European Community Health Worker Online Survey Report (D8.5)

Contract 2015 71 01 A behavioural survey for HIV/AIDS and associated infections and a survey and tailored training for community based health workers to facilitate access and improve the quality of prevention, diagnosis of HIV/AIDS, STI and viral hepatitis and health care services for men who have sex with men (MSM).

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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.

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 barriers[1]. 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, Dutarte 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 countries[3];
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 review[4] (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

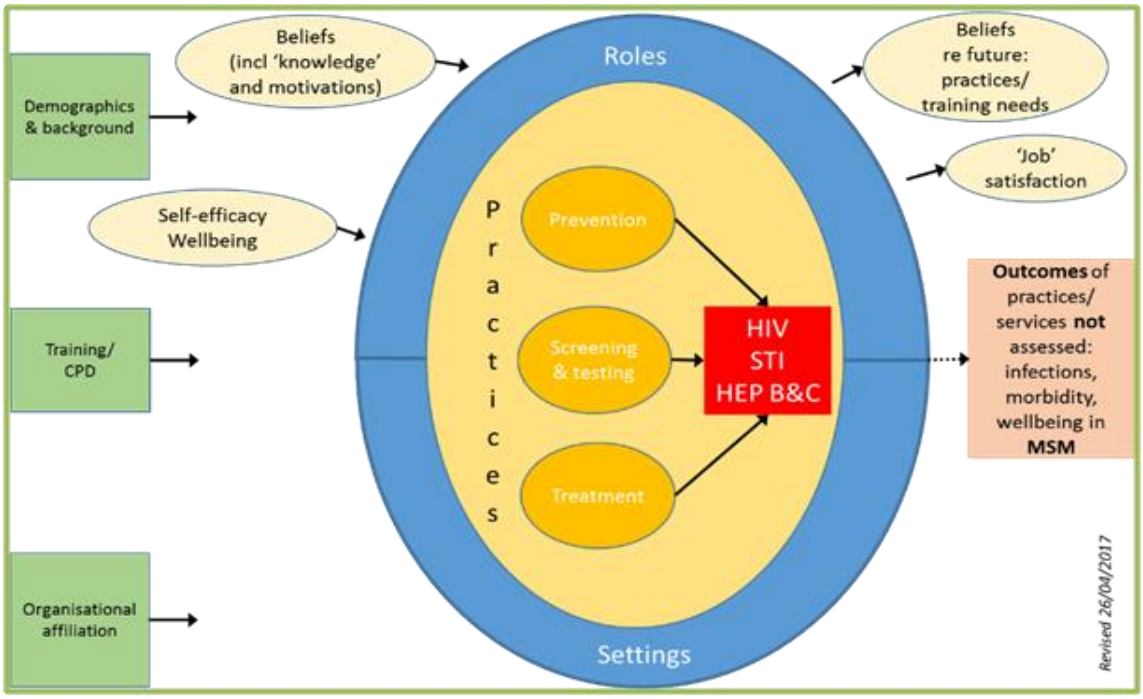
[2] Sherriff N, Huber J, McGlynn N, Llewellyn C. A final proposal for a European community health worker survey (ECHOES). Luxembourg, European Union (EU); 2017.
[3] All 28 EU Member States as well as Bosnia and Herzegovina, Iceland, Moldova, Norway, Russia, Serbia, Switzerland, and Ukraine.
[4] Reference 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 including[5]: 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 Scale[6] and WHO-5[7]. 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 II[8], HIV-COBATEST[9], EURO HIV EDAT, OPTTEST[10], Quality action[11], HA-REACT[12], INTEGRATE[13], HEPCARE EUROPE[14] and E-DETECT TB[15];
- 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 Portugal[16]
    - Setting the standards for sexual health support for MSM - Community Health Work in Slovenia[17]
    - Setting the standards for sexual health support for MSM - Community Health Work in Finland[18]
    - Setting the standards for sexual health support for MSM - Community Health Work in Italy[19]
    - Setting the standards for sexual health support for MSM - Community Health Work in Cyprus[20]
- Two articles were prepared[21] 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.

project and better understanding of the goals of ECHOES. The articles included the objectives of the survey and reinforced why it was important to participate.

Two weeks after the official promotion started, the response rate showed to be lower than expected. In order to increase the response rate, additional activities were proposed and undertaken for the second wave of promotion:

- Further people in key positions were contacted in countries where the number of responses was lower than expected;
- Promotional leaflets for ECHOES were developed for dissemination at the 16th European AIDS Conference. The leaflet was translated into English, Dutch, Bulgarian, French and Polish;
- AAE and UoB participated in a webinar initiated by the Chafea ('*ECHOES - Discussion on enhancing the participation in the survey*') which was held on 19th November 2017. The webinar was recorded and shared with partners. A section titled 'Who are community health workers?' was cut into a separate video and was used for further promotion[22];
- A word cloud of the alternative terms and descriptions of CHW was proposed by participants of the webinar (Figure 2-2);

Figure 2-2: Word cloud used to promote ECHOES

- The number of organisations contacted in countries for promotion was increased (see for final number below, Table 2-2);
- The role of LM was highlighted;
- Facebook groups were contacted directly.

During December 2017 it was decided to extend the study period of both ECHOES and EMIS 2017 until 31st January 2018. Before the winter holiday period, all LM were informed about this extension. On 3rd January 2018 the news was shared on social media and via AAE and partners' media channels.

Throughout the promotion (October 2017-January 2018), in collaboration with LM, AAE contacted an estimated 660 national and local organisations (Table 2-2). This table does not include the organisations and individuals contacted by LM who promoted the survey at national level through their communication channels. In Germany and Luxemburg the promotion was done in collaboration with DAH, a host organisation of AAE, using newsletters and national mailing lists.

[22] https://www.youtube.com/watch?v=YKWCVa61oUI (accessed on 31 May 2019).

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.

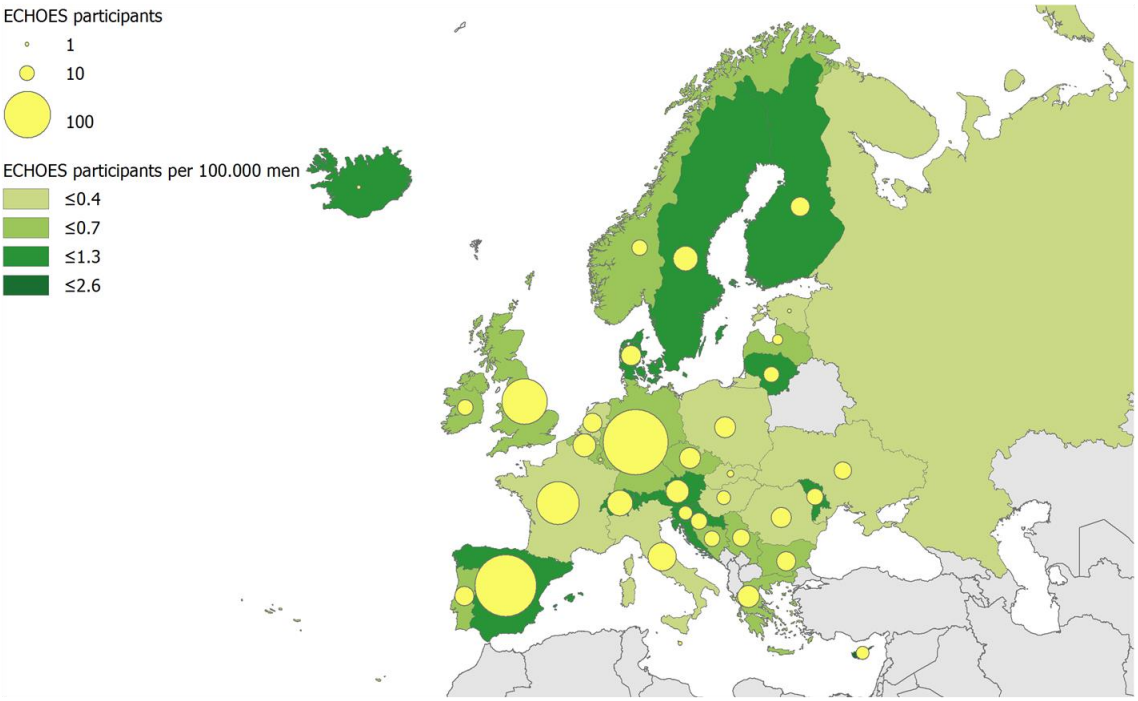


Figure 2-4: Number of ECHOES respondents by the country where they work in and per 100,000 men (aged 15 to 64 years)

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 ECHOES[23]. 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).

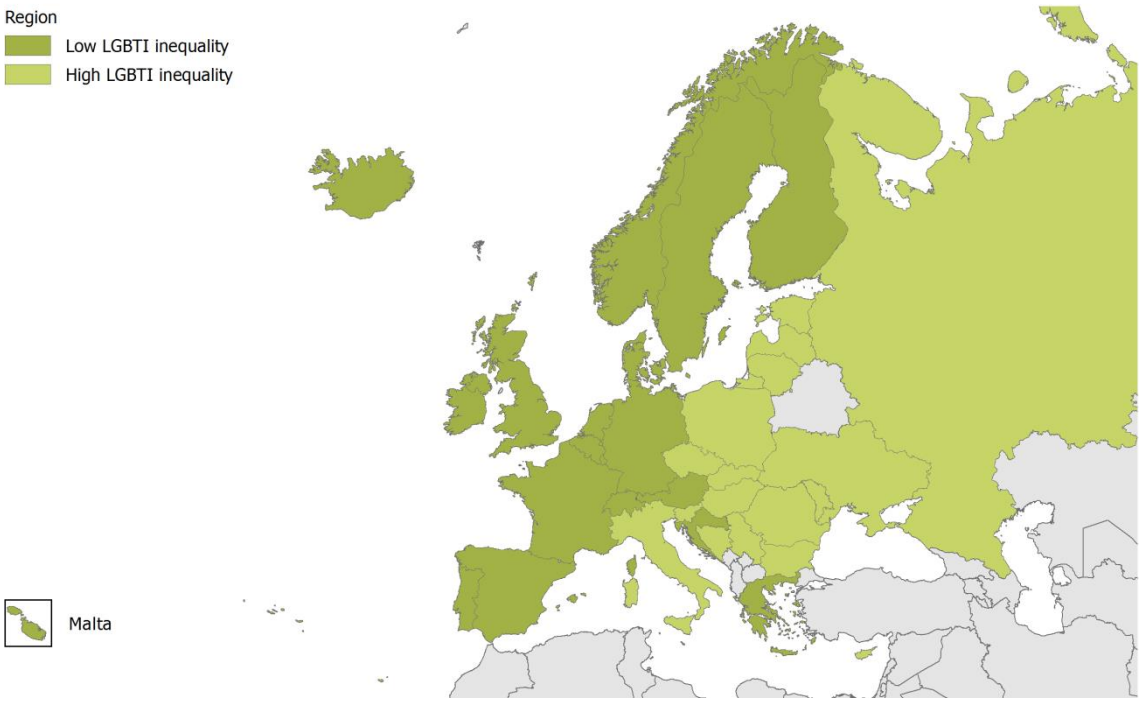


Figure 2-5: Country grouping based on the ILGA index (2016)

Despite improvements in the recent past, the human rights situation of LGBTI people in some European countries remains problematic[24]. 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 index[25]. 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 ≥ 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 policies[26] (Figure 2-6).

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

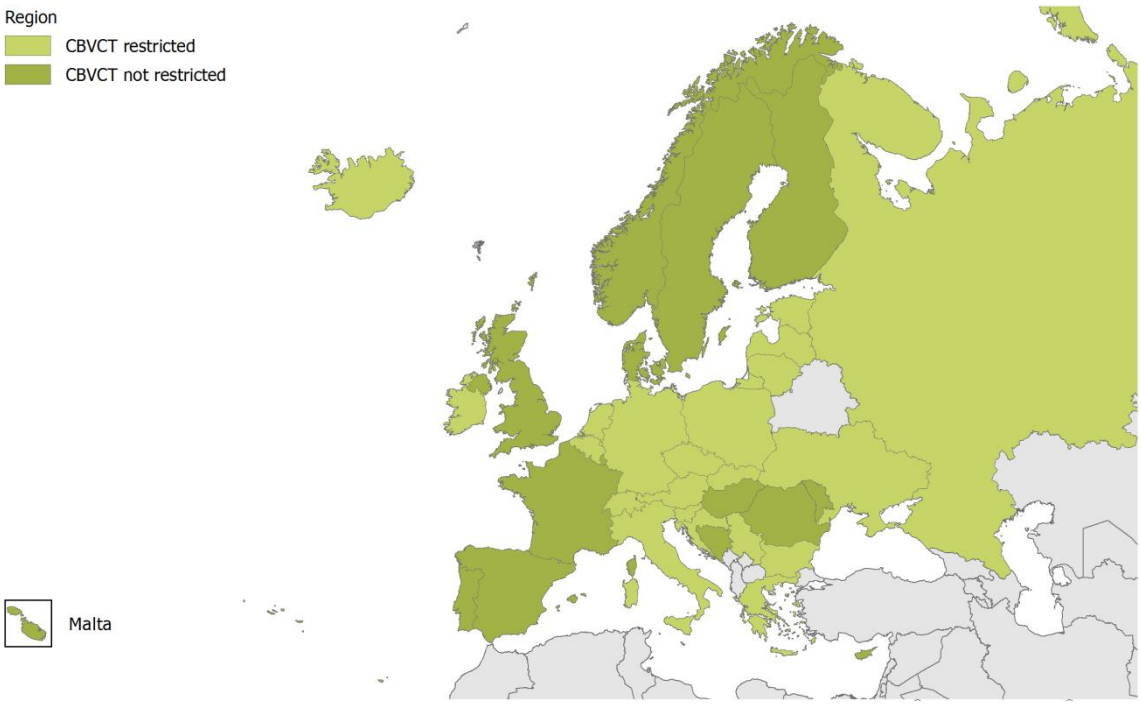


Figure 2-6: Country grouping according to the regulations regarding CBVCT by non-medical staff

[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, 2016[27] (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

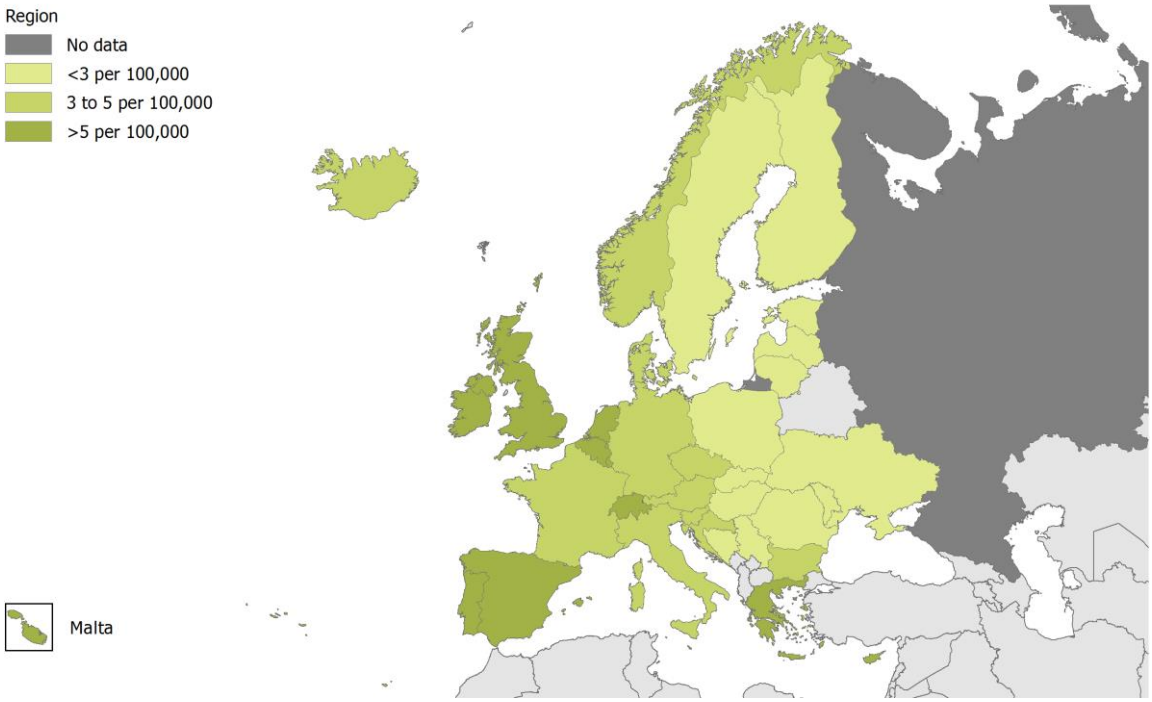


Figure 2-7: Country grouping according to the rate of new HIV diagnoses attributed to sex between men (per 100,000 male population, adapted from ECDC 2017, data from 2016)

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 the 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).

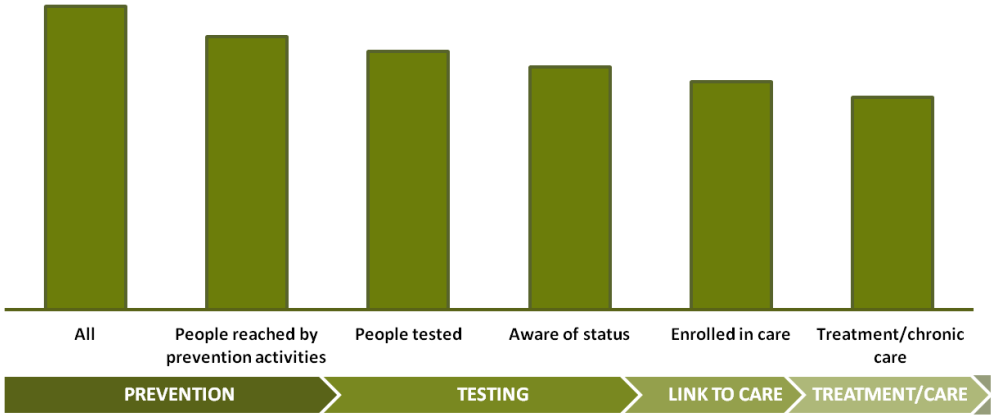


Figure 2-8: The continuum of the sexually transmitted infection services and the retention cascade[28]

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, …, p} to {0, …, 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 > α ≥ 0.5: poor internal consistency
- 0.5 > α : 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 **(2)** Some of the time **(3)** Less than half of the time **(4)** More than half of the time **(5)** Most of the time **(6)** All of the time
I have felt calm and relaxed	
I have felt active and vigorous	
I woke up feeling fresh and rested	
My daily life has been filled with things that interest me	

This very brief 5-item scale performed well in the ECHOES sample (α = 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	**(1)** Not at all true **(2)** Hardly true **(3)** Moderately true **(4)** Exactly true
I am confident that I could deal efficiently with unexpected events	
If someone opposes me, I can find means and ways to get what I want	
Thanks to my resourcefulness, I know how to handle unforeseen situations	
I can remain calm when facing difficulties because I can rely on my coping abilities	

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

This scale was also reliable (α = 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; mean-SD[= [0; 59.8[), Average self-efficacy ([mean-SD; mean+SD[= [59.8; 90.2[) and High self-efficacy ([mean+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 (α = 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.

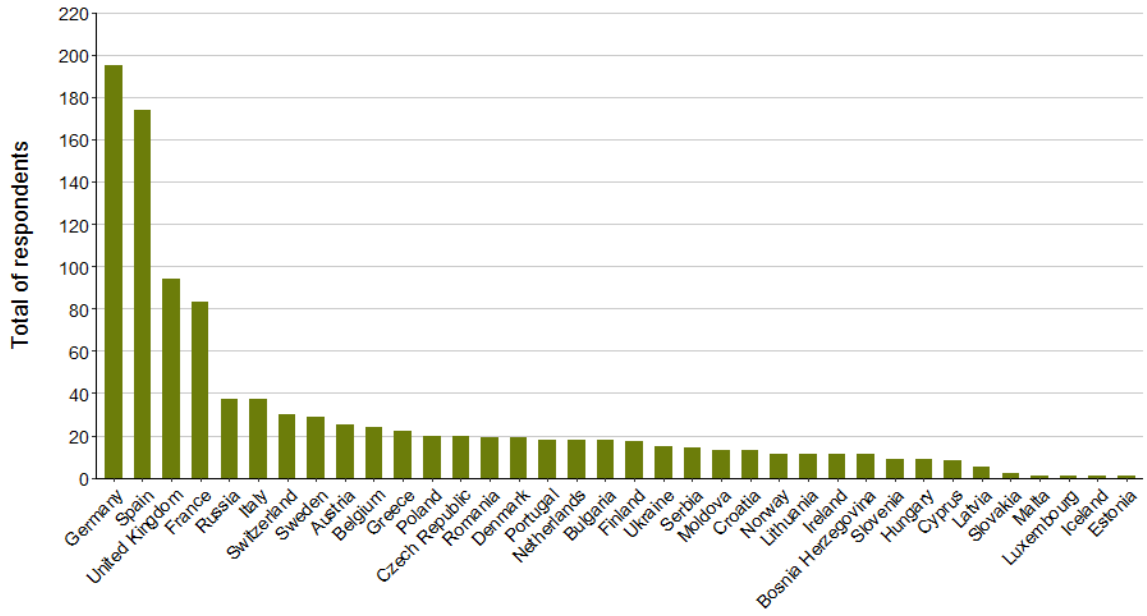


Figure 3-1: Number of CHWs by country they work in (n=1,035)

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).

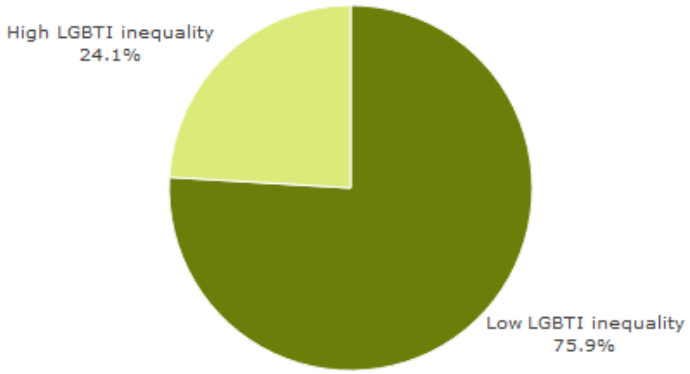


Figure 3-2: CHWs by the LGBTI inequality level of the country they work in (n=1,035)

More than three quarters of the total sample (n=786) were from 'low LGBTI inequality' countries[29]; mainly Germany (n=195), Spain (n=174), UK (n=94) and France (n=83). ECHOES respondents from 'high LGBTI inequality' countries[30] 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).

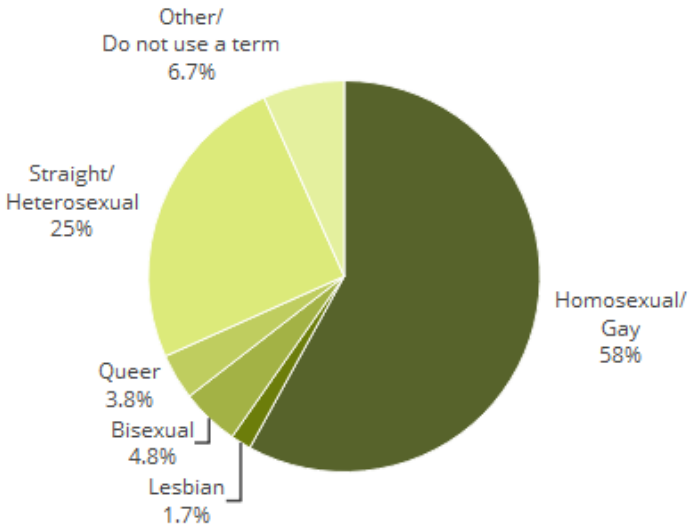


Figure 3-3: Sexual identity (n=1,035)

'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).

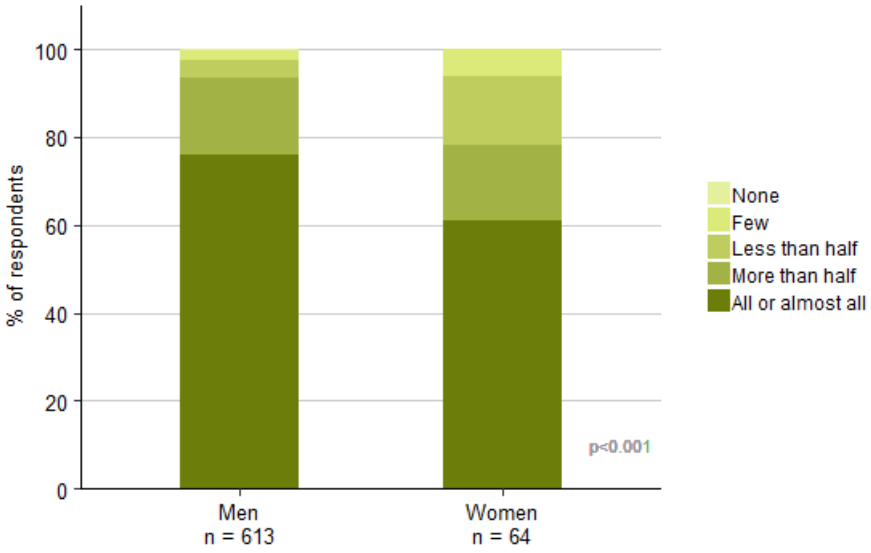


Figure 3-4: Level of outness among CHWs self-identified as gay, lesbian, bisexual or queer by gender (n=707)

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).

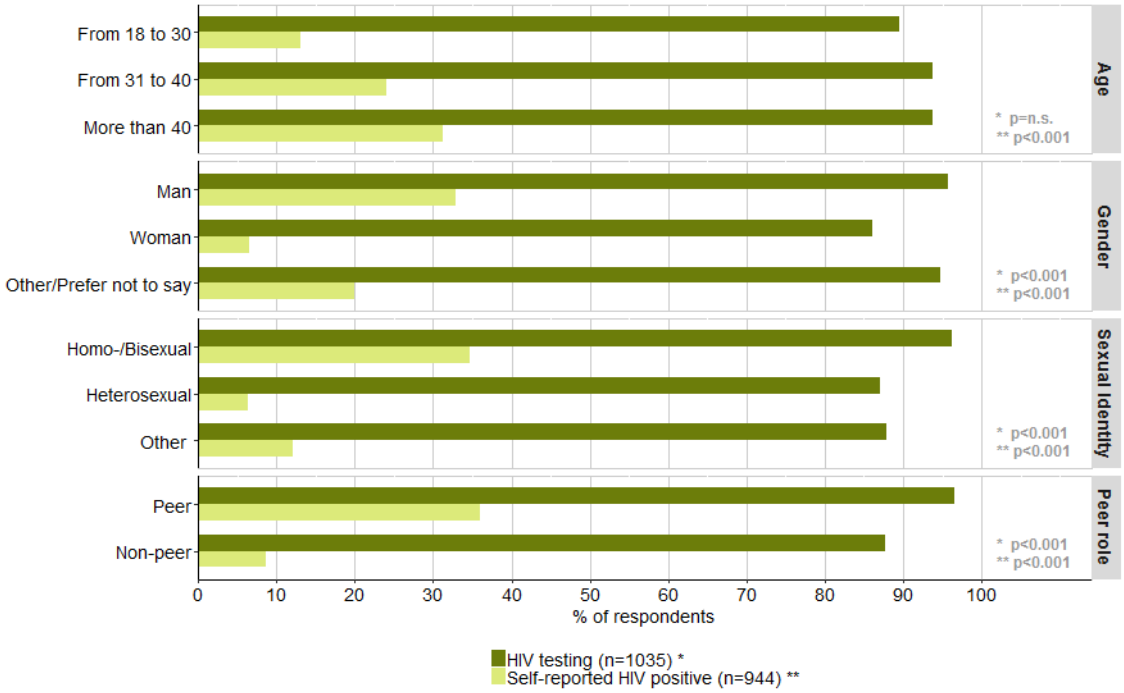


Figure 3-5: HIV testing rates and self-reported HIV status by age, gender and sexual identity (n=1,035)

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%.

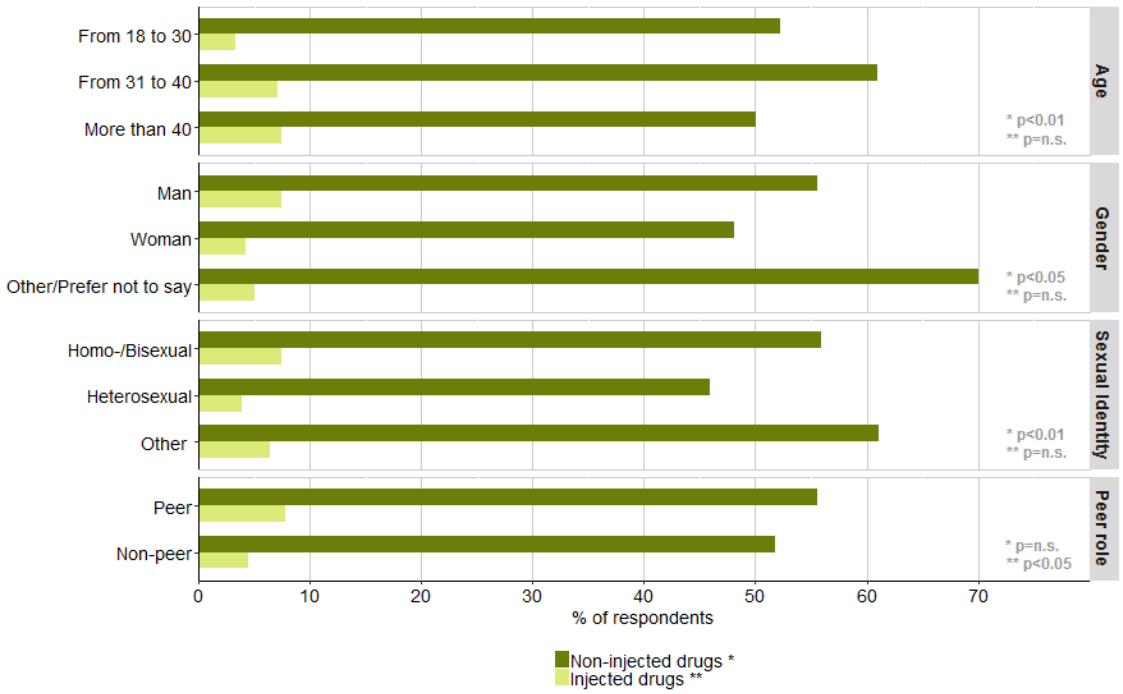


Figure 3-6: Use of injected and non-injected recreational drugs by age, gender and sexual identity (n=1,035)

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			0.003
Man	70.2	60.6	
Woman	25.6	36.5	
Other/prefer not to say	4.2	2.8	
Belonging to an ethnic minority			0.791
No	91.7	91.1	
Yes	8.3	8.9	
Years in full-time education since the age of 16			0.239
None or 1	3.4	2.5	
2 to 5 years	25.7	21.1	
6 or more years	70.9	76.4	
Sexual identity			0.031
Homo/Bisexual	64.9	56.2	
Heterosexual	23.2	30.9	
Other[a]	12.0	12.9	
Outness[b]			<0.001
Out to more than half	95.5	78.7	
Out to less than half	4.5	21.3	
Feelings about household income			0.003
Living more than comfortably	46.8	36.0	
Living less than comfortably	53.2	64.0	

[a]Queer, any other term, don't use a term. [b]If 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	

[a]Queer, any other term, don't use a term. [b]If gay, homosexual, bisexual or queer (n=557). [c]Malta, 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). [a]Malta, 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.

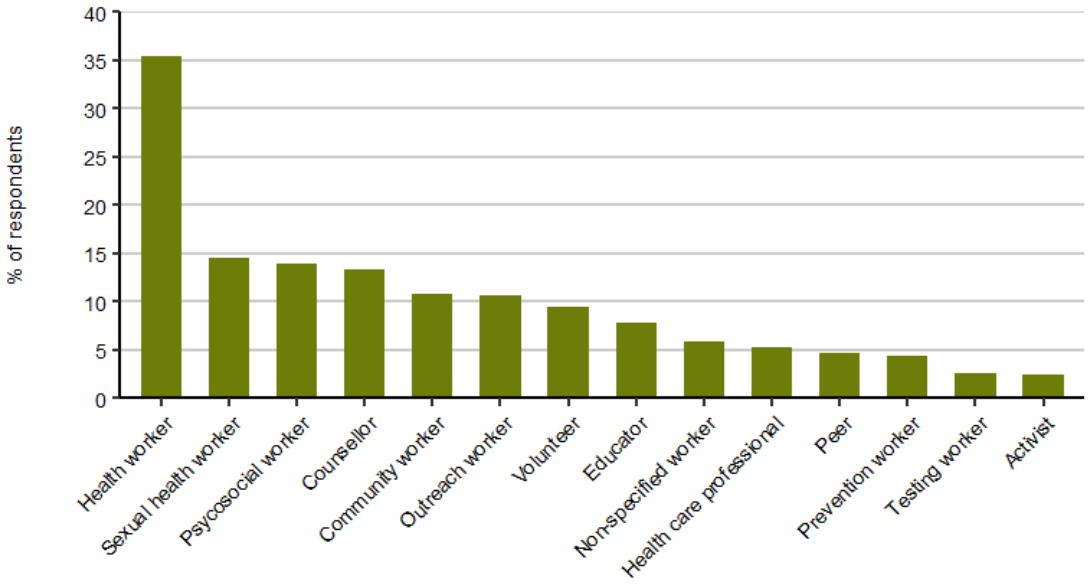


Figure 3-9: Job titles distribution (short definition) (n=1,035)

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

[a]Malta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland.

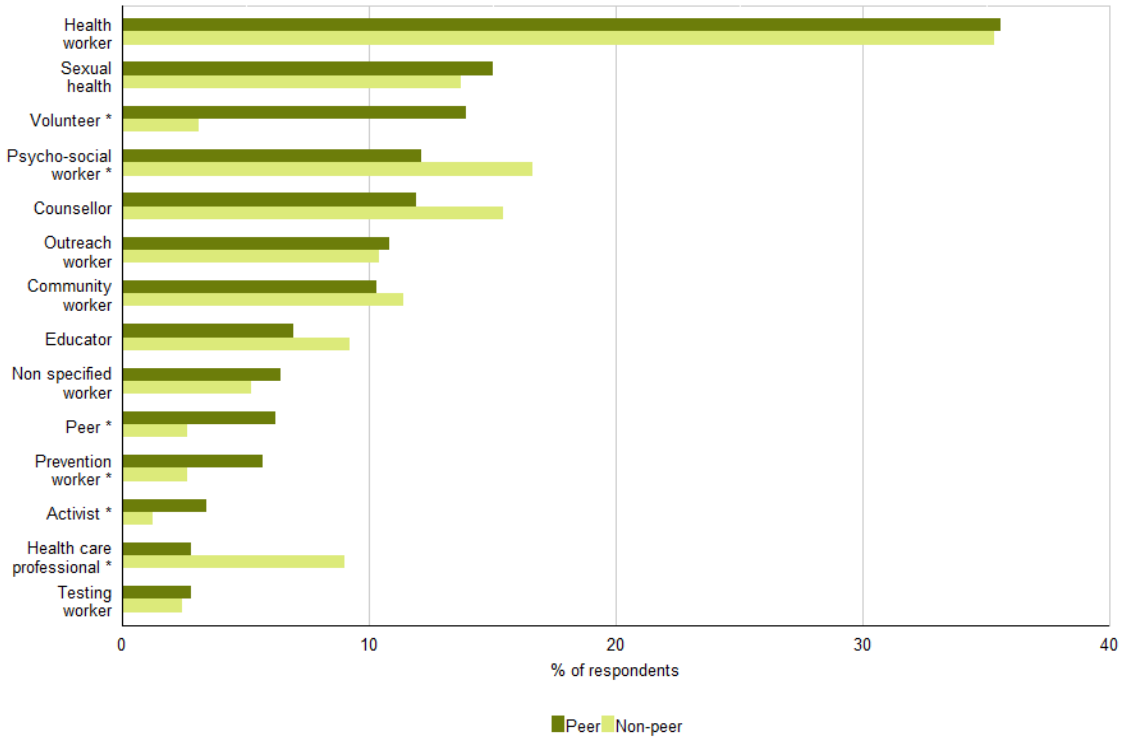


Figure 3-10: Job title categories by peer role (n=1,035)

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.

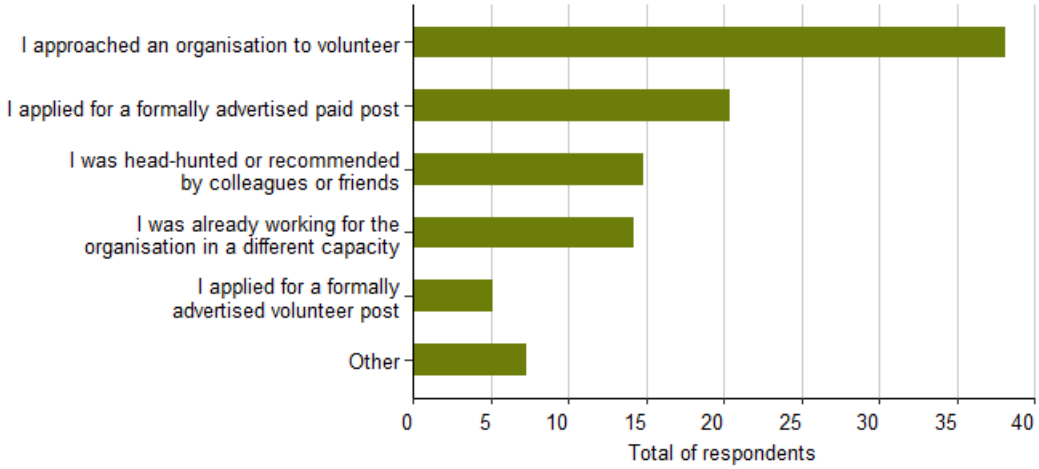


Figure 3-11: How ECHOES respondents were recruited to be a CHW (n=1,035)

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%.

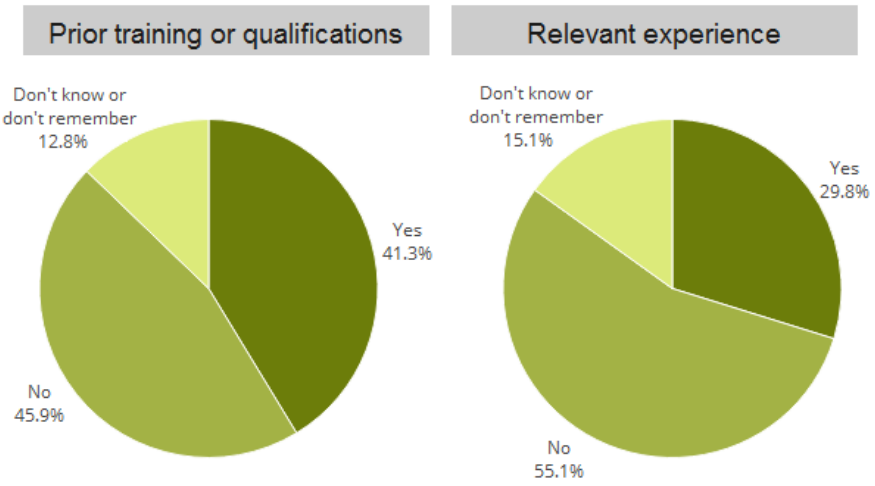


Figure 3-12: Criteria of selection when started as a CHW (n=1,035)

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	

[a]Queer, 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.

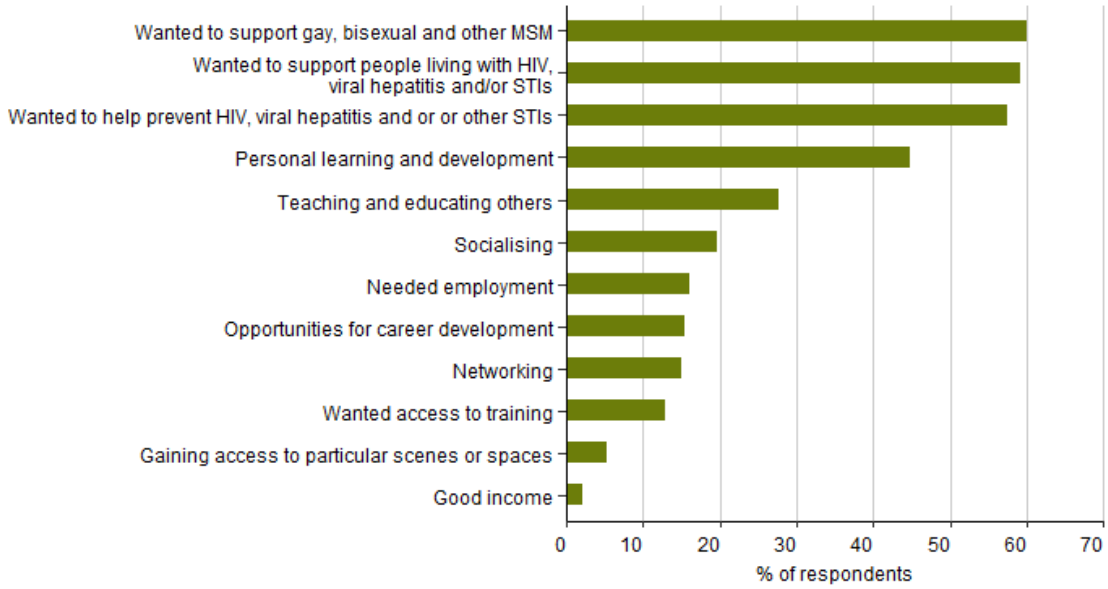


Figure 3-13: Motivations to start as a CHW (n=1,035; multiple answer)

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 inter-connected, altruistic reasons were broadly reported by CHWs (79.9%) (Figure 3-16).

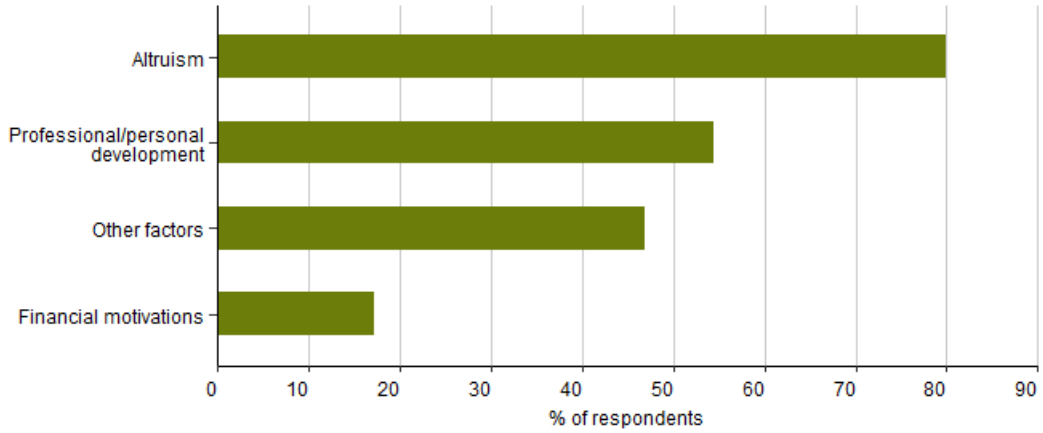


Figure 3-14: Grouped motivations to start as a CHW (n=1,035; multiple answer)

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
p-value	*0.811*	*0.811*	*0.013*	*0.270*
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
p-value	*<0.001*	*0.789*	*0.671*	*0.813*
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
p-value	*<0.001*	*0.345*	*0.232*	*0.035*
Peer role as a CHW				
No	65.5	55.7	39.8	20.0
Yes	89.7	53.6	36.4	15.3
p-value	*<0.001*	*0.509*	*0.271*	*0.049*

*Multiple answer. [a]Queer, any other term, don't use a term. [b]Socialising, 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. [a]Socialising, 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

[a]Socialising, networking, teaching others, access to particular scenes. [b]Malta, 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.

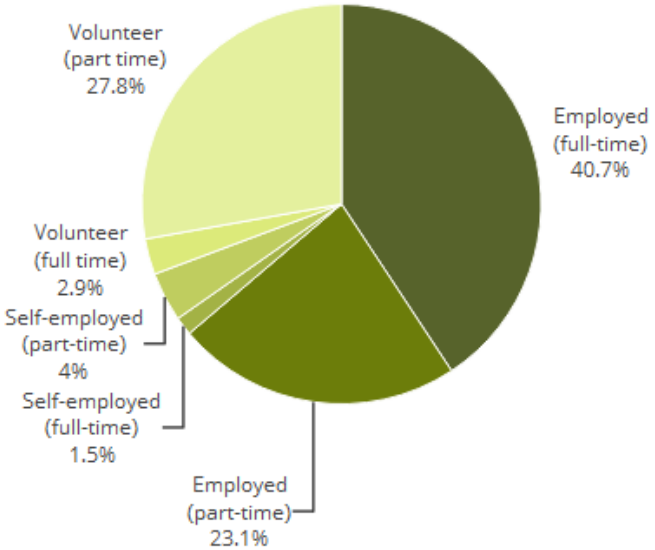


Figure 3-15: Current employment status as a CHW (n=1,035)

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).

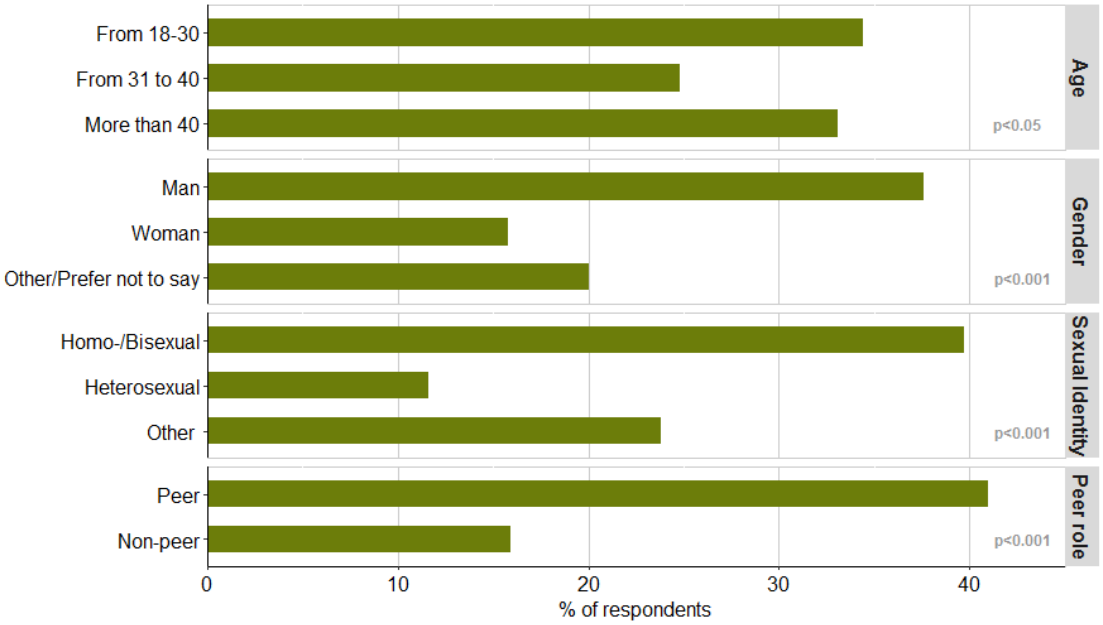


Figure 3-16: Percentage of volunteer CHWs by age group, gender, sexual identity and peer role (n=1,035)

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).

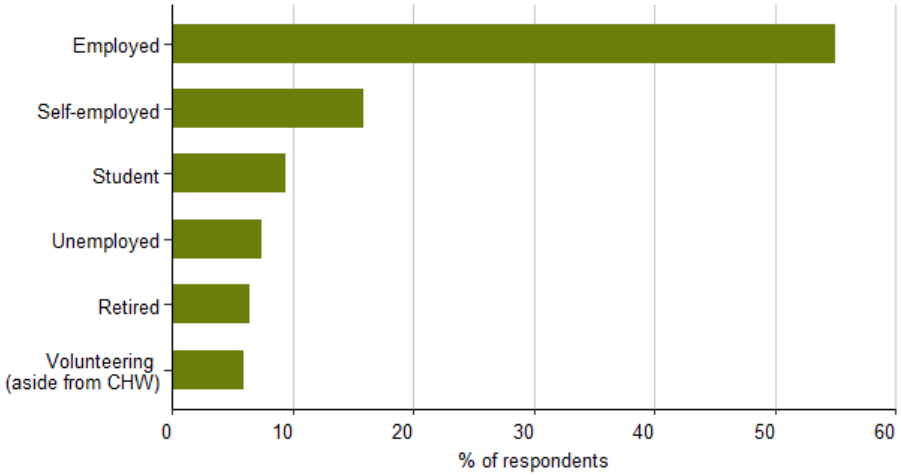


Figure 3-17: Employment status when not working as a CHW (n=416)

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).

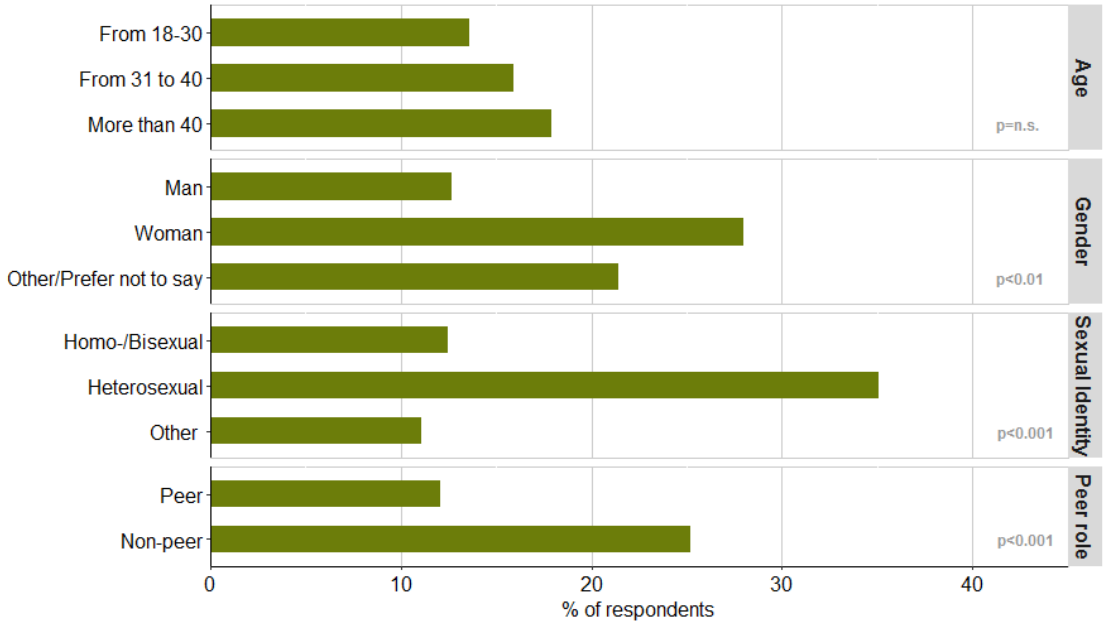


Figure 3-18: Employment status as a health-care professional (n=416)

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.

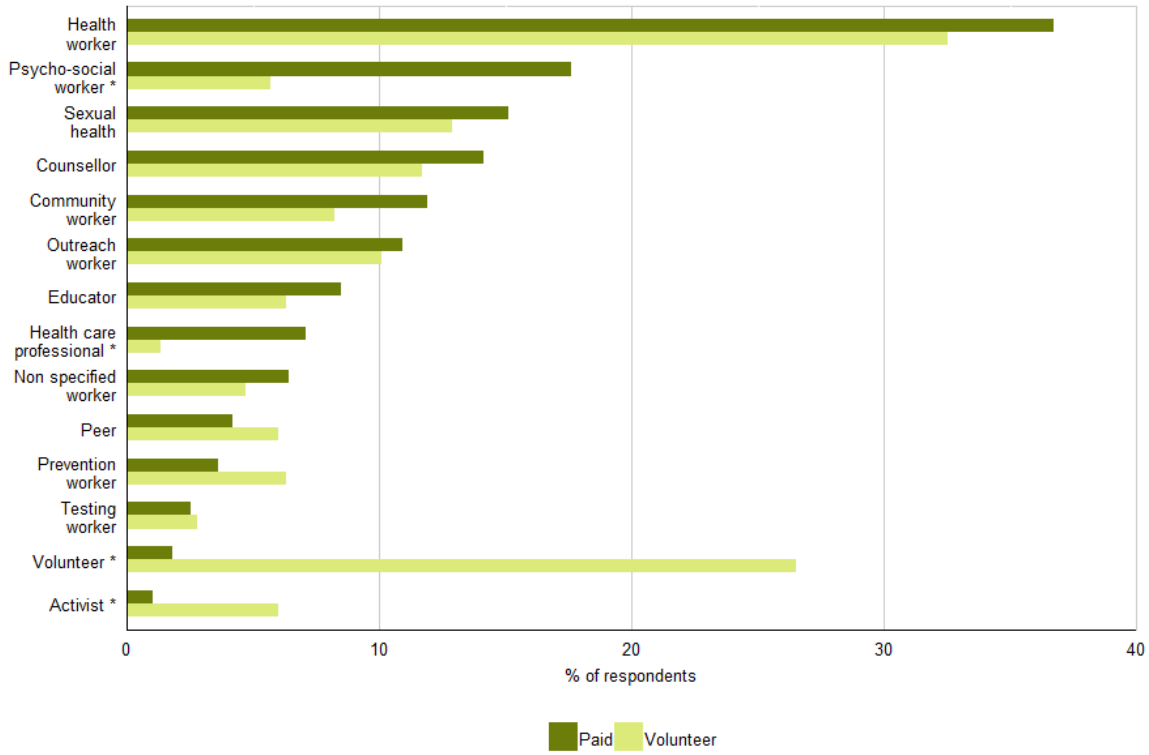


Figure 3-19: Job titles by employment status (n=416)

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).

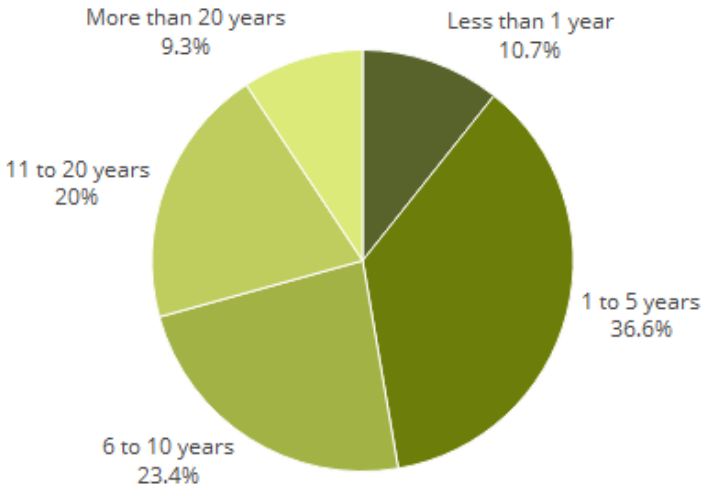


Figure 3-20: Years of experience as a CHW (n=1,035)

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	

[a]Queer, 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).

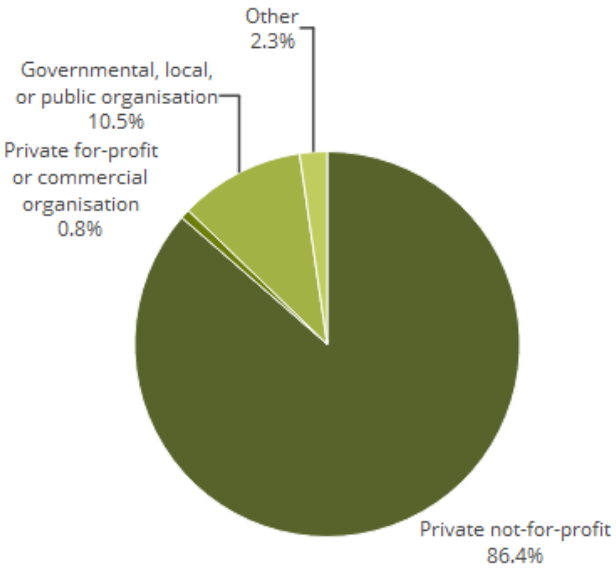


Figure 3-22: Type of organisation where CHWs work (n=975)

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	

[a]Queer, any other term, don't use a term. [b]Government/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).

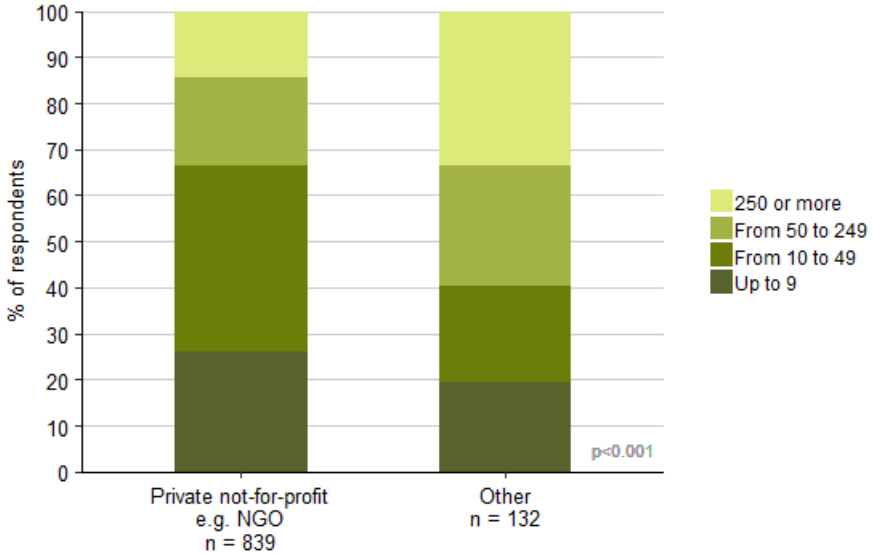


Figure 3-23: Size of the organisation where CHWs work by organisation type

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).

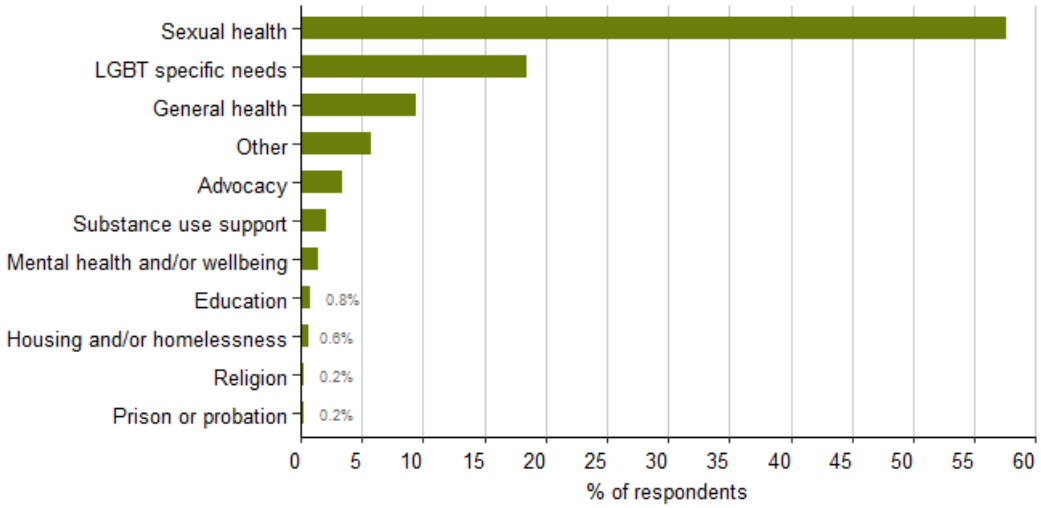


Figure 3-24: Main purpose of the organisation where CHWs work (n=975)

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%).

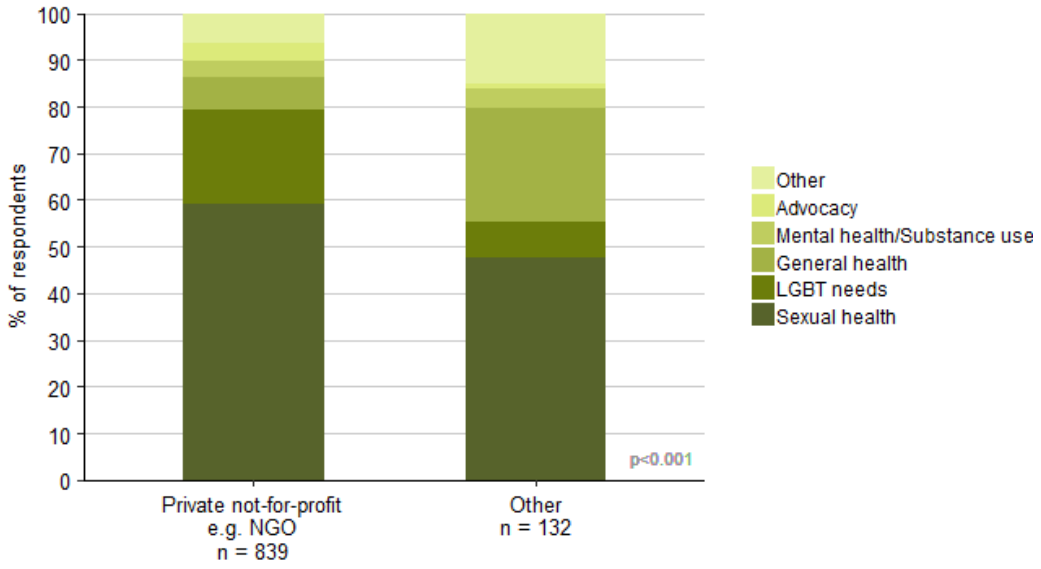


Figure 3-25: Main purpose of organisation where CHWs work by organisation type

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.

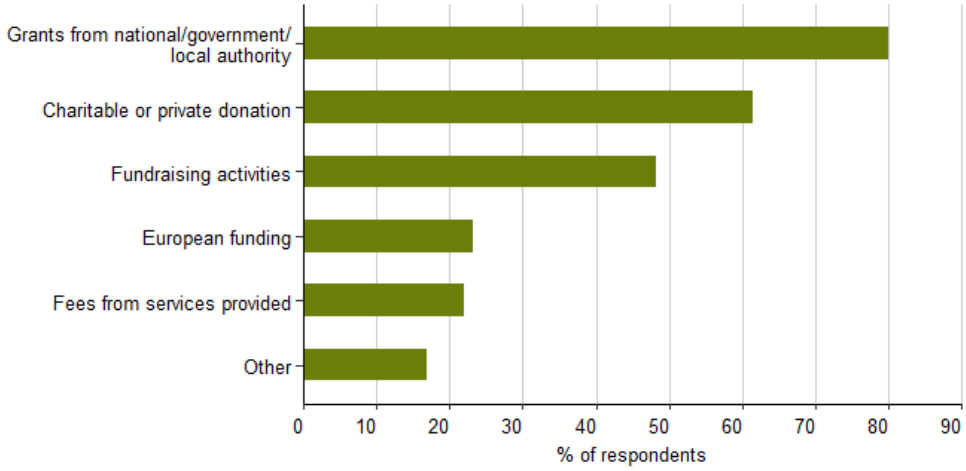


Figure 3-26: Funding sources for respondents' organisation (n=975; multiple answer)

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%).

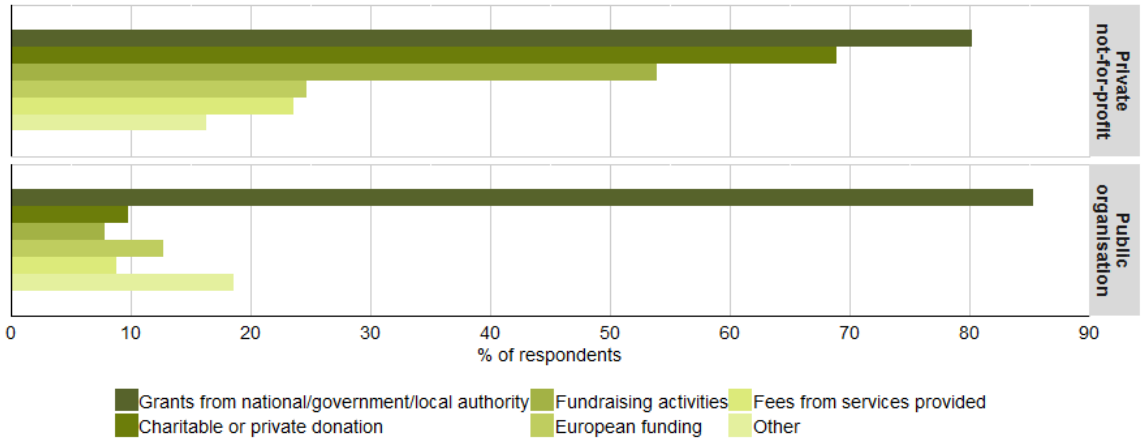


Figure 3-27: Source of funding by organisation type (n=975; multiple answer)

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	

[a]n=416 who were employed, self-employed or volunteers aside from CHW. [b]n=975 who were not self-employed. [c]Government/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	

[a]n=416 who were employed, self-employed or volunteers aside from CHW. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]Malta, 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).

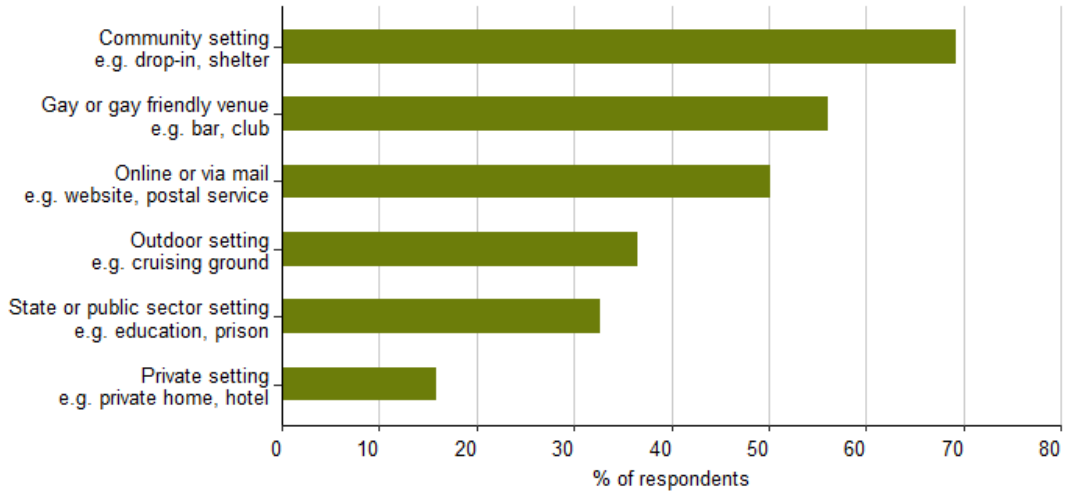


Figure 3-28: Type of settings where respondents usually perform CHW activities (n=1,035, multiple answer)

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
p-value	*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
p-value	*<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
p-value	*<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
p-value	*<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
p-value	*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
P-value	*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
p-value	*<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
p-value	*0.001*	*<0.001*	*0.040*	*<0.001*	*0.037*	*0.054*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/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.

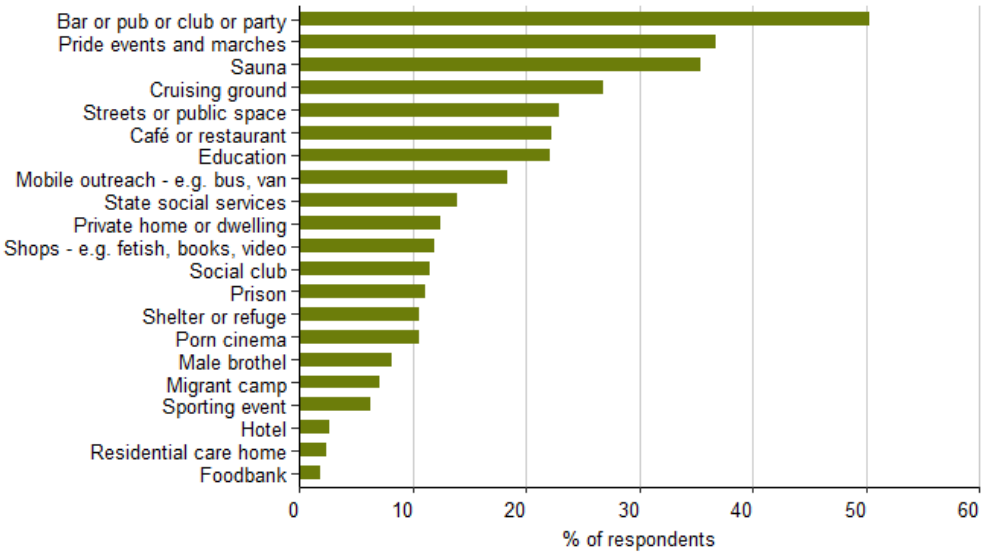


Figure 3-29: Places of outreach activities (n=1,035)

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.

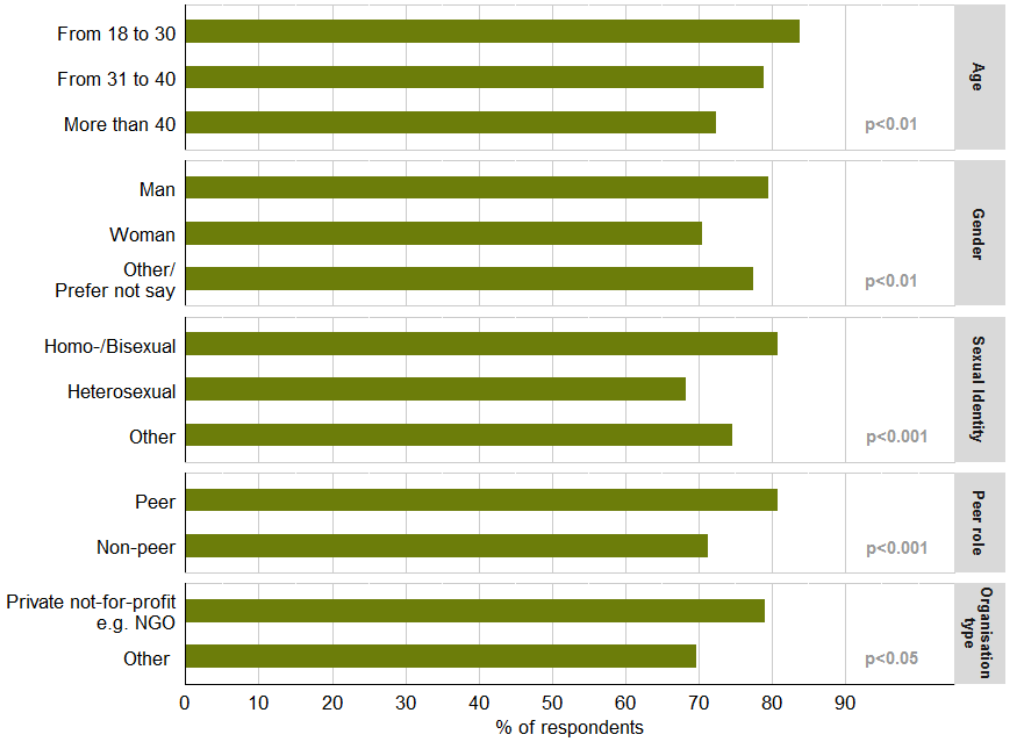


Figure 3-30: Respondents working in outreach by age, gender, sexual identity, peer role, and type of organisation worked for (n=1,035)

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. [a]Malta, 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%).

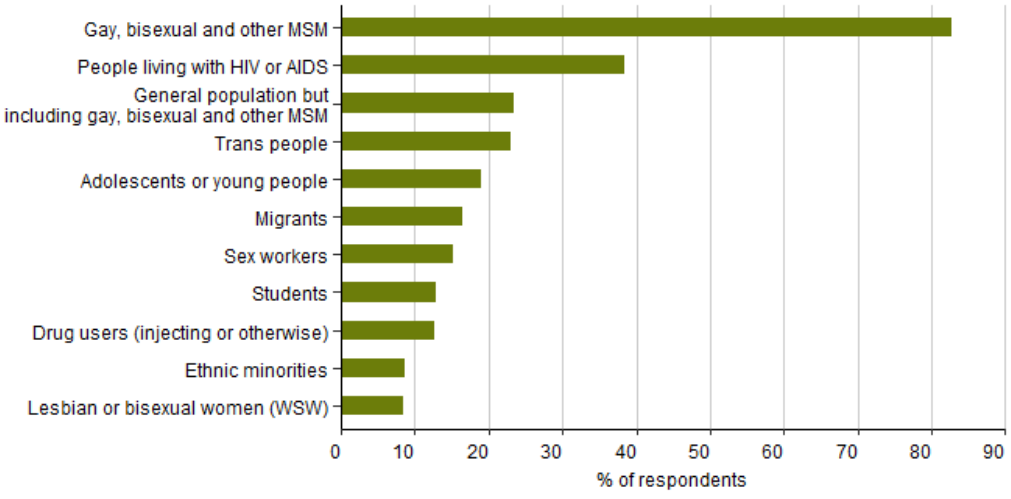


Figure 3-31: Populations of people ECHOES respondents most often work with (n=1,035, 3 choices)

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 with[31]. 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 'Ethic 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

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]Among 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).

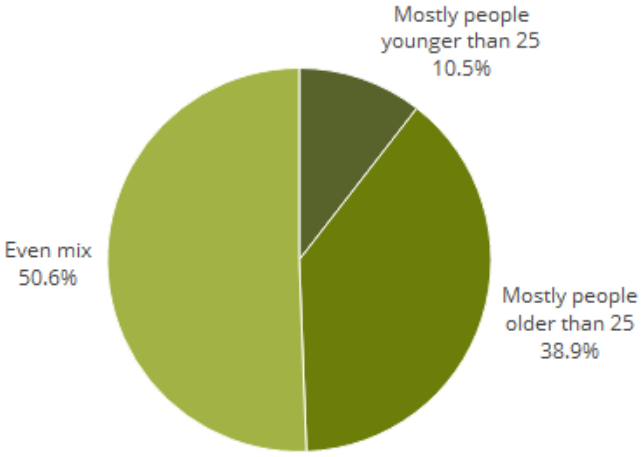


Figure 3-32: Age of users attended by CHWs (n=1,035)

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	

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/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).

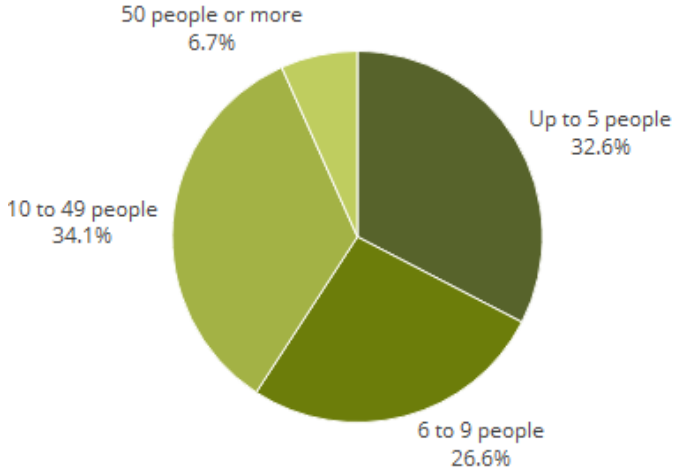


Figure 3-33: Number of users attended in a usual 7-day period (n=1,035)

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	

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/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. [b]Other 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. [a]Malta, Norway, Portugal, Finland, Denmark, Sweden, Luxembourg, Belgium, Netherlands, Croatia, Austria, Ireland, Iceland, Greece, Switzerland. [b]Other 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 2020[32].

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 activities[33] (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.

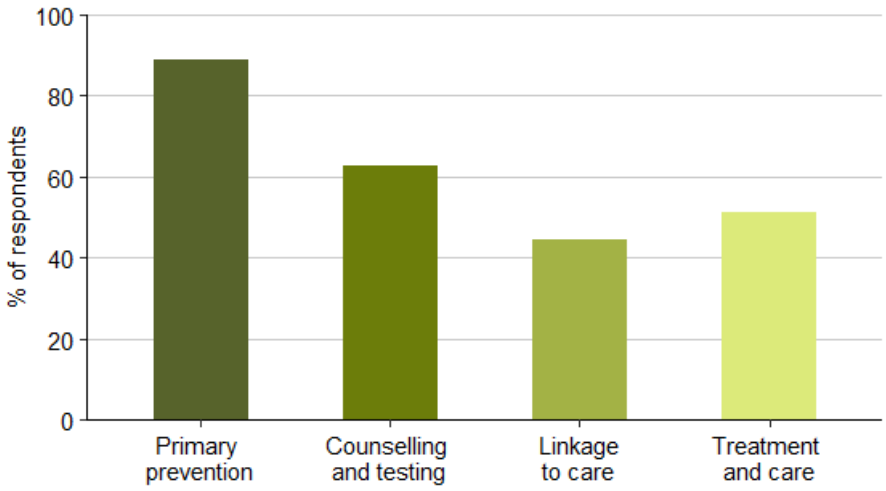


Figure 4-1: CHW activities according to the continuum of care of HIV/STI services (N=1,035, multiple answer)

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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*<0.001*	*0.379*	*0.002*	*<0.001*
CBVCT restriction in the working country				
No	--	54.8	--	--
Yes	--	45.2	--	--
P-value	--	*<0.001*	--	--

*Including CBVCT restriction for the step "counselling and testing". [a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]N=694. [e]Malta, 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).

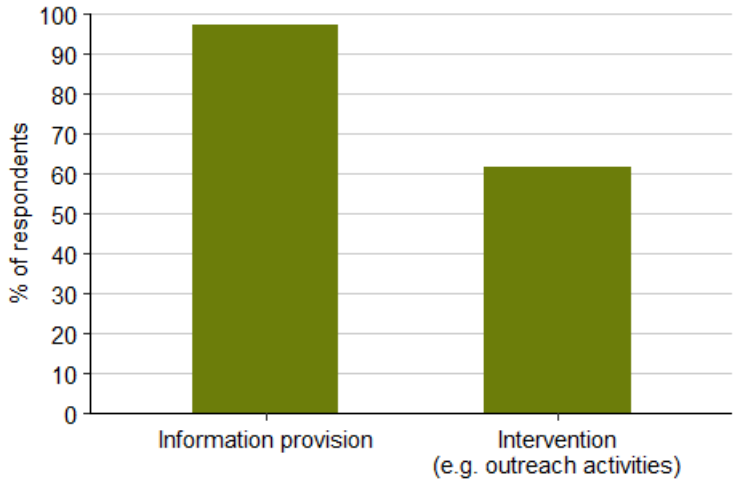


Figure 4-2: Prevention activities (N=917, multiple answer)

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
P-value	*0.092*	*0.001*
Gender		
Man	96.8	62.1
Woman	97.7	59.8
Other/prefer not say	100	65.7
P-value	*0.463*	*0.708*
Sexual identity		
Homosexual/Bisexual	96.7	60.8
Heterosexual	98.2	63.3
Other[a]	97.3	62.7
P-value	*0.513*	*0.778*
Peer role		
Peer	96.7	61.7
Non-peer	97.8	61.5
P-value	*0.307*	*0.935*
Employment status		
Paid	96.9	68.3
Volunteer	97.8	45.8
P-value	*0.433*	*<0.001*
Years as CHW		
0-5 years	97.1	58.6
5-10 years	96.3	72.1
> 10 years	97.8	59.2
P-value	*0.653*	*0.002*
Type of organisation worked for[b]		
Private not-for-profit	97.4	63.2
Other[c]	98.1	52.8
P-value	*0.628*	*0.036*
LGBTI inequality level of the working country		
Low inequality	97.6	62.8
High inequality	95.7	57.6
P-value	*0.149*	*0.175*
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
P-value	*0.645*	*<0.001*
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
P-value	*0.901*	*<0.001*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=707. [e]Malta, 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.

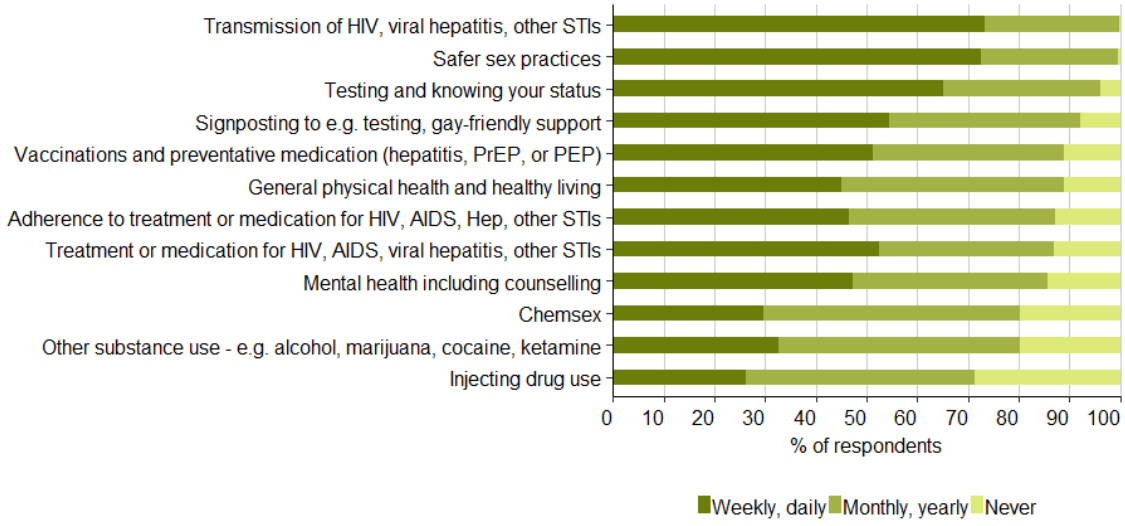


Figure 4-3: Type of information provided in prevention activities (N=891)

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).

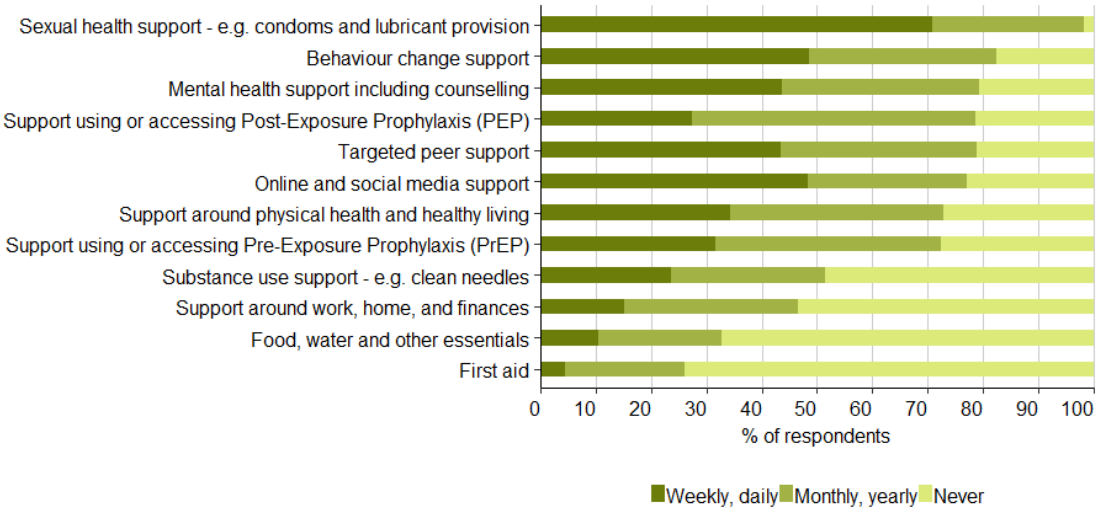


Figure 4-4: Specific intervention in prevention (N=565)

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).

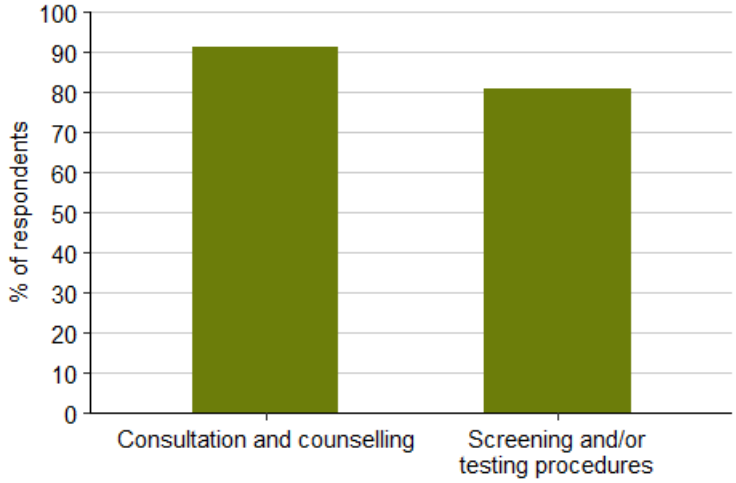


Figure 4-5: Screening and testing-related activities (N=650)

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
P-value	*0.276*	*0.646*
Gender		
Man	90.6	82.1
Woman	91.8	76.5
Other/prefer not say	89.5	89.5
P-value	*0.856*	*0.162*
Sexual identity		
Homosexual/Bisexual	91.6	80.6
Heterosexual	88.8	79.3
Other[a]	93.0	84.5
P-value	*0.461*	*0.634*
Peer role		
Peer	91.8	81.5
Non-peer	89.7	79.4
P-value	*0.348*	*0.504*
Employment status		
Paid	91.9	82.4
Volunteer	87.8	75.0
P-value	*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
P-value	*0.327*	*0.134*
Type of organisation worked for[b]		
Private not-for-profit	92.2	80.7
Other[c]	84.4	79.2
P-value	*0.025*	*0.766*
LGBTI inequality level of the working country		
Low inequality	90.1	83.0
High inequality	93.1	74.0
P-value	*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
P-value	*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
P-value	*0.279*	*<0.001*
CBVCT restriction in the working country		
No	89.6	90.7
Yes	92.5	68.4
P-value	*0.199*	*<0.001*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=477. [e]Malta, 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).

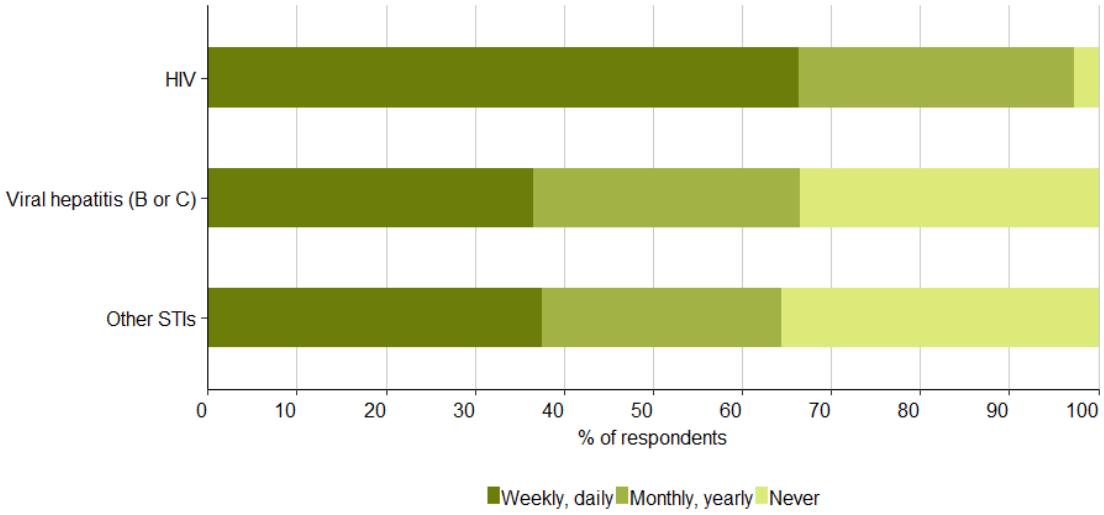


Figure 4-6: Type of screening and/or testing performed (N=524)

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.

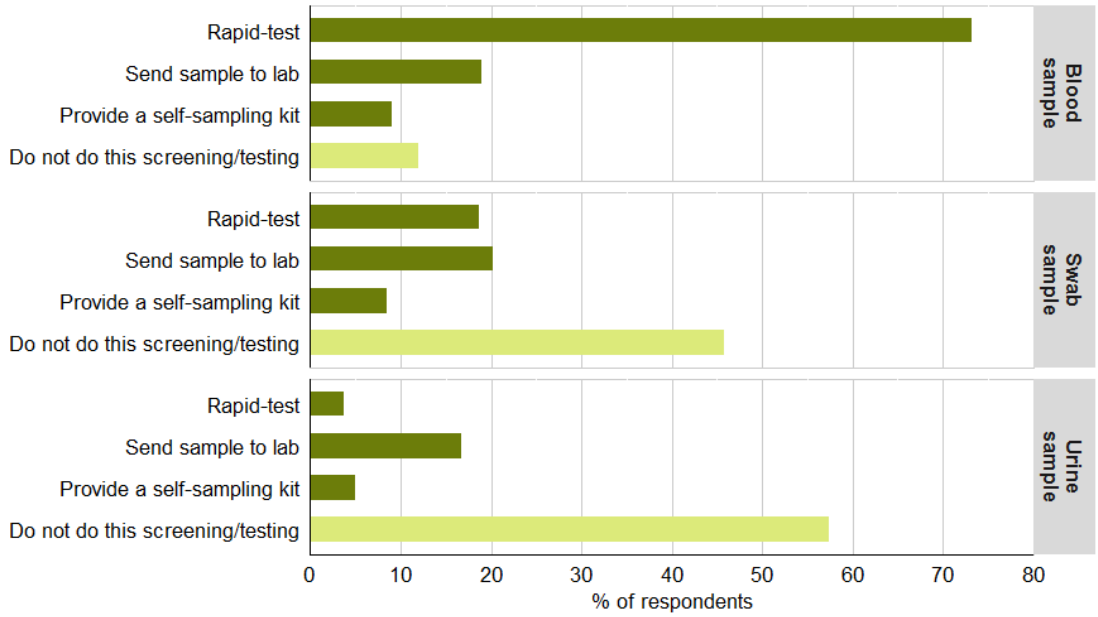


Figure 4-7: Type of tests according to the type of samples used to screen/test for HIV, viral hepatitis and other STIs (N=524)

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).

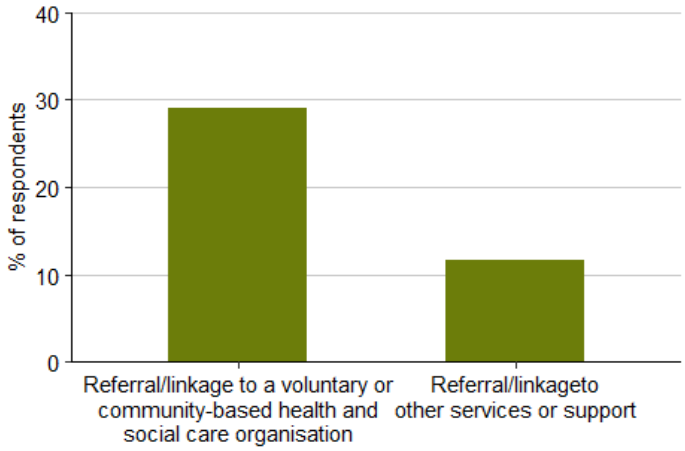


Figure 4-8: Other places where respondents refer users to for screening and testing purposes (N=1,035)

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).

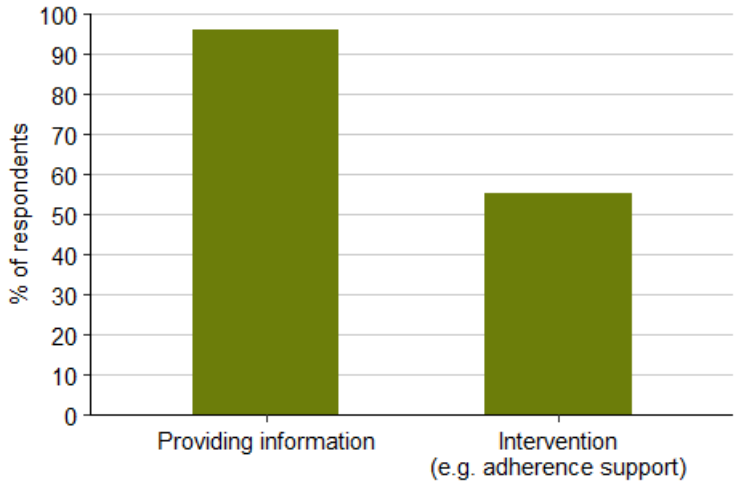


Figure 4-9: Treatment-related activities (N=531)

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.

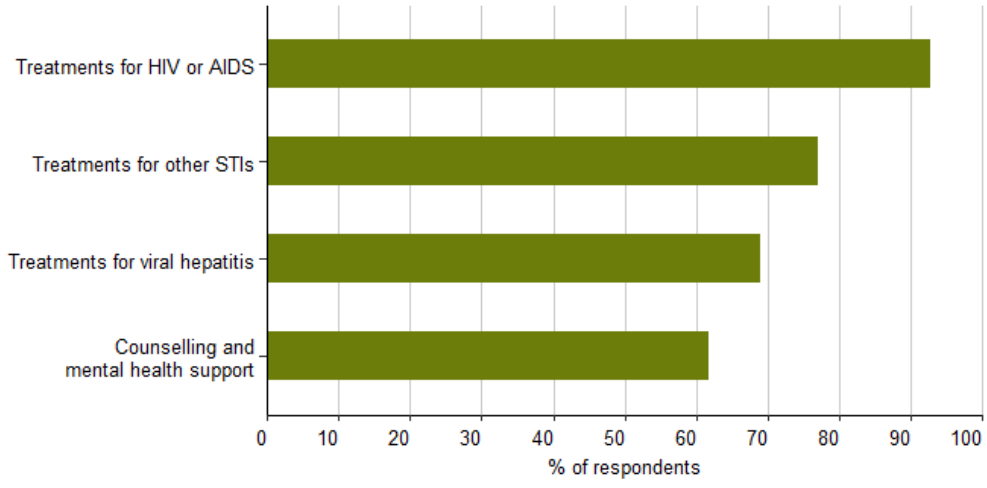


Figure 4-10: Information provision related to treatments and support (N=508, multiple answer)

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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*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
P-value	*0.646*	*0.004*	*0.009*	*0.576*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=393. [e]Malta, 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).

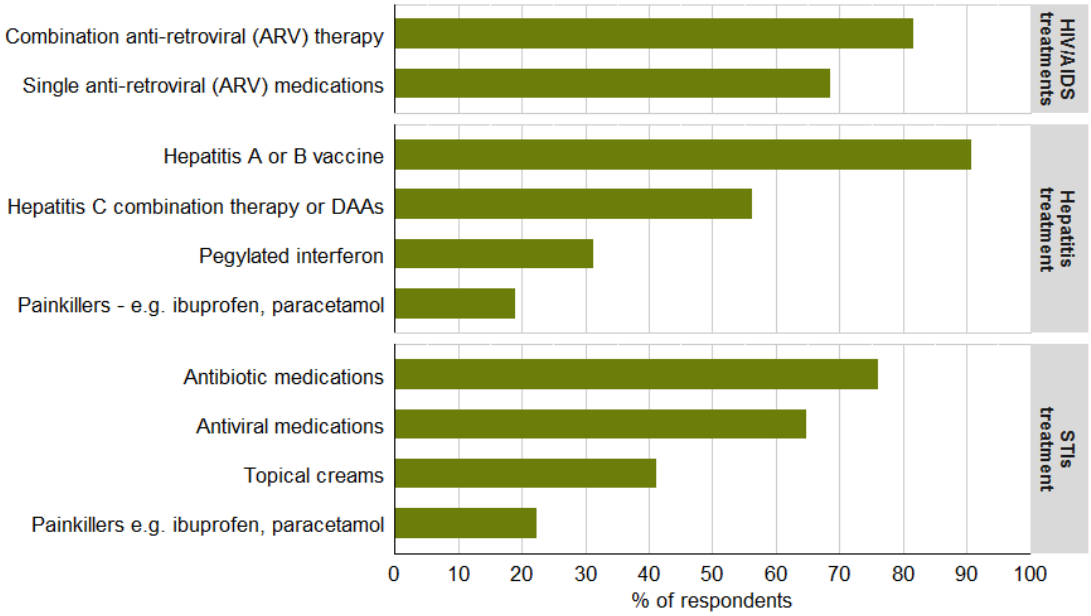


Figure 4-11: Type of information provided in relation to treatments and support (N=508, multiple answer)

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).

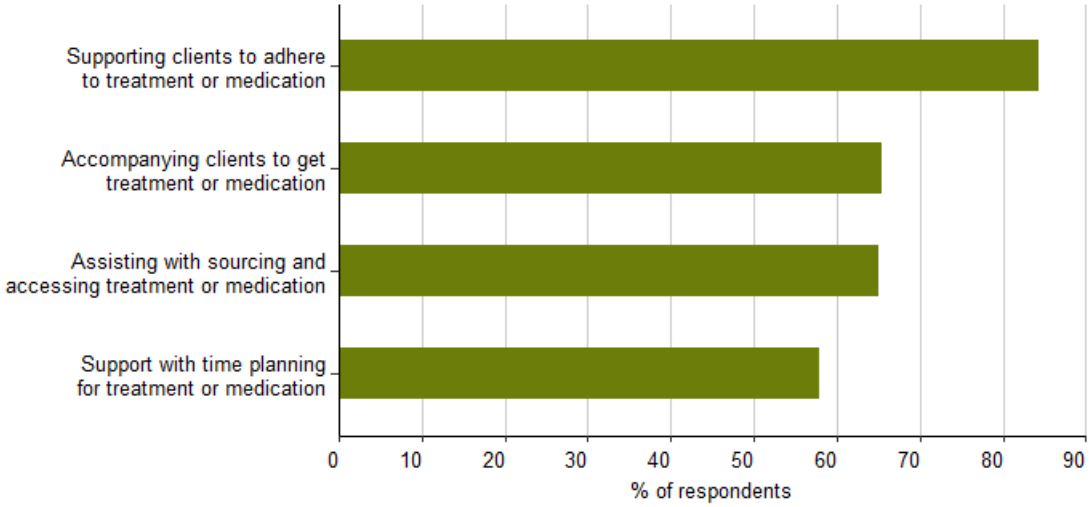


Figure 4-12: Interventions in treatment and support (N=292, multiple answer)

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).

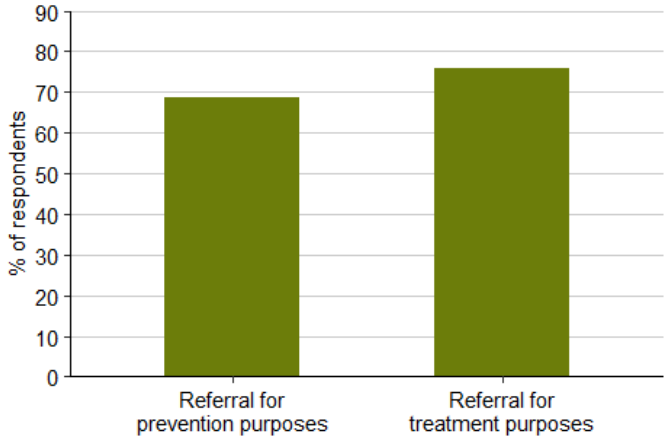


Figure 4-13: Referral of CHWs' users to other organisations (prevention: N=917; treatment: N=531)

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
P-value	*0.138*	*0.007*
Gender		
Man	68.7	71.7
Woman	69.9	83.2
Other/prefer not say	62.9	83.3
P-value	*0.694*	*0.012*
Sexual identity		
Homosexual/Bisexual	68.3	72.2
Heterosexual	69.9	80.9
Other[a]	69.1	79.4
P-value	*0.908*	*0.090*
Peer role		
Peer	69.2	71.5
Non-peer	68.2	80.8
P-value	*0.739*	*0.012*
Employment status		
Paid	74.4	78.7
Volunteer	56.0	66.1
P-value	*<0.001*	*0.006*
Years as CHW		
0-5 years	65.3	72.4
5-10 years	74.4	73.9
> 10 years	71.9	81.9
P-value	*0.035*	*0.080*
Type of organisation worked for[b]		
Private not-for-profit[c]	70.6	78.6
Other	61.1	63.3
P-value	*0.045*	*0.009*
LGBTI inequality level of the working country		
Low inequality	71.1	78.0
High inequality	61.0	67.8
P-value	*0.005*	*0.021*
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
P-value	*<0.001*	*0.353*
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
P-value	*0.045*	*0.086*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=707 (prevention) n=410 (treatment). [e]Malta, 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.

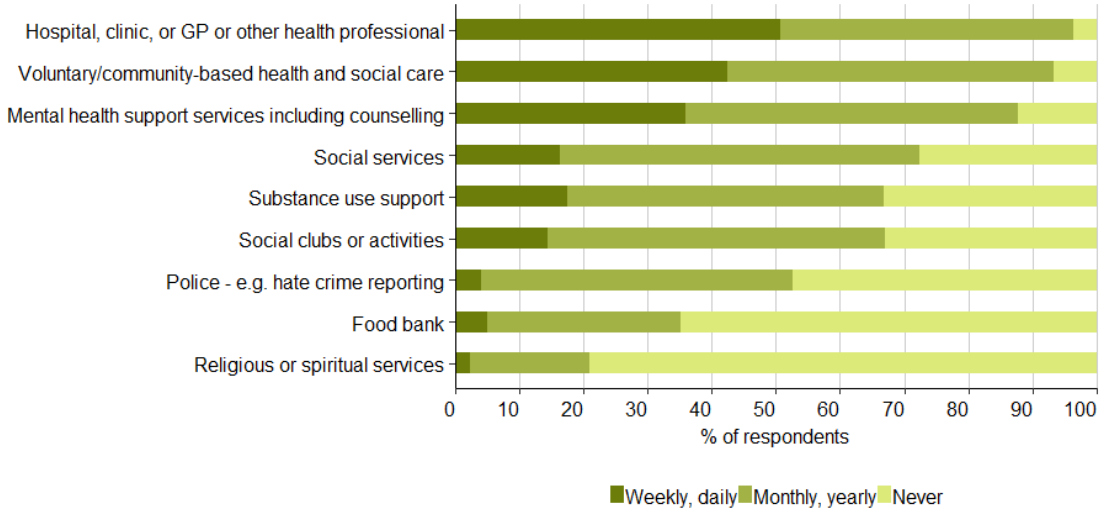


Figure 4-14: Place of referral for prevention purposes (N=631, multiple answer)

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).

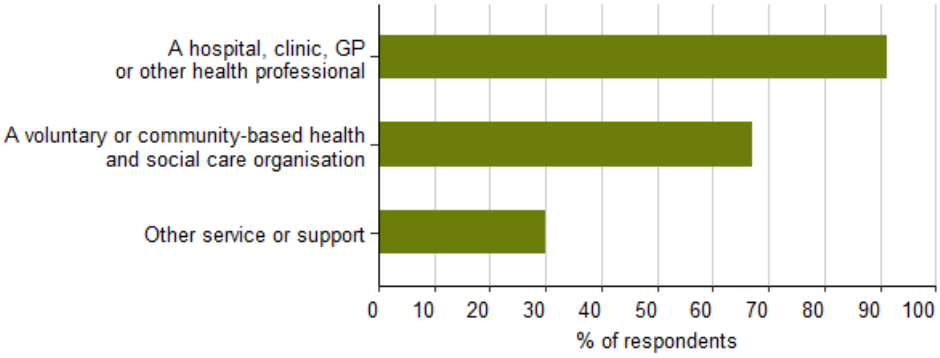


Figure 4-15: Place of referral for treatment and support purposes (N=402, multiple answer)

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	

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=376. [e]Malta, 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%).

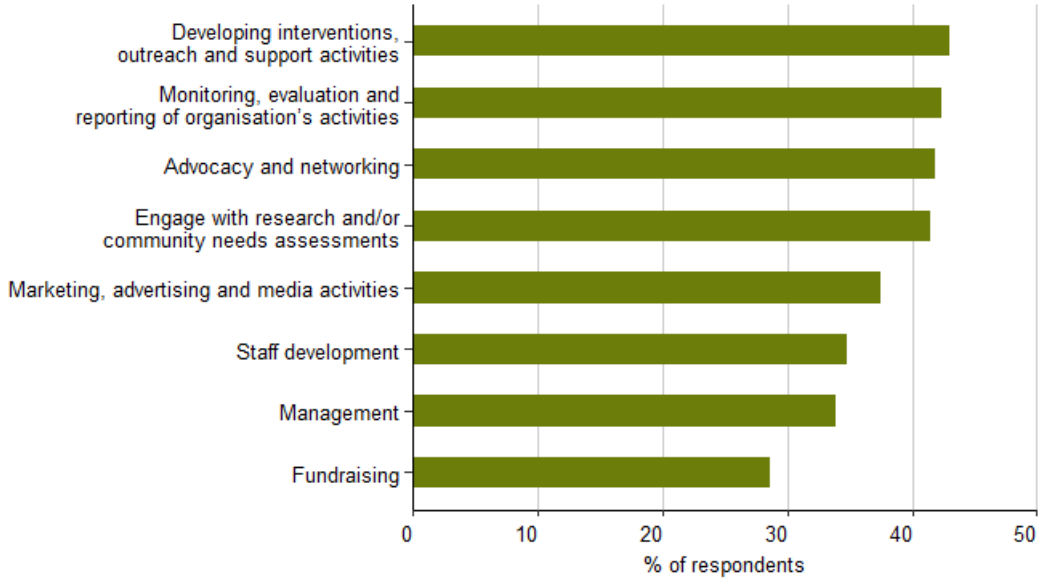


Figure 4-16: Specific transversal activities (N=1,035, multiple answer)

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
P-value	*0.01*	*0.046*	*0.005*	*0.005*	*0.007*	*0.003*	*0.002*	*0.009*
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
P-value	*0.071*	*0.062*	*0.294*	*0.453*	*0.712*	*0.041*	*0.059*	*0.231*
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
P-value	*0.039*	*0.118*	*0.081*	*0.135*	*0.641*	*0.032*	*0.22*	*0.323*
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
P-value	*0.047*	*0.124*	*0.225*	*0.243*	*0.979*	*0.043*	*0.186*	*0.334*
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
P-value	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*
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
P-value	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*
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
P-value	*0.001*	*0.004*	*0.009*	*0.002*	*0.007*	*<0.001*	*0.002*	*<0.001*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/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
P-value	*0.027*	*0.157*	*0.073*	*0.226*	*0.064*	*0.313*	*0.597*	*0.300*
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
P-value	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*0.001*
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
P-value	*<0.001*	*<0.001*	*0.009*	*0.004*	*0.008*	*<0.001*	*<0.001*	*0.001*

[d]n=320. [e]Malta, 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 'heath 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%).

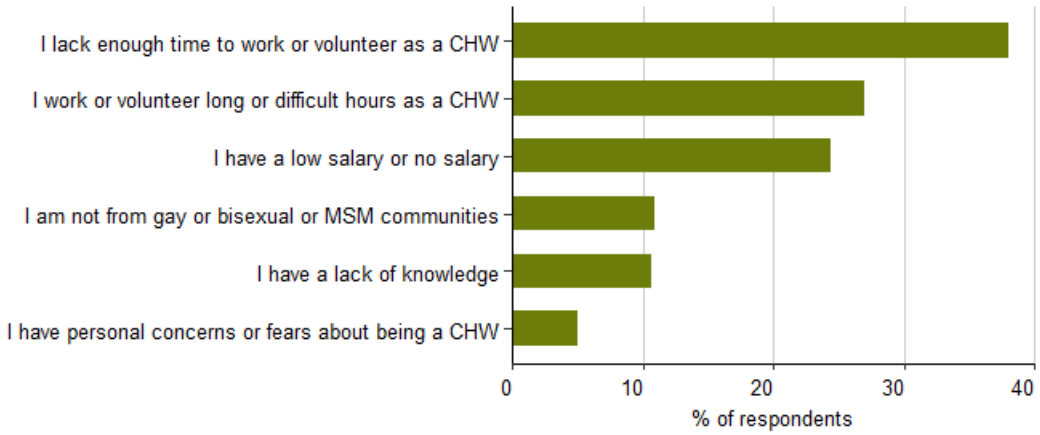


Figure 5-1: Barriers identified by ECHOES respondents at individual level (N=1,035, multiple answer)

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
P-value	*0.005*	*<0.001*	*0.001*	*0.780*	*0.005*	*0.001*
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
P-value	*0.023*	*<0.001*	*0.001*	*<0.001*	*0.022*	*0.013*
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
P-value	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*0.003*	*0.011*
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
P-value	*0.001*	*<0.001*	*<0.001*	*<0.001*	*0.192*	*0.044*
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
P-value	*0.001*	*0.147*	*0.029*	*0.002*	*0.909*	*0.254*
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
P-value	*0.073*	*0.429*	*0.017*	*0.124*	*<0.001*	*0.004*
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
P-value	*0.059*	*<0.001*	*0.005*	*0.589*	*0.662*	*0.643*
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
P-value	*0.590*	*0.028*	*<0.001*	*0.600*	*0.264*	*0.114*
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
P-value	*<0.001*	*<0.001*	*0.002*	*0.003*	*0.336*	*0.627*
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
P-value	*0.585*	*0.023*	*0184*	*0.081*	*0.135*	*0.738*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=786. [e]Malta, 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
P-value	*0.014*	*0.945*	*0.12*	*0.247*	*0.217*	*0.329*	*0.028*	*0.094*	*0.226*	*<0.001*	*0.138*	*0.204*	*0.481*
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
P-value	*0.704*	*0.967*	*0.503*	*0.072*	*0.213*	*0.992*	*0.505*	*0.078*	*0.056*	*<0.001*	*0.476*	*0.051*	*0.076*
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
P-value	*0.127*	*0.956*	*0.95*	*0.008*	*0.189*	*0.423*	*0.427*	*0.436*	*0.599*	*0.855*	*0.032*	*0.133*	*0.096*
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
P-value	*0.179*	*0.306*	*0.935*	*0.103*	*0.56*	*0.724*	*0.56*	*0.196*	*0.077*	*0.081*	*0.174*	*0.688*	*0.072*
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
P-value	*0.591*	*0.556*	*0.566*	*0.03*	*0.252*	*<0.001*	*0.208*	*0.013*	*0.695*	*0.093*	*0.245*	*0.002*	*0.35*
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
P-value	*0.334*	*0.031*	*0.691*	*0.03*	*0.134*	*0.731*	*0.278*	*0.886*	*0.835*	*0.016*	*0.602*	*0.016*	*0.111*
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
P-value	*0.002*	*0.168*	*0.31*	*0.491*	*0.368*	*0.874*	*0.123*	*0.278*	*0.243*	*0.518*	*0.543*	*0.266*	*0.926*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/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
P-value	*0.074*	*0.007*	*0.471*	*0.875*	*0.867*	*0.818*	*<0.001*	*<0.001*	*0.012*	*<0.001*	*0.865*	*0.918*	*0.001*
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
P-value	*<0.001*	*0.018*	*0.125*	*0.206*	*0.066*	*0.162*	*0.083*	*0.001*	*0.411*	*<0.001*	*0.195*	*0.036*	*0.057*
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
P-value	*0.417*	*0.31*	*0.223*	*0.239*	*0.14*	*0.203*	*0.47*	*0.025*	*0.512*	*0.003*	*0.089*	*0.122*	*0.125*

[d]n=786. [e]Malta, 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).

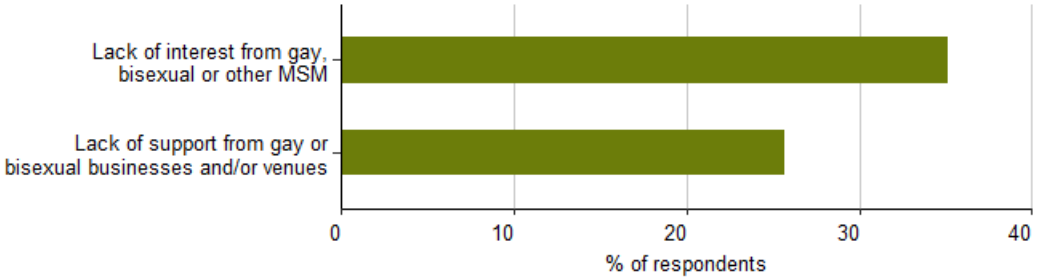


Figure 5-3: Barriers identified by ECHOES respondents at community level (N=1,035, multiple answer)

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
P-value	*<0.001*	*0.005*
Gender		
Man	37.6	26.9
Woman	30.0	23.0
Other or prefer not say	28.9	23.7
P-value	*0.059*	*0.429*
Sexual identity		
Homo/bisexual	37.7	27.7
Heterosexual	29.2	21.2
Other[a]	34.1	24.4
P-value	*0.058*	*0.131*
Peer role		
Peer	37.9	27.3
Non-peer	31.1	23.3
P-value	*0.028*	*0.153*
Employment status		
Paid	35.1	25.8
Volunteer	34.9	25.3
P-value	*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
P-value	*0.002*	*0.264*
Type of organisation worked for[b]		
Private not-for-profit	36.6	26.4
Other[c]	26.0	22.0
P-value	*0.02*	*0.302*
LGBTI inequality level of the working country		
Low inequality	29.7	22.1
High inequality	**52.3**	**37.1**
P-value	*<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
P-value	*<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
P-value	*0.003*	*0.019*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=786. [e]Malta, 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).

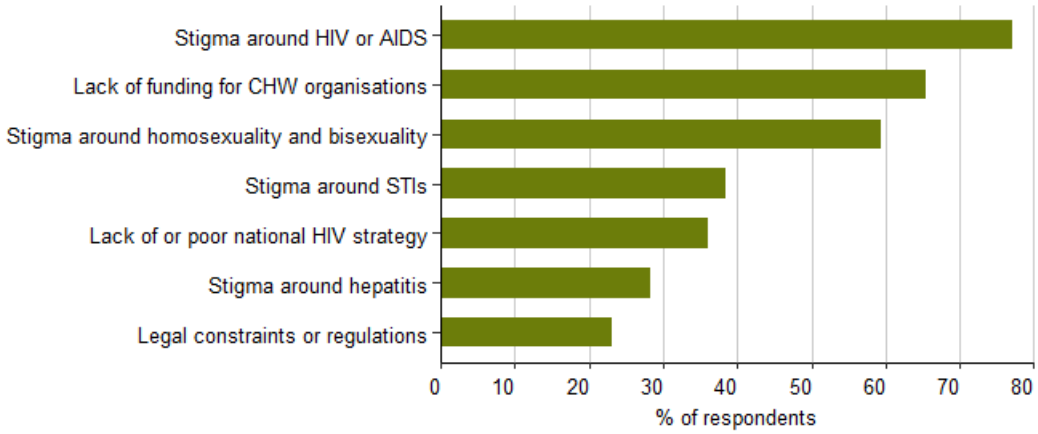


Figure 5-4: Barriers identified by ECHOES respondents at structural level (N=1,035, multiple answer)

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
P-value	*0.001*	*0.006*	*0.055*	*0.002*	*0.050*	*<0.001*	*<0.001*
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
P-value	*0.796*	*0.127*	*0.679*	*0.089*	*0.078*	*0.191*	*0.280*
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
P-value	*0.003*	*0.114*	*0.851*	*<0.001*	*0.48*	*0.015*	*0.010*
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
P-value	*0.077*	*0.005*	*0.940*	*0.003*	*0.81*	*0.050*	*0.066*
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
P-value	*0.382*	*0.883*	*0.340*	*0.041*	*0.475*	*0.801*	*0.36*
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
P-value	*<0.001*	*<0.001*	*0.242*	*0.015*	*0.004*	*0.002*	*0.007*
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
P-value	*<0.001*	*0.014*	*0.023*	*0.020*	*0.037*	*0.015*	*0.055*
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
P-value	*0.235*	*0.965*	*<0.001*	*0.146*	*<0.001*	*0.749*	*<0.001*
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
P-value	*0.126*	*0.024*	*0.093*	*0.772*	*<0.001*	*0.167*	*0.001*
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
P-value	*0.497*	*0.009*	*0.108*	*0.254*	*<0.001*	*0.508*	*0.012*

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=786. [e]Malta, 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).

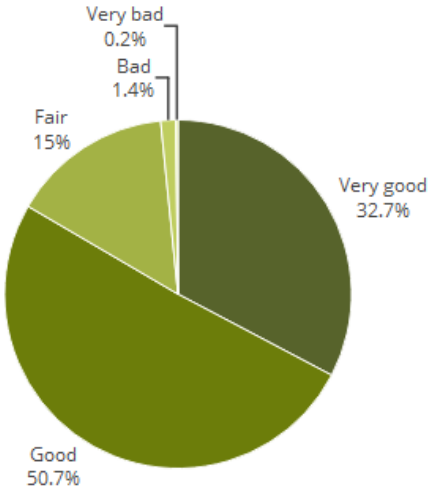


Figure 5-5: Self-perceived health status of respondents (N=1,035)

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	

[a]Queer, any other term, don't use a term. [b]n=975 who were not self-employed. [c]Government/local authority, public organisation, other type. [d]n=786. [e]Malta, 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).

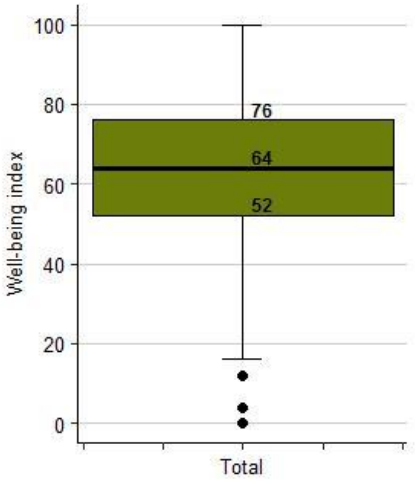


Figure 5-6: Well-being index (N=1,035)

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).

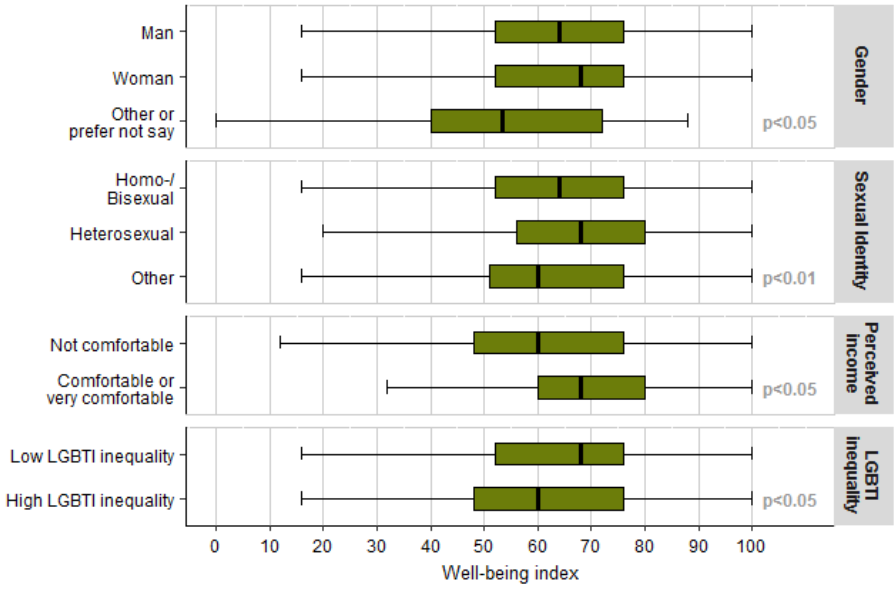


Figure 5-7: Well-being by gender, sexual identity, and level of LGBTI inequality (N=1,035)

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).

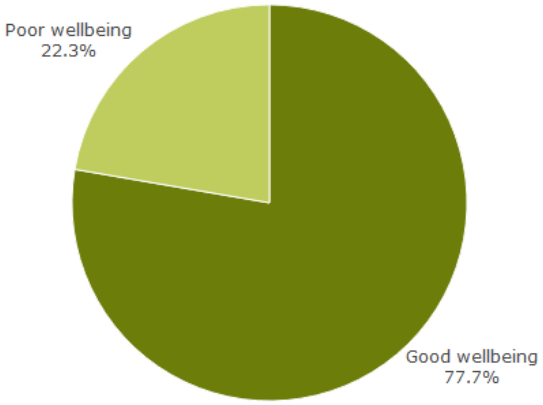


Figure 5-8: Poor/good well-being (N=1,035)

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.

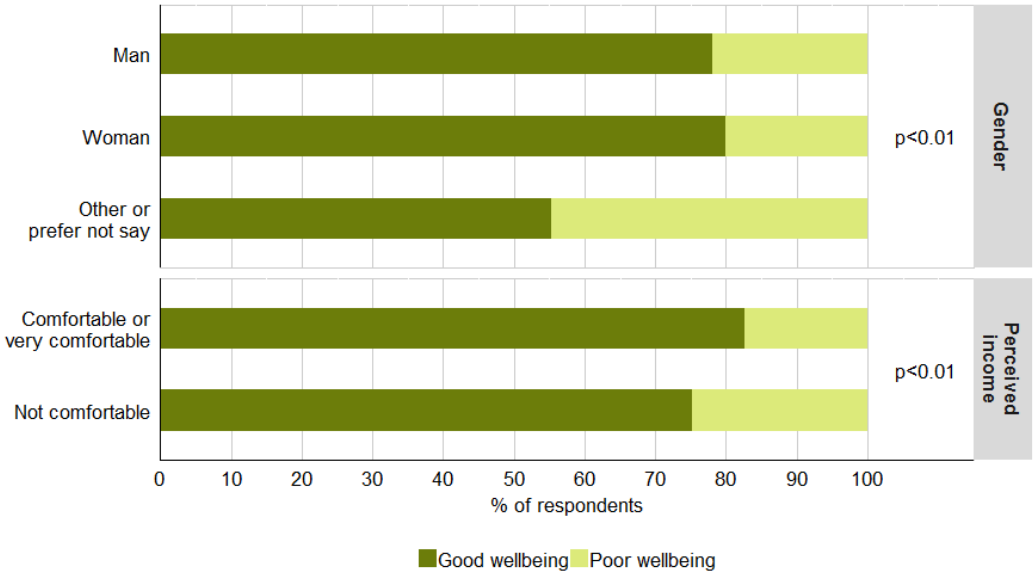


Figure 5-9: Well-being by gender, perceived household income (N=1,035)

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).

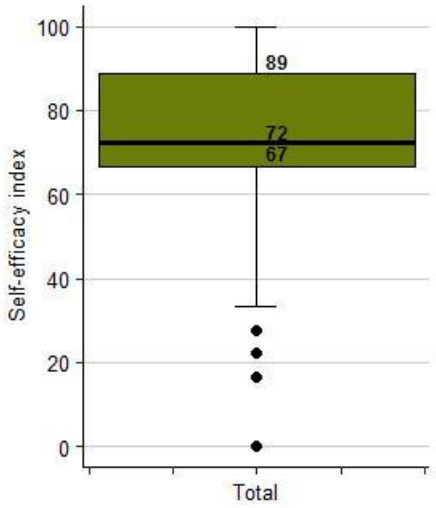


Figure 5-10: Self-efficacy (Total)

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'.

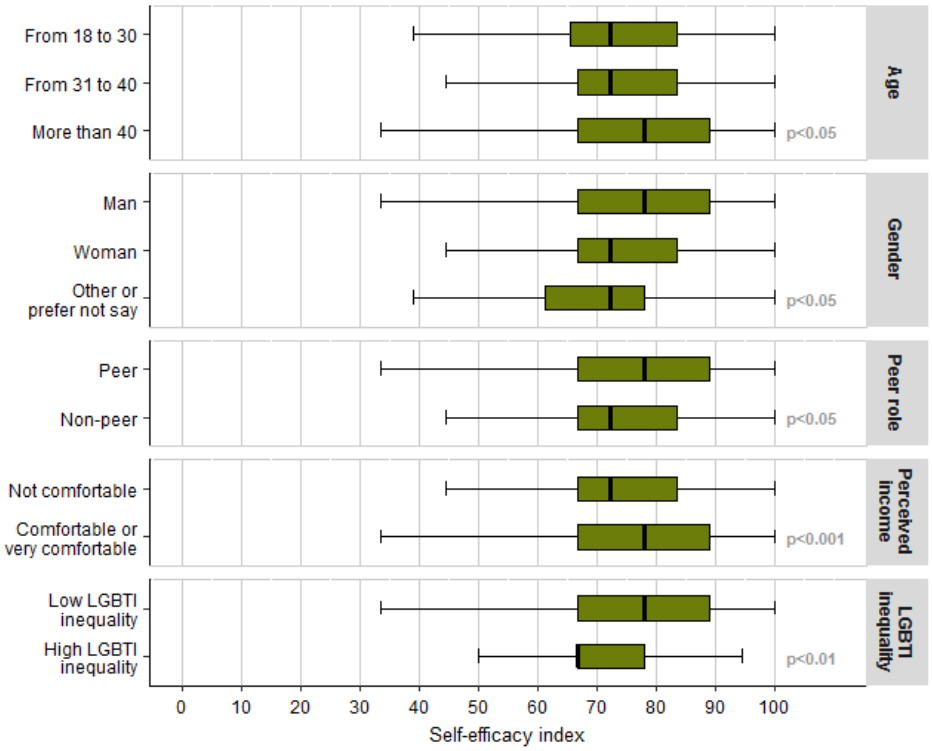


Figure 5-11: Self-efficacy by age, gender, peer role, perceived household income, and level of LGBTI inequality (N=1,035)

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).

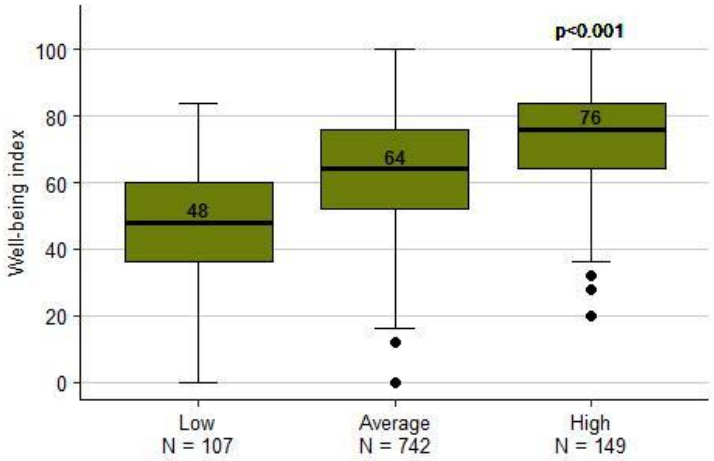


Figure 5-12: Well-being by level of self-efficacy

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).

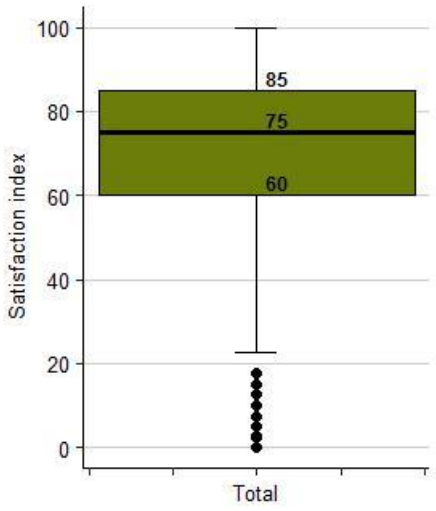


Figure 5-13: Job satisfaction (Total)

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]).

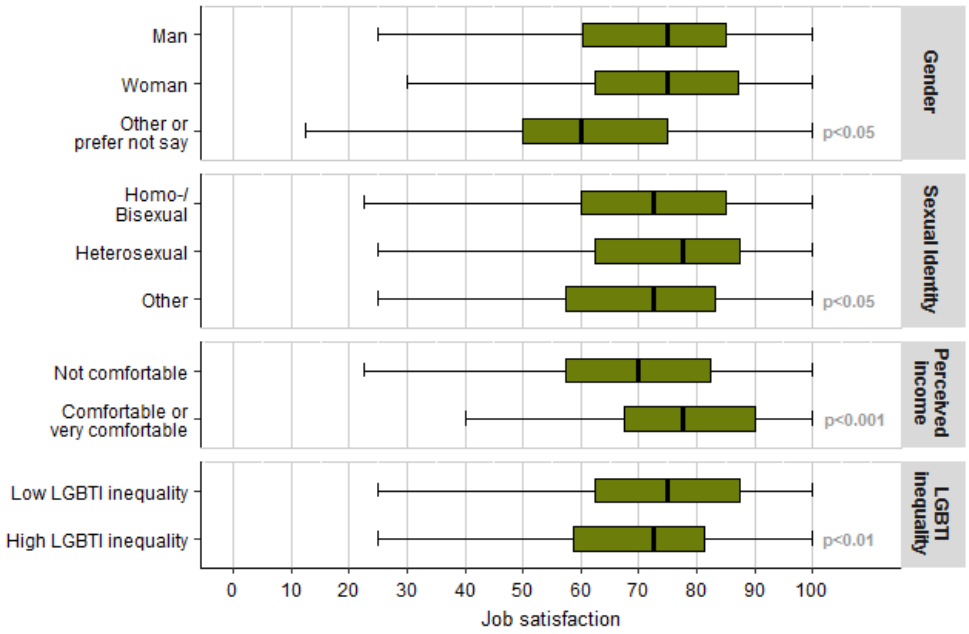


Figure 5-14: Job satisfaction by gender, sexual identity, perceived income and level of LGBTI inequality

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).

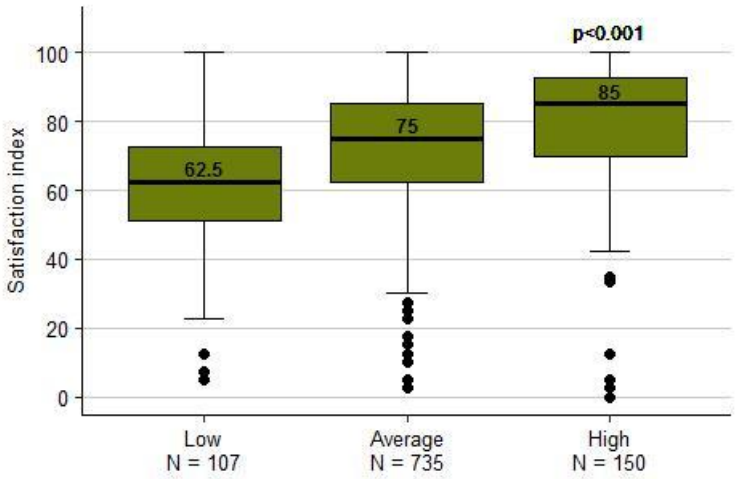


Figure 5-15: Job-satisfaction by level of self-efficacy

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).

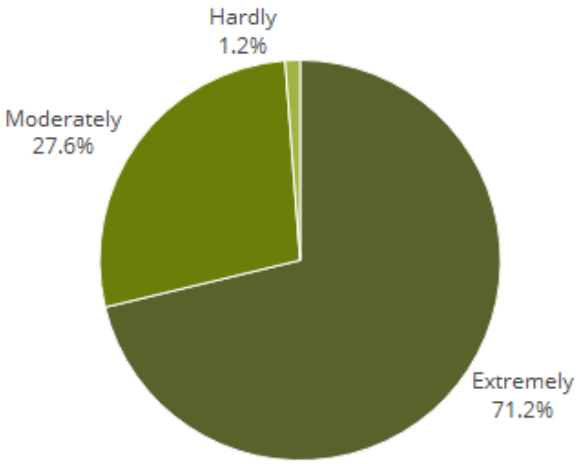


Figure 5-16: To what extent do you think gay, bisexual and other MSM 'trust' or feel confident about the CHW support that **you** are delivering? (N=1,035)

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).

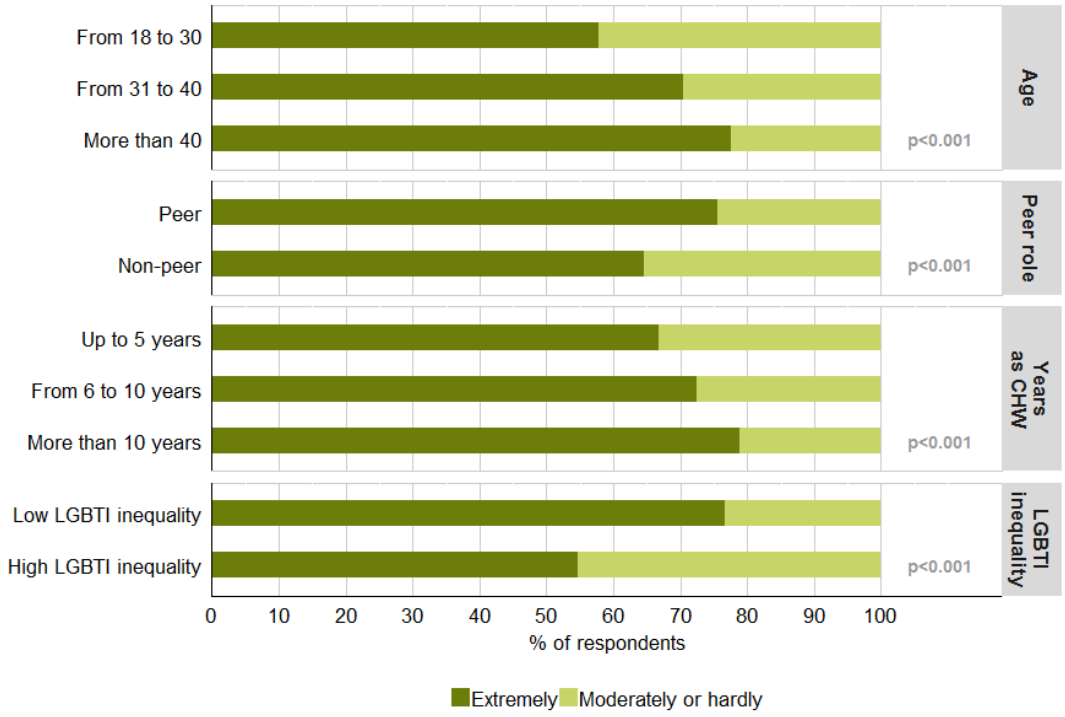


Figure 5-17: MSM confidence toward CHW support that respondents are delivering by age, peer role, years as CHW, level of LGBTI inequality and rate of new HIV diagnoses attributable to sex between men (N=1,035)

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).

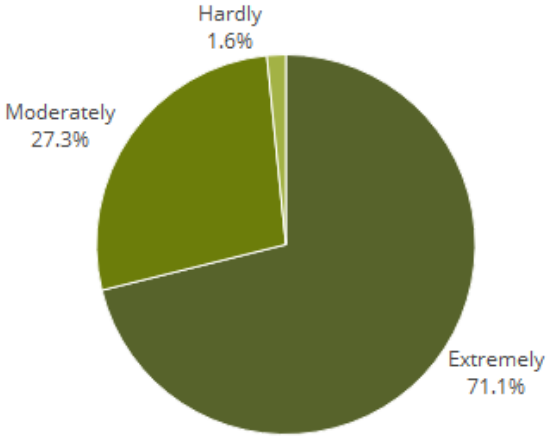


Figure 5-18: To what extent do you think gay, bisexual and other MSM 'trust' or feel confident about the CHW support that **your organisation provides**? (N=1,035)

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).

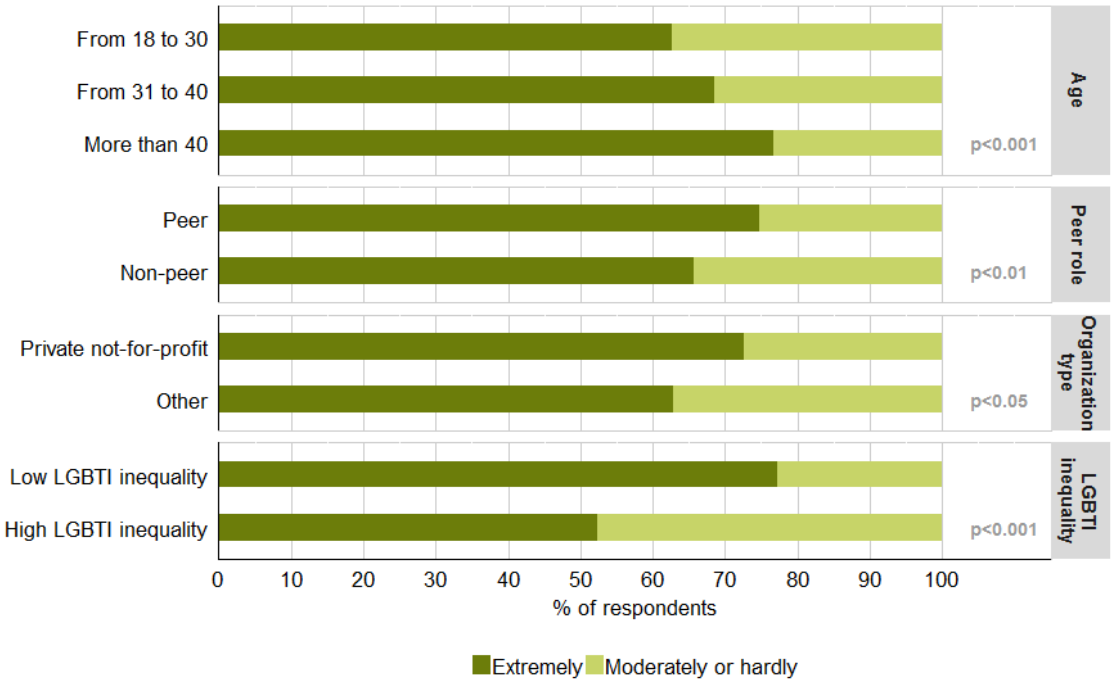


Figure 5-19: MSM confidence toward respondents' organisation by age, gender, peer role, organisation type, level of LGBTI inequality and rate of new HIV diagnoses attributable to sex between men (N=1,035)

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
p-value	*0.001*	*0.221*	*0.095*	*0.01*	*0.098*	*0.112*	*0.043*	*0.207*	*0.461*
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
p-value	*0.076*	*0.434*	*0.428*	*0.287*	*0.325*	*0.617*	*0.007*	*0.004*	*0.042*
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
p-value	*0.015*	*0.349*	*0.094*	*0.141*	*0.514*	*0.399*	*0.019*	*0.004*	*0.013*

[a]Queer, 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).

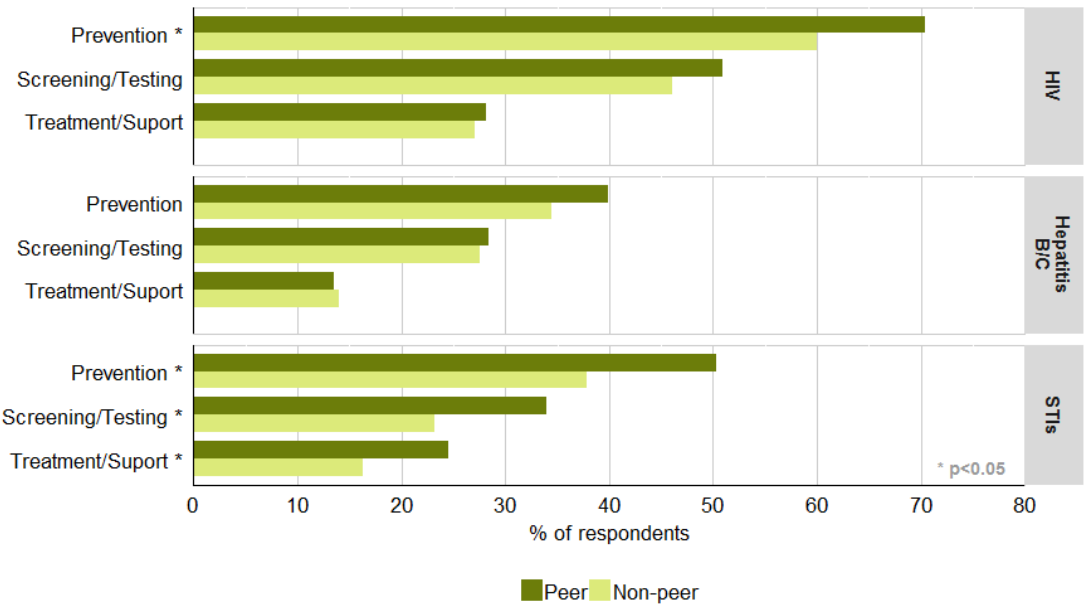


Figure 6-1: Percentage of CHWs very confident in their knowledge by peer role (n=1,035)

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).

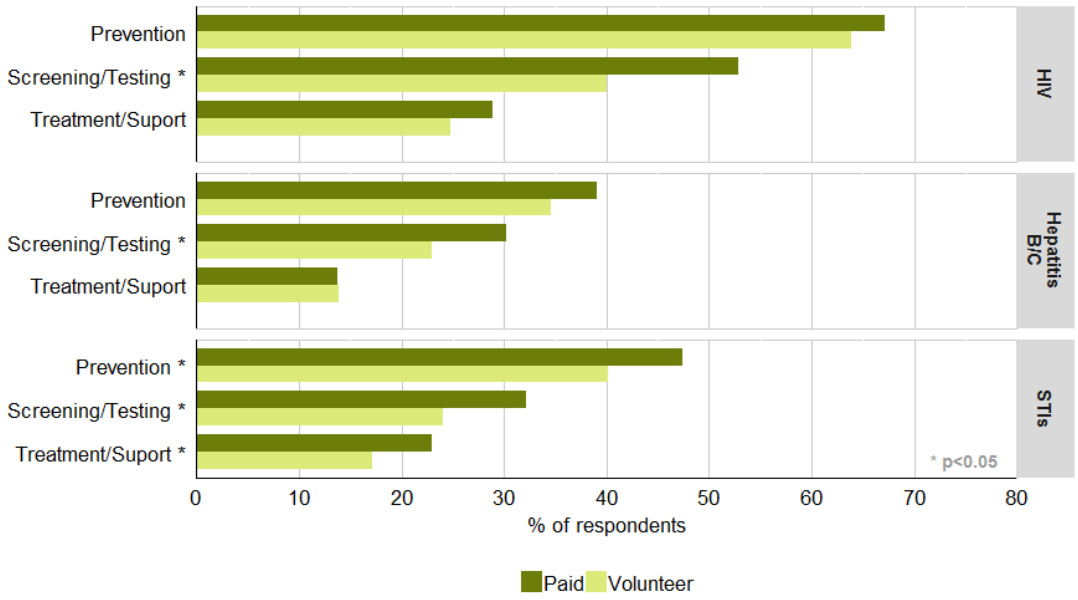


Figure 6-2: Percentage of CHWs very confident in their knowledge by employment status (n=1,035)

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

[a]Malta, 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).

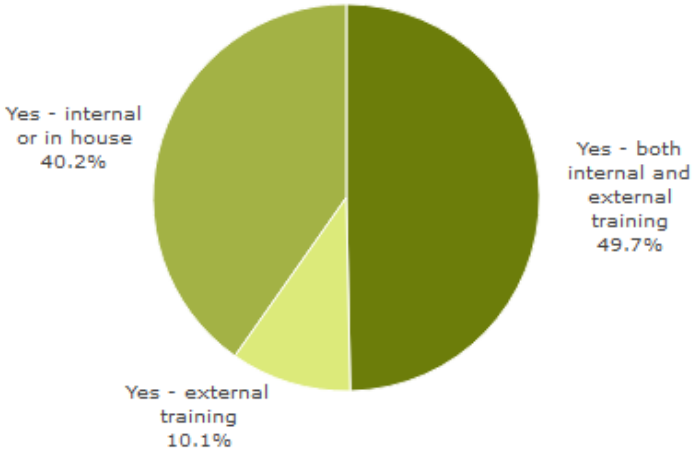


Figure 6-3: Type of training received in their role as a CHW (n=912)

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).

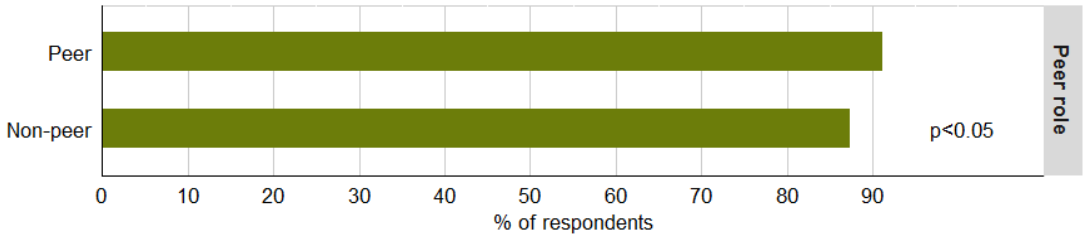


Figure 6-4: Training received by peer role (n=1,035)

As for the training methodology, face-to-face training (e.g. seminars, workshops, lectures, group work, conferences…) were most commonly reported (92.1%). Structured support[34] (52.0%) and structured observation[35] (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.

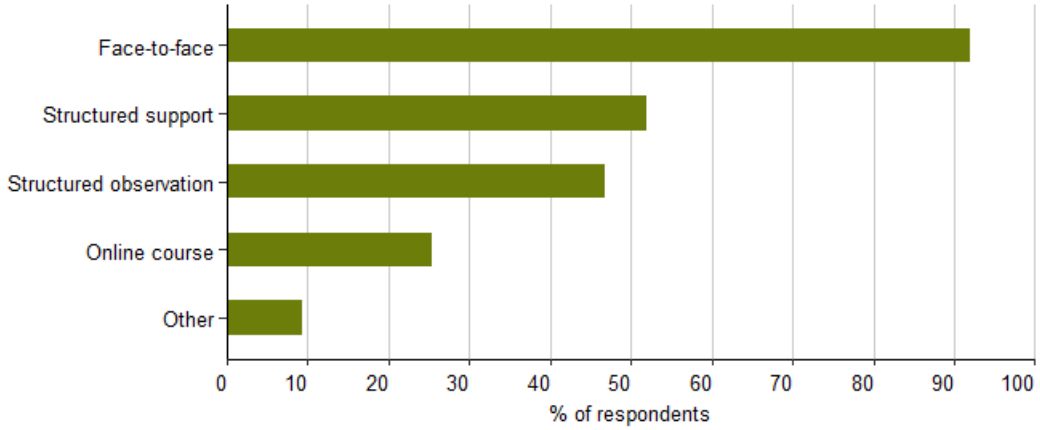


Figure 6-5: Training methodology (n=912, multiple answer)

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, $p<0.05$).

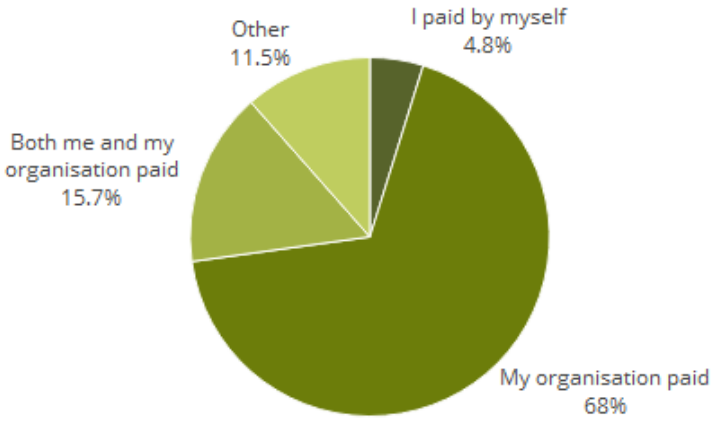


Figure 6-7: Who paid the training? (n=912)

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).

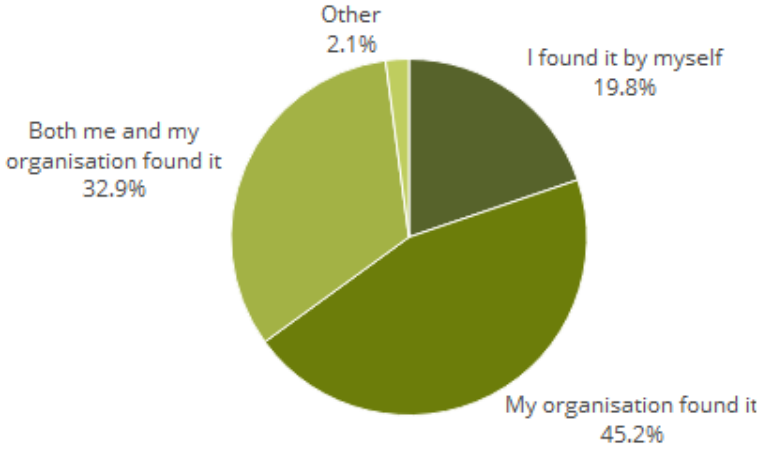


Figure 6-8: Who found the training? (n=912)

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).

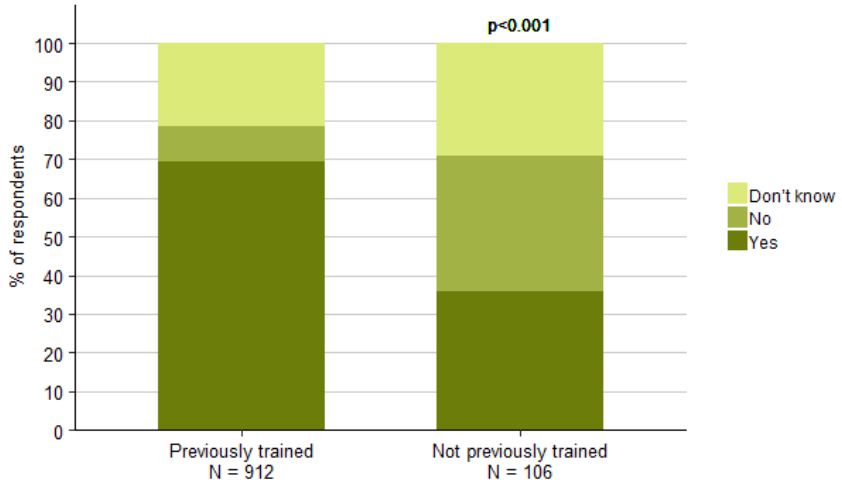


Figure 6-9: Further training opportunities available or ongoing by training received (n=1,035)

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	

[a]Queer, any other term, don't use a term. [b]n=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).

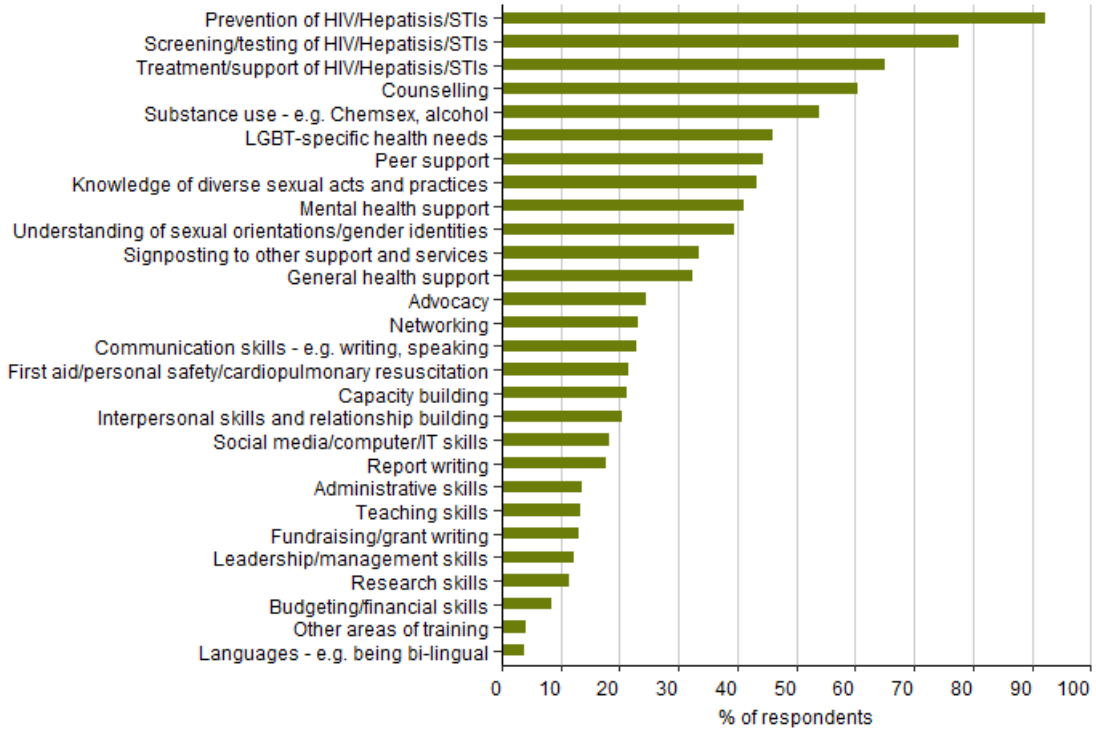


Figure 6-10: Areas covered in training (n=912, multiple answer)

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.

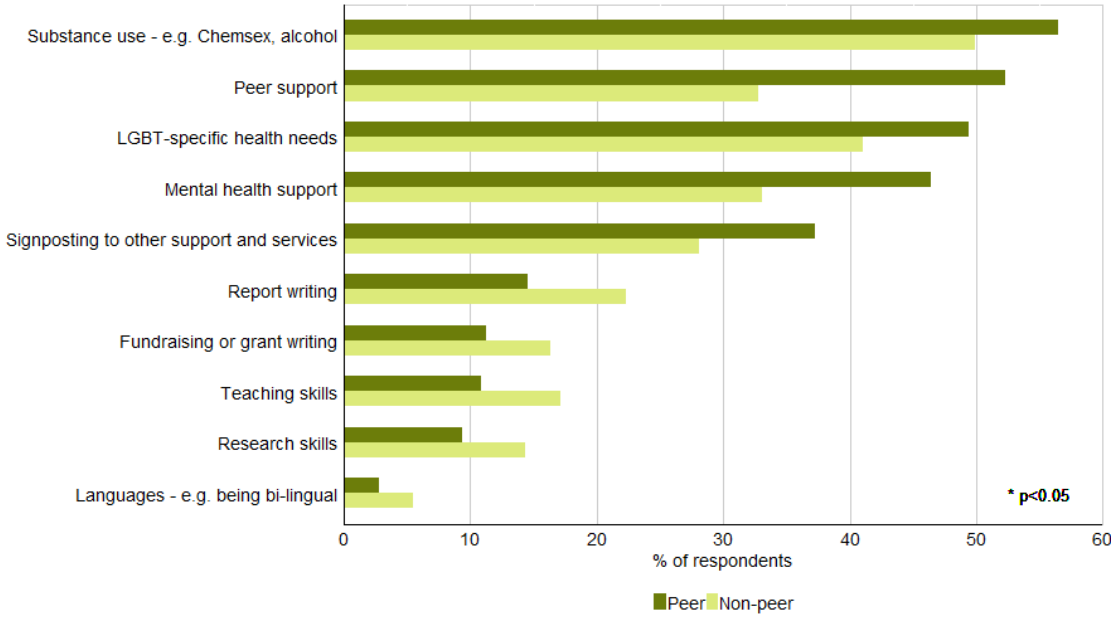


Figure 6-11: Different areas covered in training by peer role (n=912, multiple answer; significant differences only*)

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 activities[36] compared with trained peer CHWs (Figure 6-12).

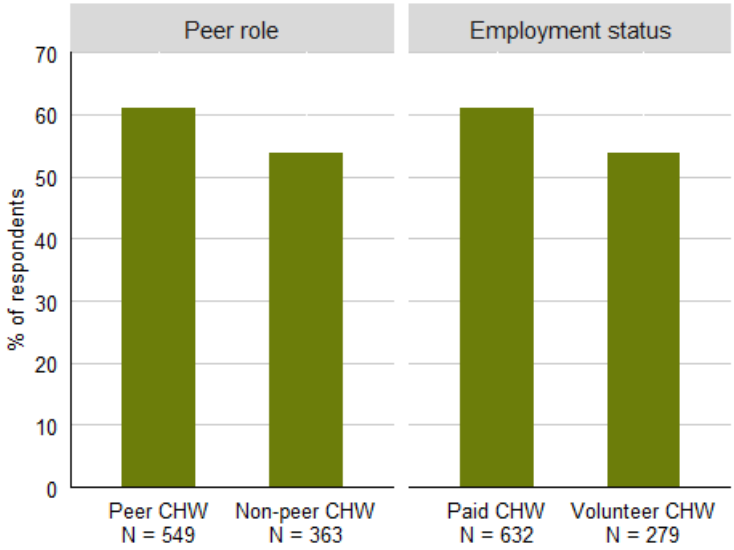


Figure 6-12: Cross-cutting activities performed by trained CHWs by peer role and employment status (n=912)

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.

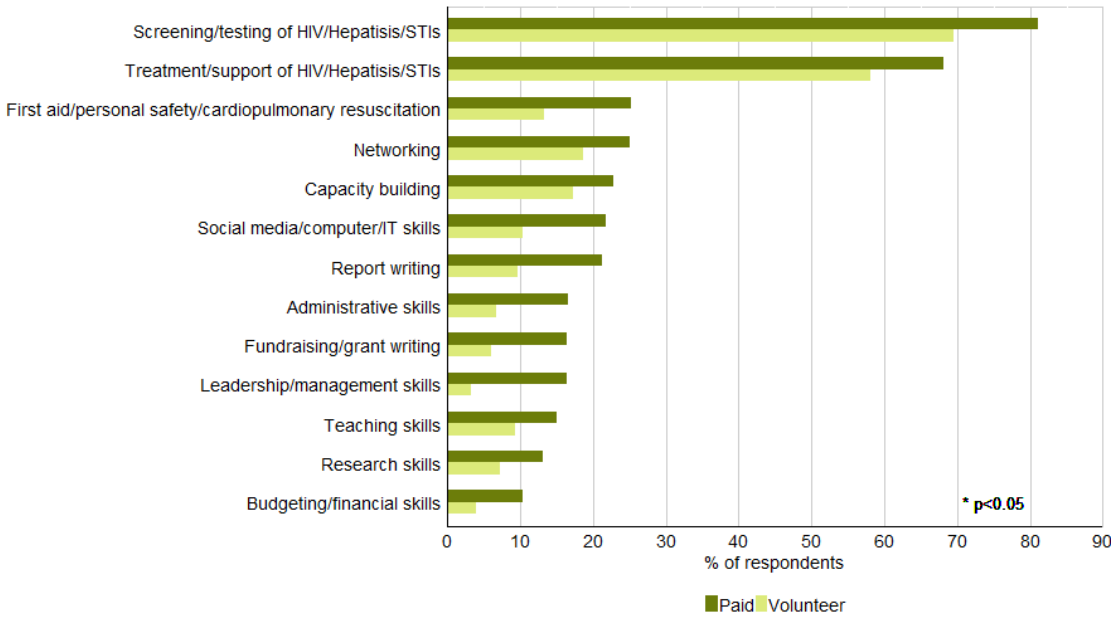


Figure 6-13: Different areas covered in training by employment status* (n=912, multiple answer)

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).

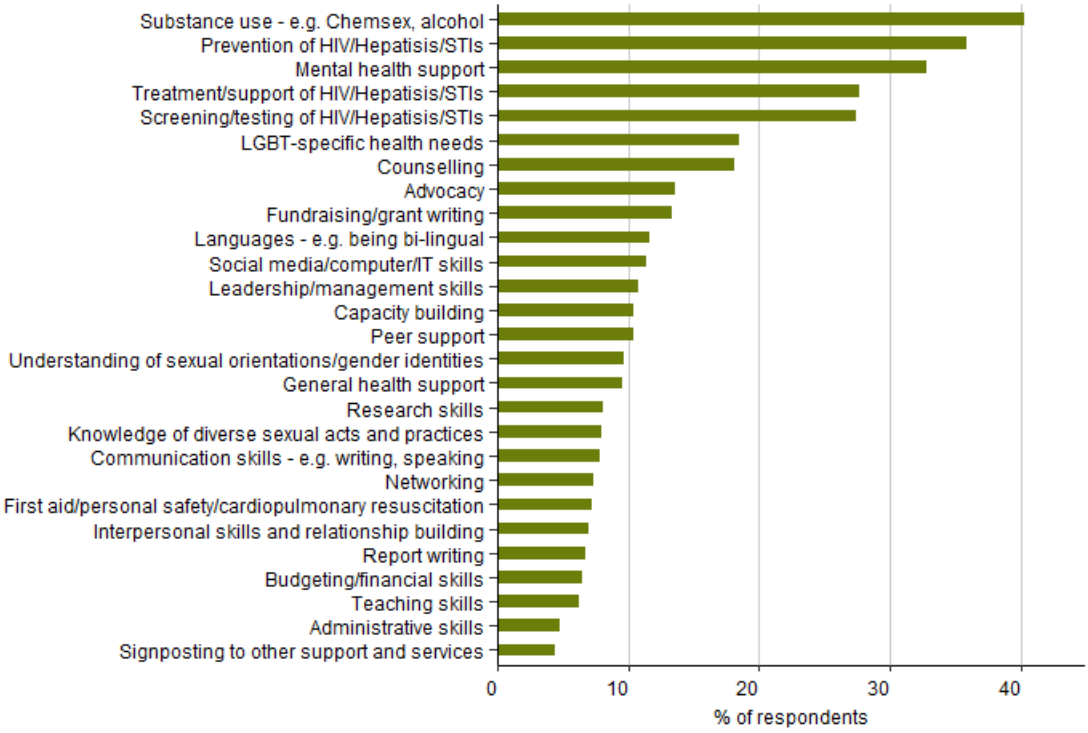


Figure 6-14: Self-reported training needs (n=1,035, multiple answer)

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).

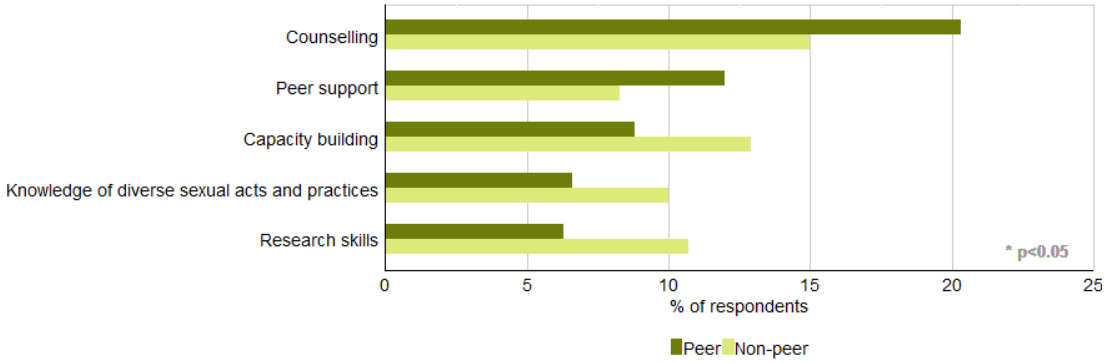


Figure 6-15: Self-reported training needs by peer role* (n=1,035, multiple answer

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.

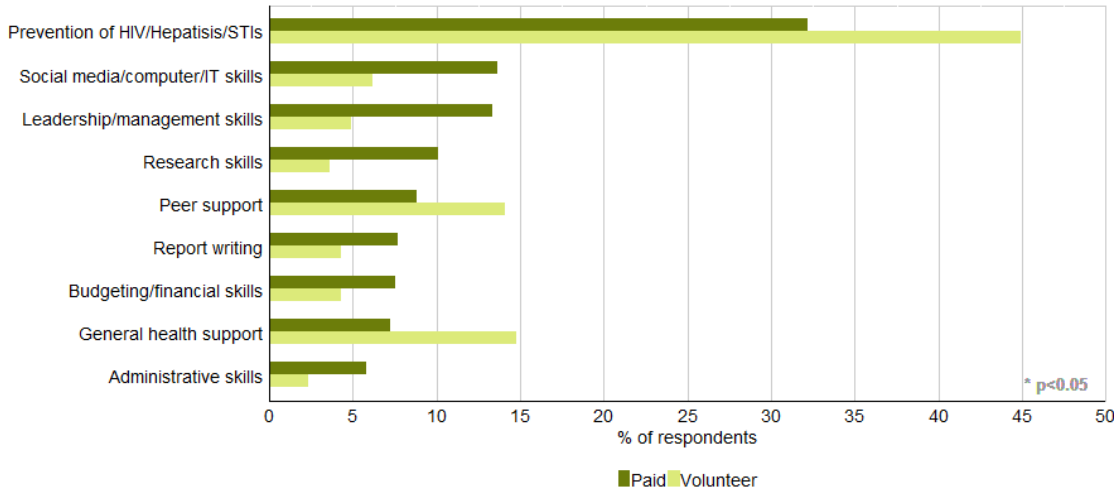


Figure 6-16: Different self-reported training needs by employment status* (n=1,035, multiple answer)

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 hepatitisand 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

[a]p=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.

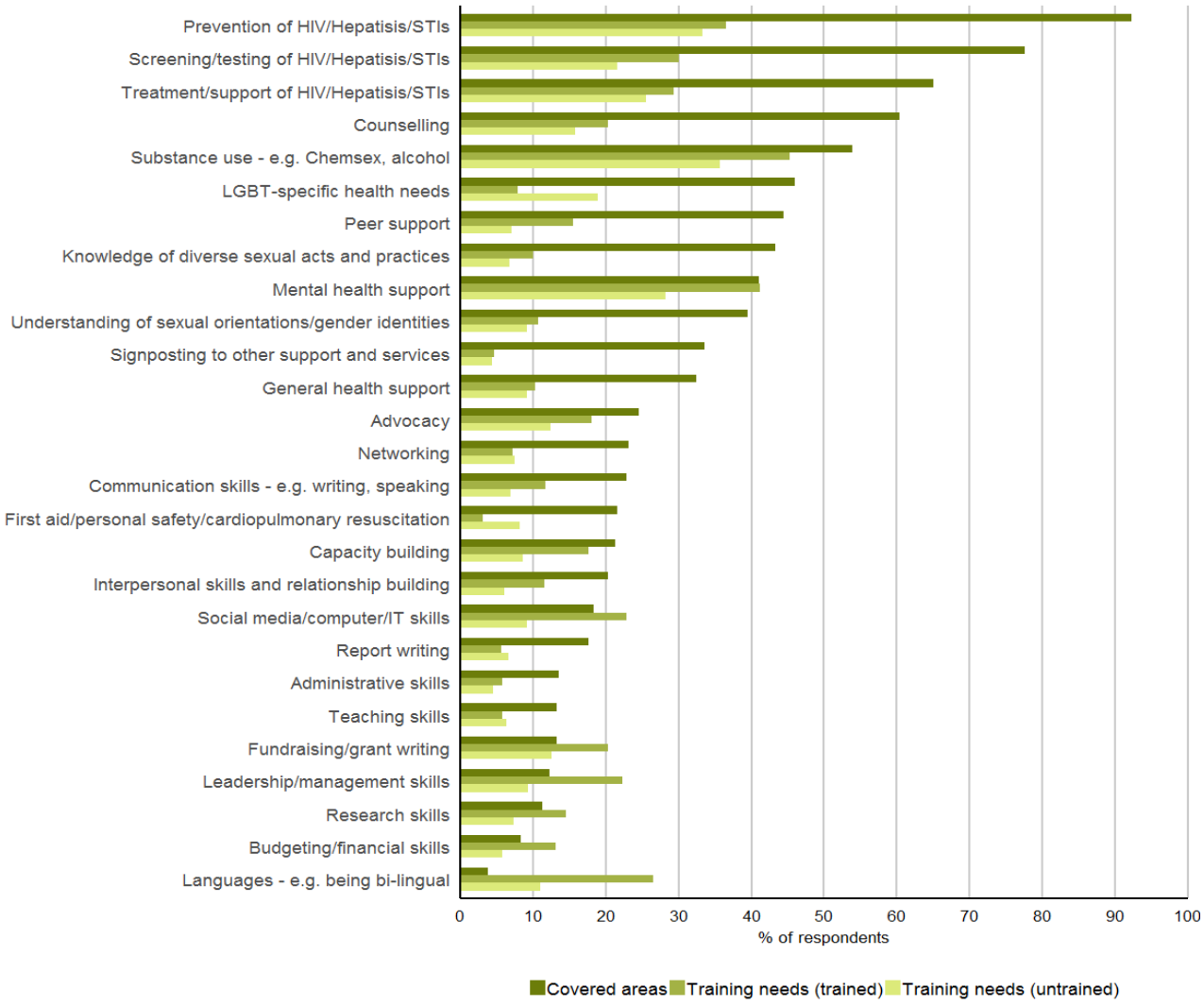


Figure 6-17: Areas covered in training and self-reported training needs (n=1,035; multiple answer)

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

[a]Malta, 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

[a]Malta, 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.

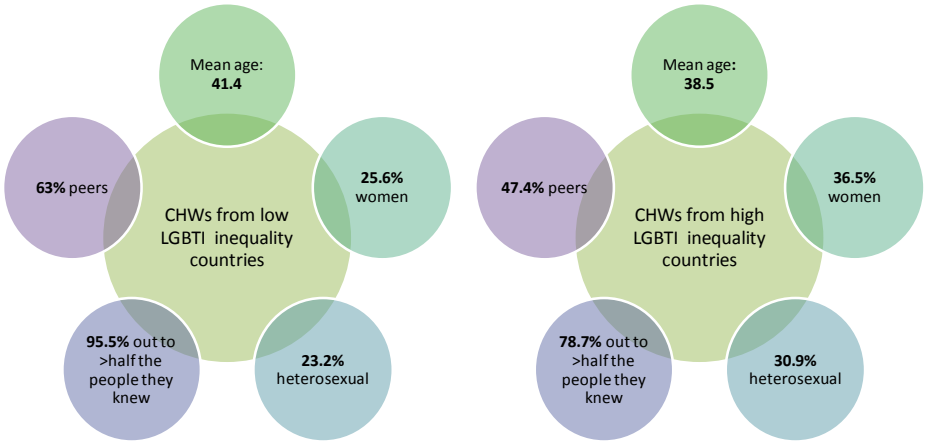


Figure 7-1: Main sociodemographic characteristics of CHWs by the LGBTI inequality level of the working country

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 review[37] 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 review[39]).

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 review[40] 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 review[41] 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 inspiring[42].
- 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).

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13. Annex

13.1. Comparison of CHWs in EMIS vs. ECHOES

The EMIS 2017 questionnaire[43] 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 or 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	3
	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 přespívá k pozitivnímu rozvoji místa vytváží nabídku služeb atd.	1
	Sampling nurse	Odberova sestra	1
Dutch	Community nurse sexual health	Sociaal verpleegkundige seksuele gezondheid	4
	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 promoter	Health promoter	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 promoter	Sexual health promoter	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 promoter, health prevention worker	Health promoter 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, counseler	Project manager counseler	1
	Consultant physician	Consultant physician	1
	Councellor and tester of hiv an syphillis	Councellor and tester of hiv an syphillis	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

	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
	Pr„ventions- 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
	Projecr management	Projecr 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

	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
	Upps”kande 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	Etsiväntyöntekijä seksuaaliterveyden työntekijä terveyden edistäjä	1
	Sexual health worker	Seksuaaliterveyden työntekijä	1

	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	Terveydenhoitaja seksuaalineuvoja	1
	Sexuality advising, sexual health promotor	Seksuaalineuvonta 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

		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 developper	Intervenant communautaire community developper	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

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 Präventionskampange	1

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	Sozailarbeiterin 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

	Sexual advisor	Beraterin für sexuelle Gesundheit	1
	Volunteer for primary prevention	Ehrenamtlicher Mitarbeiter zur Primär-Prävention	1
	Psychos-ocial 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	Sorialarbeiter 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	Gesundheitsmangement	1
	Practice assistants	Praxisassistent	1
	Sexual worker	Sexual worker	1
	Volunteer in gay community	Ehrenamtlicher in schwulen Community	1

	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 plhiv	1
	Outreach worker	Εργαζόμενη εκτός δομής	1
	Sexual education adviser	Σύμβουλος σεξουαλικής αγωγής	1
	Sexual health adviser/drug abuse adviser	Σύμβουλοσ σεξουαλικής υγείας or 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 or ακτριβιστρια or 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 ομάδές 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

	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 zakrsie 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 profissional	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

	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
	Coumunity 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

	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
	Psychologyst, 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

	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

	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

	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 здоровя 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
P-value	*0.266*	*0.401*	*0.343*	*0.001*	*0.204*
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
P-value	*0.906*	*0.000*	*0.877*	*0.000*	*0.900*
Outreach					
No	87.9	62.4	44.1	52	46.7
Yes	94.5	66.4	47.3	45.5	42.7
P-value	*0.038*	*0.414*	*0.528*	*0.194*	*0.429*
Testing worker					
No	88.5	62.0	44.0	51.8	46.6
Yes	92.6	92.6	59.3	33.3	33.3
P-value	*0.508*	*0.001*	*0.116*	*0.058*	*0.172*
Activist					
No	88.4	63.0	44.5	51.2	46.5
Yes	96.2	53.8	42.3	53.8	38.5
P-value	*0.22*	*0.339*	*0.824*	*0.793*	*0.418*
Psycho-social					
No	88.9	64.0	44.8	49.9	45.2
Yes	86.8	55.6	42.4	59.7	52.8
P-value	*0.465*	*0.052*	*0.588*	*0.029*	*0.092*
Sexual health					
No	87.7	60.3	42.4	50.8	45.8
Yes	94.0	77.3	56.7	54.0	49.3
P-value	*0.024*	*0.000*	*0.001*	*0.475*	*0.417*
Prevention worker					
No	88.3	63.4	44.9	52.4	46.4
Yes	95.7	50.0	34.8	28.3	43.5
P-value	*0.124*	*0.066*	*0.177*	*0.001*	*0.697*
Community worker					
No	87.4	62.1	43.3	50.2	45.1
Yes	98.2	68.5	54.1	60.4	55.9
P-value	*0.001*	*0.191*	*0.031*	*0.043*	*0.032*
Health worker					
No	87.4	60.0	42.1	49.6	43.7
Yes	90.7	67.8	48.8	54.5	51
P-value	*0.109*	*0.013*	*0.038*	*0.128*	*0.025*
Educator					
No	88.4	63.6	44.5	50.9	46.3
Yes	91.4	53.1	43.2	55.6	45.7
P-value	*0.416*	*0.060*	*0.816*	*0.425*	*0.910*
Volunteer					
No	88.6	63.8	45.8	52.6	49.4
Yes	88.8	53.1	31.6	38.8	16.3
P-value	*0.954*	*0.036*	*0.007*	*0.009*	*0.000*
Counsellor					
No	88.7	61.8	43	51.8	46.4
Yes	87.7	69.6	53.6	47.8	45.7
P-value	*0.716*	*0.077*	*0.020*	*0.380*	*0.874*
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
P-value	*0.966*	*0.522*	*0.074*	*0.535*	*0.640*

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