacy goals. By 2017, the A4A! team had completed country level desk reviews for Kenya and Viet Nam, developed the study methods and design, and written protocols for Kenya and Viet Nam IRB approvals.

STUDY DESIGN

Action for Access! used a mixed method, cross-sectional research design. The first phase was qualitative, consisting of in-depth individual interviews with gay and bisexual men and transgender women who have sex with men from Kenya and Viet Nam. Transcribed recordings of the hour-long interviews from the qualitative phase were coded and analyzed and findings were used to develop an online questionnaire for the quantitative phase of the study. The quantitative phase was designed to conduct online surveys with gay and bisexual men from Kenya (N=300) and Viet Nam (N=300). ISHTAR, Lighthouse and MPact investigators planned all aspects of the study and managed, analyzed and disseminated findings from the study.

QUALITATIVE METHODS

Qualitative individual in-depth interviews were conducted between September 2017 & February 2018. Eighty-two interviews (Table 1, following page) were recorded and transcribed, and Vietnamese & Swahili interviews were translated into English.

The research team developed a coding lexicon & coded interviews after reaching 80% inter-rater reliability. For this study, stigma & discrimination-coded & sexual health services-coded quotes were used to analyze patterns of association between them.

TABLE 1. Qualitative Interviews by Gender and Location

		Gay & Bisexual Men	Transgender Women
Kenya	Nairobi	8	2
	Mombasa	5	5
	Kisumu	6	4
	Lordwar	6	0
Viet Nam	Hanoi	13	3
	Son La	13	2
	Nha Trang	12	3

QUALITATIVE RESULTS

As evident in Table 2 (following page), Availability of Sexual Health Services was deficient in both countries. All gay and bisexual men and all transgender women in both countries reported experiences of sexual and/or transgender stigma and discrimination generally as well as in health care settings specifically. Access to sexual health services was deemed to be poor overall, and where they did exist, stigma and discrimination impeded access. Particularly detrimental to the health of gay and bisexual men and transgender women were experiences of stigma and discrimination on the part of health care providers. Stigma and discrimination from health care providers often resulted in abandoning sexual health services when most needed, and resorting to, for example: 1) self-care based on internet information or advice from friends or pharmacists, 2) waiting until there was a crisis to seek professional care, or 3) suffering through the indignities of the health care systems because “it is all that is available”, but not returning for follow-up.

The principal respite noted was accessing sexual health services from community-lead organizations. Additionally, friends, social networks and community level gatherings and support were critical sources of resiliency. Notably, experiences of rejection, shaming and provider discrimination toward transgender women were more virulent. Transgender-led research is urgently needed to further uncover the unique experiences of transgender women.

Particularly detrimental to the health of gay and bisexual men and transgender women were experiences of stigma and discrimination on the part of health care providers.

TABLE 2. Illustrative Quotes: Stigma, Discrimination & Community Resiliency

GAY, BI & OTHER MEN who HAVE SEX with MEN			
HEALTH PROVIDER STIGMA	KENYA	VIET NAM	
	After telling the nurse why I was there she ran out & called the rest to come & look at me. I felt humiliated by the whole incident.	After examining my condition, the doctor told me: "Do you know the cause of HIV? it's homosexuality."	
	When I left the room, everyone looked at me & I heard one nurse make comments like Huyu ni msenge (this one is gay). I felt so bad & humiliated.	Medical providers still view homosexual or transgender as sickness or disease without considering who we are whole human beings.	
		Some of the health workers still scrutinize, stare and making strange expressions, asking personal questions making me uncomfortable, so next time I am shy to go to exam.	
DISCRIMINATION	When they say Asalaam Aleikum, you are supposed to reply, Aleikum Salam. Instead, they say Salam. Generally, Salam is for someone who is not Muslim who has greeted you. Sometimes you have gone to pray, & someone does not want to stand near you, they stay far. So when I have to go to the mosque with my colleagues, I just go pray & go back home.		When the male doctor received my registration form, in which I wrote that I'm homosexual, he denied to test my blood immediately & said: "We don't accept your case since it's the rule."
			Doctors gave very brief check-up, their faces were stone cold as if they didn't care how I was feeling, they only cared about getting a sample for testing, the whole time I was sitting there they didn't bother to make a conversation, they just talked to others, & ignored me.

COMMUNITY RESILIENCY

KENYA

I always prefer going to gay men clinics or gay friendly clinics that provide services specifically tailored for the gay community, for any medical attention that is directly linked to my sexuality as a gay person.

With good education & a job I am free from all the family drama... Then, I could afford a better life so I take education seriously. I also encourage some of my friends to do the same. I feel that is the only hope I have to survive in this world.

VIET NAM

Regarding STIs, I prefer going to community organizations. They may not have expertise, but they are already carefully trained, they have positive attitudes, friendlier than health care workers. Because HIV counseling and testing services are quite simple and fast, information is kept confidential, community-based supporters are friendlier than health care workers.

TRANSGENDER WOMEN who HAVE SEX with MEN

STIGMA

KENYA

It's like they [health providers] are judging you for who you are [transgender], so you are not feeling comfortable.

My parent would always insult me, & would shame me saying "In our family & tribe there were no such things [transgender], why are you doing this. Such things happen on the coast."

VIET NAM

Doctors ask "Are you a man or a woman? Why you have long hair, why you put on lipstick. It's clear as day that these questions were not related to my health care at all.

The students who intern here, point and talk behind our back. Then they kept asking me how they should call me Mr. or Miss, they mean to tease me.

KENYA

VIET NAM

DISCRIMINATION

I was infected with an STI. While in the queue, I heard the doctors starting to talk about me. When my turn came, I was told to wait & they would attend to me later. Since then I have never gone to a government clinic.

During the exam, they asked why my name was male but my appearance female. They were annoyed, like I was a strange creature. I pay money for health care just like other people, so why they do that to me? They made me feel awfully uncomfortable. While I was paying, they scolded me & said that made people around there look at me. I decided not to take the examination and left the clinic right afterward.

COMMUNITY RESILIENCY

I don't know any organizations that offer services to Trans people. I just get my information on the internet & friends.

In my previous relationship, we used to access services together, even with regards to HIV testing & counselling we would walk together into one room & access the services together.

Since we are affiliated with an organization, we could use awareness forums for sensitization, to bring together members so that we teach each other issues around health.

We have created a WhatsApp group of members whom we connect with & each member would even add someone they know so they would benefit in that particular Whatsapp group, avenues where we could meet other gay men & transpeople.

I used to visit all clinics around Dong Da & Thai Think area but the result was zero. So, I texted a friend who also injects hormones. She introduced me to her place & advised me to tell the staff that I had had injections before without any problem; it's the only way for them to agree to give me the injections. Like, I have used this before, & I give them the instructions on how to administer the medication. Other clinics don't agree to do this.

I get health information from my friends & from the knowledge I gather from foreign books, where they write about medications that transgenders in foreign countries often use.

The group is also my family, and everyone is very nice and help me a lot. Times when I was very sad, thinking why parents do not accept and dismiss me,... I want to earn money for my parents, but sometimes I feel desperate when they do not receive my money. But then, the member of the group know that I'm desperate, they help me to feel better.

The more they tease me, the more they harass the more it helps me to be motivated to live better. So I can show them that they are wrong.

Community Level **Resiliency**



ISHTAR Dolls building resiliency in Kenya. Photo credit: ISHTAR

“

I had brothers and sisters though not biological. We all slept together and ate together. It was so fun and we worked and did the same things so we just called each other brothers and sisters though sometimes. We had sex amongst ourselves when we drank or smoked weed. We had fights sometimes and we got together to support each other, bail out one of us when they got arrested or just gang up and beat a bad client.

Community Level **Enabler**



Striking a pose in Viet Nam. Photo credit: Lighthouse



Some community organizations have clinics that offer services to us. They are friendly and have good relations with us. Most of them are community led and offer advice and support networks. They are fun places to go and meet up with people with whom you share the same identities and issues.

SURVEY DESIGN

Upon completion of the qualitative portion of the study, the A4A! study team used the qualitative narratives of gay and bisexual men to identify key domains to pursue in the quantitative phase of the study. During the analysis phase, it became clear that the concerns of gay and bisexual men varied enough from those of transgender women with regard to the services they most needed. In consultation with transgender community members, given limited resources and that ISHTAR and Lighthouse predominantly serve gay and bisexual men, the team concluded that it would be better to design the quantitative portion of the study to explore access to services among gay and bisexual men. The research team disseminated the transgender women-specific qualitative findings in transgender forums,²⁰ highlighting the critical need for transgender community led studies specifically focused on their concerns.

After specifying the study population as gay and bisexual men, country, community and Individual level domains were identified and then used to develop an outline for a quantitative survey to be administered nationally in Kenya and Viet Nam. The team then reviewed, adapted and added survey questions from previous GMHR surveys to develop a draft English-language survey.



Investigators working on survey design. Photo credit: MPact



GLOBAL MEN'S HEALTH & RIGHTS (GMHR) Study

In 2019, A4A! joined forces with four other regional community-based organizations (AGCS plus for West Africa region; Eurasian Coalition on Health, Rights, Gender and Sexual Diversity (ECOM) for EECA region, M-Coalition for MENA region, SOMOSGAY for Latin America region) in order to broaden the scope of the quantitative portion of the A4A! study from a two country study to a global study. The draft A4A! survey was then shared with the new partners for their review. A question on criminalization-based experiences of discrimination was added to the survey. In addition to strengthening the survey, the new partnership expanded the range of the study to reach gay and bisexual men worldwide. This collaboration yielded the GMHR-4 survey which was translated from English into Arabic, Chinese, French, Indonesian, Kiswahili, Portuguese, Russian, Spanish, and Vietnamese for a total of 10 survey languages.

QUANTITATIVE METHODS

From November 2019 to April 2020, a global convenience sample of cisgender or transgender, gay and bisexual men were recruited to complete the 30-minute online GMHR-4 survey in one of 10 languages: Arabic, Chinese, English, French, Indonesian, Kiswahili, Portuguese, Spanish, Russian, & Vietnamese. Survey participants were recruited globally by email, listservs, gay dating apps, & websites via MPact's

extensive networks and ties to community-based organizations; as well as regionally via Coalition PLUS (MENA Region), Eurasian Coalition on Health, Rights, Gender and Sexual Diversity (EECA region), M-Coalition (MENA region), and SOMOSGAY (Latin America region); and at country level via ISHTAR (Kenya) and Lighthouse Social Enterprise (Viet Nam). MPact also placed web banners on social networking sites popular with MSM. Finally, Hornet and Grindr promoted the GMHR-4 survey among their members. No geographical restrictions were applied. Ethical approval was obtained from the Western Institutional Review Board, which determined that GMHR-4 was exempt under Category 4.

MEASURES

For the purposes of the current report analyses yielded proportions of key variables of interest; followed by an examination of the impacts of eight different Ecological, Structural Community and Individual level factors on Access to 10 different HIV Prevention, HIV Care and Support Services among gay and bisexual men globally, and at country level for Kenya and Viet Nam.

TABLE 3. **GMHR-4 Exposure Variables and Outcome Services Access Variables**

EXPOSURE VARIABLES	HYPOTHESIZED IMPACT	OUTCOME VARIABLES Poor Access to:
Ecological Level		HIV Prevention Services
Criminalization (Dichotomous)	Barrier	Condoms
		Lubricants
Structural Level		HIV Prevention Services
Discrimination Experiences (Dichotomous)	Barrier	PrEP
Sexual Stigma (Scale)	Barrier	HIV testing
Provider Discrimination (Scale)	Barrier	HIV Care Services
Comfort w/ Provider (Scale)	Enabler	HIV care
		Antiretroviral Treatment
Community Level		Support Services
Community Engagement (Scale)	Barrier	STI Testing
Community Based Services (Dichotomous)	Enabler	STI Treatment
		Mental Health Care
		Community Support
Individual Level		
Psychological Well Being (Scale)	Enabler	

IMPORTANCE OF HEALTH SERVICES

Health Services Importance was comprised of seven questions e.g., “How important is Legal services to gay and bisexual men|MSM in your country?” with responses ranging from “Very unimportant” to “Very important”.



Photo Credit: Gays and Lesbians of Zimbabwe (GALZ)

EXPOSURE VARIABLES

Criminalization of sex between men was based on ILGA 2019 Report's indication of country status of criminalization: If the country had criminalizing policies, this was coded as yes for being a criminalizing country.

Discrimination Experience consisted of a single item question asking about experiences related to criminalization environment *"Have you ever experienced any of the following because you were perceived to be gay | bisexual | MSM?"* with 13 possible experiences to choose from such as: *"Someone called the police on you."* or, *"Someone evicted you from your home"*. Participants were asked to *"check all that apply"*, and Discrimination Experiences was dichotomized as *"none"* or *"any"* if 1 or more were checked.

Sexual Stigma, Provider Discrimination, Comfort with Provider, Community Engagement and Psychological Well Being descriptions and reliabilities for all scales are provided in Table 4. All scale items had a five-point Likert response set and scale scores were calculated as the mean for each respective scale where a higher score indicated more of the respective construct. Chronbach's Alpha coefficients indicate reliability for all scales range from moderate to very good. Out of 324 participants from Kenya, only six men completed the survey in Kiswahili (the rest were in English), rendering these coefficients irrelevant due to the small sample size.

TABLE 4. Scale Descriptions and Reliabilities

Scale Name and Description	Cronbach Alphas										
	GLOBAL	Arabic	Chinese	English	French	Indonesian	Kiswahili**	Portuguese	Russian	Spanish	Vietnamese
Sexual Stigma Country level attitudes about gay and bisexual men: 7 items, e.g., “In your country, how many people believe that male homosexuals are disgusting?” ranging from “none” to “all”.	0.82	0.6	0.86	0.83	0.86	0.7	0.06	0.78	0.84	0.76	0.76
Provider Discrimination Experiences of being discriminated against by health providers: 3 items, e.g., “In the last 6 months, has a health care provider refused to treat you because you are gay bisexual MSM?”, ranging from “No, never” to “Yes more than 5 times”.	0.87	0.91	0.88	0.88	0.86	0.77	0.98	0.78	0.89	0.87	0.93
Comfort w Provider Degree of comfort with health provider: 2 items, e.g., “In your country, how comfortable do you feel discussing your sexual health concerns with your health care provider?”, ranging from “very comfortable” to “very uncomfortable”.	0.85	0.92	0.8	0.89	0.53	0.81	0.89	0.85	0.79	0.85	0.83
Community Engagement Level of engagement in social activities with other gay and bisexual men: 10 items, e.g., “During the past 6 months, how often have you participated in gay bisexual MSM social groups or in activities such as a book or cooking club?”) ranging from “Never”, to “More than 12 times”.	0.72	0.75	0.64	0.81	0.79	0.83	0.67	0.66	0.63	0.74	0.74
Psychological Well-Being: Perceived sense of psychological well-being: 6 items, e.g., “How often do you have negative feelings such as blue mood, despair, anxiety, depression?”, ranging from “Never”, to “Always”.	0.85	0.82	0.85	0.84	0.83	0.80	0.69	0.85	0.84	0.86	0.85

* Variance among the responses was exactly zero

**The sample size for Kiswahili was 6

OUTCOME VARIABLES

Poor Access to all 11 prevention, care and support health services (e.g., “In your community, how accessible is free or affordable HIV testing?”) were measured along a 5-point Likert scale ranging from “Completely accessible” to “Completely inaccessible”. For current analysis we dichotomized the continuous outcome as “poor access” for anything less than “Somewhat accessible”.

ANALYSIS

Descriptive analyses of demographic variables were calculated separately for Global, Kenya and Viet Nam data sets. Multivariate regression analyses were conducted to assess differences in key variable outcomes between men from criminalizing and non-criminalizing countries. Multivariable regression analyses were also conducted to assess associations between eight exposure variables and poor accessibility of 11 different health services outcomes separately for Global, Kenya and Viet Nam. All models featured control variables to reduce the impact of confounding. Control variables included: age (dichotomous variable signaling whether the respondent reported being under or over the age of 30); and access to health insurance, having at least moderately enough money to meet needs. Country region and income category were also controlled for in global analysis. All data analyses were carried out using the statistical Wizard Pro (Version 1.9.44).

QUANTITATIVE RESULTS

RESPONDENT CHARACTERISTICS

Globally, a total of 6,135 observations from gay and bisexual men were included in this study, of which 324 were from Kenya and 304 were from Viet Nam. The majority of the surveys were completed in Portuguese (35%), followed by, Spanish (19%), English (15%), Arabic (9%), Russian (9%), French (6%), Vietnamese (5%), Indonesian (2%), Chinese (1%) and Kiswahili (0%). A total of 123 countries were represented in the sample.

Figures 1 through 3 more fully depict demographic proportions for global, Kenya and Viet Nam samples. Regionally, the majority of men were from Latin America and Caribbean (55%), followed by EECA, MENA and Sub-Saharan Africa regions equally proportionate (12%), East Asia & Pacific (8%), North America (2%) and South Asia (0.1%); of which 22% were from countries that criminalize sex between men. Compared to the global sample, men from Kenya and Viet Nam were younger. However, across all three samples, gay and bisexual men had high levels of education with more than half from each sample reporting post-secondary education or higher; but fewer than half reporting an ability to mostly or completely meet their financial needs. Across all three samples, most men (>70%) reported not being in relationship, and about a quarter were from a small town or rural area. Finally, compared to the global sample (6%), fewer men from Kenya or Viet Nam reported not knowing their HIV status (1%); and 20% of men globally and from Viet Nam were living with HIV compared to 13% from Kenya.

FIGURE 1. Global Demographic Proportions (N=6,135)

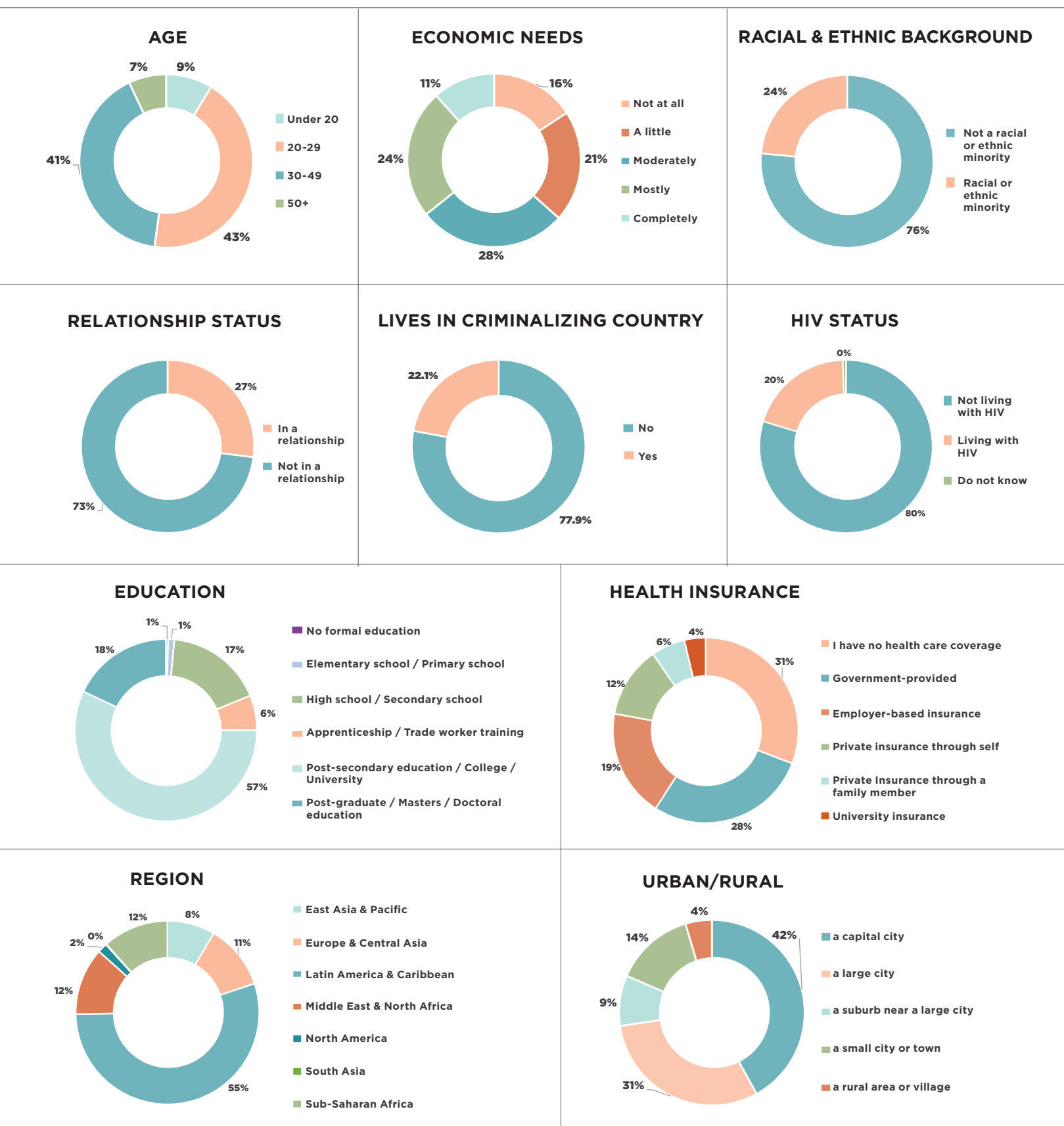


FIGURE 2. Kenya Demographic Proportions (N=324)

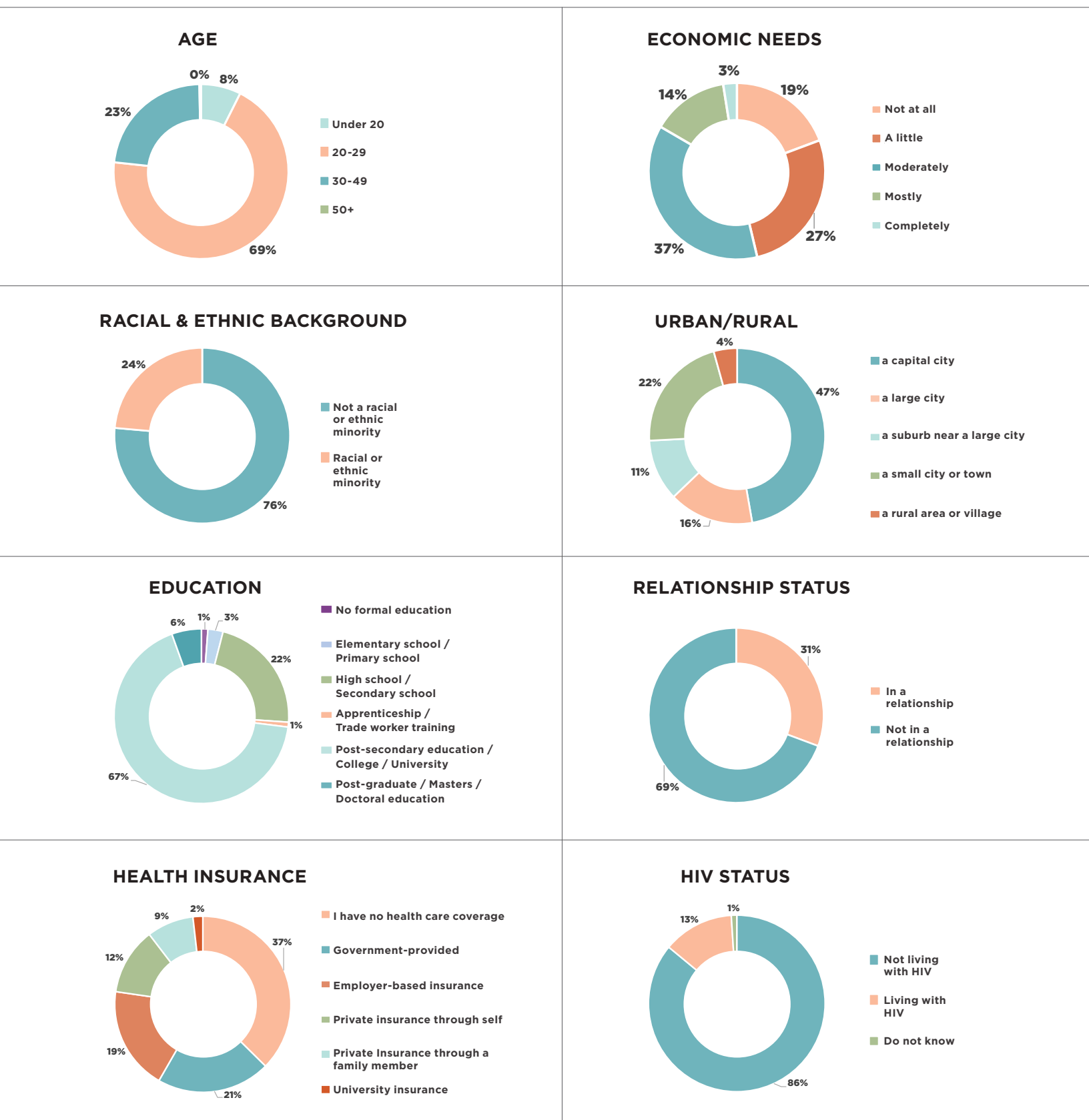
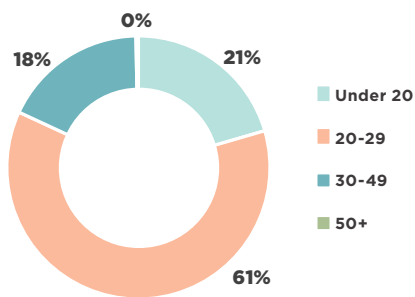
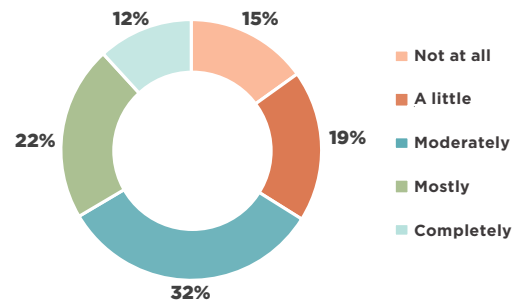


FIGURE 3. Viet Nam Demographic Proportions (N=324)

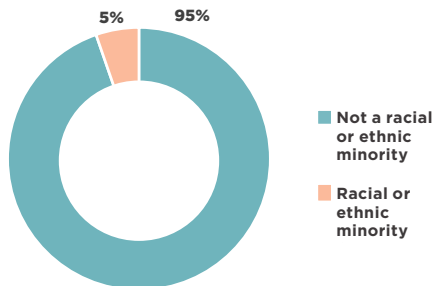
AGE



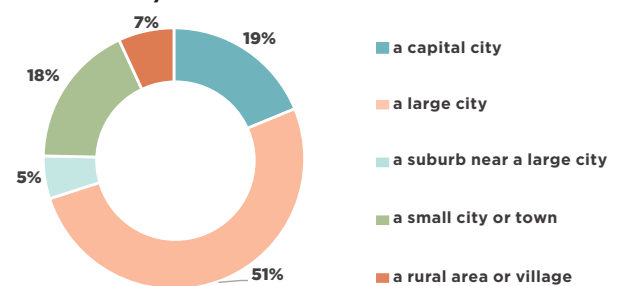
ECONOMIC NEEDS



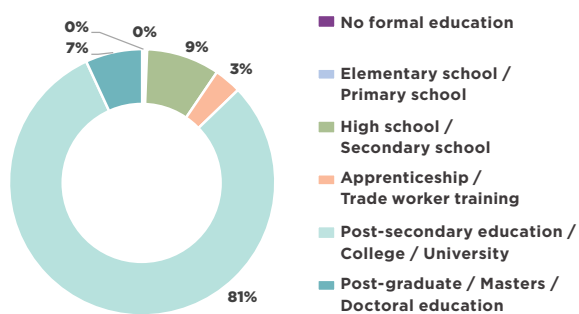
RACIAL & ETHNIC BACKGROUND



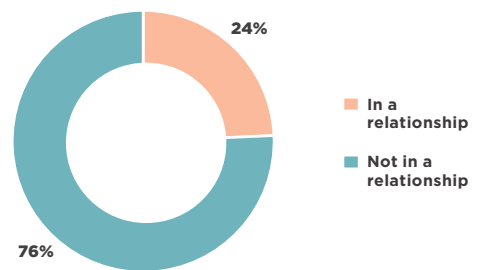
URBAN/RURAL



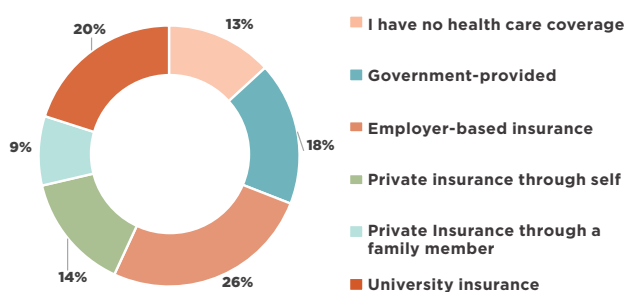
EDUCATION



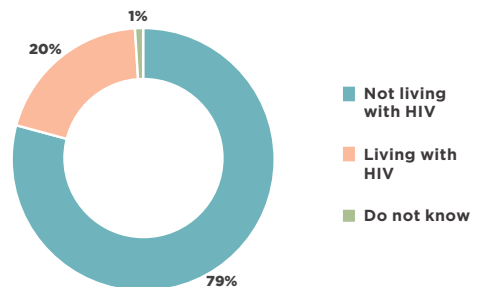
RELATIONSHIP STATUS



HEALTH INSURANCE



HIV STATUS



CRIMINALIZATION

Multivariate analysis (Table 5) revealed that gay and bisexual men from criminalizing countries had higher odds of being under age 30, working as a sex-worker, having an unknown HIV-status, experiencing financial insecurity and a higher level of education. Men from criminalizing countries reported greater sexual stigma, though only marginally significantly, and had less community engagement. Finally, men from criminalizing countries had poor access to HIV prevention programs, PrEP, and HIV care. However, they had lower odds of poor antiretroviral treatment access.

TABLE 5. **Select Multivariate Factors Associated with Living in a Criminalizing Country**

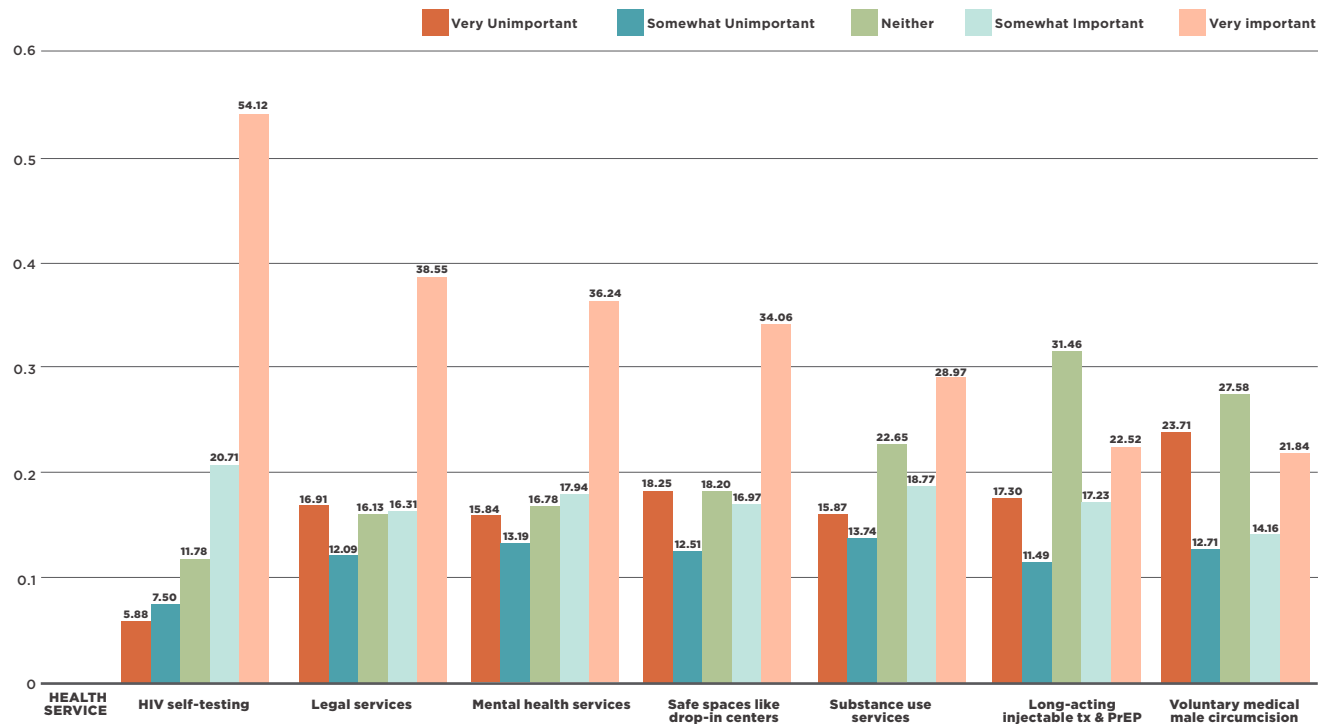
DEMOGRAPHIC	TOTAL N=6,186	AOR	95% CI	P
Age < 30		1.36	(1.18, 1.55)	<0.001
Ethnic/Racial Minority Group		1.04	(0.89, 1.21)	0.607
Unemployment		1.31	(0.93, 1.37)	0.209
Sex Worker		8.77	(4.78, 16.07)	<0.001
HIV Status (Unknown)		2.22	(1.06, 4.68)	0.035
Financial Insecurity		1.66	(1.44, 1.90)	<0.001
No Healthcare Coverage		1.06	(0.92, 1.22)	0.429
Post Secondary Education		0.65	(0.54, 0.78)	<0.001
STRUCTURAL and COMMUNITY				
Provider Discrimination		1.03	(0.89, 1.20)	0.716
Sexual Stigma		6.92	(0.91, 52.47)	0.061
Community Engagement		0.40	(0.17, 0.63)	<0.001
POOR HIV SERVICES ACCESS				
HIV-Prevention Programs		1.58	(1.36, 1.84)	<0.001
PrEP		1.37	(1.17, 1.60)	<0.001
HIV Care*		2.55	(1.58, 4.12)	<0.001
HIV ART*		0.53	(0.29, 0.94)	0.030

* Analyses for HIV Care and ART included only men living with HIV.

IMPORTANCE of HEALTH SERVICES

HIV self-testing was deemed the most important service to gay and bisexual men, with 75% reporting it was “somewhat or very important”; followed proportionately by Legal services (55%), Mental health services (54%), Safe spaces like drop-in centers (51%), Substance use services (48%), Long-acting injectable treatment & PrEP (40%) and Voluntary medical male circumcision (36%). Table 6 on the following page provides a detailed summary of findings.

TABLE 6. Level of Importance of Health Services to Gay and Bisexual Men (N=6,135)



Ecological, Structural, Community and Individual Level Barriers and Enablers of Access to Health Services

Analyses of the GMHR-4 survey data revealed significant barriers and enablers of access to health services for gay and bisexual men from the global, Kenya and Viet Nam samples. Below and on the following pages are findings for each.

GLOBAL POOR SERVICE ACCESS OUTCOMES

HIV PREVENTION SERVICES—GLOBAL (Figures 4-8)

Poor access to condoms was associated with being from a criminalizing country (OR=2.78, 95% CI [3.45, 2.22], $p<0.001$); fewer discrimination experiences (OR=0.39, 95% CI [0.25, 0.60], $p<0.001$); more sexual stigma (OR=1.57, 95% CI [1.36, 1.80], $p<0.001$); more health provider discrimination (OR=1.21, 95% CI [1.04, 1.40], $p=0.011$); less comfort w/ provider (OR=0.75, 95% CI [0.71, 0.80], $p<0.001$); and lower psychological well-being (OR=1.00, 95% CI [0.99, 1.00], $p=0.042$).

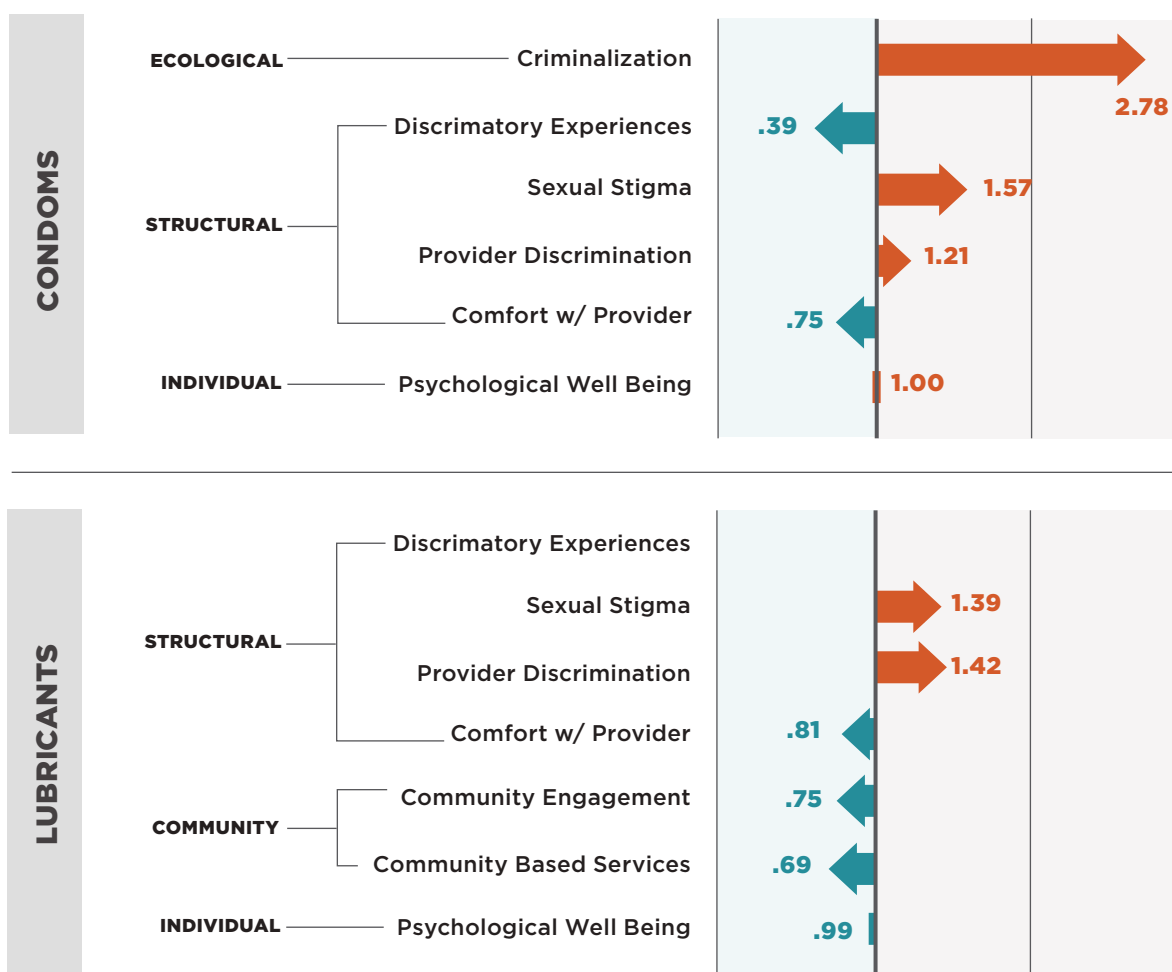
Poor access to lubricants was associated with more sexual stigma (OR=1.39, 95% CI [1.25, 1.55], $p<0.001$); more health provider discrimination (OR=1.42, 95% CI [1.22, 1.64], $p<0.001$); less comfort w/ provider (OR=0.81, 95% CI [0.77, 0.85], $p<0.001$); less community engagement (OR=0.75, 95% CI [0.64, 0.87], $p<0.001$); having fewer community based services (OR=0.69, 95% CI [0.60, 0.79], $p<0.001$); and lower psychological well-being (OR=0.99, 95% CI [0.99, 1.00], $p<0.001$).

Poor access to HIV Prevention Services was associated with more sexual stigma (OR=1.76, 95% CI [1.58, 1.97], $p<0.001$); less comfort w/ provider (OR=0.72, 95% CI [0.68, 0.75], $p<0.001$); less community engagement (OR=0.74, 95% CI [0.64, 0.87], $p<0.001$); having fewer community based services (OR=0.56, 95% CI [0.49, 0.65], $p<0.001$); and lower psychological well-being (OR=0.99, 95% CI [0.99, 1.00], $p<0.001$).

Poor access to PrEP was associated with more sexual stigma (OR=1.95, 95% CI [1.72, 2.21], $p<0.001$); less comfort w/ provider (OR=0.74, 95% CI [0.70, 0.79], $p<0.001$); less community engagement (OR=0.69, 95% CI [0.59, 0.81], $p<0.001$) and having fewer community based services (OR=0.78, 95% CI [0.66, 0.91], $p=0.002$).

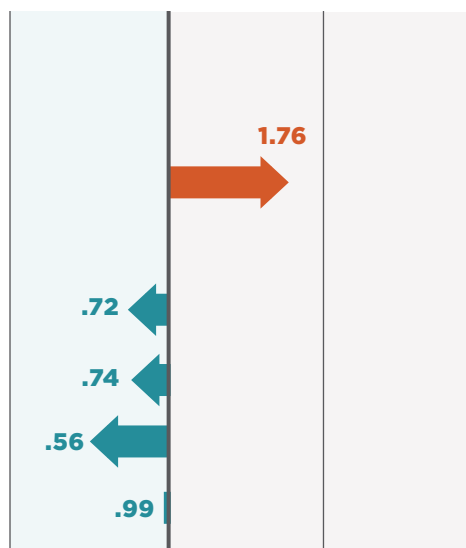
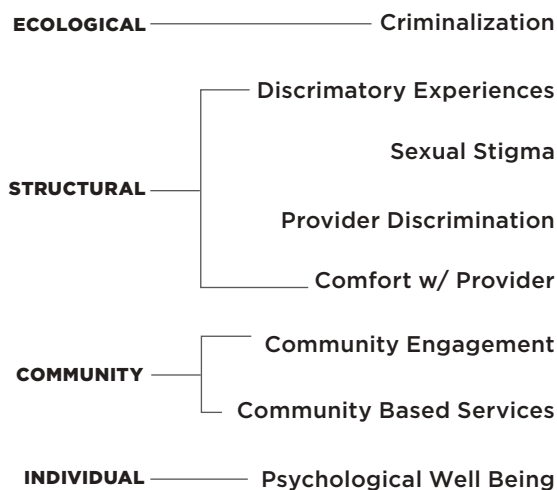
Poor access to HIV Testing was associated with being from a criminalizing country (OR=1.79, 95% CI [2.17, 1.47], $p<0.001$); fewer discrimination experiences (OR=0.6, 95% CI [0.39, 0.92], $p=0.021$); less health provider discrimination (OR=0.69, 95% CI [0.58, 0.81], $p<0.001$); less comfort w/ provider (OR=0.81, 95% CI [0.77, 0.85], $p<0.001$); having fewer community based services (OR=0.31, 95% CI [0.26, 0.36], $p<0.001$) and and lower psychological well-being (OR=0.99, 95% CI [0.99, 0.99], $p<0.001$).

FIGURES 4-8. Odds ratios* for Poor Access to HIV Prevention Services—Global

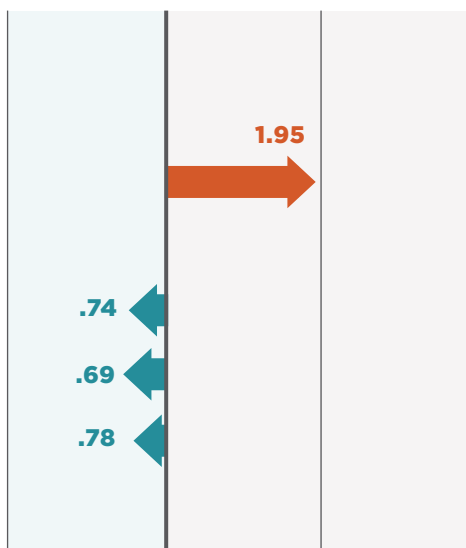
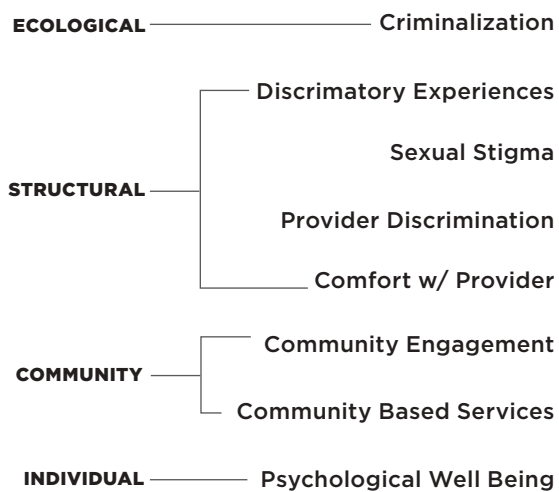


* Each statistic reported is an odds ratio significant at $p<0.05$. The height of the arrow indicates the odds of association. Above 1, the association indicates poor access; Below 1, the association indicates better access.

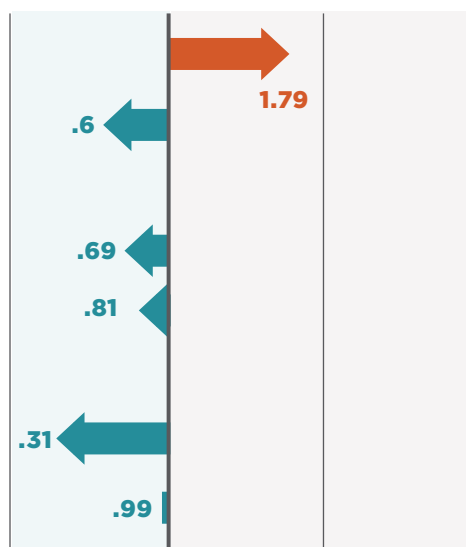
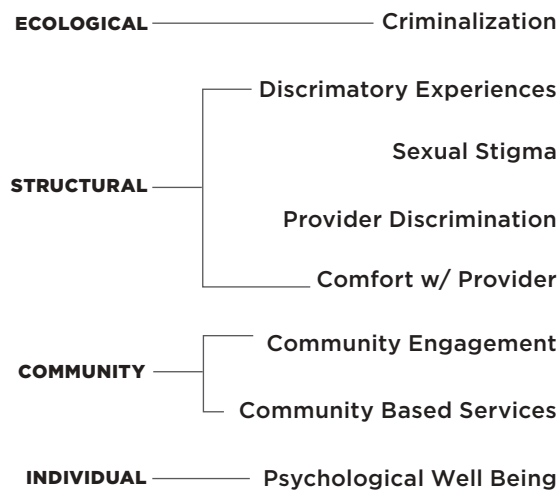
HIV PREVENTION PROGRAMS



PrEP



HIV TESTING

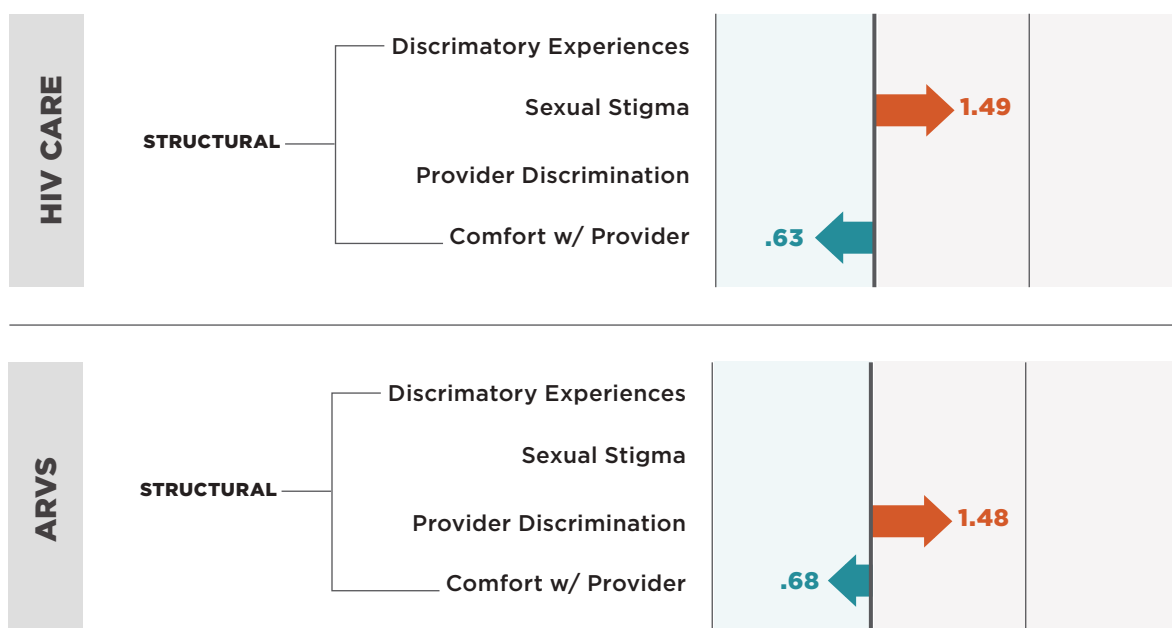


HIV CARE SERVICES—GLOBAL (Figures 9-10)

Poor access to HIV Care was associated with more sexual stigma (OR=1.49, 95% CI [1.02, 2.16], $p=0.038$) and less comfort w/ provider (OR=0.63, 95% CI [0.55, 0.73], $p<0.001$).

Poor access to Antiretroviral Treatment was associated with more health provider discrimination (OR=1.48, 95% CI [1.03, 2.14], $p=0.035$) and less comfort w/ provider (OR=0.68, 95% CI [0.56, 0.82], $p<0.001$).*

FIGURES 9-10. Odds ratios** for Poor Access to HIV Care Services—Global



* Analyses for HIV Care and ART included only men living with HIV.

** Each statistic reported is an odds ratio significant at $p<0.05$. The height of the arrow indicates the odds of association. Above 1, the association indicates poor access; Below 1, the association indicates better access.

SUPPORT SERVICES—GLOBAL (Figures 11-14)

Poor access to STI Testing was associated with being from a criminalizing country (OR=2.08, 95% CI [2.50, 1.69], $p<0.001$); more sexual stigma (OR=1.30, 95% CI [1.15, 1.48], $p<0.001$); more health provider discrimination (OR=1.20, 95% CI [1.05, 1.38], $p=0.007$); less comfort w/ provider (OR=0.71, 95% CI [0.67, 0.75], $p<0.001$); having fewer community based services (OR=0.79, 95% CI [0.68, 0.93], $p=0.004$); and lower psychological well-being (OR=0.99, 95% CI [0.99, 0.99], $p<0.001$).

Poor access to STI Treatment was associated with being from a criminalizing country (OR=1.69, 95% CI [2.04, 1.41], $p<0.001$); fewer discrimination experiences (OR=0.62, 95% CI [0.41, 0.93], $p=0.023$); more sexual stigma (OR=1.55, 95% CI [1.38, 1.74], $p<0.001$); more health provider discrimination (OR=1.16, 95% CI [1.02, 1.32], $p=0.029$); less comfort w/ provider (OR=0.71, 95% CI [0.67, 0.75], $p<0.001$); less community engagement (OR=0.79, 95% CI [0.67, 0.92], $p=0.003$); and lower psychological well-being (OR=0.99, 95% CI [0.99, 1.00], $p<0.001$).

SUPPORT SERVICES—GLOBAL, CONTINUED

Poor access to Mental Health Care was associated with fewer discrimination experiences (OR=0.5, 95% CI [0.32, 0.77], $p=0.002$); more sexual stigma (OR=1.51, 95% CI [1.35, 1.69], $p<0.001$); more health provider discrimination (OR=1.34, 95% CI [1.13, 1.59], $p<0.001$); less comfort w/ provider (OR=0.77, 95% CI [0.73, 0.81], $p<0.001$); less community engagement (OR=0.77, 95% CI [0.67, 0.89], $p<0.001$); and lower psychological well-being (OR=0.99, 95% CI [0.98, 0.99], $p<0.001$).

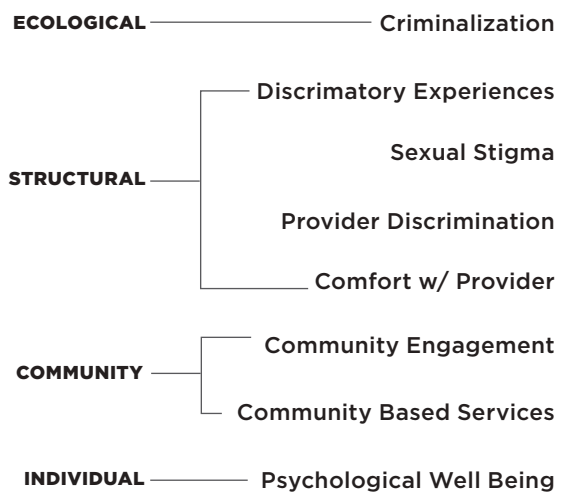
Poor access to Community Based Counseling/Support Groups was associated with being from a criminalizing country (OR=1.35, 95% CI [1.64, 1.12], $p<0.001$); more sexual stigma (OR=1.79, 95% CI [1.59, 2.00], $p<0.001$); more health provider discrimination (OR=1.32, 95% CI [1.12, 1.54], $p<0.001$); less comfort w/ provider (OR=0.77, 95% CI [0.73, 0.81], $p<0.001$); less community engagement (OR=0.62, 95% CI [0.53, 0.72], $p<0.001$); having fewer community based services (OR=0.60, 95% CI [0.53, 0.69], $p<0.001$); and lower psychological well-being (OR=0.99, 95% CI [0.98, 0.99], $p<0.001$).

FIGURES 11-14. Odds ratios* for Poor Access to Support Services—Global

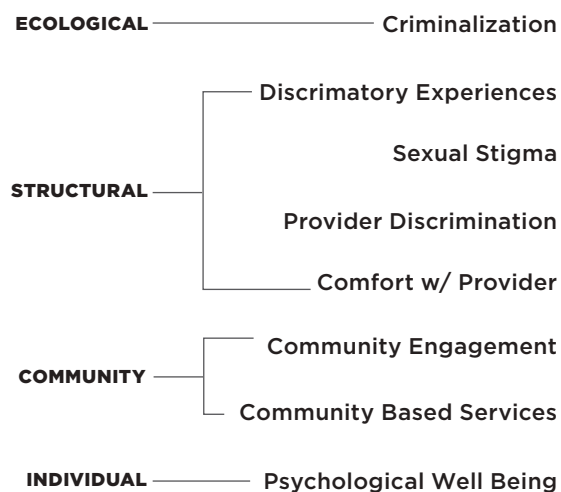


* Each statistic reported is an odds ratio significant at $p<.05$. The height of the arrow indicates the odds of association. Above 1, the association indicates poor access; Below 1, the association indicates better access.

MENTAL HEALTH CARE



COMMUNITY BASED COUNSELING



KENYA POOR SERVICE ACCESS OUTCOMES

HIV PREVENTION SERVICES—KENYA (Figures 15-18)

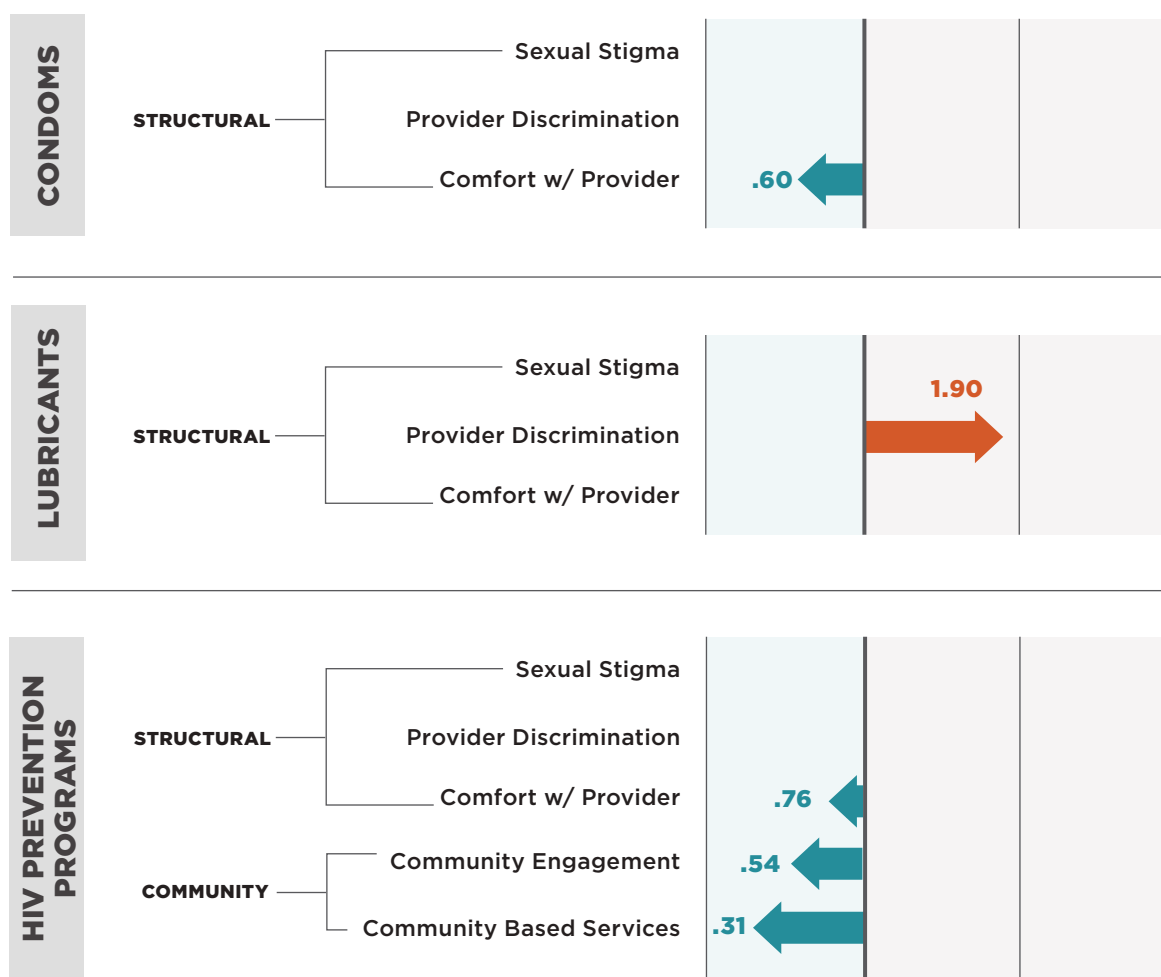
Poor access to condoms was associated with less comfort with provider (OR=0.60, 95% CI [0.42, 0.36], $p<0.005$).

Poor access to lubricants was associated with more health provider discrimination (OR=1.90, 95% CI [1.16, 3.14], $p=0.012$).

Poor access to HIV Prevention Services was associated with less comfort w/ provider (OR=0.76, 95% CI [0.62, 0.94], $p=0.009$); less community engagement (OR=0.54, 95% CI [0.34, 0.85], $p=0.009$); and having fewer community based services (OR=0.31, 95% CI [0.18, 0.55], $p<0.001$).

Poor access to HIV Testing was associated with less comfort w/ provider (OR=0.71, 95% CI [0.51, 1.00], $p=0.047$, $p<0.001$).

FIGURES 15-18. Odds ratios* for Poor Access to HIV Prevention Services-Kenya



* Each statistic reported is an odds ratio significant at $p<0.05$. The height of the arrow indicates the odds of association. Above 1, the association indicates poor access; Below 1, the association indicates better access.

HIV TESTING



.71

SUPPORT SERVICES—KENYA (Figures 19-22)

Poor access to STI Testing was associated with more sexual stigma (OR=0.48, 95% CI [0.25, 0.94], $p=0.031$); and less comfort w/ provider (OR=0.67, 95% CI [0.53, 0.85], $p<0.001$).

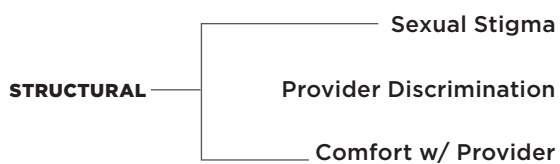
Poor access to STI Treatment was associated with less comfort w/ provider (OR=0.73, 95% CI [0.58, 0.91], $p=0.006$).

Poor access to Mental Health Care was associated with more sexual stigma (OR=2.05, 95% CI [1.05, 4.03], $p=0.036$); and less comfort w/ provider (OR=0.73, 95% CI [0.60, 0.88], $p<0.001$).

Poor access to Community Based Counseling/Support Groups was associated with less comfort w/ provider (OR=0.72, 95% CI [0.58, 0.88], $p=0.002$); less community engagement (OR=0.52, 95% CI [0.32, 0.83], $p=0.006$); having fewer community based services (OR=0.46, 95% CI [0.26, 0.80], $p=0.006$); and lower psychological well-being (OR=0.98, 95% CI [0.96, 0.99], $p=0.010$).

FIGURES 19-22. Odds ratios* for Poor Access to Support Services—Kenya

STI TESTING



.48

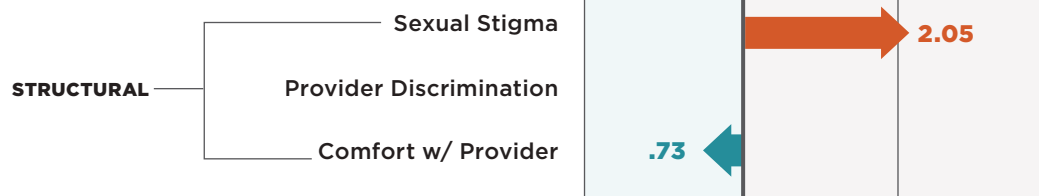
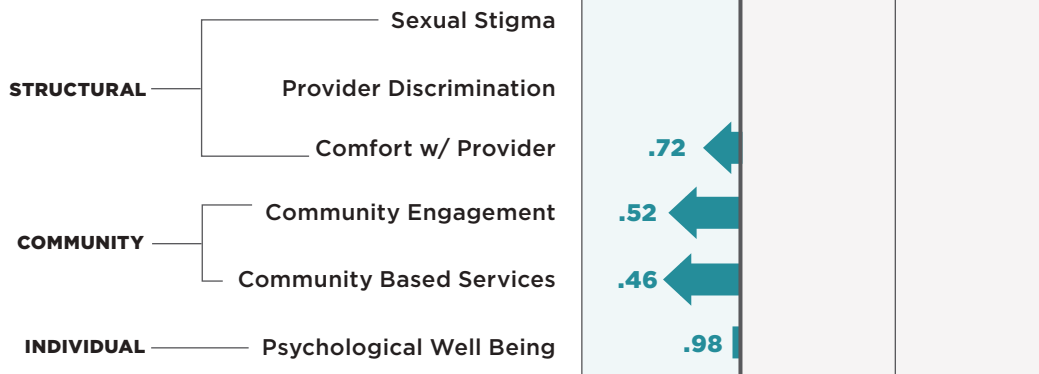
.67

STI TREATMENT



.73

* Each statistic reported is an odds ratio significant at $p<0.05$. The height of the arrow indicates the odds of association. Above 1, the association indicates poor access; Below 1, the association indicates better access.

MENTAL
HEALTH CARECOMMUNITY BASED
COUNSELING

Community partners at ICASA 2019 in Kigali, Rwanda. Photo credit: MPact

VIET NAM POOR SERVICE ACCESS OUTCOMES

HIV PREVENTION SERVICES—VIET NAM (Figures 23-27)

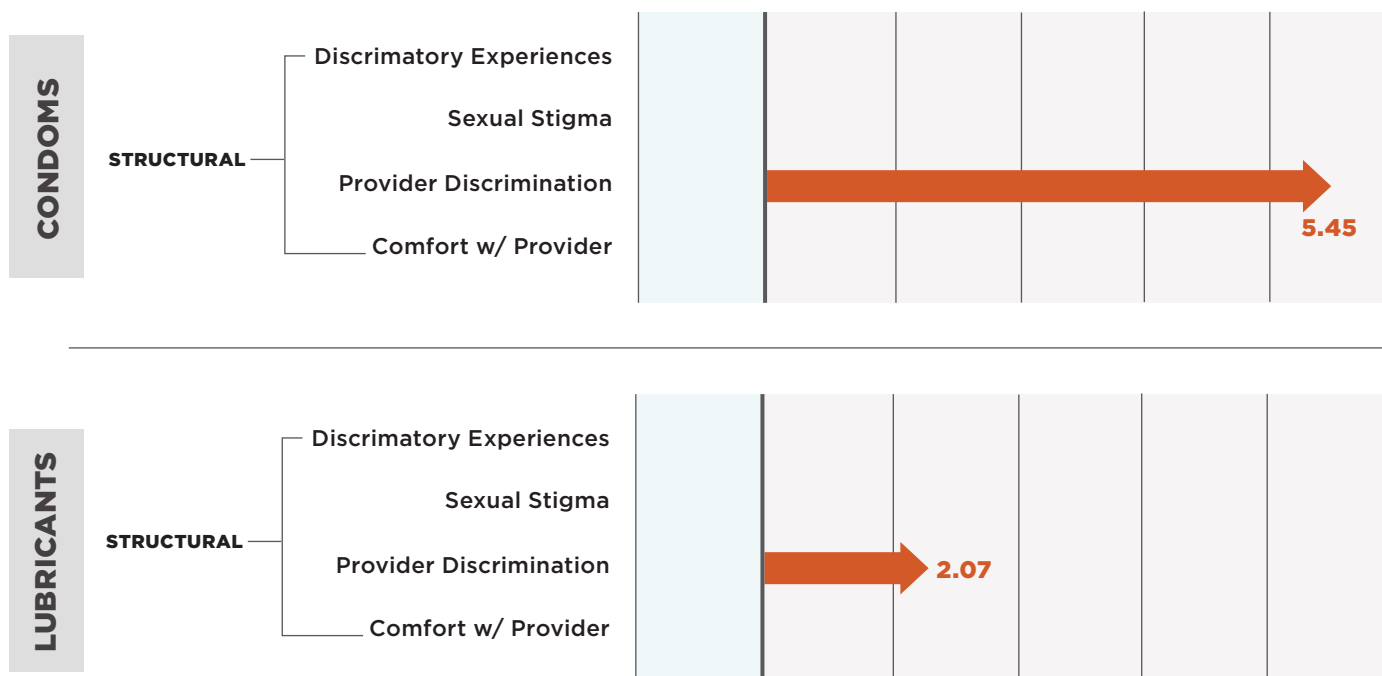
Poor access to condoms was associated with more health provider discrimination (OR=5.45, 95% CI [2.09, 14.21], $p=0.001$).

Poor access to lubricants was associated with more health provider discrimination (OR=2.07, 95% CI [1.06, 4.06], $p=0.033$).

Poor access to HIV Prevention Services was associated with less comfort w/ provider (OR=0.59, 95% CI [0.45, 0.77], $p<0.001$); having fewer community based services (OR=0.56, 95% CI [0.32, 0.96], $p=0.036$).

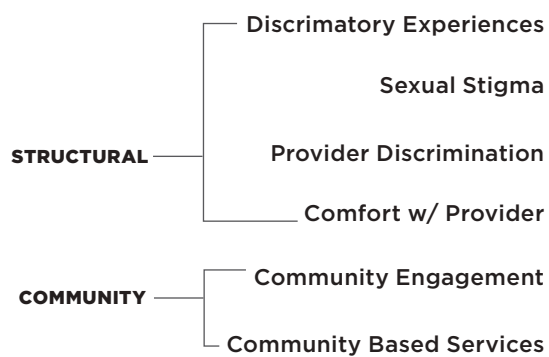
Poor access to HIV Testing was associated with more health provider discrimination (OR=2.76, 95% CI [1.27, 6.00], $p=0.010$); having fewer community based services (OR=0.53, 95% CI [0.30, 0.92], $p=0.025$).

FIGURES 23-27. Odds ratios* for Poor Access to HIV Prevention Services - Viet Nam



* Each statistic reported is an odds ratio significant at $p<0.05$. The height of the arrow indicates the odds of association. Above 1, the association indicates poor access; Below 1, the association indicates better access.

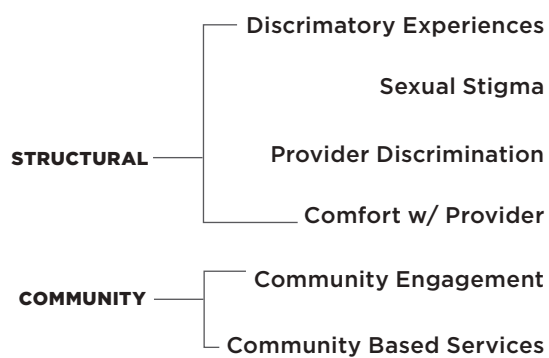
HIV PREVENTION PROGRAMS



.59

.56

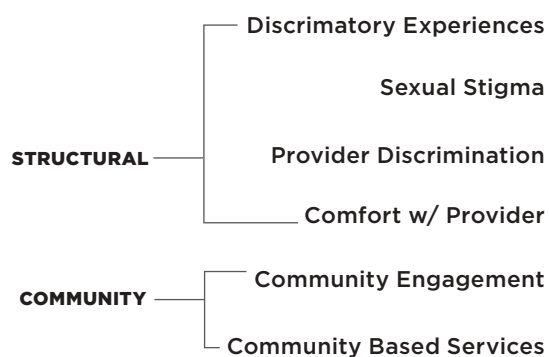
PrEP



.71

.91

HIV TESTING



2.76

.53

SUPPORT SERVICES—VIET NAM (Figures 28-31)

Poor access to STI Testing was associated with less comfort w/ provider (OR=0.70, 95% CI [0.54, 0.90], $p=0.006$).

Poor access to STI Treatment was associated with more health provider discrimination (OR=2.24, 95% CI [1.03, 4.84], $p=0.041$); and less comfort w/ provider (OR=0.69, 95% CI [0.53, 0.89], $p<0.005$).

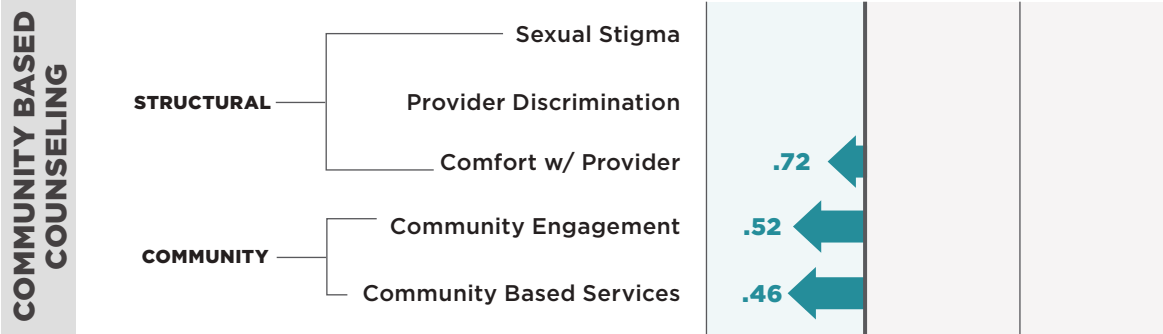
Poor access to Mental Health Care was associated with more sexual stigma (OR=1.94, 95% CI [1.03, 3.63], $p=0.039$).

Poor access to Community Based Counseling/Support Groups was associated with fewer discrimination experiences (OR=0.16, 95% CI [0.03, 1.00], $p=0.049$); less comfort w/ provider (OR=0.62, 95% CI [0.47, 0.81], $p<0.001$; and having fewer community based services (OR=0.54, 95% CI [0.32, 0.93], $p=0.027$).

FIGURES 28-31. Odds ratios* for Poor Access to Support Services—Viet Nam



* Each statistic reported is an odds ratio significant at $p<0.05$. The height of the arrow indicates the odds of association. Above 1, the association indicates poor access; Below 1, the association indicates better access.



CONCLUSIONS

Overall, findings indicate that gay and bisexual men continue to have poor access to the most essential HIV prevention services. Criminalization of sex between men at a country level is an example of the structural violence that impedes health services access for gay and bisexual men. For example, men from criminalizing countries were less likely to know their HIV status, and more likely to experience financial insecurity and sexual stigma—all with less recourse to community engagement with other gay and bisexual men.

Globally, including countries that do not criminalize sex between men, stigma and discrimination practices toward gay and bisexual men contributed to poor access to health services. During interviews, gay and bisexual men described how sexual stigma negatively affected both access to health services and health seeking behaviors. Discrimination on the part of healthcare providers was especially damaging, causing them to avoid or delay seeking services, including treatment for HIV and other sexually transmitted infections. Consistent with previous studies, the impact of structural barriers trickled down to the interpersonal and individual level, leading to social alienation, poor mental health, and further declines in access to services and health-seeking behaviors¹⁹.

The quantitative finding, that most gay and bisexual men were unable to meet their financial needs, is contrary to what would be expected given their high levels of education. However, it would be consistent in a stigmatizing

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and discriminatory context. Indeed, for all gay and bisexual men, sexual stigma and discrimination by health providers were significantly associated with poor access to most of health services, including access to condoms, lubricants, STI-testing, STI treatment, mental health services and community-based counseling. Among men living with HIV, sexual stigma impeded access to HIV-care, and discrimination by providers impeded access to ARVs. Conversely, being comfortable with health providers was a significant enabler of access to all the health services. For men living with HIV, it was the only significant enabler of access to HIV care and ARVs. Together, these findings recommend that addressing stigmatizing attitudes and behaviors on the part of health providers toward gay and bisexual men is essential for increasing their ability to access any health services. This is particularly true for access to HIV care and treatment for men living with HIV.

Gay and bisexual community participation was also an important enabler. Gay and bisexual men recounted ways they look after each other, and their preference for gay or LGBT community-led services where they feel safe and understood. Community involvement was central to their ability to navigate their health needs in unwelcome environments, as well as for their own sense of well-being. Quantitatively, community engagement in social activities with other gay and bisexual men, and receiving services from gay or LGBT community-based organizations, both proved to enable access to most prevention and support services. In parallel with addressing sexual stigma and discrimination, these community level findings offer avenues for ameliorating the negative impacts of structural violence toward gay and bisexual men. Therefore, findings call for greater investments in infrastructure, training and resources to support community led social and health services.

This study had some limitations. First, although study was designed in collaboration with transgender communities who requested to be included in the qualitative interviews, there were no transgender women on the research team. For this reason, in further collaboration with transgender communities, and due to limited resources, the quantitative phase of the study focused solely on gay and bisexual men. **Transgender-led studies using a CBPAR approach are sorely needed to advance an evidence base that conveys and can be used to advocate for the needs of transgender communities**⁴¹. Nonetheless, the current findings support previous research indicating high levels of transgender stigma, provider discrimination and violence toward transgender women⁴²⁻⁴⁴. Second, although in-depth individual interviews provided deep and compelling narratives of the subjective experiences of participants that helped guide survey development and contextualize all the findings, they were only carried out in 2 countries. Future interviews are required to characterize the experiences of gay and bisexual men from other regions. Third, the translation of the survey may have contributed to poor construct validity in some

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languages, in turn affecting the reliability of some scales in some languages. Future analyses by language are warranted to assess this possibility. Fourth, the survey data were gathered using a convenience sample, creating a possibility of selection bias for gay and bisexual men who are socially connected to HIV or LGBT organizations or online LGBT communication infrastructure, as well as for those who have Web and e-mail access. Therefore, levels of participation were limited for gay and bisexual men in regions where Internet access may be challenging. However, consistency of findings between the qualitative and quantitative analyses, as well as with previous studies, suggests that current findings are robust and accurate. Furthermore, results are most likely conservative given the probability that gay and bisexual men who were not reached probably experience greater structural violence, less community engagement and poorer access to health services. Fifth, the quantitative findings for Kenya and Viet Nam were consistent with the global results, but yielded fewer significant odds ratios. This is in part due to the small sample sizes for each country which reduces the power to detect significance even if the result is accurate. Future county-specific studies with larger sample sizes are needed. Finally, there may also be selection bias for gay and bisexual men who are particularly motivated to participate. However, this bias likely overestimated access.

In summary, findings from Action for Access! and GMHR studies provide consistent evidence underscoring the need to improve global as well as local efforts to ensure access to basic HIV prevention, HIV-care and support services for gay and bisexual men. In addition to addressing criminalization at the country level, barriers to and enablers of health services access must be addressed at structural, community and individual levels. Specifically, findings support the need for structural interventions designed to decriminalize homosexuality, reduce societal sexual stigma, train and sensitize healthcare providers, support community engagement among gay and bisexual men, and provide comprehensive health services that also address mental health needs.

Securing the health and human rights of gay and bisexual men is essential to HIV prevention and care strategies, and to the well-being of all people.

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