



D8.5 – European Community Health Worker Online Survey Report



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Glossary

| | |
|----------|--|
| AAE | AIDS Action Europe |
| CBVCT | Community-based voluntary counselling and testing |
| CEEISCAT | Centre for Epidemiological Studies on HIV/AIDS and STIs of Catalonia |
| CHAFEA | Consumers, Health, Agriculture and Food Executive Agency |
| CHW | Community Health Worker |
| DAH | Deutsche AIDS-Hilfe |
| EATG | European AIDS Treatment Group |
| ECDC | European Centre for Disease Prevention and Control |
| ECHOES | European Community Health Worker Online Survey |
| ECOM | Eurasian Coalition on Male Health |
| EEA | European Economic Area |
| EMIS | European online survey of gay, bisexual and other MSM |
| ESTICOM | European Surveys and Training to Improve MSM Community Health |
| EU | European Union |
| HVB | Hepatitis virus B |
| HVC | Hepatitis virus C |
| LGBTI | Lesbian, Gay, Bisexual, Trans and Intersex |
| ILGA | International lesbian, gay, bisexual, trans and intersex association |
| IQR | Interquartile Range |
| MSM | Men who have Sex with Men |
| NGO | Non-Governmental Organisation |
| PLHIV | People living with HIV |
| PEP | Post-Exposure Prophylaxis (PEP) |
| PrEP | Pre-Exposure Prophylaxis |
| RKI | Robert Koch Institute |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| UoB | University of Brighton |
| WHO | World Health Organisation |
| WP | Work Package |

Executive summary

The ESTICOM project (European Surveys and Training to Improve MSM Community Health), consists of three main objectives: (1) the European online survey of gay, bisexual and other men who have sex with men (EMIS-2017), (2) the European Community Health worker Online Survey (ECHOES) and (3) the development and pilot testing of a training programme focusing on men who have sex with men (MSM) for community health workers (CHWs) in Europe. This report presents the main results of the survey conducted in Objective 2 (ECHOES) and aims to be used as a tool to inform CHWs and Policy makers, at local, national and international level.

A scoping review conducted prior to ECHOES in work package 5 (WP5, Objective 2), showed that, despite CHWs being a major social actor since the emergence of HIV/AIDS, their role and characteristics when acting in sexual health promotion among gay, bisexual and other MSM were almost unknown at the European level and literature on the topic was scarce. A mapping exercise of existing CHW training materials concluded that training of CHWs was in general lacking a standardised curriculum, systematic evaluation and monitoring, as well as mechanisms for accreditation. An additional finding from the review was the wide diversity of terms used for CHWs at European level (e.g. community advocates, outreach workers, peer counsellors, peer educators, health care providers) and the absence of a clear definition of the term.

The main objective of ECHOES was to assess the knowledge, attitudes, and practices of CHWs providing sexual health services to gay, bisexual and other MSM in Europe. This first ever survey for European CHWs was available in 16 languages and went online in October 2017 for a period of four months. Descriptive analyses were made overall and stratifying by variables such as: age group, gender, sexual identity, peer role, years working as a CHW, employment status, respondents' organisation type, perceived income. Comparisons were also made by variables based on country groupings: the level of LGBTI inequality (based on the Human Rights situation of LGBTI people in European and neighbouring countries; the distribution of LGBTI inequality – high vs. low – in Europe roughly divides across Eastern vs. Western countries, respectively), the 'HIV epidemic' (based on the rate of new HIV diagnoses in the male population attributable to sex between men) and 'CBVCT restriction' (whether or not the country allows Community-Based Voluntary Counselling and Testing to be performed by non-medical staff).

Overall, 1,035 CHWs from 36 European countries participated in ECHOES. The range of nomenclature used by respondents to describe their job shows a high diversity of CHW profiles among ECHOES respondents: community health advisor, health advisor, health promoter, lay health advisor, outreach educator, outreach worker, peer advocate, peer health provider, peer educator, volunteer, etc.

One of the main characteristics of CHWs working with gay, bisexual and other MSM is that lots of them come from the 'community' (peer CHWs), or are at least well connected to the target population they work with. Peer CHWs (around 60% of the overall sample) are more often volunteers and report more involvement in outreach

activities than non-peer CHWs. Peer CHWs also appear to have received more training and to be more confident regarding the services they are delivering.

The profile of ECHOES respondents differs between the ECHOES country-grouping variables. Peer CHWs are more common in 'low LGBTI inequality' countries (mainly Western European countries), whereas female and heterosexual CHWs are more common in 'high LGBTI inequality' countries. Volunteer CHWs are more common in Eastern European country respondents than Western.

CHWs have many functions and play a major role along the retention cascade for HIV, viral Hepatitis and other STIs. CHWs recruited in ECHOES reported activities in each step of the service continuum (prevention, testing and screening, linkage to care and treatment support) but also activities which cut across the continuum: referral to other services, advocacy, report writing, etc. It was found that across the region CHWs are usually dedicated to more than one activity, and there is no clear difference between Western and Eastern European countries regarding the type of activities.

CHWs tend to report training needs on topics they have already received some training on before, and this is corroborated by the first findings from the Objective 3 Training Programme of ESTICOM. ECHOES respondents want more advanced knowledge on topics they deal with on a daily basis (prevention activities, substance use, mental health, etc.), but report training needs in other skills like communication, writing, fundraising and advocacy less even though they are essential in many CHWs' roles. These cross-cutting skills should occupy a significant part of the future CHW training, and should incorporate cultural competencies regarding LGBTI-specific needs, especially for non-peer CHWs.

Structural and social issues are the biggest barriers faced by ECHOES respondents to perform CHW activities. Shortage or lack of funding or resources are reported by more than 60% of respondents, and are reported more in respondents working for not-for-profit organisations. Non-stable funding creates programme instability and requires that resources within the organisation be directed to fund-seeking.

Stigma-related barriers – around HIV/AIDS and/or homosexuality – and other barriers such as access to or cooperation with healthcare services are reported by many ECHOES respondents, especially in 'high LGBTI inequality' countries. Stigma and legal restrictions, such as CBVCT by medical staff, also impede CHWs to act in all the domains they could, reducing the impact of CHW activities on the sexual health of gay, bisexual and other MSM.

At the end of the report, the authors suggest a series of actions at different levels (European, National and CHWs level) as well as recommendations for future CHWs Training programme and research among CHWs.

About this report

This report was prepared as part of the ESTICOM (European Surveys and Training to Improve MSM Community Health) Project, which is a three year tender from 28 August 2016 to 27 August 2019 contracted by the Consumers, Health, Agriculture and Food Executive Agency (Chafea) of the European Commission. The ESTICOM Project involves 9 organisations under a consortium led by the Robert Koch Institute (RKI) in Berlin, Germany.

The purpose of the ESTICOM project is to strengthen the community response and raise awareness about the persisting legal, structural, political and social barriers hindering a more effective response to HIV, viral Hepatitis and other sexually transmitted infections (STIs) among gay, bisexual and other men that have sex with men (MSM). With this purpose, the consortium will deliver on three interlinked projects or objectives:

- **Objective 1:** A European online survey of gay, bisexual and other MSM (EMIS-2017),
- **Objective 2:** A European online survey of community health workers (CHWs) who provide sexual health support in a community setting directly to gay, bisexual and other MSM (ECHOES),
- **Objective 3:** Development and piloting of a training programme for MSM-focused CHW to be adaptable for all EU countries.

This report falls under Objective 2, coordinated by the Centre for Epidemiological Studies on HIV/AIDS and STIs of Catalonia (CEEISCAT), which is built on four Work Packages (WPs): a review of CHW's knowledge, attitudes and practices about sexual health of gay, bisexual and other MSM, including existing surveys and training materials (WP5), a CHW online survey design (WP6), promotion and execution of the survey (WP7) and data analysis and survey report (WP8).

ECHOES aimed to assess the knowledge, attitudes, and practices of CHWs providing sexual health services to gay men, bisexual men and other MSM in European settings. This first ever survey for European CHWs was available in 16 languages and went online in October 2017 for a period of four months.

This report presents descriptive analyses of the survey and can be used as baseline data to provide a preliminary picture of the CHWs who work with gay, bisexual and other MSM in Europe and neighbouring countries. It provides the first data for the evaluation and further improvement of training programmes and materials for training of CHWs working with gay men, bisexual men and other MSM. This report may also be a useful instrument for advocacy, for enhancing CHW visibility and recognition at national, regional, and international levels, and for helping future funding applications.

This report was coordinated and prepared by Nicolas Lorente, Cinta Folch, Susanna Aussò, and Jordi Casabona (CEEISCAT). The following ESTICOM project members were involved in the writing of the introduction and/or methods section: Nigel

Sherriff and Jörg Huber (UoB), Oksana Panochenko and Michael Krone (AAE), Ulrich Marcus and Susanne Schink (RKI), and Maria Dutarte (EATG). Matthias Kuske (Deutsche AIDS-Hilfe (DAH), Objective 3 co-leader) carefully revised the final manuscript draft and gave important input for the report.

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1. Introduction

1.1. Background

HIV remains a significant public health problem in the European Union (EU) and the European Economic Area (EEA). In 2016, 29,444 people were diagnosed with HIV in the 31 countries of the EU/EEA, with a rate of 5.9 per 100,000 population [1]. Similar to recent years, the highest proportion of HIV diagnoses was reported to be in MSM (40%), with heterosexual contact the second most common transmission mode (32%). Co-infections with HIV, viral Hepatitis and other STIs were common among MSM [2,3], as well as outbreaks of rarer STIs such as lymphogranuloma venereum and shigellosis, particularly among MSM living with HIV [4,5].

In the framework of Objective 2 (WP5), a scoping review of the available literature and existing CHW training materials was conducted and published to establish what was already known of CHW knowledge, attitudes and practices relating to the health needs of gay, bisexual and other MSM in the EU and neighbouring countries. The review report (hereafter referred to as 'WP5 review') also included the results of a brief online survey and interviews about the CHW role and their perceived needs and barriers¹. One of the most important findings in this review is that CHWs operate in all of the key areas of prevention, testing, treatment for HIV, viral Hepatitis and other STIs. They help individuals and groups in their own communities to access health and social services, and educate community members about various health issues. While CHWs may not replace the need for formal health care delivery by highly skilled and specialised health care workers, CHWs play an important role in increasing access to health care and services, and in improving health outcomes. They enable a link between the community and the formal health system, and are a critical component in the efforts for a broader approach that takes into account social and environmental determinants of health [6].

An interviewee for the review report reflected on this link and the diversity of the role of CHWs:

"We've got [...] a broader programme really, [...] our sexual health work, [...] condoms and testing and the outreach and the net-reach etc. [...] that's one of many things that we do. So we also do [...] mental health and well-being work, and drugs and alcohol work, and we're looking at how to sort of integrate that [...]. So we don't want to create a situation where we've got a mental health team, and then separately a sexual health team, and separately a drugs and alcohol team, [...] there's a lot of complexity there around addressing not just sexual health need" (UK)

CHWs are a major social actor since the emergence of HIV/AIDS and have a strong presence in community-based Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) organisations. CHWs frequently represent the target communities (social, ethnic and cultural, or behavioural groups) that are at greatest risk. Many

¹ Folch C, Fernández-Dávila P, Palacio-Vieira J, Duterte M, Corbelli GM, Block K. A Review of Community Health Worker (CHW) knowledge, attitudes and practices relating to the sexual health of MSM, including existing training materials and manuals in Europe and neighbouring countries. Luxemburg, European Union (EU); 2017.

programmes, interventions, and treatment services use CHWs to attract, educate, advocate, and administer treatments to beneficiaries with great success [7].

“we do quite a lot of work, obviously going out and talking to people, [...] members of the LGBT community, we've engaged with them, [...] lots of the members of [our organisation] are themselves lesbians, gays, bisexuals, transgenders, [...] drug users, [...] migrants, [...] and as a community-based organisation [...] we reach out to people that way” (France)

The scoping review concluded that despite the important work being carried out by CHWs in Europe, the work and role of CHWs in sexual health promotion and HIV/STI prevention among gay, bisexual and other MSM remained infrequently reported. The literature available on the topic in the EU and neighbouring countries is scarce and mostly originates from the United Kingdom.

Another relevant finding from the review was the wide diversity of terms used for CHW at European level (e.g. Community Advocates, Counsellors, Health Care Providers, Health Providers, Lay Health Workers, Lay Providers, Mediators, NGO workers, Peer counsellors, Peer educators, Peer navigators, Peer supporters, Peer workers, Service Providers, Sexual Health Advisers, Street social educators). This supported the need for the ESTICOM project to propose a single definition of CHW for the European context, to facilitate future research, training and advocacy concerning this group.

Finally, the scoping review identified important gaps in the training of CHWs in Europe. A lack of definition of the theoretical framework for the training coupled with a lack of standardized training curricula, evaluation and monitoring and accreditation/ certification were observed.

1.2. ECHOES research aims and objectives

The term “Community Health Worker” (CHW) can apply to a wide range of individuals providing health services and support for different populations [8]. However, very little is known about the role of CHWs in the promotion of sexual health and HIV/STI prevention among gay, bisexual and other MSM.

The European Community Health Worker Online Survey (ECHOES) therefore aimed to assess the knowledge, attitudes, and practices of CHWs providing sexual health services to gay men, bisexual men and other MSM in European settings. Additional objectives were to:

- 1) Understand who CHWs in Europe are, what they do, where they do it, how they do it, and why they do it;
- 2) Identify gaps in CHWs' knowledge and skills to identify training needs;
- 3) Identify the barriers and challenges to CHWs who provide sexual health services in a community setting;

- 4) Inform the content, structure and approach of Objective 3: the development of a dedicated training programme for CHWs as part of the larger EU-funded ESTICOM project.

1.3. CHWs in Europe: setting the scene for ECHOES

The World Health Organisation (WHO) defines CHWs as individuals who should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers [8], though they receive a standardized training outside of the formal nursing or medical curricula [9].

In Europe, there is a wide variety of CHWs, with different titles, working voluntarily or paid, with multiple roles and tasks, but, prior to ECHOES, this group had never been object to a large scale, systematic study.

The review showed that CHWs in most cases were members of their target communities and were unpaid or low-paid people recruited by other CHWs in community-based and outreach settings, especially CBVCTs. CBVCTs are defined as any programmes or services that offer HIV counselling and testing on a voluntary basis outside formal health facilities and that have been designed to target specific at-risk groups, and are clearly adapted for and accessible to those groups [10]. CHW activities were performed in community clinics, prisons, social care centres or gay venues such as saunas, sex clubs, and nightclubs.

Based on the type of services delivered as described in the available literature, CHW activities were classified into four main groups: promoting access, providing education, advocacy, and direct service delivery. One respondent expressed his view on the anticipated role of the CHWs:

“There are several key issues that need to be taken into consideration. To keep and develop sustainable and effectively-working checkpoints- VCT centres for HIV testing and STI diagnostic. To improve the knowledge and working skills of health providers working with MSM. To raise the awareness of responsible institutions, regarding provision of funds for these activities. To improve the process of linkage to care and therapy for new HIV positive patients.”(Bulgaria)

The scoping review also looked at barriers for CHW work. Four main themes were identified in the available literature: structural and contextual barriers, work-related barriers, relationship barriers and individual barriers. At structural level, the main barriers to CHWs were the lack of funding, the poor support from national structures and stigma towards HIV or homosexuality, especially in the Eastern countries.

These were also discussed during the CHW interviews, where the most frequently mentioned barriers and needs were those at the organisation level and in terms of

cooperation with health services. At the health service-level, the main barrier was related to prejudice, stigma and discrimination, both from administrative staff and health workers.

Among respondents from several Eastern European countries, one of the main needs mentioned was to have more community-based organisations. It seems that civil society in these countries cannot be organized in such a way that it can meet the LGBTI population's needs because of funding issues. In Eastern European countries there is a misalignment between national spending on HIV/AIDS responses and spending on the most affected populations in the region [11].

One respondent described their work in a setting characterized by discrimination:

“for NGOs working in this MSM group, because this Catholic government are very homophobic [...] So, I think [...] we can see the difference between projects, [...] in the ministry of health level, the changes of the people who are working there. [...] I think the homophobi[a] would be bigger and bigger, and it's also working in the field will be harder. And also getting money for this kind of working, [...] in the last year we have some situation of attack for [...] MSM group, also for NGOs [...] people coming and crash the window, or something like that. [...] we hadn't seen it for many years, now it happened, again.” (Poland)

Some of identified barriers were linked to the CHW training needs. In order to do their jobs effectively and to grow personally and professionally through their work, CHWs should develop certain core skills. The review identified five core CHW skill areas that are important for CHW work: Communication skills, Interpersonal skills, Service coordination skills, Capacity building skills and Online Outreach Skills. Having strong intrapersonal skills as well as being able to communicate, coordinate and train others are seen as key aspects for being a “good” CHW. However, from the NGOs or community organisations workers' perspective, the main role or function of a CHW seems to be to provide information. As mentioned earlier, the review found important gaps in CHW training. There is also a shortage of information and training materials aimed specifically at CHWs. An interviewee expressed this as follows:

“booklets, brochures and information studies, that we give to those CHWs, peer-to-peer consultants, and also medicine doctors [...] there is a serious situation which we call lack of [...] right information in Turkey. We are trying to produce the right information, taken from United States, Canada and Europe... European Union, and we are trying to turn... translate some into public speech in Turkish” (Turkey)

One of the main barriers for CHWs to be able to carry out their activities mentioned in the interviews was the lack of funding or economic support which is strongly associated with needs at the organisational level: not having space to perform activities, not being able to hire highly qualified and long-term staff, not being able to give some economic compensation to CHWs for their activities.

“financial problems, we are applying as much as possible to different [...] sources, but that presents a big problem to us, across Croatia, because we are one of the countries that continue to fund [...] activities after the [Global

Fund] with the state budget but [...] last year [...] there was a huge delay in the country so this is something [...] we were [not able to] deal with [,it] was out of our hands.” (Croatia)

The scoping review provided some examples of good practice. Sander et al. included examples of successful prevention messages for MSM, planning concepts, and examples of how to implement and evaluate communication strategies and prevention campaigns at the European level [8]. The findings of the evaluation of the Positive Scotland project, a project with a particular focus on skills, employability, and the needs of older people and gay men living with HIV, were presented in a report for those professionals, such as volunteers, workers, managers and external partners, who may be working with PLHIV and/or people living with Hepatitis C [12].

In Ukraine, a report presented the outcomes of three years of the project “HIV Prevention and Psychosocial Support for MSM in Prisons” implemented by the Penitentiary Initiative NGO (2009–2012). This organisation developed an outreach model of HIV prevention and psychosocial support for MSM/MSM prisoners living with HIV. It included psychological support groups; training in HIV, viral Hepatitis and other STI prevention; individual counselling by psychologists and social workers; training peer educators for outreach work among MSM/outcast inmates; distribution of condoms, lubricant, supplies for personal hygiene, bleach and informational materials; and referrals after release. In less than three years, this project made significant headway in breaking down the barriers to HIV education and social support among MSM in Ukrainian prisons [13].

2. Methods

2.1. General design and inclusion criteria

Given the term CHW was not well known or used in Europe, a broad working definition was developed by the ECHOES team for the purposes of defining the study population. It was agreed that for ECHOES the following definition would be used:

Community Health Workers (CHWs) are known by a variety of titles including outreach worker, volunteer, health promoter, peer educator, community health advisor etc., so wherever you see the term 'Community Health Worker' (or 'CHW') in the survey, we mean:

"A CHW is someone who provides sexual health support around HIV/AIDS, viral hepatitis and other Sexually Transmitted Infections (STIs), to gay, bisexual and other MSM. A CHW delivers health promotion or public health activities in community settings (not in a hospital or clinic)."²

Based on that definition, CHWs that satisfied the following criteria were eligible to participate in ECHOES:

- a. They provided sexual health support for gay, bisexual and other MSM in a community setting (not in a hospital or clinic) during the last 12 months;
- b. They provided support as a CHW in one of the 36 eligible countries³;
- c. Were aged 18 years or older;
- d. They consented to take part in the survey.

CHWs were not eligible to participate in the survey if:

- a. They provided sexual health support for gay, bisexual and other MSM in a non-community setting (e.g. clinic, GP surgery, etc.);
- b. They provided support as a CHW more than 12 months ago;
- c. They provided support as a CHW in a non-eligible country;
- d. Were 17 years old or younger;
- e. They did not provide consent or withdrew from the study.

2.2. Questionnaire Design

The University of Brighton (UoB) as the lead partner for the survey development for ECHOES (WP6) conducted an initial scoping exercise parallel to the WP5 review⁴ (this was necessary due to a conflicting timeline in the original tender specification which meant that the WP5 review was only finalised once a draft version of ECHOES

² Sherriff N, Huber J, McGlynn N, Llewellyn C. A final proposal for a European community health worker survey (ECHOES). Luxembourg, European Union (EU); 2017.

³ All 28 EU Member States as well as Bosnia and Herzegovina, Iceland, Moldova, Norway, Russia, Serbia, Switzerland, and Ukraine.

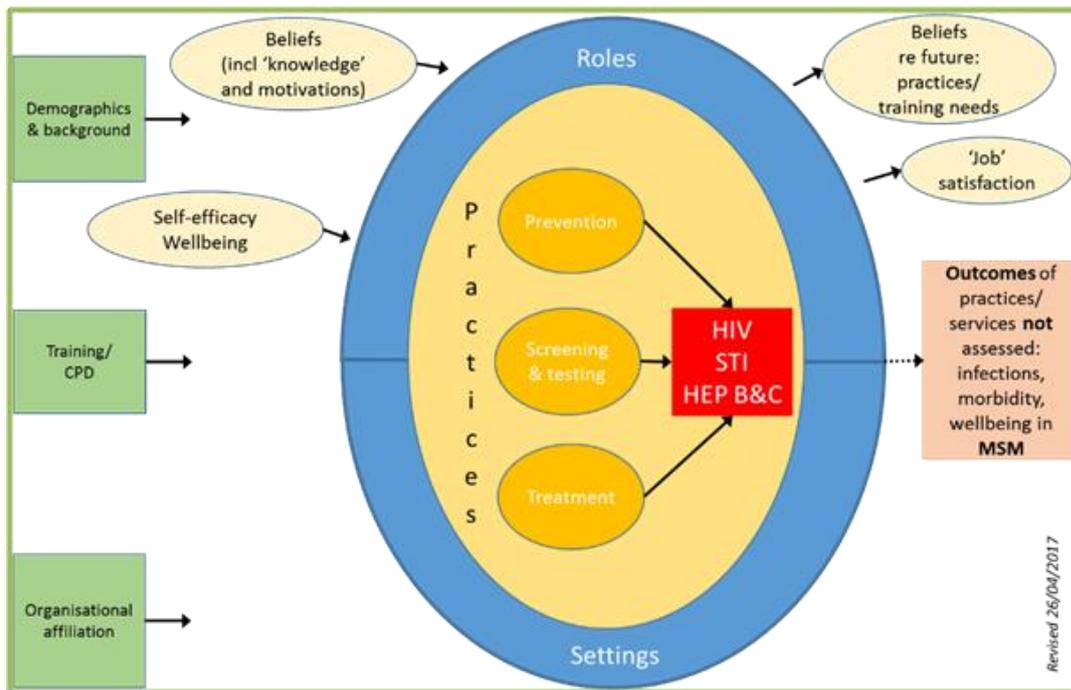
⁴ Reference in footnote 1, page 21.

had already been made available for pre-testing). The initial scoping conducted by the UoB (WP6) team aimed to develop a working definition of a 'CHW' for European contexts, and to explore any existing CHW surveys in Europe and elsewhere. A further aim was to consult with project partners to share available national or regional questionnaires targeting CHW in any language. No national or regional questionnaires targeting CHWs were submitted to the UoB, and scoping results were broadly in line with the findings of the WP5 review showing a lack of both peer-reviewed and grey literature on CHWs involved in providing sexual health support aimed at gay, bisexual and other MSM in Europe. Moreover, it became clear that the term CHW was not routinely used across Europe and is more commonly used in the United States and in many African countries. Therefore, it was acknowledged that close attention needed to be paid during the marketing and promotion of the survey (WP7) to ensure it reached the 'right' people. These initial scoping findings were discussed with ESTICOM partners at the first steering group meeting in Luxembourg (September, 2016).

In parallel to these activities, an initial conceptual map of the survey was devised by the ECHOES development team in Brighton. A further meeting arranged in Berlin (hosted by DAH during October 2016) was needed to finalise a working definition of CHW that would be used for the survey (and potentially refined later based on survey results). Moreover, the meeting was also necessary to reach a consensus on the core conceptual areas to be developed. Prior to this meeting, a brief online survey using Survey Monkey was sent by WP6 to Objective 2 colleagues in order to collate their views as experts on a number of issues including⁵: screening (who to include/exclude), the relative importance of different proposed areas of interest for the CHW survey (demographics, CHW activities/roles, settings, motivations, attitudes, knowledge, barriers, CHW development and support, training needs, and open text to propose any additional area), as well as estimates of the extent of data to be collected. Findings of this short survey were presented briefly during the Berlin meeting to consider and come to a broad consensus on the main topic areas via roundtable discussion. This process achieved a good level of consensus, and acceptability.

With regards to the conceptual map, a first draft was produced for the Berlin meeting as per the project timeline, and then revised subsequently as the survey structure developed. A third iteration was developed during January 2017 and updated in April 2017 (Figure 2-1). In short, the conceptual model is informed by the theory of planned behaviour [14,15] and other conceptual frameworks such as the health belief model [16]. Both are used widely in health psychology, public health, and health promotion. Figure 2-1 shows the key elements forming the core of ECHOES: practices around prevention, screening and testing, and treatment. Practices are embedded in roles and settings, and are shaped by beliefs including knowledge and more enduring personal characteristics (self-efficacy and well-being). Demographics, training and organisational parameters are other factors shaping CHW practices. The experiences of CHWs shape their beliefs regarding the future and 'job' satisfaction. Outcomes of CHW practices/services are not assessed as they are out of the scope of the survey but may be an important area to consider for a future phase of ECHOES.

⁵ www.surveymonkey.de/r/CHW_concept_map (accessed on 31 May 2019).



CPD: Continuing Professional Development

Figure 2-1: The ECHOES conceptual model

Following the development of the conceptual model, a first full draft of the survey was developed by the end of February 2017 both on paper and online via demographix.com (a technology provider of online research tools and services including surveys). A pre-testing phase was then initiated to make an early assessment of ECHOES. The first full draft was used for several small rounds of online pre-piloting and a more detailed consultation exercise with key partners.

The iterative rounds of small scale online pre-piloting were undertaken in February-March 2017 (M6-M7), informally and internally at the University of Brighton, as well as externally with CHWs known to the research team. The purpose of these pre-pilots was to test sections of the questionnaire as they became available, checking for acceptability, completeness, comprehension, phrasing, and ease of use. As part of this process, respondents were asked to attempt to answer the draft sections followed by feedback to add/adapt/delete questions to optimize them.

Following completion of the series of online pre-tests, a broader consultation exercise was conducted utilising ESTICOM's wider networks. In collaboration with the WP2 team (Objective 1), the draft survey was sent out for its first consultation simultaneously with the second round of consultation for EMIS-2017, on the 24th March (M7) 2017. It remained open until 10th April (M8) 2017 (16:00 hours UK time). The draft survey was emailed (via Objective 1 coordination team) using MailChimp to 412 unique email addresses of ESTICOM subscribers. Respondents were asked to download the full draft of the proposed questionnaire, and use the 'Review-Comment' tool (Microsoft Word) to answer specific questions regarding additions, omissions, and comprehension. On the 6th April 2017, a second email was sent to remind potential participants that the consultation closed on the 10th April 2017. Overall, 28 responses to the consultation were received from 18 countries representing 25 organisations including European agencies and national government departments as well as specialised Non-Governmental Organisations

(NGOs) (e.g. specialising in sexual health, HIV, or LGBTI issues), Checkpoints, Public Health agencies, other organisations. The consultation provided a very clear steer on modifying the draft ECHOES questionnaire to develop it further for online piloting and finalisation. In responding to the outcomes of the consultation, every nomination for amendment (e.g. add/adapt/delete), comment, and criticism was considered by the ECHOES questionnaire development team. Respondents identified typos and routing errors which were subsequently rectified. Discussion by the research team led to the de-selection, modification and addition of numerous questions which are listed and discussed below.

In slight variation to the original tender specification timeline, after revisions from the pre-testing phase were implemented, a small number of cognitive debrief interviews were conducted [17]. The aim of these interviews was to gather an evidence base to assess and improve the clarity, intelligibility, accessibility and acceptability of the online survey. Data generated from the interviews were used to further revise the online survey before the wider online piloting. Seven participants with experience in CHW work/volunteering or appropriate fields of sexual health were asked to complete the revised draft ECHOES online. Participants were all aged at least 18 years of age, able to read and speak English, and without any hearing or cognitive impairment which would impede participation.

Participants were sent a URL link to the draft online survey and asked to complete it as though it were the final version. A cognitive debriefing interview was then conducted, and the audio recorded within two days of completion. Four interviews were conducted in person, and three by telephone or Skype™ software. Each interview took between 30 and 45 minutes. Participants were informed of the project's nature in advance with a participant information sheet and agreed their participation through a signed informed consent form.

During the interviews, participants were asked about their experiences of completing the online survey. They were also asked to identify words, terms, or concepts that they may not have understood. Participants could also provide direct feedback through a final free-text question in the online survey, and when solicited at the end of the interview. In addition to audio recording each interview the researcher took notes to help identify potential issues. A full itemised list of responses from the cognitive debriefing interviews is available upon request.

The final ECHOES questionnaire survey comprised 175 questions (heavily routed), divided into 10 subsections: About you; Job employment and status; Role as a CHW; Clients; Barriers to CHW activities; Recruitment as a CHW; Training and skills; Thoughts and feelings about being a CHW; Knowledge, Final questions.

2.3. Translation and online preparation

To maximise time and cost efficiency as well as simplify the process and reduce the burden on national contact points in Member States, translation of the final approved ECHOES questionnaire was conducted alongside the EMIS 2017 questionnaire translation using the demographix.com platform.

To facilitate translation into the various languages, Demographix provided a custom interface for the translation of the approved English language version of both surveys. The interface allowed translators to enter the survey via a unique and personalised URL and to see a locked version of the original English version on the left of their screen while translating the survey directly over the top of a second version of the English original, on the right of their screen. Using this service ensured that all questions maintained the same routing and piping instructions in all languages, and all versions were structurally identical. Demographix also provided existing pre-translated survey completion instructions (for example, next, previous, submit) in all the required languages for ECHOES.

Multilingual proof-readers were asked to use a similar system to compare and contrast survey translations. Demographix allowed simultaneous access for all ECHOES partners who needed to review a specific version of the survey, prior to being published and launched.

Translations were outsourced to translators suggested by the national collaborating partners, thereby minimising costs. Translations involved native-speaking stakeholders from the field (such as experts in HIV prevention or in LGBTI health) as translators for each language. Two multi-language proof-readers were involved if possible to compare the translations not only with the English original but also with each other. The proof-readers ensured a harmonised multi-language questionnaire, while deliberately maintaining certain differences identified as culturally appropriate, such as explicitness of language, or the question of formal or informal address.

In ECHOES, translations into some languages were available for two of the three standardised scales: the General Self-Efficacy Scale⁶ and WHO-5⁷. In each case, some minor modifications were required. The Job Satisfaction scale was only available in English. Translators were asked to use existing versions if available, and where translations did not exist, to provide their own translation.

The final survey questionnaire was available in the following 14 EU languages as well as Russian and Ukrainian (16 in total): Bulgarian, Croatian/Serbian, Czech, Dutch, English, Finnish, French, German, Greek, Italian, Polish, Portuguese, Romanian, and Spanish. After consultation with Scandinavian (Norway, Sweden, Denmark) and Baltic country representatives (Estonia, Latvia, Lithuania), it was decided not to translate the ECHOES questionnaire into these languages because of the expected low number of respondents in these countries and because of the good working knowledge of English or Russian that CHWs were expected to have in these regions to enable them to fill in the questionnaire.

2.4. Survey promotion

The WP7 team represented by AIDS Action Europe (AAE) was responsible for the promotion of the survey. AAE is a network of national networks, AIDS service organisations, and community-based groups which, at present, represents 415 NGOs in 47 countries in the WHO European Region.

⁶ Translations available at: <http://userpage.fu-berlin.de/~health/selfscal.htm> (accessed on 6 May 2019).

⁷ Translations available at: <https://www.psykiatri-regionh.dk/who-5/who-5-questionnaires/Pages/default.aspx> (accessed on 6 May 2019).

Promotion plan preparation

In June 2017 AAE contacted its members and partners with a pre-survey to explore what might be the best ways to promote ECHOES once launched. The pre-survey contained a description of the ESTICOM project and ECHOES, introducing the term “Community Health Worker” and its definition agreed with Objective 2. The pre-survey comprised eight questions:

1. Which organisation or agency do you work for?
2. If you are willing to answer any follow-up questions about the information you provide, please tell us your email address.
3. We would like everyone to answer all the following questions about ECHOES promotion in a specific country. What country do you want to tell us about in this survey?
4. Please list below, any websites which you think might be useful to advertise ECHOES in *country* – please think about NGO HIV and sexual health websites in particular.
5. Which of the following social media / social networking platforms do you think are most widely used by Community Health Workers in *country*?
6. Please list here any Facebook groups or Twitter users you are aware of in *country* that you think we could ask to help with recruitment to ECHOES?
7. Please list below any organisation in *country* that we might ask to send a recruitment message for ECHOES?
8. What do you think additional methods would be to promote ECHOES in *country*?

In total 44 answers from 32 countries were received, of which 29 were from countries planned to be surveyed.

Respondents provided a list of national and local organisations and websites that are used by CHWs – among them national HIV/AIDS, Checkpoints and sexual health NGOs websites (Austria, Belgium, Cyprus, Croatia, Greece, Serbia, Poland, the Netherlands, Romania, France, Finland, the UK, Spain, Italy, Switzerland, Lithuania, Slovenia, and Moldova), websites of LGBTI NGOs and LGBTI organisations (Bulgaria, Serbia, Greece, the Netherlands, Malta, France, Romania, Finland, Spain, UK, Belgium, Italy, Cyprus, Switzerland, Lithuania, and Moldova), governmental websites and Public Health Institute websites (Bulgaria, Serbia, Poland, France, Spain and Germany).

Based on the pre-survey information, the main social media platform used by CHWs is Facebook, followed by Twitter and Instagram. Partners from most of the countries provided a list of Facebook pages and groups with open and with limited access, where CHWs could potentially be contacted / recruited. These were mostly local and regional HIV/AIDS and sexual health communication groups, Facebook pages of NGOs and local LGBTI related groups.

The following methods were proposed by different country contacts as being appropriate for promoting ECHOES: disseminating information through Facebook, NGOs and relevant websites, using organisations’ newsletters, sending links to the

survey directly through email, with an invitation to send the link to other CHWs, contacting national Ministries of Health, and contacting regional coordinators of HIV/sexual health programmes in specific countries (e.g. Germany, Switzerland). One of the main suggestions for promotion was direct emailing/ sharing through local networks / reaching CHWs through social network channels.

A survey of this scale would not be possible to run, promote and share without having national partners that could support promotion activities. In order to achieve maximum visibility, European health promotion associations and community-based/civil society organisations working on provision of HIV/STI services for priority groups and on the health rights of sexual minorities and PLHIV were thus contacted in order to identify organisations and individuals as well as to promote the survey at national level. Local Multipliers (LM) were identified in individual countries to play an important role in the AAE promotion strategy as part of snowball sampling. LM were representatives of local and national NGOs concerned with HIV and LGBTI issues, or MSM Checkpoints which had an understanding of and access to local CHWs. LM were crucial for the promotion thanks to their knowledge of the cultural and social context of each country as well as their language skills. Based on the database created by WP5, LM were identified in each country by contacting individuals connected to the following networks:

- EMIS-2010, SIALON I and II⁸, HIV-COBATEST⁹, EURO HIV EDAT, OPTTEST¹⁰, Quality action¹¹, HA-REACT¹², INTEGRATE¹³, HEPCARE EUROPE¹⁴ and E-DETECT TB¹⁵;
- Members of the European AIDS Treatment Group (EATG);
- Member organisations of AAE with specific focus on different vulnerable populations;
- Members of the EU HIV/AIDS, Hepatitis and Tuberculosis (TB) Civil Society Forum, the Civil Society Forum on Drugs;
- European Centre for Disease Prevention and Control (ECDC);
- Eurasian Coalition on Male Health (ECOM) mailing list subscribers;
- Correlation Network;
- National Ministries of Health;
- HIV in Europe;
- EU annual MSM Expert Meeting (organised by DAH).

Before the survey was launched, an overview was presented at the Berlin MSM Expert Meeting in August 2017. The MSM Expert Meeting is an annual meeting organised by DAH that brings together European experts and activists working in the field of sexual health of gay men and other MSM.

⁸ Capacity building in combining targeted prevention with meaningful HIV surveillance among MSM.

⁹ Operational knowledge to improve HIV early diagnosis and treatment among vulnerable groups in Europe.

¹⁰ Optimising testing and linkage to care for HIV across Europe.

¹¹ Joint Action on Improving Quality in HIV Prevention.

¹² Joint Action on HIV and Co-infection Prevention and Harm Reduction.

¹³ Joint Action on integrating prevention, testing and linkage to care strategies across HIV, viral hepatitis, TB and STIs in Europe.

¹⁴ Early diagnosis and treatment of viral hepatitis.

¹⁵ Early detection and integrated management of tuberculosis in Europe.

Approximation model to quantify CHW in the countries

Given the unknown size of the CHW population across European Member States, UoB developed a simple model to calculate sample size estimations for ECHOES countries to guide promotion of the survey and to provide broad CHW recruitment targets.

For each country, the following variables were considered in order to calculate a first estimate of population size and then sample size: country population estimate; number of major cities (over 100,000 population); number of community-based voluntary counselling and testing (CBVCT) organisations; number of NGO/LGBTI organisations; other organisations (e.g. education/training, health promotion, health trainers) who may support MSM as well as other clients); formal health service staff who may support MSM in community settings (e.g. sexual health nurse, infectious disease specialist testing in gay bars); other state services (e.g. tertiary education sexual health services); 'lone' CHWs not affiliated to an organisation. This provided a gross estimate which was reduced by 10% as a cross-over correction (e.g. NGO and CBVCT may have been counted twice). Modelling of 20, 30, 40 per cent response rates were then simulated to give a conservative sample size estimation range for each country as showed in Table 2-1. Further details of this process are expected to be made available in a forthcoming peer reviewed journal article.

Table 2-1: Sample size estimation of the CHW population across European Member States

| | Gross CHW population estimate | Crossover correction (10%) | 20% sample | 30% sample | 40% sample |
|---------------------------------------|-------------------------------|----------------------------|----------------|----------------|----------------|
| Austria | 151 | 135.9 | 27.18 | 40.77 | 54.36 |
| Belgium | 248 | 223.2 | 44.64 | 66.96 | 89.28 |
| Bosnia & Herzegovina | 128 | 115.2 | 23.04 | 34.56 | 46.08 |
| Bulgaria | 193 | 173.7 | 34.74 | 52.11 | 69.48 |
| Croatia | 66 | 59.4 | 11.88 | 17.82 | 23.76 |
| Cyprus | 13 | 11.7 | 2.34 | 3.51 | 4.68 |
| Czech Republic | 189 | 170.1 | 34.02 | 51.03 | 68.04 |
| Denmark | 56 | 50.4 | 11.2 | 15.12 | 20.16 |
| Estonia | 43 | 38.7 | 7.74 | 11.61 | 15.48 |
| Finland | 73 | 65.7 | 13.4 | 19.71 | 26.28 |
| France | 1379 | 1241.1 | 248.2 | 372.33 | 496.44 |
| Germany | 1085 | 976.5 | 195.3 | 292.95 | 390.6 |
| Greece | 41 | 36.9 | 7.38 | 11.07 | 14.76 |
| Hungary | 69 | 62.1 | 12.42 | 18.63 | 24.84 |
| Iceland | 25 | 22.5 | 4.5 | 6.75 | 9 |
| Ireland | 90 | 81 | 16.2 | 24.3 | 32.4 |
| Italy | 164 | 147.6 | 29.52 | 44.28 | 59.04 |
| Latvia | 32 | 28.8 | 5.76 | 8.64 | 11.52 |
| Lithuania | 33 | 29.7 | 5.94 | 8.91 | 11.88 |
| Luxembourg | 17 | 15.3 | 3.06 | 4.59 | 6.12 |
| Malta | 12 | 10.8 | 2.16 | 3.24 | 4.32 |
| Moldova | 23 | 20.7 | 4.14 | 6.21 | 8.28 |
| Netherlands | 53 | 47.7 | 9.54 | 14.31 | 19.08 |
| Norway | 60 | 54 | 10.8 | 16.2 | 21.6 |
| Poland | 189 | 170.1 | 34.02 | 51.03 | 68.04 |
| Portugal | 61 | 51 | 10.2 | 15.3 | 20.4 |
| Romania | 81 | 72.9 | 14.58 | 21.87 | 29.16 |
| Russia | - | - | - | - | - |
| Serbia | 74 | 66.6 | 13.32 | 19.98 | 26.64 |
| Slovakia | 16 | 14.4 | 2.88 | 4.32 | 5.76 |
| Slovenia | 31 | 27.9 | 5.58 | 8.37 | 11.16 |
| Spain | 436 | 392.4 | 78.8 | 117.72 | 156.96 |
| Sweden | 63 | 56.7 | 11.34 | 17.01 | 22.68 |
| Switzerland | 292 | 262.8 | 52.56 | 78.84 | 105.12 |
| Ukraine | - | - | - | - | - |
| United Kingdom | 1910 | 1719 | 343.8 | 515.7 | 687.6 |
| Total ECHOES sample estimation | 7396 | 6652.5 | 1332.18 | 1995.75 | 2661.00 |

ECHOES promotion implementation

ECHOES officially started on 9th October 2017. Pre-promotion activities started on 5th August 2017 on social media, announcing the originally agreed-upon formal launch date (18th September 2017). Due to technical issues and the need for additional piloting time following translation, the initial launch date was postponed and the pre-promotion messages adapted accordingly. The soft launch promotion started on 25th September 2017 and the complete ECHOES promotion started the same day as the survey was launched (October 9th, 2017).

The first promotion activities were sharing information on ECHOES via different communication channels:

- Direct emailing (using an email developed and translated prior to sharing with LM), newsletters (e.g. AAE, EATG, ILGA-Europe, European Testing Week),
- Website news (e.g. AAE, EATG, national organisations like AIDS Solidarity Movement),
- Posts and tweets on social media platforms including ECHOES hashtags (Twitter and Facebook). The decision was made to not create new social media accounts specifically for the survey, since it would require a lot of time to build a base of followers, but to use existing partner accounts which had an existing network of followers from which ECHOES could benefit (e.g. AAE and EATG Facebook and Twitter accounts, Facebook groups and pages of organisations such as HIV Hepatitis & TB Europe Policy, Advocacy for HIV Prevention in EECA, Educating and agitating for PrEP in England and beyond, Prepster, Ik Weet Wat Ik Doe, national Facebook pages like ARC - Allied Rainbow Communities, National HIV Nurses Association, Gay Outdoor Club) and encouraged partners to share and retweet,
- Personal contacts during meetings and conferences (e.g. European AIDS Conference, HIV/AIDS, TB and Hepatitis Civil Society Forum and Think Tank, and AAE Meetings: European HIV Legal Forum, Member Meeting)
- Limited paid Facebook promotion was initiated to support the promotion of the survey and ESTICOM project more broadly (this was not initially planned)
- Several interviews were realised, published online and shared in order to promote better understanding of the term 'community health workers' as well as their diverse role(s). The following interviews with community health workers were published during the promotion period:
 - Setting the standards for sexual health support for MSM - Community Health Work in Portugal¹⁶
 - Setting the standards for sexual health support for MSM - Community Health Work in Slovenia¹⁷
 - Setting the standards for sexual health support for MSM - Community Health Work in Finland¹⁸
 - Setting the standards for sexual health support for MSM - Community Health Work in Italy¹⁹
 - Setting the standards for sexual health support for MSM - Community Health Work in Cyprus²⁰
- Two articles were prepared²¹ and shared in order to promote the ESTICOM

¹⁶ <https://www.aidsactioneurope.org/en/news/setting-standards-sexual-health-support-msm-community-health-work-portugal>, accessed on 23 Nov 2018.

¹⁷ <https://www.aidsactioneurope.org/en/news/setting-standards-sexual-health-support-msm-community-health-work-slovenia>, accessed on 23 Nov 2018.

¹⁸ <https://www.aidsactioneurope.org/en/news/setting-standards-sexual-health-support-msm-community-health-work-finland>, accessed on 23 Nov 2018.

¹⁹ <https://www.aidsactioneurope.org/en/news/setting-standards-sexual-health-support-msm-community-health-work-italy>, accessed on 23 Nov 2018.

²⁰ <https://www.aidsactioneurope.org/en/news/setting-standards-sexual-health-support-msm-community-health-work-cyprus>, accessed on 23 Nov 2018.

²¹ <https://www.aidsactioneurope.org/en/news/european-community-health-workers-online-survey>; <https://www.aidsactioneurope.org/en/news/echoes-european-community-health-worker-online-survey-still-live-extended-till-january-31st>, accessed on 23 Nov 2018.

Table 2-2: List of countries for ECHOES promotion

| List of eligible countries for promotion | Minimum number of organisations contacted |
|--|---|
| Austria | 16 |
| Belgium | 43 |
| Bosnia & Herzegovina | 13 |
| Bulgaria | 11 |
| Croatia | 14 |
| Cyprus, Republic of | 8 |
| Czech Republic | 7 |
| Denmark | 11 |
| Estonia | 11 |
| Finland | 9 |
| France | 119 |
| Greece | 9 |
| Germany | 60 |
| Hungary | 9 |
| Iceland | 2 |
| Ireland, Republic of | 16 |
| Italy | 45 |
| Latvia | 6 |
| Lithuania | 7 |
| Luxemburg | 1 |
| Malta | 10 |
| Moldova | 12 |
| Netherlands | 36 |
| Norway | 10 |
| Poland | 19 |
| Portugal | 13 |
| Romania | 16 |
| Serbia | 21 |
| Slovakia | 7 |
| Slovenia | 7 |
| Spain | 36 |
| Sweden | 14 |
| United Kingdom | 110 |
| TOTAL | 728 |

Cross-promotion through EMIS

EMIS-2017 and ECHOES were planned to be launched at the same time and to run in parallel. The cooperation between the surveys included overlap in organisations and individuals who played a key role in promotion of ECHOES and EMIS 2017 and the visualisation of the ESTICOM partnership (which uses a similar image, but with differences in colour patterns for each element of the project (Figure 2-3)). As part of the collaboration between ECHOES and EMIS 2017, after filling in the EMIS 2017 questionnaire, respondents who self-identified as CHW were linked to ECHOES.



Figure 2-3: ESTICOM (EMIS, ECHOES and Training Programme) visual identity

A comparison *a posteriori* of people reporting to be CHWs in EMIS 2017 with CHWs recruited in ECHOES and reporting to be gay, bisexual or other MSM (to be comparable with the EMIS 2017 sample) showed that very few EMIS 2017 participants may have actually completed the ECHOES questionnaire (see Annex 13.1). This analysis also showed that CHWs working in organisations other than not-for-profit organisations were underrepresented in ECHOES compared to EMIS respondents reporting to be CHWs. A formative research on how to reach them would have been useful for ECHOES, and should be done prior to future research of this type.

Challenges

During the promotion the following challenges were faced:

1. The term CHW was not widely used or recognised in Europe before ECHOES, and there was a general lack of data on the workforce which supports gay, bisexual, and other MSM on issues related to HIV, viral hepatitis and other STIs. For this reason, the Objective 2 partners developed a consensus-based working definition of CHWs as well as find a way to identify the potential size of the target population in order to focus promotion and recruitment strategies. As noted earlier, the CHW working definition was developed to be as inclusive as possible to account for those working in more traditional outreach settings (such as HIV outreach workers attached to NGOs), as well as those working in non-traditional settings and sectors (such as services associated with educational institutions, homeless outreach, and formal health system services that operate in the community). However, during recruitment it became clear that some of the LM may have misunderstood the working definition. For instance, in at least four countries, LM appeared to target only those whom we may think of as traditional HIV/STI prevention outreach workers such as those attached to HIV/LGBTI NGOs. Whilst these CHWs are of course eligible, CHWs working in diverse settings and sectors were therefore most likely in many cases excluded. Such issues may well have affected the recruitment in those particular countries.
2. As the term CHW was new and/or unfamiliar in most European countries, the promotion served as a term-branding activity. This differentiates this survey from other surveys where the target audience is perhaps better known and understood. This was compounded by language issues: translating the unfamiliar term of Community Health Worker into national languages posed a serious challenge. For instance, due to difficulties in translating the term into German, the English term CHW was used instead.

In Ukraine a term closer to 'social worker' was used, and for the Russian language survey it was decided to translate the term CHW into something close to 'Consultant on Health Issues working in a community'. Given that the term CHW and its translations were unfamiliar in most countries, potential respondents may not have identified themselves as part of the target group ECHOES tried to reach. This confounded the problem and posed a challenge for the recruitment process.

3. There were difficulties building the ECHOES brand in parallel to the well-established EMIS. Even though it was useful to have EMIS as a partner in helping to promote ECHOES, LM found it quite difficult to explain that ECHOES is different to EMIS and that these are two different surveys. The EMIS team recommended creating a distinct brand and to not try to "compete" with a sexual health survey with an existing brand.

2.5. Total returns and non-qualifiers

At the close of survey recruitment, on 31st January 2018, the consolidated data file of ECHOES comprised 1,200 submitted responses. Amongst these cases, there were 19 survey responses marked as tests that were then removed from the database, resulting in a total of 1,181 valid cases.

Non-qualifiers are cases that did not meet the criteria for inclusion in the study. These cases were removed from the dataset. The following sub-sections indicate how many cases failed to qualify on each criterion. It is important to note that non-qualifier cases according to a given criterion were excluded before checking the subsequent criterion.

Respondents that did not provide sexual health support for MSM in a community setting

Respondents that did not provide sexual health support for MSM in a community setting and respondents who answered that they did not provide sexual health support for gay, bisexual and other MSM in a community setting during the last 12 months were excluded. A total of 107 cases were excluded for this reason. All these excluded cases presented missing values in questions regarding 'Age' and 'Country worked in', which were also part of the exclusion criteria.

Non-qualifier cases: 107

Respondents who do not work in countries included in the study

Respondents were asked which country they worked in and given the option of the 24 countries participating in the study plus 'Any other country'. Not counting the

cases excluded after their answers in prior questions 24 cases that chose 'Any other country' were excluded from subsequent analysis.

Non-qualifier cases: 24

Respondents under the age of 18 years or missing age

A further 15 cases were removed for not being of minimum age (18 years or older) or not responding to the question regarding their age:

- One respondent answered '17 or under';
- One respondent also marked '17 or under' but had already been excluded because of working country (case included in previous section);
- Fourteen cases were missing, of which 12 belonged to Ukraine. In this country, a technical problem was detected in the online questionnaire and subsequently fixed. The other 2 cases were from the United Kingdom.

Non-qualifier cases: 15

Total qualifiers

A total of 1,035 cases met the qualifying criteria. The number of submitted cases, number of non-qualifiers according to each criteria and total qualifiers are given by country in Table 2-3.

Table 2-3: Cases submitted and non-qualifiers by country

| | Submitted cases | No CHW activities (<12 months) | Non-eligible countries | Age missing or <18 years | Total Qualifiers |
|----------------------|-----------------|--------------------------------|------------------------|--------------------------|------------------|
| Austria | 25 | 0 | 0 | 0 | 25 |
| Belgium | 24 | 0 | 0 | 0 | 24 |
| Bosnia & Herzegovina | 11 | 0 | 0 | 0 | 11 |
| Bulgaria | 18 | 0 | 0 | 0 | 18 |
| Croatia | 13 | 0 | 0 | 0 | 13 |
| Cyprus | 8 | 0 | 0 | 0 | 8 |
| Czech Republic | 20 | 0 | 0 | 0 | 20 |
| Denmark | 19 | 0 | 0 | 0 | 19 |
| Estonia | 1 | 0 | 0 | 0 | 1 |
| Finland | 17 | 0 | 0 | 0 | 17 |
| France | 83 | 0 | 0 | 0 | 83 |
| Germany | 195 | 0 | 0 | 0 | 195 |
| Greece | 22 | 0 | 0 | 0 | 22 |
| Hungary | 9 | 0 | 0 | 0 | 9 |
| Iceland | 1 | 0 | 0 | 0 | 1 |
| Ireland | 11 | 0 | 0 | 0 | 11 |
| Italy | 37 | 0 | 0 | 0 | 37 |
| Latvia | 5 | 0 | 0 | 0 | 5 |
| Lithuania | 11 | 0 | 0 | 0 | 11 |
| Luxembourg | 1 | 0 | 0 | 0 | 1 |
| Malta | 1 | 0 | 0 | 0 | 1 |
| Moldova | 13 | 0 | 0 | 0 | 13 |
| Netherlands | 18 | 0 | 0 | 0 | 18 |
| Norway | 11 | 0 | 0 | 0 | 11 |
| Poland | 21 | 0 | 0 | 1 | 20 |
| Portugal | 18 | 0 | 0 | 0 | 18 |
| Romania | 19 | 0 | 0 | 0 | 19 |
| Russia | 37 | 0 | 0 | 0 | 37 |
| Serbia | 14 | 0 | 0 | 0 | 14 |
| Slovakia | 2 | 0 | 0 | 0 | 2 |
| Slovenia | 9 | 0 | 0 | 0 | 9 |
| Spain | 174 | 0 | 0 | 0 | 174 |
| Sweden | 29 | 0 | 0 | 0 | 29 |
| Switzerland | 30 | 0 | 0 | 0 | 30 |
| Ukraine | 27 | 0 | 0 | 12 | 15 |
| United Kingdom | 96 | 0 | 0 | 2 | 94 |
| Other countries | 24 | - | 24 | - | 0 |
| Missing country | 107 | 107 | - | - | 0 |
| Total | 1181 | 107 | 24 | 15 | 1035 |

The absolute number of ECHOES respondents by country, together with the number per 100,000 men aged from 15 to 64 years (which is a surrogate for the – unknown – size of the target population CHW should work with), is presented in Figure 2-4. Spain was the only country with both a high absolute number of ECHOES respondents and a high response rate per 100,000 men. Response rates per 100,000 men were also high in Denmark, Sweden, Finland, Iceland, Latvia, Moldova, Cyprus, Switzerland, Austria, Slovenia, and Croatia.

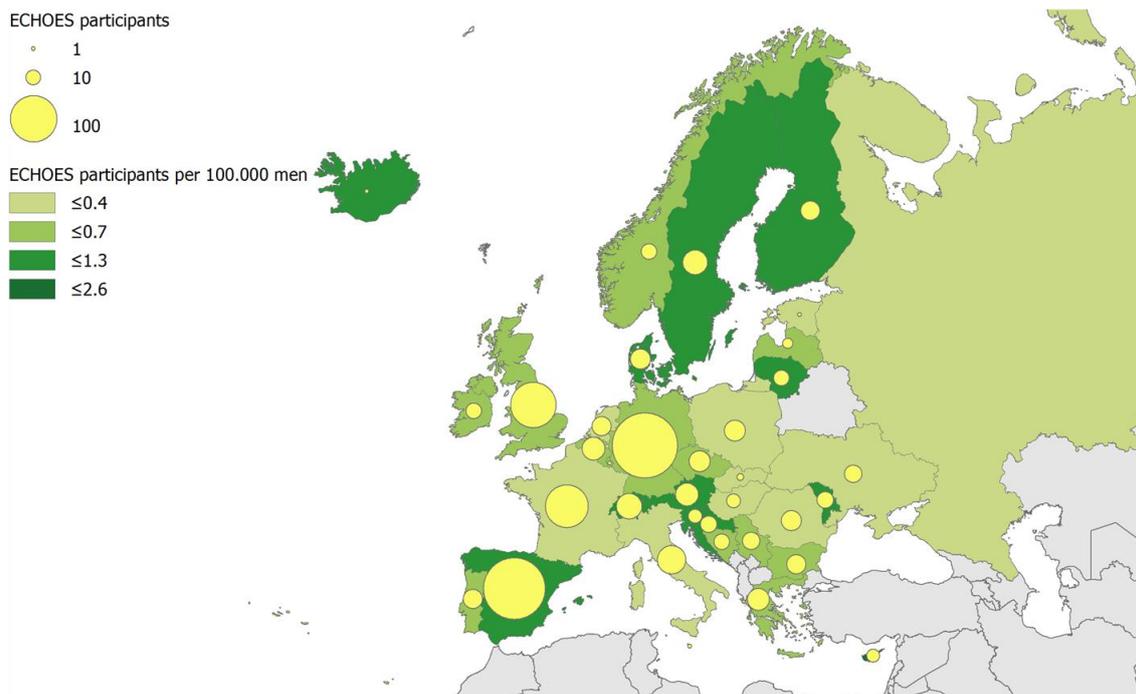


Figure 2-4: Number of ECHOES respondents by the country where they work in and per 100,000 men (aged 15 to 64 years)

2.6. Key variables for data analysis

A joint ESTICOM Expert Workshop was held at RKI on 26-27th April 2018 to discuss the overall structure of the EMIS and ECHOES reports and to reach a consensus regarding the analysis plans of both surveys. The meeting brought together more than 40 experts specifically invited to provide feedback on EMIS and ECHOES²³. After analysing data and assessing the suggestions made in the Expert Workshop, a set of key variables based on survey questions were defined to conduct the stratified analysis.

Main stratification variables

In general, all the results are stratified by the following variables (hereafter named “main stratification variables”). Not all the main stratification variables are used throughout the entire document. At the beginning of each chapter the list of variables that have been used are detailed.

- Age group:

- 1= 18-30 years old
- 2= 31-40 years old
- 3= More than 40 years old

²³ Lorente N, Folch C, Aussó S . ESTICOM Experts workshop. Meeting report of ECHOES sessions (D8.2). Berlin, April 26-27, 2018.

- **Gender:**

- 1= Man
- 2= Woman
- 3= Other → Non-binary, other or prefer not to say

- **Sexual identity:**

- 1= Homosexual / Gay / Bisexual
- 2= Straight / Heterosexual
- 3= Other → Other / Do not use a term

- **Peer role:** Peers share key personal characteristics, circumstances, or experiences (i.e., "peerness") with the target group. One's identity can derive from a variety of sources, including belonging to a group category (e.g., based on gender, race /ethnicity, sexual orientation) [18]. For the purpose of the ECHOES analysis, a variable related to the 'peer' condition was created using the information reported by the question concerning the 'Gender' as well as the 'Sexual identity'. Therefore, 'Peer CHWs' were defined as men who identified themselves as homosexual, gay, bisexual or queer

- 1= Peer → when 'Sexual identity' was any of Homosexual, Gay or Bisexual and 'Gender' was Man
- 2= Non-peer

- **Years working as a CHW:**

- 1= Up to 5 years
- 2= Between 6 and 10 years
- 3= More than 10 years

- **Employment status:**

- 1= Paid
- 2= Volunteer or unpaid

- **Respondents' organisation type:**

- 1= Private not-for-profit
- 2= Other → governmental/local authority, public and/or other type of organisation

- **Perceived income:** "your feelings about your household income"

- 1= Living very comfortably or comfortably on present income
- 2= Living neither comfortably nor struggling, struggling or really struggling on present income

- **Injecting drug use:**

- 1= At least one episode of drug injection (lifetime)
- 2= Never injected any drugs

- Non-injecting drug use

- 1= At least one episode of drug injection (lifetime)
- 2= Never used any non-injecting drugs

- Previous HIV diagnosis:

- 1= Yes
- 2= No

ECHOES country grouping variables

The variable referring to 'Country where CHW work' was recoded into different variables according to national characteristics:

- **LGBTI inequality level:** Country grouping according to the Human Rights situation of LGBTI people in European countries (Figure 2-5).

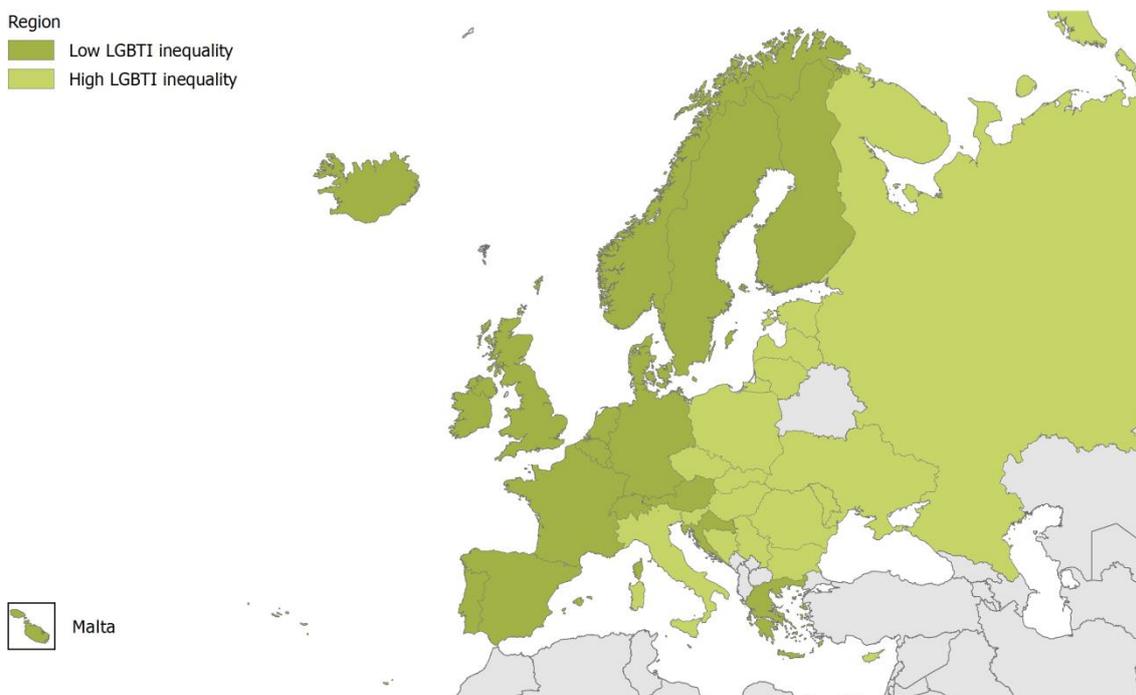


Figure 2-5: Country grouping based on the ILGA index (2016)

Despite improvements in the recent past, the human rights situation of LGBTI people in some European countries remains problematic²⁴. Due to punitive laws and policies, stigma, discrimination and violence, as well as insufficient enabling regulatory frameworks, the rights of LGBTI people are not fully respected, protected, and fulfilled. That means LGBTI people may not have adequate access to prevention, treatment, care and support in the context of HIV, viral hepatitis and other STIs. In order to better describe the profile of CHWs and understand their

²⁴ See Health4LGBTI: Reducing health inequalities experienced by LGBTI people. https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment2 (accessed on 12 Apr 2019).

needs, ECHOES data have been stratified according to the Human Rights situation of LGBTI people in European countries. The information was collected from the legal index of LGBTI equality, or ILGA rainbow index²⁵. This ranking evaluates 49 European countries and is based on 6 indicators: equality and non-discrimination, family issues, hate crime and hate speech, legal gender recognition and bodily integrity, civil society space (freedom of expression), and asylum rights. The scale ranges from 0 (gross violations of human rights, discrimination) to 100 (respect of human rights, full equality).

The legal index of LGBTI equality was used as a binary variable based on the median of ILGA indexes of ECHOES countries:

- 1 = Low LGBTI inequality (ILGA index \geq 45.7)
- 2 = High LGBTI inequality (ILGA index $<$ 45.7)

This dichotomisation based on the LGBTI inequality score at country level ('Low LGBTI inequality' vs. 'High LGBTI inequality') can broadly be labelled as 'West' vs. 'East', respectively, with the exception of Croatia and Italy.

- **CBVCT restriction:** Country grouping according to CBVCT regulations for non-medical staff (Source: ECDC 2017, [19]), collecting additional information from the OptTEST legal & regulatory barriers toolkit for those countries without laws or policies²⁶ (Figure 2-6).

- 1 = CBVCT restriction in the working country
- 2 = No CBVCT restriction in the working country

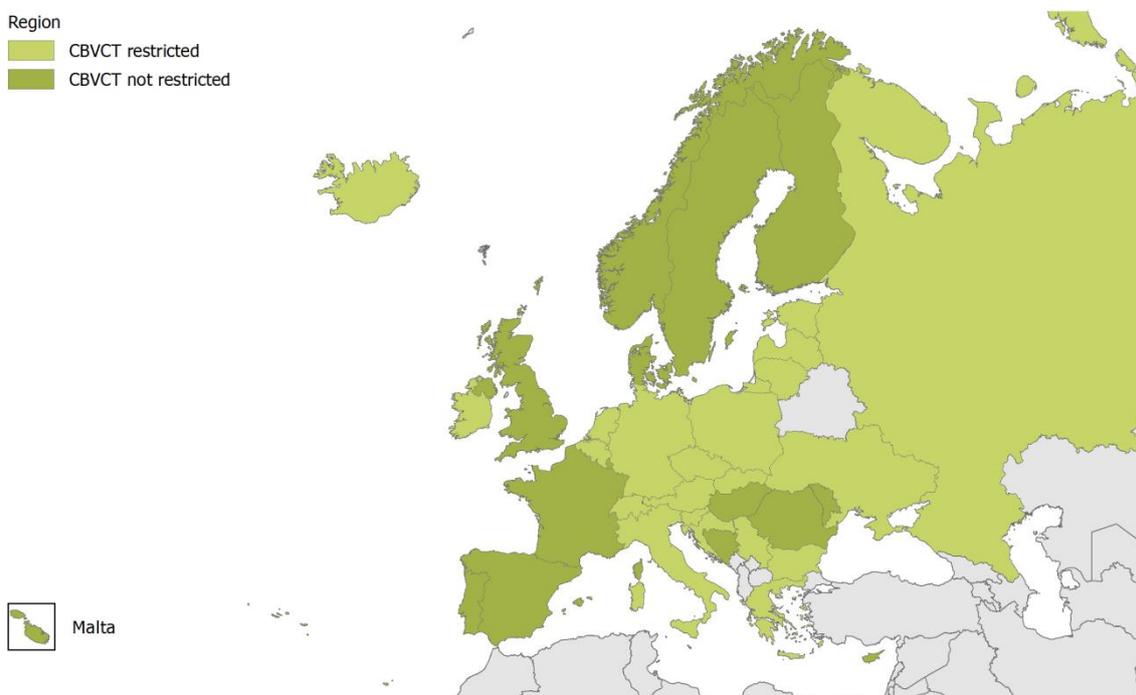


Figure 2-6: Country grouping according to the regulations regarding CBVCT by non-medical staff

²⁵ Source: ILGA <https://rainbow-europe.org/country-ranking> (accessed on 5 May 2018).

²⁶ See: <http://www.opttest.eu/Tools/Addressing-Legal-And-Regulatory-Barriers-To-Testing> (accessed on 12 Apr 2019).

- **Rate of HIV diagnoses attributed to MSM:** Country grouping according to number of new HIV diagnoses attributed to sex between men per 100,000 male population, 2016²⁷ (Figure 2-7).

- 1 = Less than 3 per 100,000
- 2 = Between 3 to 5 per 100,000
- 3 = More than 5 per 100,000

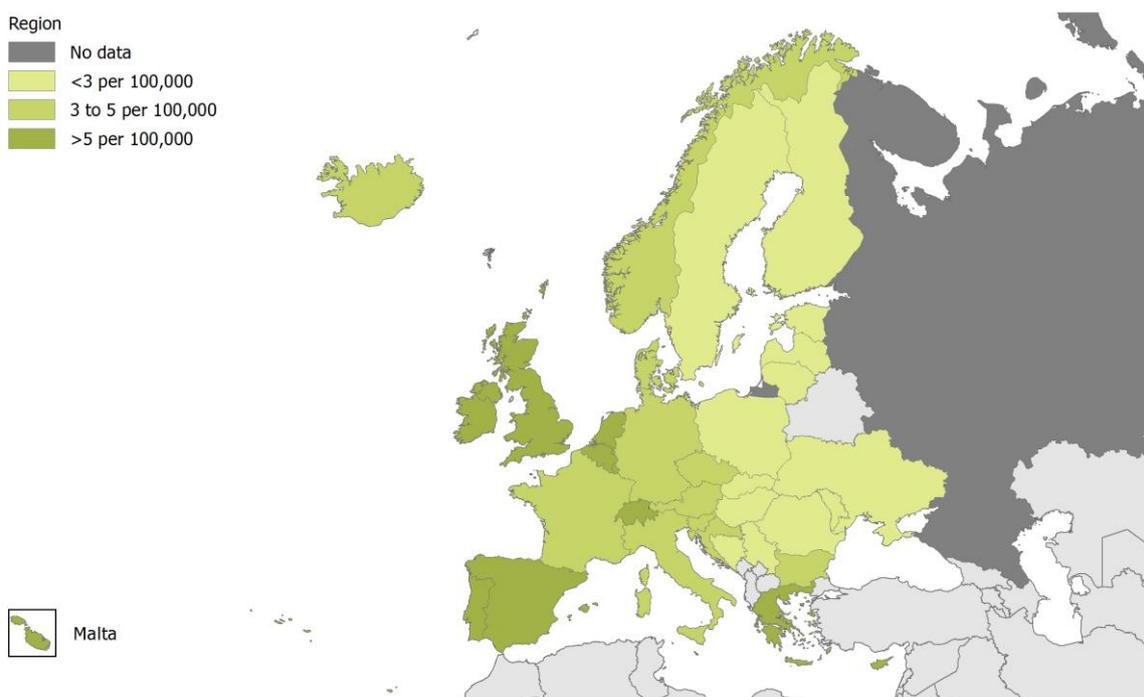


Figure 2-7: Country grouping according to the rate of new HIV diagnoses attributed to sex between men (per 100,000 male population, adapted from ECDC 2017, data from 2016)

Job title description

The section of ECHOES relating to job and employment status began with a question with open text response in which Community Health Worker (CHW) described their job: *'We know that many people do not use the term 'Community Health Worker'. How would you describe your job title? e.g. outreach worker, sexual health worker, health promoter, etc.'*. Due to the relevance of this information, and considering that this question was answered by all qualifying cases (compulsory question), the variable was recoded using a keyword method in order to classify each respondent in a reduced number of categories.

All responses were split by the language of the survey and were sent to the corresponding ECHOES translator (see Table 14-2 in Annex 13.2). All descriptions were translated into English and converted into lower case to avoid case

²⁷ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2017 – 2016 data. Stockholm: ECDC; 2017.

differences between equal words. The final set was formed of 478 different answers.

The translated answers were converted into simple job titles (short definition), as many of the responses contained long phrases that could be synthesised and some answers were written differently but could be considered identical (e.g. counselor vs. counsellor or CHW vs. Community Health Worker). When any response included more than one concept (e.g. 'counsellor, doctor and psychologist') combinations of the concepts were kept in the new variable, with words separated by a slash.

After exploring the 'short definition' variable, a total of 15 categories were identified. Each category relied on one or more keywords (Table 2-5). Each category was then used to create a dichotomous variable ('yes' or 'no'), indicating if the 'short definition' contained a keyword from the corresponding category. Each short definition could thus be coded as 'yes' in more than one dichotomous variable, as for a multiple-choice question. For instance, the response: 'counsellor, doctor, psychologist' was coded 'yes' in the following variables: 'NON-SPECIFIC COUNSELLOR', 'HEALTHCARE PROFESSIONAL and 'PSYCHO-SOCIAL WORKER'. All short definitions were classified in at least one of the 15 categories.

Table 2-4: Job title categories and assigned keywords

| Category | Keywords |
|-------------------------|--|
| PEER | Peer |
| HEALTHCARE PROFESSIONAL | doctor / nurs* / medic* / practitioner / psychi* / mental / dementia / physic* / pharma* / lab* / clin* |
| OUTREACH WORKER | outreach / field / on-site |
| TESTING WORKER | test / VCT / screen |
| ACTIVIST | Activ* / campaign* / fund* |
| PSYCHO-SOCIAL WORKER | social / socio* / caseworker / support / psycho* / accomp* / therap* / help |
| SEXUAL HEALTH WORKER | Sex* + health / sex* + educ* / sex* + couns* |
| PREVENTION WORKER | prevention / harm reduction |
| COMMUNITY WORKER | Community / NGO / organisation |
| HEALTH PROMOTER | Health |
| EDUCATOR | Educa* / monitor / train* |
| VOLUNTEER | Volunteer |
| NON-SPECIFIC COUNSELLOR | advisor / counsel* / mediator |
| NON-SPECIFIC WORKER | All definitions not grouped in previous categories that contain the following keywords: freelance / technician / employee / officer / external staff / worker / assistant lead / manager / head / chief / directo* / coord* / contact / interlocutor / consult* |
| DO NOT KNOW | 'Do not know' answers and responses not referring to job title. |

* Truncated keywords

Role of CHW in HIV/STI care continuum

New variables were created for all CHWs' reported activities over the last 12 months, taking into consideration the steps within the HIV/STI services continuum and retention cascade defined by the WHO [20]. The continuum spans the full range of required interventions that is needed to achieve strategic targets (Figure 2-8).

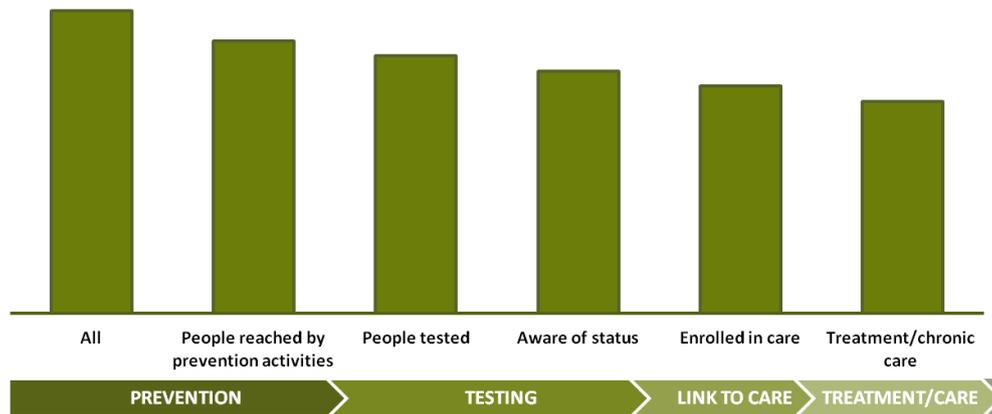


Figure 2-8: The continuum of the sexually transmitted infection services and the retention cascade²⁸

In order to describe the role of CHWs in each step of the HIV/STI service continuum, and the consequent impact on the retention cascade, the following variables were created: PREVENTION, TESTING, LINKAGE, TREATMENT/CHRONIC CARE. Additionally, some strategic activities essential throughout the continuum were included in the variable STRATEGIC and ADMINISTRATIVE.

Scales

The ECHOES questionnaire included three validated scales documenting well-being, self-efficacy, and job satisfaction of CHWs. Each scale was composed of n items and p possible answers for each item (numbered from 1 to p).

One continuous variable was built for each scale. Item values were first recoded from $\{1, \dots, p\}$ to $\{0, \dots, p-1\}$ and the mean of all items was then calculated for each scale, excluding observations with more than one missing value. The mean was calculated on the n items of the scale for observations without missing values and on $n-1$ items for those with one missing item.

The calculated mean varied from 0 to $(n*(p-1))/n$ when none of the items was missing and from 0 to $((n-1)*(p-1))/(n-1)$ when one item was missing. These means were then transformed to vary from 0 to 100: multiplying by $100/(n*(p-1))$ when none of the items was missing, and by $100/((n-1)*(p-1))$ when one item was missing.

Cronbach's α were then calculated to assess the reliability of the scales. Cronbach's α are useful to determine the internal consistency of items in a survey instrument to gauge its global reliability and can be interpreted as follows [21,22]:

- $\alpha \geq 0.9$: excellent internal consistency
- $0.9 > \alpha \geq 0.8$: good internal consistency
- $0.8 > \alpha \geq 0.7$: acceptable internal consistency
- $0.7 > \alpha \geq 0.6$: questionable internal consistency

²⁸ Adapted from WHO. Global health sector strategy on Sexually Transmitted Infections, 2016-2021. Geneva, WHO, 2016.

- $0.6 > \alpha \geq 0.5$: poor internal consistency
- $0.5 > \alpha$: unacceptable internal consistency

Well-being (WHO-5)

The WHO-5 scale is a short self-report measure of current mental well-being and assesses positive aspects of mental health, in contrast to the many traditional approaches which may assess distress, depression and anxiety [23]. This score is derived from a mental health screening tool but should not be considered as such in this study. The following table (Table 2-6) describes the items and possible answers of the scale:

Table 2-5: Items and possible answers of the well-being scale (WHO-5)

| Items (in relation to last two weeks) | Possible answers |
|--|--------------------------------|
| I have felt cheerful and in good spirits | (1) At no time |
| I have felt calm and relaxed | (2) Some of the time |
| I have felt active and vigorous | (3) Less than half of the time |
| I woke up feeling fresh and rested | (4) More than half of the time |
| My daily life has been filled with things that interest me | (5) Most of the time |
| | (6) All of the time |

This very brief 5-item scale performed well in the ECHOES sample ($\alpha = 0.88$, good reliability).

The WHO-5 Brief Well-being Scale has been developed in a psychiatric context, with a clear classificatory guidance [24]. On this basis the scale was used both as a continuous variable and dichotomised (<50 vs. >50 out of 100) because a score below 50 may indicate that the respondent is at risk of depression according to WHO.

Self-efficacy

Self-efficacy refers to the ability to overcome barriers and show persistence in the face of challenging conditions. Self-efficacy is frequently seen as a core element of resilience, i.e. the capacity to flourish in the face of adversity. In ECHOES, a validated 6-item scale has been used [25] and is presented in Table 2-7:

Table 2-6: Items and possible answers of the self-efficacy scale

| Items | Possible answers |
|--|---------------------|
| It is easy for me to stick to my aims and accomplish my goals | |
| I am confident that I could deal efficiently with unexpected events | (1) Not at all true |
| If someone opposes me, I can find means and ways to get what I want | (2) Hardly true |
| Thanks to my resourcefulness, I know how to handle unforeseen situations | (3) Moderately true |
| I can remain calm when facing difficulties because I can rely on my coping abilities | (4) Exactly true |

No matter what comes my way, I'm usually able to handle it

This scale was also reliable ($\alpha = 0.81$) in the ECHOES sample.

The self-efficacy score was thus described both as a continuous variable and as a categorical one. As guidance on classification was not available for this score, the categorical score of self-efficacy was built using the mean value of the score (75.0) and its standard deviation (SD = 15.2) in order to better fit the distribution of the data/respondents and categorise them in the low, average or high category. The three categories were: Low self-efficacy ($[0; \text{mean}-\text{SD}[= [0; 59.8[$), Average self-efficacy ($[\text{mean}-\text{SD}; \text{mean}+\text{SD}[= [59.8; 90.2[$) and High self-efficacy ($[\text{mean}+\text{SD}; 100] = [90.2; 100]$). It is important to note that these groups were used for descriptive analyses, not to test pre-established or clinical hypotheses.

Job satisfaction

The concept of job satisfaction has been introduced into occupational psychology by Herzberg et al.[26] who distinguished between satisfaction around intrinsic factors such as recognition, the work tasks themselves and the level of responsibility, and extrinsic factors including working conditions and pay. A widely-used standardised question assessing these aspects of satisfaction with work roles has been developed by Warr et al.[27] The original scale assesses 15 aspects of work plus overall job satisfaction using a single item. A shortened version by Goetz et al. [28] was used in ECHOES while keeping an item of the longer version (about opportunities to develop new skills, which was of considerable importance considering CHWs work in a dynamic field) and slight adjustments in the phrasing of items (Table 2-8).

Table 2-7: Items and possible answers of the job satisfaction scale

| Items | Possible answers |
|--|--|
| Amount of variety in job | (1) Very dissatisfied |
| Opportunity to use abilities | |
| Freedom of working method | (2) Somewhat dissatisfied |
| Amount of responsibility | |
| Physical working conditions | (3) Neither satisfied nor dissatisfied |
| Hours of work | |
| Recognition for work | (4) Somewhat satisfied |
| Colleagues and fellow workers | |
| Your rate of pay | (5) Very satisfied |
| Your opportunity to acquire new skills | |

The reliability of the scale was good in the ECHOES sample ($\alpha = 0.89$). The job satisfaction scale was used both as a continuous and categorical variable. Similarly to the categorical self-efficacy variable, and in the absence of specific guidance for categorisation, the categorical variable of job satisfaction was built using the mean value of the score in the ECHOES sample (71.6) and its standard deviation (SD = 19.3). The three categories were: Low job satisfaction ($[0; 52.3[$), Average job satisfaction ($[52.3; 90.9[$) and High job satisfaction ($[90.9; 100]$).

2.7. Statistical analysis

This report presents a descriptive analysis of the ECHOES results. As a general approach, bivariate analyses were performed using the main stratification and country grouping variables (see first part of section 2.6). If not specified, numbers presented in tables and figures are percentages.

Not all these variables were used to stratify the data. The list of stratification and country grouping variables used in each chapter is stated in the introduction of each chapter.

Chi-square tests (or Fisher's exact tests when appropriate) were used to determine significant differences between categorical variables ($p \leq 0.05$). Kruskal-Wallis tests were used in the comparisons of continuous variables.

All missing values were removed from denominators (total sample size). Sample sizes (N) are indicated in each figure and table, while the exact percentage of missing values is mentioned only when it is higher than 10%.

3. Understand who CHWs in Europe are, where they work, with whom and why

This chapter aims to present a complete picture of who CHWs providing sexual health services to gay, bisexual and other MSM are, both as individuals and as professionals.

The first section of the chapter describes the demographic profile of the 1,035 respondents of ECHOES, as well as other individual characteristics such as HIV self-reported status and drug use.

As stated in the introduction, the term "CHW" is not routinely used across Europe. As such, the second section of this chapter documents the way ECHOES respondents define themselves, based on a question with open text response included at the beginning of the ECHOES questionnaire.

The two following sections focus on: the moment when ECHOES respondents started as CHW (selection criteria at recruitment, motivations to engage as a CHW) and the main characteristics of their current CHW position (employment status, experience, description of the organisation they work for).

The last two parts of the chapter report on the settings where CHWs work and the main populations they target or attend in their activities.

In this chapter, all the results are stratified by: age, gender, sexual identity, and peer role. The last two subchapters are also stratified by the years of experience as CHW, the current employment status as a CHW (volunteer/paid), the type of organisation worked for and the country grouping according to the new HIV diagnoses attributed to sex between men per 100,000 male population.

At the end of each section of this chapter, the corresponding data are presented according to the level of LGBTI inequality in order to provide the reader with a more complete description of two different regions regarding visibility and acceptability of LGBTI people.

3.1. General profile of ECHOES respondents

Country/region

The overall distribution of the 1,035 CHWs who participated in ECHOES, by country they were working in, is presented in Figure 3-1. Germany, Spain, United Kingdom and France had more than 50 respondents.

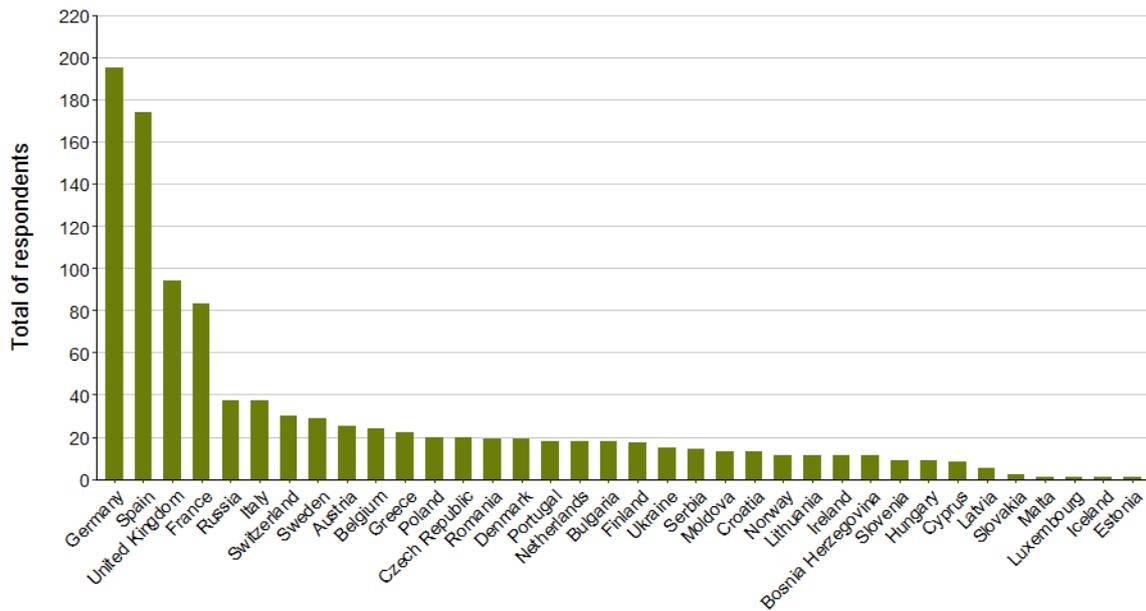


Figure 3-1: Number of CHWs by country they work in (n=1,035)

Figure 3-2 below shows the geographical distribution of respondents according to the LGBTI inequality level of the country they work in (see 'country grouping variables' in the methods chapter, section 2.7).

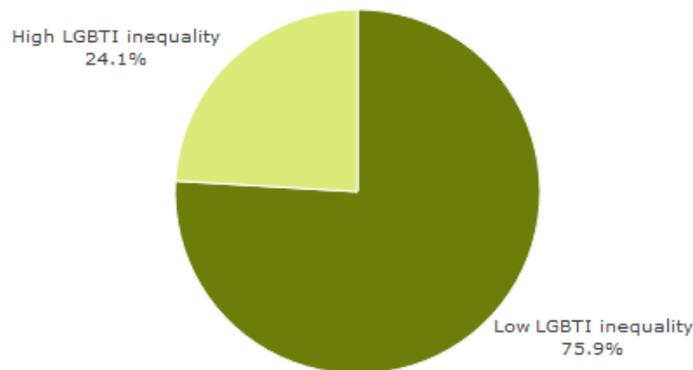


Figure 3-2: CHWs by the LGBTI inequality level of the country they work in (n=1,035)

More than three quarters of the total sample (n=786) were from 'low LGBTI inequality' countries²⁹; mainly Germany (n=195), Spain (n=174), UK (n=94) and France (n=83). ECHOES respondents from 'high LGBTI inequality' countries³⁰ represented 24.1% of the total sample.

Age, gender identity and ethnicity

ECHOES respondents were between 18 and 74 years old (mean: 40.7 years, standard deviation: 11.0), and the majority of identified as men (67.9%). Of the

²⁹ Malta, Norway, United Kingdom, France, Portugal, Finland, Denmark, Spain, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Germany, Austria, Ireland, Iceland, Greece, Switzerland.

³⁰ Hungary, Bosnia & Herzegovina, Cyprus, Romania, Moldova, Slovenia, Estonia, Serbia, Czech Republic, Slovakia, Italy, Bulgaria, Ukraine, Poland, Lithuania, Latvia, Russia.

995 CHWs who identified as men or women, 1.6% reported a different gender identity than that which was assigned at birth (trans CHWs). Less than a tenth (8.5%) self-identify as a member of an ethnic minority group (Table 3-1).

Table 3-1: Age, gender identity and ethnicity (n=1,035)

| | n | % |
|--|-----|------|
| Age group | | |
| 18-30 years | 217 | 21.0 |
| 31-40 years | 327 | 31.6 |
| Older than 40 years | 491 | 47.4 |
| Gender | | |
| Man | 703 | 67.9 |
| Woman | 292 | 28.2 |
| Other | 34 | 3.3 |
| Prefer not to say | 6 | 0.6 |
| Belonging to an ethnic minority | 87 | 8.5 |

Education, settlement size and perception of income

ECHOES respondents were asked 'How many years have you spent in full-time education since the age of 16?' (Table 3-2). Most respondents (72.2%) had been in education for 6 or more years beyond the age of 16.

Respondents were also asked about the size of the village/town/city where they work as a CHW. Overall, 56.7% of respondents indicated that they worked in a city of over 500,000 inhabitants, while only 4.5% worked in small towns, villages or rural areas (Table 3-2).

Similar percentages of CHWs reported that they were currently either living comfortably on their present income (35.6%) or neither comfortable nor struggling on present income (40.0%) (Table 3-2).

Table 3-2: Education level, settlement size and feelings about household income (n=1,035)

| | n | % |
|--|-----|------|
| Years in full education since the age of 16 | | |
| None or 1 | 32 | 3.2 |
| 2 to 5 years | 249 | 24.6 |
| 6 or more years | 731 | 72.2 |
| Settlement size | | |
| A small town or village/rural area - up to 20,000 people | 46 | 4.5 |
| A large town or small city - up to 100,000 people | 114 | 11.1 |
| A medium-sized city - up to 500,000 people | 285 | 27.7 |
| A big city -more than 500,000 people | 583 | 56.7 |
| Feelings about household income | | |
| Living very comfortably on present income | 88 | 8.6 |
| Living comfortably on present income | 363 | 35.6 |
| Neither comfortably nor struggling on present income | 408 | 40.0 |
| Struggling on present income | 141 | 13.8 |
| Really struggling on present income | 21 | 2.1 |

Sexual identity, outness and peer role

Sexual identity was asked using the question 'Which of the following best describes how you think about yourself?' Most CHWs identified themselves as being homosexual/gay (58%) or heterosexual (25.0%) (Figure 3-3).

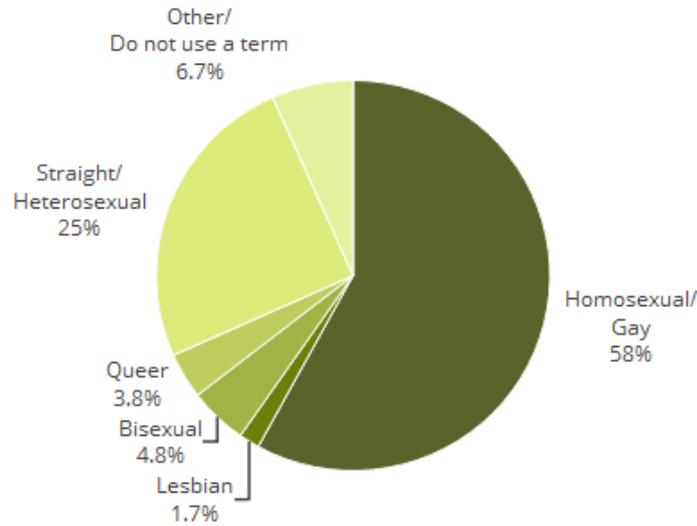


Figure 3-3: Sexual identity (n=1,035)

'Outness' was defined as the degree to which respondents are open about their sexual identity. Among CHWs self-identifying as gay, lesbian, bisexual or queer, the vast majority reported they were out to 'all or almost all' the people they knew (93.5% and 78.1% in men and women CHWs, respectively) (Figure 3-4).

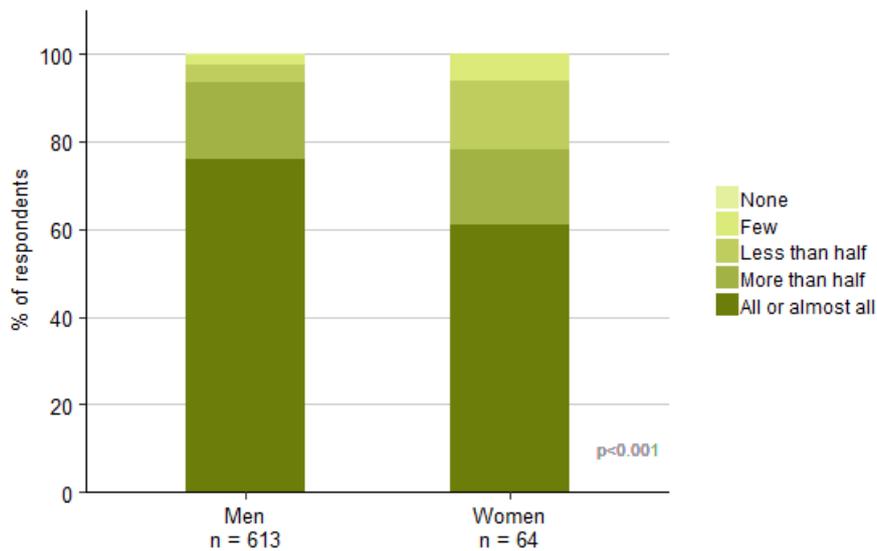


Figure 3-4: Level of outness among CHWs self-identified as gay, lesbian, bisexual or queer by gender (n=707)

In ECHOES, the percentage of peer CHWs – that is, men defining themselves as gay, bisexual or queer – was 59.2%.

HIV testing, HIV self-reported status, drug use

In ECHOES, the percentage of respondents having ever tested for HIV was 93%. Among those who had ever tested (n=944), self-reported prevalence of HIV infection was 25.3%. The percentage of respondents who have been tested for HIV and who self-reported a positive test result was higher among CHWs older than 30 years, men, homosexual/bisexual and peer CHWs (Figure 3-5).

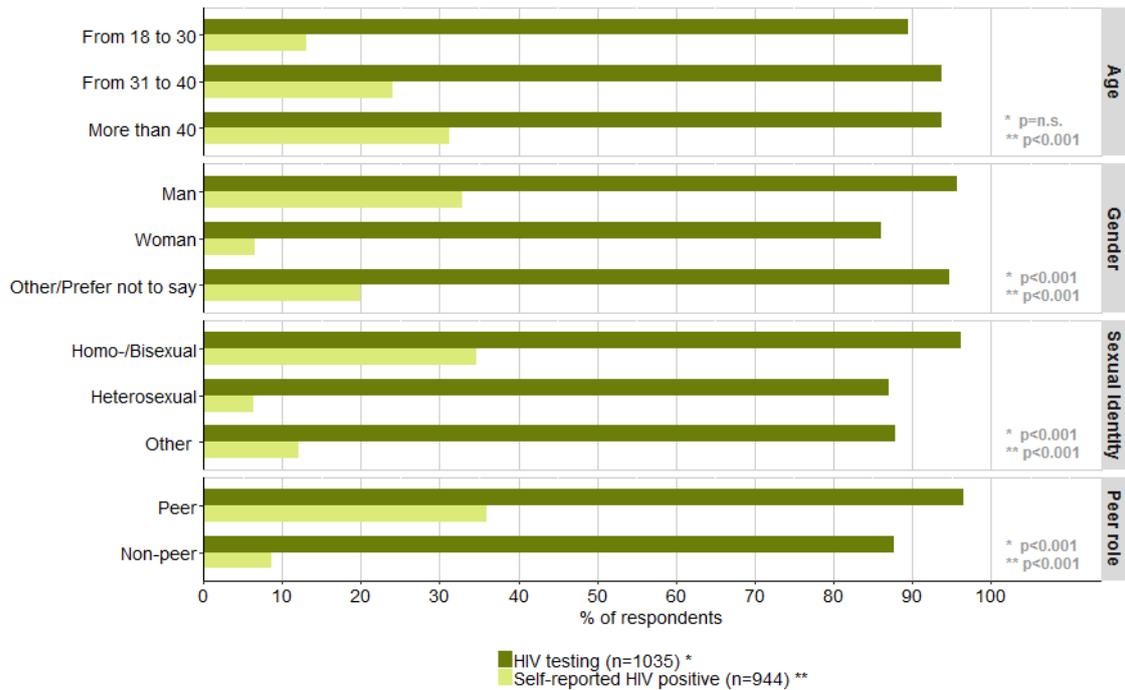


Figure 3-5: HIV testing rates and self-reported HIV status by age, gender and sexual identity (n=1,035)

Overall, the percentage of respondents who reported having used non-injected recreational drugs was 54.0%. The percentage of respondents who reported having injected illegal drugs other than anabolic steroids or medicines was 6.0%.

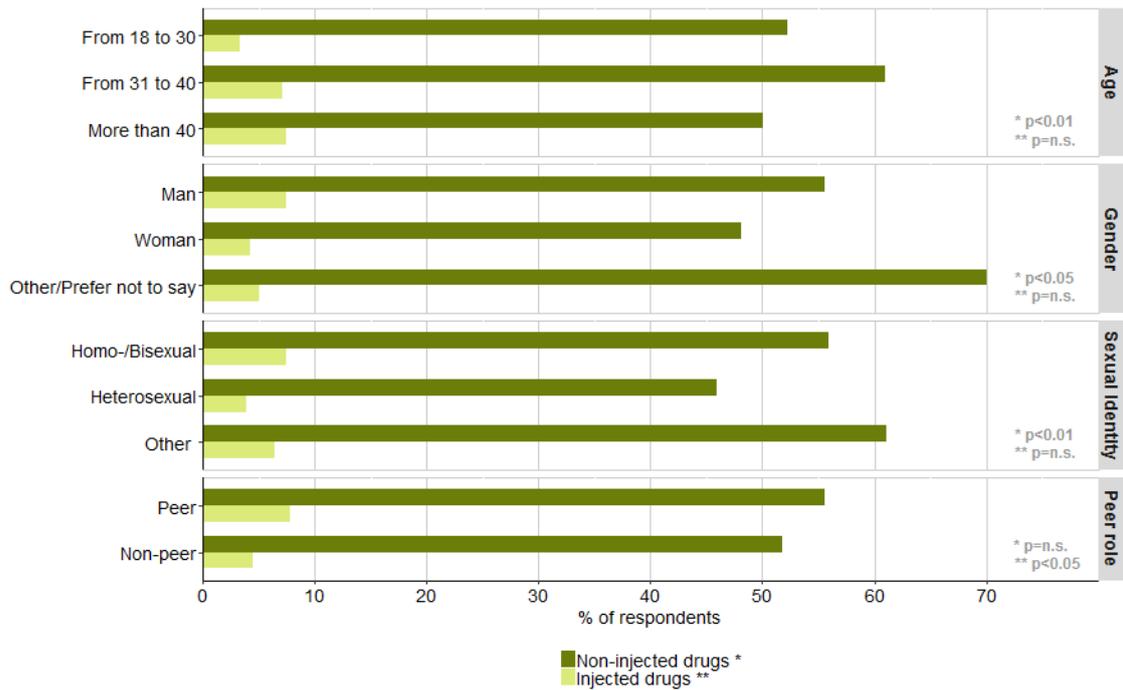


Figure 3-6: Use of injected and non-injected recreational drugs by age, gender and sexual identity (n=1,035)

The lowest percentage of non-injected recreational drug use was reported among women and heterosexual CHWs. A history of drug injection was more frequent among CHWs older than 30 years old and peer CHWs (Figure 3-6).

Profile of respondents by the LGBTI inequality level of the country in which they work

The main demographic characteristics of CHWs according to the level of LGBTI inequality in the country where they work are reported in Table 3-3. Respondents from 'high LGBTI inequality' countries were younger than those from 'low LGBTI inequality' countries (mean age=38.5 vs. 41.4) and reported a higher percentage of both women and heterosexuals (36.5% and 30.9%, respectively). Furthermore, the percentage of CHWs out to more than half the people they knew was lower in countries with a 'high LGBTI inequality' (78.7%) than with a 'low LGBTI inequality' level (95.5%). The percentage of CHWs who reported living more than comfortably on present income was lower in countries with a 'high LGBTI inequality' than with a 'low LGBTI inequality' level (36.0% vs. 46.8%, respectively).

Table 3-3: Socio-demographic characteristics by the LGBTI inequality level of the working country

| | Low LGBTI inequality (n=786) | High LGBTI inequality (n=249) | p-value |
|---|------------------------------|-------------------------------|---------|
| Age group | | | |
| 18-30 years | 19.5 | 25.7 | |
| 31-40 years | 31.0 | 33.3 | |
| More than 40 years | 49.5 | 41.0 | |
| Gender | | | |
| Man | 70.2 | 60.6 | 0.003 |
| Woman | 25.6 | 36.5 | |
| Other/prefer not to say | 4.2 | 2.8 | |
| Belonging to an ethnic minority | | | |
| No | 91.7 | 91.1 | 0.791 |
| Yes | 8.3 | 8.9 | |
| Years in full-time education since the age of 16 | | | |
| None or 1 | 3.4 | 2.5 | 0.239 |
| 2 to 5 years | 25.7 | 21.1 | |
| 6 or more years | 70.9 | 76.4 | |
| Sexual identity | | | |
| Homo/Bisexual | 64.9 | 56.2 | 0.031 |
| Heterosexual | 23.2 | 30.9 | |
| Other ^a | 12.0 | 12.9 | |
| Outness^b | | | |
| Out to more than half | 95.5 | 78.7 | <0.001 |
| Out to less than half | 4.5 | 21.3 | |
| Feelings about household income | | | |
| Living more than comfortably | 46.8 | 36.0 | 0.003 |
| Living less than comfortably | 53.2 | 64.0 | |

^aQueer, any other term, don't use a term. ^bIf gay, homosexual, bisexual or queer (n=707).

The percentage of peer CHWs was higher in 'low LGBTI inequality' than 'high LGBTI inequality' countries (63.0% and 47.4%, respectively) (Figure 3-7).

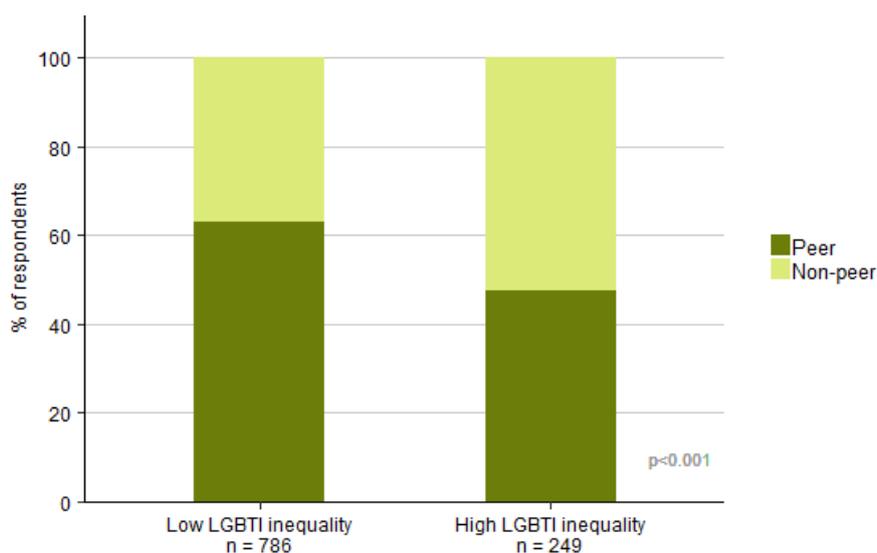


Figure 3-7: Peer CHWs by the LGBTI inequality level of the working country (n=1,035)

Socio-demographic characteristics by 'low LGBTI inequality' countries are presented in Table 3-4. Germany was the country with the lowest percentage of women (10.8%) and the country with the highest percentage of CHWs self-identified as homo/bisexual (85.1%). The percentage of peer CHWs ranged from 85.6% in Germany to 50.0% in Spain.

Table 3-4: Socio-demographic characteristics by 'low LGBTI inequality' countries

| | Germany (n=195) | Spain (n=174) | UK (n=94) | France (n=83) | Other ^c (n=240) | p-value |
|--|--------------------|------------------|--------------|------------------|-------------------------------|---------|
| Age group | | | | | | 0.154 |
| 18-30 years | 15.4 | 20.1 | 19.1 | 26.5 | 20.0 | |
| 31-40 years | 26.2 | 33.3 | 29.8 | 27.7 | 35.0 | |
| More than 40 years | 58.5 | 46.6 | 51.1 | 45.8 | 45.0 | |
| Gender | | | | | | <0.001 |
| Man | 87.7 | 61.5 | 62.8 | 77.1 | 62.9 | |
| Woman | 10.8 | 35.6 | 30.9 | 18.1 | 30.8 | |
| Other/prefer not to say | 1.5 | 2.9 | 6.4 | 4.8 | 6.3 | |
| Belonging to an ethnic minority | | | | | | <0.001 |
| No | 93.3 | 95.4 | 80.2 | 89.2 | 92.9 | |
| Yes | 6.7 | 4.6 | 19.8 | 10.8 | 7.1 | |
| Years in full-time education since the age of 16 | | | | | | <0.001 |
| None or 1 | 1.6 | 2.3 | 11.8 | 4.8 | 1.7 | |
| 2 to 5 years | 28.9 | 16.2 | 44.1 | 39.8 | 17.7 | |
| 6 or more years | 69.5 | 81.5 | 44.1 | 55.4 | 80.5 | |
| Sexual identity | | | | | | <0.001 |
| Homo/Bisexual | 85.1 | 53.4 | 66.0 | 63.9 | 56.7 | |
| Heterosexual | 8.2 | 33.3 | 21.3 | 16.9 | 30.8 | |
| Other ^a | 6.7 | 13.2 | 12.8 | 19.3 | 12.5 | |
| Outness^b | | | | | | 0.113 |
| Out to more than half | 96.0 | 99.0 | 97.1 | 91.7 | 93.3 | |
| Out to less than half | 4.0 | 1.0 | 2.9 | 8.3 | 6.7 | |
| Feelings about household income | | | | | | 0.026 |
| Very comfortable or comfortable | 44.4 | 42.2 | 53.8 | 36.1 | 53.0 | |
| Neither comfortable nor struggling, struggling, or really struggling | 55.6 | 57.8 | 46.2 | 63.9 | 47.0 | |
| Peer role as a CHW | | | | | | <0.001 |
| No | 14.4 | 50.0 | 41.5 | 33.7 | 45.4 | |
| Yes | 85.6 | 50.0 | 58.5 | 66.3 | 54.6 | |

^aQueer, any other term, don't use a term. ^bIf gay, homosexual, bisexual or queer (n=557). ^cMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

When comparing CHWs from 'high LGBTI inequality' and 'low LGBTI inequality' countries, no differences were seen in the percentage of CHWs ever tested for HIV nor in the self-reported HIV status (Table 3-5 and 3-6).

A higher percentage of respondents from countries with 'low LGBTI inequality' reported ever using non-injected recreational drugs than those from countries with 'high LGBTI inequality' (59.2% and 37.7%, respectively). Among 'low LGBTI inequality' countries, CHWs from France, Spain and UK reported the highest percentage of non-injected recreational drugs (69.9%, 64.9% and 64.5%, respectively) (Table 3-5 and 3-6).

Table 3-5: HIV testing, self-reported HIV status and drug use by the LGBTI inequality level of the working country

| | Low LGBTI inequality (n=786) | High LGBTI inequality (n=249) | p-value |
|----------------------------------|------------------------------|-------------------------------|---------|
| Previous HIV testing | | | 0.625 |
| No | 6.9 | 7.8 | |
| Yes | 93.1 | 92.2 | |
| Self-reported HIV status* | | | 0.718 |
| Negative | 75.0 | 73.8 | |
| Positive | 25.0 | 26.2 | |
| Use of non-injected drugs | | | <0.001 |
| No | 40.8 | 62.3 | |
| Yes | 59.2 | 37.7 | |
| Use of injected drugs | | | 0.947 |
| No | 93.6 | 93.5 | |
| Yes | 6.4 | 6.5 | |

*if previously tested.

Table 3-6: HIV testing, self-reported HIV status and drug use by 'Low LGBTI inequality' countries

| | Germany (n=195) | Spain (n=174) | UK (n=94) | France (n=83) | Other ^a (n=240) | p-value |
|----------------------------------|-----------------|---------------|-----------|---------------|----------------------------|---------|
| Previous HIV testing | | | | | | 0.619 |
| No | 5.2 | 5.8 | 9.9 | 7.2 | 7.7 | |
| Yes | 94.8 | 94.2 | 90.1 | 92.8 | 92.3 | |
| Self-reported HIV status* | | | | | | 0.171 |
| Negative | 68.0 | 76.4 | 76.2 | 77.6 | 78.2 | |
| Positive | 32.0 | 23.6 | 23.8 | 22.4 | 21.8 | |
| Use of non-injected drugs | | | | | | 0.006 |
| No | 49.7 | 35.1 | 35.5 | 30.1 | 43.5 | |
| Yes | 50.3 | 64.9 | 64.5 | 69.9 | 56.5 | |
| Use of injected drugs | | | | | | 0.323 |
| No | 91.2 | 94.2 | 91.4 | 94.0 | 95.8 | |
| Yes | 8.8 | 5.8 | 8.6 | 6.0 | 4.2 | |

*if previously tested (n=719). ^aMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

The percentage of CHWs who reported having injected drugs other than anabolic steroids or medicines was similar in both 'high LGBTI inequality' and 'low LGBTI inequality' countries (Table 3-5 and 3-6).

3.2. How have CHWs identified/described themselves?

ECHOES results confirmed the wide diversity of terms used to refer to "Community Health Worker" at European level, such as community health advisor, health advisor, health promoter, lay health advisor, outreach educator, outreach worker, peer advocate, peer health provider, peer educator, volunteer, etc.

In ECHOES, a CHW was defined as "Someone who provides sexual health support around HIV/AIDS, viral hepatitis and other STIs to gay, bisexual and other MSM. A

CHW delivers health promotion or public health activities in community settings (not in a hospital or a clinic).”

This definition was broad in order not to exclude those who may provide support via ‘non-traditional’ means, that is, moving away from notions of traditional outreach workers towards a diversity of service provision. This means that medical doctors who may also work in community settings (e.g. venue-based HIV testing), counsellors, but also people who provide testing in CBVCT services, programme managers, health promoters or even someone working with the general population may be eligible to participate if they work in community settings with the target population.

In order to know how CHWs define themselves, a question with open text response was included in the ECHOES questionnaire:

“We know that many people do not use the term 'Community Health Worker'. How would you describe your job title? E.g. outreach worker, sexual health worker, health promoter, etc.”

The answers were recorded using a keyword method in order to classify each respondent in a global category (*see methods section 2.1.1.3 for details*).

Figure 3-8 shows the wide variety of ways that ECHOES respondents describe their job title.



Figure 3-8: Job self-description of Community Health Workers in ECHOES

The term ‘Community Health Worker’ was used by 27 respondents (2% of the ECHOES sample). The full list of terms, including 493 different answers when translated to English, is listed in Table 14-2 in national language (Annex 13.2).

The distribution of the 'Short definition' variables for the job title (see Table 2-5 job title categories and assigned keywords in methods section 2.6), which includes 15 dichotomous variables, is presented in Figure 3-9.

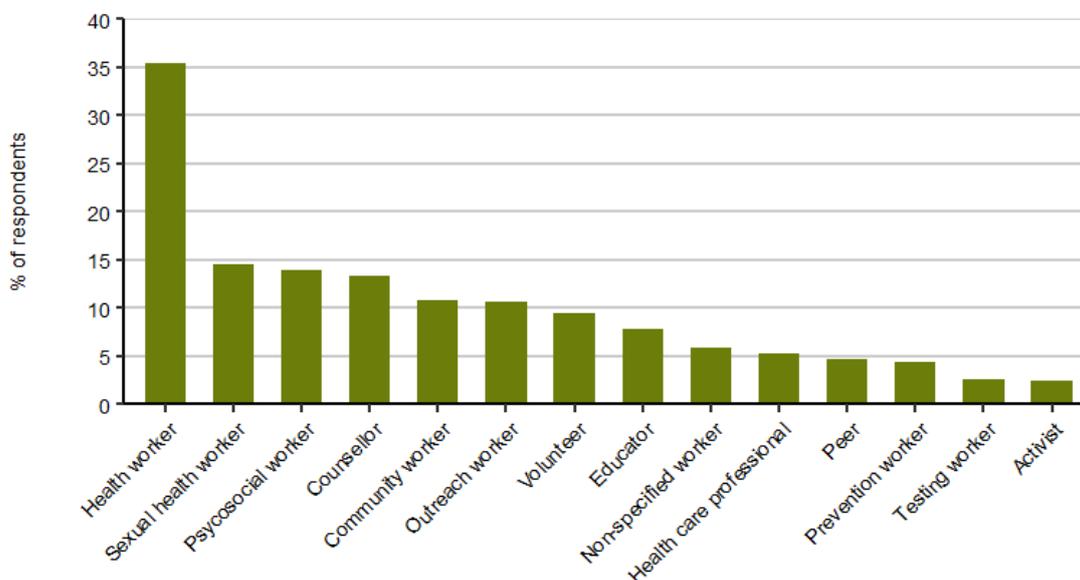


Figure 3-9: Job titles distribution (short definition) (n=1,035)

Job title categories most frequently reported were different according to the ECHOES regions and countries (Table 3-7). "Health worker" was among the three most frequent job titles reported in all the regions/countries except for France. The term "volunteer" was frequently reported in France and Spain, and "outreach" in Germany, France and the 'high LGBTI inequality' region. Only in UK and France the term "community" was in the three most frequently reported job titles by CHWs.

Table 3-7: Job title categories most frequently reported by the LGBTI inequality level of the working country

| Country grouping | | Job title categories most frequently reported |
|---|----------------------------|--|
| Low LGBTI inequality (n=786) | Germany (n=195) | 1. Health worker 2. Psycho-social worker 3. Outreach worker |
| | Spain (n=174) | 1. Health worker 2. Psycho-social worker 3. Volunteer |
| | UK (n=94) | 1. Health worker 2. Community (health) worker 3. Sexual health worker |
| | France (n=83) | 1. Volunteer 2. Community (health) worker 3. Outreach worker |
| | Other ^a (n=240) | 1. Sexual health worker 2. Health worker 3. Health-care professional |
| High LGBTI inequality (n=249) | | 1. Outreach worker 2. Health worker 3. Sexual health worker |

^aMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

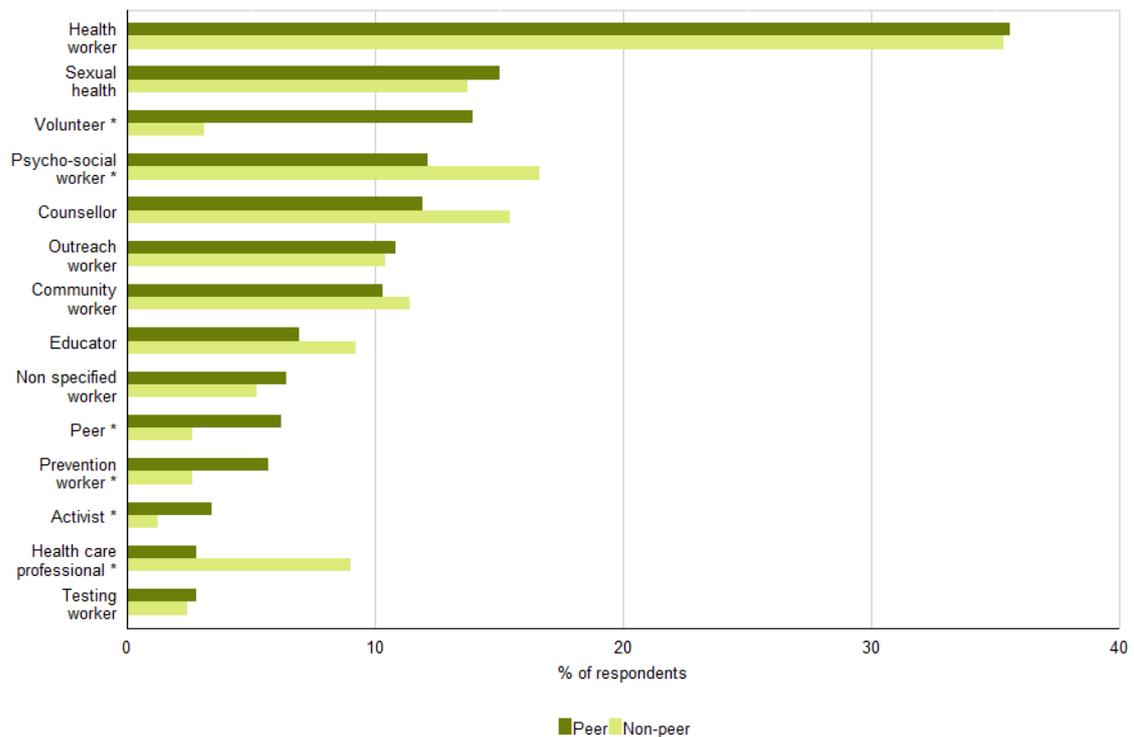


Figure 3-10: Job title categories by peer role (n=1,035)

Titles such as “activist”, “peer”, “prevention worker” and “volunteer” were more frequently reported by peer CHWs, whereas “health-care professional” and “psychosocial worker” were more common among non-peer CHWs (Figure 3-10).

3.3. Recruitment and motivation to start as a CHW

Recruitment and selection of CHWs

Recruitment of appropriate individuals to the role of a CHW is among the essential elements that contribute to a well-functioning community health service. ECHOES respondents were therefore asked how they first became a CHW, and what the criteria were for selection.

Overall, 43.2% of ECHOES respondents started as a volunteer CHW (38.1% approached an organisation to volunteer and 5.1% applied for a formally advertised volunteer post) (Figure 3-11). Among them, 53.1% were currently working as a paid CHW.

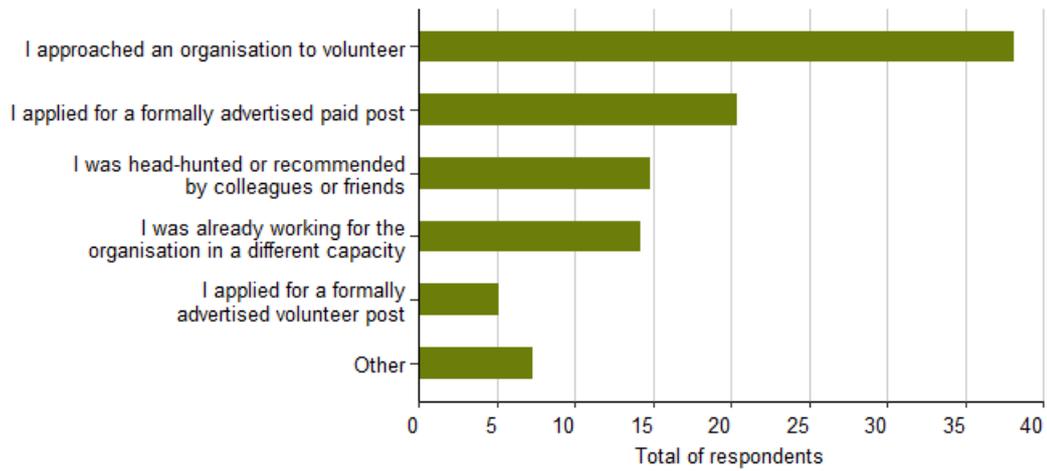


Figure 3-11: How ECHOES respondents were recruited to be a CHW (n=1,035)

When respondents started their current CHW role, 41% of CHWs were required to have prior training or qualifications, and relevant experience by 30% of the sample (Figure 3-12). The proportion of CHWs who were selected without any prior experience or prior training or qualifications was 46.9%.

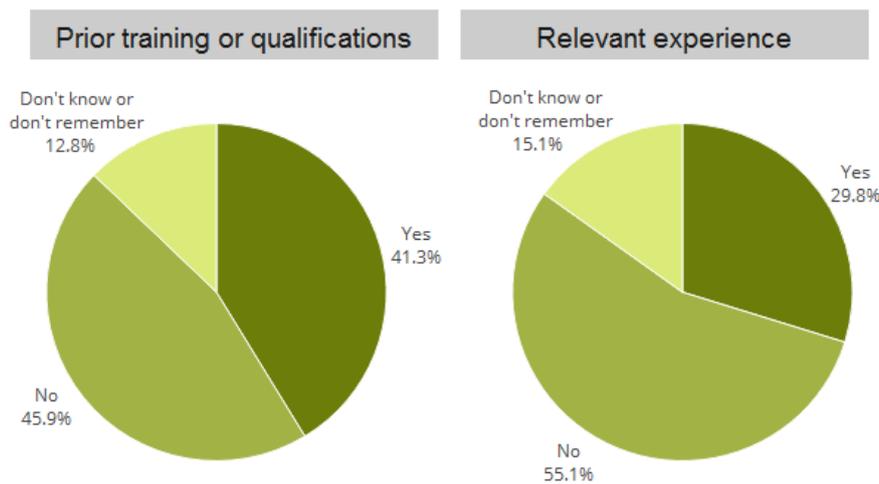


Figure 3-12: Criteria of selection when started as a CHW (n=1,035)

Previous training or qualification requirements for being a CHW were more frequently reported by women (47.6%), heterosexual (45.9%) and non-peer CHWs (45.5%). On the other hand, relevant experience was similar when comparing CHWs by age, gender, sexual identity and peer role (Table 3-8).

Table 3-8: Criteria of selection by age group, gender, sexual identity and peer role (n=1,035)

| | % Prior training or qualifications | p-value | % Relevant experience | p-value |
|---------------------------|------------------------------------|---------|-----------------------|---------|
| Age group | | 0.066 | | 0.066 |
| 18-30 years | 34.9 | | 23.4 | |
| 21-40 years | 44.9 | | 28.5 | |
| More than 40 years | 41.7 | | 33.4 | |
| Gender | | <0.001 | | 0.110 |
| Man | 39.4 | | 28.9 | |
| Woman | 47.6 | | 30.7 | |
| Other/Prefer not to say | 28.9 | | 39.5 | |
| Sexual identity | | <0.001 | | 0.555 |
| Homo/Bisexual | 39.3 | | 29.5 | |
| Heterosexual | 45.9 | | 29.7 | |
| Other ^a | 42.3 | | 31.5 | |
| Peer role as a CHW | | <0.001 | | 0.132 |
| Peer | 38.4 | | 30.1 | |
| Non-peer | 45.5 | | 29.4 | |

^aQueer, any other term, don't use a term.

Motivation to become a CHW

CHWs in ECHOES were asked about their motivations to become a CHW (Figure 3-13). Overall, more than half of the sample reported wanting to support gay, bisexual and other MSM (60%), wanting to support PLHIV/ people living with hepatitis/ people living with STIs (59.1%), and/or wanting to help prevent these infections (57.6%) as motivation for becoming a CHW.

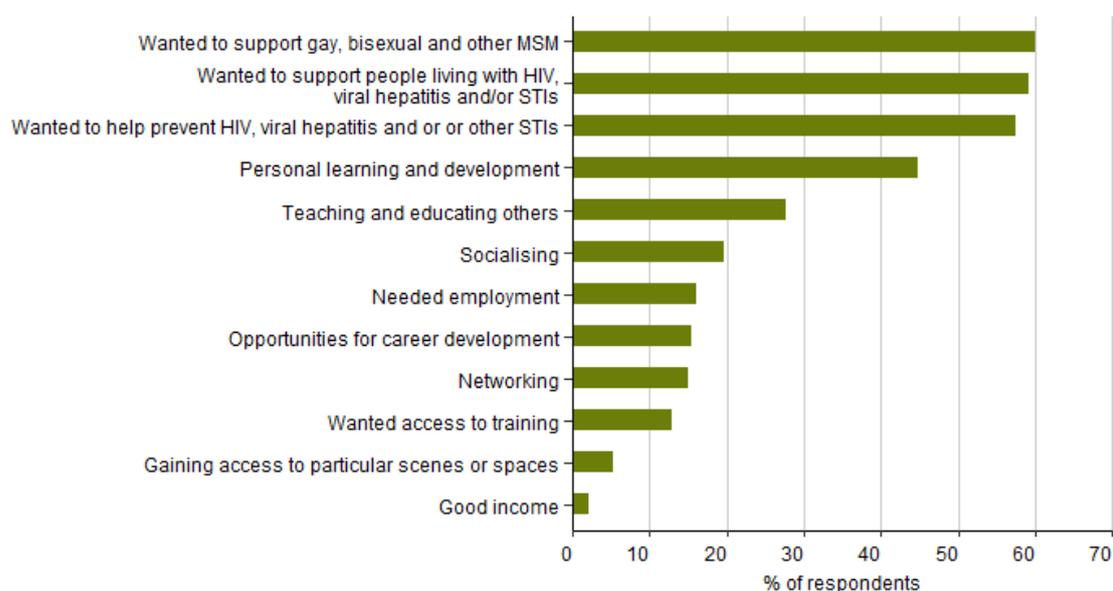


Figure 3-13: Motivations to start as a CHW (n=1,035; multiple answer)

To make comparisons easier, reasons to become a CHW were grouped into 4 categories: 1- Altruism (wanting to support/help); 2- Professional/Personal development (personal learning, career development, access to training); 3-

Financial (employment, income); 4- Other factors (socialising, networking, teaching others, access to particular scenes).

Overall, although the reasons for becoming a CHW are multiple and interconnected, altruistic reasons were broadly reported by CHWs (79.9%) (Figure 3-16).

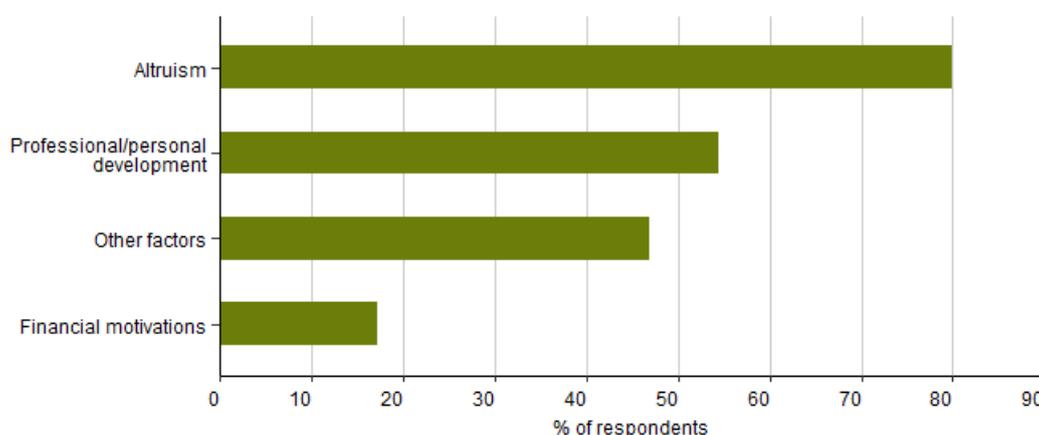


Figure 3-14: Grouped motivations to start as a CHW (n=1,035; multiple answer)

The percentage of respondents reporting wanting to support/help was highest among men, homo/bisexual and peer CHWs (85.1%, 89.2% and 89.7%, respectively, Table 3-9).

Table 3-9: Grouped motivations to start as a CHW by age group, gender, sexual identity and peer role (n=1,035)*

| | Altruism | Professional/Personal development | Other ^b | Financial |
|---------------------------|------------------|-----------------------------------|--------------------|--------------|
| Age group | | | | |
| 18-30 years | 78.8 | 65.9 | 47.1 | 19.2 |
| 31-40 years | 79.3 | 60.1 | 37.5 | 18.9 |
| More than 40 years | 80.7 | 45.8 | 35.3 | 15.2 |
| <i>p-value</i> | <i>0.811</i> | <i>0.811</i> | <i>0.013</i> | <i>0.270</i> |
| Gender | | | | |
| Man | 85.1 | 53.8 | 39.2 | 17.0 |
| Woman | 67.2 | 56.1 | 36.2 | 17.1 |
| Other/prefer not to say | 78.9 | 52.6 | 39.5 | 21.1 |
| <i>p-value</i> | <i><0.001</i> | <i>0.789</i> | <i>0.671</i> | <i>0.813</i> |
| Sexual identity | | | | |
| Homo/Bisexual | 89.2 | 54.9 | 39.7 | 14.9 |
| Heterosexual | 58.2 | 51.2 | 34.0 | 21.9 |
| Other ^a | 76.6 | 58.9 | 41.1 | 19.4 |
| <i>p-value</i> | <i><0.001</i> | <i>0.345</i> | <i>0.232</i> | <i>0.035</i> |
| Peer role as a CHW | | | | |
| No | 65.5 | 55.7 | 39.8 | 20.0 |
| Yes | 89.7 | 53.6 | 36.4 | 15.3 |
| <i>p-value</i> | <i><0.001</i> | <i>0.509</i> | <i>0.271</i> | <i>0.049</i> |

*Multiple answer. ^aQueer, any other term, don't use a term. ^bSocialising, networking, teaching others, access to particular scenes.

Recruitment and motivation to become a CHW by the LGBTI inequality level of the working country

The percentage of CHWs reporting relevant experience as a criterion for selection was lower in countries with 'high LGBTI inequality' than countries with 'low LGBTI inequality' (32.5% and 21.1%, respectively, Table 3-10). France was the country with the lowest percentage reporting training or prior experience as a requirement to start working as a CHW (30.1% of reported requiring prior training/qualifications and 21.7% reported requiring prior relevant experience). The country with highest percentage of respondents reporting previous training and/or qualifications as a requirement was Spain (52.0%), and the country with highest percentage of respondents reporting relevant experience as a requirement was the UK (57.6%) (Table 3-11).

Reported motivations to become a CHW were very similar when comparing between 'low LGBTI inequality' and 'high LGBTI inequality' regions (Table 3-10), but significant differences were observed when comparing between 'low LGBTI inequality' countries (Table 3-11). Altruistic and financial motives were less reported among CHWs from Spain (71.3% and 10.9%, respectively), but professional/personal development (63.8%) was higher compared to those from the other 'low LGBTI inequality' countries. The highest percentage of CHWs reporting financial motives was among respondents from UK (59.8%).

Table 3-10: Criteria of selection and motivation by the LGBTI inequality level of the working country*

| | Low LGBTI inequality (n=786) | High LGBTI inequality (n=249) | p-value |
|---|---------------------------------|----------------------------------|---------|
| Criteria of selection: training/qualifications | | | 0.163 |
| No | 44.2 | 51.0 | |
| Yes | 42.3 | 38.2 | |
| Don't know or don't remember | 13.5 | 10.8 | |
| Criteria of selection: Relevant experience | | | 0.003 |
| No | 52.9 | 62.0 | |
| Yes | 32.5 | 21.1 | |
| Don't know or don't remember | 14.6 | 16.9 | |
| Motivation to start as a CHW* | | | |
| Altruism | 80.1 | 79.0 | 0.705 |
| Professional/Personal development | 54.8 | 53.1 | 0.632 |
| Other factors ^a | 39.1 | 36.2 | 0.420 |
| Financial | 18.5 | 13.2 | 0.057 |

*Multiple answer. ^aSocialising, networking, teaching others, access to particular scenes.

Table 3-11: Criteria of selection and motivation by 'low LGBTI inequality' countries

| | Germany (n=195) | Spain (n=174) | UK (n=94) | France (n=83) | Other ^b (n=240) | p-value |
|---|--------------------|------------------|--------------|------------------|-------------------------------|---------|
| Training/qualifications requirements | | | | | | <0.001 |
| No | 43.8 | 34.1 | 52.2 | 68.7 | 40.3 | |
| Yes | 40.6 | 52.0 | 34.8 | 30.1 | 43.8 | |
| Don't know or don't remember | 15.6 | 13.9 | 13.0 | 1.2 | 15.9 | |
| Previous experience requirement | | | | | | <0.001 |
| No | 51.3 | 61.5 | 32.6 | 69.9 | 49.8 | |
| Yes | 31.9 | 28.2 | 57.6 | 21.7 | 30.2 | |
| Don't know or don't remember | 16.8 | 10.3 | 9.8 | 8.4 | 20.0 | |
| Motivation to start as a CHW* | | | | | | |
| Altruism | 86.9 | 71.3 | 85.9 | 81.9 | 78.3 | 0.002 |
| Professional/Personal development | 50.8 | 63.8 | 54.3 | 37.3 | 57.9 | 0.001 |
| Other factors ^a | 22.0 | 10.9 | 20.7 | 19.3 | 20.0 | 0.065 |
| Financial | 32.5 | 35.1 | 59.8 | 25.3 | 44.3 | <0.001 |

^aSocialising, networking, teaching others, access to particular scenes. ^bMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

3.4. Employment status and organisation profile

Employment status as a CHW

ECHOES respondents were asked about their current employment status as a CHW (Figure 3-15). Overall, the percentage of paid and volunteer (unpaid) CHWs was 69.3% and 30.7%, respectively. Of those who indicated they were employed (n=658), 78.2% were contracted in a long-term or permanent position and 85.8% on a fixed income salary.

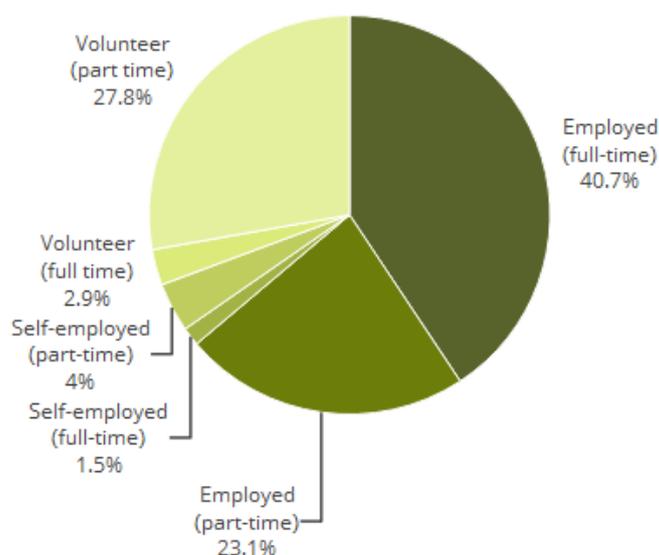


Figure 3-15: Current employment status as a CHW (n=1,035)

The percentage of volunteer CHWs was higher in men (37.6%), homo/bisexual (39.7%) and peer CHWs (41.0%). CHWs aged between 31 and 40 years old had the lowest percentage of volunteer CHWs in comparison with younger (18-30 years old) and older respondents (over 40 years old) (Figure 3-16).

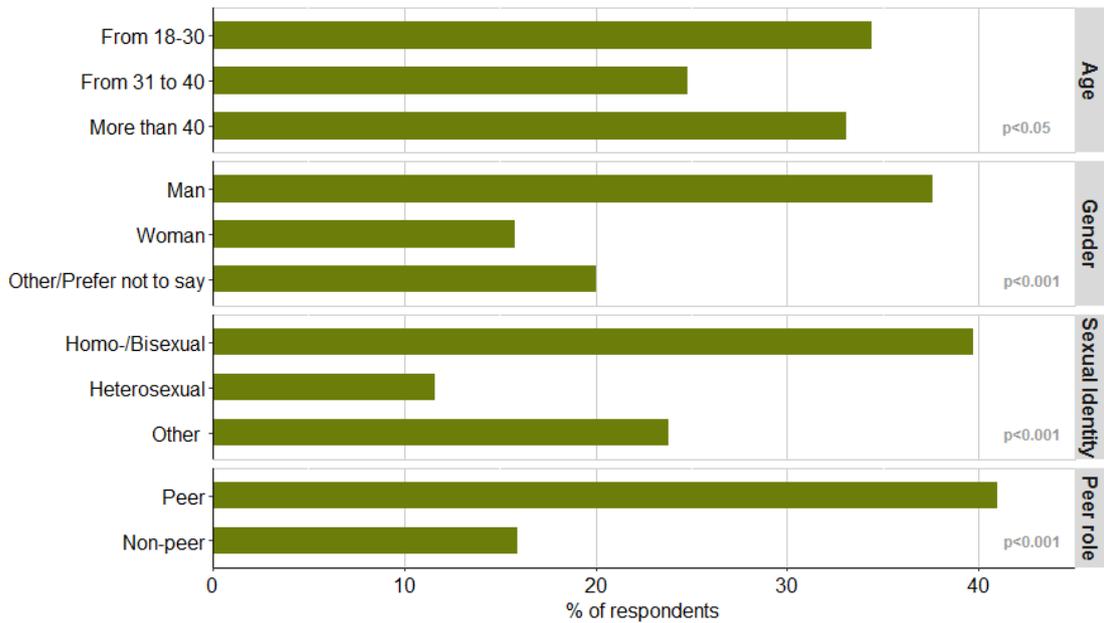


Figure 3-16: Percentage of volunteer CHWs by age group, gender, sexual identity and peer role (n=1,035)

Employment status when not working as a CHW

Respondents who were not employed full-time (n=611) were asked about their employment status when not working as a CHW. More than half reported being employed (55%), 15.9% self-employed and 5.9% volunteering (outside of being a CHW) (Figure 3-17). Among them (n=416), 16.4% reported “healthcare professional” as their job role when not working as a CHW (doctor, nurse, mental health worker).

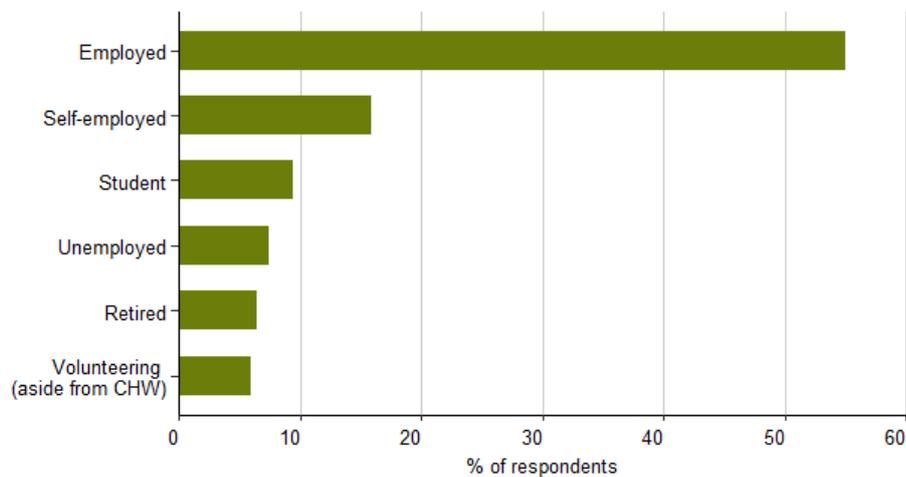


Figure 3-17: Employment status when not working as a CHW (n=416)

The percentage of CHWs working as health-care professionals outside of being a CHW was higher among women (28%), those who self-defined as heterosexual (35.1%) and non-peer CHWs (25.2%) (Figure 3-18).

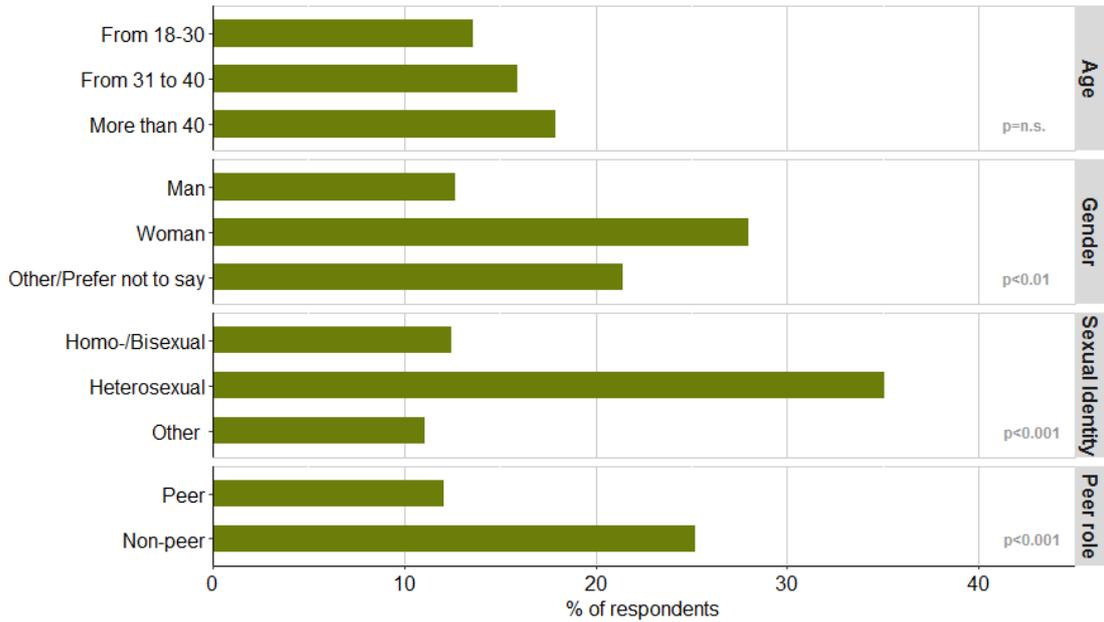


Figure 3-18: Employment status as a health-care professional (n=416)

Job titles by employment status are presented in Figure 3-19. Both job titles “psychosocial worker” and “healthcare professional” worker were more frequently reported by paid CHWs; instead, “activist” and “volunteer” were job titles more frequently reported by volunteer CHWs.

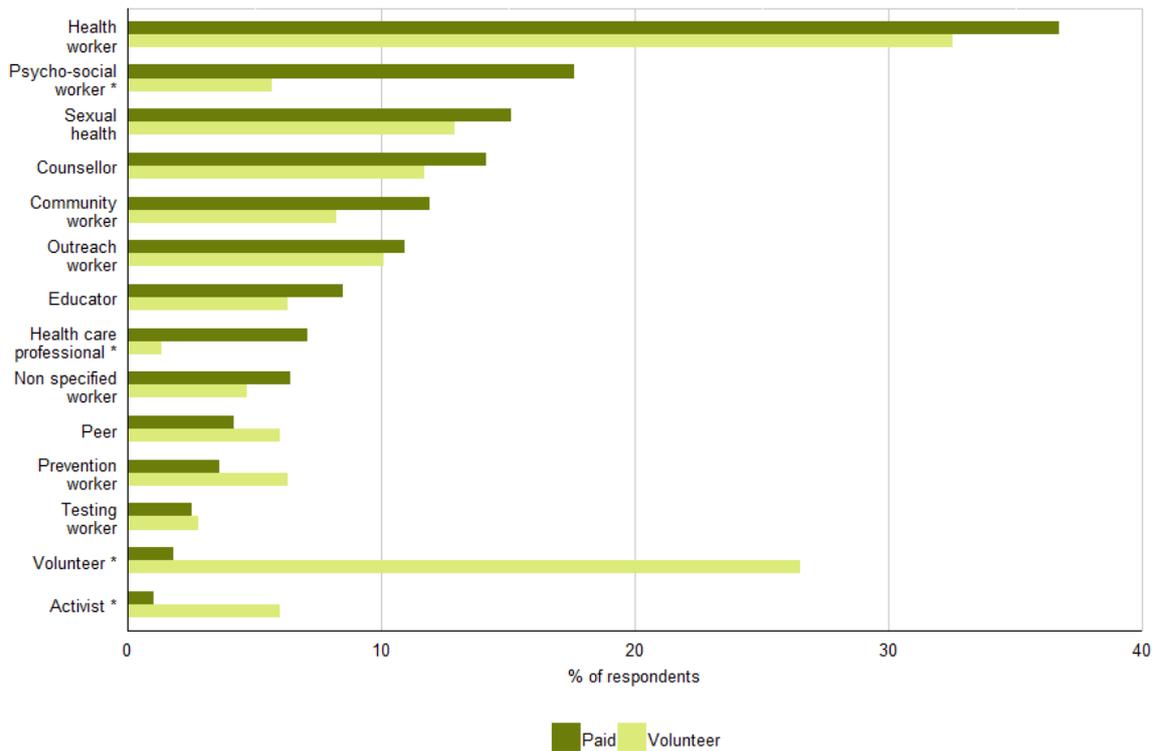


Figure 3-19: Job titles by employment status (n=416)

Months/years of experience as a CHW

ECHOES included CHWs with a wide range of work experience, from those with less than a year of experience (10.7%), to CHWs who had been working for more than a decade (29.3%) (Figure 3-20). Older CHWs (more than 40 years old) and those who self-identified as heterosexual reported more years of experience as CHWs (Table 3-12).

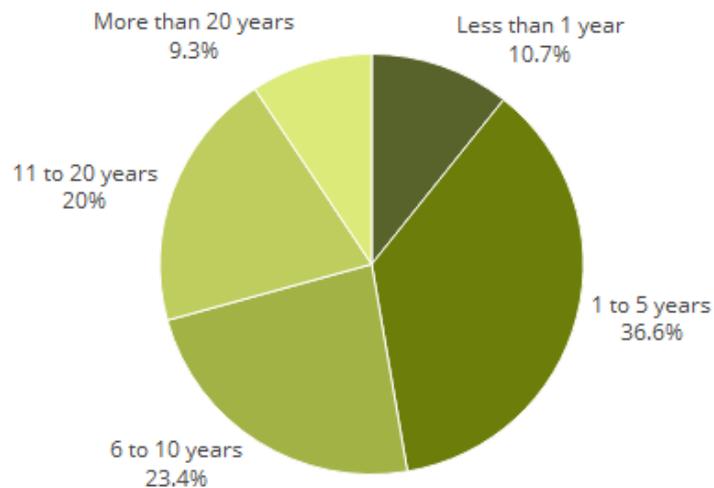


Figure 3-20: Years of experience as a CHW (n=1,035)

Table 3-12: Years of experience as a CHW by age group, gender, sexual identity and peer role (n=1,035)

| | 5 or less years | 6 to 10 years | more than 10 years | p |
|---------------------------|-----------------|---------------|--------------------|--------|
| Age group | | | | <0.001 |
| 18-30 years | 82.3 | 14.8 | 2.9 | |
| 21-40 years | 52.9 | 30.7 | 22.3 | |
| More than 40 years | 28.5 | 22.3 | 49.3 | |
| Gender | | | | 0.125 |
| Man | 48.3 | 23.1 | 28.6 | |
| Woman | 44.9 | 22.3 | 32.8 | |
| Other/Prefer not to say | 47.4 | 36.8 | 15.8 | |
| Sexual identity | | | | 0.001 |
| Homo/Bisexual | 51.0 | 21.2 | 27.8 | |
| Heterosexual | 35.9 | 27.7 | 36.3 | |
| Other ^a | 51.6 | 25.8 | 22.6 | |
| Peer role as a CHW | | | | 0.139 |
| Peer | 49.8 | 21.9 | 28.2 | |
| Non-peer | 43.6 | 25.5 | 30.8 | |

^aQueer, any other term, don't use a term.

Relevant experience requirements were higher for those with more than 10 years of CHW experience (Figure 3-21).



Figure 3-21: Years as a CHW by requirements for position (n=1,035)

Type of organisation where CHWs work

ECHOES respondents who were not self-employed were asked about the type of organisation they worked for. Overall, most respondents indicated that they worked for private, not-for-profit organisations like non-governmental, charity, community, civil society or grassroots organisations (86.4%) (Figure 3-22). The largest

proportion of CHWs working in private not-for-profit organisations were 31-40 years old, homo/bisexual and peers (Table 3-13).

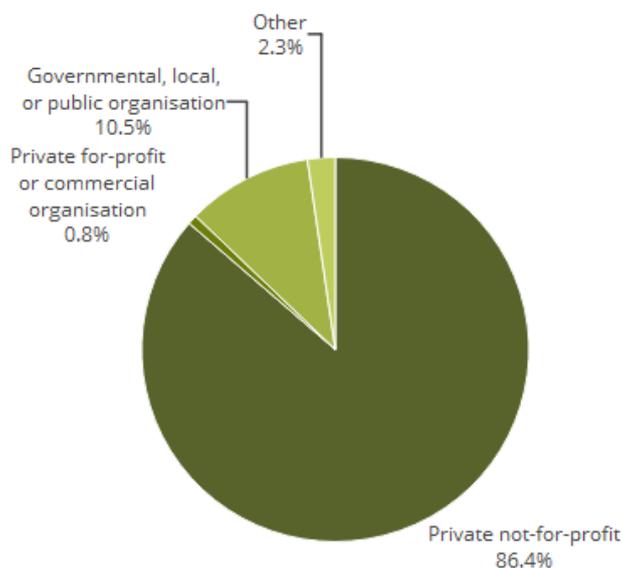


Figure 3-22: Type of organisation where CHWs work (n=975)

Table 3-13: Type of organisation where CHWs work by age group, gender, sexual identity, peer role and employment status

| | Private not-for-profit (n=839) | Other (n=132) ^b | p-value |
|---------------------------|--------------------------------|----------------------------|---------|
| Age group | | | 0.046 |
| 18-30 years | 82.7 | 17.3 | |
| 31-40 years | 90.0 | 10.0 | |
| More than 40 years | 85.6 | 14.4 | |
| Gender | | | 0.633 |
| Man | 86.9 | 13.1 | |
| Woman | 84.9 | 15.1 | |
| Other/prefer not to say | 89.2 | 10.8 | |
| Sexual identity | | | 0.012 |
| Homo/Bisexual | 88.7 | 11.3 | |
| Heterosexual | 81.0 | 19.0 | |
| Other ^a | 85.5 | 14.5 | |
| Peer role as a CHW | | | 0.003 |
| No | 82.4 | 17.6 | |
| Yes | 89.1 | 10.9 | |
| Employment status | | | 0.461 |
| Paid | 85.8 | 14.2 | |
| Volunteer | 87.6 | 12.4 | |

^aQueer, any other term, don't use a term. ^bGovernment/local authority, public organisation, other type.

Respondents were asked to provide information about the size of their organization in terms of the numbers of people working there (paid and unpaid). More than half (66.4%) of CHWs from private not-for-profit organisations (e.g. NGOs) reported less than 50 people (paid and unpaid) working there. This percentage was lower

among CHWs working in other types of organisations such as governmental, local or public organisations (40.3%) (Figure 3-23).

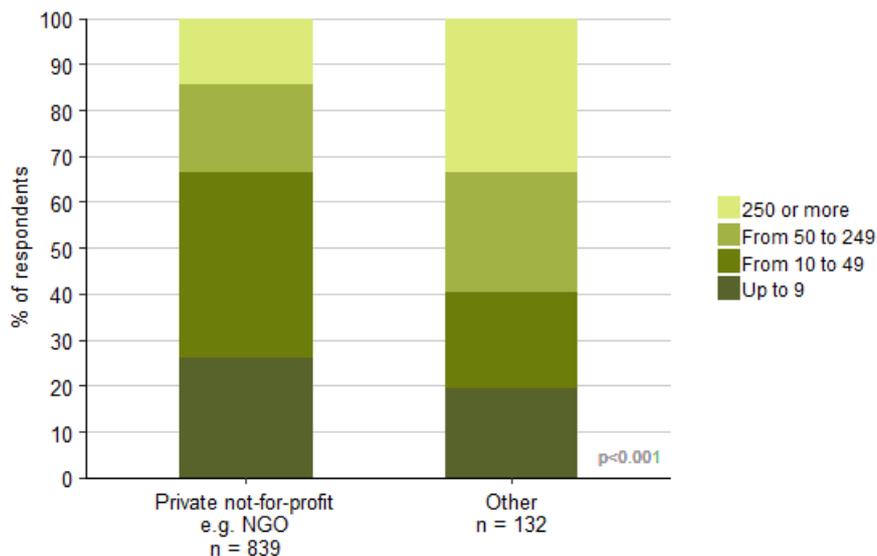


Figure 3-23: Size of the organisation where CHWs work by organisation type

Purpose of respondents' organisations

Overall, the main purpose of the organisation where CHWs work was sexual health (57.6%), followed by LGBTI-specific needs (18.4%) and general health (9.5%) (Figure 3-24).

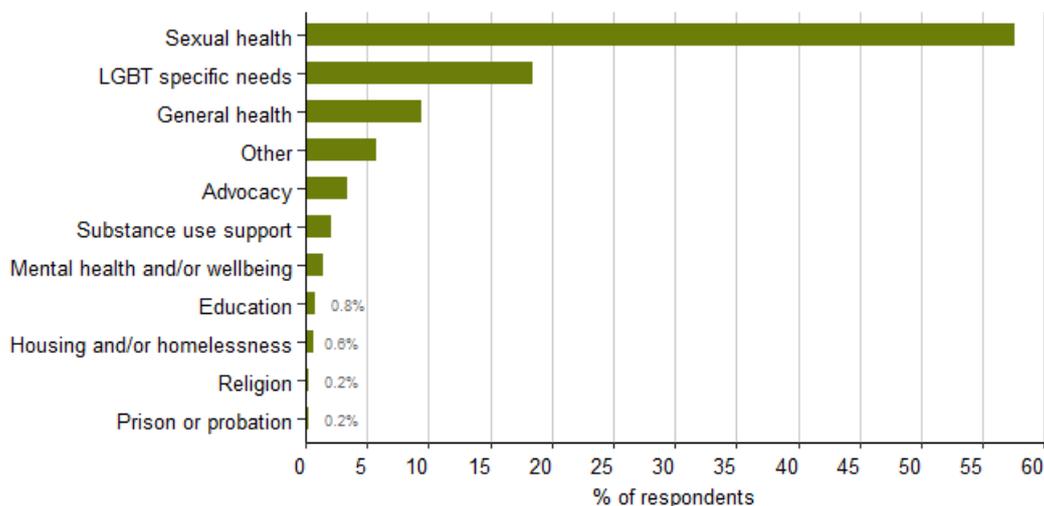


Figure 3-24: Main purpose of the organisation where CHWs work (n=975)

The main purpose of respondents' organisations was different according to the organisation type (Figure 3-25). Sexual health and LGBTI needs were more frequently reported by CHWs from private non-for-profit organisations (59.1% and 20.1%, respectively), while general health was more frequently reported by CHWs working in other types of organisations (28.4%).

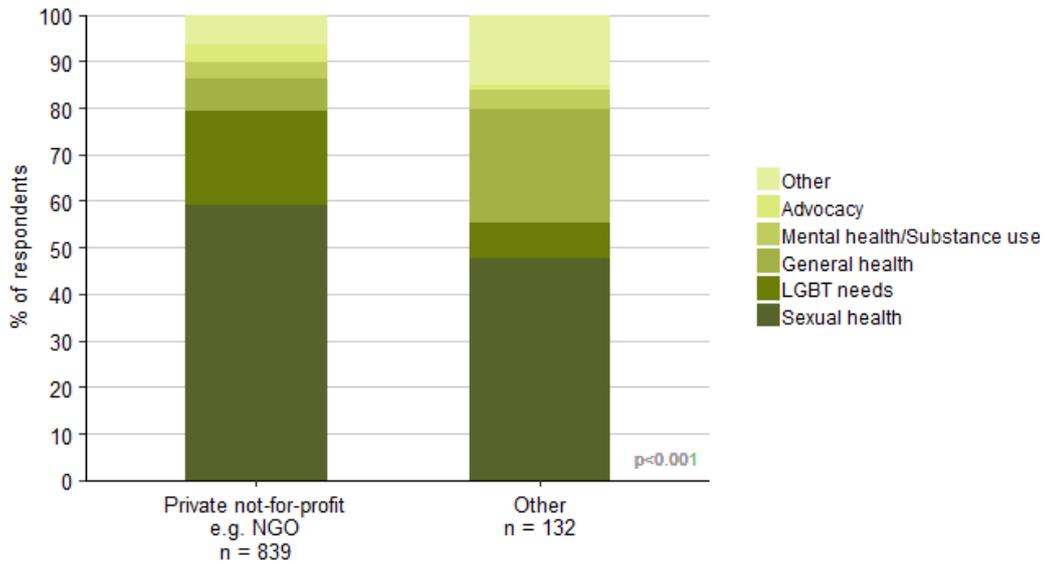


Figure 3-25: Main purpose of organisation where CHWs work by organisation type

Funding sources for respondents' organisation

ECHOES respondents were asked about their organisations' sources of funding (Figure 3-26). Overall, more than three-quarters of CHWs reported that the organisation received grants from the national government and/or local authority. Charitable/private donations and fundraising activities were also reported by a large proportion of respondents (61.5% and 48.2%). European funding was reported by 23.2% of the ECHOES sample.

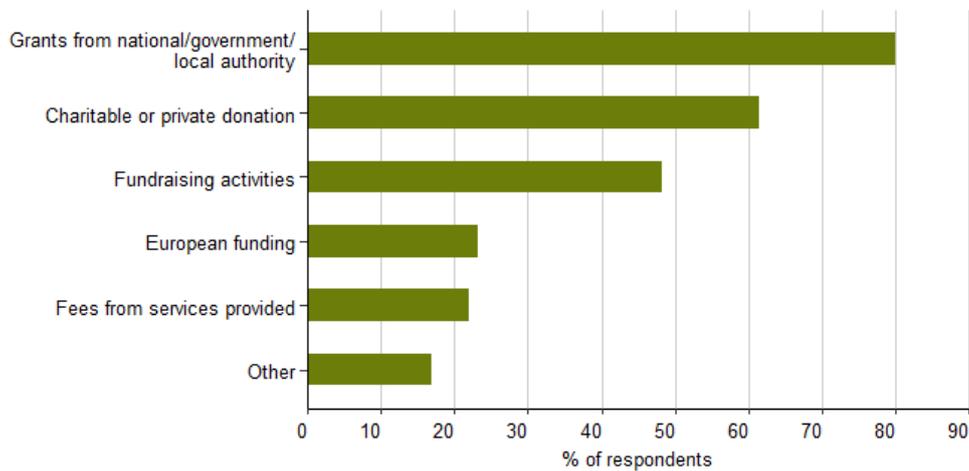


Figure 3-26: Funding sources for respondents' organisation (n=975; multiple answer)

The source of funding was different according to the type of organisation CHWs work in (Figure 3-27). CHWs working in private not-for-profit organisations more frequently reported funding from a variety of sources, such as charitable or private donations (68.9%) and from fundraising activities (53.9%), than CHWs working in other types of organisations for which the main source of funding reported was grants from national governments or local authorities (77.9%).

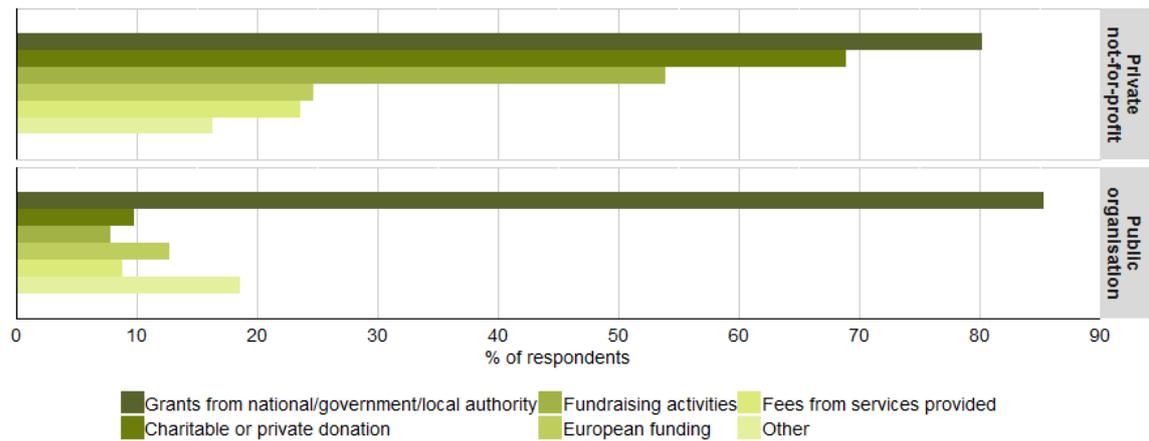


Figure 3-27: Source of funding by organisation type (n=975; multiple answer)

Employment status and profile of the CHWs' organisation by the LGBTI inequality level of the working country

The percentage of volunteer CHWs was higher in countries with 'high LGBTI inequality' than 'low LGBTI inequality' (36.5% vs. 28.9%, respectively; Table 3-14). In countries with 'low LGBTI inequality', the percentage of CHWs ranged from 52.8% in Germany to 12.8% in UK (Table 3-15).

The percentage of CHWs working in organisations focused on sexual health was lower in countries with 'high LGBTI inequality' than those with 'low LGBTI inequality' (44.6% vs. 61.4%, respectively; Table 3-14). In 'high LGBTI inequality' countries, LGBTI needs and mental health and/or substance use were more frequently reported as the purpose of the organisation (15.2% vs. 7.1%, respectively; Table 3-14). The highest percentage of CHWs working in sexual health organisations among 'low LGBTI inequality' countries was seen in France (86.6%) (Table 3-15).

Years of experience were similar between CHWs from the 'high LGBTI inequality' and 'low LGBTI inequality' countries (Table 3-14). CHWs in Germany reported the highest percentage with more than 10 year of experience (41.7%) (Table 3-15).

Table 3-14: Employment status and profile of the respondents' organisation by the LGBTI inequality level of the working country

| | Low LGBTI inequality (n=786) | High LGBTI inequality (n=249) | p-value |
|---|------------------------------|-------------------------------|---------|
| Employment status as a CHW | | | 0.023 |
| Paid | 71.1 | 63.5 | |
| Volunteer | 28.9 | 36.5 | |
| Health-care professionals (aside from CHW)^a | | | 0.091 |
| No | 81.5 | 88.1 | |
| Yes | 18.5 | 11.9 | |
| Organisation type^b | | | 0.340 |
| Private not-for-profit | 87.3 | 83.5 | |
| Other ^c | 12.7 | 16.5 | |
| Organisation purpose^b | | | <0.001 |
| Sexual Health | 61.4 | 44.6 | |
| LGBTI-specific needs | 7.8 | 15.2 | |
| General health | 18.2 | 19.2 | |
| Mental health/substance use | 2.4 | 7.1 | |
| Advocacy | 3.2 | 4.0 | |
| Other | 7.0 | 9.8 | |
| Organisation funding sources^{b*} | | | |
| Grants from national government or local authority | 87.9 | 53.4 | <0.001 |
| Charitable or private donation | 63.4 | 55.2 | 0.027 |
| Fundraising activities | 49.7 | 43.5 | 0.106 |
| European funding | 17.6 | 41.7 | <0.001 |
| Fees from services provided - e.g. Training | 24.6 | 13.5 | <0.001 |
| Other | 17.9 | 13.9 | 0.163 |
| Years of experience as a CHW | | | 0.206 |
| 5 or less | 45.9 | 51.9 | |
| 6 to 10 | 23.6 | 22.8 | |
| More than 10 | 30.5 | 25.3 | |

^an=416 who were employed, self-employed or volunteers aside from CHW. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. *Multiple answer.

Reported funding of CHWs' organisations differed by the level of LGBTI inequality. Grants from national government and/or local authority, and from charitable or private donation were more frequently reported among CHWs from countries with 'low LGBTI inequality' (87.9% vs. 63.4%, respectively), whereas European funding were more common in 'high LGBTI inequality' countries (41.7% vs. 17.4%, respectively) (Table 3-14).

Among 'low LGBTI inequality' countries, respondents from France most frequently reported receiving funds from charitable or private donation and/or fundraising activities (95.1% and 80.2%, respectively). On the other hand, European funding was more frequently reported by CHWs in Spain and 'other countries' (20.4% and 24.4%, respectively, Table 3.15).

Table 3-15: Employment status and profile of the respondents' organisation by 'low LGBTI inequality' countries

| | Germany (n=195) | Spain (n=174) | UK (n=94) | France (n=83) | Other ^d (n=240) | p-value |
|--|--------------------|------------------|--------------|------------------|-------------------------------|---------|
| Employment status as a CHW | | | | | | <0.001 |
| Paid | 47.2 | 73.1 | 87.2 | 68.3 | 85.2 | |
| Volunteer | 52.8 | 28.7 | 12.8 | 31.7 | 14.8 | |
| Health-care professionals^a | | | | | | 0.006 |
| No | 88.7 | 84.4 | 87.0 | 88.9 | 67.1 | |
| Yes | 11.3 | 15.6 | 13.0 | 11.1 | 32.9 | |
| Organisation type^b | | | | | | 0.010 |
| Private not-for-profit | 84.6 | 91.6 | 89.1 | 95.1 | 82.6 | |
| Other ^c | 15.4 | 8.4 | 10.9 | 4.9 | 17.4 | |
| Organisation purpose^b | | | | | | <0.001 |
| Sexual Health | 65.4 | 48.5 | 72.8 | 86.6 | 53.7 | |
| LGBTI-specific needs | 7.4 | 9.6 | 2.2 | 11.0 | 7.8 | |
| General health | 21.8 | 22.2 | 15.2 | 0 | 20.2 | |
| Mental health/substance use | 1.1 | 4.2 | 2.2 | 1.2 | 2.8 | |
| Advocacy | 1.6 | 2.4 | 2.2 | 0 | 6.9 | |
| Other | 2.7 | 13.2 | 5.4 | 1.2 | 8.7 | |
| Organisation funding sources^{b*} | | | | | | |
| Grants from national government or local authority | 90.3 | 88.6 | 88.0 | 97.5 | 81.6 | 0.003 |
| Charitable or private donation | 56.5 | 69.5 | 64.1 | 95.1 | 52.5 | <0.001 |
| Fundraising activities | 49.5 | 45.5 | 58.7 | 80.2 | 37.8 | <0.001 |
| European funding | 9.1 | 20.4 | 13.0 | 18.5 | 24.4 | 0.001 |
| Fees from services provided | 19.9 | 28.1 | 37.0 | 29.6 | 18.9 | 0.003 |
| Other | 25.8 | 21.0 | 10.9 | 6.2 | 16.1 | <0.001 |
| Years of experience as a CHW | | | | | | <0.001 |
| 5 or less | 42.2 | 35.6 | 51.1 | 56.6 | 50.6 | |
| 6 to 10 | 16.1 | 35.6 | 19.6 | 22.9 | 22.6 | |
| More than 10 | 41.7 | 28.7 | 29.3 | 20.5 | 26.8 | |

^an=416 who were employed, self-employed or volunteers aside from CHW. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

3.5. Settings where CHWs work

Figure 3-28 presents the settings where respondents usually perform their CHW activities. A large majority (69%) reported working in community settings. Gay or gay-friendly venues and online/via email were the second and third most common settings (56.1% and 50.1%, respectively). The majority of CHWs work in more than one setting: one in four respondents (25.3%) reported working in only one type of settings; one in five (20.2%) reported working in two settings, 22% in three settings and 32.3% in 4 or more settings (data not shown).

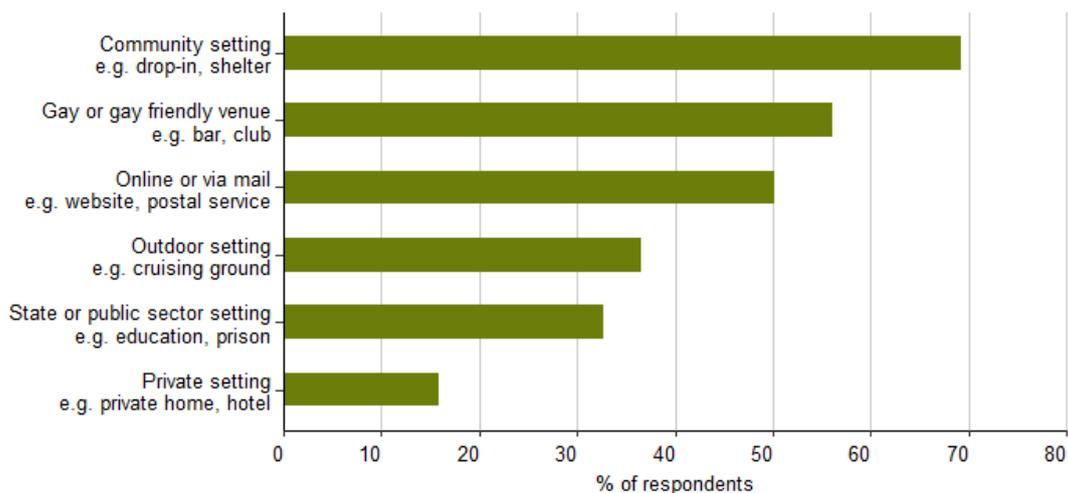


Figure 3-28: Type of settings where respondents usually perform CHW activities (n=1,035, multiple answer)

Compared with non-peer respondents, a larger proportion of peer respondents reported working or volunteering in gay or gay-friendly venues (65.3% vs. 42.9%), in outdoor settings (41.6% vs. 29.1%), online or via mail (53.7% vs. 45.0%) and a smaller proportion reported working or volunteering in state or public sector settings (27.9% vs. 39.8%, Table 3-16).

Between paid and unpaid CHWs, the former reported working more in the following settings: community (72.1% vs. 63.4%), outdoor (38.9% vs. 31.2%), state or public sector (38.5% vs. 19.9%, $p < 0.001$) and online or via email (55.2% vs. 39.1%).

Similarly, a higher proportion of respondents working for a private not-for-profit organisation reported working or volunteering in the following settings: gay or gay friendly venues (59.5% vs. 41.7%), community settings (74.9% vs. 45.5%) and online or via email (54.8% vs. 30.3%).

The percentage of CHWs working in all settings was smaller in countries with a rate of <3 new HIV diagnoses attributed to sex between men per 100,000 men in 2016, compared to countries with a rate of >5.

Table 3-16: Type of settings by the main stratification variables, employment status, years as a CHW, organisation type and HIV epidemic in MSM (N=1,035)

| | Gay or gay friendly venue | Community setting | Outdoor setting | State or public sector setting | Private setting | Online or via mail |
|---|---------------------------|-------------------|-----------------|--------------------------------|-----------------|--------------------|
| Age | | | | | | |
| 18-30 | 62.7 | 66.8 | 40.6 | 32.3 | 13.4 | 51.2 |
| 31-40 | 59.0 | 75.2 | 38.2 | 32.4 | 16.5 | 51.4 |
| 41 or older | 51.3 | 66.4 | 33.6 | 33.2 | 16.5 | 48.9 |
| <i>p-value</i> | 0.009 | 0.019 | 0.155 | 0.958 | 0.531 | 0.741 |
| Gender | | | | | | |
| Man | 62.3 | 70.8 | 40.0 | 29.3 | 16.1 | 51.6 |
| Woman | 41.4 | 66.1 | 27.7 | 40.4 | 15.1 | 44.9 |
| Other or prefer not say | 55.0 | 65.0 | 40.0 | 37.5 | 17.5 | 62.5 |
| <i>p-value</i> | <0.001 | 0.281 | 0.001 | 0.003 | 0.886 | 0.042 |
| Sexual identity | | | | | | |
| Homo/bisexual | 64.3 | 70.6 | 40.5 | 28.2 | 15.7 | 53.4 |
| Hetero | 38.2 | 66.8 | 26.3 | 40.9 | 17.0 | 40.2 |
| Other ^a | 50.8 | 67.5 | 37.3 | 39.7 | 14.3 | 54.0 |
| <i>p-value</i> | <0.001 | 0.474 | <0.001 | <0.001 | 0.781 | 0.001 |
| Peer role | | | | | | |
| Peer | 65.3 | 70.8 | 41.6 | 27.9 | 15.7 | 53.7 |
| Non-Peer | 42.9 | 67.1 | 29.1 | 39.8 | 16.1 | 45.0 |
| <i>p-value</i> | <0.001 | 0.200 | <0.001 | <0.001 | 0.844 | 0.006 |
| Employment status | | | | | | |
| Paid | 55.6 | 72.1 | 38.9 | 38.5 | 16.5 | 55.2 |
| Volunteer | 58.0 | 63.4 | 31.2 | 19.9 | 14.5 | 39.1 |
| <i>p-value</i> | 0.466 | 0.005 | 0.018 | <0.001 | 0.414 | <0.001 |
| Years as CHW | | | | | | |
| 0-5 years | 58.2 | 68.4 | 34.9 | 25.2 | 12.7 | 44.3 |
| 5-10 years | 57.6 | 74.8 | 44.1 | 38.7 | 19.3 | 57.1 |
| > 10 years | 53.0 | 68.5 | 34.9 | 41.6 | 18.8 | 56.4 |
| <i>P-value</i> | 0.341 | 0.172 | 0.037 | <0.001 | 0.022 | <0.001 |
| Type of organisation worked for^b | | | | | | |
| Private not-for-profit | 59.5 | 74.9 | 38.6 | 33.0 | 15.9 | 54.8 |
| Other ^c | 41.7 | 45.5 | 30.3 | 37.9 | 14.4 | 30.3 |
| <i>p-value</i> | <0.001 | <0.001 | 0.067 | 0.272 | 0.668 | <0.001 |
| New HIV diagnoses attributed to sex between men, in 2016 | | | | | | |
| <3 per 100,000 | 46.7 | 50.5 | 29.9 | 26.1 | 13.0 | 41.8 |
| 3 to 5 per 100,000 | 62.2 | 68.3 | 40.4 | 25.2 | 12.3 | 48.9 |
| >5 per 100,000 | 52.1 | 77.6 | 35.4 | 43.6 | 18.5 | 52.6 |
| <i>p-value</i> | 0.001 | <0.001 | 0.040 | <0.001 | 0.037 | 0.054 |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. *Multiple answer.

In the questionnaire, respondents were asked to indicate the specific venues where they usually worked (data not shown). To understand the settings used for outreach, the percentage of CHWs working in each are listed in Figure 3-29.

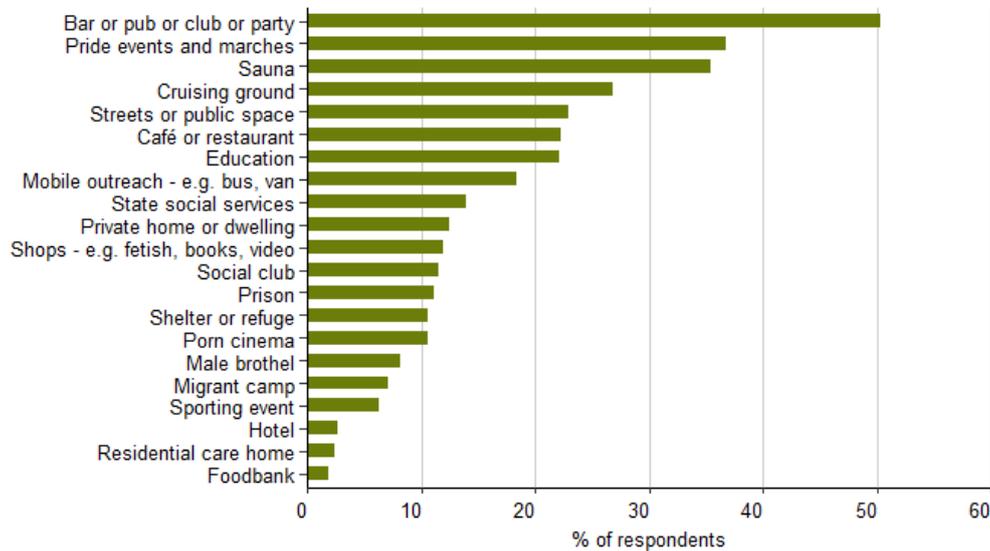


Figure 3-29: Places of outreach activities (n=1,035)

The majority of CHWs (76.9%) reported working in at least one outreach setting. Significant differences were observed by age, gender, sexual identity and peer role (Figure 3-30). The highest proportion of CHWs working in an outreach setting was seen in younger respondents (83.9% in those aged 18-30, 78.9% in those aged 31-40 and 72.5% in those aged over 40 years old), and in peer CHWs (80.8% vs. 71.3% in non-peer CHWs). Women and heterosexual CHWs reported working in outreach (70.5% and 68.3%, respectively) less compared to their counterparts: Those working for private not-for-profit organisations reported more outreach activities (79.1%) than those working for other types of organisations (69.7%). No differences were observed by employment status, years as CHW, and rates of new HIV diagnoses in the male population attributable to sex between men.

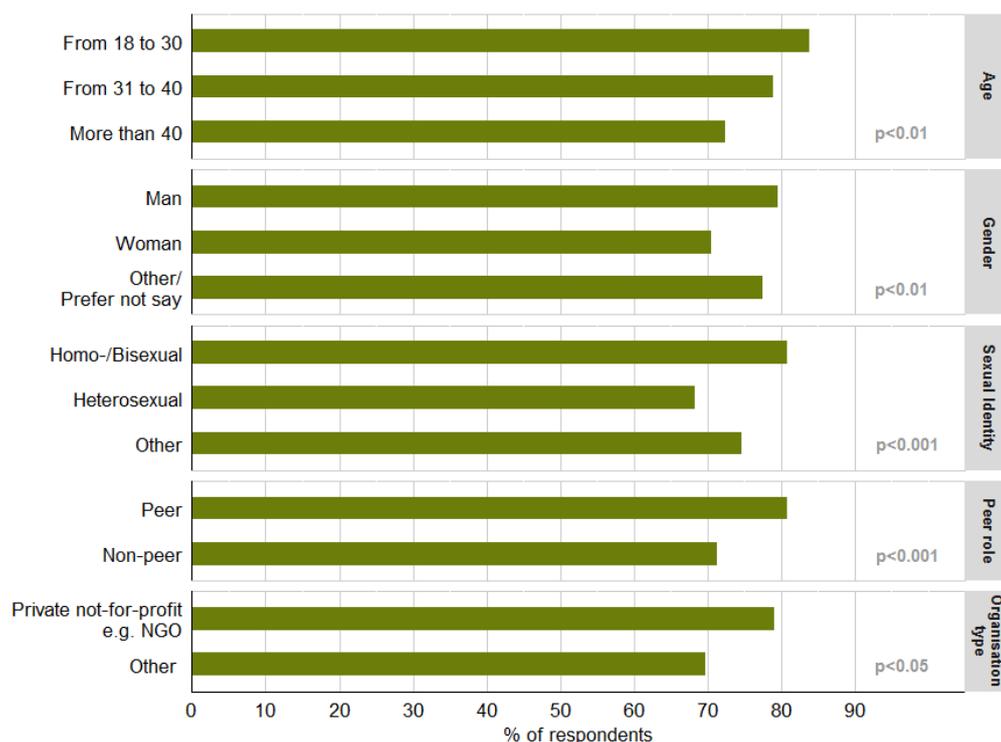


Figure 3-30: Respondents working in outreach by age, gender, sexual identity, peer role, and type of organisation worked for (n=1,035)

Settings where CHWs worked by the LGBTI inequality level of the working country

Where significant differences were observed, a higher proportion of respondents from the 'low LGBTI inequality' region reported working or volunteering in each of the settings (Table 3-17). Most CHW work in multiple settings, especially those from 'low LGBTI inequality' countries where 57.7% reported working in more than 3 different venues compared to 44.3% in 'high LGBTI inequality' countries (p<0.001, data not shown).

Table 3-17: Settings CHWs worked in by the LGBTI inequality level of the working country*

| | Low LGBTI inequality (n=786) | High LGBTI inequality (n=249) | P-value |
|---|------------------------------|-------------------------------|---------|
| Gay or gay friendly entertainment venue | 57.5 | 51.8 | 0.114 |
| Community setting | 72.6 | 58.6 | <0.001 |
| Outdoor setting | 38.3 | 30.9 | 0.035 |
| State or public sector setting | 34.7 | 26.5 | 0.016 |
| Private setting | 15.6 | 16.5 | 0.758 |
| Online or via mail | 52.5 | 42.6 | 0.006 |
| Outreach setting | 81.9 | 75.5 | 0.026 |

*Multiple answer.

A higher proportion of respondents in France and Spain reported working or volunteering in each setting than other countries in the “low LGBTI inequality” region (Table 3-18).

Table 3-18: Settings CHWs worked in by ‘low LGBTI inequality’ countries*

| | Germany (n=195) | Spain (n=174) | UK (n=94) | France (n=83) | Other ^a (n=240) | P-value |
|---|--------------------|------------------|--------------|------------------|-------------------------------|---------|
| Gay or gay friendly entertainment venue | 61.5 | 42.0 | 62.8 | 88.0 | 52.9 | <0.001 |
| Community setting | 62.6 | 84.5 | 77.7 | 83.1 | 66.7 | <0.001 |
| Outdoor setting | 31.3 | 32.2 | 50.0 | 89.2 | 26.3 | <0.001 |
| State or public sector setting | 22.6 | 52.9 | 45.7 | 43.4 | 24.2 | <0.001 |
| Private setting | 13.3 | 22.4 | 23.4 | 15.7 | 9.6 | 0.001 |
| Online or via mail | 42.1 | 55.7 | 60.6 | 77.1 | 47.1 | <0.001 |
| Outreach setting | 80.0 | 79.9 | 85.1 | 98.8 | 77.9 | <0.001 |

*Multiple answer. ^aMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

3.6. Populations which CHWs most often work with

At the time of the study or in the 12 months prior, all ECHOES respondents were working with homosexual, gay, bisexual and other MSM (inclusion criteria to participate in ECHOES), but not exclusively.

The large majority (82.7%) of ECHOES respondents reported ‘gay, bisexual and other MSM’ as one of the three main populations they work with (Figure 3-31). The second most reported population was ‘PLHIV’ (38.5%) followed by ‘general population, including gay, bisexual and other MSM’ (23.5%) and ‘trans people’ (22.9%). Other populations CHWs work with included: migrants (16.4%), sex workers (15.2%), and drug users (12.7%).

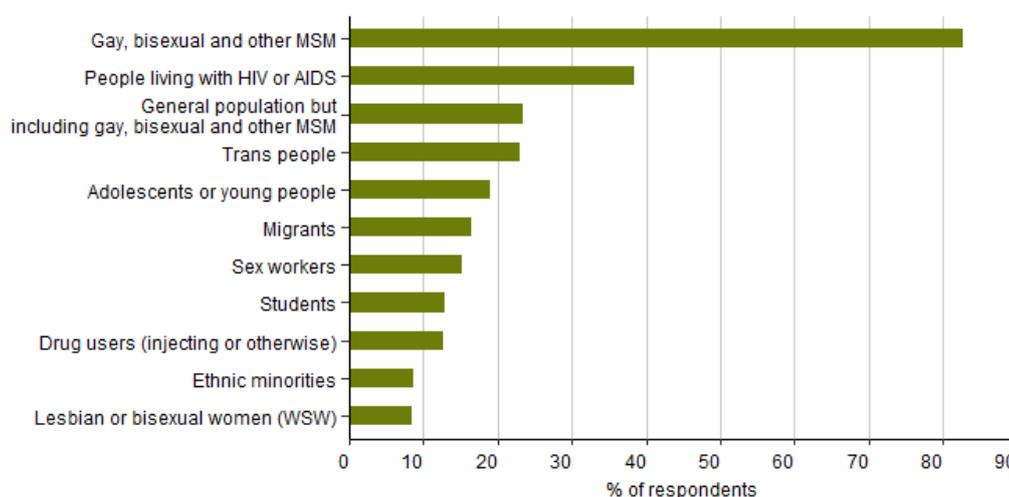


Figure 3-31: Populations of people ECHOES respondents most often work with (n=1,035, 3 choices)

Of the 17.3% (n=178) of respondents who did not select 'gay, bisexual and other MSM' as one of three populations they most often work with, more than half (n=100) reported working with the 'general population but including gay, bisexual and other MSM'; only 78 respondents did not report "gay bisexual and other MSM" nor "general population but including gay, bisexual and other MSM" as one of the three populations they most often work with.

Table 3-19 describes ECHOES respondents by the populations they most often work with³¹. Respondents who selected '**PLHIV**' as one of the three main populations they work with were more often aged 41 or older (53.7% vs. 43.9%), more often paid workers than unpaid (73.8% vs. 66.6%), more often with more than 10 years of experience as CHW (35.0% vs. 25.7%) and more often reported living with HIV themselves (36.1% vs. 18.3%), compared to those who did not report PLHIV as one of the populations they most often work with.

Respondents who selected '**trans people**' as one of the three populations they most often work with, more often defined as 'other than man or woman, or preferred not say' (10.2% vs. 1.8%), more often defined as homosexual/bisexual (71.1% vs. 60.3%), reported less experience as CHW (23.2% vs. 31.2% reporting >10 years as CHW), were less often previously diagnosed with HIV (19.1% vs. 27.2%), and were more often in countries with rates of new HIV diagnoses attributed to sex between men of >5 per 100,000 men (47.6% vs. 37.8%).

Respondent who selected '**migrant or ethnic minority**' as one of the three populations they most often worked with, more often reported being paid CHWs (78.9% vs. 66.3%), working in a private not-for-profit organisation (92.0% vs. 84.9%) and being in countries with a rate of new HIV diagnoses attributed to sex between men of between 3 and 5 per 100,000 men (48.6% vs. 39.4%).

Respondents who selected '**sex workers**' as one of the three populations they most often work with, more often reported being women (36.5% vs. 26.8%), heterosexual (41.0% vs. 22.3%), non-peer (53.8% vs. 38.4%) and paid (85.9% vs. 66.4%) CHWs, having >10 years of experience as CHW (34.6% vs. 28.4%), and being in countries with rates of new HIV diagnoses attributed to sex between men of >5 per 100,000 men (59.5% vs. 36.5%). A smaller proportion reported being HIV positive (15.4% vs. 24.4%) than those who did not select sex workers as one of the three populations they most commonly work with.

Respondents who selected '**drug users**' as one of the three populations they most often work with, more often reported being aged 31-40 years old (41.5% vs. 30.4%), heterosexual (38.5% vs. 23.2%), being non-peer (53.8% vs. 38.8%) or paid CHWs (80.0% vs. 67.8%).

³¹ NB: the target populations 'Migrant' and 'Ethnic minority' were grouped in a single category.

Table 3-19: Profile of CHWs by the main populations they work with*

| | PLHIV | | Trans people | | Migrant/ ethnic minority | | Sex workers | | Drug users | |
|---|-------------|-------------|--------------|-------------|--------------------------|-------------|-------------|-------------|-------------|-------------|
| | No (n=631) | Yes (n=395) | No (n=791) | Yes (n=235) | No (n=779) | Yes (n=247) | No (n=870) | Yes (n=156) | No (n=896) | Yes (n=130) |
| Age | | | | | | | | | | |
| 18-30 | 24.1 | 14.9 | 20.0 | 22.6 | 20.5 | 20.6 | 20.7 | 19.9 | 21.8 | 12.3 |
| 31-40 | 32.0 | 31.4 | 31.0 | 34.5 | 32.6 | 29.1 | 32.1 | 30.1 | 30.4 | 41.5 |
| 41 or older | 43.9 | 53.7 | 49.1 | 43.0 | 46.9 | 50.2 | 47.2 | 50.0 | 47.9 | 46.2 |
| Gender | | | | | | | | | | |
| Man | 68.3 | 67.6 | 67.9 | 68.5 | 67.7 | 69.2 | 69.9 | 57.7 | 68.8 | 63.1 |
| Woman | 27.3 | 29.9 | 30.3 | 21.3 | 28.0 | 29.1 | 26.8 | 36.5 | 27.5 | 33.8 |
| Other/prefer not to say | 4.4 | 2.5 | 1.8 | 10.2 | 4.4 | 1.6 | 3.3 | 5.8 | 3.8 | 3.1 |
| Sexual identity | | | | | | | | | | |
| Homo/bisexual | 61.8 | 64.3 | 60.3 | 71.1 | 63.4 | 60.7 | 65.9 | 45.5 | 65.1 | 46.9 |
| Heterosexual | 25.0 | 25.3 | 28.6 | 13.6 | 25.3 | 24.7 | 22.3 | 41.0 | 23.2 | 38.5 |
| Other ^a | 13.2 | 10.4 | 11.1 | 15.3 | 11.3 | 14.6 | 11.8 | 13.5 | 11.7 | 14.6 |
| Peer role | | | | | | | | | | |
| Peer | 58.6 | 60.3 | 57.8 | 64.3 | 59.2 | 59.5 | 61.6 | 46.2 | 61.2 | 46.2 |
| Non-peer | 41.4 | 39.7 | 42.2 | 35.7 | 40.8 | 40.5 | 38.4 | 53.8 | 38.8 | 53.8 |
| Employment status | | | | | | | | | | |
| Paid | 66.6 | 73.8 | 69.5 | 68.9 | 66.3 | 78.9 | 66.4 | 85.9 | 67.8 | 80.0 |
| Volunteer | 33.4 | 26.2 | 30.5 | 31.1 | 33.7 | 21.1 | 33.6 | 14.1 | 32.2 | 20.0 |
| Years as CHW | | | | | | | | | | |
| 0-5 years | 51.1 | 41.1 | 46.6 | 49.4 | 48.9 | 42.1 | 49.7 | 34.0 | 47.7 | 43.8 |
| 5-10 years | 23.2 | 23.9 | 22.2 | 27.5 | 22.5 | 26.3 | 22.0 | 31.4 | 23.5 | 23.1 |
| > 10 years | 25.7 | 35.0 | 31.2 | 23.2 | 28.6 | 31.6 | 28.4 | 34.6 | 28.8 | 33.1 |
| Type of organisation worked for^b | | | | | | | | | | |
| Private not-for-profit | 87.3 | 85.6 | 86.0 | 88.7 | 84.9 | 92.0 | 86.0 | 89.9 | 86.4 | 88.2 |
| Other ^c | 12.7 | 14.4 | 14.0 | 11.3 | 15.1 | 8.0 | 14.0 | 10.1 | 13.6 | 11.8 |
| Self-reported HIV status^d | | | | | | | | | | |
| Positive | 18.3 | 36.1 | 27.23 | 19.1 | 24.8 | 27.1 | 26.7 | 16.6 | 26.2 | 19.5 |
| Negative/Unknown | 81.2 | 63.1 | 72.77 | 80.9 | 75.2 | 72.9 | 73.0 | 83.5 | 73.8 | 80.5 |
| New HIV diagnoses attributed to sex between men, in 2016 | | | | | | | | | | |
| <3 per 100,000 | 17.8 | 19.2 | 18.7 | 16.9 | 20.2 | 12.3 | 18.5 | 17.0 | 17.6 | 23.2 |
| 3 to 5 per 100,000 | 40.9 | 42.9 | 43.5 | 35.6 | 39.4 | 48.6 | 45.0 | 23.5 | 41.8 | 40.8 |
| >5 per 100,000 | 41.4 | 37.9 | 37.8 | 47.6 | 40.3 | 39.1 | 36.5 | 59.5 | 40.6 | 36.0 |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dAmong those previously tested (n=944). *Multiple answer (3 choices). Numbers in bold indicate that the corresponding statistical test was significant (p<0.05).

Half of all ECHOES respondents (50.6%) reported working with people of all ages and only one in ten (10.5%) reported mostly working with young people (Figure 3-32).

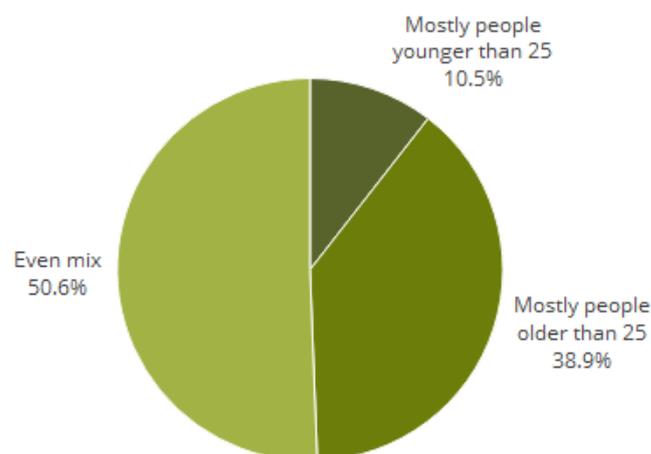


Figure 3-32: Age of users attended by CHWs (n=1,035)

Table 3-20: Age of users attended by CHWs by the main stratification variables, employment status, organisation type, years as CHW and HIV epidemic in MSM (N=1,035)

| | Mostly people < 25 | Mostly people > 25 | Even mix | P-value |
|---|--------------------|--------------------|----------|---------|
| Age | | | | <0.001 |
| 18-30 | 16.7 | 35.7 | 47.6 | |
| 31-40 | 12.6 | 33.2 | 54.2 | |
| 41 or older | 6.4 | 44.1 | 49.5 | |
| Gender | | | | 0.719 |
| Man | 10.1 | 38.9 | 51.0 | |
| Woman | 12.2 | 38.7 | 49.1 | |
| Other/prefer not say | 5.4 | 40.5 | 54.1 | |
| Sexual identity | | | | 0.051 |
| Homo/bisexual | 9.3 | 38.5 | 52.2 | |
| Heterosexual | 14.8 | 40.6 | 44.5 | |
| Other ^a | 7.4 | 37.7 | 54.9 | |
| Peer role | | | | 0.237 |
| Peer | 9.4 | 38.2 | 52.4 | |
| Non-peer | 12.1 | 40.0 | 47.9 | |
| Employment status | | | | <0.001 |
| Paid | 9.4 | 44.2 | 46.4 | |
| Volunteer | 13.1 | 27.1 | 59.9 | |
| Years as CHW | | | | 0.258 |
| 0-5 years | 12.0 | 36.6 | 51.5 | |
| 5-10 years | 9.2 | 38.2 | 52.5 | |
| > 10 years | 8.8 | 43.6 | 47.6 | |
| Type of organisation worked for^b | | | | 0.218 |
| Private not-for-profit | 10.0 | 38.6 | 51.4 | |
| Other ^c | 15.0 | 34.6 | 50.4 | |
| New HIV diagnoses attributed to sex between men, in 2016 | | | | 0.019 |
| <3 per 100,000 | 16.1 | 33.9 | 50.0 | |
| 3 to 5 per 100,000 | 7.3 | 40.8 | 51.8 | |
| >5 per 100,000 | 10.9 | 40.9 | 48.2 | |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type.

The proportion of respondents working mostly with young people was higher in young respondents (16.7% in respondents aged 18-30, 12.6% in those aged 31-40 and 6.4% in those aged of 40 or more, Table 3-20) and in heterosexuals (14.8% vs. 9.3% in homo/bisexual and 7.4% in other). A higher proportion of paid CHWs reported mostly working with people older than 25 years old (44.2% vs. 27.1% of unpaid CHWs).

Overall, 59.2% of ECHOES respondents reported working with up to 9 people per week, while only 6.7% attended 50 people or more per week (Figure 3-33).

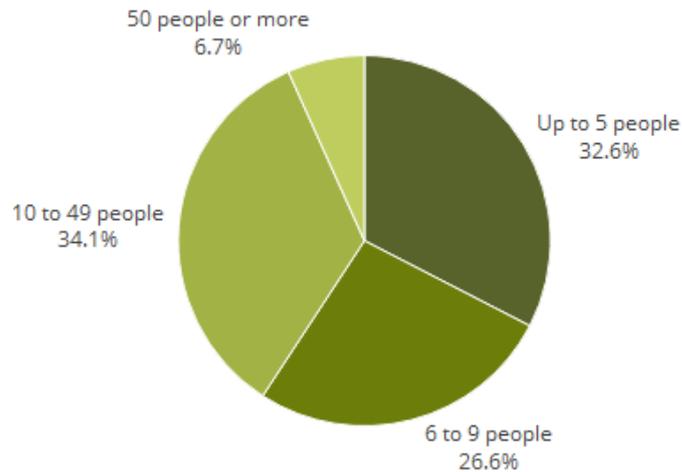


Figure 3-33: Number of users attended in a usual 7-day period (n=1,035)

Those attending up to 9 people per week were more often women (71.2%), non-peer (68.5%) and volunteer CHWs (69.7%) compared to those attending more than 10 (Table 3-21). Conversely, those attending 10 users or more per week were more often homosexual/bisexual (45.5%) and paid-CHWs (45.2%) compared to those attending up to 9 people per week.

Table 3-21: Number of users attended in a normal 7-day period by the main stratification variables, employment status, years as CHW and rates of new HIV diagnoses attributed to sex between men (N=1,035)

| | Up to 9 users per week | 10 or more users per week | P-value |
|--|------------------------|---------------------------|---------|
| Age | | | 0.506 |
| 18-30 | 57.6 | 42.4 | |
| 31-40 | 57.3 | 42.7 | |
| 41 or older | 61.1 | 38.9 | |
| Gender | | | <0.001 |
| Man | 54.5 | 45.5 | |
| Woman | 71.2 | 28.8 | |
| Other or prefer not say | 54.8 | 45.2 | |
| Sexual identity | | | <0.001 |
| Homo/bisexual | 54.5 | 45.5 | |
| Heterosexual | 69.4 | 30.6 | |
| Other ^a | 63.3 | 36.7 | |
| Peer role | | | <0.001 |
| Peer | 53.1 | 46.9 | |
| Non-peer | 68.5 | 31.5 | |
| Employment status | | | <0.001 |
| Paid | 54.8 | 45.2 | |
| Volunteer | 69.7 | 30.3 | |
| Years as CHW | | | 0.098 |
| 0-5 years | 61.8 | 38.2 | |
| 5-10 years | 60.0 | 40.0 | |
| > 10 years | 53.8 | 46.2 | |
| Type of organisation worked for^b | | | 0.523 |
| Private not-for-profit | 58.1 | 41.9 | |
| Other ^c | 61.3 | 38.7 | |
| New HIV diagnoses attributed to sex between men in 2016 | | | 0.066 |
| <3 per 100,000 | 65.2 | 34.8 | |
| 3 to 5 per 100,000 | 55.4 | 44.6 | |
| >5 per 100,000 | 61.0 | 39.0 | |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type.

Populations CHWs most often work with by the LGBTI inequality level of the working country

The proportion of CHWs most often working with each key population was compared between 'low LGBTI inequality' and 'high LGBTI inequality' countries. Where significant differences were observed, the proportion of respondents from the 'low LGBTI inequality' countries was always higher, except for attendees aged under 25 (Table 3-22).

Table 3-22: Main populations of people CHWs worked with by the LGBTI level of the working country

| | Low LGBTI inequality (n=786) | High LGBTI inequality (n=249) | p-value |
|---|------------------------------|-------------------------------|---------|
| Target populations CHWs worked with*^a | | | |
| People living with HIV/AIDS | 37.4 | 41.9 | 0.202 |
| Trans people | 25.2 | 15.7 | 0.002 |
| Migrants or ethnic minorities | 29.2 | 8.1 | <0.001 |
| Sex workers | 16.5 | 11.3 | 0.049 |
| Drug users (injecting or otherwise) | 12.2 | 14.1 | 0.433 |
| Age of people attended by CHWs | | | 0.002 |
| Mostly people < 25 | 9.1 | 15.0 | |
| Mostly people > 25 | 41.5 | 30.8 | |
| Even mix | 49.4 | 54.3 | |
| 7-day period number of people attended | | | 0.476 |
| Up to 9 people | 58.6 | 61.2 | |
| 10 or more people | 41.4 | 38.8 | |

*Multiple answer. ^bOther vulnerable populations than gay, bisexual and other MSM.

In countries in the 'low LGBTI inequality' category, CHWs in France reported the largest percentage working mainly with migrants/ethnic minorities (63.9% vs. between 18.6% and 35.9% elsewhere) and with drug users (31.3% vs. 6.5% to 12.1% elsewhere). Around a fifth of respondents from Spain, France and 'other countries' listed sex workers as one of the groups they most often worked with (25.3%, 21.7% and 20.4%, respectively, vs. 5.7% and 7.6% in Germany and the UK, respectively, Table 3-23).

Table 3-23: Population CHWs most often worked with by 'low LGBTI inequality' countries

| | Germany (n=195) | Spain (n=174) | UK (n=94) | France (n=83) | Other countries ^a (n=240) | p-value |
|---|-----------------|---------------|-----------|---------------|--------------------------------------|---------|
| Target populations CHWs worked with*^b | | | | | | |
| People living with HIV/AIDS | 41.8 | 36.8 | 35.9 | 33.7 | 36.2 | 0.677 |
| Trans people | 22.7 | 29.3 | 33.7 | 20.5 | 22.6 | 0.108 |
| Migrants/Ethnic minorities | 18.6 | 17.8 | 35.9 | 63.9 | 31.5 | <0.001 |
| Sex workers | 5.7 | 25.3 | 7.6 | 21.7 | 20.4 | <0.001 |
| Drug users (injecting or otherwise) | 9.3 | 12.1 | 6.5 | 31.3 | 10.2 | <0.001 |
| Age of people attended by CHWs | | | | | | 0.109 |
| Mostly people < 25 | 6.2 | 10.4 | 9.9 | 4.9 | 11.6 | |
| Mostly people > 25 | 35.6 | 42.8 | 41.8 | 42.7 | 45.1 | |
| Even mix | 58.2 | 46.8 | 48.4 | 52.4 | 43.3 | |
| 7-day period number of people attended | | | | | | 0.055 |
| Up to 9 people | 52.6 | 66.9 | 52.2 | 55.6 | 61.1 | |
| 10 or more people | 47.4 | 33.1 | 47.8 | 44.4 | 38.9 | |

*Multiple answer. ^aMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. ^bOther vulnerable populations than gay, bisexual and other MSM.

4. CHWs in practice: What do CHWs do to support the sexual health of MSM?

Strengthening community-based strategies across the continuum of HIV/STI services is crucial to maintain the progress already made and to reach the 90-90-90 target set for 2020³².

As shown in the ECHOES conceptual model (Figure 2-1), three main domains of CHW practices were investigated throughout the questionnaire: (i) prevention, (ii) screening and testing and (iii) treatment. The three corresponding sections of the questionnaire collected extensive information on the specific practices and activities carried out by CHWs promoting sexual health in gay, bisexual and other MSM in Europe.

The conceptual model also highlighted that CHW practices have a direct impact on HIV, viral Hepatitis and other STI transmission dynamics. Impact on transmission dynamics is not measurable using the ECHOES data as the data can only report the contribution and the type of activities carried out by CHWs outside of the traditional clinical settings. It was thus important (and recommended by the Experts after the presentation of the preliminary data of ECHOES in the Berlin Workshop) to present these data according to the continuum of HIV/STI services and retention cascade, highlighting the areas CHWs are most involved in.

The first section of this chapter presents the profile of CHWs according to the continuum of HIV services, while the following four detail the activities performed by CHWs in each step of the continuum. The last three sections of this chapter document the activities implemented in synergy with other organisations, activities cutting across the continuum (strategic and administrative activities), and a description of the main activity areas according to the job titles provided by ECHOES respondents.

This chapter aims to describe CHW practices and try to identify possible differences between countries or regions, particularly according to the level of LGBTI inequality in the working country and the proportion of MSM in national male HIV epidemics. It is important to note that practices and activities presented here are not representative of the corresponding countries or region, but they give a first insight into the current situation in Europe.

All the results presented in this chapter are stratified by age, gender, sexual identity, peer role, employment status, years as CHW and the type of organisation worked for (hereafter referred to as 'main stratification variables'). The 'country grouping variables' were also used to stratify all the data of this chapter, namely: the level of LGBTI inequality of the working country (and data disaggregated by country for the 'low' category), the rate of new HIV diagnoses attributed to sex between men in 2016 and, for the section on screening and testing activities only, the regulation of CBVCT for non-medical staff.

³² 90-90-90 - An ambitious treatment target to help end the AIDS epidemic (http://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf, accessed on 6 May 2019).

4.1. The role of CHWs in the continuum of HIV/STI services and retention cascade

Figure 4-1 presents the continuum of care steps that ECHOES respondents were involved in, from prevention to access to treatment and care activities. As expected, almost all respondents reported being involved in prevention activities³³ (88.8%), more than half in counselling and testing activities (62.8%), 44.4% in activities related to linkage to care and 50.4% in activities related to treatment and care. Overall, one in four respondents (25.7%) reported taking part in only one step of the service continuum (81.9% of those engaged in prevention activities). One in five reported working in two steps of the service continuum (20.4%), 22.9% in three and 31.0% in the four steps of the continuum.

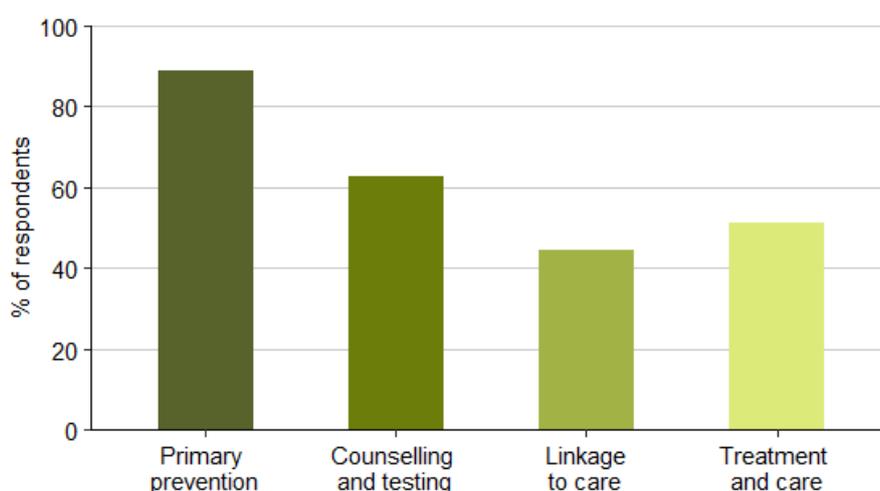


Figure 4-1: CHW activities according to the continuum of care of HIV/STI services (N=1,035, multiple answer)

Many differences were observed when stratifying each step of the cascade by main stratification and country grouping variables (Table 3-1). Women more frequently reported activities related to counselling and testing (67.1% vs. 61.9% in men and 47.5% in 'other/prefer not to say') and activities relating to treatment and care (57.2% vs. 49.2% in men and 45.0% 'other/prefer not to say'). Similarly, non-peer respondents (mostly women) reported more frequently performing testing and counselling (66.8% vs. 60.0% in non-peer respondents) and treatment and care activities (59.9% vs. 47.5% in non-peer respondents).

When looking at the steps of the continuum stratified by employment status, a higher proportion of paid respondents were involved in counselling and testing (69.0%), linkage to care (51.8%) and treatment and care activities (58.4%) compared with volunteer respondents (49.2%, 28.1% and 35.3%, respectively). Respondents working or volunteering as CHW for less than 5 years reported less involvement in linkage to care (41.2% vs. 50.0% in those with 5-10 years of experience and 47.7% in those with more than 10 years of experience) and

³³ In the ECHOES questionnaire, Prevention activities were defined as 'activity that might include but is not limited to, condoms, safe sex practices, vaccinations, PrEP, PEP, substance use, mental health, etc.'

treatment or care (44.5% vs. 59.7% in those with 5-10 years of experience and 57.4% in those with more than 10 years of experience) activities.

Table 4-1: CHW activities according to the continuum of HIV/STI services by the main stratification and country grouping variables* (N=1,035)

| | Prevention | Counselling and testing | Linkage to care | Treatment and Care |
|--|------------|-------------------------|-----------------|--------------------|
| Age | | | | |
| 18-30 | 87.6 | 67.7 | 47.0 | 40.6 |
| 31-40 | 90.8 | 61.8 | 47.7 | 55.7 |
| 41 or older | 87.6 | 61.3 | 41.1 | 53.2 |
| <i>P-value</i> | 0.309 | 0.236 | 0.125 | 0.001 |
| Gender | | | | |
| Man | 89.0 | 61.9 | 43.4 | 49.2 |
| Woman | 87.7 | 67.1 | 48.3 | 57.2 |
| Other/prefer not say | 87.5 | 47.5 | 35.0 | 45.0 |
| <i>P-value</i> | 0.804 | 0.037 | 0.173 | 0.052 |
| Sexual identity | | | | |
| Homo /Bisexual | 89.4 | 60.2 | 42.3 | 47.1 |
| Heterosexual | 87.3 | 72.6 | 52.5 | 60.6 |
| Other ^a | 87.3 | 56.3 | 38.9 | 54.0 |
| <i>P-value</i> | 0.586 | 0.001 | 0.008 | 0.001 |
| Peer role | | | | |
| Peer | 89.1 | 60.0 | 42.6 | 47.5 |
| Non-peer | 87.9 | 66.8 | 47.2 | 56.9 |
| <i>P-value</i> | 0.565 | 0.026 | 0.145 | 0.003 |
| Employment status | | | | |
| Paid | 89.8 | 69.0 | 51.8 | 58.4 |
| Volunteer | 86.8 | 49.2 | 28.1 | 35.3 |
| <i>P-value</i> | 0.154 | <0.001 | <0.001 | <0.001 |
| Years as CHW | | | | |
| 0-5 years | 86.9 | 60.7 | 41.2 | 44.5 |
| 5-10 years | 92.0 | 65.1 | 50.0 | 59.7 |
| < 10 years | 89.6 | 66.8 | 47.7 | 57.4 |
| <i>P-value</i> | 0.109 | 0.195 | 0.047 | <0.001 |
| Type of organisation worked for^b | | | | |
| Private not-for-profit | 90.5 | 65.3 | 47.6 | 54.0 |
| Other ^c | 81.8 | 58.3 | 35.6 | 45.5 |
| <i>P-value</i> | 0.003 | 0.119 | 0.01 | 0.068 |
| LGBTI inequality level of the working country | | | | |
| Low inequality | 89.9 | 60.7 | 46.2 | 52.2 |
| High inequality | 84.3 | 69.5 | 39.0 | 48.6 |
| <i>P-value</i> | 0.015 | 0.012 | 0.045 | 0.326 |
| Low LGBTI inequality countries^d | | | | |
| Germany | 86.7 | 39.5 | 26.2 | 29.7 |
| Spain | 93.7 | 63.2 | 47.7 | 66.7 |
| UK | 91.5 | 70.2 | 59.6 | 53.2 |
| France | 96.4 | 92.8 | 77.1 | 80.7 |
| Other countries of low inequality ^e | 87.1 | 61.3 | 45.4 | 49.6 |
| <i>P-value</i> | 0.024 | <0.001 | <0.001 | <0.001 |
| New HIV diagnoses attributed to sex between men in 2016 | | | | |
| <3 per 100,000 men | 79.9 | 64.7 | 35.3 | 41.3 |
| 3 to 5 per 100,000 men | 89.1 | 59.8 | 41.6 | 45.0 |
| <5 per 100,000 men | 91.8 | 63.8 | 49.9 | 60.1 |
| <i>P-value</i> | <0.001 | 0.379 | 0.002 | <0.001 |
| CBVCT restriction in the working country | | | | |
| No | -- | 54.8 | -- | -- |
| Yes | -- | 45.2 | -- | -- |
| <i>P-value</i> | -- | <0.001 | -- | -- |

*Including CBVCT restriction for the step "counselling and testing". ^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dN=694. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

Respondents working or volunteering as CHW for private not-for-profit organisations reported more involvement in activities related to prevention and linkage to care (90.5% and 47.6%, respectively) than those working for other than not-for-profit organisations (81.8% and 35.6%, respectively) (Table 3-1).

Differences were observed when comparing by country grouping variables in each step of the service continuum. Prevention and linkage to care were less commonly reported by CHWs from countries with 'high LGBTI inequality' (84.3% and 39%) compared with those from countries with 'low LGBTI inequality' (89.9% and 46.2%). Conversely, counselling and testing activities were less commonly reported by respondents from countries with 'low LGBTI inequality' (60.7% vs. 69.5% in 'high LGBTI inequality' countries). This difference is probably due to the very low percentage of respondents from Germany reporting counselling and testing activities: 39.5% vs. 61.3% to 92.8% in other countries in the 'low LGBTI inequality' category. No significant difference was found between respondents from 'low LGBTI inequality' and 'high LGBTI inequality' countries regarding treatment and care activities, possible due to the low proportion of respondents from Germany who reported this activity (29.7%) compared to respondents in other countries with 'low LGBTI inequality' (from 49.6% to 80.7%). When looking at separate countries in the 'low LGBTI inequality' category, respondents from Spain, UK and France broadly reported more involvement in each step of the service continuum compared to CHWs from Germany or "other countries".

When comparing by rate of new HIV diagnoses in the male population attributable to sex between men in each step of the service continuum, significant differences were observed in prevention, linkage to care and treatment/ care activities. The higher the rate of MSM in national HIV epidemics, the more respondents were involved in those three steps (Table 3-1).

When comparing countries grouped by CBVCT restrictions, respondents from countries with restrictions less frequently reported activities relating to testing and counselling compared with those from countries without restrictions (54.8% vs. 45.2%, respectively).

4.2. Primary prevention activities

Among the 917 respondents reporting prevention-related activities, almost all (n=891, 97.2%) reported providing clients with information and more than half (n=565, 61.6%) reported carrying out interventions in prevention (Figure 4-2).

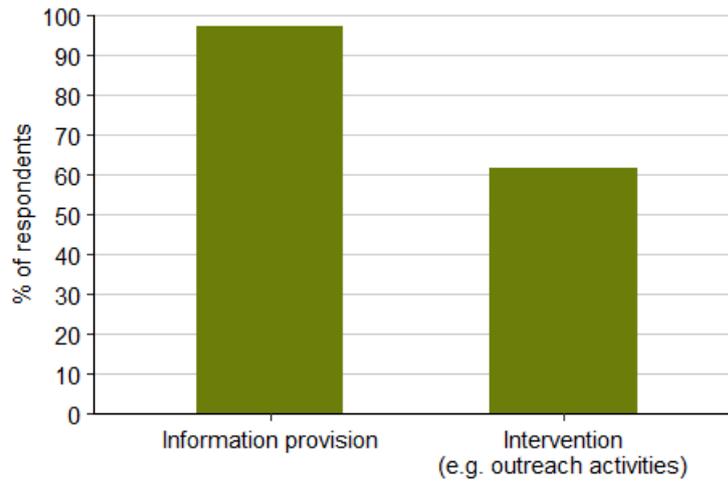


Figure 4-2: Prevention activities (N=917, multiple answer)

Table 4-2 presents these two activities (information provision and intervention) according to the main stratification and country grouping variables.

No differences were observed regarding the provision of information in prevention, this activity being highly reported elsewhere and in each stratifying category (all percentages >95.7%).

Paid respondents and those working for private not-for-profit organisation reported to be more involved in prevention interventions (68.3% and 63.2% respectively, statistically significant) compared to unpaid respondents and those working for organisations other than not-for-profits (45.8% and 52.8%, respectively).

While no differences were observed between respondents from 'low LGBTI inequality' and 'high LGBTI inequality' countries, respondents from Germany reported much less involvement in intervention activities (32.5%) compared to both respondents from other 'low LGBTI inequality' countries (from 66.0% to 91.3%) and respondents from 'high LGBTI inequality' countries (57.6%).

Interventions in prevention were more reported by respondents from countries with higher rates of new HIV diagnoses attributed to sex between men: 70.1% where the rate was >5 per 100,000 men; 53.0% where the rate was between 3 and 5 per 100,000 men and 60.5% where the rate was <3 per 100,000 men.

Table 4-2: Prevention activities by the main stratification and country grouping variables (N=917)

| | Information provision | Interventions in prevention |
|--|-----------------------|-----------------------------|
| Age | | |
| 18-30 | 99.5 | 65.8 |
| 31-40 | 96.3 | 68.4 |
| 41 or older | 96.7 | 55.1 |
| <i>P-value</i> | <i>0.092</i> | <i>0.001</i> |
| Gender | | |
| Man | 96.8 | 62.1 |
| Woman | 97.7 | 59.8 |
| Other/prefer not say | 100 | 65.7 |
| <i>P-value</i> | <i>0.463</i> | <i>0.708</i> |
| Sexual identity | | |
| Homosexual/Bisexual | 96.7 | 60.8 |
| Heterosexual | 98.2 | 63.3 |
| Other ^a | 97.3 | 62.7 |
| <i>P-value</i> | <i>0.513</i> | <i>0.778</i> |
| Peer role | | |
| Peer | 96.7 | 61.7 |
| Non-peer | 97.8 | 61.5 |
| <i>P-value</i> | <i>0.307</i> | <i>0.935</i> |
| Employment status | | |
| Paid | 96.9 | 68.3 |
| Volunteer | 97.8 | 45.8 |
| <i>P-value</i> | <i>0.433</i> | <i><0.001</i> |
| Years as CHW | | |
| 0-5 years | 97.1 | 58.6 |
| 5-10 years | 96.3 | 72.1 |
| > 10 years | 97.8 | 59.2 |
| <i>P-value</i> | <i>0.653</i> | <i>0.002</i> |
| Type of organisation worked for^b | | |
| Private not-for-profit | 97.4 | 63.2 |
| Other ^c | 98.1 | 52.8 |
| <i>P-value</i> | <i>0.628</i> | <i>0.036</i> |
| LGBTI inequality level of the working country | | |
| Low inequality | 97.6 | 62.8 |
| High inequality | 95.7 | 57.6 |
| <i>P-value</i> | <i>0.149</i> | <i>0.175</i> |
| Low LGBTI inequality countries^d | | |
| Germany | 97.0 | 32.5 |
| Spain | 96.9 | 63.8 |
| UK | 97.7 | 86.0 |
| France | 100 | 91.3 |
| Other countries of low inequality ^e | 97.6 | 66.0 |
| <i>P-value</i> | <i>0.645</i> | <i><0.001</i> |
| New HIV diagnoses attributed to sex between men in 2016 | | |
| <3 per 100,000 men | 96.6 | 60.5 |
| 3 to 5 per 100,000 men | 97.3 | 53.0 |
| >5 per 100,000 men | 97.3 | 70.1 |
| <i>P-value</i> | <i>0.901</i> | <i><0.001</i> |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=707. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

Information provision in prevention

Figure 4-3 presents the frequency with which 891 respondents provided the listed information to clients. Almost 100% of CHWs reported providing information on HIV, viral Hepatitis and other STI transmission (only 0.1% reported never having done so) and on safer sex practices (0.3% reported never having done so). Information about testing and the importance of knowing one's status was also an important element of their prevention activities (96% overall and 65.1% on a weekly or daily basis) as well as information about prevention including PrEP (88.9% overall and 51.4% on a weekly or daily basis). Mental health information provision, including counselling, was reported by almost half of respondents involved in prevention (47.3% did so on a weekly or daily basis). A large proportion (80.2%) had given information about chemsex but only 29.6% reported that chemsex information provision was part of their daily or weekly work. Almost half (46.5%) reported providing information about adherence to treatment on a weekly basis.

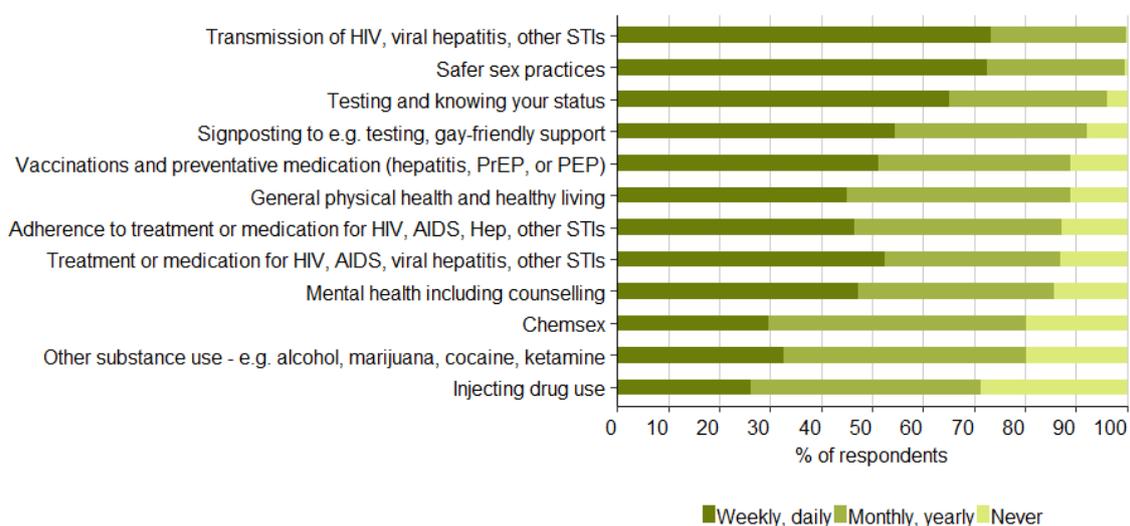


Figure 4-3: Type of information provided in prevention activities (N=891)

Interventions in prevention

Among the 565 respondents who engaged in prevention interventions, 98.2% provided sexual health support (70.8% on a daily or weekly basis, Figure 4-4). Mental health was also an important element of prevention interventions, with 79.3% reporting provision of mental health support to gay, bi and MSM users (43.7% on a daily or weekly basis). PrEP interventions (support use or access) was more commonly reported than substance use support, both overall (72.4% vs. 51.5%, respectively) and on a daily or weekly basis (31.6% vs. 23.5%, respectively).

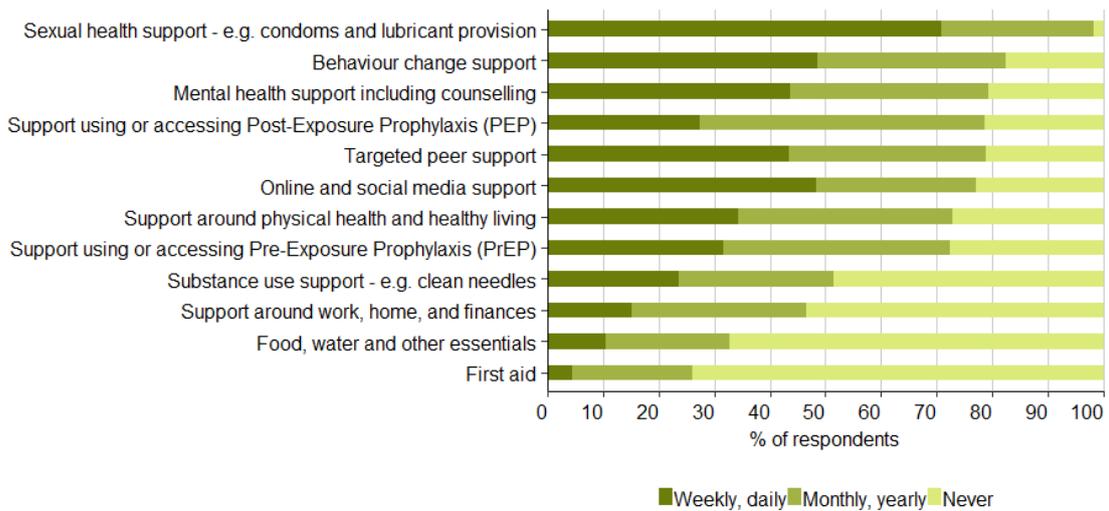


Figure 4-4: Specific intervention in prevention (N=565)

4.3. Counselling and testing activities

Among the 650 respondents who engaged in counselling and testing activities, 591 (90.9%) were involved in consultation and counselling of gay, bisexual and other MSM (consisting mainly of providing information about testing as well as performing pre- and post-test counselling) and 524 (80.6%) were involved in performing tests (Figure 4-5).

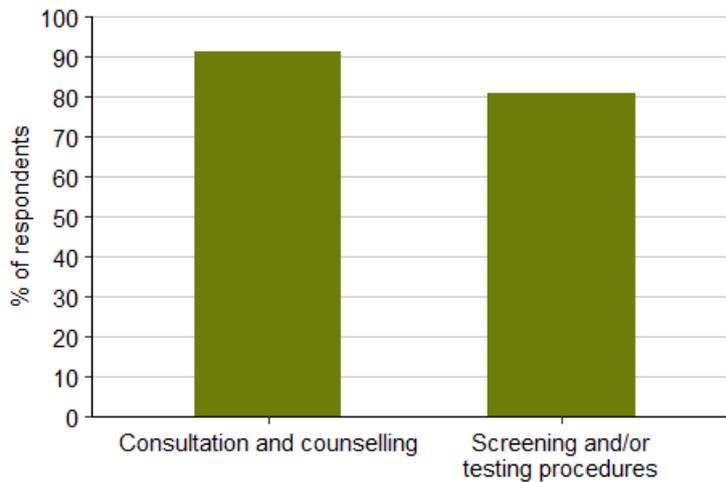


Figure 4-5: Screening and testing-related activities (N=650)

The proportion of CHWs performing screening and testing activities by the main stratification and country grouping variables are presented in table 4-3.

Table 4-3: Screening and testing-related activities by the main stratification and country grouping variables, and CBVCT restriction (N=650)

| | Consultation and counselling | Screening and/or testing procedures |
|--|------------------------------|-------------------------------------|
| Age | | |
| 18-30 | 89.1 | 81.6 |
| 31-40 | 93.6 | 82.2 |
| 41 or older | 90.0 | 79.1 |
| <i>P-value</i> | 0.276 | 0.646 |
| Gender | | |
| Man | 90.6 | 82.1 |
| Woman | 91.8 | 76.5 |
| Other/prefer not say | 89.5 | 89.5 |
| <i>P-value</i> | 0.856 | 0.162 |
| Sexual identity | | |
| Homosexual/Bisexual | 91.6 | 80.6 |
| Heterosexual | 88.8 | 79.3 |
| Other ^a | 93.0 | 84.5 |
| <i>P-value</i> | 0.461 | 0.634 |
| Peer role | | |
| Peer | 91.8 | 81.5 |
| Non-peer | 89.7 | 79.4 |
| <i>P-value</i> | 0.348 | 0.504 |
| Employment status | | |
| Paid | 91.9 | 82.4 |
| Volunteer | 87.8 | 75.0 |
| <i>P-value</i> | 0.124 | 0.043 |
| Years as CHW | | |
| 0-5 years | 89.0 | 80.5 |
| 5-10 years | 92.9 | 85.8 |
| > 10 years | 92.0 | 77.4 |
| <i>P-value</i> | 0.327 | 0.134 |
| Type of organisation worked for^b | | |
| Private not-for-profit | 92.2 | 80.7 |
| Other ^c | 84.4 | 79.2 |
| <i>P-value</i> | 0.025 | 0.766 |
| LGBTI inequality level of the working country | | |
| Low inequality | 90.1 | 83.0 |
| High inequality | 93.1 | 74.0 |
| <i>P-value</i> | 0.253 | 0.010 |
| Low LGBTI inequality countries^d | | |
| Germany | 92.2 | 58.4 |
| Spain | 94.5 | 87.3 |
| UK | 80.3 | 95.5 |
| France | 90.9 | 90.9 |
| Other countries of low inequality ^e | 89.8 | 83.0 |
| <i>P-value</i> | 0.040 | <0.001 |
| New HIV diagnoses attributed to sex between men in 2016 | | |
| <3 per 100,000 men | 92.4 | 77.3 |
| 3 to 5 per 100,000 men | 91.9 | 71.3 |
| >5 per 100,000 men | 88.3 | 89.5 |
| <i>P-value</i> | 0.279 | <0.001 |
| CBVCT restriction in the working country | | |
| No | 89.6 | 90.7 |
| Yes | 92.5 | 68.4 |
| <i>P-value</i> | 0.199 | <0.001 |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=477. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

Consultation and counselling activities differed according to the type of organisation worked for: respondents working for not-for-profit organisations engaged more in consultation and counselling activities (92.2%) than those working for other organisation types (84.4%). No difference was observed between respondents from 'low LGBTI inequality' and 'high LGBTI inequality' countries. However, respondents working in the UK reported this activity less frequently (80.3%) compared to those from the other 'low LGBTI inequality' countries (from 89.8% to 94.5%).

A higher proportion of paid respondents reported performing testing or screening than unpaid respondents (82.4% vs. 75.0%) and a higher proportion of those working in 'low LGBTI inequality' countries compared to 'high LGBTI inequality' countries (83.0% vs. 74.0%).

Respondents working in Germany reported less involvement in testing or screening activities (58.4%) compared to respondents working in other 'low LGBTI inequality' countries (from 83.0% to 95.5%). This may be due to the CBVCT restrictions still in place in Germany. As expected, respondents working in countries where CBVCT is restricted (i.e. where non-medical staff are not allowed to perform testing) reported less involvement in testing or screening than those from countries without such restriction (68.4% vs. 90.7%, respectively).

In ECHOES respondents, involvement in testing or screening also depended on the level of new HIV diagnoses attributed to sex between men in the national epidemics: 89.5% of those working in countries with a rate >5 per 100,000 men reported screening and testing activities, 71.3% in countries with a rate comprised of between 3 and 5 per 100,000 men and 77.3% in countries with a rate <3 per 100,000 men.

Type of testing/screening performed

A large majority of the 524 respondents who engaged in screening or testing activities performed HIV tests: 97.3% overall and 66.3% on a daily or weekly basis (Figure 4-6). Around two in three respondents reported performing Hepatitis B and/or C tests (66.5%) or tests for other STIs (64.5%); more than one in three respondents reported doing so on a daily or weekly basis (36.5% and 37.5%, respectively).

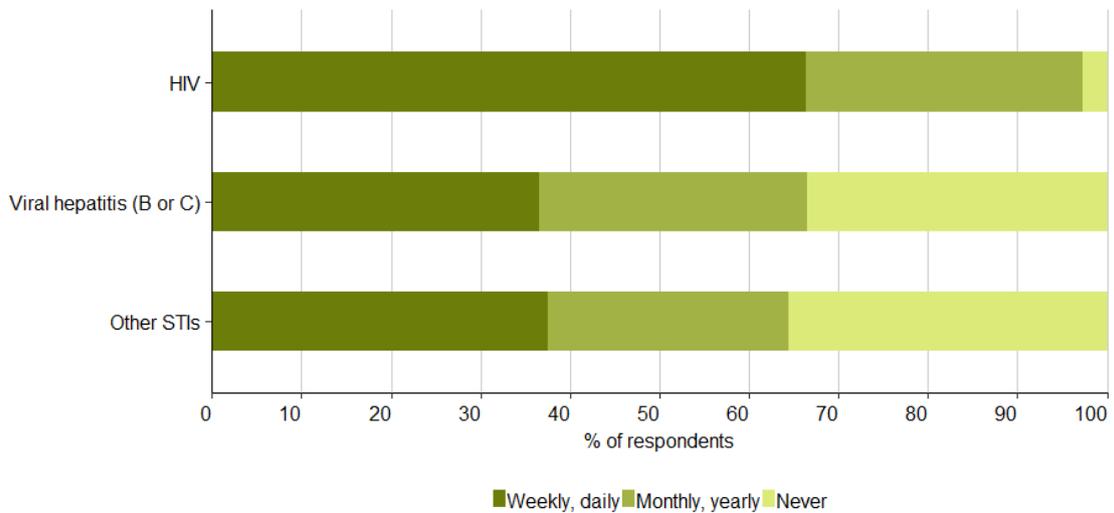


Figure 4-6: Type of screening and/or testing performed (N=524)

Types of samples and type of tests used for screening or testing

The 524 ECHOES respondents who performed screening and testing were also asked about the type of test they were using according to type of sample collected (Figure 4-7). Overall, blood samples were the most commonly used (only 11.9% never used them), followed by swab samples (45.9% never used them) and urine samples (57.4% never used them). With blood samples, the rapid test is the most commonly used (73.2%), while sending the sample to a lab was the most common way to test users when collecting swab (20.2%) or urine (16.8%) samples.

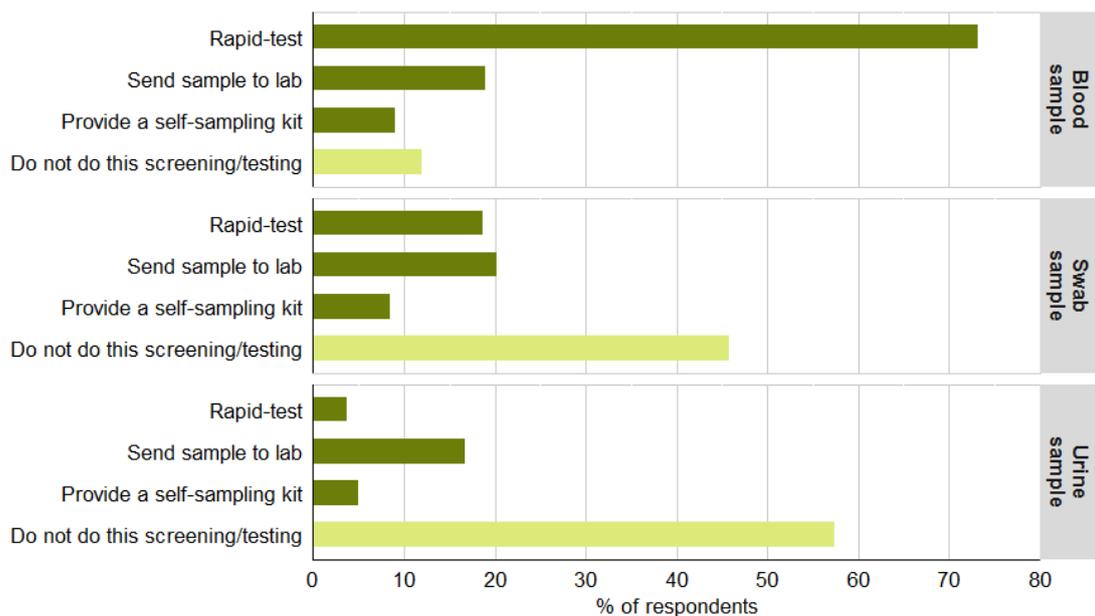


Figure 4-7: Type of tests according to the type of samples used to screen/test for HIV, viral hepatitis and other STIs (N=524)

4.4. Linkage to care

To design the steps of the service continuum presented at the beginning of this section (Figure 4-1), linkage to care was defined as referring or linking gay, bisexual and other MSM to hospital, clinic or other healthcare professionals for those CHWs involved in testing or screening activities (44.4% of the overall sample). Almost a third (29.1%) of the respondents also reported referrals to voluntary community-based health and social organisations and 11.6% to other services or support in relation to testing or screening activities (Figure 4-8).

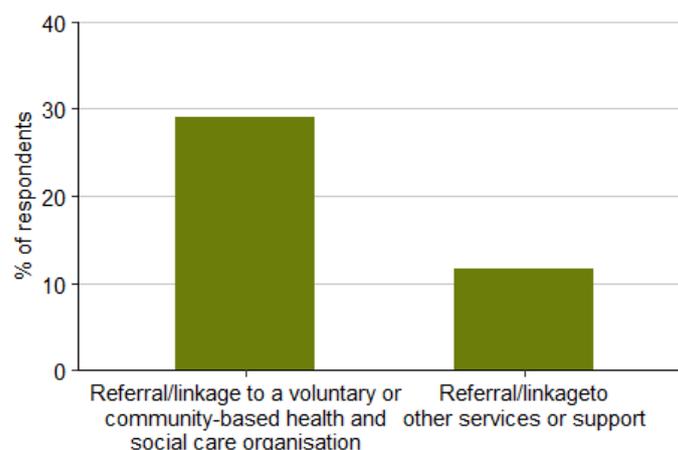


Figure 4-8: Other places where respondents refer users to for screening and testing purposes (N=1,035)

4.5. Activities related to treatment and support

Among the 531 respondents who reported activities related to treatment and support, 95.7% (**n=508**) reported they were providing information on these topics and 55.0% (**n=292**) reported involvement in interventions such as supporting adherence to treatment (Figure 4-9).

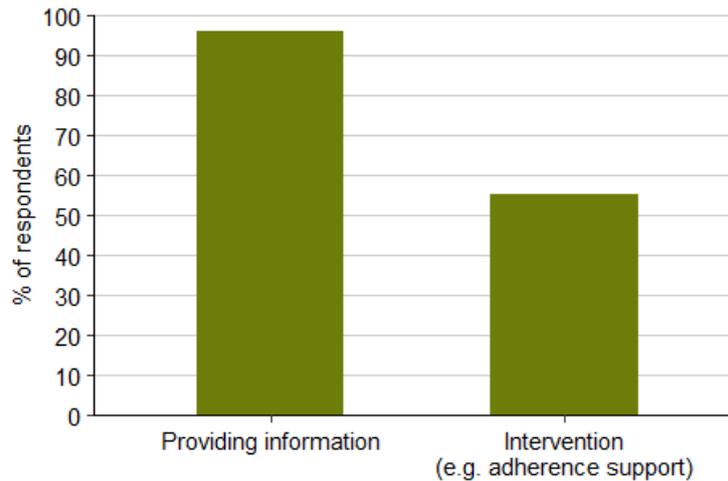


Figure 4-9: Treatment-related activities (N=531)

No differences were observed regarding information provision according to the main stratification and country grouping variables.

Involvement in interventions related to treatment and support was more frequent in paid CHWs (58.3%) than unpaid CHWs (42.7%; $p=0.004$, data not shown). There were also no differences when making comparisons according to the country grouping variables, except between countries within the 'low LGBTI inequality' category, where respondents working in Germany reported less involvement in treatment interventions (41.4%) compared to the other countries in the same category (from 49.3% to 59.7%, $p=0.036$, data not shown).

Providing information in treatment and support

Among the 508 respondents reporting providing information, the most commonly reported was information on HIV treatment (92.6%), followed by STI treatment (77.1%) and hepatitis treatment (68.9%, Figure 4-10). Providing counselling and mental health support related to treatment was also reported by 61.8% of respondents involved in treatment-related activities.

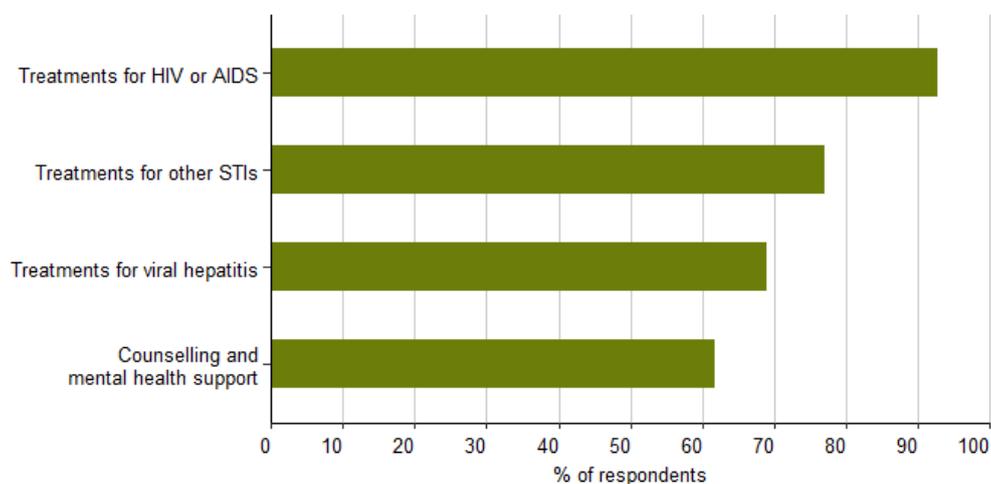


Figure 4-10: Information provision related to treatments and support (N=508, multiple answer)

A description of different types of information provided according to the main stratification and country grouping variables is provided in table 4-3.

Provision of information about viral hepatitis was more reported in paid respondents (72.2%) than in unpaid respondents (57.1%). The same difference was observed regarding information on treatment for other STIs, more reported in paid respondents (80.5%) than in unpaid respondents (64.8%).

Information about STI treatment was more reported in respondents from the 'low LGBTI inequality' countries (80.4% vs. 65.8% in 'high LGBTI inequality' countries) and in those from countries with a higher rate of new diagnoses in the male population attributable to sex between men (80.3% when the rate is between 3 and 5 per 100,000 men, 79.4% when the rate is >5 per 100,000 men and 65.8% when the rate is <3 per 100,000 men).

Providing counselling and mental health support related to treatments was less reported in respondents with less experience as CHW (55.0% in those with 0-5 years of experience vs. 64.2% of those with 5-10 years of experience and 68.9% of those with >10 years of experience) and less reported in volunteer CHWs (44.8% vs. 66.1% in paid CHWs).

Respondents working in the UK and in Germany were more involved in counselling and mental health support (81.6% and 78.6%, respectively, vs. between 50.0% and 66.7% in the other 'Low LGBTI inequality' countries).

Table 4-4: Type of information related to treatments provided by ECHOES respondents by the main stratification and country grouping variables (N=508)

| | Treatments for HIV or AIDS | Treatments for viral hepatitis | Treatments for other STIs | Counselling and mental health support |
|--|----------------------------|--------------------------------|---------------------------|---------------------------------------|
| Age | | | | |
| 18-30 | 94.0 | 73.5 | 84.3 | 50.6 |
| 31-40 | 94.2 | 66.5 | 75.7 | 66.5 |
| 41 or older | 91.1 | 69.1 | 75.6 | 62.2 |
| <i>P-value</i> | 0.416 | 0.523 | 0.228 | 0.049 |
| Gender | | | | |
| Man | 92.7 | 69.2 | 79.3 | 62.2 |
| Woman | 92.9 | 68.6 | 73.1 | 59.6 |
| Other or prefer not say | 88.9 | 66.7 | 72.2 | 72.2 |
| <i>P-value</i> | 0.821 | 0.969 | 0.28 | 0.559 |
| Sexual identity | | | | |
| Homo/bisexual | 93.2 | 68.8 | 81.7 | 64.4 |
| Heterosexual | 91.0 | 69.7 | 72.4 | 57.2 |
| Other ^a | 93.5 | 67.7 | 66.1 | 59.7 |
| <i>P-value</i> | 0.681 | 0.962 | 0.008 | 0.326 |
| Peer role | | | | |
| Peer | 93.2 | 69.2 | 81.0 | 63.4 |
| Non-peer | 91.9 | 68.6 | 72.2 | 59.6 |
| <i>P-value</i> | 0.591 | 0.892 | 0.02 | 0.384 |
| Employment status | | | | |
| Paid | 93.2 | 72.2 | 80.5 | 66.1 |
| Volunteer | 91.4 | 57.1 | 64.8 | 44.8 |
| <i>P-value</i> | 0.541 | 0.003 | 0.001 | <0.001 |
| Years as CHW | | | | |
| 0-5 years | 94.0 | 67.5 | 78.0 | 55.0 |
| 5-10 years | 92.0 | 67.9 | 78.1 | 64.2 |
| > 10 years | 91.3 | 71.4 | 75.2 | 68.9 |
| <i>P-value</i> | 0.594 | 0.695 | 0.773 | 0.021 |
| Type of organisation worked for^b | | | | |
| Private not-for-profit | 94.0 | 70.5 | 77.0 | 62.3 |
| Other ^c | 85.7 | 58.9 | 78.6 | 57.1 |
| <i>P-value</i> | 0.023 | 0.079 | 0.789 | 0.453 |
| LGBTI inequality level of the working country | | | | |
| Low inequality | 92.8 | 69.3 | 80.4 | 64.7 |
| High inequality | 92.1 | 67.5 | 65.8 | 51.8 |
| <i>P-value</i> | 0.807 | 0.717 | 0.001 | 0.012 |
| Low LGBTI inequality countries^d | | | | |
| Germany | 89.3 | 69.6 | 78.6 | 78.6 |
| Spain | 96.2 | 67.6 | 80.0 | 56.2 |
| UK | 89.8 | 63.3 | 81.6 | 81.6 |
| France | 100 | 95.3 | 85.9 | 50.0 |
| Other countries of low inequality ^e | 88.6 | 58.8 | 78.1 | 66.7 |
| <i>P-value</i> | 0.022 | <0.001 | 0.770 | <0.001 |
| New HIV diagnoses attributed to sex between men in 2016 | | | | |
| <3 per 100,000 men | 91.8 | 64.4 | 65.8 | 50.73 |
| 3 to 5 per 100,000 men | 93.8 | 77.5 | 80.3 | 62.9 |
| >5 per 100,000 men | 91.9 | 63.2 | 79.4 | 63.2 |
| <i>P-value</i> | 0.646 | 0.004 | 0.009 | 0.576 |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=393. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

Figure 4-11 presents the type of treatments respondents talked about with gay, bisexual and other MSM regarding HIV, viral Hepatitis and other STIs. Overall, 90.7% of CHWs provided information about the Hepatitis A and B vaccination. A high percentage of respondents provided information about Combination ARV therapy and antibiotic medications for STI treatment (81.6% and 76.1%, respectively).

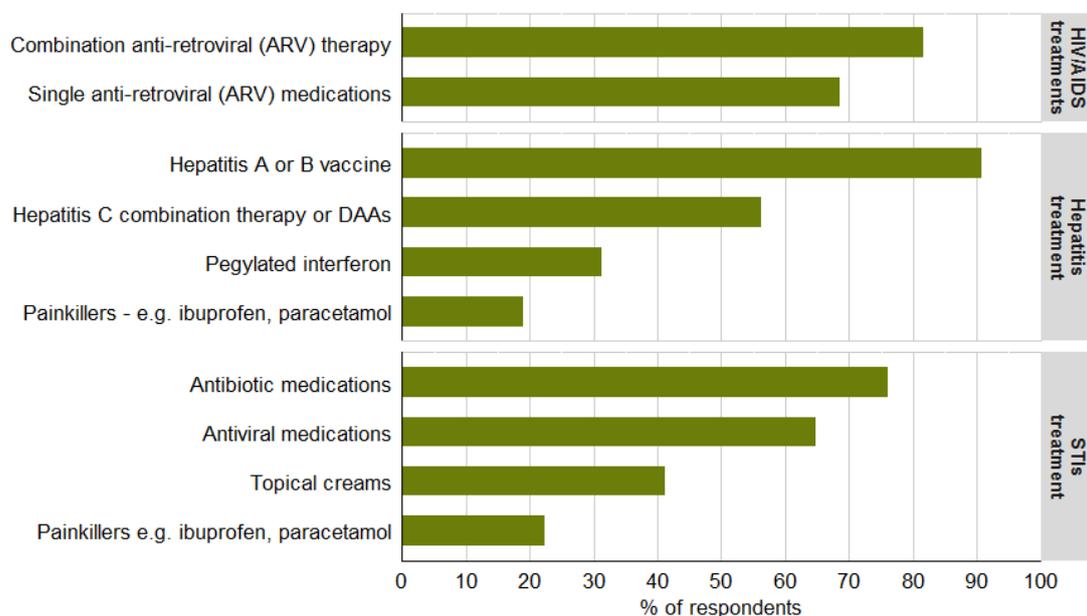


Figure 4-11: Type of information provided in relation to treatments and support (N=508, multiple answer)

Interventions in treatment and support

Among the 292 CHWs involved in treatment-related interventions, the most commonly reported was providing support to adhere to treatment (84.3%), followed by accompanying clients to get treatment (65.4%), assisting with sourcing and accessing treatment or medication (65.0%) and providing support with time planning for treatment (57.9%, Figure 4-12).

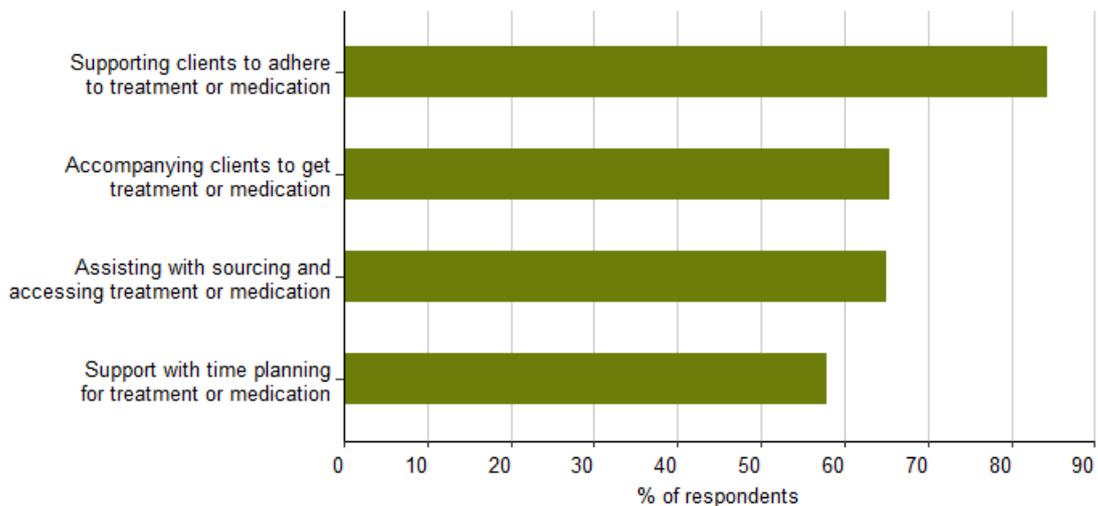


Figure 4-12: Interventions in treatment and support (N=292, multiple answer)

4.6. Synergies with other organisations and services

In the ECHOES questionnaire, respondents could also report where users were referred to, for purposes other than screening and/or testing for HIV, viral Hepatitis and other STIs. Among the 917 respondents involved in the prevention step of the service continuum (Figure 4-13), 631 (68.8%) reported offering referrals for prevention purposes and 402 (75.7%) respondents of the 531 involved in the treatment step of the service continuum reported offering referral for treatment purposes (Figure 4-13).

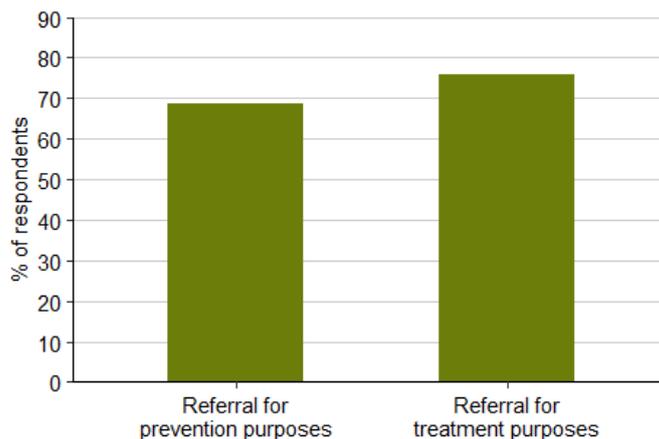


Figure 4-13: Referral of CHWs' users to other organisations (prevention: N=917; treatment: N=531)

Table 4-5 describes CHWs who offer referral for prevention and referral for treatment purposes according to the main stratification and country grouping variables.

Table 4-5: Referral activities for other than testing purposes by the main stratification and country grouping variables (prevention: N=917; treatment: N=531)

| | Referral for prevention purposes | Referral for treatment purposes |
|--|----------------------------------|---------------------------------|
| Age | | |
| 18-30 | 69.5 | 68.2 |
| 31-40 | 72.7 | 83.5 |
| 41 or older | 65.8 | 72.8 |
| <i>P-value</i> | <i>0.138</i> | <i>0.007</i> |
| Gender | | |
| Man | 68.7 | 71.7 |
| Woman | 69.9 | 83.2 |
| Other/prefer not say | 62.9 | 83.3 |
| <i>P-value</i> | <i>0.694</i> | <i>0.012</i> |
| Sexual identity | | |
| Homosexual/Bisexual | 68.3 | 72.2 |
| Heterosexual | 69.9 | 80.9 |
| Other ^a | 69.1 | 79.4 |
| <i>P-value</i> | <i>0.908</i> | <i>0.090</i> |
| Peer role | | |
| Peer | 69.2 | 71.5 |
| Non-peer | 68.2 | 80.8 |
| <i>P-value</i> | <i>0.739</i> | <i>0.012</i> |
| Employment status | | |
| Paid | 74.4 | 78.7 |
| Volunteer | 56.0 | 66.1 |
| <i>P-value</i> | <i><0.001</i> | <i>0.006</i> |
| Years as CHW | | |
| 0-5 years | 65.3 | 72.4 |
| 5-10 years | 74.4 | 73.9 |
| > 10 years | 71.9 | 81.9 |
| <i>P-value</i> | <i>0.035</i> | <i>0.080</i> |
| Type of organisation worked for^b | | |
| Private not-for-profit ^c | 70.6 | 78.6 |
| Other | 61.1 | 63.3 |
| <i>P-value</i> | <i>0.045</i> | <i>0.009</i> |
| LGBTI inequality level of the working country | | |
| Low inequality | 71.1 | 78.0 |
| High inequality | 61.0 | 67.8 |
| <i>P-value</i> | <i>0.005</i> | <i>0.021</i> |
| Low LGBTI inequality countries^d | | |
| Germany | 59.8 | 77.6 |
| Spain | 76.1 | 75.0 |
| UK | 81.4 | 86.0 |
| France | 88.8 | 83.6 |
| Other countries of low inequality ^e | 65.6 | 74.8 |
| <i>P-value</i> | <i><0.001</i> | <i>0.353</i> |
| New HIV diagnoses attributed to sex between men in 2016 | | |
| <3 per 100,000 men | 63.3 | 64.5 |
| 3 to 5 per 100,000 men | 66.3 | 77.4 |
| >5 per 100,000 men | 73.1 | 77.1 |
| <i>P-value</i> | <i>0.045</i> | <i>0.086</i> |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=707 (prevention) n=410 (treatment). ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

Referral of gay, bisexual and other MSM for prevention purposes was much more reported in paid respondents (74.4% vs. 56.0% in volunteer respondents), and in those having more experience as CHW (74.4% and 71.9% in those with 5-10 years and more than 10 years of experience, respectively, vs. 65.3% in those with up to 5 years of experience).

A higher proportion of CHWs working in 'low LGBTI inequality' countries (71.1%) reported offering referral for prevention purposes compared to those working in countries with 'high LGBTI inequality' (61.0%). Respondents from France reported more prevention referrals (88.8%) compared to other 'low LGBTI inequality' countries (from 59.8% to 81.4%). The higher the rate of new HIV diagnoses in the male population attributable to sex between men, the greater the proportion of respondents reporting prevention referral: 63.3% in countries with a rate <3 per 100,000 men, 66.3% with a rate of 3 to 5 per 100,000 men and 73.1% with a rate >5 per 100,000 men.

Referral for prevention purposes

Among the 631 respondents who reported offering referral for prevention purposes, the main places they referred gay, bisexual and other MSM to was the hospital, clinic or other health professionals (96.5% overall, 50.6% on a daily or weekly basis) and community-based health and social care services (93.3% overall, 42.5% on a daily or weekly basis, Figure 4-14). Referral for mental health support was also notable; overall 87.8% of CHWs offered it and 35.8% offered it on a daily or weekly basis. Referral for substance use support was offered by 66.8% of CHWs but only 17.5% reported this activity on a daily or weekly basis.

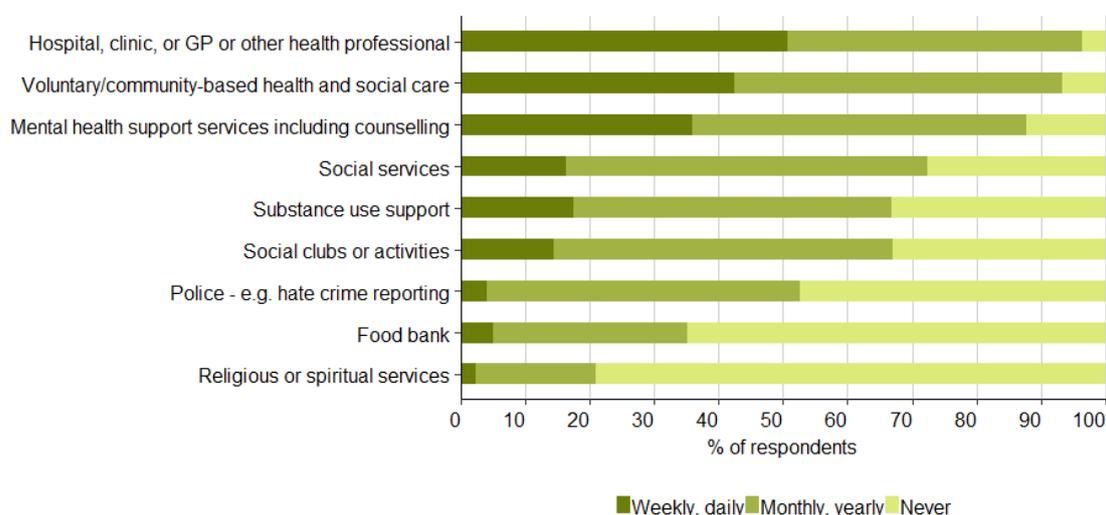


Figure 4-14: Place of referral for prevention purposes (N=631, multiple answer)

Referral for treatment purposes

Among the 402 respondents who reported offering referral for treatment purposes, the main places they referred people to were the hospital, clinic or other health

professionals (91.2%) and community-based and social care organisations (67%, Figure 4-15).

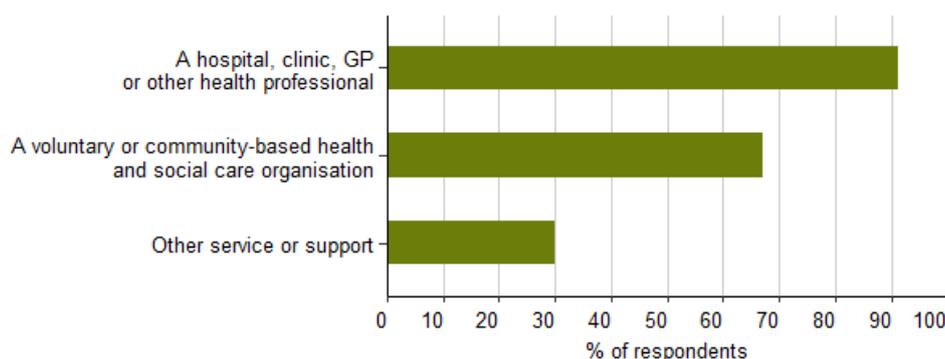


Figure 4-15: Place of referral for treatment and support purposes (N=402, multiple answer)

4.7. Cross-cutting activities

Cross-cutting activities refer to strategic and administrative activities which cross the service continuum and are not linked to one specific step, for example: advocacy, developing interventions, community needs assessments, fundraising, report writing, staff management. Overall, 46.3% of ECHOES respondents were involved in cross-cutting activities.

Table 4-6 presents percentages of respondents involved in cross-cutting activities according to the main stratification and country grouping variables. Overall, women (53.4%), non-peer (50.9%) and paid (58.1%) respondents and those working for private not-for-profit organisation (48.2%) were more involved in cross-cutting activities compared with their counterparts. Conversely, respondents aged 30 or less (38.2%), homo/bisexual respondents (42.8%), and respondents with 0 to 5 years of experience as CHW (35.8%) were less involved in cross-cutting activities compared with their counterparts.

No differences were observed between CHWs working in 'low LGBTI inequality' and those working in 'high LGBTI inequality' countries. However, respondents working in Germany reported less involvement in cross-cutting activities (29.7% vs. from 48.8% to 58.5% in other 'low LGBTI inequality' countries).

Cross-cutting activities were also more reported in countries with a rate of new HIV diagnoses in the male population attributable to sex between men of >5 per 100,000 men (53.6%, vs. 38.5% when the rate is comprised between 3 and 5 per 100,000 men and 45.1% when it is <3 per 100,000 men).

Table 4-6: Cross-cutting activities by the main stratification and country grouping variables (N=1,035)

| | Transversal activities | P-value |
|--|------------------------|---------|
| Age | | 0.018 |
| 18-30 | 38.2 | |
| 31-40 | 50.5 | |
| 41 or older | 47.0 | |
| Gender | | 0.014 |
| Man | 43.7 | |
| Woman | 53.4 | |
| Other or prefer not say | 40.0 | |
| Sexual identity | | 0.013 |
| Homo/bisexual | 42.8 | |
| Heterosexual | 52.1 | |
| Other ^a | 52.4 | |
| Peer role | | 0.012 |
| Peer | 43.1 | |
| Non-peer | 50.9 | |
| Employment status | | <0.001 |
| Paid | 58.1 | |
| Volunteer | 19.6 | |
| Years as CHW | | <0.001 |
| 0-5 years | 35.8 | |
| 5-10 years | 53.4 | |
| > 10 years | 59.7 | |
| Type of organisation worked for^b | | 0.007 |
| Private not-for-profit | 48.2 | |
| Other ^c | 35.6 | |
| LGBTI inequality level of the working country | | 0.074 |
| Low inequality | 47.8 | |
| High inequality | 41.4 | |
| Low LGBTI inequality countries^d | | <0.001 |
| Germany | 29.7 | |
| Spain | 56.3 | |
| UK | 58.5 | |
| France | 57.8 | |
| Other countries of low inequality ^e | 48.8 | |
| New HIV diagnoses attributed to sex between men in 2016 | | <0.001 |
| <3 per 100,000 men | 45.1 | |
| 3 to 5 per 100,000 men | 38.5 | |
| >5 per 100,000 men | 53.6 | |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=376. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

Figure 4-16 presents the complete list of cross-cutting activities performed by ECHOES respondents. The main ones were: Developing interventions, outreach and support activities (43.0%), monitoring, evaluation and reporting of organisation's activities (42.4%), advocacy and networking (41.8%) and engaging with research and/or community needs assessments (41.4%).

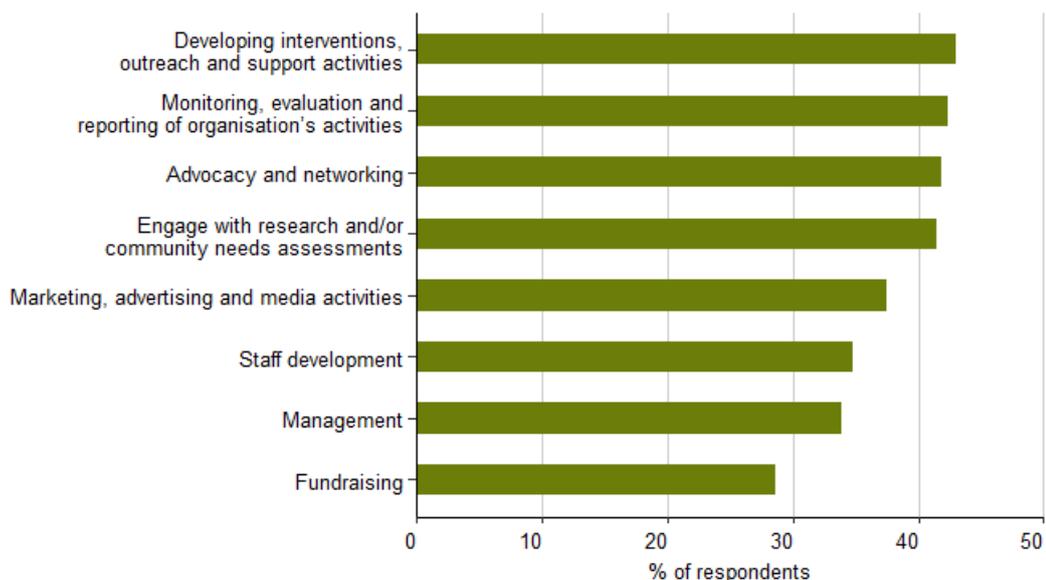


Figure 4-16: Specific transversal activities (N=1,035, multiple answer)

Differences highlighted in table 4-6 were still observed when checking each type of cross-cutting activity (see table 4-7). The following subgroups reported less involvement in cross-cutting activities: younger respondents (between 20.7% and 35.0% in those aged 18-30 vs. between 29.1% and 47.1% in 31-40 and between 32.0% and 44.6 in >41), volunteer respondents (from 12.3% to 17.7% vs. 36.1% to 54.5% in paid respondents) and those working for organisations other than private not-for-profits (between 13.6% and 31.8% vs. between 31.2% and 45.5% in those working for private not-for-profit organisations).

The more experienced a CHW reported to be, the more involved they were in all cross-cutting activities: between 17.9% and 32.0% of those with <5 years of CHW experience, between 37.0% and 50.8% of those with 5-10 years of experience and between 40.9% and 57.7% of those with >10 years of experience.

Cross-cutting activities were also more reported in respondents working in countries whose rate of new HIV diagnoses in the male population attributable to sex between men was higher (between 33.4% and 42.9% when the rate was >5 per 100,000 men vs. between 22.0% and 41.6% elsewhere).

The only difference between respondents from 'low LGBTI inequality' and 'high LGBTI inequality' countries was observed for 'developing intervention' which was more reported in CHWs in 'low LGBTI inequality' countries (44.9% vs. 36.9% in those from 'high LGBTI inequality' countries). However, respondents working in Germany reported less involvement in all specific transversal activities (between 19.0% and 28.2% vs. between 27.7% and 57.8% in other 'low LGBTI inequality' countries). It can also be noted that, while 'fundraising' was the least reported transversal activity overall (28.7%, figure 4-16), the proportion of respondents from the UK involved in this activity was higher (41.5%) than those working in other 'low LGBTI inequality' countries (between 20.0% and 36.2% vs. 26.1% for those working in 'high LGBTI inequality' countries).

Table 4-7: Specific cross-cutting activities by main stratification and country grouping variables (N=1,035)*

| | Developing interventions | Monitoring, evaluation and reporting | Advocacy and networking | Research, community needs assessment | Marketing, advertising and media | Staff development | Management | Fundraising |
|--|--------------------------|--------------------------------------|-------------------------|--------------------------------------|----------------------------------|-------------------|------------------|------------------|
| Age | | | | | | | | |
| 18-30 | 34.1 | 35.0 | 32.3 | 33.2 | 28.6 | 24.9 | 24.0 | 20.7 |
| 31-40 | 46.5 | 44.6 | 45.0 | 47.1 | 38.2 | 37.9 | 36.1 | 29.1 |
| 41 or older | 44.6 | 44.2 | 44.0 | 41.3 | 40.9 | 37.1 | 36.9 | 32.0 |
| <i>P-value</i> | <i>0.01</i> | <i>0.046</i> | <i>0.005</i> | <i>0.005</i> | <i>0.007</i> | <i>0.003</i> | <i>0.002</i> | <i>0.009</i> |
| Gender | | | | | | | | |
| Man | 40.8 | 40.5 | 40.5 | 40.3 | 36.8 | 32.4 | 32.3 | 27.2 |
| Woman | 48.6 | 47.9 | 45.5 | 44.5 | 39.4 | 40.8 | 39.0 | 32.5 |
| Other/prefer not say | 40.0 | 35.0 | 37.5 | 40.0 | 35.0 | 32.5 | 25.0 | 27.5 |
| <i>P-value</i> | <i>0.071</i> | <i>0.062</i> | <i>0.294</i> | <i>0.453</i> | <i>0.712</i> | <i>0.041</i> | <i>0.059</i> | <i>0.231</i> |
| Sexual identity | | | | | | | | |
| Homosexual/Bisexual | 40.0 | 40.0 | 39.2 | 39.4 | 37.1 | 32.0 | 32.0 | 27.1 |
| Heterosexual | 47.5 | 45.9 | 45.6 | 43.2 | 36.7 | 37.8 | 37.8 | 31.7 |
| Other ^a | 49.2 | 47.6 | 47.6 | 48.4 | 41.3 | 42.9 | 35.7 | 31.0 |
| <i>P-value</i> | <i>0.039</i> | <i>0.118</i> | <i>0.081</i> | <i>0.135</i> | <i>0.641</i> | <i>0.032</i> | <i>0.22</i> | <i>0.323</i> |
| Peer role | | | | | | | | |
| Peer | 40.5 | 40.5 | 40.3 | 40.0 | 37.5 | 32.3 | 32.3 | 27.6 |
| Non-peer | 46.7 | 45.3 | 44.1 | 43.6 | 37.4 | 38.4 | 36.3 | 30.3 |
| <i>P-value</i> | <i>0.047</i> | <i>0.124</i> | <i>0.225</i> | <i>0.243</i> | <i>0.979</i> | <i>0.043</i> | <i>0.186</i> | <i>0.334</i> |
| Employment status | | | | | | | | |
| Paid | 54.5 | 53.9 | 52.5 | 52.5 | 46.8 | 44.5 | 43.1 | 36.1 |
| Volunteer | 17.0 | 16.7 | 17.7 | 16.4 | 16.4 | 13.2 | 13.6 | 12.3 |
| <i>P-value</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> |
| Years as CHW | | | | | | | | |
| 0-5 years | 32.0 | 31.0 | 30.1 | 32.0 | 25.8 | 23.3 | 22.9 | 17.9 |
| 5-10 years | 49.2 | 50.0 | 50.8 | 47.5 | 47.1 | 43.3 | 39.5 | 37.0 |
| > 10 years | 57.7 | 56.7 | 55.4 | 53.7 | 50.3 | 48.0 | 48.7 | 40.9 |
| <i>P-value</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> |
| Type of organisation worked for^b | | | | | | | | |
| Private not-for-profit ^c | 45.5 | 44.5 | 43.9 | 43.5 | 39.6 | 37.1 | 36.0 | 31.2 |
| Other | 30.3 | 31.1 | 31.8 | 29.5 | 27.3 | 20.5 | 22.0 | 13.6 |
| <i>P-value</i> | <i>0.001</i> | <i>0.004</i> | <i>0.009</i> | <i>0.002</i> | <i>0.007</i> | <i><0.001</i> | <i>0.002</i> | <i><0.001</i> |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type.

Table 4-7 (continued): Specific cross-cutting activities by main stratification and country grouping variables (N=1,035)*

| | Developing interventions | Monitoring, evaluation and reporting | Advocacy and networking | Research, community needs assessment | Marketing, advertising and media | Staff development | Management | Fundraising |
|--|--------------------------|--------------------------------------|-------------------------|--------------------------------------|----------------------------------|-------------------|------------------|--------------|
| LGBTI inequality level of the working country | | | | | | | | |
| Low inequality | 44.9 | 43.6 | 43.4 | 42.5 | 39.1 | 35.6 | 34.4 | 29.5 |
| High inequality | 36.9 | 38.6 | 36.9 | 38.2 | 32.5 | 32.1 | 32.5 | 26.1 |
| <i>P-value</i> | <i>0.027</i> | <i>0.157</i> | <i>0.073</i> | <i>0.226</i> | <i>0.064</i> | <i>0.313</i> | <i>0.597</i> | <i>0.300</i> |
| Low LGBTI inequality countries^d | | | | | | | | |
| Germany | 27.7 | 26.7 | 28.2 | 25.6 | 27.2 | 19.0 | 22.6 | 20.0 |
| Spain | 50.0 | 52.3 | 43.7 | 45.4 | 40.2 | 50.6 | 46.6 | 36.2 |
| UK | 57.4 | 56.4 | 56.4 | 55.3 | 55.3 | 46.8 | 42.6 | 41.5 |
| France | 57.8 | 49.4 | 54.2 | 54.2 | 39.8 | 33.7 | 32.5 | 27.7 |
| Other countries of low inequality ^e | 45.8 | 44.2 | 46.7 | 45.0 | 41.3 | 34.6 | 32.5 | 28.3 |
| <i>P-value</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i>0.001</i> |
| New HIV diagnoses attributed to sex between men in 2016 | | | | | | | | |
| <3 per 100,000 men | 41.9 | 42.9 | 40.8 | 41.9 | 35.3 | 33.2 | 34.8 | 30.4 |
| 3 to 5 per 100,000 men | 35.8 | 33.9 | 36.1 | 34.9 | 32.0 | 24.9 | 25.9 | 22.0 |
| >5 per 100,000 men | 49.6 | 49.6 | 46.6 | 46.4 | 42.4 | 44.1 | 40.2 | 33.4 |
| <i>P-value</i> | <i><0.001</i> | <i><0.001</i> | <i>0.009</i> | <i>0.004</i> | <i>0.008</i> | <i><0.001</i> | <i><0.001</i> | <i>0.001</i> |

^dn=320. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

4.8. Description of CHW job titles according to reported activities

Table 4-8 shows the significant differences observed when comparing activities related to the cascade or cross-cutting activities by job titles provided by respondents (full data presented in Table 13-4, Annex 13.3).

Compared to their counterparts, a larger proportion of respondents classified in 'community worker', 'outreach' and 'sexual health' reported being involved in prevention activities while respondents in 'non-specified work' reported less engagement in prevention activities.

A larger proportion of respondents classified in 'health care professional', 'testing worker', 'sexual health', 'health worker' and 'counsellor' reported counselling and testing activities compared with their counterparts, while those with job title 'psycho-social', 'educator' and 'volunteer' reported less counselling and testing activities.

Linkage-to-care activities were reported significantly more in respondents classified in 'community worker' and 'sexual health' and less reported in 'volunteer'.

Respondents in 'community worker', 'health care professional', 'peer' and 'psycho-social' reported more treatment and support activities compared with their counterparts. 'Prevention worker' and 'volunteer' were the two categories least likely to report treatment and support activities.

Cross-cutting activities were significantly more reported in 'health worker' and less reported by 'volunteer', compared with their counterparts.

Table 4-8: Job titles by type of activity

| Job title (vs. those not reporting this job title) | Prevention | Testing and counselling | Linkage to care | Treatment and support | Cross-cutting activities |
|--|------------|-------------------------|-----------------|-----------------------|--------------------------|
| Activist | | | | | |
| Community worker | + | | + | + | |
| Counsellor | | + | | | |
| Educator | | - | | | |
| Health care professional | | + | | + | |
| Health worker | | + | | | + |
| Non specified work | - | | | | |
| Outreach | + | | | | |
| Peer | | | | + | |
| Prevention worker | | | | - | |
| Psycho-social | | - | | + | |
| Sexual health | + | + | + | | |
| Testing worker | | + | | | |
| Volunteer | | - | - | - | - |

The "+" and the "-" show the significant differences ($p < 0.05$) between the subgroup mentioned here (e.g. 'activist') and its respective counterpart ('non-activist'). E.g. treatment and support activities are significantly more reported among peer respondents compared to non-peer respondents. All percentages and p-values are presented in Table 14-4, Annex 13.3.

5. Barriers and facilitators to service provision

Chapter 4 showed that CHW practices and activities varied significantly when splitting by sociodemographic or personal characteristics and when grouping respondents according to structural characteristics such as the level of LGBTI inequality or the rate of new HIV diagnoses in the male population attributable to sex between men in the country they worked in.

The ECHOES respondents were asked about the main barriers which hinder their activities as CHW. Each option was available at the following levels: 'for you as an individual', 'from your organisation', 'from local communities' and 'from wider society' (presented in the first part of this chapter). Responses are based on ECHOES respondents' perceptions, and they may not have all the information especially regarding organisational and structural barriers. This should be kept in mind while interpreting the results presented here in order to avoid making strong conclusions regarding barriers faced in a given country. This section can be considered as a proxy of the barriers/facilitators in the work of CHWs, but it should be complemented with country or region-level studies in order to have a broader vision of this multidimensional issue.

In the second part of this chapter, the individual factors that may influence CHWs activities are presented. They are based on respondents' perceptions about their health status and well-being, as well as their level of self-efficacy. The satisfaction with their work as CHWs and their perception of MSM users' confidence in both CHWs and the organisation are presented at the end of this chapter.

Similarly to chapter 4, all data in the first part of this chapter (section 5.1) are presented by the main stratification variables (age, gender, sexual identity, peer role, employment status, years as CHW and the type of organisation worked for) and country grouping variables (level of LGBTI inequality of the working country, country-level comparisons for respondents working in 'low LGBTI inequality' countries and the rate of new HIV diagnoses attributed to sex between men at national level in 2016). In the second part of this chapter (section 5.2), data are stratified by the main stratification variables, plus the perception of the respondent's income. Comparisons were made by self-reported HIV status and episodes of injecting or non-injecting drug use, but no significant difference was observed and so the variables are not presented here.

Data presented in tables are stratified by all corresponding variables, but graphs only show those where significant differences were found.

5.1. Individual, community and structural barriers faced by CHWs

Barriers identified by CHWs at individual level

Figure 5-1 presents barriers at the individual level that may have hindered respondents' activities as CHWs. Lack of time was the barrier most commonly reported at the individual level (38.0%), followed by the time of work/volunteering (long or difficult hours, 27.0%), and having a low salary or none at all (24.4%).

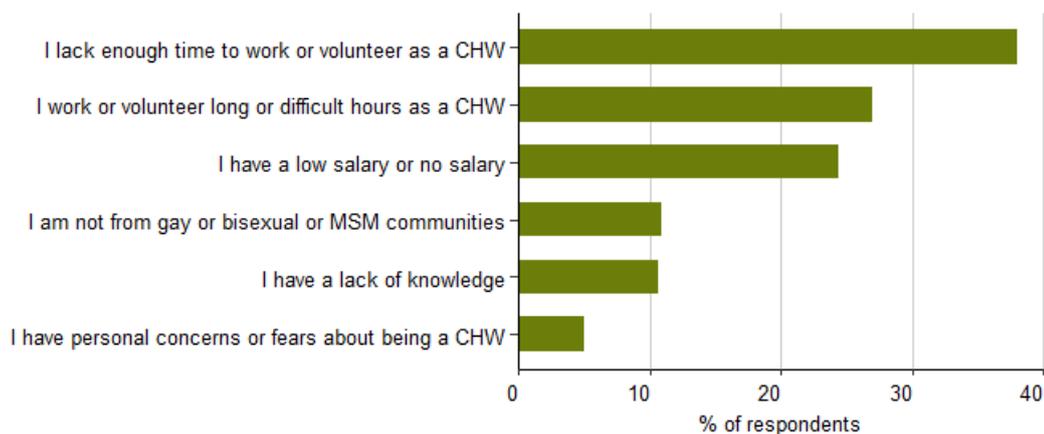


Figure 5-1: Barriers identified by ECHOES respondents at individual level (N=1,035, multiple answer)

Table 5-1 presents the individual barriers by main stratification and country grouping variables. The first three barriers (lack of time, long or difficult hours, low or no salary) were significantly more reported by peer respondents (42.4%, 32.7% and 29.1%, respectively) and less reported by women (31.7%, 16.9% and 16.6%, respectively). Having long or difficult hours as CHW and low or no salary were more reported by those working or volunteering for private not-for-profit organisations (29.4% and 26.2%, respectively). 'Low or no salary' was less reported by those with more than 10 years of experience as CHWs (18.5%). Respondents from the 'low LGBTI inequality' countries more often reported 'long or difficult hours' (28.7%) while those from the 'high LGBTI inequality' countries more often reported 'low or no salary'. Strong differences were also observed when looking at countries in the 'low LGBTI inequality' category, with respondents from France being those who most often reported the first three barriers (63.9%, 51.8% and 32.5%, respectively).

Not being from gay or bisexual or MSM communities as a barrier was most often reported by women (27.9%), heterosexuals (33.7%), non-peer (26.6%) and paid (12.9%) respondents.

Having a lack of knowledge and personal concerns or fear about being a CHW were less reported in older respondents (7.6% and 2.5%, respectively) as well as in those having more than 10 years of CHW experience (5.4% and 3.0%, respectively). 'Personal concerns' was more often reported by peer respondents (6.1%).

Table 5-1: Individual barriers by main stratification and country grouping variables (N=1,035)*

| | Lack of time | Long or difficult hours | Low or no salary | Not from gay, bi or MSM communities | Lack of knowledge | Personal concerns about being a CHW |
|--|------------------|-------------------------|------------------|-------------------------------------|-------------------|-------------------------------------|
| Age | | | | | | |
| 18-30 | 45.9 | 28.2 | 27.8 | 9.6 | 15.3 | 8.1 |
| 31-40 | 39.9 | 34.1 | 30.3 | 11.5 | 12.4 | 6.8 |
| 41 or older | 33.4 | 21.7 | 19.1 | 11.1 | 7.6 | 2.5 |
| <i>P-value</i> | <i>0.005</i> | <i><0.001</i> | <i>0.001</i> | <i>0.780</i> | <i>0.005</i> | <i>0.001</i> |
| Gender | | | | | | |
| Man | 40.9 | 31.1 | 27.7 | 3.6 | 9.7 | 5.5 |
| Woman | 31.7 | 16.9 | 16.6 | 27.9 | 11.4 | 2.8 |
| Other or prefer not say | 34.2 | 28.9 | 23.7 | 13.2 | 23.7 | 13.2 |
| <i>P-value</i> | <i>0.023</i> | <i><0.001</i> | <i>0.001</i> | <i><0.001</i> | <i>0.022</i> | <i>0.013</i> |
| Sexual identity | | | | | | |
| Homo/bisexual | 42.6 | 31.7 | 28.7 | 0.8 | 10.0 | 6.0 |
| Heterosexual | 26.4 | 14.7 | 15.1 | 33.7 | 8.1 | 1.6 |
| Other ^a | 38.7 | 28.2 | 21.8 | 15.3 | 19.4 | 7.3 |
| <i>P-value</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i>0.003</i> | <i>0.011</i> |
| Peer role | | | | | | |
| Peer | 42.4 | 32.7 | 29.1 | 0 | 9.6 | 6.1 |
| Non-peer | 31.8 | 18.7 | 17.7 | 26.6 | 12.2 | 3.3 |
| <i>P-value</i> | <i>0.001</i> | <i><0.001</i> | <i><0.001</i> | <i><0.001</i> | <i>0.192</i> | <i>0.044</i> |
| Employment status | | | | | | |
| Paid | 34.6 | 28.3 | 22.4 | 12.9 | 10.6 | 5.5 |
| Volunteer | 45.7 | 24.0 | 28.8 | 6.4 | 10.9 | 3.8 |
| <i>P-value</i> | <i>0.001</i> | <i>0.147</i> | <i>0.029</i> | <i>0.002</i> | <i>0.909</i> | <i>0.254</i> |
| Years as CHW | | | | | | |
| 0-5 years | 41.2 | 27.4 | 27.0 | 8.6 | 15.5 | 7.3 |
| 5-10 years | 38.0 | 29.5 | 27.0 | 12.7 | 7.6 | 2.5 |
| > 10 years | 33.0 | 24.6 | 18.5 | 12.5 | 5.4 | 3.0 |
| <i>P-value</i> | <i>0.073</i> | <i>0.429</i> | <i>0.017</i> | <i>0.124</i> | <i><0.001</i> | <i>0.004</i> |
| Type of organisation worked for^b | | | | | | |
| Private not-for-profit | 38.9 | 29.4 | 26.2 | 10.8 | 10.6 | 4.8 |
| Other ^c | 30.2 | 14.0 | 14.7 | 12.4 | 9.3 | 3.9 |
| <i>P-value</i> | <i>0.059</i> | <i><0.001</i> | <i>0.005</i> | <i>0.589</i> | <i>0.662</i> | <i>0.643</i> |
| LGBTI inequality level of the working country | | | | | | |
| Low inequality | 38.5 | 28.7 | 21.3 | 10.6 | 10.1 | 4.4 |
| High inequality | 36.6 | 21.5 | 34.1 | 11.8 | 12.6 | 6.9 |
| <i>P-value</i> | <i>0.590</i> | <i>0.028</i> | <i><0.001</i> | <i>0.600</i> | <i>0.264</i> | <i>0.114</i> |
| Low LGBTI inequality countries^d | | | | | | |
| Germany | 31.8 | 25.0 | 27.6 | 6.3 | 6.3 | 5.7 |
| Spain | 37.9 | 26.4 | 14.9 | 13.8 | 12.1 | 3.4 |
| UK | 35.5 | 25.8 | 17.2 | 3.2 | 9.7 | 3.2 |
| France | 63.9 | 51.8 | 32.5 | 9.6 | 10.8 | 2.4 |
| Other countries of low inequality ^e | 36.6 | 26.3 | 18.5 | 15.1 | 11.6 | 5.2 |
| <i>P-value</i> | <i><0.001</i> | <i><0.001</i> | <i>0.002</i> | <i>0.003</i> | <i>0.336</i> | <i>0.627</i> |
| New HIV diagnoses attributed to sex between men in 2016 | | | | | | |
| <3 per 100,000 | 39.4 | 18.3 | 24.4 | 15.6 | 10.0 | 5.6 |
| 3 to 5 per 100,000 | 40.1 | 27.8 | 24.8 | 9.3 | 8.1 | 4.2 |
| >5 per 100,000 | 36.6 | 28.8 | 19.7 | 10.6 | 12.4 | 4.3 |
| <i>P-value</i> | <i>0.585</i> | <i>0.023</i> | <i>0.184</i> | <i>0.081</i> | <i>0.135</i> | <i>0.738</i> |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=786. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

Barriers identified by CHWs at organisational level

Among the barriers that may hinder CHW activities at organisational level, the most reported ones were: economic resources (61.7%), staff resources (25.0%) and space or venues resources (21.2%, Figure 5-2).

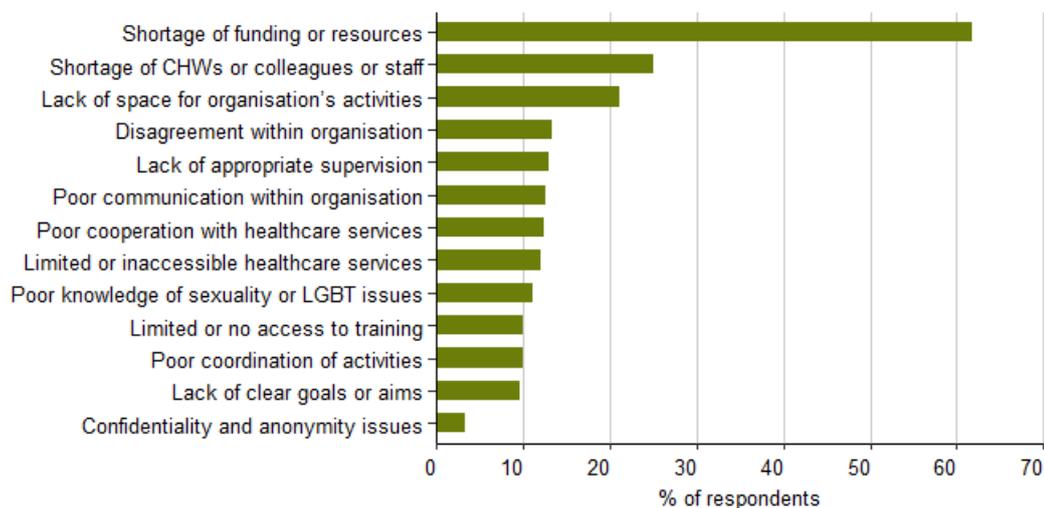


Figure 5-2: Barriers identified by ECHOES respondents at organisational level (N=1,035, multiple answer)

Many differences were observed when comparing by main stratification and country grouping variables (Table 5-2).

Shortage of funding or resources was reported significantly more in respondents working for private not-for-profit organisations (63.6%) while shortage of staff was reported more in those working in 'high LGBTI inequality' countries (31.4%). In respondents from the 'low LGBTI inequality' countries, those from UK more often reported shortage of funding (73.1%) while those from Spain and France more often reported shortage of colleagues or staff (28.9% and 32.5%, respectively).

Paid respondents more often reported "internal" barriers at organisational level: disagreement within the organisation (14.9%), poor communication within the organisation (15.6%) and lack of clear goals or aims (11.5%).

Barriers more commonly reported by respondents from 'high LGBTI inequality' countries regarded the link between their organisation and external services, or the limitations of external services: poor cooperation with healthcare services (19.2%), limited or no access to healthcare services (18.8%) and poor knowledge of sexuality and LGBTI issues in healthcare services (15.5%).

Limited or no access to training was more often reported by respondents from 'high LGBTI inequality' countries (16.3%) but also by respondents from the UK (14.0%) and respondents from 'other countries' in the 'low LGBTI inequality' category (13.2%).

Table 5-2: Organisation level barriers by main stratification and country grouping variables (N=1,035)*

| | Shortage of funding or resources | Shortage of colleagues or staff | Lack of space for activities | Disagreement within organisation | Lack of appropriate supervision | Poor communication within organisation | Poor cooperation with healthcare services | Limited or inaccessible healthcare services | Poor knowledge of sexuality or LGBTI issues in healthcare services | Limited or no access to training | Poor coordination of activities | Lack of clear goals or aims | Confidentiality and anonymity issues |
|--|----------------------------------|---------------------------------|------------------------------|----------------------------------|---------------------------------|--|---|---|--|----------------------------------|---------------------------------|-----------------------------|--------------------------------------|
| Age | | | | | | | | | | | | | |
| 18-30 | 61.4 | 24.6 | 26.1 | 15.0 | 14.0 | 13.5 | 14.0 | 13.0 | 10.1 | 9.2 | 13.0 | 12.1 | 4.3 |
| 31-40 | 67.9 | 25.6 | 21.3 | 15.1 | 15.1 | 14.5 | 15.7 | 14.8 | 13.6 | 15.4 | 10.5 | 10.5 | 3.7 |
| 41 or older | 57.7 | 24.6 | 19.1 | 11.5 | 11.1 | 11.1 | 9.7 | 9.9 | 9.9 | 6.8 | 8.2 | 8.0 | 2.7 |
| <i>P-value</i> | <i>0.014</i> | <i>0.945</i> | <i>0.12</i> | <i>0.247</i> | <i>0.217</i> | <i>0.329</i> | <i>0.028</i> | <i>0.094</i> | <i>0.226</i> | <i><0.001</i> | <i>0.138</i> | <i>0.204</i> | <i>0.481</i> |
| Gender | | | | | | | | | | | | | |
| Man | 62.5 | 24.7 | 20.4 | 14.3 | 13.7 | 12.6 | 12.4 | 11.4 | 9.8 | 9.3 | 10.4 | 9.3 | 2.5 |
| Woman | 60.2 | 25.3 | 23.5 | 10.0 | 10.4 | 12.8 | 11.8 | 12.1 | 12.8 | 9.0 | 8.3 | 9.0 | 5.2 |
| Other or prefer not say | 57.9 | 26.3 | 18.4 | 21.1 | 18.4 | 13.2 | 18.4 | 23.7 | 21.1 | 31.6 | 13.2 | 21.1 | 5.3 |
| <i>P-value</i> | <i>0.704</i> | <i>0.967</i> | <i>0.503</i> | <i>0.072</i> | <i>0.213</i> | <i>0.992</i> | <i>0.505</i> | <i>0.078</i> | <i>0.056</i> | <i><0.001</i> | <i>0.476</i> | <i>0.051</i> | <i>0.076</i> |
| Sexual identity | | | | | | | | | | | | | |
| Homo/bisexual | 63.7 | 24.6 | 21.5 | 15.5 | 14.0 | 13.7 | 13.5 | 11.3 | 10.4 | 9.7 | 11.8 | 8.9 | 2.7 |
| Heterosexual | 60.1 | 25.6 | 20.5 | 7.8 | 9.7 | 10.5 | 10.5 | 14.3 | 12.0 | 10.1 | 6.2 | 8.9 | 5.4 |
| Other ^a | 54.5 | 25.2 | 21.1 | 13.8 | 14.6 | 12.2 | 11.4 | 11.4 | 13.0 | 11.4 | 8.1 | 14.6 | 2.4 |
| <i>P-value</i> | <i>0.127</i> | <i>0.956</i> | <i>0.95</i> | <i>0.008</i> | <i>0.189</i> | <i>0.423</i> | <i>0.427</i> | <i>0.436</i> | <i>0.599</i> | <i>0.855</i> | <i>0.032</i> | <i>0.133</i> | <i>0.096</i> |
| Peer role | | | | | | | | | | | | | |
| Peer | 63.4 | 23.8 | 21.1 | 14.8 | 13.5 | 13.0 | 13.0 | 11.0 | 9.7 | 8.7 | 11.0 | 9.3 | 2.5 |
| Non-peer | 59.2 | 26.6 | 21.3 | 11.3 | 12.2 | 12.2 | 11.8 | 13.7 | 13.2 | 12.0 | 8.4 | 10.1 | 4.6 |
| <i>P-value</i> | <i>0.179</i> | <i>0.306</i> | <i>0.935</i> | <i>0.103</i> | <i>0.56</i> | <i>0.724</i> | <i>0.56</i> | <i>0.196</i> | <i>0.077</i> | <i>0.081</i> | <i>0.174</i> | <i>0.688</i> | <i>0.072</i> |
| Employment status | | | | | | | | | | | | | |
| Paid | 61.2 | 24.5 | 20.8 | 14.9 | 13.8 | 15.6 | 13.4 | 13.8 | 11.4 | 11.1 | 10.7 | 11.5 | 3.7 |
| Volunteer | 62.9 | 26.2 | 22.4 | 9.9 | 11.2 | 6.1 | 10.5 | 8.3 | 10.5 | 7.7 | 8.3 | 5.4 | 2.6 |
| <i>P-value</i> | <i>0.591</i> | <i>0.556</i> | <i>0.566</i> | <i>0.03</i> | <i>0.252</i> | <i><0.001</i> | <i>0.208</i> | <i>0.013</i> | <i>0.695</i> | <i>0.093</i> | <i>0.245</i> | <i>0.002</i> | <i>0.35</i> |
| Years as CHW | | | | | | | | | | | | | |
| 0-5 years | 59.5 | 21.4 | 20.1 | 13.0 | 14.7 | 11.9 | 13.0 | 12.6 | 10.7 | 12.6 | 10.9 | 10.3 | 4.4 |
| 5-10 years | 64.7 | 29.4 | 22.6 | 17.9 | 13.2 | 14.0 | 14.5 | 12.3 | 11.1 | 8.9 | 8.9 | 12.8 | 3.0 |
| > 10 years | 63.4 | 27.9 | 22.1 | 10.1 | 9.7 | 12.8 | 10.1 | 11.4 | 12.1 | 6.4 | 9.1 | 5.7 | 1.7 |
| <i>P-value</i> | <i>0.334</i> | <i>0.031</i> | <i>0.691</i> | <i>0.03</i> | <i>0.134</i> | <i>0.731</i> | <i>0.278</i> | <i>0.886</i> | <i>0.835</i> | <i>0.016</i> | <i>0.602</i> | <i>0.016</i> | <i>0.111</i> |
| Type of organisation worked for^b | | | | | | | | | | | | | |
| Private not-for-profit | 63.6 | 25.8 | 20.9 | 13.3 | 13.8 | 12.9 | 13.4 | 12.7 | 12.1 | 10.4 | 9.9 | 9.3 | 3.3 |
| Other ^c | 49.6 | 20.2 | 24.8 | 15.5 | 10.9 | 12.4 | 8.5 | 9.3 | 8.5 | 8.5 | 11.6 | 12.4 | 3.1 |
| <i>P-value</i> | <i>0.002</i> | <i>0.168</i> | <i>0.31</i> | <i>0.491</i> | <i>0.368</i> | <i>0.874</i> | <i>0.123</i> | <i>0.278</i> | <i>0.243</i> | <i>0.518</i> | <i>0.543</i> | <i>0.266</i> | <i>0.926</i> |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. *Multiple answer.

Table 5-2 (continued): Organisation level barriers by main stratification and country grouping variables (N=1,035)*

| | Shortage of funding or resources | Shortage of colleagues or staff | Lack of space for activities | Disagreement within organisation | Lack of appropriate supervision | Poor communication within organisation | Poor cooperation with healthcare services | Limited or inaccessible healthcare services | Poor knowledge of sexuality or LGBTI issues in healthcare services | Limited or no access to training | Poor coordination of activities | Lack of clear goals or aims | Confidentiality and anonymity issues |
|--|----------------------------------|---------------------------------|------------------------------|----------------------------------|---------------------------------|--|---|---|--|----------------------------------|---------------------------------|-----------------------------|--------------------------------------|
| LGBTI inequality level of the working country | | | | | | | | | | | | | |
| Low inequality | 60.2 | 22.9 | 20.7 | 13.5 | 13.1 | 12.8 | 10.3 | 10.0 | 9.7 | 8.0 | 9.8 | 9.6 | 2.3 |
| High inequality | 66.5 | 31.4 | 22.9 | 13.1 | 12.7 | 12.2 | 19.2 | 18.8 | 15.5 | 16.3 | 10.2 | 9.8 | 6.5 |
| <i>P-value</i> | <i>0.074</i> | <i>0.007</i> | <i>0.471</i> | <i>0.875</i> | <i>0.867</i> | <i>0.818</i> | <i><0.001</i> | <i><0.001</i> | <i>0.012</i> | <i><0.001</i> | <i>0.865</i> | <i>0.918</i> | <i>0.001</i> |
| Low LGBTI inequality countries^d | | | | | | | | | | | | | |
| Germany | 64.8 | 21.2 | 23.8 | 12.4 | 11.9 | 12.4 | 8.3 | 11.9 | 10.9 | 4.1 | 10.4 | 5.7 | 1.6 |
| Spain | 61.3 | 28.9 | 24.9 | 11.0 | 7.5 | 8.7 | 6.4 | 5.8 | 6.4 | 3.5 | 9.8 | 11.0 | 0 |
| UK | 73.1 | 19.4 | 21.5 | 9.7 | 14.0 | 12.9 | 16.1 | 18.3 | 11.8 | 14.0 | 5.4 | 5.4 | 4.3 |
| France | 37.5 | 32.5 | 13.8 | 20.0 | 18.8 | 20.0 | 12.5 | 1.3 | 7.5 | 5.0 | 16.3 | 8.8 | 5.0 |
| Other countries of low inequality ^e | 58.1 | 17.9 | 17.1 | 15.4 | 15.8 | 13.7 | 12.0 | 11.1 | 11.1 | 13.2 | 9.0 | 13.7 | 3.0 |
| <i>P-value</i> | <i><0.001</i> | <i>0.018</i> | <i>0.125</i> | <i>0.206</i> | <i>0.066</i> | <i>0.162</i> | <i>0.083</i> | <i>0.001</i> | <i>0.411</i> | <i><0.001</i> | <i>0.195</i> | <i>0.036</i> | <i>0.057</i> |
| New HIV diagnoses attributed to sex between men in 2016 | | | | | | | | | | | | | |
| <3 per 100,000 | 59.4 | 22.2 | 18.3 | 9.4 | 8.3 | 9.4 | 13.3 | 15.6 | 12.2 | 14.4 | 6.7 | 12.2 | 5.6 |
| 3 to 5 per 100,000 | 58.6 | 26.9 | 20.2 | 14.5 | 13.1 | 14.5 | 10.3 | 8.4 | 11.3 | 5.9 | 11.8 | 7.4 | 2.7 |
| >5 per 100,000 | 63.0 | 22.8 | 24.1 | 12.9 | 14.2 | 11.9 | 12.7 | 12.7 | 9.4 | 9.9 | 8.4 | 10.6 | 2.5 |
| <i>P-value</i> | <i>0.417</i> | <i>0.31</i> | <i>0.223</i> | <i>0.239</i> | <i>0.14</i> | <i>0.203</i> | <i>0.47</i> | <i>0.025</i> | <i>0.512</i> | <i>0.003</i> | <i>0.089</i> | <i>0.122</i> | <i>0.125</i> |

^dn=786. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

Barriers identified by CHWs at community level

Two barriers at community level were proposed in the questionnaire: lack of interest from gay/bisexual or other MSM (35.1%) and lack of support from gay business and/or venues (25.7%, Figure 5-3).

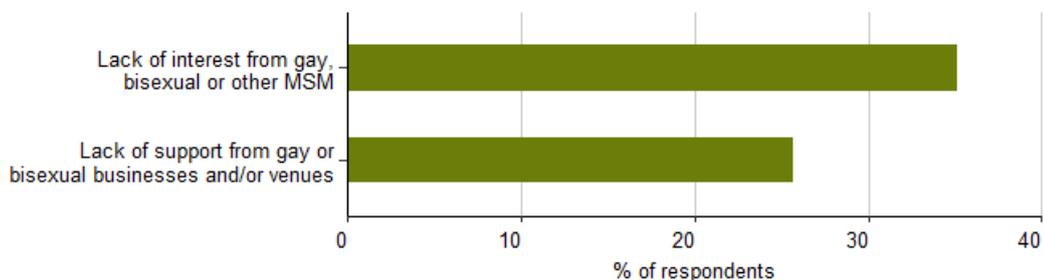


Figure 5-3: Barriers identified by ECHOES respondents at community level (N=1,035, multiple answer)

lack of interest from gay/bisexual or other MSM and lack of support from gay business and/or venues were more often reported by respondents aged 40 or less (approximately 40% and 30%, respectively) and by respondents working in 'high LGBTI inequality' countries (52.3% and 37.1%, respectively; Table 5-3). Differences were observed between countries in respondents from 'low LGBTI inequality' countries: those from Spain and France more often reported 'lack of interest from gay, bisexual or other MSM' (41.9% and 53.2%, respectively); those from Spain more often reported 'lack of support from gay businesses and venues' (35.3%).

The lack of interest from the community was more often reported by peer respondents (37.9%) and those working for private not-for-profit organisations (36.6%).

The lack of interest from the community was more reported by respondents from countries with less than 3 new HIV diagnoses attributed to sex between men per 100,000 men (44.8%), while those from countries with a rate of more than 5 per 100,000 men more often reported a lack of support from gay businesses and venues (29.0%).

Table 5-3: Barriers at community level by the main stratification and country grouping variables (N=1,035)*

| | Lack of interest from gay, bisexual or other MSM | Lack of support from gay businesses or venues |
|--|--|---|
| Age | | |
| 18-30 | 42.4 | 29.3 |
| 31-40 | 41.5 | 30.4 |
| 41 or older | 27.7 | 21.0 |
| <i>P-value</i> | <0.001 | 0.005 |
| Gender | | |
| Man | 37.6 | 26.9 |
| Woman | 30.0 | 23.0 |
| Other or prefer not say | 28.9 | 23.7 |
| <i>P-value</i> | 0.059 | 0.429 |
| Sexual identity | | |
| Homo/bisexual | 37.7 | 27.7 |
| Heterosexual | 29.2 | 21.2 |
| Other ^a | 34.1 | 24.4 |
| <i>P-value</i> | 0.058 | 0.131 |
| Peer role | | |
| Peer | 37.9 | 27.3 |
| Non-peer | 31.1 | 23.3 |
| <i>P-value</i> | 0.028 | 0.153 |
| Employment status | | |
| Paid | 35.1 | 25.8 |
| Volunteer | 34.9 | 25.3 |
| <i>P-value</i> | 0.938 | 0.867 |
| Years as CHW | | |
| 0-5 years | 38.5 | 24.9 |
| 5-10 years | 38.6 | 29.6 |
| > 10 years | 26.7 | 23.6 |
| <i>P-value</i> | 0.002 | 0.264 |
| Type of organisation worked for^b | | |
| Private not-for-profit | 36.6 | 26.4 |
| Other ^c | 26.0 | 22.0 |
| <i>P-value</i> | 0.02 | 0.302 |
| LGBTI inequality level of the working country | | |
| Low inequality | 29.7 | 22.1 |
| High inequality | 52.3 | 37.1 |
| <i>P-value</i> | <0.001 | <0.001 |
| Low LGBTI inequality countries^d | | |
| Germany | 13.5 | 12.0 |
| Spain | 41.9 | 35.3 |
| UK | 28.9 | 24.4 |
| France | 53.2 | 27.8 |
| Other countries of low inequality ^e | 26.6 | 17.9 |
| <i>P-value</i> | <0.001 | <0.001 |
| New HIV diagnoses attributed to sex between men in 2016 | | |
| <3 per 100,000 | 44.8 | 23.6 |
| 3 to 5 per 100,000 | 30.2 | 20.4 |
| >5 per 100,000 | 33.2 | 29.0 |
| <i>P-value</i> | 0.003 | 0.019 |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=786. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

Barriers identified by CHWs at structural level

The structural level barriers were the most reported by ECHOES respondents overall, compared to individual, organisation and community levels; stigma around HIV and AIDS (77.1%), lack of funding for CHW organisations (65.5%) and stigma around homosexuality and bisexuality (59.4%, figure 5-4).

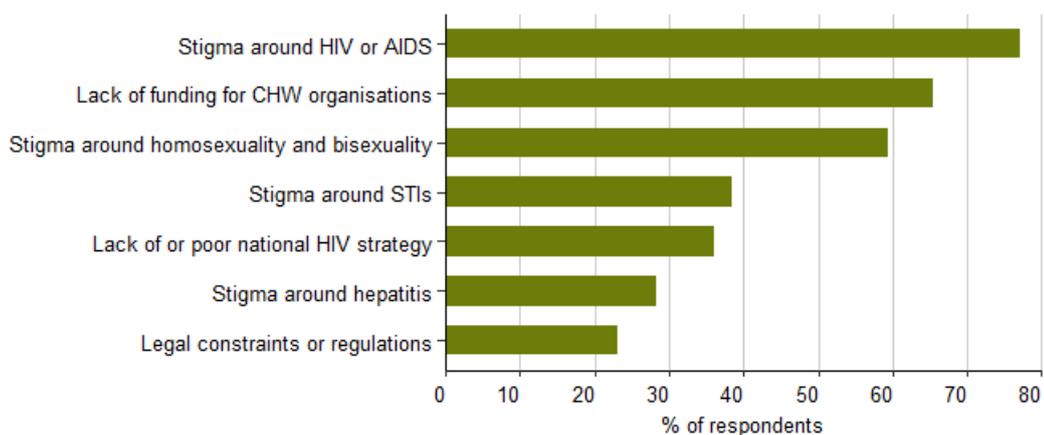


Figure 5-4: Barriers identified by ECHOES respondents at structural level (N=1,035, multiple answer)

When differences are observed (Table 5-4), stigma-related barriers were more often reported by younger respondents, those not defining themselves as heterosexual, peer, those having less than 10 years of experience as CHW, and those working for private not-for-profit organisations. 'Stigma around homosexuality/bisexuality' was much more reported by respondents from 'high LGBTI inequality' countries (72.5% vs. 55.2% in those working in 'low LGBTI inequality' countries). Stigma-related barriers did not differ according to the rate of new HIV diagnoses attributed to sex between men in the working country.

Other than stigma-related barriers, structural barriers were less reported in respondents aged 41 or older: 'Lack of funding for CHW organisations' (61.1%), 'Lack of or poor national HIV strategy' (32.4%), and 'Legal constraints or regulations' (17.2%). 'Lack of or poor national HIV strategy' and 'Legal constraints or regulations' were also less reported in CHWs with more than 10 years of experience, while 'Lack of funding for CHW organisations' was less reported in respondents with <5 years of experience (59.9%).

'Lack of funding for CHW organisations' was more reported in peer respondents (68.9%) and in those working for private not-for-profit organisations (66.8%). No differences were observed between those from 'low LGBTI inequality' and 'high LGBTI inequality' countries, but significantly higher percentages were observed in respondents from Spain (72.3%) and the UK (73.1%) compared to respondents from other 'low LGBTI inequality' countries.

'Lack of or poor national HIV strategy' was more reported in those working for a private not-for-profit organisation (37.4%) or in 'high LGBTI inequality' countries (47.1%), although those from Spain (59.9%) and France (44.6%), both 'low LGBTI inequality' countries, reported similar rates.

Table 5-4: Structural level barriers by main stratification and country grouping variables (N=1,035)*

| | Stigma around HIV/AIDS | Lack of funding for CHW organisations | Stigma around homo-/bisexuality | Stigma around STIs | Lack/poor national HIV strategy | Stigma around hepatitis | Legal constraints or regulations |
|--|------------------------|---------------------------------------|---------------------------------|--------------------|---------------------------------|-------------------------|----------------------------------|
| Age | | | | | | | |
| 18-30 | 82.8 | 65.6 | 63.6 | 47.4 | 37.3 | 42.6 | 23.9 |
| 31-40 | 81.1 | 72.0 | 62.4 | 40.1 | 40.7 | 26.4 | 31.4 |
| 41 or older | 72.1 | 61.1 | 55.5 | 33.4 | 32.4 | 23.4 | 17.2 |
| <i>P-value</i> | <i>0.001</i> | <i>0.006</i> | <i>0.055</i> | <i>0.002</i> | <i>0.050</i> | <i><0.001</i> | <i><0.001</i> |
| Gender | | | | | | | |
| Man | 77.6 | 67.5 | 58.8 | 40.2 | 36.0 | 29.8 | 24.4 |
| Woman | 75.8 | 61.6 | 61.2 | 33.2 | 33.9 | 24.2 | 19.7 |
| Other or prefer not say | 78.9 | 57.9 | 55.3 | 44.7 | 52.6 | 31.6 | 23.7 |
| <i>P-value</i> | <i>0.796</i> | <i>0.127</i> | <i>0.679</i> | <i>0.089</i> | <i>0.078</i> | <i>0.191</i> | <i>0.280</i> |
| Sexual identity | | | | | | | |
| Homo/bisexual | 79.9 | 67.8 | 60.0 | 42.9 | 35.8 | 30.6 | 25.3 |
| Heterosexual | 69.5 | 62.2 | 57.9 | 27.8 | 34.4 | 21.2 | 16.2 |
| Other ^a | 78.9 | 60.2 | 59.3 | 37.4 | 40.7 | 30.9 | 26.0 |
| <i>P-value</i> | <i>0.003</i> | <i>0.114</i> | <i>0.851</i> | <i><0.001</i> | <i>0.48</i> | <i>0.015</i> | <i>0.010</i> |
| Peer role | | | | | | | |
| Peer | 79.1 | 68.9 | 59.5 | 42.2 | 35.7 | 30.6 | 25.1 |
| Non-peer | 74.3 | 60.4 | 59.2 | 32.9 | 36.5 | 24.9 | 20.1 |
| <i>P-value</i> | <i>0.077</i> | <i>0.005</i> | <i>0.940</i> | <i>0.003</i> | <i>0.81</i> | <i>0.050</i> | <i>0.066</i> |
| Employment status | | | | | | | |
| Paid | 76.4 | 65.3 | 60.4 | 36.4 | 35.4 | 28.0 | 22.3 |
| Volunteer | 78.9 | 65.8 | 57.2 | 43.1 | 37.7 | 28.8 | 24.9 |
| <i>P-value</i> | <i>0.382</i> | <i>0.883</i> | <i>0.340</i> | <i>0.041</i> | <i>0.475</i> | <i>0.801</i> | <i>0.36</i> |
| Years as CHW | | | | | | | |
| 0-5 years | 79.8 | 59.9 | 61.3 | 40.3 | 37.4 | 31.7 | 23.9 |
| 5-10 years | 81.9 | 74.7 | 60.3 | 42.6 | 42.6 | 30.0 | 28.3 |
| > 10 years | 69.1 | 67.1 | 55.4 | 31.5 | 29.2 | 20.5 | 17.1 |
| <i>P-value</i> | <i><0.001</i> | <i><0.001</i> | <i>0.242</i> | <i>0.015</i> | <i>0.004</i> | <i>0.002</i> | <i>0.007</i> |
| Type of organisation worked for^b | | | | | | | |
| Private not-for-profit | 80.2 | 66.8 | 60.2 | 40.1 | 37.4 | 29.8 | 23.9 |
| Other ^c | 60.5 | 55.8 | 49.6 | 29.5 | 27.9 | 19.4 | 16.3 |
| <i>P-value</i> | <i><0.001</i> | <i>0.014</i> | <i>0.023</i> | <i>0.020</i> | <i>0.037</i> | <i>0.015</i> | <i>0.055</i> |
| LGBTI inequality level of the working country | | | | | | | |
| Low inequality | 76.3 | 65.4 | 55.2 | 39.6 | 32.5 | 28.5 | 19.5 |
| High inequality | 79.9 | 65.6 | 72.5 | 34.4 | 47.1 | 27.5 | 34.4 |
| <i>P-value</i> | <i>0.235</i> | <i>0.965</i> | <i><0.001</i> | <i>0.146</i> | <i><0.001</i> | <i>0.749</i> | <i><0.001</i> |
| Low LGBTI inequality countries^d | | | | | | | |
| Germany | 76.3 | 60.3 | 55.2 | 41.2 | 16.0 | 28.4 | 21.1 |
| Spain | 79.2 | 72.3 | 57.2 | 39.9 | 50.9 | 28.9 | 15.6 |
| UK | 82.8 | 73.1 | 48.4 | 44.1 | 28.0 | 32.3 | 7.5 |
| France | 78.3 | 68.7 | 67.5 | 37.3 | 44.6 | 37.3 | 31.3 |
| Other countries of low inequality ^e | 70.7 | 60.3 | 52.2 | 37.1 | 30.2 | 23.7 | 21.6 |
| <i>P-value</i> | <i>0.126</i> | <i>0.024</i> | <i>0.093</i> | <i>0.772</i> | <i><0.001</i> | <i>0.167</i> | <i>0.001</i> |
| New HIV diagnoses attributed to sex between men in 2016 | | | | | | | |
| <3 per 100,000 | 73.7 | 61.5 | 64.8 | 33.5 | 35.8 | 25.1 | 26.3 |
| 3 to 5 per 100,000 | 77.0 | 61.3 | 58.6 | 38.2 | 27.0 | 27.2 | 23.0 |
| >5 per 100,000 | 78.2 | 70.9 | 55.4 | 40.8 | 41.8 | 29.6 | 16.5 |
| <i>P-value</i> | <i>0.497</i> | <i>0.009</i> | <i>0.108</i> | <i>0.254</i> | <i><0.001</i> | <i>0.508</i> | <i>0.012</i> |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=786. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

'Legal constraints or regulations' was more reported in respondents working in 'high LGBTI inequality' countries (34.4%), although the percentage of respondents from France ('Low LGBTI inequality' country) was similar (31.3%).

When differences were observed according to the rate of new HIV diagnoses attributed to sex between men, respondents working in countries with a rate of more than 5 per 100,000 men more often reported 'lack of funding for CHW organisations' and 'lack of or poor national HIV strategy' (70.9% and 41.8%, respectively), while respondents working in countries with a rate of less than 3 per 100,000 men more often reported 'legal constraints or regulations' (26.3%).

5.2. Other factors influencing CHWs work

The health conditions of CHWs are likely to influence their activities. In the ECHOES questionnaire, health conditions were documented using a single question related to the perception of their own health status, and a scale (WHO-5) measuring the well-being of respondents.

Perceived general health status

Overall, 32.7% of respondents reported their health status to be very good, half (50.7%) to be good, 15% fair, 1.4% bad, and 0.2% very bad (Figure 5-5).

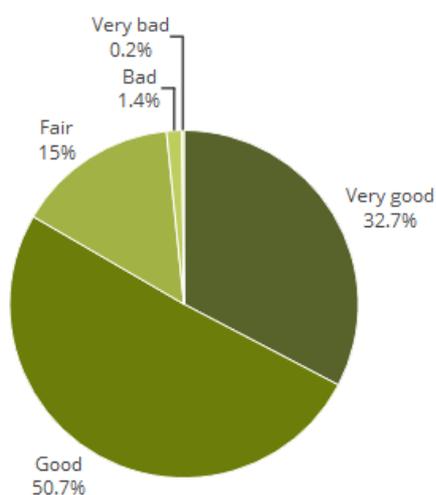


Figure 5-5: Self-perceived health status of respondents (N=1,035)

When comparing respondents with a 'Very good' or 'Good' self-perceived health status to those with a 'Fair', 'Bad' or 'Very bad' health status, differences were observed (Table 5-5).

Table 5-5: Perceived general health status by the main stratification and country grouping variables, as well as perceived income (N=1,035)

| | Very good or good | Fair, bad or very bad | p-value |
|--|-------------------|-----------------------|---------|
| Age | | | 0.043 |
| 18-30 | 87.0 | 13.0 | |
| 31-40 | 85.7 | 14.3 | |
| 41 or older | 80.4 | 19.6 | |
| Gender | | | 0.001 |
| Man | 84.1 | 15.9 | |
| Woman | 84.7 | 15.3 | |
| Other or prefer not say | 60.5 | 39.5 | |
| Sexual identity | | | 0.002 |
| Homo/bisexual | 82.8 | 17.2 | |
| Heterosexual | 89.0 | 11.0 | |
| Other ^a | 75.0 | 25.0 | |
| Peer role | | | 0.985 |
| Peer | 83.4 | 16.6 | |
| Non-peer | 83.4 | 16.6 | |
| Employment status | | | 0.108 |
| Paid | 84.7 | 15.3 | |
| Volunteer | 80.6 | 19.4 | |
| Years as CHW | | | 0.014 |
| 0-5 years | 85.7 | 14.3 | |
| 5-10 years | 85.2 | 14.8 | |
| > 10 years | 78.0 | 22.0 | |
| Type of organisation worked for^b | | | 0.784 |
| Private not-for-profit | 83.8 | 16.2 | |
| Other ^c | 82.8 | 17.2 | |
| Perceived income | | | <0.001 |
| Very comfortable or comfortable | 89.8 | 10.2 | |
| Neither comfortable nor struggling, struggling, or really struggling | 78.6 | 21.4 | |
| LGBTI inequality level of the working country | | | 0.001 |
| Low inequality | 85.6 | 14.4 | |
| High inequality | 76.3 | 23.7 | |
| Low LGBTI inequality countries^d | | | <0.001 |
| Germany | 74.9 | 25.1 | |
| Spain | 96.5 | 3.5 | |
| UK | 82.4 | 17.6 | |
| France | 80.7 | 19.3 | |
| Other countries of low inequality ^e | 89.3 | 10.7 | |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^cGovernment/local authority, public organisation, other type. ^dn=786. ^eMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

The older the respondents, the worse the self-perceived health status was (19.6% reported 'fair', 'bad' or 'very bad' perceived health status in those aged 41 or more), also reflected in the years of experiences as CHW (22% of those with more than 10 years of experience reported 'fair', 'bad' or 'very bad' perceived health status). When comparing by gender and sexual identity, health status was reported to be 'fair', 'bad' or 'very bad' in 39.5% of those not defining as men or women and 25% of those not defining as homosexual/bisexual or heterosexual.

More respondents working in 'high LGBTI inequality' countries reported 'fair', 'bad' or 'very bad' health status compared to those working in 'low LGBTI inequality' countries (23.7% vs. 14.4%); an even higher proportion of those working in

Germany reported having a 'fair', 'bad' or 'very bad' health status (25.1% vs. between 3.5% and 19.3% in other 'low LGBTI inequality' countries).

Respondents living in 'Very comfortable' or 'comfortable' conditions more often reported having a 'Very good' or 'Good' health status (89.8% vs. 78.6% in those who reported living conditions as 'Neither comfortable nor struggling', 'Struggling', or 'Really struggling').

Well-being and mental health status

Overall, the median score of well-being (WHO-5 scale) in ECHOES respondents was 64 out of 100. Around 25% of the sample had a score lower than 52, and 25% higher than 76 (Figure 5-6).

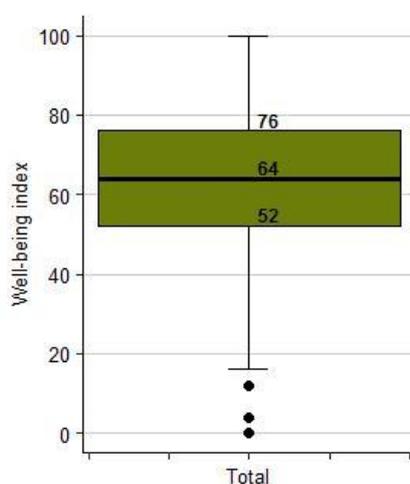


Figure 5-6: Well-being index (N=1,035)

Comparing well-being by gender, women appeared to have a higher level of well-being (median [inter-quartile range, IQR]: 68 [52-76]) followed by men (64 [52-76]) and 'other/ prefer not say' (53.5[40-72], Figure 5-7). Similarly, heterosexual respondents had the highest levels of well-being (68 [56-80]), followed by homosexual/bisexual (64 [52-76]) and 'other' (60 [50-76]).

Respondents working in 'low LGBTI inequality' countries had a higher level of well-being (68[52-76]) compared with those from 'high LGBTI inequality' countries (60[48-76]).

Those reporting to live in 'Very comfortable' or 'Comfortable' conditions also had a higher well-being score than those not living in comfortable conditions (68[60-80] vs. 60[48-76], respectively).

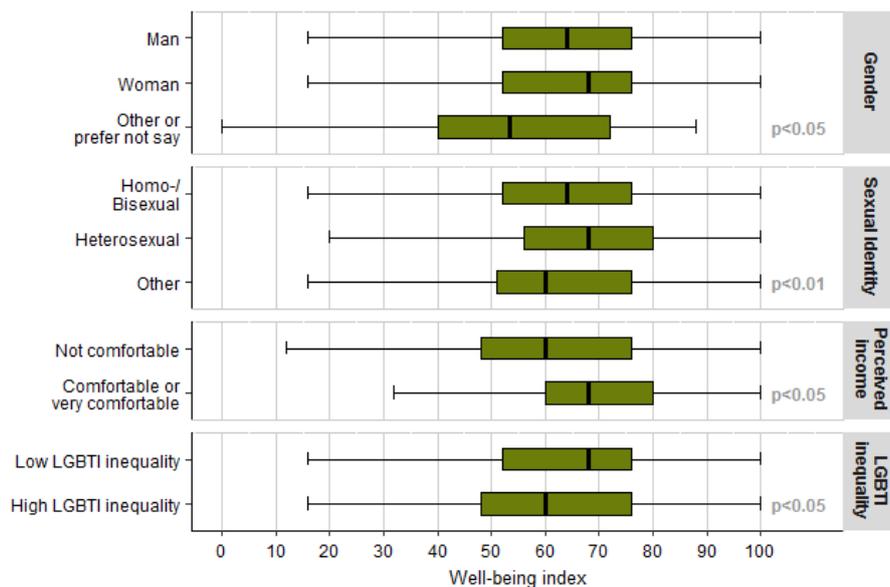


Figure 5-7: Well-being by gender, sexual identity, and level of LGBTI inequality (N=1,035)

Dichotomising the well-being index (see method section 2.6), 22.3% of ECHOES respondents could be considered at higher risk of depression (score >50/100; Figure 5-8).

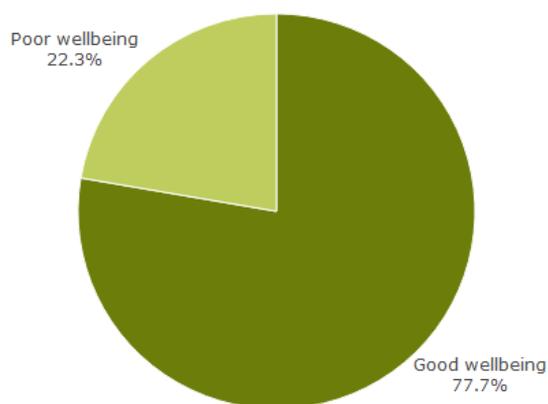


Figure 5-8: Poor/good well-being (N=1,035)

Poor well-being was more often reported in those not defining themselves as men or women (44.7%, vs. 21.9% in men and 20.1% in women) and those reporting living in 'not comfortable' conditions (27.7% vs. 15.0% in those living in 'Very comfortable' or 'comfortable' conditions, Figure 5-9). No other significant differences were observed.

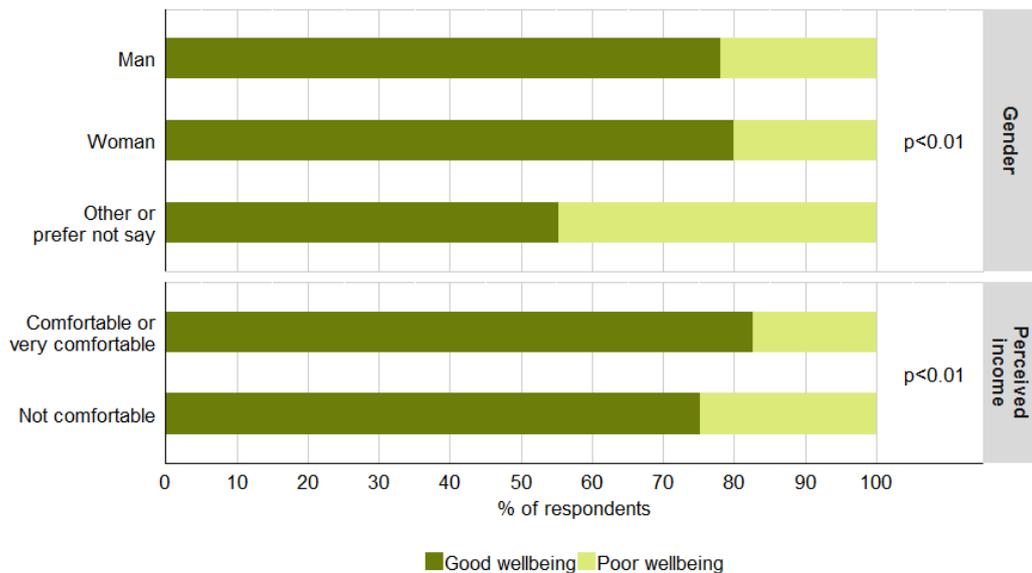


Figure 5-9: Well-being by gender, perceived household income (N=1,035)

Self-efficacy

Self-efficacy varied considerably in ECHOES respondents with a median of 72 out of 100. Around 25% of the sample had a score lower than 67, 50% between 67 and 89 and 25% between 89 and 100 (Figure 5-10).

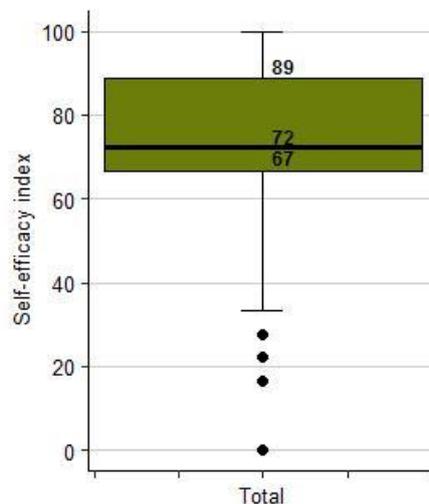


Figure 5-10: Self-efficacy (Total)

Differences in self-efficacy were observed by age, gender and peer role (Figure 5-11). The older the respondents, the higher the self-efficacy: 72.2[63.9-83.3] in 18-30 years old, 72.2[66.7-83.3] in 31-40 years old and 77.8[66.7-88.9] in more than 40 years old. Comparing by gender, men had the highest level of self-efficacy (77.8[66.7-88.9]), followed by women (72.2[66.7-83.3]) and 'other or prefer not say' (72.2[61.1-77.8]). Peer respondents had a higher level of self-efficacy (77.8[66.7-88.9]) as well as those living in comfortable conditions (77.8[66.7-

88.9]) than their respective counterparts (72.2[66.7-83.3] in non-peer respondents and 72.2[66.7-83.3]) in those not living in comfortable conditions).

Self-efficacy was higher in respondents working in 'low LGBTI inequality' countries: 77.8[66.7-88.9] vs. (66.7[66.7-77.8] in respondents from 'high LGBTI countries'.

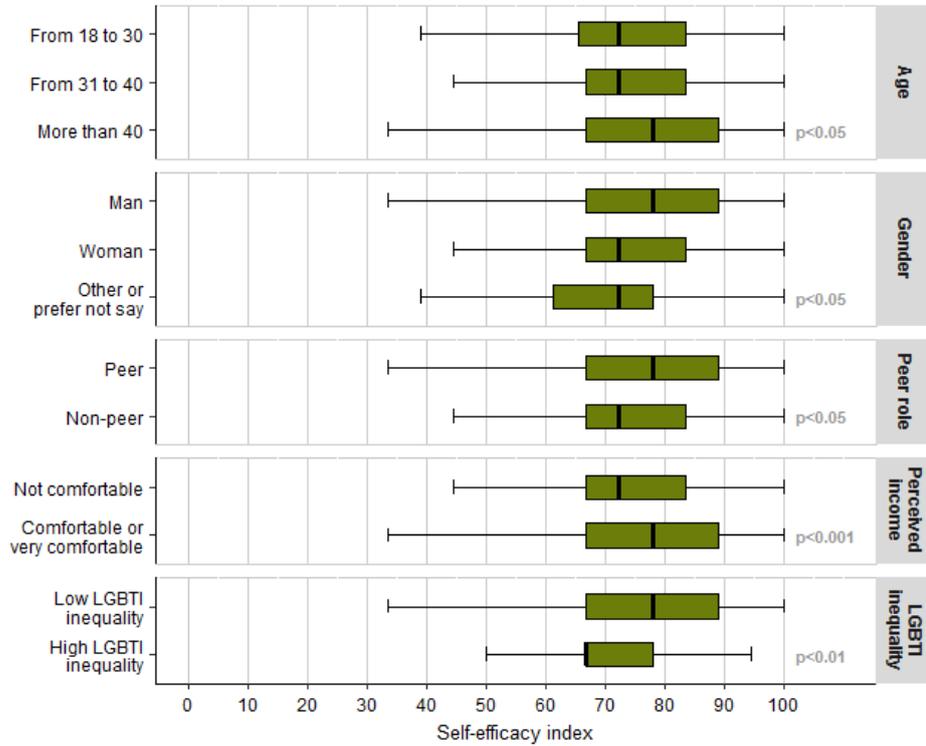


Figure 5-11: Self-efficacy by age, gender, peer role, perceived household income, and level of LGBTI inequality (N=1,035)

When considering the categorical score of self-efficacy (low, average, high; see method section 2.6), a strong association with well-being was observed: the higher the self-efficacy, the better the well-being (Figure 5-12).

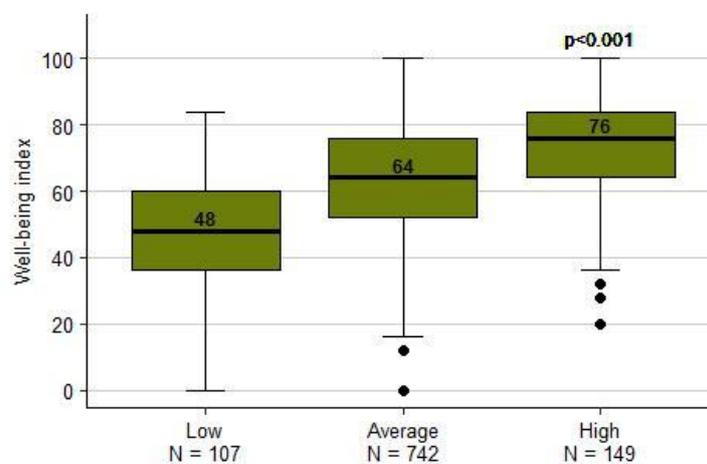


Figure 5-12: Well-being by level of self-efficacy

Job satisfaction

A high level of satisfaction regarding their role as a CHW can facilitate respondents' day-to-day activities as a CHW. The median score of job satisfaction among ECHOES respondents was high: 75 out of 100 (IQR = [60-85], Figure 5-13).

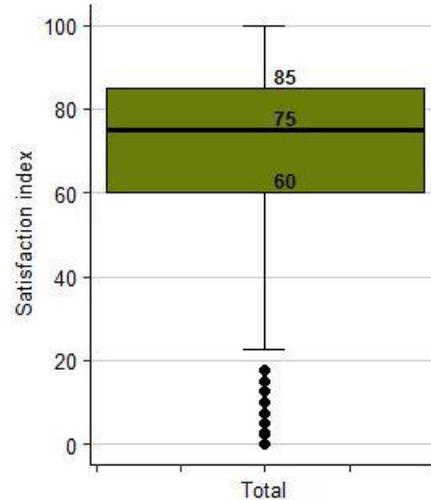


Figure 5-13: Job satisfaction (Total)

Significant differences in respondents' job satisfaction were observed when comparing by gender, sexual identity, perceived income and level of LGBTI inequality (Figure 5-14). No difference was observed when comparing by employment status (paid vs. unpaid).

Women had a slightly higher score of job satisfaction (75[62.5-87.5]) than men (75[60-85]), but much higher than those not defining themselves as man or woman (60[50-75]). Heterosexuals had the highest score of job satisfaction (77.5[62.5-87.5]) followed by homosexual/bisexuals (72.5[60-85]) and 'other' (72.5[57.5-83.8]). Respondents reporting to live in 'Very comfortable' or 'Comfortable conditions' had a higher level of job satisfaction (77.5[67.5-90]) compared with those who reporting living in 'not comfortable' conditions (70[57.5-82.5]).

Respondents working in 'low LGBTI inequality' countries had a higher level of job satisfaction (75[62.5-87.5]) compared to those from 'high LGBTI inequality' countries (72.5[57.5-82.5]).

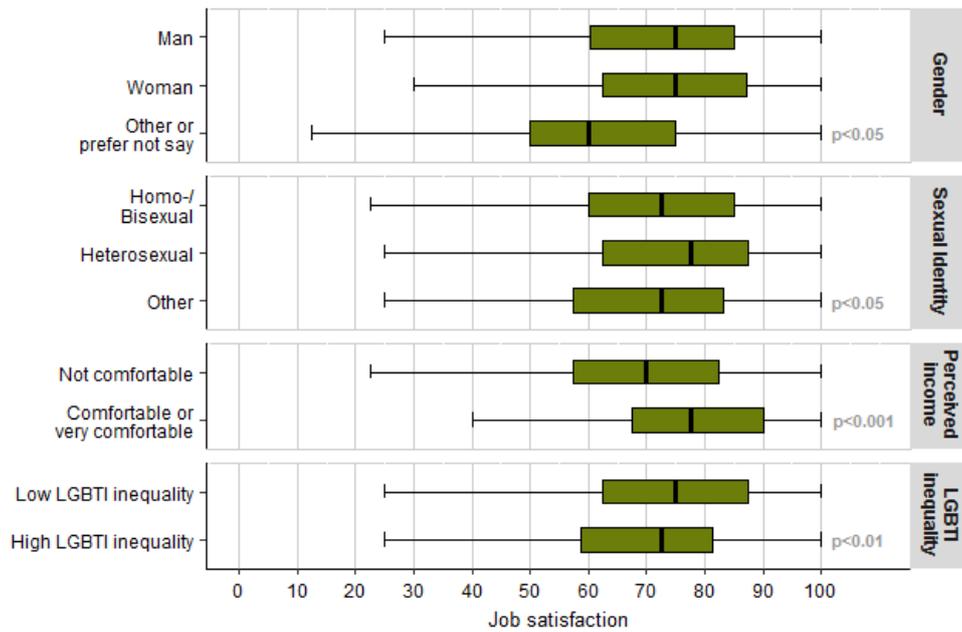


Figure 5-14: Job satisfaction by gender, sexual identity, perceived income and level of LGBTI inequality

Considering the self-efficacy score as categorical, a strong association with job satisfaction was observed: the higher the self-efficacy, the higher the job satisfaction (Figure 5-15).

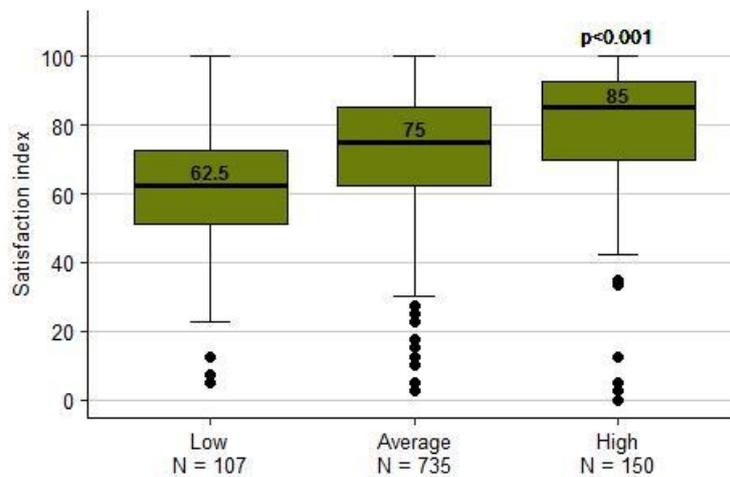


Figure 5-15: Job-satisfaction by level of self-efficacy

MSM users' confidence about CHW support and the organisations they work for

Confidence about the support CHWs or their organisation were providing to gay, bisexual and other MSM was asked using the two following questions: "To what extent do you think gay, bisexual and other MSM 'trust' or feel confident about the CHW support that **you** are delivering?" and "To what extent do you think gay, bisexual and other MSM 'trust' or feel confident about **your CHW organisation**?".

Overall, 71.3% of ECHOES respondents perceived that gay, bisexual and MSM users were extremely confident regarding the support provided by CHWs, and only 1.2% perceived that users were hardly confident or not confident at all (Figure 5-16).

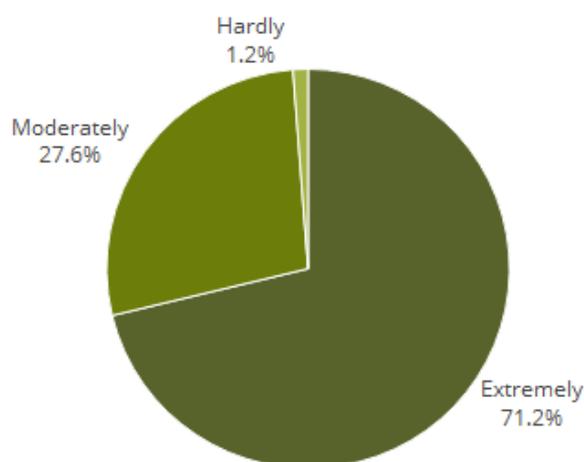


Figure 5-16: To what extent do you think gay, bisexual and other MSM 'trust' or feel confident about the CHW support that **you** are delivering? (N=1,035)

Comparing those who answered that gay, bisexual and other MSM were extremely confident in the support delivered to those who answered that they were moderately or hardly confident regarding the support delivered, significant differences were observed by age, peer role, years as CHW, and level of LGBTI inequality (Figure 5-17).

Peer respondents reported more confidence (75.6%) than non-peer respondents (64.5%) and the older the respondents, the higher the perceived level of confidence from gay, bi and MSM users: 57.8% in those aged 18-30, 70.4% in those aged 31-40 and 77.6% in those aged 41 or more. Similarly, the longer the experience as a CHW, the higher the level of perceived confidence: 66.7% in those with up to 5 years, 72.5% for those with 5 to 10 years and 78.8% for those with more than 10 years of experience.

Respondents working in 'high LGBTI inequality' countries perceived less confidence regarding their work (57.7%) than those working in 'low LGBTI inequality' countries (76.7%). Among respondents working in 'low LGBTI inequality' countries, those from Spain reported lower level of user confidence: 57.4% vs. between 74.7% and 86.0% in respondents from other 'Low LGBTI inequality' countries (data not shown).

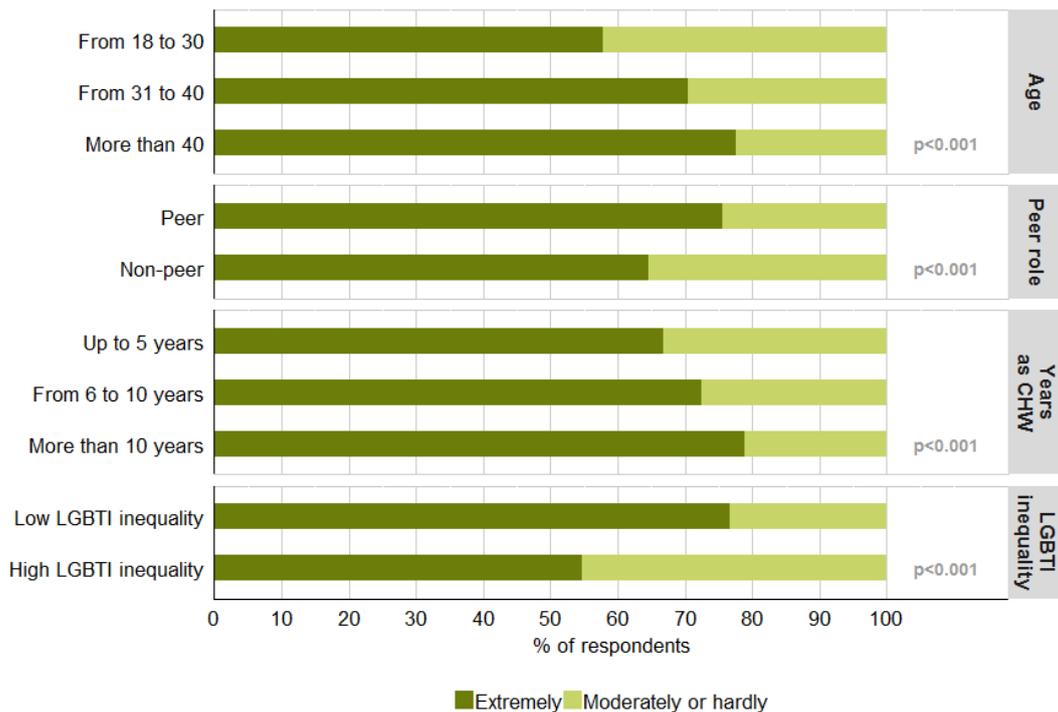


Figure 5-17: MSM confidence toward CHW support that respondents are delivering by age, peer role, years as CHW, level of LGBTI inequality and rate of new HIV diagnoses attributable to sex between men (N=1,035)

Regarding the confidence of gay, bisexual and other MSM service users about the organisation ECHOES respondents work for, most respondents perceived that users were extremely confident (71.2%), and only 1.6% perceived that users were hardly or not confident at all (Figure 5-18).

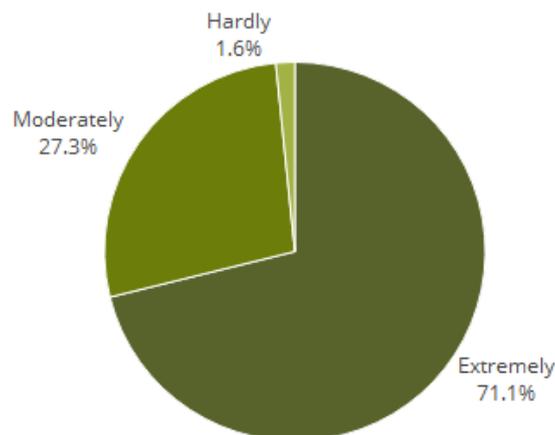


Figure 5-18: To what extent do you think gay, bisexual and other MSM 'trust' or feel confident about the CHW support that **your organisation provides?** (N=1,035)

Comparing those who answered that gay, bisexual and other MSM service users were extremely confident about the support provided by their organisation with those who answered they were moderately or hardly confident, significant differences were observed by age, peer role, type of organisation, and level of LGBTI inequality in the country (Figure 5-19).

The perception of MSM service users' confidence about respondents' organisations was higher in peer respondents than in non-peer (74.8% vs. 65.6%, respectively). The older the respondents, the higher the perceived level of confidence from gay, bi and MSM users: 62.7% in those aged 18-30, 68.5% in those aged 31-40 and 76.7% in those aged 41 or more. Respondents working in private not-for-profit organisations also more often reported perceiving confidence from their users compared to those working in other types of organisations (72.6% vs. 62.8%, respectively).

As with confidence in CHWs' support, the perceived confidence of ECHOES respondents' users in the organisation is lower in those working in 'high LGBTI inequality' countries (52.3% vs. 77.2% in those from 'low LGBTI inequality' countries). Among respondents working in countries with 'low LGBTI inequality', those from Germany reported a higher level of perceived user confidence in their organisation: 87.4% vs. between 69.5% and 79.8% in respondents from other countries of the 'Low LGBTI inequality' category (data not shown).

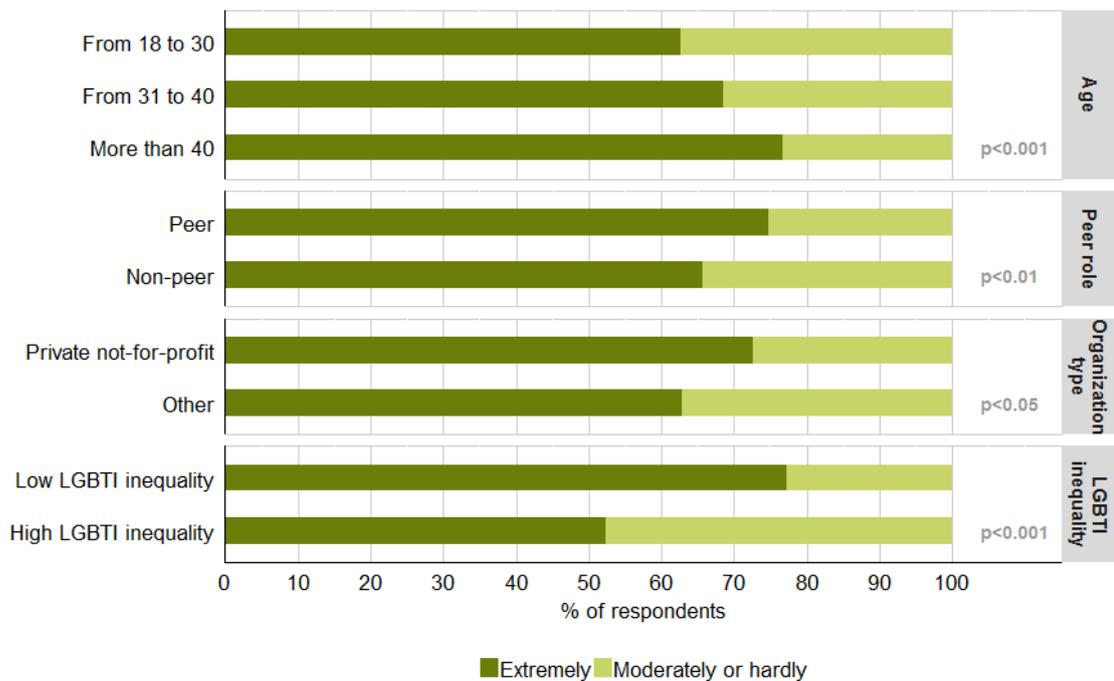


Figure 5-19: MSM confidence toward respondents' organisation by age, gender, peer role, organisation type, level of LGBTI inequality and rate of new HIV diagnoses attributable to sex between men (N=1,035)

6. Knowledge and training issues in CHWs

Several studies note that CHWs' level of knowledge is an important factor in determining the success of a CHW program [9,29]. Effective training programmes will be essential to ensure that CHWs possess the necessary knowledge and competencies to develop and implement a range of activities and services to improve access to HIV, viral Hepatitis and other STI prevention and health care for gay, bisexual and other MSM. Training has also been found to influence CHW motivation, job satisfaction and CHW confidence[30].

ECHOES included questions to assess the confidence CHWs had in their knowledge around HIV/AIDS, viral hepatitis, and other STIs. ECHOES respondents were also asked about the kind of training received (if any) during their work as a CHW, the areas covered in training, and the areas of additional training they would most benefit from (hereafter called 'training needs').

In this chapter, all the results are stratified by the main stratification variables (age group, gender, sexual identity, peer role, employment status as a CHW (volunteer/paid), the purpose of the CHW's organisation), as well as the CHWs' reported activities in the continuum of HIV/STI services.

A detailed description of the self-perceived confidence in knowledge and training issues by the country groupings according to the LGBTI inequality is presented at the end of each subchapter.

6.1. Confidence in one's knowledge of HIV, viral Hepatitis and other STIs

For practical purposes, and because ECHOES was designed to inform training needs, knowledge of HIV/AIDS, viral hepatitis, and other STIs as a CHW was not assessed directly; it was assessed in terms of confidence in one's knowledge, a good measure of actual knowledge [31]. CHWs were asked to rate how confident they were in their knowledge of HIV/AIDS, viral hepatitis and STIs on a scale from 1 (not confident at all) to 5 (very confident) in three different areas: (1) prevention, (2) screening and/or testing, (3) treatment and/or support, drawing on self-efficacy theory [32].

Overall, confidence in one's knowledge of HIV infection was higher than of viral Hepatitis and other STIs for all three activities that CHWs were involved in (prevention/screening and testing/treatment and support). Higher levels of self-perceived confidence were reported for prevention activities, the activities that they performed more frequently (see chapter 4.1), than for screening/testing and/or treatment/support activities (Table 6-1).

Table 6-1: Self-perceived confidence in knowledge of HIV, viral Hepatitis and other STIs as a CHW (n=1,035)

| Area of knowledge | Level of confidence | HIV or AIDS % | Hepatitis B/C* % | Other STIs** % |
|--------------------------|---------------------------|---------------|------------------|----------------|
| Prevention | 1 (not confidence at all) | 0.1 | 2.5 | 0.9 |
| | 2 | 1.3 | 6.5 | 5.5 |
| | 3 | 5.6 | 23.9 | 15.0 |
| | 4 | 26.8 | 29.4 | 33.3 |
| | 5 (very confident) | 66.2 | 37.7 | 45.2 |
| Screening/testing | 1 (not confidence at all) | 1.1 | 5.2 | 3.5 |
| | 2 | 6.2 | 17.0 | 13.9 |
| | 3 | 13.4 | 23.1 | 23.7 |
| | 4 | 30.4 | 26.7 | 29.2 |
| | 5 (very confident) | 48.9 | 28.0 | 29.7 |
| Treatment/support | 1 (not confidence at all) | 1.8 | 5.9 | 3.5 |
| | 2 | 9.3 | 21.7 | 16.9 |
| | 3 | 24.6 | 31.6 | 25.6 |
| | 4 | 36.6 | 27.1 | 32.8 |
| | 5 (very confident) | 27.7 | 13.7 | 21.1 |

*10.7% missing value. **10.4% missing value.

In all disease areas – HIV, viral Hepatitis or other STIs– CHWs older than 40 years more often reported feeling “very confident” in their knowledge about prevention (70.6%, 42.2% and 48.9%, respectively) compared to their counterparts (Table 6-2).

Regarding STIs, men more often reported feeling ‘very confident’ in their knowledge regarding prevention, screening/testing and treatment/support activities (48.6%, 33.0%, and 23.4%, respectively) compared to women or those identifying as another gender. These percentages were also higher among homosexual/bisexual CHWs compared to heterosexual and other CHWs reporting a different sexual identity (48.5%, 33.4%, and 24.2%, respectively) (Table 6-2).

Homosexual/bisexual CHWs more often reported feeling “very confident” in their knowledge of HIV prevention (69.3%) compared to their counterparts (Table 6-2).

Table 6-2: Percentage of CHWs very confident in their knowledge regarding HIV/AIDS, hepatitis B/C and other STIs by age, gender and sexual identity (n=1,035)

| | HIV/AIDS | | | Hepatitis | | | STIs | | |
|-------------------------|--------------|--------------------|--------------------|--------------|---------------------|--------------------|--------------|---------------------|--------------------|
| | Prevention | Screening /testing | Treatment /support | Prevention | Screening /testing* | Treatment /support | Prevention | Screening /testing* | Treatment /support |
| Age group | | | | | | | | | |
| 18-30 years | 56.2 | 43.7 | 23.7 | 30.4 | 22.2 | 11.9 | 44.9 | 29.9 | 22.9 |
| 31-40 years | 66.0 | 49.0 | 25.5 | 35.4 | 27.8 | 11.1 | 39.8 | 26.0 | 18.8 |
| More than 40 years | 70.6 | 51.1 | 30.9 | 42.2 | 30.6 | 16.1 | 48.9 | 32.1 | 22.0 |
| <i>p-value</i> | <i>0.001</i> | <i>0.221</i> | <i>0.095</i> | <i>0.01</i> | <i>0.098</i> | <i>0.112</i> | <i>0.043</i> | <i>0.207</i> | <i>0.461</i> |
| Gender | | | | | | | | | |
| Man | 68.5 | 50.2 | 28.7 | 39.8 | 29.1 | 14.3 | 48.6 | 33.0 | 23.4 |
| Woman | 60.9 | 46.6 | 24.8 | 33.0 | 26.1 | 12.0 | 38.1 | 22.3 | 15.8 |
| Other/prefer not to say | 64.7 | 41.9 | 31.2 | 35.3 | 22.6 | 16.1 | 36.1 | 22.6 | 21.2 |
| <i>p-value</i> | <i>0.076</i> | <i>0.434</i> | <i>0.428</i> | <i>0.287</i> | <i>0.325</i> | <i>0.617</i> | <i>0.007</i> | <i>0.004</i> | <i>0.042</i> |
| Sexual identity | | | | | | | | | |
| Homo/Bisexual | 69.3 | 50.2 | 28.2 | 39.2 | 69.1 | 13.8 | 48.5 | 33.4 | 24.2 |
| Heterosexual | 62.5 | 48.4 | 30.3 | 36.7 | 30.9 | 15.3 | 38.1 | 23.3 | 15.7 |
| Other ^a | 57.0 | 42.9 | 19.5 | 31.5 | 23.1 | 9.9 | 43.1 | 22.9 | 17.0 |
| <i>p-value</i> | <i>0.015</i> | <i>0.349</i> | <i>0.094</i> | <i>0.141</i> | <i>0.514</i> | <i>0.399</i> | <i>0.019</i> | <i>0.004</i> | <i>0.013</i> |

^aQueer, any other term, don't use a term. *10.7% missing values.

Regarding STIs, peer CHWs more often reported feeling 'very confident' in their knowledge of prevention, screening and/or testing, and treatment and/or support (50.3%, 34.0% and 24.5%, respectively) compared to non-peer CHWs (37.8%, 23.2% and 16.3%, respectively). Regarding HIV, peer CHWs more often reported feeling 'very confident' in their knowledge of prevention (70.4%) compared to non-peer CHWs (60.0%). Regarding hepatitis B and C, no differences in confidence in one's knowledge were observed by peer role (Figure 6-1).

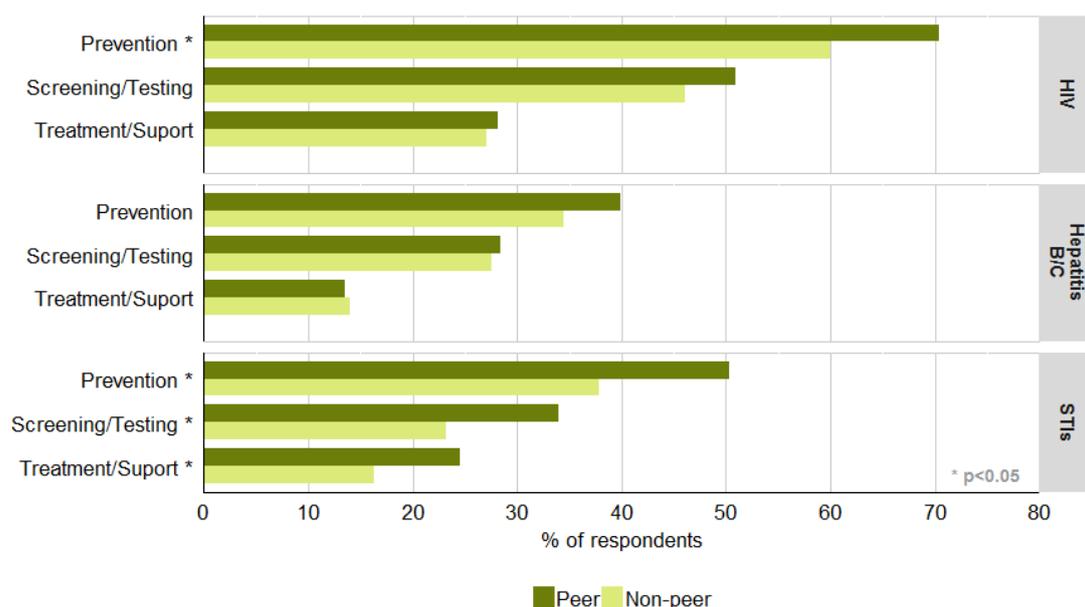


Figure 6-1: Percentage of CHWs very confident in their knowledge by peer role (n=1,035)

Regarding STIs, paid CHWs more often reported feeling 'very confident' in their knowledge about prevention, screening and/or testing, and treatment and/or support (47.4%, 32.1% and 22.9%, respectively) compared to volunteer CHWs (40.2%, 24.0% and 17.1%, respectively). Regarding HIV/AIDS and Hepatitis, paid CHWs also reported more confidence in their knowledge of screening and testing activities (Figure 6-2).

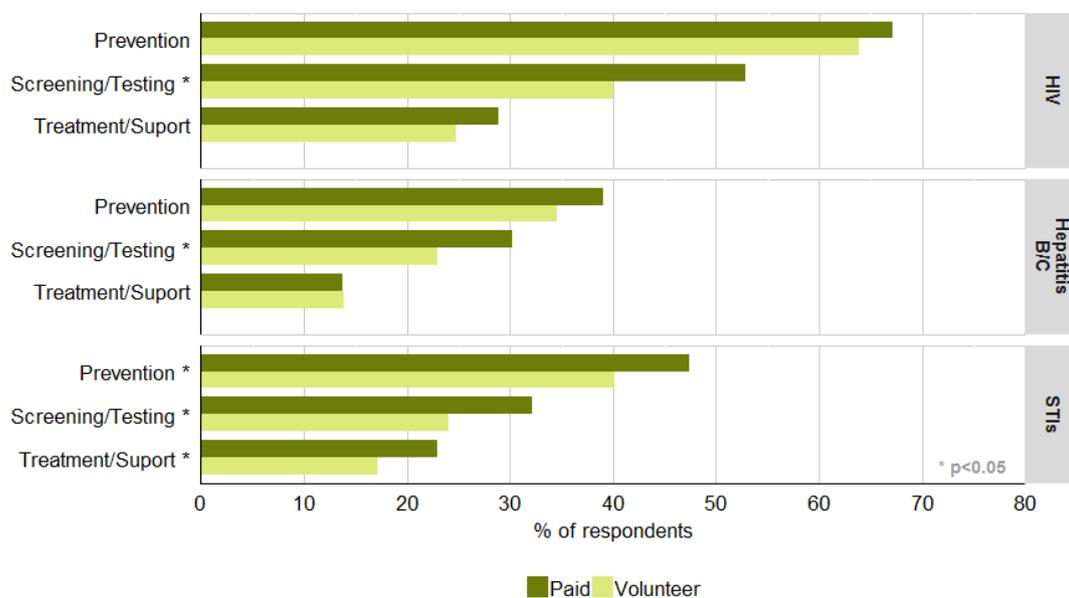


Figure 6-2: Percentage of CHWs very confident in their knowledge by employment status (n=1,035)

Self-reported confidence in knowledge by the LGBTI inequality level of the working countries

The level of confidence in knowledge of HIV infection for CHWs from both 'low LGBTI inequality' and 'high LGBTI inequality' countries was higher than for Hepatitis and other STIs across all three activities (prevention/screening and testing/treatment and support). The percentage of CHWs from countries with 'low LGBTI inequality' reporting that they were 'very confident' in their knowledge on STI screening/testing and STI treatment/support (32.4% and 23.0%, respectively) was higher than CHWs from 'high LGBTI inequality' countries (20.7% and 15.2%, respectively) (Table 6-3).

Table 6-3: Percentage of CHWs very confident in their knowledge regarding HIV/AIDS, hepatitis B/C and other STIs by the LGBTI inequality level of the working country

| | Low LGBTI inequality (n=786) | High LGBTI inequality (n=249) | p-value |
|----------------------------------|------------------------------|-------------------------------|---------|
| HIV/AIDS | | | |
| Knowledge on prevention | 67.5 | 61.7 | 0.106 |
| Knowledge on screening/testing | 49.9 | 45.6 | 0.254 |
| Knowledge on treatment/support | 28.4 | 25.3 | 0.362 |
| Hepatitis B/C | | | |
| Knowledge on prevention | 37.4 | 38.7 | 0.718 |
| Knowledge on screening/testing* | 28.2 | 27.5 | 0.849 |
| Knowledge on treatment/support | 13.2 | 15.3 | 0.424 |
| Other STIs | | | |
| Knowledge on prevention | 46.9 | 39.6 | 0.053 |
| Knowledge on screening/testing** | 32.4 | 20.7 | 0.001 |
| Knowledge on treatment/support | 23.0 | 15.2 | 0.014 |

*10.7% missing value. **10.4% missing value.

Stratifying by 'low LGBTI inequality' countries (Table 6-4), the country with the lowest percentage of CHWs who were 'very confident' in their knowledge on screening/testing (in the three disease areas: HIV/AIDS, Hepatitis B or C and STIs) was Germany (36.9%, 18.6% and 25.4%, respectively), probably because of the laws or policies that prevent community-based testing being delivered by non-medical staff.

Table 6-4: Percentage of CHWs very confident in their knowledge regarding HIV/AIDS, hepatitis B/C and other STIs by low LGBTI inequality countries

| | Germany (n=195) | Spain (n=174) | UK (n=94) | France (n=83) | Other ^a (n=240) | p-value |
|-----------------------------------|-----------------|---------------|-----------|---------------|----------------------------|---------|
| HIV/AIDS | | | | | | |
| Knowledge on prevention | 68.6 | 66.3 | 78.0 | 62.7 | 65.1 | 0.176 |
| Knowledge on screening/testing | 36.9 | 48.2 | 62.9 | 57.8 | 54.1 | <0.0001 |
| Knowledge on treatment/support | 19.4 | 31.9 | 40.9 | 18.3 | 32.3 | <0.0001 |
| Hepatitis B/C | | | | | | |
| Knowledge on prevention | 36.9 | 38.9 | 36.0 | 41.0 | 36.0 | 0.926 |
| Knowledge on screening/testing** | 18.6 | 27.9 | 25.0 | 39.5 | 33.5 | 0.002 |
| Knowledge on treatment/support | 13.1 | 18.7 | 9.3 | 7.3 | 13.1 | 0.102 |
| Other STIs | | | | | | |
| Knowledge on prevention | 48.4 | 43.1 | 54.4 | 35.4 | 49.6 | 0.084 |
| Knowledge on screening/testing*** | 25.4 | 28.2 | 40.2 | 25.8 | 40.3 | 0.004 |
| Knowledge on treatment/support | 19.6 | 20.8 | 27.3 | 15.4 | 28.5 | 0.066 |

^aMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. **10.7% missing value. ***10.4% missing value.

6.2. Training received and training needs

Training received and further training opportunities

ECHOES respondents were asked about the kind of training received (if any) during their work as a CHW. Overall, 912 respondents (89.6%) reported previous training. For a large majority of them, the training was internal or in-house (89.9%, figure 6-3).

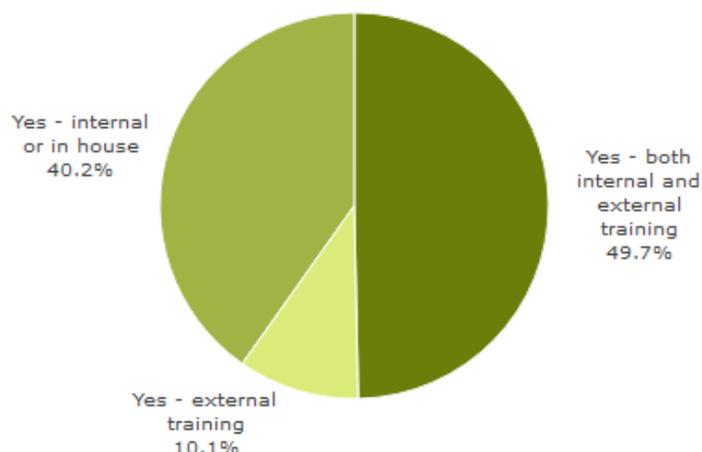


Figure 6-3: Type of training received in their role as a CHW (n=912)

No differences were observed in the percentage of trained CHWs by age, sexual identity, gender, and employment status. However, differences by peer role emerged: the percentage of trained peer CHWs (91.2%) was higher than the percentage of trained non-peer CHWs (87.3%, Figure 6-4).

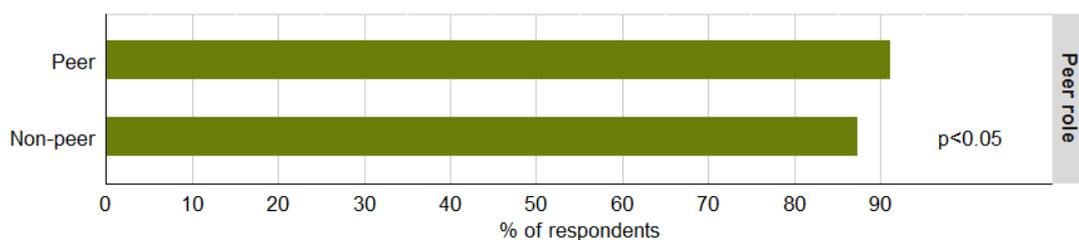


Figure 6-4: Training received by peer role (n=1,035)

As for the training methodology, face-to-face training (e.g. seminars, workshops, lectures, group work, conferences...) were most commonly reported (92.1%). Structured support³⁴ (52.0%) and structured observation³⁵ (47.7%) were also reported often as training methodologies. Online courses such as webinars, online training programmes and online lectures, were only mentioned by 25.3% of respondents (Figure 6-5).

³⁴ Structured support (e.g. supervision or mentoring) has a clear purpose and a structured framework but is less formalised than a face-to-face or online course. Structured support may happen on one or numerous occasions over a longer period of time.

³⁵ Structured observation (e.g. shadowing opportunities) has a formalised structure and purpose but is conducted less 'hands-on' and at more of a 'distance' than structured support.

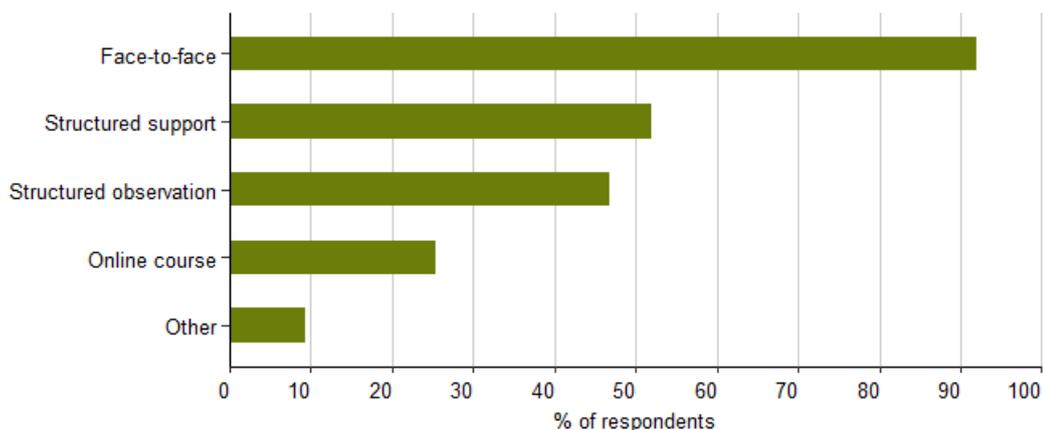


Figure 6-5: Training methodology (n=912, multiple answer)

Training providers (i.e. the individuals or organisations which provided the training) were firstly CHWs' own organisation (80%), followed by other HIV/Hepatitis/STI or sexual health community organisations (50%) and LGBTI community organisations (38.2%, Figure 6-6).

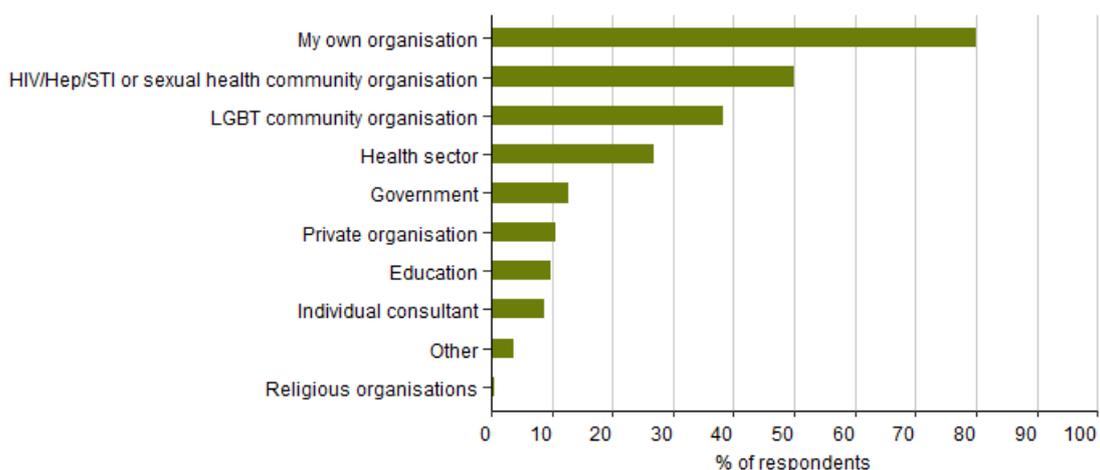


Figure 6-6: Training providers (n=912, multiple answer)

Training was paid mainly by their organisations (68%, Figure 3-7). Other sources of payment reported were mainly: donors, organisers, government, external sources, laboratories, NGOs, public funds, and Global Fund. More than three-quarter of CHWs who received training (79.5%) reported that it was totally free of charge (financed by their organisation or other external sources). No differences by age, sexual identity, gender and peer role were observed in the percentage of CHWs who received free training. However, volunteer CHWs reported less frequently free training received than paid CHWs (74.4% and 80.6%, respectively, $p < 0.05$).

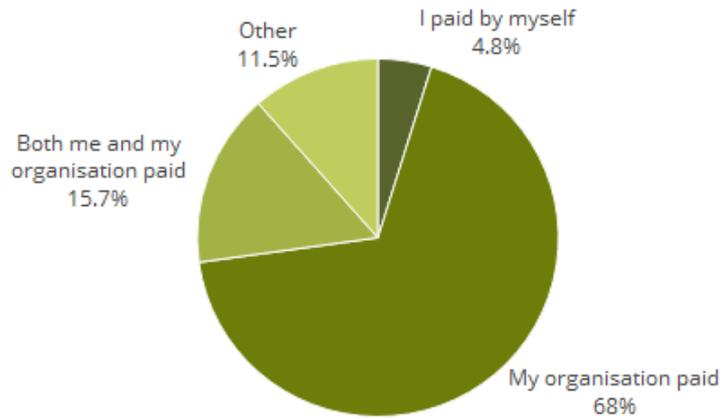


Figure 6-7: Who paid the training? (n=912)

The percentage of CHWs who reported having found the training by themselves was 20.0%; and 45% reported that the training was found by their organisation (Figure 6-8).

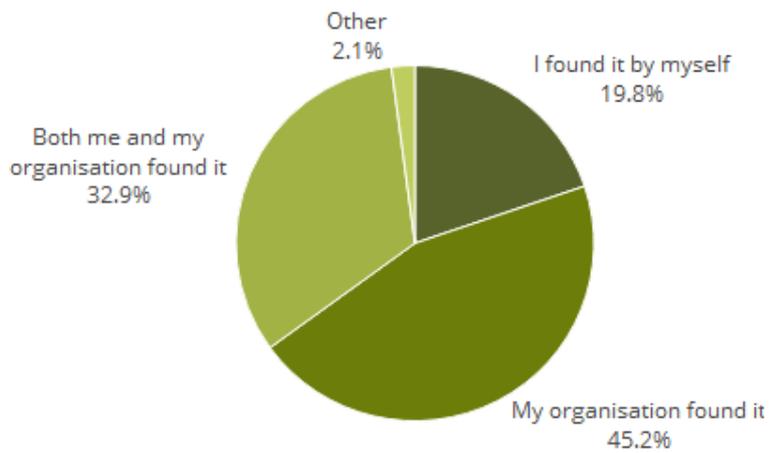


Figure 6-8: Who found the training? (n=912)

Further training opportunities seemed to be available for 65.3% of respondents. Untrained CHWs reported lower training opportunities available than CHWs who were previously trained (Figure 6-9).

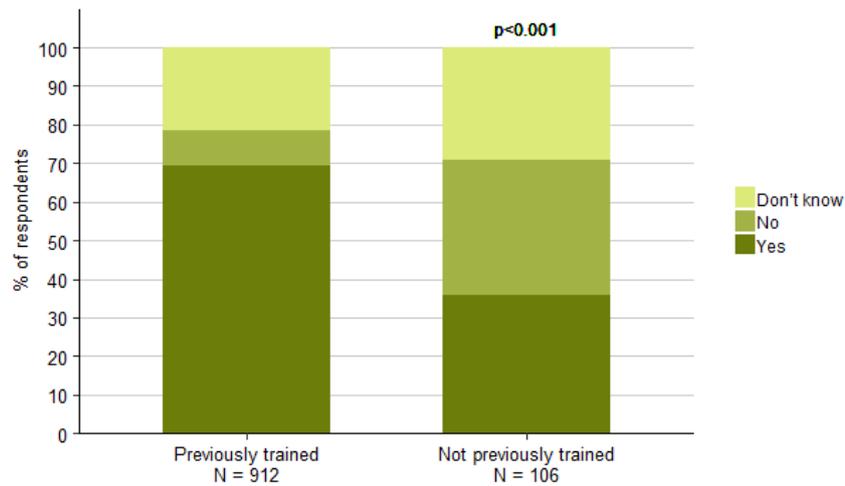


Figure 6-9: Further training opportunities available or ongoing by training received (n=1,035)

Who are those CHWs who did not receive training?

Overall, 106 respondents (10.4%) did not receive any training for their current role as a CHW, representing a core audience for future training. When looking at the socio-demographic characteristics of CHWs who had received vs. not received training, there was no significant difference by age, gender, level of education, ethnic minority status, sexual identity and employment status. The percentage of CHWs with 5 or less years of experience as a CHW was higher among untrained CHWs in comparison with CHWs with a longer career (60.6% vs. 45.9%, respectively), as well as being higher in non-peer CHWs compared to peer CHWs(50.0% vs. 39.8%, respectively) (Table 6-5).

Table 6-5: Comparison of socio-demographic characteristics, years of experience as a CHW and organisation type of trained and untrained CHWs

| | Untrained CHWs n=106 (%) | Trained CHWs n=912 (%) | p-value |
|---|-----------------------------|---------------------------|---------|
| Age group | | | 0.342 |
| 18-30 years | 15.1 | 21.2 | |
| 31-40 years | 34.0 | 31.5 | |
| More than 40 years | 50.9 | 47.4 | |
| Gender | | | 0.269 |
| Man | 61.3 | 68.8 | |
| Woman | 34.0 | 27.6 | |
| Other/prefer not to say | 4.7 | 3.6 | |
| Belonging to an ethnic minority | | | 0.271 |
| No | 94.3 | 91.2 | |
| Yes | 5.7 | 8.8 | |
| Years in full-time education since the age of 16 | | | 0.540 |
| 0-7 years | 48.6 | 51.7 | |
| More than 7 years | 51.4 | 48.3 | |
| Sexual identity | | | 0.111 |
| Homo/Bisexual | 53.8 | 63.6 | |
| Heterosexual | 33.0 | 24.3 | |
| Other ^a | 13.2 | 12.1 | |
| Peer role as a CHW | | | 0.043 |
| No | 50.0 | 39.8 | |
| Yes | 50.0 | 60.2 | |
| Employment status as a CHW | | | 0.816 |
| Paid | 70.5 | 69.4 | |
| Volunteer | 29.5 | 30.6 | |
| Years as a CHW | | | 0.014 |
| 0 to 5 | 60.6 | 45.9 | |
| 6 to 10 | 15.4 | 24.4 | |
| More than 10 | 24.0 | 29.7 | |
| Organisation type^b | | | 0.276 |
| Private not-for-profit | 83.2 | 87.2 | |
| Other ^c | 16.8 | 12.8 | |

^aQueer, any other term, don't use a term. ^bn=975 who were not self-employed. ^c Government/local authority, public organisation, other type.

Among untrained CHWs, 21.9% reported 'lack of knowledge' as one of the main barriers to performing activities as a CHW (compared to 9.4% of trained CHWs). This result is consistent with the self-perceived level of knowledge of HIV/AIDS, viral hepatitis and STIs between CHWs who reported receiving some training in prevention, screening/testing and/or treatment/support areas and CHWs who did not (Table 6-6). A higher percentage of trained CHWs reported feeling 'very confident' in their knowledge of prevention, screening/testing and treatment/support activities regarding HIV, viral Hepatitis and other STIs.

Table 6-6: Percentage of CHWs very confident in their knowledge regarding HIV, viral Hepatitis and other STIs by type of training received

| | Training received on "prevention" area | | |
|---|--|-------------|---------|
| | No (n=194) | Yes (n=837) | p-value |
| % Very confident in their knowledge on prevention | | | |
| HIV | 56.2 | 68.3 | 0.002 |
| Hepatitis B/C | 28.3 | 39.8 | 0.006 |
| STIs | 36.3 | 47.1 | 0.010 |
| | Training received on "screening and/or testing" area | | |
| | No (n=327) | Yes (n=724) | p-value |
| % Very confident in their knowledge on screening/testing | | | |
| HIV | 29.0 | 57.4 | <0.001 |
| Hepatitis B/C* | 19.6 | 31.7 | <0.001 |
| STIs** | 21.8 | 33.1 | 0.001 |
| | Training received on "treatment and/or support" area | | |
| | No (n=440) | Yes (n=591) | p-value |
| % Very confident in their knowledge on treatment/support | | | |
| HIV | 18.0 | 34.5 | <0.001 |
| Hepatitis B/C | 9.1 | 16.8 | 0.001 |
| STIs | 14.7 | 25.5 | <0.001 |

*10.7% missing value. **10.4% missing value.

Areas covered in training

ECHOES respondents were asked which areas were covered in training received prior to working as a CHW, if any. There was substantial variation in the topics covered in training, with a range of 3.9 to 92.2% across the 28 topics (Figure 6-10).

Overall, the CHW training was largely prevention, screening/testing and treatment (with topics focussing mainly on knowledge rather than soft skills), while areas such as communication and interpersonal skills received less coverage. Training covering administrative, leadership & management or financial skills were barely reported (Figure 6-10).

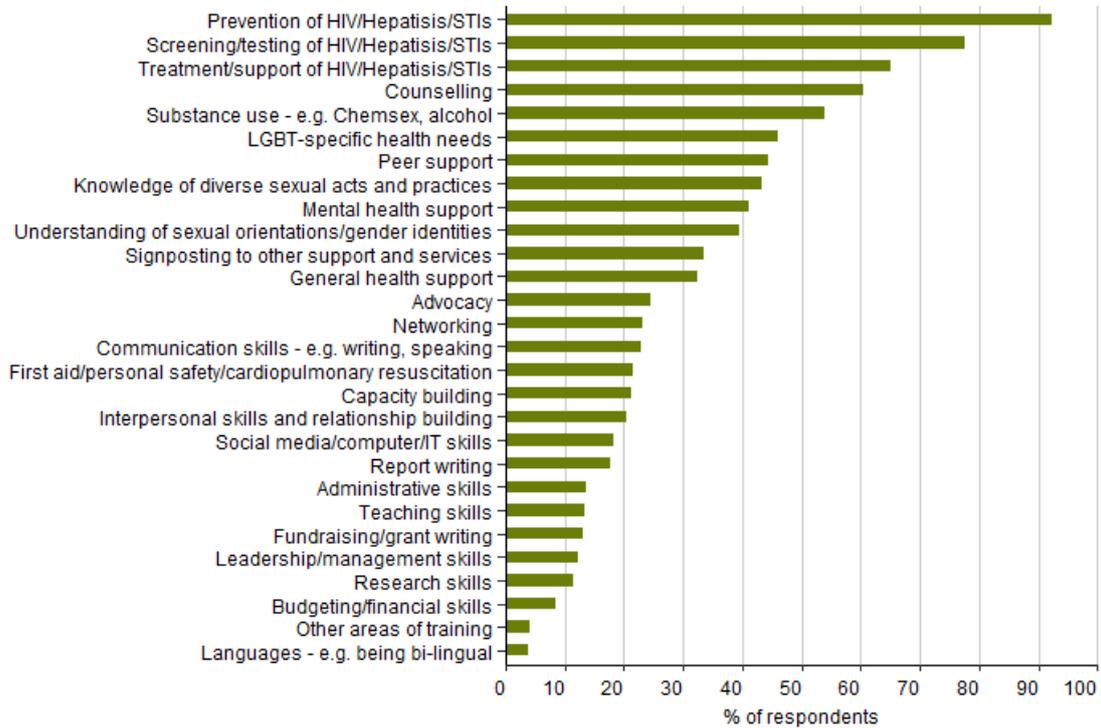


Figure 6-10: Areas covered in training (n=912, multiple answer)

Differences in the areas covered in training according to the peer role are presented in Figure 6-11. Compared to non-peer CHWs, peer CHWs reported more frequently having been trained on topics around substance use, LGBTI-specific health needs, peer support, mental health support, and referral to other support and services.

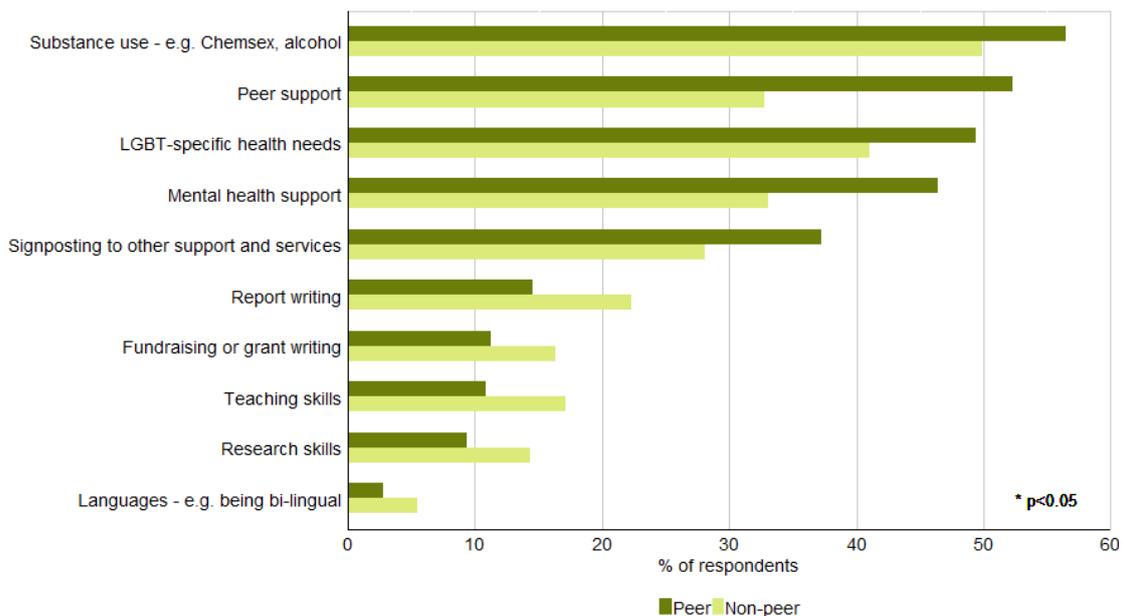


Figure 6-11: Different areas covered in training by peer role (n=912, multiple answer; significant differences only*)

Compared to peer CHWs, a higher proportion of non-peer CHWs reported prior training in the areas report/grant writing, research, and teaching. This is consistent with the higher percentage of trained non-peer CHWs reporting cross-cutting activities³⁶ compared with trained peer CHWs (Figure 6-12).

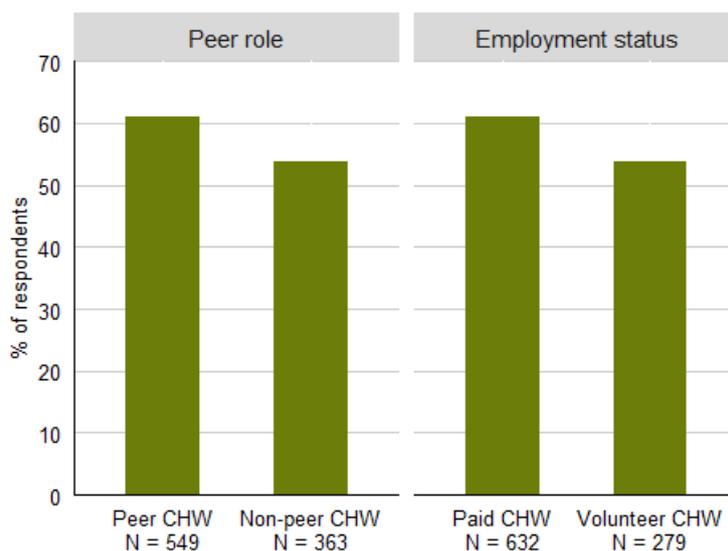


Figure 6-12: Cross-cutting activities performed by trained CHWs by peer role and employment status (n=912)

Regarding employment status (Figure 6-13), paid CHWs more often reported being trained in activities such as screening/testing, treatment and/or support of HIV, viral hepatitis and other STIs, general skills such as first aid or personal safety, as well as capacity building, communication skills such as report/grant writing, social media or computer skills, networking and research skills, consistent with their higher frequency of reported cross-cutting activities compared to volunteer CHWs (Figure 6-11).

³⁶ See details of cross-cutting activities in section 4.7.

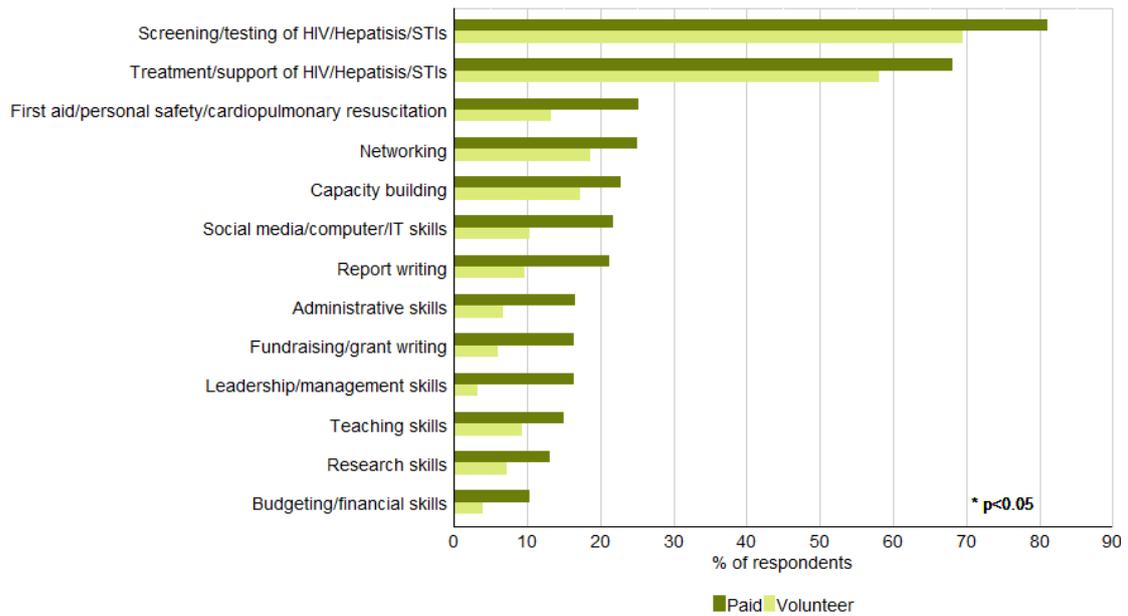


Figure 6-13: Different areas covered in training by employment status* (n=912, multiple answer)

Self-reported training needs

ECHOES respondents were asked to choose up to 5 areas in which they would most benefit from additional training (hereafter referred to as 'training needs'). Overall, ECHOES respondents indicated they needed more training on: 1) substance use, 2) prevention of HIV, viral hepatitis and other STIs and 3) mental health support (40.3%, 35.9%, and 32.8%, respectively). Screening/testing and Treatment/support areas were reported by approximately 27% of CHWs. Leadership, capacity building and/or communication skills were not among the most important needs indicated (10.7%, 10.5% and 7.9%, respectively) (Figure 6-14).

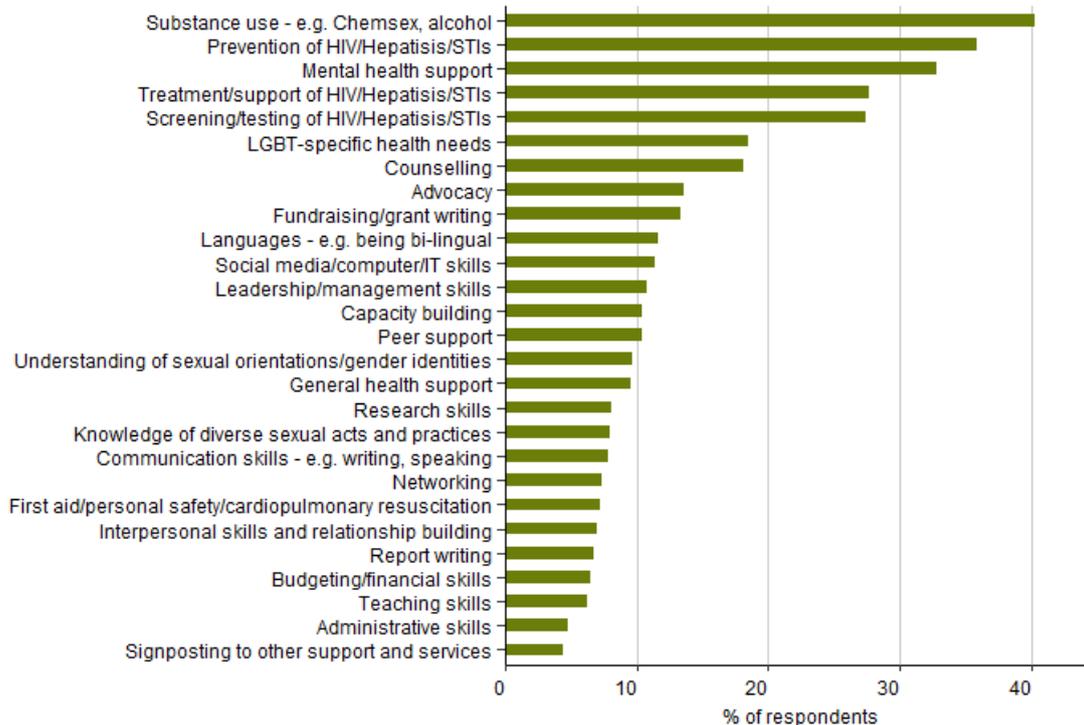


Figure 6-14: Self-reported training needs (n=1,035, multiple answer)

Differences in self-reported training needs according to the peer role are presented in Figure 3-15. Research and capacity building training needs were more frequently reported by non-peer CHWs (10.7% and 12.9%, respectively) in comparison to peer CHWs (6.3% and 8.8%, respectively). Training needs to improve knowledge of diverse sexual acts and practices was more reported by non-peer CHWs (10% and 6.6% among non-peer and peer CHWs, respectively). On the other hand, counselling skills and peer support were more often reported as training needs by peer CHWs (20.3% and 12.0%, respectively) compared to non-peer CHWs (15.0% and 8.3%, respectively).

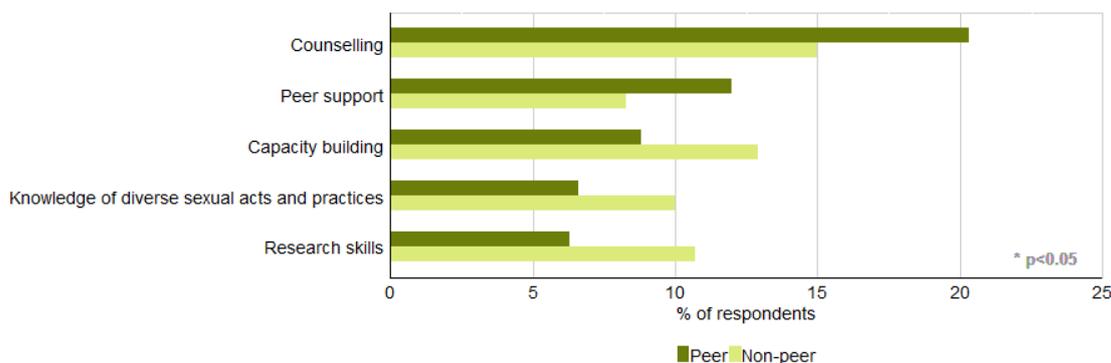


Figure 6-15: Self-reported training needs by peer role* (n=1,035, multiple answer)

Differences in self-reported training needs by employment status are presented in Figure 6-16. As seen in 'training received', a larger proportion of paid CHWs wanted

to be trained in “soft skills” such as communication (report writing, social media or computer skills) and leadership, as well as in administration, finance, and research compared to volunteer CHWs.

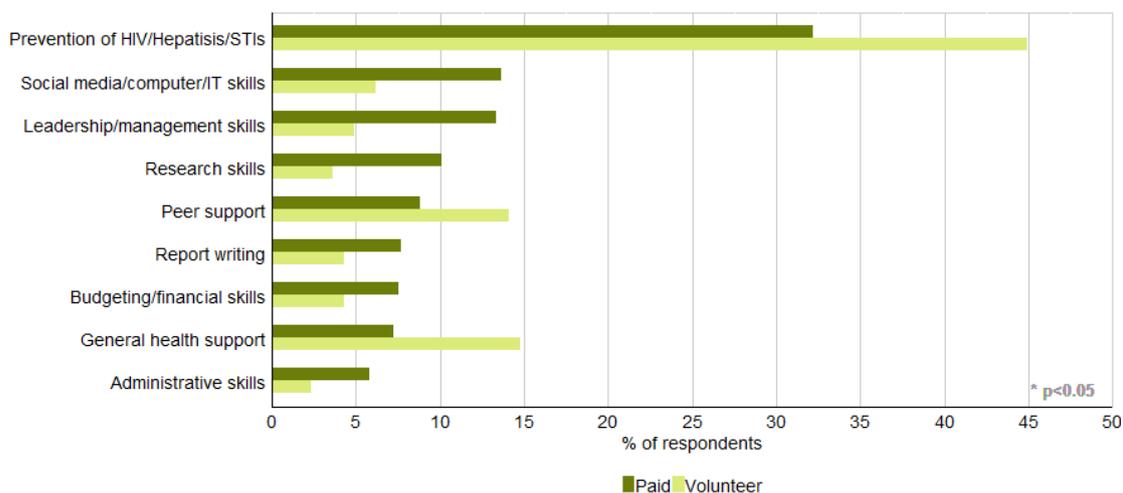


Figure 6-16: Different self-reported training needs by employment status* (n=1,035, multiple answer)

Broadly, self-reported training needs were not associated with the main purpose of the organisation (Table 6-7). Differences in self-reported training needs by activities performed by CHWs are presented in Table 6-8. Substance use as a reported training need was more reported by CHWs performing counselling/testing activities than those who did not report this activity. On the other hand, advocacy and capacity building as a training need was more frequently reported by CHWs who perform treatment-related activities such as adherence support, referrals to health services, etc.

Table 6-7: Self-reported training needs by organisation purpose (n=975)*

| | Sexual health (n=559) | LGBTI needs/advocacy (n=212) | Mental /substance use (n=34) | Other (n=166) |
|---|--------------------------|------------------------------------|------------------------------------|------------------|
| Substance use - e.g. Chemsex, alcohol | 40.9 | 43.1 | 37.5 | 34.4 |
| Prevention of HIV, viral hepatitis and other STIs | 66.6 | 58.9 | 62.5 | 62.6 |
| Mental health support | 34.1 | 33.5 | 40.6 | 27.0 |
| Treatment and/or support of HIV/hepatitis/other STIs | 25.4 | 33.0 | 21.9 | 29.4 |
| Screening and/or testing of HIV/hepatitis/other STIs | 26.6 | 29.7 | 21.9 | 29.4 |
| LGBT-specific health needs ^a | 14.4 | 26.8 | 25.0 | 17.8 |
| Counselling | 19.3 | 18.7 | 6.2 | 13.5 |
| Advocacy | 12.4 | 14.8 | 21.9 | 14.1 |
| Fundraising or grant writing | 13.3 | 12.0 | 12.5 | 14.1 |
| Languages - e.g. being bi-lingual | 10.8 | 12.0 | 15.6 | 16.6 |
| Social media or computer or IT skills | 13.1 | 10.0 | 6.2 | 9.8 |
| Leadership or management skills | 10.9 | 11.0 | 12.5 | 9.8 |
| Capacity building | 10.2 | 10.0 | 9.4 | 13.5 |
| Peer support | 9.5 | 10.5 | 9.4 | 14.1 |
| Sexual orientations and gender identities understanding | 10.8 | 8.1 | 12.5 | 8.6 |
| General health support | 8.8 | 8.6 | 15.6 | 11.7 |
| Research skills | 7.5 | 8.1 | 9.4 | 9.2 |
| Knowledge of diverse sexual acts and practices | 8.4 | 8.1 | 6.2 | 7.4 |
| Communication skills - e.g. writing, speaking | 6.9 | 8.6 | 6.2 | 10.4 |
| Networking | 6.2 | 9.1 | 12.5 | 8.6 |
| First aid or personal safety or CPR | 7.3 | 6.2 | 6.2 | 7.4 |
| Interpersonal skills and relationship building | 6.6 | 7.7 | 3.1 | 6.7 |
| Report writing | 6.9 | 6.7 | 6.2 | 4.3 |
| Budgeting or financial skills | 7.7 | 5.3 | 3.1 | 5.5 |
| Teaching skills | 5.8 | 7.7 | 9.4 | 3.7 |
| Administrative skills | 4.2 | 4.3 | 0 | 8.6 |
| Signposting to other support and services | 3.8 | 3.8 | 3.1 | 7.4 |

^ap=0.001. *Multiple answer.

Table 6-8: Self-reported training needs by and CHW activities in the continuum of HIV/STI services (n=1,035)*

| | Prevention | | Counselling /testing | | Linkage to care | | Treatment and care | |
|---|------------|-------------|----------------------|-------------|-----------------|-------------|--------------------|-------------|
| | No (n=118) | Yes (n=917) | No (n=385) | Yes (n=650) | No (n=575) | Yes (n=460) | No (n=504) | Yes (n=531) |
| Substance use - e.g. Chemsex, alcohol | 33.9 | 41.2 | 36.3 | 42.7 | 38.9 | 42.1 | 40.2 | 40.4 |
| Prevention of HIV, viral hepatitis and other STIs | 29.6 | 39.7 | 39.7 | 33.6 | 40.9 | 29.7 | 44.1 | 28.3 |
| Mental health support | 26.1 | 36.0 | 36.0 | 31.0 | 34.8 | 30.4 | 33.7 | 32.1 |
| Treatment and/or support of HIV/hepatitis/STIs | 27.0 | 25.3 | 25.3 | 29.1 | 27.7 | 27.8 | 28.5 | 26.9 |
| Screening and/or testing of HIV/hepatitis/STIs | 22.6 | 24.0 | 24.0 | 29.4 | 27.9 | 26.9 | 31.4 | 23.7 |
| LGBT-specific health needs | 13.9 | 17.9 | 17.9 | 18.9 | 17.7 | 19.6 | 20.5 | 16.7 |
| Counselling | 19.1 | 20.3 | 20.3 | 16.9 | 19.6 | 16.3 | 19.3 | 17.1 |
| Advocacy | 9.6 | 13.3 | 13.3 | 13.8 | 11.8 | 15.9 | 8.0 | 18.8 |
| Fundraising or grant writing | 10.4 | 11.5 | 11.5 | 14.6 | 11.3 | 16.1 | 10.3 | 16.3 |
| Languages - e.g. being bi-lingual | 10.4 | 10.1 | 10.1 | 12.5 | 10.5 | 13.0 | 9.2 | 13.9 |
| Social media or computer or IT skills | 9.6 | 11.5 | 11.5 | 11.4 | 9.8 | 13.4 | 9.4 | 13.3 |
| Leadership or management skills | 11.3 | 8.8 | 8.8 | 11.9 | 8.4 | 13.7 | 7.6 | 13.7 |
| Capacity building | 10.4 | 9.6 | 9.6 | 11.0 | 10.0 | 11.0 | 6.4 | 14.2 |
| Peer support | 13.9 | 13.6 | 13.6 | 8.6 | 11.6 | 9.0 | 12.3 | 8.7 |
| Sexual orientations/gender identities understanding | 9.6 | 9.9 | 9.9 | 9.5 | 9.8 | 9.5 | 9.2 | 10.1 |
| General health support | 13.9 | 12.3 | 12.3 | 8.0 | 10.9 | 7.9 | 10.3 | 8.9 |
| Research skills | 6.1 | 5.9 | 5.9 | 9.4 | 6.1 | 10.6 | 6.0 | 10.1 |
| Knowledge of diverse sexual acts and practices | 6.1 | 8.3 | 8.3 | 7.8 | 8.8 | 7.0 | 9.9 | 6.3 |
| Communication skills - e.g. writing, speaking | 11.3 | 8.3 | 8.3 | 7.7 | 7.7 | 8.1 | 7.4 | 8.3 |
| Networking | 10.4 | 7.7 | 7.7 | 7.2 | 7.1 | 7.7 | 6.8 | 8.0 |
| First aid or personal safety or CPR | 9.6 | 8.3 | 8.3 | 6.6 | 7.9 | 6.4 | 8.2 | 6.3 |
| Interpersonal skills and relationship building | 6.1 | 7.7 | 7.7 | 6.6 | 8.2 | 5.5 | 8.0 | 6.1 |
| Report writing | 7.8 | 6.1 | 6.1 | 7.0 | 5.4 | 8.4 | 5.3 | 8.0 |
| Budgeting or financial skills | 6.1 | 5.3 | 5.3 | 7.2 | 5.0 | 8.4 | 5.1 | 7.8 |
| Teaching skills | 7.8 | 8.0 | 8.0 | 5.2 | 6.1 | 6.4 | 6.2 | 6.3 |
| Administrative skills | 3.5 | 5.1 | 5.1 | 4.5 | 3.8 | 5.9 | 4.1 | 5.3 |
| Signposting to other support and services | 6.1 | 4.8 | 4.8 | 4.2 | 5.0 | 3.7 | 5.1 | 3.8 |

Significant differences (p<0.05) highlighted in bold. *Multiple answer.

Training needs compared to what CHWs had received training in

We compared training needs with training received among CHWs who reported having received training (Figure 6-17), and found that CHWs generally request training on aspects they have already received some training in before. Moreover, training needs were broadly higher among those who received previous training than CHWs who did not. CHWs who had previously received training in languages, finance, research, leadership, fundraising, social media, interpersonal and capacity building skills, perceived the need for more advanced training compared to those who had never received such training.

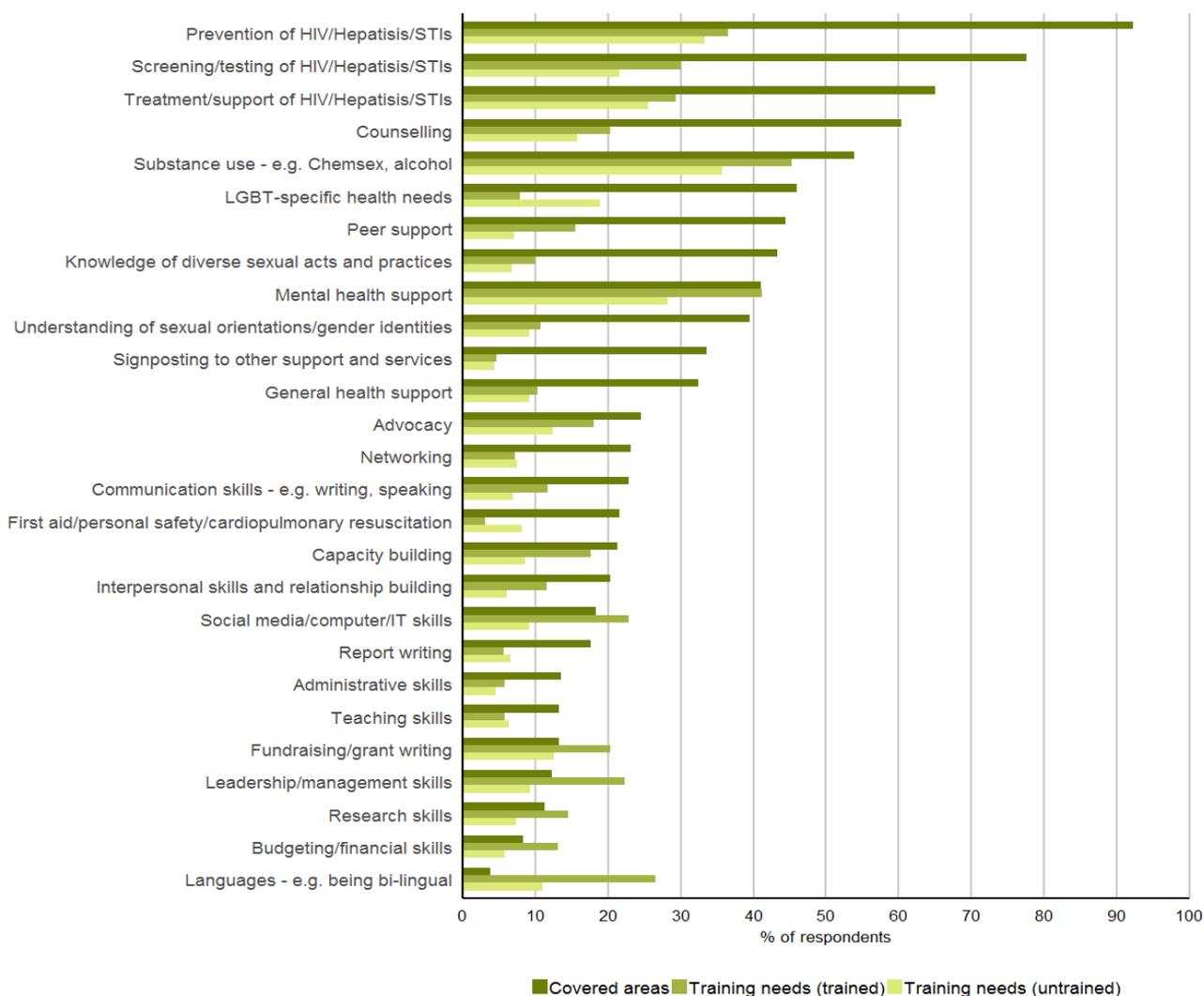


Figure 6-17: Areas covered in training and self-reported training needs (n=1,035; multiple answer)

Areas covered in training and self-reported training needs by the LGBTI inequality level of the working country

The percentage of respondents who received training during their work as a CHW was similar between CHWs from 'low LGBTI inequality' and 'high LGBTI inequality' countries (89.7% and 89.3%, respectively). No differences were seen in the percentage of trained CHWs between the different countries of the 'low LGBTI inequality' category.

Topics of training received by CHWs are described by level of LGBTI inequality in the working country (Table 6-9). Substance use and mental health topics were more frequently reported by CHWs from 'low LGBTI inequality' countries (58.5% and 43.6%, respectively). Cultural competency skills such as understanding of different sexual orientations or gender identities, and LGBTI-specific health needs were less frequently reported by CHWs from 'high LGBTI inequality' countries (32.3% and 37.3%, respectively). However, in these respondents from 'high LGBTI inequality' countries, skills related to advocacy (31.8%), report writing (25.8%), fundraising or grant writing (21.7%), financial skills (12.4%), management skills (17.5%), and research skills (16.6%) were more frequently reported than in respondents from 'low LGBTI inequality' countries.

Table 6-9: Areas covered in training by the LGBTI inequality level of the working country*

| | Low LGBTI inequality (n=694) | High LGBTI inequality (n=218) | p-value |
|---|---------------------------------|----------------------------------|---------|
| Prevention of HIV, viral hepatitis and other STIs | 92.6 | 90.8 | 0.380 |
| Screening and/or testing of HIV, viral hepatitis and other STIs | 77.0 | 79.3 | 0.484 |
| Treatment and/or support of HIV, viral hepatitis and other STIs | 65.0 | 65.4 | 0.901 |
| Counselling | 57.7 | 68.7 | 0.04 |
| Substance use - e.g. Chemsex, alcohol | 58.5 | 39.2 | <0.0001 |
| LGBT-specific health needs | 48.8 | 37.3 | 0.003 |
| Peer support | 44.9 | 43.3 | 0.690 |
| Knowledge of diverse sexual acts and practices | 45.0 | 37.8 | 0.061 |
| Mental health support | 43.6 | 33.2 | 0.007 |
| Understanding of diverse sexual orientations/gender identities | 41.8 | 32.3 | 0.012 |
| Referral to other support and services | 37.9 | 18.8 | <0.0001 |
| General health support | 32.3 | 33.2 | 0.803 |
| Advocacy | 22.3 | 31.8 | 0.005 |
| Networking | 23.2 | 23.0 | 0.972 |
| Communication skills - e.g. writing, speaking | 23.0 | 22.6 | 0.896 |
| First aid or personal safety or cardiopulmonary resuscitation | 22.9 | 17.5 | 0.094 |
| Capacity building | 21.0 | 22.1 | 0.721 |
| Interpersonal and Relationship-building skills | 19.4 | 23.5 | 0.190 |
| Social media or computer or IT skills | 18.4 | 18.0 | 0.892 |
| Report writing | 15.1 | 25.8 | <0.0001 |
| Administrative skills | 12.7 | 16.1 | 0.203 |
| Teaching skills | 12.3 | 16.6 | 0.105 |
| Fundraising or grant writing | 10.6 | 21.7 | <0.0001 |
| Leadership or management skills | 10.7 | 17.5 | 0.008 |
| Research skills | 9.7 | 16.6 | 0.005 |
| Budgeting or financial skills | 7.1 | 12.4 | 0.013 |
| Languages - e.g. being bi-lingual | 3.3 | 5.5 | 0.142 |
| Other areas of training | 5.2 | 0.9 | 0.006 |

*Multiple answer.

With regards to the self-reported training needs (Table 6-10), when comparing 'low LGBTI inequality' to 'high LGBTI inequality' countries, no differences were seen in the percentage of CHWs who reported 'substance use' and 'mental health' as important areas to be considered in future training. Prevention of HIV, viral hepatitis and other STIs was an area more frequently reported by CHWs from 'high LGBTI inequality' countries (47.5% vs. 32% in 'low LGBTI inequality' countries). Fundraising or grant writing was also more frequently reported as a training need by respondents from 'high LGBTI inequality' countries (20.5% vs 11.2% in 'low LGBTI inequality' countries).

Table 6-10: Self-reported training needs by the LGBTI inequality level of the working country*

| | Low LGBTI inequality (n=694) | High LGBTI inequality (n=218) | p-value |
|--|---------------------------------|----------------------------------|---------|
| Prevention of HIV, viral hepatitis, and other STIs | 32.2 | 47.5 | <0.0001 |
| Screening and/or testing of HIV, viral hepatitis, other STIs | 27.1 | 28.3 | 0.729 |
| Treatment and/or support of HIV, viral hepatitis, other STIs | 26.6 | 31.1 | 0.169 |
| Counselling | 17.7 | 19.7 | 0.478 |
| Substance use - e.g. Chemsex, alcohol | 41.0 | 38.1 | 0.417 |
| LGBT-specific health needs | 17.9 | 20.5 | 0.368 |
| Peer support | 10.3 | 11.1 | 0.720 |
| Knowledge of diverse sexual acts and practices | 8.1 | 7.8 | 0.894 |
| Mental health support | 33.0 | 32.4 | 0.860 |
| Understanding of diverse sexual orientations/gender identities | 10.4 | 7.4 | 0.165 |
| Referral to other support and services | 4.8 | 3.3 | 0.313 |
| General health support | 8.8 | 11.9 | 0.158 |
| Advocacy | 13.6 | 13.5 | 0.965 |
| Networking | 7.9 | 5.7 | 0.256 |
| Communication skills - e.g. writing, speaking | 7.8 | 8.2 | 0.838 |
| First aid or personal safety or cardiopulmonary resuscitation | 6.9 | 8.2 | 0.489 |
| Capacity building | 9.5 | 13.5 | 0.072 |
| Interpersonal and Relationship-building skills | 6.6 | 8.2 | 0.401 |
| Social media or computer or IT skills | 11.9 | 9.8 | 0.366 |
| Report writing | 6.8 | 6.6 | 0.915 |
| Administrative skills | 4.2 | 6.6 | 0.124 |
| Teaching skills | 6.0 | 7.0 | 0.575 |
| Fundraising or grant writing | 11.2 | 20.5 | <0.0001 |
| Leadership or management skills | 11.4 | 8.6 | 0.215 |
| Research skills | 8.1 | 8.2 | 0.942 |
| Budgeting or financial skills | 7.0 | 4.9 | 0.248 |
| Languages - e.g. being bi-lingual | 11.3 | 12.7 | 0.551 |
| Other areas of training | 2.7 | 0.4 | 0.030 |

*Multiple answer.

Differences were found in topics covered in training and self-reported training needs when countries in the 'low LGBTI inequality' grouping were compared (Table 6-11 and 6-12). For example, the highest percentage of CHWs who had received training on mental health support was seen in Germany and UK, while CHWs from France reported the highest percentage of previous training in advocacy issues. Mental health training was considered as a training need by 43% of CHWs in France, whereas these percentages were lower in the other countries.

Table 6-11: Areas covered in training by low LGBTI countries*

| | Germany (n=172) | Spain (n=157) | UK (n=84) | France (n=77) | Other ^a (n=204) | p-value |
|--|--------------------|------------------|--------------|------------------|-------------------------------|---------|
| Prevention of HIV, viral hepatitis, other STIs | 93.5 | 96.2 | 90.5 | 97.4 | 88.2 | 0.017 |
| Screening and/or testing of HIV, viral hepatitis, other STIs | 66.5 | 76.4 | 83.3 | 89.6 | 78.8 | 0.001 |
| Treatment and/or support of HIV, viral hepatitis, other STIs | 50.6 | 79.6 | 67.9 | 75.3 | 60.6 | <0.0001 |
| Counselling | 57.1 | 58.6 | 22.6 | 92.2 | 59.1 | <0.0001 |
| Substance use - e.g. Chemsex, alcohol | 49.4 | 62.4 | 65.5 | 68.8 | 56.2 | 0.015 |
| LGBT-specific health needs | 48.8 | 47.8 | 59.5 | 33.8 | 50.7 | 0.024 |
| Peer support | 39.4 | 47.8 | 44.0 | 46.8 | 46.8 | 0.554 |
| Knowledge of diverse sexual acts and practices | 41.8 | 49.7 | 39.3 | 44.2 | 46.8 | 0.477 |
| Mental health support | 58.2 | 33.1 | 54.8 | 18.2 | 44.3 | <0.0001 |
| Understanding of diverse sexual orientations/gender identities | 40.0 | 42.0 | 44.0 | 46.8 | 40.4 | 0.854 |
| Referral to other support and services | 39.4 | 47.8 | 59.5 | 13.0 | 29.6 | <0.0001 |
| General health support | 27.6 | 21.7 | 39.3 | 59.7 | 31.0 | <0.0001 |
| Advocacy | 7.1 | 23.6 | 26.2 | 48.1 | 22.7 | <0.0001 |
| Networking | 22.9 | 24.2 | 23.8 | 14.3 | 25.6 | 0.377 |
| Communication skills - e.g. writing, speaking | 33.5 | 15.3 | 16.7 | 15.6 | 25.6 | <0.0001 |
| First aid or personal safety or cardiopulmonary resuscitation | 17.6 | 15.9 | 48.8 | 24.7 | 21.2 | <0.0001 |
| Capacity building | 4.7 | 36.9 | 14.3 | 40.3 | 17.7 | <0.0001 |
| Interpersonal and Relationship-building skills | 17.1 | 17.2 | 15.5 | 27.3 | 21.7 | 0.228 |
| Social media or computer or IT skills | 18.2 | 15.3 | 31.0 | 6.5 | 20.2 | 0.002 |
| Report writing | 8.2 | 16.6 | 22.6 | 7.8 | 19.2 | 0.003 |
| Administrative skills | 12.4 | 8.3 | 19.0 | 5.2 | 16.7 | 0.013 |
| Teaching skills | 8.8 | 12.7 | 17.9 | 3.9 | 15.8 | 0.020 |
| Fundraising or grant writing | 11.2 | 8.3 | 22.6 | 6.5 | 8.4 | 0.003 |
| Leadership or management skills | 4.7 | 11.5 | 22.6 | 3.9 | 12.8 | <0.0001 |
| Research skills | 1.8 | 14.0 | 14.3 | 7.8 | 11.8 | 0.001 |
| Budgeting or financial skills | 6.5 | 5.1 | 9.5 | 2.6 | 9.9 | 0.164 |
| Languages - e.g. being bi-lingual | 4.1 | 3.2 | 2.4 | 3.9 | 3.0 | 0.947 |
| Other areas of training | 5.9 | 4.5 | 10.7 | 7.8 | 2.0 | 0.028 |

^aMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

*Multiple answer.

Table 6-12: Self-reported training needs by 'low LGBTI inequality' countries

| | Germany (n=172) | Spain (n=157) | UK (n=84) | France (n=77) | Other ^a (n=204) | p-value |
|--|--------------------|------------------|--------------|------------------|-------------------------------|---------|
| Prevention of HIV, viral hepatitis and other STIs | 43.7 | 33.1 | 17.2 | 12.0 | 35.3 | <0.0001 |
| Screening and/or testing of HIV, viral hepatitis, other STIs | 29.5 | 30.2 | 17.2 | 13.3 | 31.9 | 0.002 |
| Treatment and/or support of HIV, viral hepatitis, other STIs | 17.9 | 38.5 | 26.9 | 16.9 | 28.5 | <0.0001 |
| Counselling | 19.5 | 10.1 | 22.6 | 14.5 | 20.9 | 0.027 |
| Substance use - e.g. Chemsex, alcohol | 36.3 | 44.4 | 41.9 | 49.4 | 39.1 | 0.257 |
| LGBT-specific health needs | 15.3 | 20.1 | 15.1 | 6.0 | 23.8 | 0.004 |
| Peer support | 13.7 | 11.8 | 5.4 | 1.2 | 11.5 | 0.011 |
| Knowledge of diverse sexual acts and practices | 9.5 | 4.7 | 9.7 | 2.4 | 10.6 | 0.060 |
| Mental health support | 34.7 | 36.7 | 43.0 | 21.7 | 28.9 | 0.017 |
| Understanding of diverse sexual orientations/gender identities | 11.1 | 7.1 | 8.6 | 8.4 | 13.6 | 0.254 |
| Referral to other support and services | 4.7 | 7.1 | 5.4 | 3.6 | 3.4 | 0.512 |
| General health support | 6.3 | 8.3 | 7.5 | 13.3 | 10.2 | 0.364 |
| Advocacy | 2.6 | 18.9 | 6.5 | 25.3 | 17.4 | <0.0001 |
| Networking | 8.9 | 9.5 | 2.2 | 2.4 | 10.2 | 0.037 |
| Communication skills - e.g. writing, speaking | 12.6 | 5.9 | 3.2 | 10.8 | 6.0 | 0.018 |
| First aid or personal safety or cardiopulmonary resuscitation | 6.3 | 4.7 | 7.5 | 12.0 | 6.8 | 0.305 |
| Capacity building | 3.2 | 13.0 | 11.8 | 15.7 | 8.9 | 0.003 |
| Interpersonal and Relationship-building skills | 9.5 | 4.7 | 2.2 | 8.4 | 6.8 | 0.139 |
| Social media or computer or IT skills | 18.4 | 7.7 | 10.8 | 10.8 | 10.6 | 0.026 |
| Report writing | 3.2 | 7.7 | 10.8 | 9.6 | 6.4 | 0.105 |
| Administrative skills | 5.8 | 3.6 | 2.2 | 4.8 | 3.8 | 0.641 |
| Teaching skills | 6.3 | 6.5 | 5.4 | 4.8 | 6.0 | 0.984 |
| Fundraising or grant writing | 5.8 | 11.2 | 25.8 | 7.2 | 11.1 | <0.0001 |
| Leadership or management skills | 6.8 | 13.6 | 15.1 | 13.3 | 11.5 | 0.183 |
| Research skills | 1.6 | 14.2 | 8.6 | 9.6 | 8.1 | 0.001 |
| Budgeting or financial skills | 7.9 | 4.7 | 10.8 | 8.4 | 6.0 | 0.376 |
| Languages - e.g. being bi-lingual | 13.7 | 13.0 | 2.2 | 15.7 | 10.2 | 0.024 |
| Other areas of training | 4.7 | 0.6 | 5.4 | 3.6 | 1.3 | 0.035 |

^aMalta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. *Multiple answer.

7. Discussion

7.1. Establishing profiles of CHWs

In Europe, there is a diverse workforce providing support for gay, bisexual and other MSM in order to improve (sexual) health outcomes regarding HIV, viral Hepatitis and other STIs.

'Community Health Worker' as an umbrella term to refer to the roles and tasks of CHWs is not widely known in European contexts. ECHOES is the first time that a survey has collected a detailed profile and description of this workforce which dedicates their time to improving sexual health among some of the most vulnerable populations in terms of HIV, viral Hepatitis and other STIs. Results from ECHOES report the diversity of profiles and activities performed by CHWs. Documenting similarities and differences among CHWs across Europe allows strengthening of knowledge and understanding of the role played by CHWs in the promotion of sexual health and HIV/STI prevention for gay, bisexual and other MSM.

Socio-demographic profile

CHWs recruited in ECHOES are predominantly men (67.9%), middle-aged (mean: 40.7 years), identifying as homosexual or bisexual (58%), and are delivering their services in large cities (56.7% work in cities with more than 500,000 people). However, the profile of CHWs in Europe differs when considering the level of LGBTI inequality in the country they work in. For example, peer CHWs are more common in 'low LGBTI inequality' countries (mostly in Western Europe), whereas female and heterosexual CHWs are more represented in 'high LGBTI inequality' countries (mostly in Eastern Europe). In general, the epidemiological pattern regarding HIV in Eastern European countries differs from other parts of Europe, with the majority of HIV infections occurring in people who inject drugs and (non-migrant) heterosexuals [1]. The main socio-demographic characteristics of CHWs by the LGBTI inequality level of the working country have been summarised in Figure 7-1.

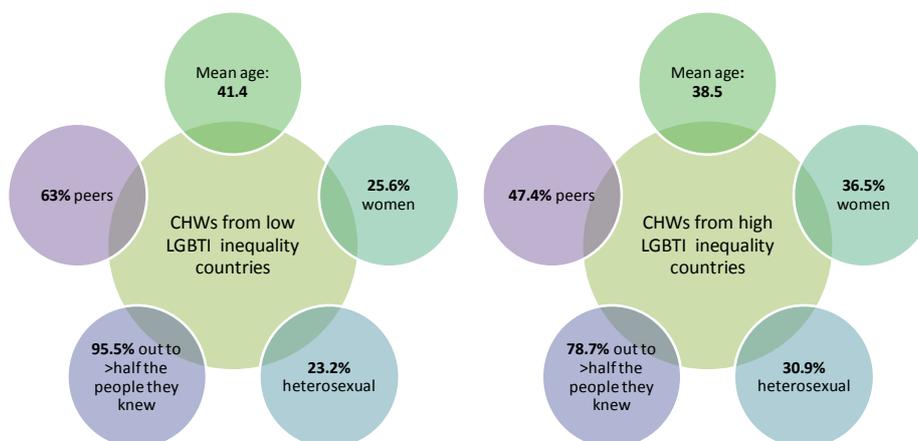


Figure 7-1: Main sociodemographic characteristics of CHWs by the LGBTI inequality level of the working country

CHWs generally have a great deal of work experience in the field. More than half of the sample (52.7%) reported being active in their work as a CHW for six years or more, including 29.3% who had over 10 years of experience.

It is important to mention the representation of women in CHWs promoting sexual health among gay, bisexual and other MSM (28.2% of the overall sample). Female CHWs report being volunteers less frequently than male CHWs (15.8% vs. 37.6%). Female CHWs more often work as healthcare professionals outside of their work as CHWs (28.0% vs. 12.7% in men), reflecting that more female CHWs have a medical background.

Recruitment and professional profile

Recruitment of CHWs relies heavily on the individual's sense of social responsibility since altruistic motivators are the most commonly reported in ECHOES CHWs, regardless of the working country. Overall, more than half of the sample reported wanting to support gay, bisexual and other MSM, wanting to support PLHIV, viral hepatitis or other STIs, and/or wanting to help prevent these infections (57.6%) as the motivation for becoming a CHW. These reasons are more commonly reported in peer CHWs, suggesting a strong community responsibility among gay, bisexual and other MSM working as CHW. Financial incentives is the lowest reported reason.

Prior training and/or qualifications required at recruitment to be a CHW are reported by less than half of the sample (41%), and this percentage is even lower in peer CHWs (38.4%), possibly because being a member of the 'community' implies a type of knowledge that non-members would have to gain through training.

Overall, 30.7% of the ECHOES respondents are volunteer CHWs. The highest percentages of volunteer CHWs are observed in 'high LGBTI inequality' countries, mainly Eastern European countries. ECHOES respondents from this region also report fewer public funds being awarded to their organisation. In 'low LGBTI inequality' countries (mostly Western European countries) less CHWs are volunteers (28.9% overall) but there are discrepancies; more than half (52.8%) of CHWs from Germany report being volunteers, while the proportion is only 12.8% in the UK. Differences in the health systems of the UK and Germany could explain this disparity. In Germany, the majority of the prevention work is carried out by the national NGO Deutsche AIDS-Hilfe, while in the UK this work is largely covered by the government-run National Health Service (NHS).

Most ECHOES respondents work for private not-for-profit organisations (86.4%). This may be partly due to a selection bias since the percentage of people who work for another type of organisation is higher in EMIS 2017 respondents reporting to be CHWs. In ECHOES, less respondents from 'high LGBTI inequality' countries (mainly Eastern European countries) reporting working in private not-for-profit organisations than other organisations. This is consistent with the WP5 review³⁷ that found CHWs from several Eastern European countries reporting a need to have more community-based organisations.

³⁷ Reference in footnote 1, page 21.

The main purpose of the organisation where ECHOES CHWs work differs according to the organisation type: CHWs working in private non-for-profit organisations report that the organisation addresses 'Sexual health' and 'LGBTI needs', CHWs working for other types of organisations report that the organisation addresses 'general health'. This is consistent with feedback from the Objective 3 Training Programme where CHWs working organisations other than private not-for-profits, seemed to work more with the general population, including MSM, compared to those working for NGOs for instance, who usually target specific populations. CHWs from 'high LGBTI inequality' countries (mainly Eastern Europe countries) more frequently report working in organisations addressing LGBTI specific needs and mental health/substance use while they less frequently report working at organisations addressing sexual health compared to CHWs from 'low LGBTI inequality' countries.

7.2. How do CHWs in Europe identify/define themselves?

The way CHWs identified themselves was an important issue in ECHOES. As observed previously [33], the diversity of roles and nomenclature of CHWs make it difficult to answer the question 'who is a CHW?'. CHWs who participated in ECHOES define their job title based on their roles and tasks as CHWs. From the answers given, it is clear that the term 'CHW' is not as widely used across Europe as it is in the United States and in sub-Saharan African countries.

This lack of a widely accepted, recognisable and commonly used title to describe CHWs has not helped the European recognition this group as a valuable workforce of paid and unpaid CHWs. To date, this population and its practices have been the subject of little research.

The word 'community' itself is commonly used in English-speaking countries but in other countries may have different connotations [34]. 'Community' may also be understood as a pejorative term, for instance 'communitarianism' in France or 'communism' in some Eastern European countries. It may refer to a geographic space, a geopolitical or civil entity, or a place of emotional identity [35]. In the ECHOES questionnaire, the word 'community' was mainly used in the context of 'community settings' to differentiate from 'health-care and/or clinical settings' such as hospitals or clinics.

In summary, common themes were identified from the key words in the role description self-reported by respondents:

- **Roles and/or tasks as a CHW:** counsellor, educator, prevention worker, sexual health worker, testing related worker, psychosocial worker, outreach, activist.
- **Medical background:** doctor, nurse, physician.

- **“Community” dimension:** community, volunteer and peer [36], i.e. using the relationship between the CHW and the community served to define themselves.

The description CHWs give of their job/role differs according to the activities they perform. CHWs engaging in testing and counselling activities tended to define themselves according to their professional background or their role: ‘healthcare professional’, ‘health worker’, ‘sexual health’, ‘counsellor’, ‘testing worker’. On the other hand, those engaging in prevention-related activities tend to define themselves according to their proximity to the population they serve: ‘community worker’, ‘outreach’; although they also frequently use titles linked to ‘sexual health’ to define themselves. CHWs who are engaged in treatment and care related activities report proximity to the population they work for (‘community worker’, ‘peer’) and a professional role or background: ‘healthcare professional’ and ‘psycho-social’.

The diversity in CHW profiles is reflected in the way they define themselves, seemingly confirming that, prior to ECHOES, there was no ‘CHW identity’ among those currently working as CHWs in Europe. However, after ECHOES and especially during and after the implementation of Objective 3 Training Programme, many people working with the common aim of supporting sexual health of gay, bisexual and other MSM “realised that despite different approaches, job titles, backgrounds or knowledge, they all cover similar tasks, have common aims”³⁸.

7.3. Added value of CHW work in the continuum of care

Roles and activities

When exploring the activities of CHWs in Europe, although differences are observed between regions, several core activities can be highlighted as features of CHWs in Europe.

Overall, those who participated in ECHOES work mainly in prevention (88.8%) but are also involved in the other steps of the continuum of care: testing and counselling (62.8%), linkage to care (44.4%), and treatment and care support (50.4%). They also facilitate linkage of gay, bisexual and other MSM to other health services, and are involved in many other cross-cutting activities (46.3%) including monitoring and evaluation of the organisation’s services, advocacy, engaging in research, etc.

CHWs perform diverse tasks and generally are active in more than one step of the service continuum: almost one in three reported activities in the four steps of the service continuum (31.0%), and only one in four (25.7%) worked in one area only.

The most commonly reported activity in all steps of the service continuum was providing consultations and information to gay, bisexual and other MSM. This

³⁸ See deliverable D10.6 of the ESTICOM project, p. 27 (soon available at www.esticom.eu).

activity was reported by 97.2% of CHWs involved in prevention, by 90.9% of those involved in counselling and testing (both information about testing and pre/post-test counselling) and by 95.7% of those involved in treatment and care activities. This is consistent with previous studies conducted in CHWs, which found their main role was to provide users with information (see WP5 review³⁹).

CHW activities reported in ECHOES suggest that gay, bisexual and other MSM using their services have mental health needs. CHWs primarily provide information about mental health, but also conduct interventions (mental health support, online and social media support) and facilitate referral to mental health support services.

The other commonly reported activities depend on the steps of the service continuum the CHW is working in: sexual health and behaviour change support in prevention activities, screening and testing (mainly using rapid blood tests, but also collecting swab or blood samples to be sent to the lab), adherence support as well as accompanying newly diagnosed individuals to get treatment or assisting them with sourcing and accessing treatments. Cross-cutting activities mainly consist of: developing interventions, monitoring and evaluation, reporting of organisation's activities, advocacy and networking, and involvement in research or community needs assessments.

Profiles of CHWs vary considerably and the limited sample sizes (especially when looking at specific activities) limit interpretation and conclusions. However, some differences can be highlighted.

Involvement in prevention or linkage to care activities is more frequent amongst CHWs in 'low LGBTI inequality' countries (mainly Western European countries) than those in 'high LGBTI inequality' countries. Similarly, prevention, and linkage to care and treatment-related activities are more frequent in countries where the rate of new HIV diagnoses in the male population attributable to sex between men is higher. This difference is also reflected in referral for prevention purposes, suggesting that synergies with other services facilitating referrals for gay, bisexual and other MSM are more available or accessible in countries with low LGBTI inequality. In turn, this may be the consequence of a less visible 'gay scene' in 'high LGBTI inequality' countries, as observed in Objective 3 Training Programme.

Looking at screening or testing activities, CHWs from 'low LGBTI inequality' countries are more involved than those from 'high LGBTI inequality' countries (83.0% vs. 74.0%, respectively), even if there are discrepancies between countries of the 'low LGBTI inequality' category: 58.4% in Germany vs. 83.0% to 95.5% in other countries of the 'low LGBTI inequality' countries. This difference shows the direct impact of CBVCT regulation on screening and testing activities, since Germany is the only country of the 'low LGBTI inequality' countries where non-medical staff are not allowed to perform tests. The comparison of CHW performing screening or testing according to the presence/absence of CBVCT restrictions for non-medical staff (68.4% vs. 90.7%, respectively) clearly shows the impact of the legislation on CHWs' testing-related activities.

³⁹ Reference in footnote 1, page 21.

Settings CHWs work in and main populations worked with

CHWs recruited in ECHOES work in many different settings and often, especially in 'low LGBTI inequality' countries, work in more than one, (more so in France and Spain). Overall, one in four CHWs (25.3%) report working in only one type of setting, while almost one in three (32.3%) work in four different types.

More than three in four CHWs report working outside their organisation's premises, i.e. working in outreach. Outreach activities are more commonly reported by younger and peer CHWs working for private not-for profit organisations.

Although all CHWs recruited in ECHOES work with gay, bisexual and other MSM (82.7% say this was one of main populations they work with; the most commonly reported population), many of them also work frequently with other populations. Second most frequently reported population worked with is 'PLHIV' (38.5%) followed by 'general population but including gay, bisexual and other MSM' (23.5%) and 'trans people' (22.9%). Among the three main populations worked with, many CHWs also reported 'Migrants' (16.4%), 'sex workers' (15.2%), and 'drug users' (12.7%).

Beyond the definition of 'peer CHW' as has been defined in this report (i.e. CHWs identifying as homosexual/bisexual), many CHWs have a proximity to other populations they work for.

For instance, CHWs reporting 'PLHIV' as one of the three main population worked for tended to have more experience as CHW and to be living with HIV. Those working with trans people tend to not define themselves as men or women, not define themselves as heterosexual or homosexual/bisexual, and to work in 'low LGBTI inequality' countries and high rates of new HIV diagnoses in the male population attributable to sex between men. This roughly corresponds to Western European countries, where trans people are probably more 'visible' than in 'high LGBTI inequality' countries (mostly Eastern European countries). CHWs reporting working mostly with people <25 tend to be younger (i.e. aged 40 or less).

7.4. The value of peer CHWs in service delivery

In general, the term 'peer' is used to label a group of people sharing characteristics or identities based on their sexuality, gender, ethnicity or other characteristics. These shared characteristics may influence the ways in which peers provide services and are perceived by patients or service users, so that their status as peers is an added value to the health services they provide, reducing the generally marked distance between healthcare provider / doctor and patients [37].

In ECHOES, approximately 60% of CHWs can be considered 'peers', that is, they are sharing a similar identity to service users based on their gender and sexual identity. However, other kinds of 'peers' can be identified based on background characteristics and shared experiences, for example PLHIV working with PLHIV (see previous section).

Compared with non-peer, peer CHWs more frequently work in 'low LGBTI inequality' countries, for private not-for-profit organisations like NGOs, charities, community organisations focussed on sexual health and/or LGBTI specific needs, and they often receive lower pay than comparable non-peer CHWs (bearing in mind the percentage of volunteers is higher among peer than non-peer CHWs). Peer CHWs report more direct contact with the target population as they are more frequently involved in outreach activities (80.8%) and less involved in cross-cutting – administrative and strategic – activities.

Peer CHWs received more training to provide sexual health support to gay, bisexual and other MSM, reported more confidence in their knowledge around HIV and STIs and higher levels of self-efficacy than non-peer CHWs. These results are consistent with other studies which have found that training generally resulted in expanded CHW knowledge and improvements in skills and competencies [30], highlighting the need to increase access to training for non-peer CHWs.

In addition, peer CHWs tend to report that gay, bisexual and other MSM service users feel extremely confident regarding the support their organisation and the individual CHW are delivering compared to non-peer CHWs. This high level of confidence is probably due to increased proximity to the service users but may also result from the history of CHWs working with MSM in Europe. Gay, bisexual and other MSM spontaneously mobilised and organised the fight against HIV when the first HIV/AIDS cases appeared, while governments did not get involved. Today peer CHWs still have, and continue to acquire, considerable knowledge about HIV, viral Hepatitis and other STIs, but also about MSM behaviour and the needs of this population with respect to sexual health.

7.5. How do European CHWs feel?

General health condition and perceptions

Most ECHOES respondents report a very good or a good health status, while 16.6% of the overall sample perceived their health status as fair, bad or very bad, which is much lower than the average of the European Union countries (32.5%)[38]. CHWs from 'high LGBTI inequality' countries report good or very good health conditions less often compared to those from the 'low LGBTI inequality' countries. As expected, the older the respondents the poorer the perceived health status. Similarly, those working as CHWs for more than 10 years and those reporting that they are not living in comfortable conditions report poorer perceived health status.

The median score of well-being in ECHOES (64 out of 100) is slightly lower than the often used reference score of 70 for the Danish general population [39]. Although no differences are observed by age or experience as CHWs, those working in 'high LGBTI inequality' countries have lower reported well-being than those working in 'low LGBTI inequality' countries. Lower reported well-being is also observed in those not living in comfortable conditions compared to those living in good conditions. Interestingly, women participating in ECHOES have a higher well-being index compared to men, unlike what was observed in recent studies in both the general population [39], and in health professionals [40] in Europe.

According to the WHO criteria, almost one in four ECHOES respondent could be considered at risk of depression. No difference was detected between CHWs from 'low LGBTI inequality' and 'high LGBTI inequality' countries. The only significant differences found are that those not defining themselves as a man or woman have a lower level of well-being, as well as those not living in comfortable conditions compared to those living in good ones. The WHO-5 scale is a screening tool to identify and manage depression and psychological problems, but its high sensitivity may overestimate the real risk of depression. In addition, although the cut point (50/100) is highly reliable across countries, variations of the average national score cannot be excluded [39].

Self-efficacy, job satisfaction and perception of service users' confidence towards CHWs' work or organisation

Self-efficacy in CHWs recruited in ECHOES appears to be quite high (median 72 out of 100) but in the absence of previous similar studies of CHWs in Europe, this measure is the first which will be useful for future comparison. Self-efficacy is higher in older CHWs, in men, in those working in countries with low LGBTI inequality level and in peer CHWs. Self-efficacy being higher in peer CHWs may indicate that the proximity between CHWs and the population served reinforce the feeling of self-efficacy compared with non-peer CHWs. Those working in 'high LGBTI inequality' countries (mostly Eastern European countries, with less peer CHWs) may feel more distant and less confident regarding their work with gay, bisexual and other MSM.

In fact, when CHWs were asked their perception of the level of confidence gay, bisexual and other MSM service users had in the support delivered by CHWs or the

organisation (an indirect way to ask about CHWs' own level of confidence regarding their work) the same differences are observed as in self-efficacy. Non-peer CHWs and those working in 'high LGBTI inequality' countries report lower confidence levels compared to peers and CHWs working in 'low LGBTI inequality' countries. Other factors such as: being older, having more experience as a CHW, and working for an NGO, may help CHWs feel more confident about the services they or their organisation deliver.

The general satisfaction of CHWs regarding their activity is high overall (median: 75 out of 100), and differs by the level of LGBTI inequality in the working country: CHW from 'high LGBTI inequality' countries are less satisfied with their work as CHW than those from 'low LGBTI inequality' countries. No difference is observed between peer and non-peer CHWs. Other factors associated with CHW job satisfaction are: gender (men are more satisfied than women who in turn are more satisfied than people identifying as 'other/prefer not say'); sexual identity (heterosexuals are more satisfied than homosexuals/bisexuals who in turn are more satisfied than 'others'); and perceived income (those living in comfortable conditions are more satisfied than those who do not), which is not surprising since the job satisfaction score also takes into account the satisfaction with the rate of pay. The economic factor may partly explain the difference between CHWs from 'low LGBTI inequality' and 'high LGBTI inequality' countries in so far as the proportion of volunteer CHWs is higher in 'high LGBTI inequality' countries.

Perception of health status and well-being are strongly associated with perception of income. It seems that CHWs who report poor health status and well-being are those who experience worse economic conditions. CHWs from 'high LGBTI inequality' countries (mainly Eastern European countries) require a specific response, because of their poorer health status and because they are less satisfied with their role as CHW and less confident regarding their work. Burn-out or other personal and professional issues which were not addressed in this survey may also explain those differences and could be included in future studies.

7.6. Main barriers faced by CHWs in Europe

Financial concerns

ECHOES respondents report funding for their CHW organisations comes from various sources, and the sustainability of this funding is the biggest challenge their organisation faces. The most commonly reported funding source is public funds but a large proportion of ECHOES respondents also report that their organisation is also funded by donations (61.5%) or fundraising activities (48.5%). These sources have no guarantee of renewal, which is a major problem since unstable funding has been shown to be a significant barrier to implementing and sustaining CHW programmes [30]. The situation is even worse in 'high LGBTI inequality' countries (mainly Eastern European countries) where ECHOES respondents report organisations less often receive grants from national and/or governmental authorities than CHWs in

the 'low LGBTI inequality' countries. A high proportion of CHWs in 'high LGBTI inequality' countries are working in NGOs funded by EU programmes.

Funding issues are identified as a major barrier in their organisation by ECHOES respondents. More than three in five CHWs report 'lack of funding for CHW organisations' at the structural level, and 'shortage of funding or resources' at organisational level. No differences are observed when comparing respondents from 'low LGBTI inequality' versus 'high LGBTI inequality' countries. However, these two barriers are significantly more reported by CHWs working for private not-for-profit organisations.

Direct consequences of these financial issues for CHWs and their organisations are the non-sustainability of their activities and the inability to plan long-term or continuous activities. Lack of funding also requires organisational efforts to be constantly focused on seeking funds, to the detriment of programme activities.

Other individual, social and political barriers

Although barriers and facilitators faced by CHWs in Europe have previously been documented qualitatively, no data are available to quantify them. For the first time in Europe, ECHOES data permit understanding of the barriers facing CHWs from their own viewpoint. Table 7-1 presents barriers identified in the WP5 review⁴⁰ and data from ECHOES. It is important to note that ECHOES data are based on CHWs' perceptions and that they may not have all the information to accurately evaluate all barriers, especially at the organisational and structural level.

Table 7-1: Main barriers faced by CHWs (Combining results of WP5 Review and ECHOES)

| Main barriers identified in WP5 Review* | % in ECHOES |
|---|-------------|
| Structural and contextual barriers | |
| HIV stigma and homophobia | 81%** |
| Economic barriers | 65% |
| Lack of a national HIV strategy (for MSM) | 35% |
| Legal barriers | 23% |
| Organisational barriers | |
| Lack of resources | 62% |
| Lack of supervision | 13% |
| Lack of training | 10% |
| Community-related barriers | |
| Lack of support from gay bar owners | 26% |
| Individual barriers | |
| Lack of time | 38% |
| Lack of knowledge | 11% |
| Lack of motivation | na |

*scoping review/interviews with stakeholders from key organisations; na: not available

** Percentage of ECHOES respondents who selected 'stigma around HIV/AIDS' and/or 'stigma around homosexuality'.

⁴⁰ Reference in footnote 1, page 21.

CHWs recruited in ECHOES report that, regardless of the economic barriers, stigma-related barriers – around homosexuality, HIV/AIDS, viral hepatitis and other STIs – are the biggest barriers that hinder daily activities. As expected, stigma around homosexuality/bisexuality is much more commonly reported by respondents from 'high LGBTI inequality' countries (mostly Eastern European countries).

In regions with higher levels of stigma, the gay scene is less developed or at least less visible. This may explain why CHWs from 'high LGBTI inequality' countries feel much more affected by community-level barriers: lack of interest from gay, bisexual or other MSM and lack of support from gay businesses; both reported by more than one in four respondents overall. This situation makes CHW activities even more complicated because the involvement of the target population ('peers') in services is crucial for accessing this highly marginalised population. Women CHWs may experience more difficulties in carrying out their activities since they more often report 'I am not from gay, bisexual or other MSM communities' as an individual barrier and would benefit from specific training to empower them.

The other most commonly reported barriers, overall, are at structural level (lack of or poor national HIV strategy, legal constraints or regulations) and at individual level (long or difficult working hours, low or no salary). Both structural barriers are more reported by CHWs in 'high LGBTI inequality' countries. 'Low or no salary' is also more reported by CHWs in 'high LGBTI inequality' countries, probably because of the higher presence of volunteer CHWs in those countries. Conversely, 'long or difficult working hours' is reported more by CHWs from 'low LGBTI inequality' countries, suggesting a heavier workload and a possible risk of burn-out in this group that should be monitored in future studies of CHWs.

7.7. Training issues

Knowledge and previous training

Overall, CHWs' self-perceived confidence in their knowledge of HIV infection was higher than for viral Hepatitis and other STIs. Higher levels of self-perceived confidence were reported for prevention activities, the most common activities reported by 88.8% of ECHOES respondents, than for screening/testing and/or treatment/support activities. The level of confidence in knowledge may be influenced in part by the current activities CHWs perform. The more they perform an activity, the more they feel confident. This fact can explain why Germany is the country where CHWs report less confidence in their knowledge of HIV screening/testing activities, a country where CHWs who participated in ECHOES report much lower involvement in screening and testing compared to other respondents in 'low LGBTI inequality' countries, but also compared to those in 'high LGBTI inequality' countries.

As shown in previous studies, training experience increases CHW knowledge and in turn their confidence in their capacity to perform their duties [8]. This is confirmed in ECHOES, where trained CHWs more often report feeling 'very confident' in their

knowledge of prevention, screening/testing and treatment/support activities regarding HIV, viral Hepatitis and other STIs compared to non-trained CHWs.

In their current role as a CHW, 89.6% of respondents report having received training, mainly internal or in-house training and delivered face-to face. Online courses such as webinars, online training programmes and online lectures, are reported by 25.3% of respondents. However, CHWs also require regular training and supervision to be successful in their role and keep their knowledge up-to-date [8]. In ECHOES, further training opportunities were reported available to 65.3% of respondents.

Training needs

The proper amount and type of training required by CHWs must be understood in relation to the health system context, the CHWs' pre-existing capacities, and the duties that CHWs are expected to perform. It seems that short and insufficient training erodes CHW confidence and reduces community trust and uptake of CHWs' services [41].

In ECHOES, CHWs who reported that they did not receive any training (10.4%) represent a core audience for future training. Among them, 21.9% reported 'lack of knowledge' as one of the main barriers to performing their activities as a CHW. While knowledge and competency among CHWs is acknowledged as central to the success of CHW programs, previous studies showed that many programs continue to provide training that is insufficient or of poor quality, resulting in knowledge gaps among CHWs [29].

The WP5 review⁴¹ was unable to identify a standardised training curriculum in Europe for community health work with gay, bisexual and other MSM. This is also reported by the team of Objective 3 Training Programme in their first training needs assessments. CHWs' training should be adapted to the needs of CHWs in their daily job, the tasks they are expected to perform and the context in which they work. Training should seek to impact technical competency, soft skills such as communication and cross-cutting skills such as writing and fundraising. The CHW review report concluded that communication, interpersonal skills, service coordination and capacity building were seen as key aspects for being a "good" CHW; however, the ECHOES data show that current training is focused mainly on prevention, screening/testing and treatment/support activities (topics focused on knowledge), while areas such as communication and interpersonal skills receive less attention.

Consistent with previous studies included in the WP5 review, ECHOES respondents have identified unmet training needs in new topic areas such as substance use and mental health, highlighting the need for an integrated approach to MSM health and well-being as previously reported [42]. Mental health training is warranted because mental health is of high importance in many activities: information provision about

⁴¹ Reference in footnote 1, page 21.

mental health in prevention, interventions, counselling sessions related to testing or treatment support, or referral to mental health support services.

Communication and advocacy skills are not identified as an important training need in ECHOES respondents, despite being frequently needed by CHWs. Based on the preliminary findings of Objective 3 Training Programme, CHWs broadly believe they have good communication skills, especially with their main target group. This might result in not identifying this as a training need, although they could benefit from further training to improve communication with sub-groups of MSM (migrants, PLHIV, etc.) with who they may not feel so 'confident'. In ECHOES, CHWs request training on aspects they have already received some training in before. It seems there is a need for more advanced knowledge on topics CHWs deal with on a daily basis (prevention activities, substance use, etc.). It will be interesting to interpret these results in light of the conclusions of the needs assessments and the training pilots in the final report of Objective 3 Training Programme.

Training on cultural competencies with regards to LGBTI specific needs, sexuality, (sub-)communities is less frequently reported by CHWs in 'high LGBTI inequality' countries compared with those in 'low LGBTI inequality' countries. However, 'high LGBTI inequality' countries have the largest number of non-peers CHWs and therefore, they are in general less familiar with LGBTI characteristics, values, beliefs and needs, so they may benefit from training on these issues. Respondents from 'high LGBTI inequality' countries more frequently report skills related with advocacy (31.8%), report writing (25.8%), fundraising or grant writing (21.7%), financial skills (12.4%), management skills (17.5%), and research skills (16.6%) than respondents from 'low LGBTI inequality' countries. Training on strategic and administrative activities in 'high LGBTI inequality' countries is required due to the higher percentage of CHWs reporting fundraising or grant writing as a training need, in comparison with CHWs from 'low LGBTI inequality' countries.

7.8. Towards a European definition and recognition of CHWs

A single definition of CHWs may not convey the diversity of the group nor reflect the diverse contexts, norms, and cultures. Defining CHWs from the sole perspective of sexual health may be limiting since sexual health is often associated with reproductive health, which does not reflect the wide variety of gay, bisexual and MSM needs. In addition, ECHOES data show that CHWs address many health issues beyond sexual health; they also provide mental health support, harm reduction services for people using drugs and/or for chemsex users, help improving adherence to treatment, etc. In this sense, CHWs are already demonstrating a more holistic approach to health and well-being.

The new proposed definition is another step toward a better characterisation and recognition of CHWs working with MSM in Europe:

Community health workers (CHWs) are people who provide sexual health and other health-related support (whether being paid or unpaid) to gay, bisexual and other MSM. A CHW may deliver health promotion and/or public health activities outside of formal health settings. They may be members of, or connected to, the communities they serve (peers).

This definition is based on both ECHOES results and internal discussion with Objective 2 and Objective 3 partners and, while many CHWs do work with other population or communities, this definition focuses only on CHWs working with gay, bisexual and other MSM.

This definition may require future adaptation depending on the local social norms, contextual factors, and with direct input from the community. ECHOES shows that the typical profile of CHWs coming from early HIV/AIDS movements in the first years of the HIV epidemic and working exclusively in the community for the community has changed a lot. Although many CHWs are still peers, nowadays more and more non-peers including men, women, and medical staff are working with different target populations. In ECHOES, only CHWs working in 'community settings' were eligible, but in the current era of medicalisation of HIV prevention (PrEP, TasP), it would be interesting to survey health workers working with gay, bisexual and other MSM in clinical settings as well. The limit between Health Workers and CHWs may be more fluid than before, with most, but not all, CHW activities occurring outside of clinical settings. One of the core elements defining CHWs is the close connection to and the good understanding of the community they serve, and their perception of community health needs, which probably differ from that of traditional health workers.

8. Strengths

- ECHOES provides, for the first time in Europe, an insight into who CHWs working with gay, bisexual and other MSM are, what their needs are and what the similarities and differences are in the delivery of sexual health services in community settings across Europe.
- The development of a comprehensive questionnaire to characterise and understand a section of the community sexual health workforce, including both paid and unpaid CHWs working with gay, bisexual and other MSM, will be useful both in Europe and elsewhere.
- The first available data on CHWs in Europe can be used as a reference and benchmark for future comparisons, but also as a sound basis for future mixed methods studies, at the European and national level, to further explore knowledge and practices of those involved in delivering community-based sexual health and well-being services to gay, bisexual and other MSM.
- ECHOES findings will be valuable to help design future CHW training programmes to improve gay, bisexual and other MSM's sexual health, and facilitate capacity building in this workforce.
- ECHOES and the Objective 3 Training Programme have opened up the discussion of the situation of CHWs working with gay, bisexual and other MSM in Europe and show that CHWs previously had no sense of belonging to a wider network in Europe. ECHOES and the Objective 3 Training Programme have promoted a feeling of being part of a broader, international workforce doing similar tasks and having a common aim, despite the diversity of their roles, jobs titles, backgrounds and cultural differences.

9. Limitations

- With an unknown population of CHWs (both in composition and size) it is difficult to assess the extent to which this study provides a good overview of CHWs in Europe. The estimated national population sizes and expected samples were much larger than the actual sample sizes reached with ECHOES and allude to a possible failure in reaching eligible people in the promotion and recruitment process.
- A number of countries had a small sample size which did not allow national analysis to be conducted. Regional comparisons (using the 'country grouping variables') should also be interpreted with caution because they may disguise disparities between the individual countries in the group.
- During the promotion of the survey, examples of work and activities were used (through short descriptions, interviews, etc.) to explain the role of CHWs, in line with the definition proposed and used by the ECHOES team. The aim was to be as inclusive as possible, and this is reflected in the variety of job titles provided by the respondents. However, the possibility of a selection bias cannot be discounted.
- In line with the inclusion criteria, ECHOES only recruited CHWs working in 'community settings', i.e. outside of clinical settings. However, the wider workforce of health workers supporting gay, bisexual and other MSM in Europe may also include people, especially peer workers, working in specialised clinics or services in the health system that are not represented in ECHOES.
- The number of CHWs with a medical background may be underestimated because the information was collected indirectly ('job title') instead of asking the type of education received.
- This report may not have succeeded in taking into account the broader context in Europe, such as differences between countries in epidemics (HIV, viral Hepatitis and other STIs), populations most at-risk, types of health systems, and social acceptance of homosexuality. This was attempted using country grouping variables, but the small sample sizes did not allow more detailed comparisons.

10. Recommendations

10.1. Actions that European organisations and institutions could take

- The EU institutions and EU agencies e.g. Chafea and ECDC, are well-placed to help increase the visibility and understanding of the specific role and contribution of CHWs as part of the healthcare system.
- ECHOES and the Objective 3 Training Programme constitute an excellent starting point to gain a better understanding of the reality of CHWs in Europe, and to foster a network where CHWs can meet each other. This should be a long-term initiative to establish a strong community of people working and volunteering in the same field.
- Networks of non-governmental organisations such as EATG and AAE are well-placed to provide training for CHWs across European countries, based on the outcomes of the Objective 3 Training Programme and ECHOES data, and to ensure sustainability.
- Setting-up a European CHW forum could be valuable to increase CHWs' visibility and voice, and to promote cohesiveness and networking among within the group. The model of the European Chemsex forum (mainly online but with annual physical meetings) could be inspiring⁴².
- It is important to ensure that ECHOES is updated and repeated in the future to track and quantify the workforce of CHWs in each Member State, particularly in countries with low sample sizes, and to be proactive in developing and supporting CHW knowledge, practice, and strategies across Europe.

10.2. Actions that national or local governments could take

- National and local governments should provide sustainable financing for community health services and their staff as part of the health system, or at least for key activities performed by CHWs (e.g. community-based testing).
- CHW certification at the national level to set minimum standards for education and practice could be considered to recognise and legitimise CHWs with respect to the healthcare system
- Governments should reform laws and regulations to enable community organisations to provide much-needed sexual health services outside of medical settings, especially with regards to testing. Removing restrictions on non-medical staff performing CBVCT, would considerably increase the workforce dedicated to one of the most important issues in prevention.

⁴² The European Chemsex Forum aims to facilitate partnerships for action and to be a platform for dialogue. Members can share resources, get/provide mutual mentorship and planning regarding activities linked with Chemsex. The next annual meeting of the European Chemsex Forum will be held in Paris in November 2019 (<https://ihp.hiv/>, accessed on 28 May 2019).

10.3. Actions that CHWs could take

- CHWs need more opportunities for networking with each other, both nationally and internationally. They need to speak with CHWs in other contexts to gain perspective on their work, and find solutions to overcome specific barriers.
- CHWs could drive local or national programmes, finding ways to engage the community and to address stigma issues.
- CHWs need to reflect on their knowledge gaps and training needs in general to identify opportunities for continuing professional development.

10.4. Recommendations for future research

- A large-scale qualitative study, or case studies, of CHWs involving local community organisations in different European countries should be conducted to complement the findings of ECHOES and to document specific contexts in terms of legal and healthcare system characteristics, types of epidemics etc.
- Future research should focus on both clinical and non-clinical settings in order to have a full picture of people working on improving the sexual health of gay, bisexual and other MSM, and also to facilitate comparisons that help to distinguish CHWs from general Health Professionals.
- Promotion strategies for future large-scale quantitative research such as ECHOES should:
 - Provide local multipliers with some form of financial compensation to encourage a more engaged and strategic approach to penetrating CHW networks at the national level.
 - Use both a clear online promotion strategy and direct promotion through personal contacts from the local multipliers (phone calls, emails, meetings, etc.).
 - Use link tracking to better understand how survey respondents were linked to the questionnaire and to make targeted promotion efforts and activities easier.
 - Formative research on how to reach CHWs working in organisations other than not-for-profit organisations (underrepresented in ECHOES) would be necessary.

10.5. Recommendations for training implementation

- Key issues to be covered by the training of CHWs include how to address stigma and soft skills (e.g. communication, interpersonal skills).
- Training programmes need to be updated regularly to better reflect the changes in target population profiles and the additional tasks assigned to CHWs.

- Considering that 'lack of time' was the biggest barrier identified at individual level, the use of online training methodologies to facilitate ongoing (refresher) training should be explored further.
- Training should include cultural competency concepts to embrace the diversity of the community of gay, bisexual and other MSM, especially for CHWs who are non-peers and not previously trained, or CHWs working with other communities (e.g. migrant MSM, trans people).

11. References

1. European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2017 – 2016 data. Stockholm: ECDC; 2017 [cited 2018 Oct 29]. Available from: <https://ecdc.europa.eu/en/publications-data/hivaids-surveillance-europe-2017-2016-data>
2. Mohammed H, Mitchell H, Sile B, Duffell S, Nardone A, Hughes G. Increase in sexually transmitted infections among men who have sex with men, England, 2014. *Emerg Infect Dis* [Internet]. 2016 [cited 2018 Oct 29];22(1):88–91. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/26689861>
3. Jansen K, Thamm M, Bock C-T, Scheufele R, Kücherer C, Muenstermann D, et al. High Prevalence and High Incidence of Coinfection with Hepatitis B, Hepatitis C, and Syphilis and Low Rate of Effective Vaccination against Hepatitis B in HIV-Positive Men Who Have Sex with Men. *PLoS One* [Internet]. 2015 [cited 2018 Oct 29];10(11):e0142515. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/26555244>
4. European Centre for Disease Prevention and Control. Lymphogranuloma venereum. In: ECDC. Annual epidemiological report for 2016. Stockholm: ECDC; 2018.
5. European Centre for Disease Prevention and Control. – Shigellosis. In: ECDC. Annual epidemiological report for 2016. Stockholm: ECDC; 2018.
6. World Health Organisation, Global Health Workforce Alliance. Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals. Community Health. 2010.
7. Landers SJ, Stover GN. Community Health Workers—Practice and Promise. *Am J Public Health* [Internet]. 2011;101(12):2198–2198. Available from: <http://ajph.aphapublications.org/doi/10.2105/AJPH.2011.300371>
8. Lehmann U, Sanders D. Community Health Workers: What do we know about them? Technical Report. Geneva: World Health Organization; 2007.
9. USAID. Factors impacting the effectiveness of community health workers behavior change: a literature review. 2015; Available from: <http://healthcommcapacity.org/wp-content/uploads/2015/06/Barriers-to-CHW-Svc-Provision-Lit-Review-June2015.pdf>
10. Rojas Castro D, Quatremère G, Le Gall J-M H-CPSC. Implementation of Community-Based Voluntary Counseling and Testing (CBVCT) Programs and Services [Internet]. Europe; 2012. Available from: https://eurohivedat.eu/arxiu/ehe_cdocsmenu_cdocsmenu_doc_13-Qualitative_Study_Report_FINAL__V1_.pdf
11. Craig AP, Thein HH, Zhang L, Gray RT, Henderson K, Wilson D, et al. Spending of HIV resources in Asia and Eastern Europe: Systematic review reveals the need to shift funding allocations towards priority populations. *J Int AIDS Soc*. 2004;17(1):18822.
12. Sidhva D. The Impact of Positive Scotland - Now and Into the Future [Internet]. 2013 [cited 2019 Mar 29]. Available from: <http://www.waverleycare.org/wp-content/uploads/2015/03/Positive-Scotland-Evaluation.pdf>
13. Kononenko L. HIV Prevention and Psychosocial Support for MSM in Prisons: Results and Lessons Learned [Internet]. Nikolaev, Ukraine; 2012. Available from: www.noombd-pi.org.
14. Ajzen I, Fishbein M. Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ Prentice Hall. 1980.
15. Ajzen I. The theory of planned behavior. *Organ Behav Hum Decis Process*. 1991;50(2):179–211.

16. Becker MH, Maiman LA. Sociobehavioral determinants of compliance with health and medical care recommendations. *Med Care* [Internet]. 1975 [cited 2018 Oct 22];13(1):10–24. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/1089182>
17. Beatty PC, Willis GB. CH3: The Practice of Cognitive Interviewing. *Public Opin Q* [Internet]. 2007;71(2):287–311. Available from: <http://epa.sagepub.com/cgi/doi/10.3102/01623737026001001>
18. Simoni JM, Franks JC, Lehavot K, Yard SS. Peer interventions to promote health: conceptual considerations. *Am J Orthopsychiatry* [Internet]. 2011 [cited 2018 Oct 22];81(3):351–9. Available from: <http://doi.apa.org/getdoi.cfm?doi=10.1111/j.1939-0025.2011.01103.x>
19. European Centre for Disease Prevention and Control. HIV testing Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2017 progress report. [cited 2018 Oct 22]; Available from: www.ecdc.europa.eu
20. World Health Organization. Global health sector strategy on viral hepatitis 2016-2021. *Glob Hepat Program Dep HIV/AIDS*. 2016; Available from: <http://www.who.int/iris/handle/10665/246177>
21. Cronbach LJ. Coefficient alpha and the internal structure of tests. *Psychometrika* [Internet]. 1951. [cited 2018 Nov 16]; 16(3):297-334. Available from: <https://pdfs.semanticscholar.org/e985/ac2e151903000cac310ffbc5b2cb4fbb9dd5.pdf>
22. Kline P. *The handbook of psychological testing*, 2nd ed. 1993. vii, 744-vii, 744.
23. Bech P. *Quality of life in the psychiatric patient*. London: Mosby-Wolfe.; 1998.
24. Becha P, Pichot P. Rating scales for psychopathology, health status and quality of life. *Compendium on documentation in accordance with the DSM-m-r and WHO systems*. *Nord J Psychiatry*. 1994;48(4):300–1.
25. Romppel M, Herrmann-Lingen C, Wachter R, Edelmann F, Dungen H-D, Pieske B, et al. A short form of the General Self-Efficacy Scale (GSE-6): Development, psychometric properties and validity in an intercultural non-clinical sample and a sample of patients at risk for heart failure. *Psychosoc Med* [Internet]. 2013 [cited 2018 Nov 16];10:Doc01. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23429426>
26. Herzberg F, Mausner B, Snyderman B. *The motivation to work*. NY: John Wiley & Sons.; 1967.
27. Warr P, Cook J, Wall T. Scales for the measurement of some work attitudes and aspects of psychological wellbeing. *J Occup Psychol* [Internet]. 1979 [cited 2018 Nov 16];52(2):129–48. Available from: <http://doi.wiley.com/10.1111/j.2044-8325.1979.tb00448.x>
28. Goetz K, Campbell SM, Steinhäuser J, Broge B, Willms S, Szecsenyi J. Evaluation of job satisfaction of practice staff and general practitioners: an exploratory study. *BMC Fam Pract* [Internet]. 2011;12:137. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22151354>
29. Perry H, Crigler L, Hodgins S. *Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policymakers*. 2014. Available at: https://www.chwcentral.org/sites/default/files/MCHIP_CHW%20Ref%20Guide.pdf
30. Kok MC, Kane SS, Tulloch O, Ormel H, Theobald S, Dieleman M, et al. How does context influence performance of community health workers in low and middle-income countries? Evidence from the literature. *Heal Res Policy Syst* [Internet]. 2015 [cited 2018 Oct 29];13(1):13. Available from: <http://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-015-0001-3>

31. Perfect TJ, Watson EL, Wagstaff GF. Accuracy of Confidence Ratings Associated With General Knowledge and Eyewitness Memory. *J Appl Psychol.* 1993; 78(1):144-147.
32. Bandura A. Towards a Unifying Theory of Behavioral Change. *Psychol Rev.* 1977;84(2):191.
33. Olaniran A, Smith H, Unkels R, Bar-Zeev S, van den Broek N. Who is a community health worker? - a systematic review of definitions. *Glob Health Action* [Internet]. 2017 [cited 2018 Oct 29];10(1):1272223. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/28222653>
34. Hillery Jr. GA. Definitions of community: areas of agreement. *Rural Sociol.* 1955;20(2):111-23.
35. Clark A. Understanding Community: A Review of Networks, Ties and Contacts. *ESRC Natl Cent Res Methods.* 2007;9(7):37.
36. South J, Meah A, Bagnall A-M, Jones R. Dimensions of lay health worker programmes: results of a scoping study and production of a descriptive framework. *Glob Health Promot* [Internet]. 2013 [cited 2018 Oct 29];20(1):5-15. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23563775>
37. Simoni JM, Nelson KM, Franks JC, Yard SS, Lehavot K. Are Peer Interventions for HIV Efficacious? A Systematic Review. *AIDS Behav* [Internet]. 2011 [cited 2018 Oct 29];15(8):1589-95. Available from: <http://link.springer.com/10.1007/s10461-011-9963-5>
38. Eurostat. Self-perceived health statistics [Internet]. *Statistics explained.* 2018. p. 1-16. Available from: http://ec.europa.eu/eurostat/statistics-explained/index.php/Self-perceived_health_statistics
39. Topp CW, Østergaard SD, Søndergaard S, Bech P. The WHO-5 Well-Being Index: A Systematic Review of the Literature. *Psychother Psychosom* [Internet]. 2015 [cited 2019 May 20];84(3):167-76. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/25831962>
40. Gómez-Baya D, Lucia-Casademunt A, Salinas-Pérez J. Gender Differences in Psychological Well-Being and Health Problems among European Health Professionals: Analysis of Psychological Basic Needs and Job Satisfaction. *Int J Environ Res Public Health* [Internet]. 2018 [cited 2019 May 28];15(7):1474. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/30002335>
41. Scott K, Beckham SW, Gross M, Pariyo G, Rao KD, Cometto G, et al. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. [cited 2018 Oct 31]; Available from: <https://doi.org/10.1186/s12960-018-0304-x>
42. Santos G-M, Do T, Beck J, Makofane K, Arreola S, Pyun T, et al. Syndemic conditions associated with increased HIV risk in a global sample of men who have sex with men. *Sex Transm Infect* [Internet]. 2014 [cited 2018 Oct 31];90(3):250-3. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/24431183>

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13. Annex

13.1. Comparison of CHWs in EMIS vs. ECHOES

The EMIS 2017 questionnaire⁴³ included several screening questions developed in collaboration with the ECHOES team to identify EMIS respondents who might fit the ECHOES definition of CHWs. The intention behind these questions was to link the respondents to the ECHOES questionnaire. Recruitment patterns of EMIS and ECHOES respondents and the number of CHW recruited for EMIS and ECHOES suggests these two surveys finally had only marginal overlaps of respondents. This raises questions as to why the intended linkage to ECHOES of CHW participating in EMIS failed. Respondents in EMIS and ECHOES who were CHWs identifying as gay, bisexual or other MSM were compared to help identify groups or sub-groups of CHW who were missed or not adequately reached by the ECHOES promotion strategy.

In EMIS, the following questions were available to identify CHWs:

Q406. Do you work as a community health worker to gay/bisexual and other MSM (that is, provide sexual health services outside of a clinical setting)?

- 1=Yes, as a paid worker
- 2=Yes, as a volunteer
- 3=No

[If Q406=1 or 2]

Q407. Which of the following best describes the type of organisation you work for/with when working as a community health worker?

- 1=Private not-for-profit (non-governmental organisation, charity, civil society, grassroots organisation)
- 2=Private for-profit/commercial organisation
- 3=Government/local authority/public organisation
- 4=None – I do not work for an organisation

[If Q406=1 or 2]

Q408. What is the main purpose of the organisation you work for/with when working as a community health worker?

- 1=Sexual health
- 2=General health (e.g. hospital, clinic, community health, GP)
- 3=Religion
- 4=Education (school, college or university)
- 5=Housing/homelessness
- 6=Advocacy
- 7=Transport
- 8=Prison/probation
- 9=Other answer

Based on these questions 4,089 EMIS respondents self-identified as community health workers.

⁴³ <http://sigmaresearch.org.uk/questionnaires/tags/tag/EMIS-2017> (accessed on 31 May 2019).

The question to determine sexual preferences of ECHOES respondents was:

C12. Which of the following best describes how you think about yourself?

- 1=Gay
- 2=Homosexual
- 3=Lesbian
- 4=Bisexual
- 5=Queer
- 6=Straight/heterosexual
- 7=Any other term
- 8=I don't usually use a term

Based on this question, 613 ECHOES respondents who identified as male and choose either 'gay', 'homosexual', 'bisexual', or 'queer' were categorised as gay, bisexual or other MSM.

We compared the 4,089 gay, bisexual or other MSM CHWs in EMIS with the 613 in ECHOES with respect to their socio-demographic characteristics (Table 14-1), and the organisation profile they worked for (Table 14-2). The questions that informed this data were queried in the same way in both surveys.

- The proportion of respondents younger than 30 was higher in EMIS than in ECHOES.
- ECHOES respondents more often reported living in a city with more than 500,000 inhabitants compared to EMIS CHWs; while >85% of ECHOES CHW lived in cities with more than 500,000 inhabitants, >50% of EMIS CHWs lived in cities with fewer than 500,000 inhabitants, towns or villages, or in the countryside.
- ECHOES CHWs more often reported having been in education for 7 or more years beyond the age of 16 compared to EMIS CHWs.
- ECHOES CHWs less often reported being on the two extremes of the income scale (i.e. less likely to live very comfortably on their income and less likely to really struggle) than EMIS CHWs.
- ECHOES CHWs less often reported working as a volunteer compared to EMIS CHWs.
- ECHOES CHWs less often reported self-identifying as a member of an ethnic minority group compared to EMIS CHWs.
- ECHOES CHWs more often reported having been diagnosed with HIV compared to EMIS CHWs.
- EMIS CHWs less often reported being out to all the people they know compared to ECHOES CHWs.

Table 13-1: Comparison of EMIS and ECHOES CHWs. Socio-demographic characteristics

| | EMIS (n=4,089) | ECHOES (n=613) | Total (n=4,702) | p-value |
|---|-------------------|-------------------|--------------------|---------|
| Age group | | | | <0.001 |
| 18-30 years | 32.6 | 21.2 | 31.1 | |
| 31-40 years | 24.9 | 30.3 | 25.6 | |
| >40 years | 42.5 | 48.5 | 43.3 | |
| City size | | | | <0.001 |
| A very big city (1,000,000+ people) | 30.7 | 61.4 | 34.7 | |
| A big city/town (500,000-999,999 people) | 19.0 | 26.1 | 19.9 | |
| A medium-sized city/town (100,000-499,999 people) | 23.5 | 8.4 | 21.5 | |
| A small city/town (10,000-99,999 people) | 18.0 | 3.0 | 16.1 | |
| A village or the countryside (< than 10,000 people) | 8.8 | 1.2 | 7.8 | |
| Education beyond age of 16 | | | | 0.165 |
| up to 7 years | 57.1 | 54.0 | 56.6 | |
| more than 7 years | 43.0 | 46.0 | 43.4 | |
| Feelings about your income | | | | <0.001 |
| Living really comfortably on present income | 16.4 | 9.8 | 15.6 | |
| Living comfortably on present income | 33.1 | 36.3 | 33.5 | |
| Neither comfortable nor struggling | 31.2 | 37.0 | 31.9 | |
| Struggling on present income | 13.8 | 14.6 | 13.9 | |
| Really struggling on present income | 5.6 | 2.3 | 5.1 | |
| Ethnic minority | | | | <0.001 |
| No | 85.1 | 90.6 | 85.8 | |
| Yes | 14.9 | 9.4 | 14.2 | |
| Diagnosed with HIV | | | | <0.001 |
| No | 80.6 | 64.0 | 78.5 | |
| Yes | 19.4 | 36.0 | 21.5 | |
| Outness | | | | <0.001 |
| All or almost all | 61.4 | 76.1 | 63.3 | |
| More than half | 15.4 | 17.4 | 15.7 | |
| Less than half | 7.6 | 3.8 | 7.1 | |
| Few | 11.2 | 2.3 | 10.1 | |
| None | 4.4 | 0.5 | 3.9 | |
| Paid or volunteer | | | | <0.001 |
| Paid | 37.0 | 58.7 | 39.8 | |
| Volunteer | 63.1 | 40.8 | 60.1 | |
| Unknown | 0.0 | 0.5 | 0.1 | |

Almost 90% of the comparable group in ECHOES worked for NGOs, compared to 66% in EMIS. The respondents in the EMIS comparable group more often report working in governmental/local authority/public organisations, private for-profit or commercial organisations or not working for any organisation. The primary purpose of the organisation ECHOES respondents work for was sexual health. ECHOES respondents less often reported working in the areas of general health (e.g. hospital, clinic, community health, GP), religion, education (school, college or university), housing or homelessness, or advocacy (reference group: sexual health). No ECHOES respondents worked in transport or in prison/probation. EMIS respondents were also most active in the domains of sexual health, but the purpose of the organisations they worked for was more diverse than for ECHOES respondents.

Table 13-2: Comparison of EMIS and ECHOES CHWs. Organisation profiles

| | EMIS (n=4,089) | ECHOES (n=613) | Total (n=4,702) | p-value |
|--|-------------------|-------------------|--------------------|---------|
| Type of organisation | | | | <0.001 |
| Private not-for-profit organisation | 66.3 | 89.1 | 69.2 | |
| Private for-profit or commercial organisation | 6.9 | 0.5 | 6.1 | |
| Government/local authority/public organisation | 15.8 | 8.1 | 14.8 | |
| I do not work for an organisation | 11.0 | 2.3 | 9.9 | |
| Purpose of organisation | | | | <0.001 |
| Sexual health | 46.1 | 83.6 | 50.9 | |
| General health | 17.1 | 8.3 | 16.0 | |
| Religion | 1.4 | 0.2 | 1.3 | |
| Education | 6.1 | 0.9 | 5.4 | |
| Housing or homelessness | 1.7 | 0.2 | 1.5 | |
| Advocacy | 8.9 | 2.9 | 8.1 | |
| Transport | 0.5 | 0.0 | 0.4 | |
| Prison or probation | 0.5 | 0.0 | 0.5 | |
| Other answer | 17.7 | 4.0 | 16.0 | |

The comparison of CHWs in EMIS vs. ECHOES show that ECHOES mainly reached a specific segment of CHWs, namely those who work for not-for-profit, non-governmental organisations whose primary purpose is the sexual health of MSM, but most other CHW are underrepresented in the ECHOES sample. This is likely due to a failure to engage other types of organisations with the recruitment strategies that were used for ECHOES. If the goal of future research is reaching a broader sample of CHW, formative research on how to address CHW working in organisations other than not-for-profit organisations working in MSM sexual health will be necessary.

13.2. Complete list of job titles provided by ECHOES respondents

Table 13-3: Table including the list of job titles in original language and English translation

| Language | Job title - English translation | Job title - Original language | Freq |
|--|---|--|---|
| Bulgarian | Health promotion counsellor | Консултант промоция на здраве | 4 |
| | Counsellor | Консултант | 3 |
| | Field work associate / field worker | Сътрудник на терен | 1 |
| | Field work associate / field worker | Теренен сътрудник | 1 |
| | Field worker and MSM community representatives counsellor | Консултант на екип от теренни сътрудници и на представители на мсм общност | 1 |
| | Volunteer | Доброволец | 1 |
| | Health worker | Здравен работник | 1 |
| | Local sexual health expert | Местен експерт по сексуално здраве | 1 |
| | Sexual health worker | Сексуален здравен работник | 1 |
| | HIV counselor | Hiv counsellor | 1 |
| | HIV/AIDS counsellor | Консултант хив от спин | 1 |
| | Field worker and project coordinator | Сътрудник на терен и координатор на проекти | 1 |
| | Doctor | Лекар | 1 |
| | Vulnerable groups public health expert | Експерт по обществено здраве и здравеопазване на уязвими групи | 1 |
| | Czech | Advisor | Odborný poradce |
| Advisor | | Poradce | 3 |
| Contact worker | | Kontaktný pracovník | 2 |
| Health worker | | Zdravotník | 2 |
| LGBTQ psychology researcher | | Výzkumník v oblasti lgbtq psychologie | 1 |
| Doctor - sexologist | | Lékař - sexuolog | 1 |
| Community worker | | Komunitní pracovník | 1 |
| I provide HIV testing in the gay community | | Poskytuji testování na hiv pro gay-komunitu | 1 |
| Advisor in the "aids center" | | Poradce aids centra | 1 |
| Pre-test consultant | | Předtestový poradce | 1 |
| Consultant with medical and philosophical background/education | | Konzultant s lékařským a filosofickým vzděláním | 1 |
| Prevention worker | | Preventista | 1 |
| Manager of health services | | Manažer zdravotních služeb | 1 |
| Contact health worker | | Kontaktní zdravotník | 1 |
| Community development | | Ten kdo svou činností přispívá k pozitivnímu rozvoji místa vytváří nabídku služeb atd. | 1 |
| Sampling nurse | | Odberova sestra | 1 |
| Dutch | | Community nurse sexual health | Sociaal verpleegkundige seksuele gezondheid |
| | Community nurse | Sociaal verpleegkundige | 2 |

| | | | |
|----------------|--|---|----|
| | Peer educator | Peer-educator | 1 |
| | Advocate | Belangenbehartiger | 1 |
| | General practitioner | Huisarts | 1 |
| | Advisor | Adviseur | 1 |
| | Nurse Community & Health - Sexual Health (Municipal Health Services) | Verpleegkundige m and g seksuele gezondheid (ggd) | 1 |
| | Physician-researcher at the STI clinic | Arts-onderzoeker bij de soa poli | 1 |
| | Teacher of nursing care | Docent verpleegkunde | 1 |
| | Volunteer hiv prevention | Vrijwilliger hiv preventie | 1 |
| | Policy officer | Beleidsmedewerker | 1 |
| | Psychosocial care worker | Psychosociaal hulpverlener | 1 |
| | Care worker | Hulpverlener | 1 |
| | Social worker | Sociaal werker | 1 |
| | Educator/coach chemsex issues | Voorlichter or coach chemsex issues | 1 |
| | Counselor | Consulent | 1 |
| | Health promotor | Gezondheidspromotor | 1 |
| English | Outreach worker | Outreach worker | 13 |
| | Sexual health worker | Sexual health worker | 13 |
| | Health promotor | Health promotor | 8 |
| | Social worker | Social worker | 7 |
| | Community health worker | Community health worker | 6 |
| | Counsellor | Counsellor | 6 |
| | Community development worker | Community development worker | 6 |
| | Health promotion specialist | Health promotion specialist | 5 |
| | Peer educator | Peer educator | 3 |
| | Manager | Manager | 3 |
| | Counselor | Counselor | 2 |
| | Community worker | Community worker | 2 |
| | Volunteer | Volunteer | 2 |
| | Sexual health promotor | Sexual health promotor | 2 |
| | Project manager | Project manager | 2 |
| | Sexual health counsellor | Sexual health counsellor | 2 |
| | Personal support worker | Personal support worker | 2 |
| | Advisor | Advisor | 2 |
| | Health promotion manager | Health promotion coordinator | 1 |
| | Health promotion manager | Health promotion manager | 1 |
| | Community sexual health worker | Community sexual health worker | 1 |
| | Consultant - advocacy adviser | Consultant - advocacy adviser | 1 |
| | Md | Md | 1 |
| | Sexual health professional | Sexual health professional | 1 |
| | Nurse | Nurse | 1 |
| | Prevention worker | Prevention worker | 1 |
| | Health promotor, health prevention worker | Health promotor health prevention worker | 1 |

| | | |
|---|---|---|
| MSM Health promoter | Msm health promoter | 1 |
| Sexual health worker or health promoter | Sexual health worker or health promoter | 1 |
| Client manager | Client manager | 1 |
| Project leader - sexual health | Project leader - sexual health | 1 |
| Health professional | Health professional | 1 |
| Hiv project worker | Hiv project worker | 1 |
| Community director | Community director | 1 |
| Basegroupleader in a camp for MSM | Basegroupleader in a camp for msm | 1 |
| Volunteer for a community based association | Volunteer for a community based association | 1 |
| CEO (of an NGO that provides community advocacy) | Ceo (of an ngo that provides community advocacy) | 1 |
| Counselor on hiv/STI in CBVCT | Counselor on hiv or sti in cbvct | 1 |
| Support worker | Support worker | 1 |
| Hiv services adviser | Hiv services adviser | 1 |
| Preventor | Preventor | 1 |
| Health promotion practitioner | Health promotion practitioner | 1 |
| Senior Practitioner/ Health trainer | Senior practitioner or health trainer | 1 |
| Consultant on hiv and sti's | Consultant on hiv and sti's | 1 |
| Project manager and counsellor | Project manager and counsellor | 1 |
| Peer support coordinator | Peer support coordinator | 1 |
| Not sure | Not sure | 1 |
| Health promoter to men who have sex with men. | Health promoter to men who have sex with men. | 1 |
| Activist | Activist | 1 |
| Checkpoint manager | Checkpoint manager | 1 |
| Health promotion officer | Health promotion officer | 1 |
| Project manager, counselor | Project manager counselor | 1 |
| Consultant physician | Consultant physician | 1 |
| Councillor and tester of hiv an syphilis | Councillor and tester of hiv an syphilis | 1 |
| Operations manager | Operations manager | 1 |
| Counsollour - testperson | Counsollour - testperson | 1 |
| Prep Activist | Prep activist | 1 |
| Nurse working wiht sexual health hiv sti and more | Nurse working wiht sexual health hiv sti and more | 1 |
| Sexual health manager | Sexual health manager | 1 |
| Outreach and sexual health worker | Outreach and sexual health worker | 1 |
| Sexual health officer | Sexual health officer | 1 |
| Peer helper | Peer helper | 1 |
| Communication officer | Communication officer | 1 |
| Hiv test worker | Hiv test worker | 1 |
| Project manager, sex educator. | Project manager sex educator. | 1 |
| Services manager | Services manager | 1 |
| Health promotion & intersectionality lead | Health promotion and intersectionality lead | 1 |

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|---|---|---|
| Support Project worker | Support project worker | 1 |
| Director | Director | 1 |
| Psychotherapist in private practice | Psychotherapist in private practice | 1 |
| Clinical projects manager | Clinical projects manager | 1 |
| Hiv support lead & men's sexual health worker | Hiv support lead and men's sexual health worker | 1 |
| Community support worker | Community support worker | 1 |
| Community HIV Support and Prevention Worker | Community hiv support and prevention worker | 1 |
| Präventions- Mitarbeitern | Präventions- mitarbeitern | 1 |
| Hiv specialist social worker | Hiv specialist social worker | 1 |
| Services and Health Promotion Director | Services and health promotion director | 1 |
| HIV counselor | Hiv counselor | 1 |
| Project management | Project management | 1 |
| No specific title | No specific title | 1 |
| Outreach activist | Outreach activist | 1 |
| Men's health worker | Men's health worker | 2 |
| Psychotherapist/counsellor | Psychotherapist or counsellor | 1 |
| An outreach worker | An outreach worker | 1 |
| Consulting | Consulting | 1 |
| Vice chair non ngo Hiv-Sverige | Vice chair non ngo hiv-sverige | 1 |
| Program coordinator | Program coordinator | 1 |
| Educator / public health worker | Educator or public health worker | 1 |
| Charity worker and volunteer | Charity worker and volunteer | 1 |
| Sexual helth worker in a quicktest point | Sexual helth worker in a quicktest point | 1 |
| Project leader in sexual health and hiv for men who have sex with men | Project leader in sexual health and hiv for men who have sex with men | 1 |
| Buddy | Buddy | 1 |
| None | None | 1 |
| Senior HIV Prevention and Support officer | Senior hiv prevention and support officer | 1 |
| Prep and hiv activist and informant (health promoter) | Prep and hiv activist and informant (health promoter) | 1 |
| Have no answer | Have no answer | 1 |
| Clinical nurse specialist (hiv community) | Clinical nurse specialist (hiv community) | 1 |
| Group Psychotherapist in HIV organisation | Group psychotherapist in hiv organisation | 1 |
| Sexual health informant | Sexual health informant | 1 |
| Sexual Health Worker and Educator | Sexual health worker and educator | 1 |
| Non clinical sexual health practitioner | Non clinical sexual health practitioner | 1 |
| Psychotherapist | Psychotherapist | 1 |
| Life quality consultant | Life quality consultant | 1 |
| Senior practitioner | Senior practitioner | 1 |
| Sexual health promotion specialist | Sexual health promotion specialist | 1 |
| Senior health promotion specialist | Senior health promotion specialist | 1 |
| Assistant Practitioner in nursing (Sexual Health Worker) | Assistant practitioner in nursing (sexual health worker) | 1 |

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|----------------|--|---|---|
| | HIV Prevention and Testing Worker | Hiv prevention and testing worker | 1 |
| | Gay Men's Outreach Worker and Tester | Gay men"s outreach worker and tester | 1 |
| | Volunteer HIV tester | Volunteer hiv tester | 1 |
| | Hiv charity manager | Hiv charity manager | 1 |
| | Peer mentor officer | Peer mentor officer | 1 |
| | Peer based community sexual health and well being manager | Peer based community sexual health and well being manager | 1 |
| | Sexual health community hiv worker | Sexual health community hiv worker | 1 |
| | Specialist health promotion officer | Specialist health promotion officer | 1 |
| | Sexual health volunteer | Sexual health volunteer | 1 |
| | A doctor treating AIDS patients | A doctor treating aids patients | 1 |
| | Laboratory worker | Laboratory worker | 1 |
| | Fundraiser | Fundraiser | 1 |
| | Medical student working with sexual education and information | Medical student working with sexual education and information | 1 |
| | Community hiv worker | Community hiv worker | 1 |
| | Outreach | Outreach | 1 |
| | Health counselor | Health counselor | 1 |
| | Sexual health researcher and advocate | Sexual health researcher and advocate | 1 |
| | Hiv prevention manager | Hiv prevention manager | 1 |
| | Prison nurse | Prison nurse | 1 |
| | Uppsökande arbetstagare | Uppsökande arbetstagare | 1 |
| | Consultant | Consultant | 1 |
| | Harm reduction and outreach worker | Harm reduction and outreach worker | 1 |
| | Digital outreach worker | Digital outreach worker | 1 |
| | Programme manager HIV prevention | Programme manager hiv prevention | 1 |
| | Medical student | Medical student | 1 |
| | HIV community tester | Hiv community tester | 1 |
| | Assistant practitioner | Assistant practitioner | 1 |
| | Volunteer and Training Development Worker | Volunteer and training development worker | 1 |
| | Community development worker (MSM) | Community development worker (msm) | 1 |
| | Service coordinator | Service coordinator | 1 |
| | Community testing worker | Community testing worker | 1 |
| | Community evelopment worker | Community evelopment worker | 1 |
| | Netreach worker (using Grindr and other hookup/dating apps). I also ran one bi community sexual health event recently. | Netreach worker (using grindr and other hookup or dating apps). I also ran one bi community sexual health event recently. | 1 |
| | Sexual health outreach worker | Sexual health outreach worker | 1 |
| | Sexual health activist | Sexual health activist | 1 |
| Finnish | Sexual health promotor | Seksuaaliterveyden edistäjä | 2 |
| | Sexuality advisor | Seksuaalineuvoja | 2 |
| | Obcene word | Pylly | 1 |
| | Outreach worker, sexual health worker, health promotion worker | Etsivätyöntekijä seksuaaliterveyden työntekijä terveyden edistäjä | 1 |
| | Sexual health worker | Seksuaaliterveyden työntekijä | 1 |

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| | Coordinator of development | Kehittämiskoordinaattori | 1 |
| | Social worker | Sosiaaliohjaaja | 1 |
| | NGO worker | Järjestötyöntekijä | 1 |
| | Support person and outreach worker | Tukihenkilö ja etsiväntyön tekijä | 1 |
| | Nurse, sexuality advisor | Terveystenhoitaja seksuaalivoujoja | 1 |
| | Sexuality advising, sexual health promotor | Seksuaalivouvoista seksuaaliterveyden edistäjä | 1 |
| | Sexual health worker, worker for physical and psychological support | Seksuaaliterveyden työntekijä psyykkistä ja sosiaalista terveyttä edistävä työntekijä | 1 |
| French | Volunteer | Volontaire | 22 |
| | Community intervention officer | Intervenant communautaire | 9 |
| | Campaigner | Militant | 7 |
| | Volunteer | Bénévole | 3 |
| | Outreach worker | Animateur d'action | 3 |
| | Community caseworker | Accompagnatrice communautaire | 2 |
| | Community caseworker | Accompagnant communautaire | 2 |
| | Volunteer campaigner | Militant volontaire | 2 |
| | Social worker | Travailleur social | 2 |
| | Counsellor | Counsellor | 2 |
| | Peer educator | Pair éducateur | 2 |
| | Fieldworker | Agent de terrain | 2 |
| | Project coordinator | Chargé de projet | 2 |
| | Community worker (female) | Travailleuse communautaire | 2 |
| | Outreach worker | Animateur de prévention | 1 |
| | Outreach worker | Travailleur de proximité | 1 |
| | Outreach worker | Animateur d'actions | 1 |
| | Community caseworker | Acteur en santé communautaire | 1 |
| | Community caseworker | Accompagnateur communautaire | 1 |
| | Volunteer | Volontaire associatif | 1 |
| | Volunteer campaigner | Volontaire militant | 1 |
| | Community caseworker (prep) | Prep accompagnateur communautaire | 1 |
| | Community caseworker (prep) | Accompagnateur communautaire prep | 1 |
| | Counsellor in Sexual Health | Conseiller en santé sexuelle | 1 |
| | Counsellor in Sexual Health | Conseiller psycho social en santé sexuelle | 1 |
| | Outreach worker (female) | Animatrice | 1 |
| | Outreach worker (female) | Animatrice d'action | 1 |
| | Community/Outreach worker | Animateur d'actions communautaires | 1 |
| | Community/Outreach worker | Animateur communautaire | 1 |
| | Outreach worker in prevention | Animateur d'action de prévention | 1 |
| | Employee in community health | Salarié en santé communautaire | 1 |
| | Counsellor VCT | Conseiller vct | 1 |
| | Nurse specialised in sexual health counsel (female) | Infirmière spécialisé en conseil en santé sexuelle | 1 |
| Fieldworker, counsellor in Sexual Health | Agent de terrain conseiller en santé | 1 | |

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|--|---|----|
| | sexuelle | |
| Activist | Activiste | 1 |
| Community intervention officer in sexual health | Intervenant communautaire en santé sexuelle | 1 |
| Educator | Éducateur | 1 |
| Prep Caseworker | Accompagnateur prep | 1 |
| Social intervention officer | Intervenant social | 1 |
| Community intervention officer in harm reduction | Intervenant en rdr | 1 |
| Doctor in a community health centre | Médecin dans un centre de santé communautaire | 1 |
| Unpaid volunteer | Volontaire non rémunéré | 1 |
| Outreach worker in sexual prevention | Animateur d'actions en prévention sexuelle | 1 |
| Outreach worker in sexual health and harm reduction (female) | Animatrice d'actions en santé sexuelle et réduction des risques | 1 |
| Counsellor | Conseill_er | 1 |
| Community health project coordinator | Chargé de projet en santé communautaire | 1 |
| Community worker | Acteur communautaire | 1 |
| Caseworker | Animateur | 1 |
| Outreach worker in community health / social work | Animateur d'action en santé communautaire et travail social | 1 |
| Community/NGO intervention officer | Intervenant associatif | 1 |
| Promoter of sexual health | Promoteur de la santé sexuelle | 1 |
| Community intervention officer, community developer | Intervenant communautaire community developer | 1 |
| NGO employee | Salarié associatif | 1 |
| Promoter of community health | Promoteur en santé communautaire | 1 |
| Outreach worker in community health | Animateur d'actions en santé communautaire | 1 |
| Prevention project coordinator | Chargé de prévention | 1 |
| I don't know | Je ne sais pas | 1 |
| Community health intervention officer | Intervenant en santé communautaire | 1 |
| Fieldworker / Outreach worker | Acteur de terrain | 1 |
| Officer | Acteur | 1 |
| Nurse (male) | Infirmier | 1 |
| Educator (graduate) | Educateur gradué | 1 |
| German | | |
| Sexual health worker | Sexual health worker | 17 |
| Social worker | Sozialarbeiter | 13 |
| Health promoter | Health promoter | 13 |
| Prevention worker | Präventionist | 12 |
| Outreach worker | Outreach worker | 12 |
| Chw | Chw | 11 |
| Consultant | Berater | 10 |
| Health consultant | Gesundheitsberater | 6 |
| Health Advisor for Sexual Health | Gesundheitsberater für sexuelle Gesundheit | 3 |
| Volunteer | Ehrenamtler | 3 |

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| Street-worker | Streetworker | 3 |
| Specialist in health promotion | Fachperson für Gesundheitsförderung | 3 |
| Psychological counselor | Psychologischer berater | 3 |
| Health supporter | Health supporter | 3 |
| Social worker | Sozialarbeiterin | 2 |
| Social worker | Sozialarbeiter or in | 2 |
| Prevention worker | Präventionsarbeiter | 2 |
| Consultant | Beraterin | 2 |
| On-site workers | Vorortarbeiter | 2 |
| Honorary advisor | Ehrenamtlicher berater | 2 |
| Health worker | Health worker | 2 |
| Honorary health adviser | Ehrenamtlicher gesundheitsberater | 2 |
| Sexual health worker | Sexual health worker = Gesundheitsberater or in für sexuelle Gesundheit | 2 |
| Prevention worker | Präventionist in der Vorortarbeit | 1 |
| Outreach worker | Outreacher definitiv | 1 |
| Consultant | Fachberater | 1 |
| Chw | Comunity Health Worker | 1 |
| Health consultant | Gesundheitsbberaterin | 1 |
| Health Advisor for Sexual Health | Gesundheitsberaterin für sexuelle Gesundheit | 1 |
| Health Advisor for Sexual Health | Gesundheitsberater or in für sexuelle Gesundheit | 1 |
| Health Advisor for Sexual Health | Gesundheitsberater or in für sexuelle Gesundheit health promoter | 1 |
| Volunteer | Ehrenamtlicher mitarbeiter | 1 |
| Volunteer | Ehrenämtler | 1 |
| Health promoter | Health promotor (planer) | 1 |
| Health promoter | Health promoteor | 1 |
| Health promoter | Health promotor | 1 |
| Health promoter | Health promoter or Fachperson für Gesundheitsförderung | 1 |
| Street-worker | Streetworker im Bereich Schwulensex | 1 |
| Specialist in health promotion | Fachperson für Gesundheitsföerdrung | 1 |
| On-site workers | Vor-ort-arbeiter | 1 |
| Honorary advisor | Ehrenamtliche beraterin | 1 |
| Sexual health worker | Sexuell health worker | 1 |
| Psycho-social counselor | Psycho-sozialer Berater | 1 |
| Psycho-social counselor | Psychosozialer Berater | 1 |
| Prevention specialist | Präventionsfachkraft | 1 |
| Prevention specialist | Präventionsspezialist | 1 |
| Community health worker | Community health worker | 1 |
| Psychologist | Psychologe | 1 |
| Peer-to-peer counsellor | Peer-to-peer counsellor | 1 |
| Volunteer of a prevention campaign | Ehrenamtlicher Mitarbeiter einer Präventionskampagne | 1 |

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| Social educator | Sozialpädagoge | 1 |
| Sexual health worker / Street-worker / Prevention worker | Sexual health worker Streetworker Referend Präventionist | 1 |
| Graduate social worker (FH) | Diplom-sozialpädagoge (fh) | 1 |
| Employee in primary prevention | Mitarbeiter im Bereich Primärprävention | 1 |
| Doctor | Arzt | 1 |
| Volunteer in HIV and sti outreach prevention | Ehrenamtler in der HIV und sti vor Ort Prävention | 1 |
| STI prevention staff | Sti-präventionsmitarbeiter | 1 |
| Campaign staff | Kampagnemitarbeiter | 1 |
| Volunteer consultant for gays and MSM | Ehrenamtlich tätiger Berater für Schwule und MSM | 1 |
| Staff and consultants at Checkpoint and healthchat | Mitarbeiter und Berater im Checkpoint und healthchat | 1 |
| On-site workers / Outreach worker | Vorortarbeiter or outreach worker | 1 |
| Prep Activist | Prep aktivist | 1 |
| Psychological counselor / Sex educator / Social worker | Psychologischer Berater or Sexualpädagoge or Sozialarbeiter | 1 |
| Volunteer at Hein and Fiete | Ehrenamtlicher Mitarbeiter bei Hein and Fiete | 1 |
| Social advisor / sex advisor | Sozialberater sexualberater | 1 |
| Sexual consultants / Prevention worker | Sexualberater - preventionist | 1 |
| Self-help | Selbsthilfe | 1 |
| Safe sex counselor | Safer sex berater | 1 |
| Interlocutor | Gesprächspartner | 1 |
| Workers in the field of msm | Arbeiter im fachbereich msm | 1 |
| Contact / Conversation person | Kontakt or Gesprächsperson | 1 |
| Bodyworker | Bodyworker | 1 |
| Youthworker mentor for healthcare | Youthworker Mentor für Gesundheitswesen | 1 |
| Prevention staff | Präventionsmitarbeiter*in | 1 |
| Outreach worker / Sexual health worker | Outreach worker und sexual health worker | 1 |
| Consultant for MSM | Berater für MSM | 1 |
| Social Worker / Sex pedagogue | Sozialarbeiterin sexualpädagogin | 1 |
| Volunteer in community-based HIV prevention | Ehrenamtlicher in der communitynahen HIV-Prävention | 1 |
| Specialist MSM | Fachmann MSM | 1 |
| Social pedagogue in the field of ambulatory assisted single living for mentally or addicted people | Sozialpädagoge im Bereich ambulant betreuteseinzelwohnen für psychisch or suchtkranke Menschen | 1 |
| Sexual consultants | Sexualberater | 1 |
| Checkpoint manager | Checkpoint-mitarbeiter | 1 |
| HIV related worker | HIV related worker | 1 |
| Employees in the area of | Mitarbeiter im bereich prävention | 1 |
| AIDS service organisation | AIDS service organisation | 1 |
| Freelancer | Freier mitarbeiter | 1 |
| Prevention worker / Outreach worker | Präventionsarbeiter or outreach sowie checkpoint Mitarbeiter | 1 |

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| Sexual advisor | Beraterin für sexuelle Gesundheit | 1 |
| Volunteer for primary prevention | Ehrenamtlicher Mitarbeiter zur Primär-Prävention | 1 |
| Psychosocial lay counselor | Psychosozialer laienberater | 1 |
| Social worker in education and counseling | Sozialarbeiter in Aufklärung und Beratung | 1 |
| Social Worker in Health Promotion Health Advisor for Sexual Health | Socialarbeiter in der Gesundheitsförderung Gesundheitsberater für sexuelle Gesundheit | 1 |
| Social Worker thinking that I want to move on to a sexual health worker | Sozialarbeiter wobei ich denke dass ich mich in Richtung sexual health worker weiterentwickeln möchte | 1 |
| Sexual health worker / Health consultant (for sexual health) | (sexual) health worker = Gesundheitsberater or in (für sexuelle Gesundheit) | 1 |
| Supporter | Unterstützer | 1 |
| Specialist in internal medicine in a center with community outreach | Fachärztin für Innere Medizin in einem Center mit community outreach | 1 |
| Outreach worker / Advice Low-threshold test offer | Outreach Worker or Empfang or Beratung niederschwelliges Testangebot | 1 |
| Buddy | Buddy der aidshilfe | 1 |
| Group therapist | Gruppentherapeut | 1 |
| Psychologist / Addiction therapist | Psychologe und Suchttherapeut | 1 |
| Psychotherapist in an AIDS-help | Psychotherapeut in einer Aidshilfe | 1 |
| Red ribbon angel | Red ribbon angel | 1 |
| Voluntary prevention Primary or secondary prevention Explainers on safe sex and HIV medication | Ehrenamtlicher Präventionist Primär- or Sekundärprävention Erklärer zu Safer Sex und HIV-Medikamenten | 1 |
| Counselor and Prevention in HIV or STI | Berater and Präventionist HIV or STI | 1 |
| Buddy or volunteer | Buddy or ehrenamtler | 1 |
| Accompanist | Begleiter | 1 |
| Prevention worker / Health consultant | Präventionist or Gesundheitsberater | 1 |
| Volunteer in prevention | Ehrenamtlicher Mitarbeiter in der Prävention | 1 |
| Health Advisor for HIV or STI | Gesundheitsberater für HIV or STI | 1 |
| Community coordinator | Community-koordinator | 1 |
| Specialist in dementia | Fachkraft für Demenz | 1 |
| Sex educator | Sexualpädagoge | 1 |
| HIV+ supporting buddy | Arbeit als Buddy im Projekt Sprungbrett | 1 |
| Life consultant | Life consultant | 1 |
| Telephone consultant / Buddy | Telefonberater und Buddy | 1 |
| Counsellor (without professional training) | Beratung ohne Ausbildung | 1 |
| Management with responsibility for Gay Health | Geschäftsführung mit Zuständigkeit zum Thema Schwule Gesundheit | 1 |
| Social worker / consultant | Sozialarbeiter or Berater | 1 |
| Health management | Gesundheitsmanagement | 1 |
| Practice assistants | Praxisassistent | 1 |
| Sexual worker | Sexual worker | 1 |
| Volunteer in gay community | Ehrenamtlicher in schwulen Community | 1 |

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| | Employee | Mitarbeiter | 1 |
| Greek | Sexual health adviser | Σύμβουλος σεξουαλικής υγείας | 7 |
| | Volunteer | Εθελοντης | 2 |
| | Community Worker in support of seropositive people | Εργαζόμενος στην κοινότητα για την υποστήριξη οροθετικών | 1 |
| | Worker in empowerment of People Living with HIV/AIDS (PLHIV) | Εργαζομενος στον τομέα ενδυναμωτης ρηθιν | 1 |
| | Outreach worker | Εργαζόμενη εκτός δομής | 1 |
| | Sexual education adviser | Σύμβουλος σεξουαλικής αγωγής | 1 |
| | Sexual health adviser/drug abuse adviser | Σύμβουλος σεξουαλικής υγείας οr σύμβουλος βλάβης από χρήση ουσιών | 1 |
| | Social worker | Κοινωνικός λειτουργός | 1 |
| | Activist | Ακτιβιστής | 1 |
| | Community health worker | Εργαζόμενη υγείας στην κοινότητα | 1 |
| | Health Adviser of vulnerable groups | Σύμβουλος υγείας για ευπαθείς ομάδες | 1 |
| | Volunteer/Activist/Trainer in gender identity and sexuality | Εθελοντρια οr ακτριβιστρια οr εκπαιδευτρια για θεματα φυλου και σεξουαλικοτητας | 1 |
| | Outreach volunteer | Εθελόντρια εκτός δομής | 1 |
| | Worker in a stationary community setting | Εργαζόμενη εντός δομής στην κοινότητα | 1 |
| | Sexual health adviser | Ενημερωτης σεξουαλικης υγειας | 1 |
| | Health promoter | Προαγωγός υγείας | 1 |
| | Public health promoter | Προαγωγός δημόσιας υγείας | 1 |
| | Worker | Εργαζομενος | 1 |
| | Mental health professional in a stationary setting | Επαγγελματίας ψυχικής υγείας σε σταθερή δομή | 1 |
| | Part time volunteer | Εθελοντής μερικής απασχόλησης | 1 |
| Outreach worker | Εργαζόμενος εκτός δομής | 1 | |
| Volunteer in a help line, coordinator of groups, training groups | Εθελόντρια σε γραμμή βοήθειας συντονίστρια σε ομάδες εκπαίδευση ομάδων | 1 | |
| Italian | Operator on sexual health issues | Operatore sui temi della salute sessuale | 8 |
| | Volunteer | Volontario | 6 |
| | Health promoter | Promotore di salute | 4 |
| | Counselor | Counselor | 2 |
| | Counsellor | Counsellor | 2 |
| | Sexual counselor | Counselor sessuale | 1 |
| | Operator on health issues | Operatore sui temi della salute | 1 |
| | Peer counselor on sexuality and health issues | Peer counsellor in tema di salute e sessualità | 1 |
| | Peer counselor | Peer counsellor | 1 |
| | Sexual health operator and promoter | Operatore e promotore sui temi della salute sessuale | 1 |
| | Health Group manager | Responsabile gruppo salute | 1 |
| | Volunteer as sexual health operator | Operatore salute sessuale volontario | 1 |
| | Working group manager | Responsabile gruppo lavoro | 1 |
| | Social operator | Operatore sociale | 1 |
| | Sexual health operator | Operatore della salute sessuale | 1 |

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| | Promoter of health policies, publisher of a magazine on HIV | Promotore di politiche sanitarie editore di periodico hiv | 1 |
| | Female health promoter | Promotrice della salute | 1 |
| | Volunteer on health | Volontario sulla salute | 1 |
| | CHW is ok | Chw va bene | 1 |
| | Peer support worker | Peer support worker | 1 |
| Polish | Health promoter/ health educator | Promotor zdrowia | 4 |
| | Sociar worker | Pracownik socjalny | 2 |
| | VCT check point counselor | Doradca w punkcie konsultacyjno-diagnostycznym | 1 |
| | VCT check point counselor | Doradca punktu anonimowego testowania w kierunku hiv | 1 |
| | Sexual health counselor | Doradca w zakresie zdrowia seksualnego | 1 |
| | Sexual health counselor | Doradca w zakresie zdrowia seksualnego | 1 |
| | Community worker | Pracownik środowiskowy | 1 |
| | Health educator | Edukator zdrowotny | 1 |
| | Psychotherapist | Psychoterapeuta | 1 |
| | Check point counselor | Doradca okołotesrowy | 1 |
| | Educator - counselor | Edukator doradca | 1 |
| | Responsible sexual behaviors promoter | Promotor odpowiedzialnych zachowań seksualnych | 1 |
| | Educator - health promotion | Edukator - promotor zdrowia | 1 |
| | Outreach worker, street worker | Outreachworker streetworker | 1 |
| | HIV/AIDS educator | Edukator hiv or aids | 1 |
| | Partyworker in MSM venues, sexual health educator | Partyworker w klubach dla msm edukator z zakresu seksualności | 1 |
| | Don't know | Nie wiem | 1 |
| Educator, trainer | Edukator trener | 1 | |
| Portuguese | Nurse | Enfermeiro | 3 |
| | Nurse | Enfermeira | 2 |
| | Sexual health professional | Profissional na área da saúde sexual | 1 |
| | Health educator | Educador de saúde | 1 |
| | Psychologist | Psicólogo | 1 |
| | Screening technician | Técnico de rastreio | 1 |
| | Peer educator | Educador de pares | 1 |
| | Outreach health promotor | Promotor de saúde outreach | 1 |
| | Doctor | Médico | 1 |
| | Technician | Técnica | 1 |
| | Social health support technician, aimed for people infected or affected with HIV/AIDS | Técnico de acompanhamento social na area da saude especificamente a pessoas infectadas e afectadas pelo vih or sida | 1 |
| | Harm reduction technician | Técnica de redução de riscos | 1 |
| | Health informer | Informador na área da saúde | 1 |
| | Social health educator, Peer, Person who use drugs | Educador social de saúde-par-pwud | 1 |
| | Community assistant | Assistente comunitária | 1 |

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|-----------------|--|--|---|
| | Social worker, Outreach worker, Health professional | Assistente social; trabalhador de outreach; profissional na área da saúde | 1 |
| Romanian | Health promoter | Promotor de sanatate | 5 |
| | Sexual health worker | Lucrator in sanatate sexuala | 3 |
| | Outreach worker | Lucrător outreach | 3 |
| | Community health worker | Lucrator comunitar de sanatate | 3 |
| | Lgbt health program coordinator | Coordonator program sanatatea lgbt | 1 |
| | Outreach worker trainer | Formator de lucratori de outreach | 1 |
| | Sexual health counselor | Consilier in sanatate sexuala | 1 |
| | Social worker | Asistent social (social worker) | 1 |
| | Counselor | Consilier | 1 |
| | Volunteer | Voluntar | 1 |
| | Social worker - no university studies | Lucrător social | 1 |
| Russian | Peer consultant | Равный консультант | 8 |
| | Outreach worker | Аутрич-работник | 6 |
| | Counsellor | Консультант | 4 |
| | Social worker | Социальный работник | 2 |
| | Volunteer | Волонтер | 2 |
| | Outreach worker | Аутрич | 1 |
| | Counsellor | Konsultant | 1 |
| | Coordinator | Координатор | 1 |
| | Project manager | Менеджер проекта | 1 |
| | Social co-worker, outreach worker, peer consultant | Социальный сотрудник аутрич-работник равный консультант | 1 |
| | Community health worker | Консультант по здоровью работающий в сообществе" | 1 |
| | Project coordinator | Координатор проекта | 1 |
| | Outreach manager, men`s health counsellor | Менеджер-аутрич консультант по мужскому здоровью | 1 |
| | Должность - заместитель председателя правления. Также я выполняю аутрич-работу консультирую по телефонупровожу очные консультации осущес | Должность - заместитель председателя правления. Также я выполняю аутрич-работу консультирую по телефонупровожу очные консультации осущес | 1 |
| | Outrech work manager | Менеджер аутрич работы | 1 |
| | Medical specialist | Медицинский специалист | 1 |
| | HIV/STI counsellor | Консультант по профилактике вич or иппп | 1 |
| | HIV counsellor | Консультан по вич | 1 |
| | Volunteering counsellor | Добровольный консультант | 1 |
| | Projects coordinator | Координатор проектов | 1 |
| | Outreach worker, counsellor | Аутрич-консультант | 1 |
| | Outreach worker, social worker (according to the employment contract) | Аутрич-работник по договору социальный работник | 1 |
| | Working with LGBT-community program coordinator | Координатор программы по работе с сообществом лгбт | 1 |
| | Outrech worker, street lawyer | Аутрич-работник уличный юрист | 1 |
| | MSM community health worker, peer consultant | Консультан по вопросам здоровья мсм равный консультант | 1 |

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| | Head of Board, outreach worker, social worker | Председатель совета аутрич соцработник | 1 |
| | Head of project | Руководитель проекта | 1 |
| | Info-manager, outreach worker | Инфо-менеджер аутрич-работник | 1 |
| | Psychologist | Психолог | 1 |
| | Head of MSM project, manager | Руководитель мсм проекта менеджер | 1 |
| | Counsellor, outreach worker | Консультант аутрич-работник | 1 |
| | Formally - director, imformally -I am doing everything, including peer counselling | Формально - директор. Неформально: делаю всё включая равное консультирование и пр. | 1 |
| | Psychologist, assistant in communication with medical specialists, organisation`s leader | Психолог помощник по коммуникации с медицинскими специалистами лидер организации | 1 |
| | Testing and outreach activities coordinator | Координатор проекта по тестированию и аутрич деятельности | 1 |
| | Outreach worker, counsellor, activist | Аутрич-работник волонтер активис | 1 |
| Serbo-Croatian | Outreach worker | Outreach radnik | 3 |
| | Health promotor | Promotor zdravlja | 3 |
| | Sexual health protection worker | Radnik na zaštiti seksualnog zdravlja | 3 |
| | Counselor | Savjetnik | 2 |
| | Peer counselor | Vršnjački savetnik | 2 |
| | Field worker | Terenski radnik | 2 |
| | Voluntary counseling and testing counselor | Vct savjetnik | 1 |
| | Voluntary counseling and testing counselor | Dpst savetnik | 1 |
| | Health promoter | Zravstveni promoter | 1 |
| | Project manager, includes working with the community (MSM) | Project manager including working with community (msm) | 1 |
| | Community health activities coordinator | Koordinator zdravstvenih aktivnosti u zajednici | 1 |
| | Sexual health counselor | Savjetnik o seksualnom zdravlju | 1 |
| | Volunteer | Volonter | 1 |
| | Female sexual health protection worker | Radnica na zaštiti seksualnog zdravlja | 1 |
| | Psychologist, Voluntary counseling and testing counselor | Psihologinja savjetnica u centru za dobrovoljno savjetovanje i testiranje | 1 |
| | Professional sexual and reproductive health counselor | Stručni savjetnik za spolno i reproduktivno zdravlje | 1 |
| | Health counselor and outreach worker | Zdravstveni savetnik i outreach worker | 1 |
| | Health promotor, outreach worker | Promoter zdravlja outreach radnik | 1 |
| | External staff | Vanjski radnik | 1 |
| | STD peer educator (HIV and AIDS) | Peer edukator o spolno prenosivim bolestima (konkretno hiv i aids-a) | 1 |
| | Health worker, promoting sexual health and HIV and STD prevention | Ydravstveni radnik na promociji seksualnog zdrav i prevenciji hiv-a i ostalih spi | 1 |
| | Community work program coordinator | Programski koordinator za rad sa zajednicom | 1 |
| | Health protection worker | Radnik na zaštiti zdravlja | 1 |
| Infectious disease specialist, counselor and counseling trainer | Specijalista infektolog savetnik i trener u savetovalistu | 1 | |
| Health promotion worker | Radnik promotor zdravlja | 1 | |

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|----------------|--|---|----|
| | A sexual health worker (working on sexual health protection) | Djelatnik spolnog zdravlja (radnik na zaštiti seksualnog zdravlja) | 1 |
| Spanish | Health worker | Agente de salud | 28 |
| | Volunteer | Voluntario | 19 |
| | Peer educator | Educador de pares | 9 |
| | Health technician | Técnico de salud | 8 |
| | Educator | Educador | 7 |
| | Social worker | Trabajador social | 6 |
| | Educator | Educadora | 3 |
| | Doctor | Médico | 3 |
| | Psychologist | Psicólogo | 3 |
| | Psychologist | Psicóloga | 3 |
| | Health educator | Educador para la salud | 2 |
| | Community health worker | Trabajador de salud comunitario | 2 |
| | Sexual health worker | Agente de salud sexual | 2 |
| | Health mediator | Mediadora de salud | 2 |
| | Mediator | Mediadora | 2 |
| | Technician | Técnico | 2 |
| | Health worker | Agente de salud y voluntario fuera de mi horario laboral | 1 |
| | Health worker | Agente de salud técnico de prevención. | 1 |
| | Health worker | Agente de salud or técnico de salud | 1 |
| | Health worker | Agente de salud y responsable de formación y voluntariado de la entidad | 1 |
| | Health worker | Psicologa-agente de salud | 1 |
| | Health worker | Trabajadora de salud | 1 |
| | Health worker | Agente de salud voluntario | 1 |
| | Health worker | Profesional sanitario | 1 |
| | Volunteer | Voluntario no remunerado | 1 |
| | Peer educator | Educador de pares or voluntario | 1 |
| | Peer educator | Educador or a de pares | 1 |
| | Peer educator | Educadora de pares | 1 |
| | Social worker | Trabajador social por la salud | 1 |
| | Social worker | Trabajadora social coordinadora | 1 |
| | Social worker | Trabajadora social socio-sanitaria | 1 |
| | Social worker | Agente social | 1 |
| | Social worker | Trabajadrod social | 1 |
| | Educator | Educador en salud y diversidad de género | 1 |
| | Health educator | Educador en salud sexual educador par | 1 |
| | Health educator | Monitor de educación para la salud o voluntario or a | 1 |
| | Health educator | Educador o docente | 1 |
| | Health educator | Educador en salud | 1 |
| | Community health worker | Trabajador de salud comunitaria. Psicóloga | 1 |

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| Community health worker | Birgada de salud comunitaria | 1 |
| Sexual health worker | Agente de salud sexual y diversidad | 1 |
| Sexual health worker | Técino en salud sexual | 1 |
| Health mediator | Mediador de salud | 1 |
| Mediator | Mediador | 1 |
| Peer educator/Health educator | Educador or a en salud programa de pares | 1 |
| Peer educator/Health educator | Educador para la salud educador par... | 1 |
| Project technician | Técnico de proyectos | 1 |
| Project technician | Técnica de proyectos | 1 |
| Nurse | Enfermera | 1 |
| Consultant | Asesora | 1 |
| Community pharmacist | Farmacéutico comunitario | 1 |
| Social educator | Educadora social | 1 |
| Social health technician | Técnico de intervención social | 1 |
| Health/social worker | Trabajadora social | 1 |
| Volunteer / Sexual health educator | Voluntario educador en salud sexual | 1 |
| Psychosocial educator | Educadora psicosocial | 1 |
| Volunteer (testing) | Voluntario del servicio de la prueba | 1 |
| Health promotor | Promotor de salud | 1 |
| Outreach educator | Educadora de calle | 1 |
| Community social worker | Trabajador sociocomunitario | 1 |
| Monitor | Monitora | 1 |
| Volunteer sexual health worker | Voluntario de salud sexual | 1 |
| Sexual health technician | Técnico en salud sexual | 1 |
| Volunteer (health area) | Voluntario en el área de salud | 1 |
| HIV technician | Técnico en vih | 1 |
| Social/sexual educator | Educadora social or sexual | 1 |
| Drug addiction doctor | Medico de drogodependencia | 1 |
| Counsellor | Counsellor- promotora de salud | 1 |
| Health psychologist | Psicologa de salud | 1 |
| Sexual educator | Asesor juvenil or educador sexual | 1 |
| Social health worker | Trabajador de salud social | 1 |
| NGO worker | Trabajador en ong | 1 |
| Sexologist and pedagogue | Sexólogo y pedagogo | 1 |
| Psychiatrist | Psiquiatra | 1 |
| Sexual health/prevention technician | Técnica en salud sexual y prevención del vih y otras its | 1 |
| Educator as nurse | Enfermera educadora | 1 |
| Social technician | Tecnico social | 1 |
| Health promotion technician | Técnica en promoción de salud | 1 |
| Volunteer / Health worker | Voluntaria y agente de salud | 1 |
| Health technician / Sexual health educator | Técnico de salud; educador de la salud sexual; | 1 |
| Social action project technician | Técnico de proyectos de acción social | 1 |

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|------------------|--|--|---|
| | Technician specialized in attention to sexual and gender diversity | Técnico especializado en atención a la diversidad sexual y de género | 1 |
| | Volunteer health worker | Voluntario agente de salud | 1 |
| Ukrainian | Social worker | Соціальний працівник | 4 |
| | Employee in health system | Працівник охорони здоров'я | 2 |
| | Outreach worker | Аутріч-працівник | 1 |
| | The head of MSM HIV prevention department | Керівник напрямку профілактики віл серед чсч | 1 |
| | Employee in social sphere | Працівник соціальної сфери | 1 |
| | Health protection manager | Менеджер охорони здоров'я | 1 |
| | Representative of social services | Представитель социальных услуг | 1 |
| | Manager in social sphere | Менеджер у соціальній сфері | 1 |
| | Documentary worker in sexual health direction | Працівник сексуального здоров'я а саме документатор | 1 |
| | Psychologist | Психолог | 1 |

13.3. Description of activities (service continuum) by job titles

Table 13-4: Type of activity by job titles

| | Prevention | Counselling and testing | Linkage to care | Treatment and support | Transversal activities |
|---------------------------------|--------------|-------------------------|-----------------|-----------------------|------------------------|
| Peer | | | | | |
| No | 88.8 | 63.1 | 44.1 | 50.1 | 45.8 |
| Yes | 83.7 | 57.1 | 51.0 | 75.5 | 55.1 |
| <i>P-value</i> | <i>0.266</i> | <i>0.401</i> | <i>0.343</i> | <i>0.001</i> | <i>0.204</i> |
| Health-care professional | | | | | |
| No | 88.6 | 61.5 | 44.4 | 50.0 | 46.3 |
| Yes | 89.1 | 85.5 | 45.5 | 74.5 | 45.5 |
| <i>P-value</i> | <i>0.906</i> | <i>0.000</i> | <i>0.877</i> | <i>0.000</i> | <i>0.900</i> |
| Outreach | | | | | |
| No | 87.9 | 62.4 | 44.1 | 52 | 46.7 |
| Yes | 94.5 | 66.4 | 47.3 | 45.5 | 42.7 |
| <i>P-value</i> | <i>0.038</i> | <i>0.414</i> | <i>0.528</i> | <i>0.194</i> | <i>0.429</i> |
| Testing worker | | | | | |
| No | 88.5 | 62.0 | 44.0 | 51.8 | 46.6 |
| Yes | 92.6 | 92.6 | 59.3 | 33.3 | 33.3 |
| <i>P-value</i> | <i>0.508</i> | <i>0.001</i> | <i>0.116</i> | <i>0.058</i> | <i>0.172</i> |
| Activist | | | | | |
| No | 88.4 | 63.0 | 44.5 | 51.2 | 46.5 |
| Yes | 96.2 | 53.8 | 42.3 | 53.8 | 38.5 |
| <i>P-value</i> | <i>0.22</i> | <i>0.339</i> | <i>0.824</i> | <i>0.793</i> | <i>0.418</i> |
| Psycho-social | | | | | |
| No | 88.9 | 64.0 | 44.8 | 49.9 | 45.2 |
| Yes | 86.8 | 55.6 | 42.4 | 59.7 | 52.8 |
| <i>P-value</i> | <i>0.465</i> | <i>0.052</i> | <i>0.588</i> | <i>0.029</i> | <i>0.092</i> |
| Sexual health | | | | | |
| No | 87.7 | 60.3 | 42.4 | 50.8 | 45.8 |
| Yes | 94.0 | 77.3 | 56.7 | 54.0 | 49.3 |
| <i>P-value</i> | <i>0.024</i> | <i>0.000</i> | <i>0.001</i> | <i>0.475</i> | <i>0.417</i> |
| Prevention worker | | | | | |
| No | 88.3 | 63.4 | 44.9 | 52.4 | 46.4 |
| Yes | 95.7 | 50.0 | 34.8 | 28.3 | 43.5 |
| <i>P-value</i> | <i>0.124</i> | <i>0.066</i> | <i>0.177</i> | <i>0.001</i> | <i>0.697</i> |
| Community worker | | | | | |
| No | 87.4 | 62.1 | 43.3 | 50.2 | 45.1 |
| Yes | 98.2 | 68.5 | 54.1 | 60.4 | 55.9 |
| <i>P-value</i> | <i>0.001</i> | <i>0.191</i> | <i>0.031</i> | <i>0.043</i> | <i>0.032</i> |
| Health worker | | | | | |
| No | 87.4 | 60.0 | 42.1 | 49.6 | 43.7 |
| Yes | 90.7 | 67.8 | 48.8 | 54.5 | 51 |
| <i>P-value</i> | <i>0.109</i> | <i>0.013</i> | <i>0.038</i> | <i>0.128</i> | <i>0.025</i> |
| Educator | | | | | |
| No | 88.4 | 63.6 | 44.5 | 50.9 | 46.3 |
| Yes | 91.4 | 53.1 | 43.2 | 55.6 | 45.7 |
| <i>P-value</i> | <i>0.416</i> | <i>0.060</i> | <i>0.816</i> | <i>0.425</i> | <i>0.910</i> |
| Volunteer | | | | | |
| No | 88.6 | 63.8 | 45.8 | 52.6 | 49.4 |
| Yes | 88.8 | 53.1 | 31.6 | 38.8 | 16.3 |
| <i>P-value</i> | <i>0.954</i> | <i>0.036</i> | <i>0.007</i> | <i>0.009</i> | <i>0.000</i> |
| Counsellor | | | | | |
| No | 88.7 | 61.8 | 43 | 51.8 | 46.4 |
| Yes | 87.7 | 69.6 | 53.6 | 47.8 | 45.7 |
| <i>P-value</i> | <i>0.716</i> | <i>0.077</i> | <i>0.020</i> | <i>0.380</i> | <i>0.874</i> |
| Non-specified worker | | | | | |
| No | 88.6 | 62.4 | 43.2 | 50.9 | 46.1 |
| Yes | 88.5 | 64.9 | 50.6 | 53.4 | 49.2 |
| <i>P-value</i> | <i>0.966</i> | <i>0.522</i> | <i>0.074</i> | <i>0.535</i> | <i>0.640</i> |