Experiences and knowledge capitalization report

Life path, health care pathway of users in four Community-based sexual health services settings implemented by member associations of Coalition PLUS:

Le Spot & L'Antenne (AIDES and Le 190), Access medical center, Douala (Alternatives-Cameroun), Les Halles Clinic (ARCAD Santé PLUS), Quito community medical center (Kimirina)

Knowledge Management Division

Experience and Knowledge Capitalization Unit

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List of abbreviations and acronyms

ANRS: *Agence nationale de recherches sur le sida et les hépatites virales* [French Agency for Research on AIDS and Viral Hepatitis]

APTE: *Aide et prévention des toxico-dépendances par l'entraide* [Drug addiction recovery and prevention through mutual aid]

ARS: *Agence régionale de santé* [Regional Health Authority]

ARV: Antiretroviral therapy

CegiDD: *Centre gratuit d'information, de dépistage et de diagnostic* [free information, screening and diagnostic centers]

CESAC: *Centre de soins, d'animation et de conseils pour les personnes vivant avec le VIH/SIDA* [Center for Treatment, Activities and Counseling for People Living with HIV/AIDS]

CBSHS: Community-based sexual health services settings

DAAs: Direct-acting antivirals

GBV: Gender-based violence

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

HPV: Human papillomavirus

IBBS: Integrated Biological and Behavioral Surveillance

ICASA: International Conference on AIDS and Sexually Transmitted Infections in Africa

IEC: Information, Education & Communication

KP: Key populations

MSM: Men who have sex with men

PARC: *Parcours d'accompagnement renforcé Chemsex* [Chemsex reinforced support program]

PE: Peer educators

PET: Post-exposure treatment

PFAO: Coalition PLUS West Africa capacity-building platform regional network

PPE: Post-Exposure Prophylaxis

PrEP: Pre-Exposure Prophylaxis

PSCs: Psychosocial Counselors

PWID: People who inject drugs

RDTs: Rapid diagnostic tests

RR: Risk Reduction

SHS: Sexual health services

SRR: Sexual Risk Reduction

STI: Sexually transmitted infection

TW: Transgender/trans women

USAC: *Unités de soins, d'accompagnement et de conseil* [Care and Counseling Units]

WHO: World Health Organization

WSW: Women who have sex with women

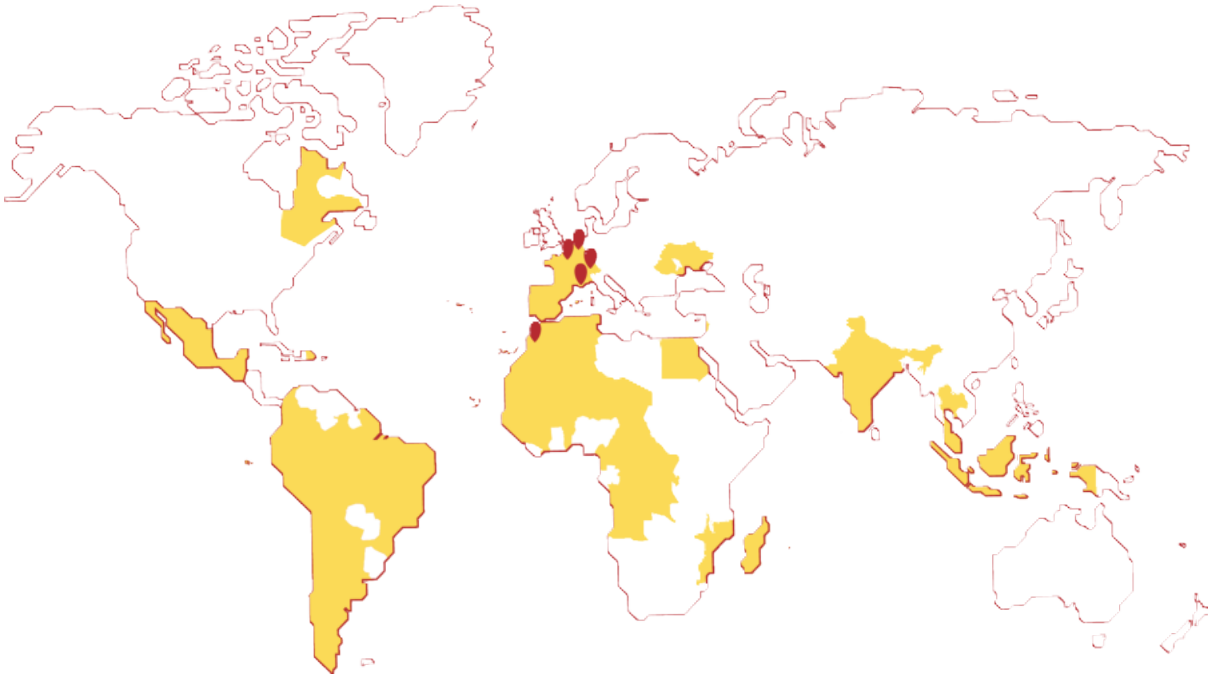
Presenting Coalition PLUS

Coalition PLUS is an international union of community-based associations engaged in the fight against HIV/AIDS and viral hepatitis created in 2008, operating in 52 countries and alongside some one hundred civil society organizations.

Our member and partner associations involve the communities most vulnerable to HIV/AIDS and hepatitis in the determination and implementation of prevention, care and advocacy programs.

They promote innovative methods adapted to the individuals facing the most discrimination in access to healthcare.

Our values: solidarity, respect for diversity and non-judgment, innovation.



- **5 continents and 52 countries**
- **100+** partner associations
- **16** member organizations form the governing board:
    - 100% LIFE, Ukraine
    - AIDES, France
    - ALCS, Morocco
    - ANCS, Senegal
    - ANSS, Burundi
    - ARAS, Romania
    - ARCAD Santé PLUS, Mali
    - COCQ-SIDA, Canada (Quebec)
    - Fundación Huésped, Argentina
    - GAT, Portugal
    - Groupe santé Genève, Switzerland
    - IDH, Bolivia
    - Kimirina, Ecuador
    - Malaysian AIDS Council, Malaysia
    - PILS, Mauritius
    - REVS PLUS, Burkina Faso
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The Coalition PLUS regional, thematic and linguistic networks:

● Central and East Africa capacity-building platform regional network (PACE): Burundi, Cameroon, Central African Republic, Chad, Congo-Brazzaville, Democratic Republic of Congo, Rwanda

● West Africa capacity-building platform regional network (PFAO): Mali, Benin, Burkina Faso, Côte d'Ivoire, Guinea-Conakry, Niger, Senegal, Togo

● Americas-Caribbean capacity-building platform regional network (PFAC): Ecuador, Bolivia, Canada (Quebec), Colombia, Democratic Republic, France (French Guyana, Martinique, Guadeloupe, Saint-Martin), Guatemala

● South and Southwest Asia capacity-building platform regional network (PFSASEA): Malaysia, India, Indonesia, Thailand

● Europe capacity-building platform regional network (PFE): France, Belgium, Portugal, Romania, Switzerland (Geneva), Ukraine

● North Africa & Middle East Africa capacity-building platform regional network (PF MENA): Morocco, Algeria, Egypt, Lebanon, Mauritania, Tunisia

● Indian Ocean capacity-building platform regional network (PFOI): Republic of Mauritius (Mauritius Island, Rodrigues Island), Comoros, France (Mayotte, Réunion), Madagascar, Seychelles

● Alliance globale des communautés pour la santé et les droits (AGCS PLUS): Algeria, Benin, Burkina Faso, Côte d'Ivoire, Burundi, Cameroon, Guinea-Conakry, Mali, Morocco, Senegal, Togo, Tunisia

● Research network on the well-being and global health of gay men, bisexuals, men who have sex with men and the trans population in Latin America (RIGHT PLUS): Bolivia, Brazil, Chili, France, Guatemala, Mexico, Peru, Portugal, Spain

● Lusophone network: Angola, Brazil, Cape Verde, East Timor, Guinea-Bissau, Mozambique, Portugal, São Tomé and Príncipe

Summary

Key populations vulnerable to HIV, to viral hepatitis and to sexually transmitted infections (STIs) are faced with health inequalities[1] due to the many challenges they must overcome to access differentiated care determined according to their needs and with respect for their human rights.

In this context, one of Coalition PLUS' strategic priorities is to promote and valorize the **community-based healthcare approach** of its member and partner associations, an approach based on the effective participation of users in the development and implementation of actions concerning them, the recognition of their experience as people living with a disease as a legitimate and valid source of knowledge and know-how, useful to the collective effort for social change, advocacy for health democracy and for a healthcare system centered on the person, their best state of health and their empowerment.

One of the specific aspects of the community-based healthcare approach is that it targets **determinants of health** in particular, that is to say the factors (social, economic, family environment, education, employment, income, etc.) found in the **life path** of an individual and **that influence their state of health**. Consideration of the life path (in its entirety, sequentially and/or partially) makes it possible to construct a personalized plan and a set of differentiated services thanks to knowledge of the person, their life story, their relationships, their general health, their preferences and their interests.

It is this consideration of the user's life path that served as the framework for the capitalization of the operations of the four sexual health services (SHS) settings put in place by the Coalition PLUS associations in Cameroon, Ecuador, France and Mali, and presented in this document.

First of all, in the form of synoptic sheets, the various aspects of the implementation of the four schemes, that is to say: i) the national context (epidemiological context, access of vulnerable populations to sexual health services); ii) the objectives and key moments in the development of the SHS scheme, the intervention strategies (mobilization of the target audience, user's health care pathways and interconnection with their life path); iii) the results (target audience, services provided, advocacy actions to incorporate SHS schemes into national public health strategies); and iv) the challenges encountered, success factors, levers and the lessons learned from this experience of implementing a community-based SHS scheme.

Below is a summary of some of the elements of each of these schemes:

The Le Spot & L'Antenne scheme in Paris (France) provides a hybrid range of health services comprising medical assistance and peer assistance. The project is the result of a partnership between two structures with relatively different approaches — a sexual health center managed by health professionals on the one hand, and community workers (peers) on the other. It primarily provides two health care pathways: (1) HIV and STI testing, PrEP and HIV follow-up, (2) Chemsex and mental health. The target audience is men who have sex with men, some of whom are drug users. With regard to the community-based approach, the presence of peer workers in the center's team who, through their experience, understand the dynamics of dependence and addiction and the life situations that users face, is essential to the relation between users and the scheme.

Access medical center in Douala (Cameroon) works in a national context of criminalization of same-sex sexual activity, multiple forms of violence and stigmatization of key populations, which pose a constant challenge.

This Alternatives-Cameroun health center, with other similar initiatives at community level, fills the gaps in the public health system in terms of services adapted to the needs of the populations most vulnerable to HIV and STIs, such as men who have sex with men, transgender and intersex people, people who use drugs, and women who have sex with women. In addition to treatment and prevention of STIs, HIV and perianal pathologies, as well as reproductive health services, the center also covers subjects like

[1] UNAIDS, February 2022, Report *"Many key populations avoid health services"*.

assistance to victims of gender-based violence, hormonal treatment for transgender people and awareness of HIV status among the patient's entourage.

Guidance in looking for work and/or housing, family mediation in situations of rejection, help in obtaining identity documents, as well as other social services, are also incorporated into users' personalized health care pathways.

Furthermore, training run by the association for key workers in the public health system (doctors, authorities, etc.) concerning, among others, the impact of discrimination and stigmatization of vulnerable key populations, their access to care and treatment services, are a key factor in better care for these people.

Les Halles clinic in Bamako (Mali) is a sexual health center managed by the association ARCAD Santé PLUS, a major national association with 16 community treatment centers, some of which are run in partnership with public structures. The clinic operates in a context of a fragile public health system where the HIV epidemic is concentrated within key populations — men who have sex with men, people who use drugs, sex workers, transgender/trans people. These populations as well as young people aged 15 to 24 constitute the clinic's target audience. Its services are focused on HIV and STI prevention and on treatment of medical conditions connected to sexual and anal health, given that the clinic is a national benchmark in this area. Peer educators are present at all levels of the clinic's response chain.

Nowadays, the clinic aims to become a benchmark sexual health center at sub-regional level where people can receive health services that are not available everywhere in Africa. The clinic is also a force for change in Bamako and at national level with regard to the deconstruction of stereotypes and social representations linked with homosexuality and key populations.

The Quito community medical center (Ecuador) operates in a context of a HIV epidemic mainly concentrated among men who have sex with men and transgender women, who are the targets of this service provided by the center, along with sex workers and people who use drugs. The center was created in 2017 as part of a combination prevention project put in place in partnership with the Ministry of Health. The scheme is centered around the prevention, diagnosis and treatment of HIV (including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis and treatment (PEP/PET) and STIs, as well as psychological support of migrants. As part of a recent research-action project, the center intercedes in protection measures for key populations and, in particular, transgender women and sex workers, who are most often victims of different types of gender-based violence. Kimirina's expertise in mobilization strategies for men who have sex with men regarding HIV testing is recognized and sought by the country's Ministry of Health.

A proposed modeling of a sexual health circuit/pathway for a person using drugs has been established based on the cross-cutting analysis of the treatment pathways of the four schemes studied.

Lastly, the cross-cutting analysis of the health services of the four schemes *(see chapter V)*, based on the more detailed presentations in the previous chapters, highlights the particular needs of key populations. Indeed, there is a prevalence of needs when it comes to assistance from peer educators on risk reduction and prevention geared towards people who practice chemsex, treatment of anal and genital conditions and other types of proctological pathologies, consideration of different socio-economic health determinants, as well as the importance of the roll-out of services in response to these needs in a national context where there is less or no recognition of these needs within public health systems.

The analysis also highlights the essential role of peer education in the health care pathways developed by each scheme.

The analysis of the various testimonies from users of these four schemes, who were interviewed on their pathways and their experience, revealed points of convergence particularly in their perceptions with regard to what defines these SHS schemes: the safe and family-like environment, the quality and efficiency of services, as well as the importance of their provision free of charge. The different user accounts also show a high level of empowerment that they have achieved with regard to their initial situation, even their willingness to engage with these schemes, and the development of a feeling of belonging to the community of users and to the values of the community-based association that created this SHS scheme.

Introduction

Issue

Sexual health, as defined by the WHO, is *"a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."* (WHO, 2006)[2].

For Coalition PLUS, **sexual health is an integral part** of the fight against AIDS, because:

"*If we want to bring an end to the HIV epidemic by 2030, the people most exposed to HIV must have access to quality health services adapted to their needs, regardless of their practices, their orientation, their gender identity, their profession, and their immigration status. **That's why we have been developing community sexual health clinics for a number of years.** These one-of-a-kind structures provide services designed and implemented by and for people infected with or exposed to risks of HIV infection with the support of educated and trained community-based health workers and health professionals."*[3]

The sexual health services (SHS) developed by the associations in the Coalition PLUS network are scalable services based on three fundamental principles of action[4]: ***a holistic, needs-based approach***, that is to say consideration of users' interconnected health and social needs; ***a community-based approach***, based on building the capacities of people from key population allowing them to take an active part in their own care, the role of peer educators and peer navigators[5] being essential in this regard; ***defense of human rights and the fight against violence, stigmatization and discrimination***, which involves advocacy actions as well as direct legal assistance to key populations[6].

Across Africa, Europe and Latin America, 24 sexual health clinics in the Coalition PLUS network offer not only prevention and medical treatment services, but also economic, psychological and legal support, notably in the case of violence[7].

Through an analysis of the community-based initiatives of four SHS settings — health clinics and/or centers implemented by the associations in the Coalition PLUS network in Mali, Ecuador, Cameroon and France — and through the formalization/documentation of the experiential knowledge of the community-based actors behind these settings, this capitalization report aims to demonstrate these three fundamental principles in action and highlight the added value of these settings for key populations.

This report aims to support to the associations in the Coalition PLUS network that are considering replicating and scaling up this response model, as well as to advocacy actions with a view to promoting community-based SHS among health authorities and their integration in national health systems.

The capitalization analysis specifically focused on the consideration by the SHS settings of users' life contexts, particularly in order to monitor the implementation of the three aforementioned fundamental principles of community-based SHS, as well as on users' experiences in the health care pathways proposed by the four settings and their perspective with regard to their own participation in the SHS.

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[2] World Health Organization. Sexual health
[3] Hakima Himmich, President of Coalition PLUS, AFRAVIH 2022. Source: https://www.coalitionplus.org/vih-sida-a-lafravih-marseille-2022-coalition-plus-se-mobilise-pour-la-sante-sexuelle%EF%BF%BC
[4] PFAO, Coalition PLUS. (2019). Sexual health services in West Africa: Bold, innovative solutions for access to care for key populations!
[5] Peer navigators: peers experienced in the sexual health system who know how to adequately support people in need of referral and act as a guide.
[6] PFAO, Coalition PLUS. (2019). Sexual health services in West Africa: Bold, innovative solutions for access to care for key populations!. pp.15-18
[7] Coalition PLUS, AFRAVIH 2022. Communique published on April 5, 2022, on the Coalition PLUS mobilization on sexual health for the AFRAVIH conference. VIH /sida : à l'AFRAVIH Marseille 2022, Coalition PLUS se mobilise pour la santé sexuelle - Coalition PLUS

Using a cross-cutting approach, we also put forward a preliminary outline for modeling users' health care pathways within the four settings as well as a comparative table of the services provided.

Document structure

The first four chapters of the report present, in the form of synoptic sheets, the different aspects of the implementation of SHS settings – national context, objectives, key moments in the development of the scheme, skills mobilized, partnerships, actors and skills mobilized, intervention strategy (mobilization of the target audience, user circuit and interconnection with their life context), results (audiences reached/services provided, advocacy actions, success factors), challenges encountered, levers to overcome them and lessons learned. Chapter V presents the full services of the four settings, illustrating the commonalities and specificities of each, as well as a proposed model of an optimal sexual health circuit. Chapter VI sets out a cross-cutting analysis of users' perspectives of their health care pathways within the settings and the way in which the health care pathways interlink with the current trajectory of their life path, as well as their engagement with the community-based approach.

Methodology

The four synoptic sheets were drawn up based on semi-structured individual and group interviews with the coordinators of each setting, an analysis of various documents and resources provided by the four organizations, as well as ad hoc documentary research to trace the history of the implementation of certain schemes, to understand and collect information relating to the health context of certain countries, etc.

The synoptic table of services was produced based on the model presented in the Coalition PLUS PFAO SHS regional guide[8] and based on the information gathered directly from the schemes' coordinators.

For the cross-cutting analysis of the SHS schemes through user testimonies, we carried out four semi-structured individual interviews. To develop the interview guides, we used elements of interpretative phenomenological analysis[9] and the pre-test phase of these among peer educators in the four SHS schemes. The four users interviewed represent several key population categories — a sex worker, a transgender person, a man having sex with men and a person who injects drugs.

The coordinators and users of the four settings were involved in all stages of the capitalization process, contributing clarifications, nuances and additional information.

[8] Ibidem 3, p. 26

[9] Method – IPA – (IPA) is a qualitative discourse analysis method [that] suits the understanding of individuals lived experience and their sense making of life events. Restivo, L., Julian-Reynier, C., Apostolidis, T. (2018). Pratiquer l'analyse interprétative phénoménologique : intérêts et illustration dans le cadre de l'enquête psychosociale par entretiens de recherche [Performing interpretative phenomenological analysis: A perspective for psychosocial investigation], Pratiques Psychologiques, 24(4), pp. 427-449. https://doi.org/10.1016/j.prps.2017.12.001

I. Factsheet 1: Le Spot & L'Antenne – AIDES and Le 190, Paris, France

1. Overview of the country context and the structure

According to Santé Publique France, global sexual health indicators are relatively good in this country. "*Since the 2000s, more than 85% of young people use a condom during their first sexual encounter. More than 80% of men and women say they are satisfied with their sex life. However, other indicators linked to sexual health are unsatisfactory. Despite progress in the recognition of the rights of LGBT individuals, discriminatory and violent attitudes persist towards them – in 2019, 35% of LGBT said they had experienced at least one form of discrimination at some point in their lives due to their sexual orientation or gender identity*"[10]. At the same time, HIV transmission, primarily sexual transmission, is a challenge for the health system and for community-based health actors. Men who have sex with men and heterosexual people born abroad remain the two populations most affected by HIV and respectively represented 42% and 38% of new HIV cases in 2020. From a geographic standpoint, the number of new HIV cases in relation to the total population is much higher in Île-de-France compared to the rest of mainland France[11]. Alongside HIV, the number of cases of certain bacterial STIs (gonococcal and/or chlamydial infections) continues to increase among men who have sex with men, but also among young heterosexuals[12].

With regard to men who have sex with men, the National Sexual Health Strategy, 2017-2030 Agenda, provides for means to "Strengthen wide-ranging prevention" Aim 1.1/56 and notably – promoting the use of condoms, regular screening for HIV and other sexually transmitted infections, knowing the HIV status of one's partner(s) and the use of **PrEP** and **TasP**, as well as to "*Develop an overall sexual health strategy that takes into account mental health, other chronic diseases, and the reduction of risks and damages related to addiction*" – Aim 1.1/58, one of the priorities of which is to **reduce the risks and harm related to "chemsex"**, in that they contribute to maintaining the dynamic of the HIV epidemic and to the increase of hepatitis C (HCV) infections in the homosexual population[13].

It should be noted, regarding the increase in HCV infections, that the systematization of "Test and Treat" for people newly infected with HCV in the acute phase was not in place. Some doctors refused this test-and-treat approach once direct-acting antivirals (DAAs) were available, on the grounds of a marketing authorization (MA) indicated for chronic and non-acute HCV infections or to achieve a potential spontaneous recovery. We now know that the impact of this approach could have favored lower transmission rates within the population and is beneficial for men who have sex with men living with HIV and infected with HCV[14].

PrEP is available in France since November 2015. Since January 2016, the social security system covers the full cost of this drug, 70% of the cost of consultations to begin treatment and between 60% and 100% of the cost of PrEP follow-up exams, as appropriate. The Bill on the modernization of the health system adopted in January 2016 provides for **PrEP** to be made available to those who are most at risk at free information, screening and diagnostic centers (CegiDD)[15].

Chemsex refers to the use of psychoactive drugs in a sexual context. This practice has wide-ranging repercussions on the mental and somatic health and on the emotional, social and economic lives of users[16]. In France, **chemsex** practices were identified in the mid-2000s, but surged in the early 2010s

[10] Santé Publique France. Santé sexuelle [Sexual health]
[11] VIH/sida - Santé publique France [HIV/AIDS - Santé publique France]
[12] Santé Publique France. Santé sexuelle [Sexual health]
[13] French Ministry of Social Affairs and Health. (2017). National Sexual Health Strategy 2017-2030, p. 36
[14] Castry, M., Cousien, A. & Supervie, V., Velter, A., Ghosn, J., Paltiel, A., Yazdanpanah, Y., & Deuffic-Burban, S. (2020). Impact of test-and-treat and risk reduction strategies on HCV transmission among MSM living with HIV in France: A modelling approach. Gut. 70. gutjnl-2020. doi: 10.1136/gutjnl-2020-321744
[15] https://vih.org/20151124/la-prep-en-france-et-ailleurs-dans-le-monde
[16] Fédération Addiction. (2021). Chemsex : un futur projet avec AIDES pour un accompagnement amélioré [Chemsex: a future project with AIDES for improved support]. federationaddiction.fr

with the arrival of new synthetic products[17]. A **report on chemsex in France**[18], commissioned by the Ministry of Health published on March 17, 2022 and open to criticism in certain areas, underlines the importance of actions in the areas of prevention, risk reduction and identification of complications by the community-based associations concerned, in collaboration and close cooperation for referral and treatment with medical-social structures and hospitals concerned with the global health issues connected with chemsex practices[19].

Created in 1984, **AIDES** is the leading association in the fight against AIDS and hepatitis in France and Europe. AIDES operates across the entire country for and with HIV-positive individuals and the populations most at risk of HIV and viral hepatitis. The association plays a major role in improving recognition of patients in the health system in France, advances in the rights of at-risk individuals and the fight against discrimination. The association runs outreach actions in addition to actions on its premises[20].

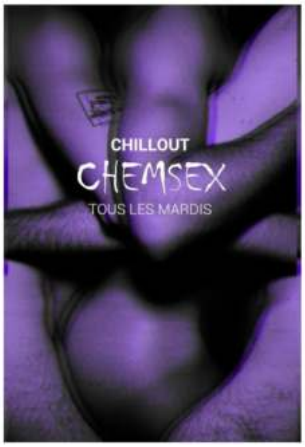
Le 190 is a private, non-profit community health center that aims to break down the barriers to prevention, screening and treatment by combining community-based support and biomedical techniques with the sole aim of lowering the epidemic of HIV/AIDS infections within the population of its users[21]. Supported by AIDS since 2016, Le 190 created the first chemsex addiction treatment service in 2012. Its satellite center, L'Antenne, at Le Spot Beaumarchais covers certain medical activities directly and refers patients to Le 190 for others. Note that the two sites are in close geographic proximity.

2. Implementation of the scheme

2.1 Opening of the center, health services and key moments

Created in 2016, Le Spot Beaumarchais in Paris is one of four sexual health centers run by the association AIDES in France[22] dedicated to men who have sex with men (cis and trans). Close to the Marais district of Paris, an area with a strong gay community presence, the center addresses two needs identified with this population: 1) having a respectful and secure center managed by peers, where they can discuss their life practices (notably chemsex and other at-risk practices) without moral judgment; 2) making PrEP more accessible and developing a preventive approach, at a time when appointments to begin treatment were still difficult to obtain.

Before PrEP became available in France in December 2015, HIV-negative men who have sex with men who received support from AIDES between 2012 and end 2014 and had declared being at high risk of HIV, took part in the ANRS IPERGAY[23] study on on-demand PrEP. The study generated widespread interest in this new treatment, in a context where government authorization was still uncertain; AIDES consequently began examining the possibility of a community site for PrEP initiation as of the end of 2014, with imported generic drugs.



In January 2016, PrEP became available in France. AIDES continued with its plans for a sexual health center for men who have sex with men in Paris, which opened in May 2016. Between May and October 2016, the team at Le Spot Beaumarchais consulted widely to assess needs and to reflect on the center's actions[24]. A gay health think tank was put in place, bringing together men who have sex with men involved in community-based health in Paris. As the group's meetings progressed, the subject of chemsex emerged — it came to the attention of the group that there were no community spaces linked to this practice in Île-de-France. The **Chillout Chemsex** action was thus initiated at Le Spot: weekly meetings for people who want to talk freely about products consumed, pleasure and complications, jointly led by a sex therapist and AIDES peer educators. Participants in the Chillout evenings were then invited to take part in the think tank, which led to the idea of providing support to

[17] Benyamina A. (2022). Rapport « Chemsex » ["Chemsex" report], p.4
[18] Rapport « Chemsex » ["Chemsex" report]
[19] Rapport « Chemsex » ["Chemsex" report], p. 41-42.
[20] AIDES en France [AIDES in France]
[21] Qui sommes-nous – Le190 [Who we are – Le 190]
[22] The three others are in Marseille, Montpellier and Nice.
[23] ANRS | Maladies infectieuses émergentes. (2016, 20 juillet). Press release from July 20, 2016 regarding « Résultats finaux de l'essai ANRS IPERGAY : la très haute efficacité de la PrEP à la demande est confirmée » [High efficacy of on-demand pre-exposure prophylaxis confirmed by final results from ANRS IPERGAY]
[24] Spot Beaumarchais : un point d'étape et des rendez-vous [Spot Beaumarchais: update and meetings]. Seronet

stop taking psychoactive products in a sexual context. An initial pilot pathway was developed in 2016 by a consumer who had experience of quitting this practice. It should be noted that the subject of chemsex was already an increasingly common topic in the gay community in Paris at that time.

"It was then that people realized that their friends were dying every other week or every week and that it's not fun to realize that your friends are no longer dying of HIV, that everyone has treatment. If there is a death, it's sadly a consequence of chemsex. That's also what led Le Spot to focus on chemsex." - Stéphane Morel, AIDES, coordinator Le Spot & L'Antenne

In the first five years of operation, Le Spot offered other activities: HIV and STI testing and peer counseling, distribution of condoms and risk reduction equipment for drug users. Le Spot also developed partnerships with different health system structures, both public and community-based, to recruit users from these structures in need of peer support on issues related to chemsex and referral, on medical aspects (treatment, exams, etc.), to these structures of people visiting and receiving support from Le Spot. **Le 190** sexual health center, around two kilometers from Le Spot, was one of these partnerships from the outset. Le Spot referred its users who tested HIV positive to Le 190 for confirmation tests and treatment initiation, and in return received chemsexers referred from **Le 190** for peer support (motivational interviews, support groups, etc.). In 2019, the partnership between the two structures resulted in a new element added to the services at Le Spot: **on-site PrEP consultations and treatment initiation**, following a negative HIV rapid diagnostic test, conducted by Michel Ohayon, general practitioner and medical director of Le 190. This new collaboration allowed Le Spot to step up PrEP initiation among HIV-negative chemsexers who did not yet have access to this treatment[25].

The two structures also began discussions in 2019 on a joint service offer. The Le Spot team was already considering a framework to allow them to develop medical services on its premises, while Le 190 (which had set up a psychological/addiction/sexology support service[26] for chemsexers several years ago) wanted to work on a more specific mental health and wellness support program for people who need to stop chemsex. The exchanges between the two associations and the amendment in 2021 of Article 51 of the Social Security Financing Act in France on experimentation with new sexual health care pathways[27] allowed Le 190, as a CeGIDD[28], to expand its activity in the form of a satellite site, which took shape in **November 2021** with the inauguration of **Le Spot & L'Antenne** (190) at Le Spot Beaumarchais premises.

*"Le Spot's premises allowed for the introduction of a hybrid service where we could provide medical assistance as well as peer support, which was something we already did elsewhere. So it became **Le Spot & L'Antenne.** In practice, we work as two different entities at the same site, but we work together." Stéphane Morel, AIDES, coordinator Le Spot & L'Antenne*

Two parallel service offers at Le Spot & L'Antenne:

Test & PrEP

- Testing for all STIs using RDT and/or self-testing
- PrEP initiation (possible on the day of testing)

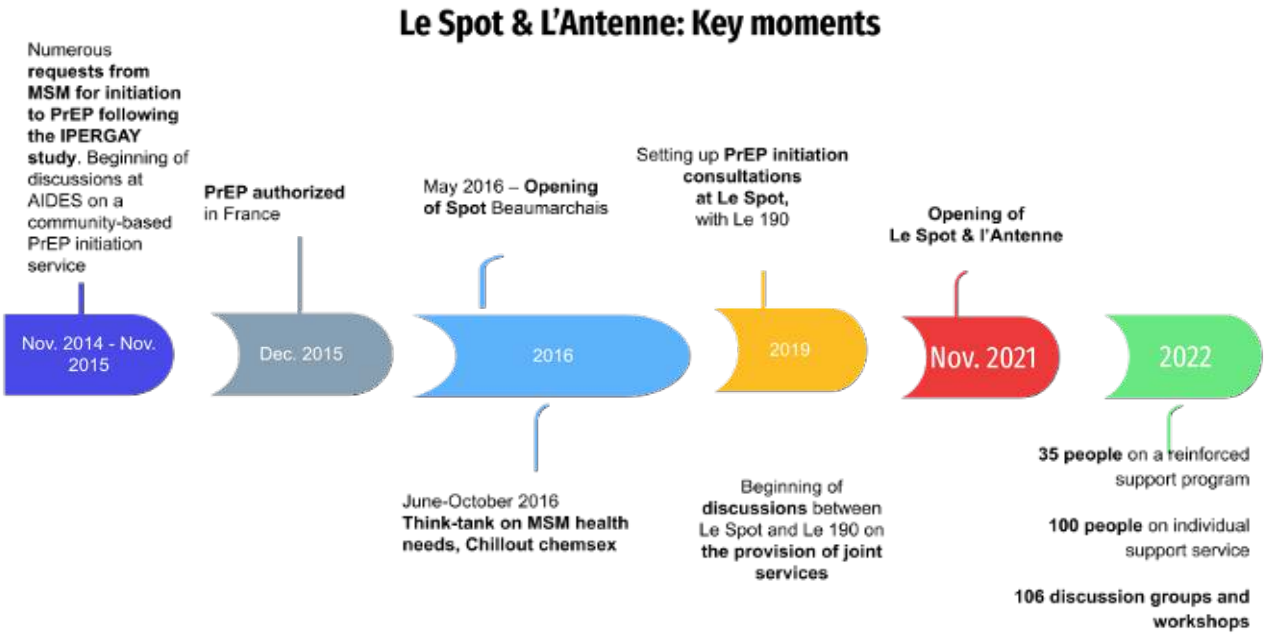
[25] According to the Spot team's estimates, about 60% of its users at the time were HIV-negative, and of those who were HIV-negative, 20% were not on PrEP.
[26] Ce qu'on fait – Le190 [What we do – Le 190].
[27] The Social Security Financing Act of 2018 introduced, in its Article 51, a framework for experimentation with new health organizations based on new methods of financing. In 2021, the article was supplemented by new experimentations in the field of sexual health: four sexual health centers open to all members of the public in priority regions to provide a global response to health needs and a "test and treat" service through a specific community-based approach aimed at target populations – men who have sex with men, transgender people, sex workers. French Ministry of Social Affairs and Health. (2021). Rapport au Parlement 2021 sur les expérimentations innovantes en santé [Report to Parliament 2021 on innovative health experiments], p.122.
[28] Free information, screening and diagnostic centers (publicly funded).

- Referral to a PrEP follow-up service in ambulatory care

Chemsex and mental health
- Information and HR/SHR with happy chemsexers
- Support for people in difficulty with chemsex
- Reinforced follow-up for a dozen people over 3 months
- Preparation/referral for hospitalization and post-hospitalization

The staff at the two structures (Le Spot & L'Antenne 190) bring their own expertise to these two offers. For chemsex, the doctors at L'Antenne help people in difficulty linked to drug use (mental health and physical health), while the peer educators at Le Spot work on prevention/harm reduction linked to drug use in a sexual context, but also on regular motivational follow-up of users based on their goal. The same goes for Test & PrEP, where L'Antenne care providers are responsible for PrEP initiation (in accordance with the partnership in place since 2019) and other medical aspects linked to HIV and STIs, while the community workers at Le Spot provide information on dating websites and applications and organize the reception of users, regular motivational follow-up, external referral and connection to PrEP follow-up in ambulatory care.

Le Spot & L'Antenne: Key moments



2.2 Main actors and skills mobilized

- 1 coordinator
- 5 community workers
- 3 general practitioners: addiction treatment follow-up consultations, Test & PrEP
- 1 psychologist
- 1 sexologist
- 1 hypnotherapist
- 4 nurses
- 4 reception/admin staff

2.3 Partners *(non-exhaustive)*

- **Partnership with a sex therapist at Marmottan Hospital in Paris**[29], specialized in addictions, who co-runs each of the two weekly support groups at Le Spot — **Chillout chemsex** and **Chillout abstinents** (for people who want to take a break from or stop chemsex) — once a month. The therapist refers the hospital's patients to the center's groups and also facilitates treatment at the hospital of users receiving support from the center.

- **Informal partnerships with the APTE addiction treatment, support and prevention center of the Aurore association in Bucy le Long, with the addiction treatment teams at Pitié-Salpêtrière hospital in Paris**[30] and **with the Association Traits d'Union**[31] (social and medical-social services and establishments, communal housing) which provide support for users during their consumption severance. The center works on diversifying hospitalization and housing solutions to this effect.

- **Partnership with psychologists at the Institut Alfred Fournier**[32] in Paris for cross-referrals of users.

- **Partnership with** the association Séropotes to jointly run the **DISpositif** evening — a monthly discussion group for men who have sex with men and who are living with HIV.

- **In 2022, Le Spot & L'Antenne submitted funding applications to the Île-de-France Regional Health Authority (ARS).** Prior to that, all activities at Le Spot Beaumarchais were funded by AIDES.

- **Partnership under development with the association OUTrans**[33] (feminist trans self-help association) with a view to the introduction of walk-in hours with the possibility of endocrinology consultations.

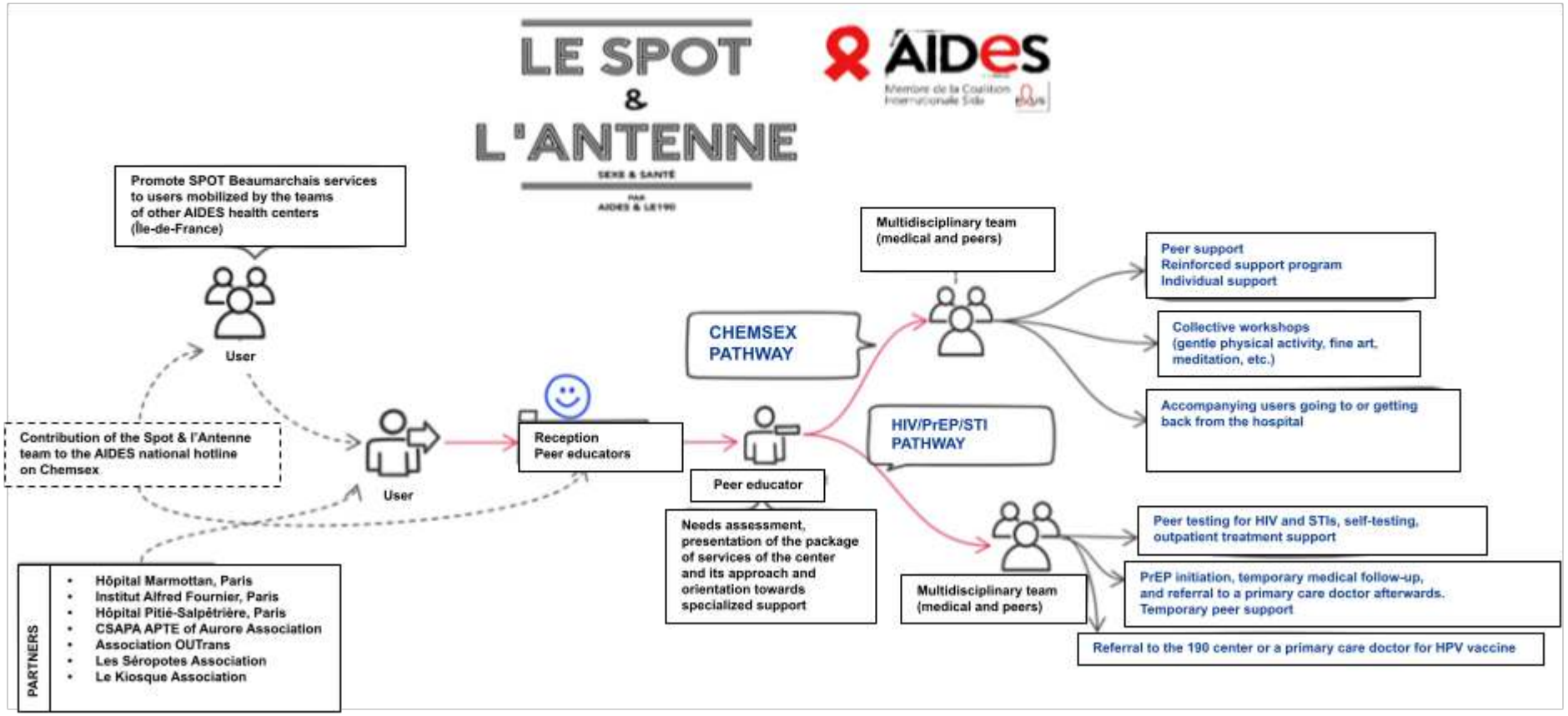
2.4 The scheme's intervention strategy

2.4.1 Mobilization of the target audience

Le 190 recruits most users for the new Antenne at the sexual health center established since 2012. Le Spot, meanwhile, whose team is primarily composed of employees, promotes its services among users of the other AIDES outreach teams in Île-de-France. The AIDES teams specialized in prevention operations in community-based establishments (clubs, saunas, etc.) among people who practice chemsex have been approached with a view to referring users who could benefit from the center's services and its chemsex program. For the Test & PrEP pathway, walk-in referral coupons for Le Spot (with two boxes to check: PrEP need and/or STI needs) were distributed to all of the AIDES Paris teams. Le Spot team also contributes to the national AIDES chemsex hotline on WhatsApp, Signal and Telegram. When they come to Le Spot, all users are also invited to sign up to a weekly newsletter also posted on social media. Another monthly newsletter aimed at health professionals is currently under production.

[29] Marmottan Hospital - Center for Care and Support for Addictive Practices.
[30] Hôpitaux Universitaires Pitié Salpêtrière
[31] Présentation - La maison des enfants [Presentation – La maison des enfants]
[32] Institut Alfred Fournier
[33] Équipe, statuts et règlement intérieur – OUTrans – Association féministe d'autosupport trans à Paris [Team, statutes and internal regulations – OUTrans – Feminist trans self-help association in Paris]

2.4.2 User circuit at Le Spot & L'Antenne



I. Welcome The person is welcomed by a peer educator at reception. They are made to feel at ease while waiting for the assessment interview with a peer worker.

II. Needs assessment interview with a peer worker and referral to specialized support (immediately or by appointment). Assessment of the person's needs, presentation of the center's services and its non-judgmental approach . Choice of a suitable health care pathway by the user. At this stage, all users are seen with and without appointments. Given that there are two health care pathways with different hours, the availability of peers for the HIV (test, PrEP) and STI pathway is more limited and interviews are more frequently conducted by phone:

Chemsex pathway
Walk-in assessment interview: **3 p.m. to 7 p.m. Tuesday to Friday.** Healthcare team generally available by appointment, except for emergencies.

HIV (test, PrEP) and STI pathway
Walk-in: **Thursday 3 p.m. to 7 p.m**. People are, if possible, directly referred to care providers or otherwise by later appointment, after a brief needs assessment at reception. They are then all contacted by a peer worker for an initial motivational follow-up phone interview.

III. Specialized support
Users' intake to the pathway is defined collectively, after discussions and validation by the center's joint team. Particular attention is paid to not duplicating medical services that the user already benefits from elsewhere, as well as providing specialized support involving a team (i.e., several professionals at Le Spot & L'Antenne and not just one).

Chemsex pathway, Healthcare services:

1 - Consultations and treatment: general practitioner, nurse, addiction expert, psychologist, sexologist, peer workers, auriculotherapy expert, foot reflexology expert. By appointment, Monday to Friday. Medical prescriptions issued are renewable remotely, up to 12 months after the last face-to-face prescription, through any site and any remote medical consultation applications.

2 - Peer support (2 options): during the assessment interview, we present the support options and different workshops to the user. This can be simple peer support (weekly or twice monthly).

A - Motivational interviews with peers, by appointment;
B - Reinforced community-based support for 10 people in pre-treatment or aftercare, with the aspiration to stop or not. Users are seen at Le Spot three to four times per week in addition to their appointment with care providers and peer workers: workshops, self-help groups and friendly interactions; coordination with care providers and peer workers with the aim of empowerment.

3 - Group workshops: moderate physical activities, art, mindfulness meditation, hypnosis, etc.

4 - Support for users for hospitalization and/or recovery after discharge.

HIV (test, PrEP, etc.) and STI pathway. Healthcare services:

1. Consultations: general practitioner, nurse. By appointment: Tuesdays from 1 p.m. to 7 p.m. and Wednesdays and Thursdays from 3 p.m. to 7 p.m. Medical prescriptions issued are renewable remotely, up to 12 months after the last face-to-face prescription, via the LIVI application.

2. HIV + all STI screening through rapid tests and advice (by peers) and self-testing, support for external treatment initiation. Users who test positive for HIV are referred to Le 190 center.

3. PrEP initiation without prescription, on-site prescriptions. Medical follow-up up until the appointment one month after initiation and referral to ambulatory care afterwards. Peer support is given through regular phone appointments during the first six months of use and then on request by phone message.

4. Vaccination against HPV – referral to Le 190 or ambulatory care.

2.4.3. Linking services with users' life contexts

- Partnerships under development on social rights issues. Some users living in a vulnerable situation need support to access the different State social services. In partnership with the association Le Kiosque[34] (AIDS and drug addiction information), a care pathway for access to social rights is currently under development.

- Informal exchanges, social activities outside of the center, leisure activities. The discussion groups and workshops held every evening at the center are usually followed by informal exchanges lasting around 30 minutes between the peer counselors and users on the topic of the workshop, or on any other topic raised by the users. These informal exchanges also take place after individual interviews. The discussion topics can vary from the issue directly concerning users to their life context in general. These discussions can also take place during cigarette breaks, in the reception area, during waiting periods or as users are leaving. During these exchanges, new ideas for activities can emerge, like the **Apéro Free'k'end** [Drink Free'k'end], notably initiated following a discussion after one of the **Chillout Abstinents** [Abstinent Chillout] evenings where users expressed their interest in a more convivial evening. This laid-back get-together is now held every Friday evening for LGBTQI+ people who want to socialize, laugh, put forward suggestions, organize or participate in activities over the weekend (visits, walks, board games, cinema, etc.) and is linked to a WhatsApp group comprising participants in this 'Apéro'.

3. Results

3.1 Number of users per year at Le Spot & L'Antenne

Around 35 people on the Chemsex reinforced support program (PARC).
Around 100 people for Chemsex individual support from peers over short periods (motivational interviews, etc.).
329 people for peer support on the PrEP pathway in 2021
106 self-help groups set up in 2021.
2 to 4 self-help groups and 4 workshops per week in 2022.

3.2 Advocacy actions

A focus area of advocacy considered by Le Spot & L'Antenne **concerns the valorization of peers as health mediators**[35] **in public health establishments.**

The presence of a community health mediator in hospitals and health facilities and centers who work with chemsexers, men who have sex with men (cis and trans) is vital to the quality of care; however, it is still not sufficiently established, is low-profile at those sites where it is, and remains still too poorly integrated by health professionals. The challenge of advocacy for community workers is therefore to raise awareness and to mobilize professionals as well as the authorities in this regard in order to raise its profile.

The experience of the IPERGAY study *(see note 13)* jointly led by AIDES revealed to what extent peer health mediators can drive forward the interactions between patients and hospital healthcare teams. Beyond their contribution to passing on the specific needs of patients, peer mediators acted as an interface and regularly direct patients to care providers (for specific matters like drug use, medication and vaccination) by strengthening patients' confidence in hospital personnel. This allowed doctors to understand the added value of mediators. *"The doctors in the IPERGAY study stated that working alongside community-based workers completely transformed their practice. It also changed my practice*

[34] http://www.lekiosque.org/le-kiosque
[35] Health mediation establishes a connection between people far removed from prevention and healthcare on the one hand, and the actors in the health system on the other hand. falls clearly within the field of public health and the initiatives to promote health and refers to the outreach interface function to facilitate, on the one hand, access to rights, to prevention and to treatment for the most vulnerable populations and, on the other hand, awareness-raising for stakeholders in the health system regarding the barriers of populations in accessing healthcare. Haute Autorité de Santé. (2017). La médiation en santé pour les personnes éloignées des systèmes de prévention et de soins [Health mediation for people outside prevention and care systems], p.9

of working with doctors, because you gain an entirely different understanding." *Stéphane Morel, AIDES, coordinator Le Spot & L'Antenne*

3.3 Success factors

- **Co-evaluation and adapting services with users**. After the introduction of the first Chemsex reinforced support program, the team at the center organized a discussion session with the first 10 users to evaluate their satisfaction, hear their impressions of the workshops, the hours and days chosen, and suggestions for improvement. Some activities in the program had to be adapted. These sessions during the long-term support program are currently being structured to become a permanent feature.

- **Having a care provider (doctor, nurse) /peer educator pair who listen to users on the health care pathways facilitates the sharing of information in a climate of trust.** The presence of peer educators as discussion facilitators instills trust in users and also allows care providers to recognize and appreciate their skills in terms of passing on the needs of users.

- **Presence of peer workers on the center's team who understand the dynamics of dependence and addiction, and who are also able to facilitate this understanding for users-consumers.** Some skills were acquired by the staff at Le Spot from Narcotiques Anonymes, the French branch of the association Narcotics Anonymous[36] (NA). Some workers also have direct experience of addiction, which can be an asset in this type of service.

- **The presence of this Le 190 satellite site, L'Antenne, made it possible to offer full STI testing to users of Le Spot.** Beforehand, gonococcal and chlamydial infections could not be tested for at Le Spot, despite the fact that these STIs are most often asymptomatic.

- **Weekly two-hour meetings attended by the center's joint team (Le Spot & L'Antenne)** on the follow-up of the center's users, pathways and practical everyday questions ensure coordination and mutual updating, while the AIDES and Le 190 teams are respectively present at the site from 11 a.m. to 10 p.m. and from 3 p.m. to 7 p.m.

4. Challenges, levers and key lessons

- One of the major challenges of the Le Spot & L'Antenne partnership **is learning to function between professionals who come from different contexts (peers and healthcare professionals) and who are not used to working together**. Taking the time to **listen to one another** and talk is vital. Working together on a common definition of the community-based approach, responding to frustrations that can come to light in this sometimes long process of pooling. It is also a process of co-constructing **mutual trust** between peers and care providers, which requires, for example, the acceptance by peers of the inability to put in place an activity due to the technical limits or the risks identified by the care providers, or greater flexibility on the part of care providers when support workshops are initiated by the users themselves.

- **Effectively managing the workload of individual peer workers (motivational interviews), preventing an emotional overload.** The difficult topics and contexts that are shared by users during motivational interviews can have an impact on the emotional stability of the peers who provide them with support. In order to prevent this, the team at the center decided to set a maximum of four interviews per day and per peer, given that the peer workers have administrative tasks to manage; a notion of social support may be added to their everyday tasks.

- **One of the limits is the sharing of dossiers/interview records between the different members of staff (peers, care providers)**, given that each health professional includes what they deem necessary to share. The difficulty lies in the fact that the peer workers do not have access to the files; yet the role of peer worker is also to make sense of some points or complex medical data.

[36] What is Narcotiques Anonymes? Presentation of NA France. "NA is a nonprofit fellowship or society of men and women for whom drugs had become a major problem."

- **Consideration is being given to the users supported who have a certain distance with their initial problem (people who have stopped using, for example) and who have expressed an interest in becoming volunteers at the center**. The question is: how could they be included in the development of the center's services? Some possible options include: suggesting that they set up new activities and hubs with regard to the current services; including them in existing activities and setting aside a time to help them get started; simply asking them – how do you see your involvement? – and drawing up an integration plan based on the answer.
- **The location of injection equipment distribution in an area used by all people at Le Spot, next to reception, is inappropriate for users who have stopped using drugs who often pass by**. For now, the current space does not allow for better circulation that could avoid this inconvenience, hence kits have been created to reduce the visibility of harm reduction material while keeping in place the consultation time for its handover.
- **When activities and meetings are scheduled, allow for flexibility in the timetable while keeping free periods to compensate for any unforeseeable circumstance** , for example, the need to push back the meetings of people running late, or address unexpected requests or activities and urgent situations that may arise.
- **Put greater efforts into communication, particularly a website for Le Spot & L'Antenne, which is currently lacking**. This is a project that the center intends to implement.

II. Factsheet 2: Access Medical Center– Alternatives-Cameroun, Douala, Cameroon

1. Overview of the country context and the structure

In 2021, Cameroon had a HIV prevalence rate of 2.9% (of which 3.8% among women and 1.8% among men) within the general population aged 15 to 49[37].
According to the Unity Platform, there has been a continuous upsurge in violence against sexual and gender minorities[38].
Legislation in Cameroon criminalizes same-sex sexual acts – "any person who has sexual intercourse with a person of the same sex" risks a sentence of up to 5 years in prison (Art. 347.1 of the new Cameroon Penal Code) – while Article 83 of the law on cybercrime and cybersecurity punishes "any person who make sexual advances towards someone of the same sex through communication technologies" with a sentence of up to two years in prison. This sentence is doubled if these advances lead to sexual relations.
On the basis of these articles, people are arrested and incarcerated, often arbitrarily and in breach of the Code of Criminal Procedure[39]. LGBTQI+ individuals are also victims of physical and/or psychological violence, cases of which have been on the rise in recent years. In 2020, there were more than 2,000 cases of violence and violations of rights affecting 930 members of sexual and gender minorities, compared to 1,400 cases in 2019. More than half of the reported cases involved psychological violence, with the rest consisting of cases of physical, sexual, economic or legal violence and hate speech. Men who have sex with men were the most affected victims of violence (552), followed by women who have sex with women (214) and transgender people (64)[40]. The consequences of these acts of violence and violation of rights on the physical and psychological health of sexual minorities were highlighted by a community-based study in 2017, according to which almost one-third of gay men and lesbian women suffer from severe depression (the national average for depression in Cameroon, according to the WHO, was less than 5% of the general population in 2018). Lastly, in 2016, an IBBS (Integrated Biological and Behavioral Surveillance) study on key populations showed that HIV infection rates are twice as high among key populations who are victims of violence compared to those who had not suffered from violence[41]. The acts of violence suffered by LGBQTI+ individuals drive them underground and prevent them from accessing the prevention and treatment services they need.

It was within this context that young activists in Douala decided to create **Alternatives-Cameroun** in 2016 to assert the rights of sexual minorities: rights to health, education, information, privacy, etc.[42]. With a multi-disciplinary team of around 40 people and 2 community medical centers in Douala (2008) and Yaoundé (2020)[43], the association provides support and assistance to victims of sexual- and gender-based violence and provides care, listening, information and treatment services for HIV, STIs and hepatitis[44]. Since 2015, the association runs

[37] https://www.unaids.org/en/regionscountries/countries/cameroon
[38] See "Rapport annuel 2020 sur la violence à l'encontre des minorités sexuelles et de genre au Cameroun" [Annual Report 2020 on violence against sexual and gender minorities in Cameroon]
[39] Humanity First Cameroon, Alternatives-Cameroun. (2019). Rapport annuel 2018 des violences et violations faites aux minorités sexuelles et de genre au Cameroun" [Annual Report 2018 on violence and violations against sexual and gender minorities in Cameroon], p. 6. http://www.coalitionplus.org/wp-content/uploads/2019/05/RAPPORT-DE-VIOLATION-LGBTI-AU-CAMEROUN-2018-FINAL-1.pdf
[40] UNITY Platform publishes annual report on violence against sexual and gender minorities in Cameroon
[41] Humanity First Cameroon, Alternatives-Cameroun, loc. cit. (IBBS data cited by UNAIDS).
[42] Alternatives-Cameroun (ACM) - Plateforme Elsa
[43] Information gathered during an interview on May 4, 2022 with Joachim Ntetmen Mbetbo, Programs Director, and Hermine Ngo Ndaptie, Health Officer.
[44] Coalition PLUS. (2019). Communique on Combattre l'homophobie pour vaincre le sida : une urgence ! - Coalition PLUS [Fighting homophobia to end AIDS is an emergency!]

training for institutional actors in the health system (doctors, authorities, etc.) on the rights, vulnerabilities and needs of key populations.

2. Implementation of the scheme

2.1 Opening of the center, health services and key moments

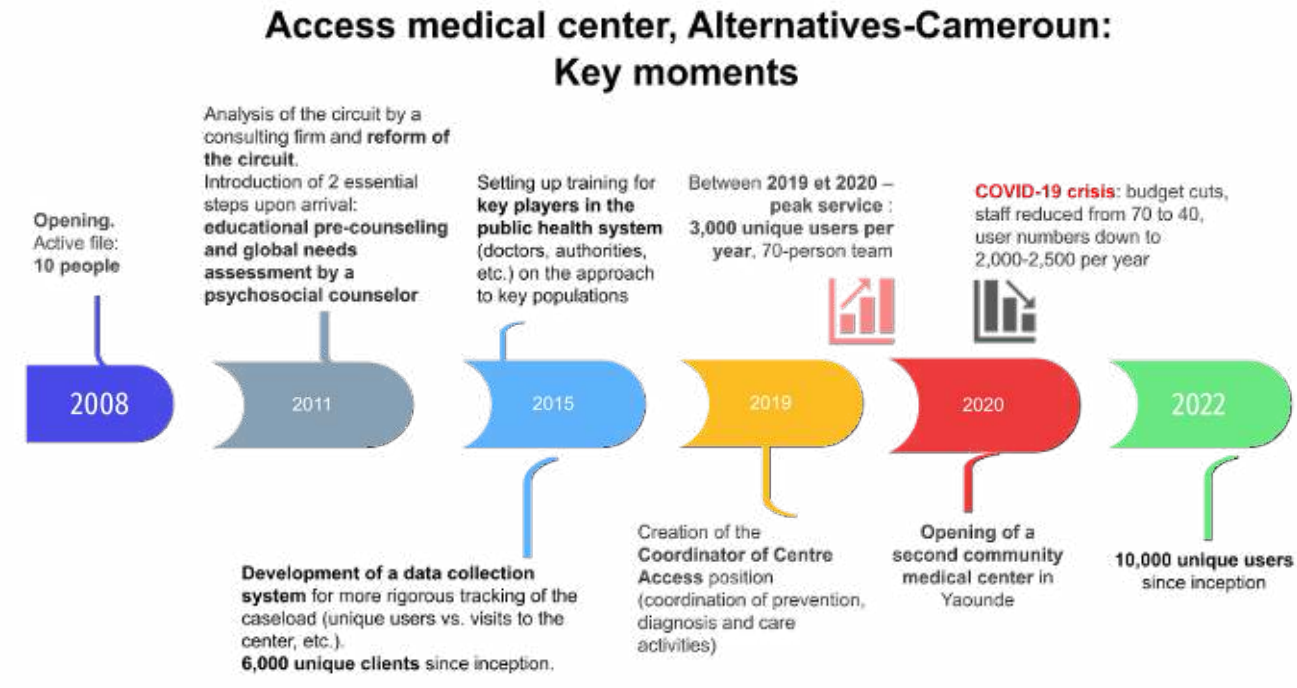
Access medical center in Douala was originally created in 2008 to combat the discrimination and violence against LGBTQI+ people within Cameroonian society and the difficulties in access to the country's health services due to their sexual orientation. The goal of the creation of this structure was to offer people a platform to express their experience, as sexual minorities, and their health issues. The vulnerability of the first users in terms of health-related information prompted the center's team to develop adapted healthcare services, centered on:

- ➢ diagnosis, treatment and prevention of HIV and STIs;
- ➢ reproductive health;
- ➢ perianal pathologies.

Specific topics were incorporated into the center's health services over the years, including:

- balance of power in couples,
- GBV,
- sexual and emotional fulfillment (shared life plans, sexual dysfunction, sexual identity management strategies and sexual rights),
- hormone treatment for transgender people,
- awareness of HIV status among the person's entourage,
- guidance with job-searching,
- family mediation,
- housing solutions for people rejected by their families,
- help in obtaining identity documents.

Access medical center: key moments



In 2018, Alternatives-Cameroun recruited a focal point in Yaoundé, the country's capital and second largest city, for advocacy activities aimed at State, technical and diplomatic partners. In January 2020, a second community medical center was opened by the association in Yaoundé, in the Biyem Assi district, an area with a large number of people from key populations: the LGBTQI+ community, people who inject drugs, sex workers. Nowadays, the Yaoundé center provides identical services to the one in Douala in terms of diagnosis, but is less advanced in treatment services[45].

The two Alternatives-Cameroun health centers, along with other similar initiatives at community level, counterbalance the near vacuum in the public health system in terms of services adapted to the needs of the populations most vulnerable to HIV and STIs. Indeed, the sexual health and reproductive services available in some public health centers are limited to family planning. HIV testing is offered by medical-social centers, school and university nurses, according to the Sectoral Plan for HIV/AIDS adopted by the authorities in 2020[46]. However, the activity of these centers is limited, according to the association's activists, to isolated testing actions without addressing the different determinants of health (social, legal, economic) and without holistically assessing the health needs of the people exposed to risk of HIV infection .

2.2 Main actors, skills and resources mobilized

The team at the Access medical center in Douala**:**

- A **center coordinator**, since 2019, who oversees all of the prevention, diagnosis and treatment services.

- A Health Department, including: **two doctors** – **one general practitioner**, full time, with skills in proctology[47] and **one specialist in dermatology, venereology and proctology,** a service provider, offering consultations once a week; **one nurse; three psychosocial counselors; one psychologist; one social worker; one laboratory technician; one pharmacist; one dietitian.** The Douala center has a laboratory and a community pharmacy. A central role in this department is played by the *psychosocial counselor* who, other than providing psychosocial support to users, also assesses their needs, which can lead to a referral to another internal or external service. The counselors generally have a diploma in social sciences and/or at least two years' experience in support work. It is a position that also requires a certain dynamism – the counselor must reach out to users in the community, make home visits and undertake continuous learning and training as it is important to constantly return to the basics of psychosocial support in order to best respond to the specific needs of key populations.

- A Community Engagement Department, including two types of **peer educators**: those who run walk-in counseling and referral for users at the center, and those who solely work in the community, also known as peer mobilizers, and community outreach workers.

- Positions dedicated to human and gender rights issues: **a paralegal, a Human Rights Watch entity supervised by the Advocacy Officer, a Gender Ambassador**.

2.3 Partners

- Technical and financial support from Sidaction[48] has been in place since before the center even opened – the French association encouraged the Alternatives-Cameroun team to open the first center in 2008 and continues to be one of its main partners for the medical care aspect.

[45] L'ouverture officielle du centre Alternatives-Cameroun à Yaoundé [The official opening of the Alternatives-Cameroun center in Yaoundé]. 76 Crimes en français
[46] Enseignement supérieur : le sida, hors des campus [Higher education: HIV/AIDS, off campus]
[47] Skills acquired through capacity building, put in place by the Coalition PLUS West Africa Platform (PFAO), coordinated by ARCAD Santé PLUS (Mali)
[48] Notre organisation | Sidaction - French AIDS association.

- PEPFAR[49] has also contributed to the center's development through financing for the CHAMPS Project[50], which encompasses some of its prevention, care and treatment services.

- A pharmacy in the city of Douala, which allows users to freely collect drugs prescribed by the center's doctors that are not available at the community pharmacy. The costs are reimbursed by the association at the end of the month.

- Partnership with a surgeon at public hospital in Douala, which allows users to undergo free proctological procedures (also covered by the association).

- Various partnerships with associations for a joint response to gender- and identity-based violence, in terms of advocacy/legal aid, etc.

2.4 The Douala Access center's intervention strategy

2.4.1 Mobilization of the target audience

The target population of the Access center is comprised of men who have sex with men, women who have sex with women, transgender people, intersex people, and people who use drugs. Most of the beneficiaries live in Douala and Yaoundé, while a small proportion live on the outskirts or in rural areas.

The sexual health services are run at the center and as outreach activities – at places of work or socialization for key populations. The majority of people in need of care come to the health center as a result of this outreach work within the community. In general, a peer educator and a community outreach worker with previous training carry out door-to-door activities. This intervention consists of: the assessment of the risk of HIV infection and various STIs, and of the signs and symptoms of anal pathologies (pain, bleeding, lumps) using the risk assessment grids drawn up by specialist doctors, as well as of GBV; HIV testing is offered, either via a rapid test done there and then, using a test strip, with an instant result, or via distribution of self-tests, with guidance adapted to the person; if the HIV test comes back negative, the peer educator explains the advantages of PrEP to the person and invites them to visit the center to start treatment. Generally speaking, if the peer educator does not feel able to provide the person with an appropriate response, they invite them to visit the Access medical center for a specialist consultation.

It should also be noted that some beneficiaries subsequently become peer educators themselves. After receiving training from the team at the center, they go out to meet their peers in the community. Another relatively effective way of recruiting users is mobilization within a target group; for example, transgender people often refer other transgender people to the center.

The outreach strategy also involves the use of two-person follow-up between the peer educator and the psychosocial counselor to treat people who test positive for HIV. Before the peer educator goes out into the community, the two actors coordinate to ensure the counselor's availability in case of a positive test result. In the latter case, the peer educator contacts the counselor so that they can come out and accompany the person tested to the hospital for confirmation and to start treatment.

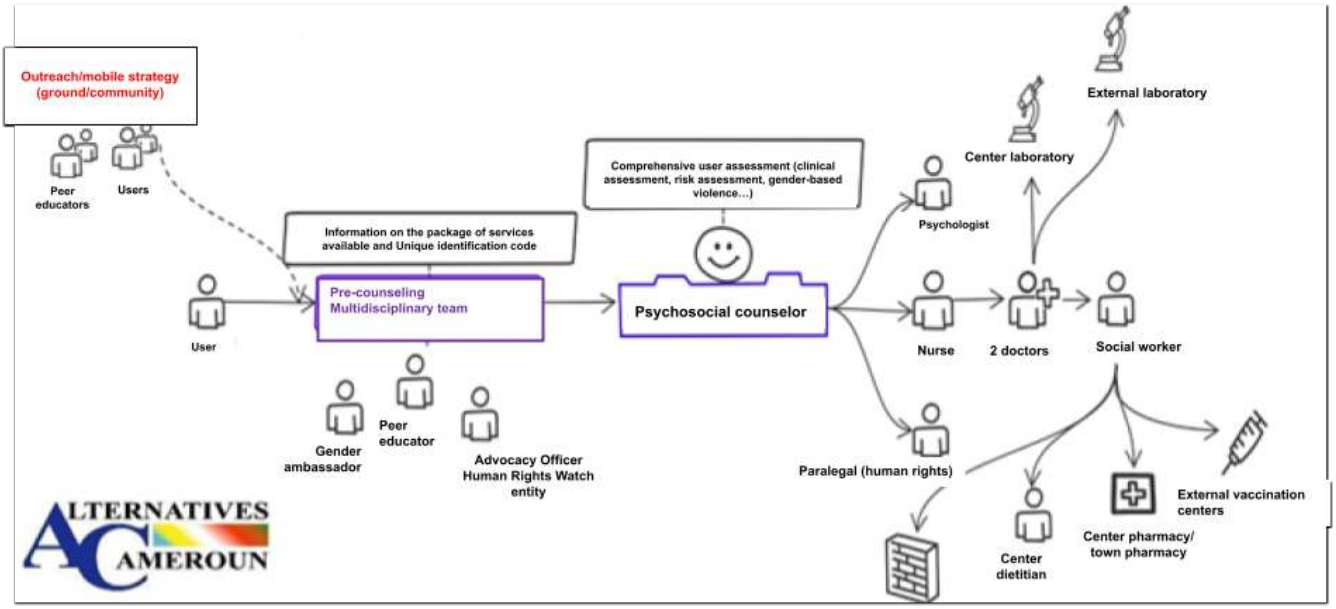
2.4.2 User circuit at the Douala Access center

The initial user circuit at the Access center was a response to the patient's health request. Despite the diversity of specialties covered, it was the user who assessed their own health needs and sought out services. This model encouraged a relatively limited interaction with the center's sexual health services. For example, a person who associated their needs with the specific skills of a doctor or nurse would solely interact with that individual, without knowledge of the other specialties available, such as

[49] PEPFAR: U.S. President's Emergency Plan for AIDS Relief.
[50] The CHAMP PROJECT - "Continuum of Prevention, Care and Treatment of HIV/AIDS with Most-at-Risk Populations" is a sub-beneficiary program of the association CARE Cameroon created in 2014. https://pdf.usaid.gov/pdf_docs/PA00ZF5Q.pdf

psychology, social work and psychosocial counseling, which could potentially also meet another need of theirs. After an analysis of the circuit conducted by an Ivorian consulting firm in 2011, an intervention model favoring more comprehensive needs assessment and care was recommended to the association and was put in place shortly after. Based on this new model, in place currently, on their arrival at the center all users go through 2 steps: 1) educational pre-counseling; 2) a global needs assessment by a psychosocial counselor and referral to the various specialties. The new system thus allows each user "*to have a greater chance of benefiting from the full range of services*", according to Joachim Ntetmen Mbetbo, Programs Director, Alternatives-Cameroun.

2.4.2 User circuit at Access medical center, Douala



Current user circuit step by step:

1. Point of access: **educational pre-counseling, which provides information** on all of the available prevention, diagnostic, treatment, human rights, and gender services, and discussion, with the agreement of the user, on a health topic promoted by the center during the month in question (e.g., PrEP). Peer educators, a gender ambassador and a paralegal involved in this step coordinate to work in concert. At this stage, a unique identification code, the personal data within which is encrypted, is allocated to each user.

2. **Global needs assessment by a psychosocial counselor, followed by referral to the various specialties** (by the counselor).

"Anyone who comes even to collect prevention products (gel, condoms, etc.) stops off at the psychosocial counselor because a discussion could solve an underlying problem they may not have realized at first. In this situation we can really get a feel for the user's life in order to better elucidate these problems." Hermine Ngo Ndaptie, Health Officer, Alternatives-Cameroun

The needs assessment primarily covers: a clinical STI assessment (symptom identification); a sexual and emotional life assessment; a discussion on the proctology consultation, the risk assessment and a risk reduction plan; exploration of violence based on sexual identity. The counselor also administers, depending on the case, different psychological tests to assess the person's level of stress and anxiety, their self-esteem, and the dynamics of their social relationships (conflict management, etc.). Based on

the issues identified, the psychosocial counselor refers the user to the **psychologist, the nurse, or the paralegal specialized in human rights**.

3. **The team at the medical center** is composed of **two doctors** (**a general practitioner**, full time, with skills in **proctology**, and a volunteer, **dermatologist, venereologist and proctologist**) and a **nurse**, who share the same office. Although consultations are conducted solely by the doctors, the nurse is responsible for the preliminary procedures ahead of the consultation and taking patient parameters, giving injections and applying bandages.

A grid to **assess material comfort** divides users into four categories: A, B, C and D. The last being the most vulnerable, these are people who have the most right to all care without exception. The most important vulnerability criteria include HIV-positive status, belonging to several categories of key populations (multi-key), being a transgender or intersex person, being unemployed, the presence of materially dependent adults and/or with disabilities in the household, suffering from a chronic illness and or being regularly ill, the presence of minor children in the household, the presence of HIV-positive children or with disabilities in the household.

3.1 If the doctor prescribes medication, the user is referred to **the social worker** who will collect the medication either at the **center's community pharmacy** or at the center's partner **pharmacy** in the city. The drugs at the community pharmacy are essential medicines. If exams are also prescribed, the person is either referred to the **center's laboratory**, or referred to the social worker who will help them make an appointment with an **external laboratory**.

3.2 In some **emergency situations,** or in cases where the user's viral load is too high for them to be treated at home, the doctor organizes the user's transfer to a certified care unit or treatment center.

4. The social worker is an important link within this structure, especially when it comes to the user management process. Other than obtaining prescribed medication and patient referral to external exams, she writes up reports for hospitalization and proctological surgery requests and submits them to management for approval, refers users to external vaccination centers when vaccines are not available at the center, and to the center's dietitian. She carries out an advance material comfort assessment which best orients the user category, thus determining the type of care to give them.

2.4.3. Linking the SHS scheme with the user's life context

Various factors in users' life contexts are taken into account in their support within the health care pathway at the center:

- The **affordability of care.**

"A barrier often invoked by vulnerable people for not going to the hospital is the lack of financial means – I don't have the money for that." Joachim Ntetmen Mbetbo, Programs Director, Alternatives-Cameroun.

All the services received at the center are free for users. For treatment, exams conducted outside of the center and medication only available from external pharmacies, the costs are covered by the association based on its available resources. Funding arrangements have thus been developed, adapted to the different levels of users' vulnerability.

- Housing **for homeless users**.

For vulnerable people who have been rejected by their families because of their sexual or gender identity, the association provides a house where they can stay over a period of up to three months while waiting for mediation with their families.

- **Home mediation sessions for children rejected by their families.**

A multidisciplinary team works alongside a psychologist or a psychosocial counselor in general, and sometimes a human rights focal point. Community-based actors always introduce themselves to families as health workers, telling them that the child is seen at the association's medical center. While at the

same time prioritizing this dialog with the family, the team underlines the potential risks of people living on the street (assault, theft, etc.) and the importance of keeping the child within the family cocoon[51].

- Collaboration **with the National Employment Fund to support users in their job search.** The center's team helps users with application submission and the follow-up steps.

- Help with **securing identity cards** for people who do not have them and are estranged from their family, including those without a birth certificate, for example.

- **Home-based medical and/or psychological assistance** services for people who do not have the possibility of traveling to the center.

- Support for **users in managing their HIV-positive status and awareness of it among the person's entourage**.

3. Results

3.1 Evolution of the Access center's active file

Between 2008 and 2019, the annual number of people who benefited at least once from the center's services rose from approximately 100 to 3,000 maximum. The cumulative total number of single users between 2008 and 2022 is approximately 10,000. The Douala Access center currently receives around 2,000 to 3,000 people per year, while the Yaoundé center receives around 500 to 1,000.

3.2 The effect of services on users' determinants of sexual health[52]

- 100% of men who have sex with men and women who have sex with women among the association's beneficiaries have already tested positive for HIV;
- 75% of men who have sex with men and 85% of women who have sex with women are aware of their partner's status;
- 63% of men who have sex with men and 56% of women who have sex with women have a good understanding of HIV;
- Proctology needs covered for 52% of the total number of users;
- 33% of users under ART have already had at least one proctology consultation. The center's target is to achieve 50% in the near future;
- 65% of men who have sex with men have used a condom during their recent sexual encounters;
- 70% of men who have sex with men and 52% of WSW are comfortable with their sexual orientation.

3.3 Advocacy actions

1. As a result of the association's participation in meetings at national level to draw up a strategic plan for HIV, during which the health needs of key populations were shared, the authorities **incorporated men who have sex with men and sex workers for the first time in the National Strategic Plan for HIV in 2011**.

2. The assistance provided by the association to victims of GBV – cis women and transgender people –, the evidence supplied to the authorities concerning the connection between GBV and the escalation of the HIV epidemic, and the advocacy efforts for consideration of this aspect in health policies, combined with the efforts of the different civil society partners, have contributed to **the inclusion of GBV in the 2018-2022 National Strategic Plan for HIV**:

[51] PFAO, Coalition PLUS. (2019). Sexual health services in West Africa: Bold, innovative solutions for access to care for key populations!. p. 33
[52] Data provided by Alternatives-Cameroun.

"...Prevention in the general population and among youths and adolescents will be strengthened, alongside efforts targeting key populations. This will take into account the […] gender-based violence that has reached worrisome rate. In Cameroon, women are more affected by the experience of spousal violence: 43.2% of women living common law experience physical violence; 39.8% and 14.5% experience emotional and sexual violence respectively […][53]" **2018-2022 National Strategic Plan for HIV/AIDS and STIs**

3. As of **2015,** the association put in place **training courses for key actors in the public health system (doctors, authorities, etc.)** on the key population approach. One of the doctors trained testified that the training had enabled her to understand the subject of key populations and sexual minorities in particular, and shortly afterwards she became chief of the health district in which the association is located. It is thanks to this awareness-raising and the link with this person that the association is regularly invited to district meetings on public health issues, where it also brings up the needs of key populations.

4. **Advocacy actions targeting international human rights bodies** on issues such as decreasing violence based on gender and sexual orientation and the decriminalization of homosexuality have resulted in remarks and/or recommendations made to the State of Cameroon. These bodies include the UN Human Rights Council, the UN Committee on the Elimination of Discrimination against Women, and the African Commission on Human and Peoples'' Rights. In Cameroon, the association is affiliated with the National Commission on Human Rights and Freedoms.

3.4 Success factors

- **Offering vulnerable people a safe space**, where they can be themselves and express themselves without fear of being judged or indexed, encourages entry to treatment and provides a complete picture of their situation. *"It may seem strange to hear people say: 'I'm sick and I'm afraid to go to the hospital'. And yet, the hospital is a place that many learn to fear. The added value of our centers is that they try to reverse this trend and to ensure that people feel comfortable seeking care."* Joachim Ntetmen Mbetbo, Programs Director, Alternatives-Cameroun.

- In 2017, **the Director of Alternatives-Cameroun was elected to the Global Fund Country Coordinating Mechanism for Cameroon as the representative for key populations.** This position bolstered the relaying of the needs of key populations and sexual minorities within this body.

- The **training of doctors and representatives of authorities** as of 2015 proved to be an important means of relaying the needs of key populations. The authorities are now much more aware in this respect, as their actors gradually receive training.

- The **participation of the center's actors in international and regional conferences** (the most recent example being the ICASA) often inspires the center to put in place new care practices and new services seen elsewhere.

4. Challenges, levers and key lessons

- One challenge overcome by the center's workers was **being able to constantly refine the services available to respond to the specific needs of those most exposed**. For example, regular focus groups are organized with transgender users to assess the services they already benefit from and to identify their specific needs. Over time, three topics have emerged from these meetings in terms of needs: assistance in cases of GBV, assistance in obtaining identity documents (these were subsequently included in the services provided), and access to hormone treatment – a need that is still not covered and with regard to which the center's team is endeavoring to increase the involvement of the people concerned.

- The **sexual health needs of women who have sex with women** are relatively poorly covered according to the association's assessments. The team at the Access center is endeavoring to further develop the services aimed at this group, both at the center and in outreach activities. One of the topics currently under consideration is support for women who want to become mothers.

[53] Plan stratégique national de lutte contre le VIH, le SIDA et les IST (2018-2022). 2018-2022 National Strategic Plan for HIV/AIDS and STIs pp. 148-150

- **Unconditional listening to users and non-judgment need to be at the core of the support approach within the health care pathway**. Injunction with regard to the user when it comes to their health decisions should be avoided.

"Before, I worked in a hospital as a psychosocial counselor. There we really gave a good telling off to beneficiaries who had problems sticking to their medication – 'what do you mean you're not taking your medication? do you know what that means for your health? you need to take it more seriously', etc., and we thought we were doing the right thing. When I came to Alternatives-Cameroun, I understood that that didn't work at all. You can say those things to the user, but they might leave and never come back, and then they die. So this approach needs to be revised and be much more neutral and more open to listening. There is still much progress to be made to ensure that sexual minorities feel accepted and fully included." Joachim Ntetmen Mbetbo, Programs Director, Alternatives-Cameroun

III. Factsheet 3: Les Halles clinic – ARCAD Santé PLUS, Bamako, Mali

1. Overview of the country context and the structure

Mali is a country with a generalized epidemic and an HIV prevalence of 1.1% in the general population aged 15 to 49 (EDSM 2012-2013)[54], a figure that indicates a stabilization in the epidemic within this population. The epidemic is **more concentrated in urban areas (1.9%)** than in rural areas (0.9%). The data collected from different surveys show **a prevalence of 1.3% among women compared with 0.8% among men** in the same age group (15-49 years) and a **disproportionate prevalence within key populations:** 12.6% among men who have sex with men in 2020 (CSLS[55]/PI Mali/CDC[56] 2020), 8.7% (IBBS 2019) among sex workers, 5.1% among people who inject drugs and 11.7% among transgender people[57]. This prevalence concentrated within key populations is **an indicator of a dynamic epidemic** which greatly impacts the incidence of HIV in the country, in the absence of measures to reduce inequalities in access to health services (particularly sexual health services) and services adapted to these vulnerable, stigmatized populations who are victims of discrimination. *"Multiple studies have shown that the low level of adaptation of services to the environment and to the sexual practices of the people they target is a significant barrier to the use of services"*[58].

Created in 1994, ARCAD Santé PLUS is a key actor in the HIV/AIDS response in Mali and West Africa. The organization's main mission is to ensure equal access to health and to development for all, including vulnerable populations in Mali. Its main areas of intervention are: 1/ **prevention, treatment and follow-up primarily based on:** (a) **an integrated approach** to services interlinking the medical and psychosocial aspects to empower the user; (b) **a community-based approach** which consists of designing and implementing health interventions with the involvement of the people concerned. This approach also aims to transform users into **actors** of prevention and treatment when it comes to HIV, STIs, viral hepatitis and tuberculosis; 2/ **capacity-building** through the pooling of community-based expertise in Mali and in other world regions, particularly in West and Central Africa; 3/ **community-based research** to improve the quality of services provided and to strengthen the impact of advocacy actions; 4/ **advocacy** for access to care and defense of the human rights of particularly vulnerable populations.

ARCAD Santé PLUS was recognized in 2016 as a non-governmental organization operating in the public interest (Decree No. 216-0270/P-RM). In 1996, it established the first community treatment site for people living with HIV – the Center for Treatment, Activities and Counseling for People Living with HIV/AIDS (CESAC) – and, in 2010, the first sexual health clinic dedicated to key populations in Mali (Les Halles clinic). A founding member of Coalition PLUS (2008), ARCAD Santé PLUS coordinates the PFAO[59], an innovative South-South regional cooperation mechanism put in place by Coalition PLUS since 2014.

In 2020, ARCAD Santé PLUS comprised 16 community-based treatment centers: 2 CESAC (in Bamako and Mopti), 1 sexual health clinic in Bamako (Les Halles clinic) and 13 Care and Counseling Units (USAC) incorporated within reference health structures (public structures). ARCAD Santé PLUS is rolling out sexual health clinics in Kayes, Ségou and Sikasso. **At the end of December 2018**

[54] Demographic and Health Survey in Mali (EDSM).
[55] CLCS: Cellule sectorielle de lutte contre le VIH/sida au Mali [Sectoral Committee for the fight against HIV/AIDS in Mali].
[56] CDC: Centers for Disease Control and Prevention
[57] See Plan stratégique national intégré de lutte contre le VIH/sida, la TB et les hépatites virales du Mali 2021-2025 [Integrated National Strategic Plan for the fight against HIV/AIDS, TB and viral hepatitis in Mali 2021-2025].
[58] Coulibaly, A., Dembelé Keita, B., Henry, É. & Trénado, E. (2014). Faciliter l'accès aux soins des populations les plus exposées : l'expérience de la clinique nocturne de santé sexuelle de Bamako au Mali [Facilitating access to care for most-at-risk populations: the Bamako night sexual health clinic experience in Mali]. Santé Publique, 1, pp. 67-70. https://doi.org/10.3917/spub.140.0067
[59] The PFAO (West Africa Platform) encompasses 23 community-based associations in the fight against HIV/AIDS, located in 8 countries: Benin, Burkina-Faso, Côte d'Ivoire, Guinea-Conakry, Mali, Niger, Senegal, Togo.

across its treatment sites, ARCAD had an active file of 23,854 people living with HIV[60], regularly monitored under antiretroviral therapy.

2. Implementation of the scheme

2.1 Opening of the center, health services, and key moments

A real need identified on the ground with the active participation of key populations

A survey conducted[61] by ARCAD Santé PLUS with the technical support of UNAIDS over the 2004-2007 period indicated a prevalence rate of 24.6% among sex workers at national level, and 17% among men who have sex with men. This initial study on the practices of these groups was conducted at national level among around 400 men who have sex with men[62] and highlighted, among other things, the difficulties these populations face in accessing care due to the fear of stigmatization and discrimination that can result from a positive HIV test or from their sexual orientation, their gender identity or their status as a sex worker.

In addition, a **CESAC assessment** conducted over the same period[63] has shown that vulnerable people from key populations (men who have sex with men, sex workers, people who inject drugs, transgender people) would prefer not to come to the CESAC, despite a high demand for sexual health services and far better healthcare conditions than on the ground, that is to say sites specific to their lifestyle. This reluctance was mainly due to the fact that the CESAC was known as a care center for people living with HIV, also stigmatized and discriminated against. Accessing the center's services would therefore subject key populations to **double stigmatization**. Another reason was the **CESAC's hours which did not match their rather nocturnal lifestyle**.

"We needed to create this environment to make these care services accessible to these populations who had nowhere to go, who had STIs, who tended to self-medicate, who were dying in impossible conditions. So there was a real need that called for coverage."
Dr Alou Coulibaly, Capacity-Building Director, ARCAD Santé PLUS

It was within the context of the search for strategies to facilitate the access of key populations to prevention and medical care services for HIV, STIs, viral hepatitis B and C and other associated pathological conditions that **ARCAD Santé PLUS set up Les Halles sexual health clinic in Bamako in August 2010**. The creation of this clinic stemmed from a **real need**, a demand from some CESAC users, people vulnerable to HIV, STIs and viral hepatitis.

Les Halles clinic is open to the public**, to young people aged 15 to 24, and to key populations** – men who have sex with men, sex workers, people who inject drugs, and transgender people. All of the health services offered by the Clinic[64] are **free of charge**. Since 2010, the services have evolved to align with the needs of users.

Between 2010 and 2012, the Clinic provided **services more centered on prevention ('classic services')**. Since 2012, the range of services has been supplemented by **services specialized in sexual health, virtual prevention and anal health**. As of 2019, the Clinic has day and night programs so that the services for key populations

[60] Elise Cabout MSc, Robert Launois PhD, Élaboration d'un modèle économique d'offre de services de santé communautaires, Mission France Expertise à ARCAD Santé PLUS, Bamako 11-21 février 2020 [Development of an economic model for community health services, Mission France Expertise to ARCAD Santé PLUS, Bamako, 11-21 February 2020]. https://rees-france.com/wp-content/uploads/2020/03/PL-2002-Mission-MALI-V3.pdf
[61] ARCAD-SIDA. Analyse de la situation des hommes ayant des rapports sexuels avec d'autres hommes [Situation analysis of men who have sex with men]. 2004, p. 32.
[62] See experience capitalization interview with Dr. Coulibaly, Capacity-building Director, ARCAD Santé PLUS, 29 April 2022.
[63] The first day center created by ARCAD in 1996, in Bamako, for medical care and psychological assistance for people living with HIV.
[64] By convention, the word 'Clinic' will also be used to refer to the ARCAD Santé PLUS Les Halles clinic.

are as closely adapted as possible to the factors linked to their life paths, particularly their living and working environments. Currently, the Clinic covers all of the categories included in an optimal health service package, that is to say:

- **prevention, medical treatment for HIV and STIs and referral to public health system structures,**
- **biological follow-up (biochemical analyses, viral load measurement and CD4 count, etc.),**
- **psychosocial and economic support,**
- **legal support.**

2.2 Main actors, skills and resources mobilized

> *"We worked in partnership with the beneficiaries (...). Together, we looked at what we could do to make healthcare more accessible to key populations. It was these discussions that led to the creation of the Clinic. Do we need to create a center that's different from classic/public centers? Yes... we arrived at a consensus."*
> **Dr. Alou Coulibaly, Capacity-Building Director, ARCAD Santé PLUS**

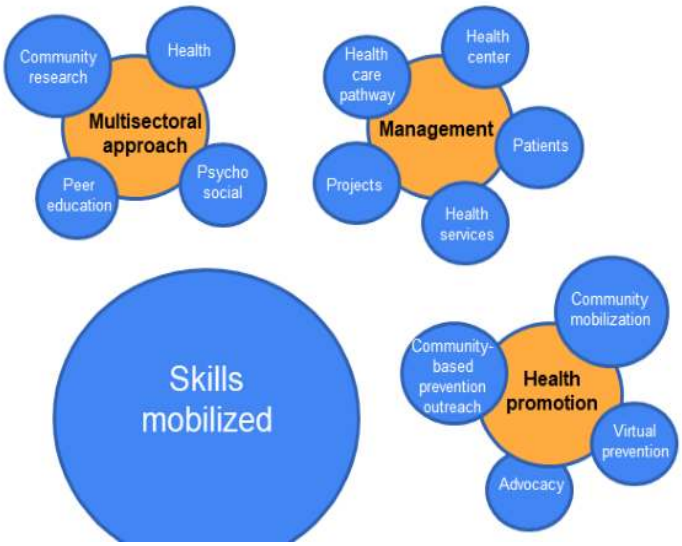
The **community mobilization strategy** for key populations with regard to their access to the Clinic's services was implemented first and foremost by peer educators, peer workers and focal points – men who have sex with men, sex workers and people who inject drugs (also peers).

Between March and July 2010, the multidisciplinary ARCAD team, primarily composed of doctors, nurses and peer educators, began to prepare the implementation strategy for the Les Halles clinic **in coordination with** users from key populations.

The Clinic has a **multidisciplinary team** for the intake, support and treatment of users, composed of 4 doctors, 1 pharmacist, 1 nurse, 2 lab technicians, 2 community-based research assistants, 2 psychosocial counselors (PSCs) who are what are called "PLWHIV expert patients", a dozen peer workers who each coordinate a minimum of 4 peer educators (PE), 3 focal points – peers (1 man who has sex with men, 1 sex worker, 1 person who injects drugs) and a vast PE network. The Clinic is also examining the possibility of recruiting a psychologist.

The core skills mobilized for the creation and development of the Clinic are summarized in the diagram below:

Main skills mobilized for the creation and development of Les Halles clinic



2.3 Partners

The mobilization **of partners and allies** with the potential to provide technical and financial support and to support the development of the Clinic was one of the main strategies adopted by ARCAD Santé PLUS.

First of all, **institutional partners**: the district VI reference health center in Bamako (in particular the chief medical officer)[65], the Regional Health Authority, the National High Council for the Fight against HIV, the Bamako 7th District Police Precinct, and the Vice Squad.

Next, **community partners**: associations within the Les Halles market area of Bamako (youth associations, merchants association, etc.), key population associations. Lastly, **partners that could provide technical and, above all, financial support**: the Global Fund, AIDES, Sidaction, Coalition PLUS, FHI360/PEPFAR. **These partners currently support Les Halles clinic.**

2.4 The scheme's intervention strategy

The **community-based intervention model used by the Les Halles clinic** is indicative, given that the life path of users is the main starting point for constructing individualized health care pathways/projects, as well as the scheme's sexual health services (adaptation to the hours and lifestyles of key populations, bringing health services to their places of work/socialization, specific consultations on anal health, family mediation or within the community in the case of gender-based violence, management of emergency housing, etc.).

The approach of Les Halles clinic and, generally speaking, of ARCAD Santé PLUS is based on a strong rooting within the community primarily aimed at the empowerment of vulnerable people, social change ('breaking taboos') and health democracy.

Its intervention strategy is based on consideration of health determinants, particularly socio-economic factors, the family environment, level of education, employment and income. All these determinants are in fact elements in the **life path** and influence the state of health of the person/population.

2.4.1 Mobilization of the target audience

The Clinic's services are offered according to **two types of strategy**: **fixed** (at the clinic) and **outreach/mobile** (on the ground, within key population communities).

"The complementarity of these approaches makes it possible to reach key populations more broadly, at their gathering places or places of work in the case of sex workers, and to offer an extended range of services"[66].

Peer educators play a central role in the implementation of the outreach/mobile strategy: "The mobile strategy still stands, but not like before because peer educators are given prominence. The peer educators know how to do all sorts of things these days and they do so directly on the ground. We [doctors], we only come out when requested, for cases of syndromic management for STIs, for example, or for other needs which the peer educators cannot provide a response to." **Dr Alou Coulibaly, Capacity-Building Director, ARCAD Santé PLUS**

It should be emphasized that the peer educators are present at all levels of the "community-based health response chain"[67] or the health care pathway of the Clinic's users.

The health care pathway represents all of the steps and the journey of a person through a structured health and social system (in this case, the sexual health services of community-based association schemes), within a given time and space. It encompasses all the determinants of health, interlinking prevention, treatment/medical care and social aspects:

[65] More information on the reference health centers in Mali: Plan décennal de développement sanitaire et social (PDDSS) 2014-2023 [Ten-Year Health and Social Development Plan]
[66] Coalition PLUS, Regional Guide Sexual health services in West Africa: Bold, innovative solutions for access to care for key populations!. (2019). PFAO, Coalition PLUS. PFAOSexualHealthServicesGB.pdf (coalitionplus.org)
[67] A concept promoted by the ARCAD Santé PLUS community workers, interviewed as part of the capitalization process.

"The health care pathway represents the result of coordinated health, medical-social and social services to meet the prevention and treatment needs of people within the framework of controlled expenses. Their organization results from the day-to-day work of the actors within local or regional organizations."[68] *"From the user's point of view, the health care pathway encompasses information on the illness and the treatment options, the establishment of a health plan and help with adherence to it, the right to a second opinion, support and assistance for the patient and their entourage."*[69]

"The health care pathway of a user starts with community mobilization". It is through this mobilization that key populations become aware of the existence of the clinic and the fact that healthcare services exist that they can access without being stigmatized or discriminated against. It is also at this stage that the peer educators provide information on HIV and STIs, prevention kits, testing and, if necessary, refer users to the clinic for other services.

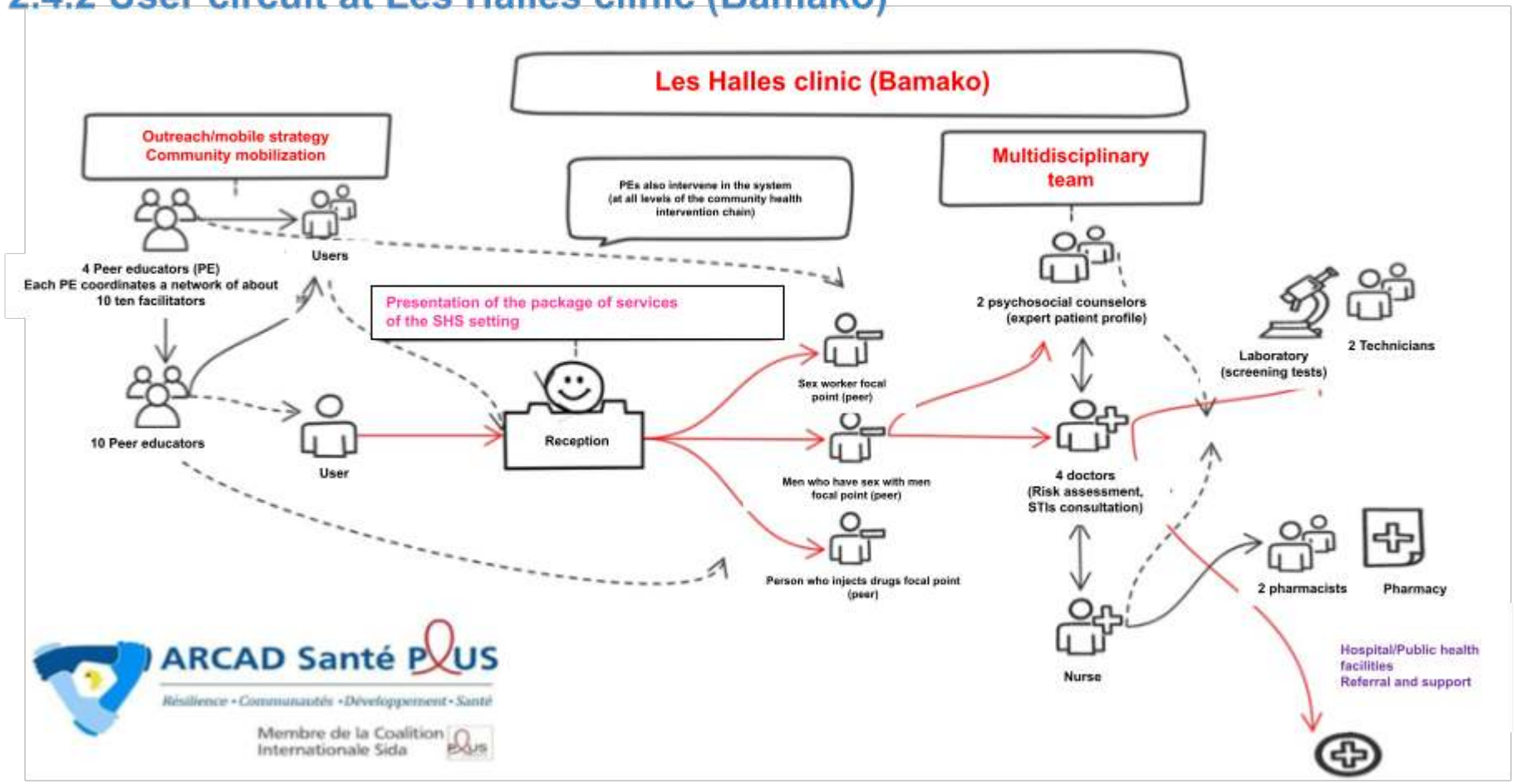
With a view to improving the quality of services and their development, users are mobilized not only prior to the intervention but also to evaluate the clinic's services: "We have a tool that works really well, what we call the **sexual health workshop**, a workshop we run in three sessions over one month with 10 participants, which aims to help each participant identify their own risks with regard to HIV infection and to develop personalized strategies to reduce risk and vulnerability. So on the whole, we have developed new tools, but also other services like anal health". **Dr Alou Coulibaly, Capacity-building Director, ARCAD Santé PLUS**

With the same goal in mind, **community-based research** is also a means effectively employed by ARCAD Santé PLUS and its clinic, both for advocacy actions and to develop its range of services. One example of this concerns access to PrEP:

"It's thanks to the results of the CohMSM-PrEP cohort study that the State accepted to promote PrEP to men who have sex with men on a national level. Although access to PrEP is guaranteed by the State, its distribution at country level is not yet wholly effective, as there are still sites/zones that are not covered." **Dr Alou Coulibaly, Capacity-Building Director, ARCAD Santé PLUS**

[68] Haute Autorité de Santé, France, 2015 [translation from the original French]
[69] Definition of the President of the Collectif Interassociatif sur la santé (CISS, collective unit of user associations) and the Bourgogne-Franche-Comté Regional Health Authority (ARS), France.

2.4.2 User circuit at Les Halles clinic (Bamako)



The user pathway within the Clinic begins at reception, where a member of the team presents the full range of services available. Then, depending on the situation, the user is directed to one of the **three focal points** – sex workers, men who have sex with men, people who inject drugs –, also peers who, through active and reassuring listening, identify medical and other needs so as to more precisely refer them to the clinic's appropriate services. At this stage, and depending on the case, the focal points can propose a rapid HIV test (around 20 minutes) at the Clinic's laboratory, psychosocial support provided by a PSC (who is originally an expert patient), and a consultation with a doctor. "Once you arrive, you meet with someone (focal point) you recognize yourself in, who greets you, guides you." **Dr Alou Coulibaly, Capacity- building Director, ARCAD Santé PLUS**

Testing is carried out on a voluntary and confidential basis by one of the two lab technicians and the result is given to the person (and to the doctor) by the PSC. In some cases, the doctor may intervene as of the person's arrival if they need clarification regarding their medical need. The doctor intervenes (where necessary) to assess the risks and manage treatment for HIV and STIs. If the doctor issues a prescription, the person is accompanied by the PSC or the nurse to the Clinic's pharmacy. In some situations, the person is referred to the hospital or to other public health structures. In this case, the focal point or the doctor at the Clinic accompanies the person to prevent risks of discrimination and stigmatization.

It should be noted that Les Halles clinic offers services to HIV-positive and HIV-negative people. "What we recommend to the person, whether they are HIV-positive or negative, is to go for a twice-yearly full exam. For sex workers, we suggest a check-up every three months if they want. For men who have sex with men, we suggest a full six-monthly exam, including a genital exam and an anal exam." **Dr Alou Coulibaly, Capacity-building Director, ARCAD Santé PLUS**

In addition to regular medical exams, the clinic systematically carries out cervical screening and HPV screening.

2.4.3. Linking the SHS scheme with the user's life context

Based on the **elements provided by key populations with regard to the current trajectory of their life path**, ARCAD was able to establish a series of aspects connected to the Clinic's operation: **opening times** (from **4 p.m. to midnight**, so a **night clinic**); **the location** (a **marketplace**, Les Halles in Bamako, a site accessible in terms of transport (distance and cost) and visible, with no risk in terms of disclosure of sexual orientation or medical status; **the general population as another target audience** outside of key populations in order to reduce the risk of discrimination and stigmatization of the latter.

"**There was no question of saying there's a clinic in Bamako that exclusively treats key populations**." **Dr Alou Coulibaly, Capacity-building Director, ARCAD Santé PLUS**

In order to meet the demand for health services among the general population and key populations, the Clinic changed its opening times to 8 a.m. to midnight in 2021.

> *"Before I came to Les Halles clinic, I didn't protect myself. I didn't even care about my health. But that's not the case anymore. I've changed a lot (…) My family rejected me, but the clinic has been a really exceptional family for me. I feel very safe here."*
> ***S.S., sex worker and user of services at Les Halles clinic***

3. Results

- Les Halles clinic organizes training sessions twice a year for around 30 participants, health professionals, public health service professionals, particularly the doctors involved in HIV and STI treatment. These training sessions are strategically used by the Clinic to inform participants and raise their awareness of the problems linked to the stigmatization and discrimination that key populations face currently when it comes to access to health services, and consequently to have in place care providers with a certain awareness within healthcare structures.
- The creation of a favorable environment for access to care and treatment for vulnerable populations. Since its creation, Les Halles clinic acts as a real force for change in Bamako and within the entire country when it comes to mentalities, stereotypes and social representations regarding homosexuality and key populations (*"we started to break taboos"*).

- The Les Halles clinic has become a reference model at national level, but also at sub-regional level thanks to the transfer of knowledge and expertise by ARCAD Santé PLUS to the member organizations and partners of the Coalition PLUS PFAO.
- Improvement of access to care and quality of life for key populations.

3.1 Active file and services

In the first quarter of 2022, through the Les Halles clinic's services, 4,600 adults (M/W) received advice and testing (HIV, STIs, viral hepatitis B and C) of which 1,311 men who have sex with men, 1,835 sex workers, 34 transgender people, and 2 people who inject drugs. 146 were notified as being HIV-positive and started ART at the Clinic. 2,452 adults and children under ART are monitored by the Clinic[70].

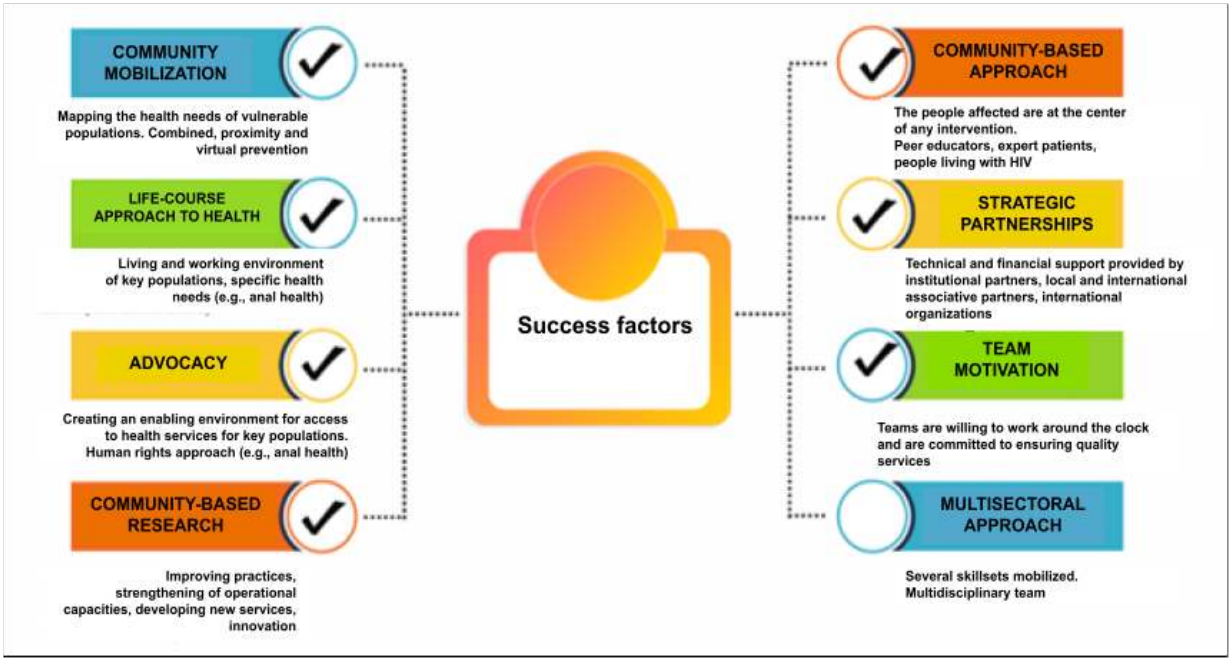
3.2 Advocacy actions

1. Through advocacy actions to promote the WHO guidelines on HIV prevention and treatment, as well as through the various scientific research conducted by Les Halles clinic, ARCAD Santé PLUS has managed to convince the government to include PrEP in the National Strategic Plan for the fight against HIV/AIDS. It should be noted that PrEP is already included in the Clinic's combined prevention program. Well before that, and also thanks to the advocacy actions aimed at the Ministry of Health and the country's College of Physicians, ARCAD Santé PLUS successfully introduced, for the first time, key populations into the national HIV treatment protocol and within the directorates of the National Strategic Framework for the fight against HIV/AIDS 2012-2017.

2. In connection with the prevention of unwanted pregnancies among sex workers, a legislative restriction excludes the possibility of safe abortion: "as abortion is prohibited in Mali, there is no official circuit to have an abortion in safe conditions". ARCAD Santé PLUS is currently considering an advocacy strategy to influence this legislative framework, as the consequences of unsafe abortion can be serious for the health and lives of women sex workers.

3.3 Success factors

3.3 Success factors



[70] Les Halles clinic quarterly activity report.

4. Challenges, levers and key lessons

- The treatment of anal conditions represented a challenge when Les Halles clinic started up. For a simple case of condyloma that could be sorted in 20 minutes, the Clinic's doctors had to accompany patients to public health structures. Many of them did not want to go due to fear of stigmatization and discrimination. In order to respond to this demand for specific medical services, the Clinic's coordinator, a general practitioner by training, had to take further training courses and proctology classes. That's how **anal health evolved from a major concern to a service offered by the Clinic**.
- Key populations are fairly mobile, they move around the country, particularly sex workers, and that makes retention of people living with HIV under ART a major challenge, for example. To counter this problem, ARCAD Santé PLUS reinforced communication and interconnection within its network of health centers and units, spread across a large area of Mali including: the Bamako District (Commune I, Commune II, Commune III, Commune IV, Commune V, Commune VI), Kayes (Kayes Cercle, Kita, Nioro), Koulikoro (Koulikoro and Kati Cercles, Fana area), Ségou (Ségou Cercle), Sikasso (Sikasso, Koutiala and Kadiolo Cercles). A **unique identification code at national level** – a digital or alphanumeric code that allows an individual to identify themselves in order to access various health services – could be one solution, but according to ARCAD Santé PLUS, the State of Mali is not in a position to implement this system for now. This code **needs to be anonymous**, but must be connected to a database stored separately and containing personal information. ARCAD Santé PLUS is continuing its advocacy actions to this end.
- A **low attendance rate** at health services by people who inject drugs (PWID): *"At the moment, the Clinic is not able to properly frame, to properly identify needs, firstly of PWID, but also help them. PWID come much more often to our Center for Treatment, Activities and Counseling (CESAC) in Bamako."* A possible explanation identified by the Clinic's team is the proximity of the CESAC to their places of socialization.
- A similar situation has also been seen among **transgender people**. In this case, **an important lever** in resolving this problem is the Coalition PLUS network and the potential exchange with other associations like Kimirina in Ecuador, reputed within the network for its best practices concerning healthcare services for transgender people (including endocrinology consultation services for better management of hormone use).
- The need to expand the scope of **prevention methods for unwanted pregnancies**, in particular for sex workers, as up until now the prevention strategy based around the fight against HIV and STIs has been **centered on condoms**. Contraception for women and family planning programs are under consideration by the Clinic among the solutions to put in place.

"Our vision is to make the clinic a reference center for sub-regional sexual health services, including anal health, where people can come for procedures that are not available everywhere in Africa (for example, high-resolution anoscopy, treatment of fistula using photodynamic therapy, use of fibrin sealant, instrumental treatment of hemorrhoids notably using infrared or rubber band ligation)." **Dr Alou Coulibaly, Capacity-building Director, ARCAD Santé PLUS**

IV. Factsheet 4: Community medical center – Kimirina, Quito, Ecuador

1. Overview of the country context and the structure

According to the most recent data, there are approximately 45,000 people living with HIV in Ecuador, of which 76% are on ART[71]. While the prevalence rate in the general populations of adult age (between 15 and 49) is 0.3%[72], the epidemic is particularly concentrated within two groups of vulnerable populations[73]: **16.5% of men who have sex with men are HIV-positive yet only 56.3% know their status, and 34% of trans women are HIV-positive, of which only 60.4% know their status**[74].

LGBTQI+ individuals, and particularly transgender people, face systematic discrimination at an institutional and social level when it comes to access to health, education, work, and forming legally recognized families[75]. The new Organic Law for Civil Identity and Civil Data Management allows people to choose their sex on their national identity card as that right is guaranteed by the Constitution itself, which ensures that there can be no discrimination based on gender identity[76]. Nonetheless, these people continue to suffer physical and sexual violence and fatal assaults. 2020 was the deadliest year for at least a decade for **men who have sex with men** and for transgender people in Ecuador. Some civil society activists see this recent upsurge in violence as a backlash against the new laws enshrining LGBTQI+ rights adopted in recent years[77].

As for the country's health system, Ecuador's constitution enshrines the right of free access to healthcare for all people living in Ecuador, including migrants. Yet the health system has its limits – often the waiting times for medical appointments is relatively long and the exams prescribed at health establishments are not available free of charge due to a lack of resources[78].

Created in **1999 in Quito**, **Kimirina** is the leading organization in Ecuador and an expert in HIV/AIDS prevention and comprehensive treatment and the defense of the rights of people living with HIV. Kimirina is also active in promoting the health of vulnerable and at-risk populations – **men who have sex with men**, transgender people, young people suffering social exclusion, and sex workers – as well as the social inclusion of migrants. An important part of Kimirina's work consists of promoting and participating in the processes surrounding the development of national proposals for the community-based response to HIV and sexual and reproductive health based on an approach centered on promoting health and citizenship[79]. Between 2010 and 2019, the organization was the Principal Recipient of the Global Fund in Ecuador.

[71] Ecuador | UNAIDS
[72] Ibidem
[73] Estudio de vigilancia del comportamiento y prevalencia del vih y otras its en hombres que tiene sexo con otros hombres y mujeres transfemeninas en las ciudades de Quito y Guayaquil [Behavioral surveillance study and prevalence of hiv and other stis in MSM and FSM]. (2017). p. 2. https://www.kimirina.org/images/kimirina/documentos/publicaciones/kimirina/Estudio-de-prevalencia-1.pdf
[74] Ecuador | UNAIDS
[75] Violation of the Rights of Trans People due to their Sexual Orientation, Gender Identity or Expression Contribution to the List p.2
[76] Ley orgánica de gestión de la identidad y datos civiles [Organic Law on Identity Management and Civil Data], art.94, LEY ORGANICA DE GESTIÓN DE LA IDENTIDAD Y DATOS CIVILES, p. 20-21
[77] Ecuador's LGBT+ community seen suffering deadliest year in a decade | Reuters
[78] Comment made during an interview with Jimmy Medina, coordinator of the Quito community medical center, Kimirina.
[79] Kimirina website. History

2. Implementation of the scheme

2.1 Opening of the center, services and key moments

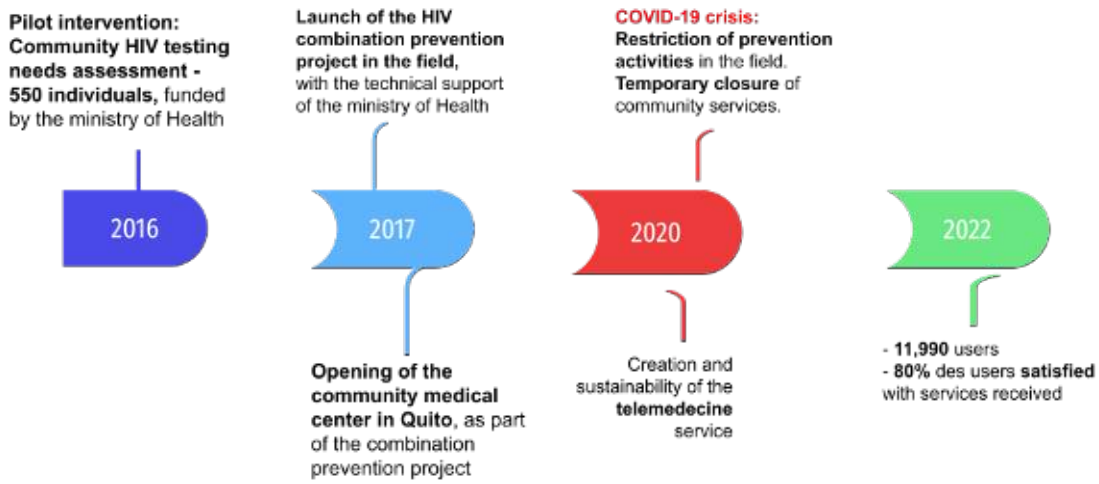
Kimirina manages seven community medical centers in seven cities in the country: Esmeraldas, Portoviejo, Machala, Santo Domingo, Santa Elena, Guayaquil, Quito. These centers receive a total of 34,285 users (2021 data). The **Guayaquil** and **Quito** centers are more advanced in terms of services and have more staff due to the higher demand for services in these more heavily populated cities (more than 2 million inhabitants). These two centers also receive project funding within the framework of the Global Fund.

The **Quito** community medical center was created in 2017 as part of a combination prevention project[80] implemented by Kimirina in partnership with the Ecuadorean Ministry of Health. The project was preceded by a pilot study to assess HIV testing needs in the community, conducted by the association in 2016 among 550 people from groups vulnerable to HIV, with the support of the Ministry of Health and the Global Forum on MSM & HIV. Combination prevention activities were initially run on an outreach basis in the various places of socialization for key populations in Quito, in accordance with the needs expressed by the people tested during the initial pilot project. It is mainly based on outreach activities that the target audience of the Quito community medical center was established.

Over its six years of operation, Kimirina has developed a range of services at its centers in Quito and Guayaquil primarily focused on:

- **diagnosis, treatment and prevention of HIV and various STIs (syphilis, gonorrhea, chlamydia) and viral hepatitis;**
- **PrEP and PEP/PET, since 2019;**
- **various lab analyses (blood biometrics, biochemical profiling, serology, parasitological stool samples and urine tests, immunology, viral load, CD4);**
- **more recently, psychological support services for migrant people .**

Quito community medical center, Kimirina - Key moments



[80] Combination prevention is a strategy in the response to HIV and STIs consisting of a combination of prevention tools, based on the situation, needs, practices and lifestyle of the person. These tools include the use of condoms, testing, advances in treatment such as 'undetectable = untransmittable', PrEP and PEP/PET. La prévention combinée, c'est quoi [website in French]

2.2 Main actors, skills and resources mobilized

The team at the Quito community medical center is composed of:

- 1 coordinator
- 2 physicians specialized in internal medicine
- 3 peer educators/community “brigadistas”
- 1 psychologist
- 1 technician
- 1 receptionist

2.3 Partners

The partnerships forged by the Quito community medical center involve public authorities as well as civil society actors. They generally consist of two types: development of joint prevention services and actions on the one hand, and training and capacity-building actions on the other hand.

Since 2016, thanks to cooperation agreements with the Health Ministry, Kimirina has been equipped for on-site and outreach actions carried out by the association: condoms, lubricant, HIV and STI rapid test kits. More recently, the Ministry also started to supply PrEP and PEP/PET medication.

The center’s partnerships with human and LGBTQI+ rights associations in Ecuador include the introduction of joint prevention activities for the populations vulnerable to HIV and STIs.

At the request of the Ministry of Health, the team at the Quito community center regularly runs training for public and private institutions on topics such as access to health services for key populations, sexual diversity, the HIV epidemic and PEP/PET.

The partnerships with civil society actors regarding this second component, meanwhile, aim to build the capacities of associations in HIV-related areas – prevention, testing, treatment.

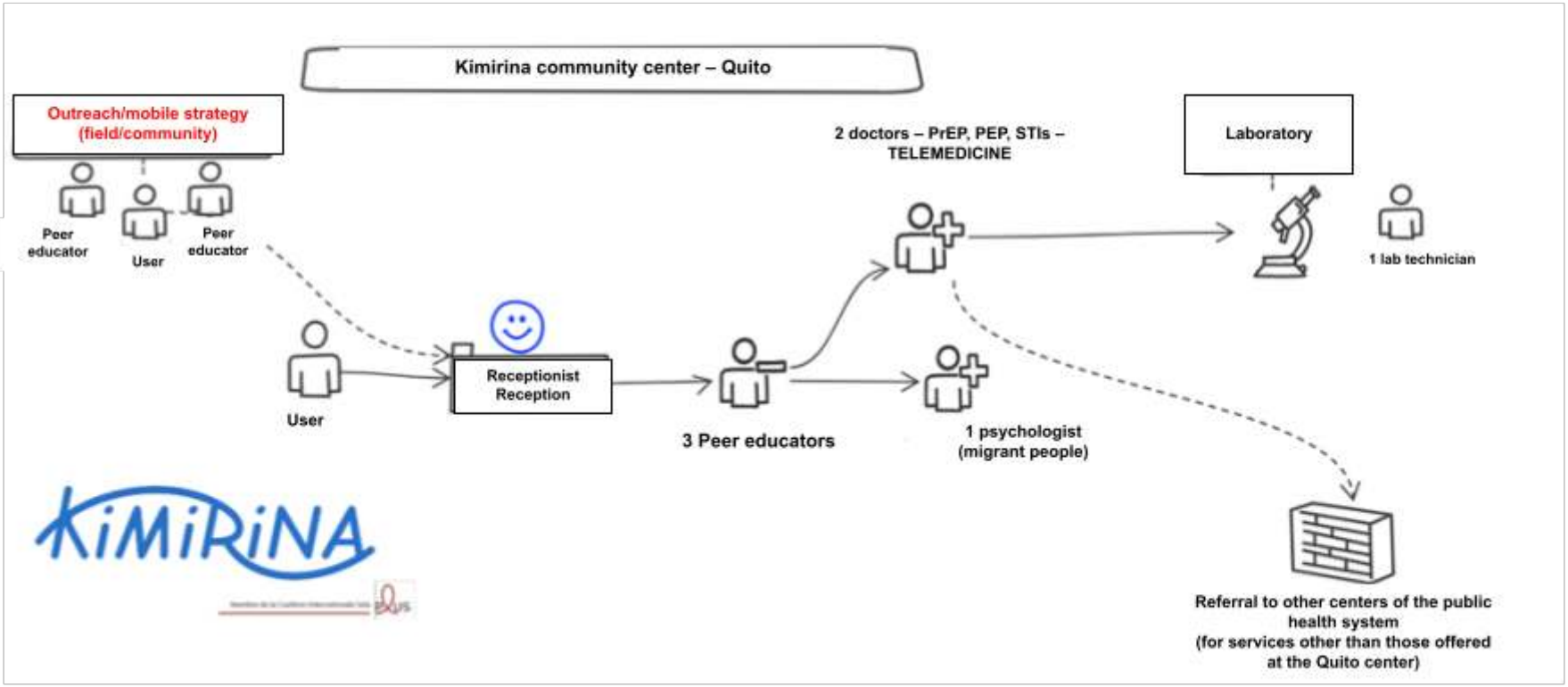
2.4 The scheme’s intervention strategy

2.4.1 Mobilization of the target audience

Out of a total of 34,285 Kimirina users in the seven community centers in 2021, 21,246 were men who have sex with men, 5,267 transgender people and 753 sex workers. These are also the three largest categories among users of the Quito center, men who have sex with me being the most strongly represented by far. The average age of the center’s users (and around 80% of all of the organization’s active file) is between 20 and 32. Around 60% to 70% of all users have access to education.

As of 2015, within the framework of the combined prevention project, the team at the Quito satellite site introduced a mapping of the different gathering spots for key populations in the city – the exact location, operating hours and target groups that come to the venue. This process, begun in Quito, was subsequently extended to all the Kimirina centers in the country and is updated every year. This information has been systematized thanks to the help of people from key populations, peers. Preventing and testing operations were then made available at all these gathering places, primarily for HIV, but also with the goal of publicizing the center’s health services to the populations. Awareness-raising and prevention activities are put in place (use of condoms and lubricants, benefits of testing, its confidentiality, etc.) along with rapid HIV tests and awareness-raising regarding PrEP. After being tested by the outreach team, those who test HIV-negative are generally invited to take another test at the center every three months and thus become regular users of the center.

2.4.2 User circuit at Quito community medical center



1. Appointments
With the exception of emergencies, users are required to make an appointment with Kimirina in advance by telephone, mobile apps (WhatsApp, etc.) or social media. The center is open between 9 a.m. and 5 p.m. The appointment system was introduced during the COVID-19 lockdown, when so required by the health protocol. It is still in place because of Quito users' preferences, although care is also provided upon spontaneous request.

2. **Arrival at the center – Reception.** The reception staff welcome the user and ask them to wait for a peer educator to see them.

3. Discussion with a peer educator in an office.
The user sets out their health needs – for example, with regard to a high risk of HIV acquisition, that they have had recently, the different symptoms they present with, their emotional state, etc. The PE guides them using specific questions so as to steer them in their pathway by presenting the full range of services provided by the center. A rapid test for HIV and other STIs (syphilis, gonorrhea, chlamydia, hepatitis B and C) at the center's lab is usually recommended to the user at this stage, with counseling before and after the test by the peer. The PE then refers the person to the center's doctor for PrEP, PEP/PET, or testing and treatment for STIs or hepatitis.

At this stage, one important aspect to underscore is the involvement in these discussions of people from the users' specific communities. In order to best assess their needs, the center's team ensures that they are received by their peers.

4. Medical unit

A) Physician specialized in internal medicine
PrEP – Following outreach testing, if the result is negative, the person is invited to undergo a medical check-up at the center every three months. The doctor assesses whether the person engages in behavior that entails a risk of HIV and includes them in the PrEP program if the risk is considered real.

PEP/PET – This service falls in the emergency category. Users who have experienced a situation with a high risk of HIV infection can come to the center within 72 hours of the contact, without making an appointment. The treatment protocol first provides for an HIV test, which is carried out at the center. If the result is negative, the person is directly seen by the doctor to assess their risk of infection and decide, based on medical criteria, whether or not to prescribe medication. Treatment is covered by the Ministry of Health since the start of 2022.

Referral to viral load and **CD4 exams,** in partnership with the Red Cross, which speeds up initiation of antiretroviral therapy in hospitals.

STI treatment – syphilis, gonorrhea, chlamydia; rapid tests and counseling and referral.

Referral to a specialized public Ministry of Health site for **treatment of hepatitis B and C.**

B) Laboratory
Exams conducted by the lab technician:

- Blood biometrics
- Biochemical profiling
- Serology
- Parasitological stool samples and urine tests
- Immunology
- Viral load
- CD4

Rapid tests carried out by peer educators:

- HIV
- Syphilis
- Hepatitis B
- Hepatitis C
- COVID-19 tests

2.4.3. Linking the SHS setting with the user's life context

- During the COVID-19 lockdown, medical consultations at the center were all conducted online (telemedicine). A survey conducted among users in 2021 on a potential return to face-to-face consultations after the fall in the pandemic revealed that **the majority prefer remote consultations**, online, as **this service is better adapted to their schedule**. As their working hours do not allow them to fit with the center's opening times, many of them prefer remote consultations and make an effort to travel only to collect medication or for exams. Remote consultations have thus continued to be developed.

Within the framework of an action-research project, Kimirina intervenes in protection measures for key populations that are a priority. In this regard, prevention operations are carried out with the Global Fund.

3. Results

3.1 Active file and services

In 2021, the center had 3,854 users. In the same year, the following tests were carried out:
10,942 HIV tests by the center's team (on-site and outreach)
4,059 syphilis tests, **1,726** hepatitis B tests, **1,726** hepatitis C tests

An internal satisfaction survey conducted in 2021 showed that **80% of all users are satisfied with the services** currently offered by the association.

3.2 Advocacy actions

1. Kimirina's expertise in strategies to reach men who have sex with men for HIV testing is sometimes called upon by the country's Ministry of Health, because this population is one of the most difficult to reach (only 56.3% of men who have sex with men know their status). The organization has always shared its experience with the health authorities by suggesting outreach activities to reach this population on the ground, which is not yet part of the latter's actions. At the same time, according to Jimmy Medina, the Quito community center's medical coordinator, "*MSM avoid being tested in public health establishments due to the continued discrimination suffered".*

2. In 2020, during the COVID-19 lockdown, following coordination with the health authorities, Kimirina delivered ART at home to migrant people living with HIV stuck in the country[81]. The association is currently evaluating the possibility of putting in place a permanent ART delivery program to migrant and foreign people recently diagnosed.

3.3 Success factors

- **Co-construction of actions and programs with key populations**.
  "When we put in place a program, we always do it with the participation of the key population. We always put in place focus groups and satisfaction surveys that help us identify new needs among our users."
  Jimmy Medina, Quito community center's medical coordinator, Kimirina.

- **The good relationships with the Ministry of Health and the mutual trust built over time** have allowed the association to make its voice heard regarding strategies to control the HIV epidemic. The support given by other member associations of Coalition PLUS to Kimirina has also contributed to raising its profile with regard to the authorities.

- **The organization has always backed up its public health initiatives with scientific evidence.**

[81] "La coordination des associations communautaires, membres de Coalition PLUS, avec les autorités nationales et le système de santé publique dans le contexte de la crise sanitaire due à la COVID-19", fiche de capitalisation ["Coordination of community associations, members of Coalition PLUS, with national authorities and the public health system in the context of the COVID-19 health crisis", Capitalization factsheet]. Coalition PLUS. 2020. https://www.coalitionplus.org/wp-content/uploads/2021/01/FICHE_CAPI_EXPERIENCE_KIMIRINAvs2_NOV2020-1.pdf

- **Continuous training for the center's staff.**
- **National coverage of community-based health services (7 sites).**

4. Challenges, levers and key lessons

- **Convincing the people met on the ground to access the center's fixed services took time**. This initiative primarily consisted in systematically raising people's awareness of the importance of regular testing and on-going work to promote the center.

- **Tests for other STIs** could supplement the current range of services in order to make it more attractive.

- **The center needs to improve its communication on social media**. Around 60% of current users use social media and this is an important factor in access to the center's services for many people.

- One lesson learned over the years of working with communities is that **we cannot miss any opportunity to bring people to care, all the time, whenever an opportunity presents itself, in order to allow people to take control of their health**. Pursue prevention and awareness-raising actions to reach these people, change their perspective of HIV and what it means to live with HIV.

"For me, one of the greatest lessons I've learned is that not everyone is equal, that everyone is different and that everyone has their own particularities. On the question of access to services ... if they ask for something it's because they have a need and sometimes they have an immediate need, now, in that moment, and we can't let those opportunities slip by. And my message is always aimed at everyone... by reaching some people through prevention actions, and others by changing their way of life so that they see things differently: that living with HIV is not synonymous with death, that it is life." Jimmy Medina, Quito community center's medical coordinator, Kimirina.

V. Comparative overview: the sexual health services of the four structures

SERVICES / AREAS OF ACTION[82]	Le Spot & L'Antenne	Douala Access medical center	Les Halles clinic	Quito community medical center
Prevention (which involves a combined approach at the 4 centers)				
Education/awareness-raising/communication for behavior change	✓	✓	✓	✓
Prevention on social media	✓	✓	✓	✓
Distribution of information, education and communication materials on sexual health and STIs	✓	✓	✓	✓
Distribution of prevention materials (internal and external condoms, lubricating gels)	✓	✓	✓ External condoms only	✓
PrEP	✓	✓	✓	✓
Community-based HIV testing with the use of rapid diagnostic tests and self-testing	✓	✓	✓	✓ No self-tests
Cancer screening (cervical, prostate, anal)		✓	✓	
Contraception (including emergency contraception) for women		✓		

[82] The list of services has been established based on the regional guide *Sexual health services in West Africa: Bold, innovative solutions for access to care for key populations!*. PFAO, Coalition PLUS, 2019. https://www.coalitionplus.org/wp-content/uploads/2020/07/PFAOSexualHealthServicesGB.pdf

Hepatitis B screening and vaccination	✓	✓	✓	✓
Risk reduction related to drug use with distribution of sterile drug-use equipment	✓		✓	
Medical care and referral				
Syndromic management of STIs (diagnosis and treatment)	✓	✓	✓	✓
Link and care referral	✓	✓	✓	✓
Treatment and care for people living with HIV	✓	✓	✓	✓
Diagnosis and treatment of HIV/TB co-infection		✓	✓ Diagnosis only	
STI (genital or anal) treatment including complex STIs	✓	✓	✓	✓
Gynecology and proctology consultations		✓	✓	✓
Treatment of proctological pathologies		✓	✓	
Referrals for post-abortion care		✓	✓	
Obstetric care and follow-up			✓	
Referral to risk reduction services and addiction treatment	✓		✓	
Addiction diagnosis	✓			

Prescription and follow-up of opioid substitution treatment				
Biological follow-up				
Biochemical analyses (creatinine, blood glucose, cholesterol, triglyceride)		✓	✓	✓
Hematology (complete blood count)		✓	✓	✓
Regular monitoring/measurement of CD4 lymphocytes			✓	✓
Regular monitoring/measurement of viral load			✓	✓
Psychosocial and economic support				
Community mobilization and self-support (self-esteem, human rights, sexual health, etc.)	✓	✓	✓	✓
Psychosocial counseling and support including adherence assistance	✓	✓	✓	
Adherence assistance and treatment education	✓	✓	✓	
Family mediation		✓	✓	
Referral for psychosocial care	✓	✓	✓	
Comprehensive care in cases of GBV		✓		

Referral to dedicated structures in the case of GBV	✓	✓	✓	✓
Mediation in situations of GBV		✓	✓	
Emergency shelter/accommodation		✓	✓	
Income-generating activities, vocational training, entry into the job market		✓		
Legal support				
Recording and documentation of cases of human rights violations		✓	✓	
Legal assistance		✓		

Quantitative overview of the four schemes:

Scheme	Number of users 2021	Number of team members	Number of services offered
Le Spot & l'Antenne	465	20	19
Douala Access medical center	2,000-3,000	15*	31
Les Halles clinic	683	25*	32
Quito community medical center	3,854	9	18

*not including peer educators involved in different stages of the pathway

Commonalities and specificities of the sexual health services of the four structures

- The range of services within the four structures have been developed as part of a **multidimensional approach**, including prevention and medical treatment services, psychosocial services, community-based research activities in the field of health, advocacy actions aimed at decision-makers for the incorporation of SHS schemes in public health policies and for the promotion and protection of human rights, as well as education by peers with a view to building the capacities of and empowering users as community-based workers.

- The range of services in the four SHS schemes are provided by **multidisciplinary teams** – doctors, pharmacists, nurses, lab technicians, social workers, psychologists, psychological counselors, human rights focal points, paralegals, gender ambassadors, etc.

- **Peer educators are involved in almost all stages of users' health care pathways** within the four schemes: community mobilization/awareness, outreach prevention and testing, reception within the structure (center or clinic), needs assessment, medical care (including specific exams – genital and anal), referral and accompaniment of users to external health structures.

- **Importance of outreach awareness-raising and prevention within the strategies to mobilize the target audience of the SHS schemes**. Each of the four structures puts in place outreach or mobile strategies with the help of the peer educators in order to publicize their range of sexual health services to key populations vulnerable to HIV, STIs and viral hepatitis. This strategy represents the **main point of access** for users to the community-based prevention and treatment system within these health services. In addition to raising awareness on sexual health issues and providing information on the structure's services, within the communities or door to door (Douala Access center), the peer educators put in place actions to prevent HIV, STIs and viral hepatitis, including (depending on the case) testing at gathering places for key populations (Quito center, Les Halles clinic, Le Spot & L'Antenne) or at their places of work (Les Halles clinic).

- In the national and local health contexts, the SHS schemes **address the shortcomings in the health systems in terms of the specific needs of key populations**, whether in the field of prevention and risk reduction for chemsexers, free treatment of anal and genital STIs (provided by the four schemes), treatment of proctological pathologies and help with HIV treatment adherence and treatment education, to take just a few examples. These specific services **are run in secure spaces** where users can be themselves and express themselves without fear of being judged or stigmatized.

- Always with the aim of meeting the specific needs of the user populations, two commonalities should be noted between the African schemes, the Les Halles clinic and the Access center in Douala – **treatment of proctological pathologies** and **services with a gender component**, in response to the specific needs of women from key populations, that is **gynecology and obstetrics consultations, comprehensive care in cases of GBV, contraception (including emergency contraception) and prevention of unwanted pregnancies, post-abortion care.** The fact that these two centers have a more developed range of services on these issues than the other countries could be due to the fragility of the health system, and therefore, a lack of resources to respond to these specific needs in the public system.

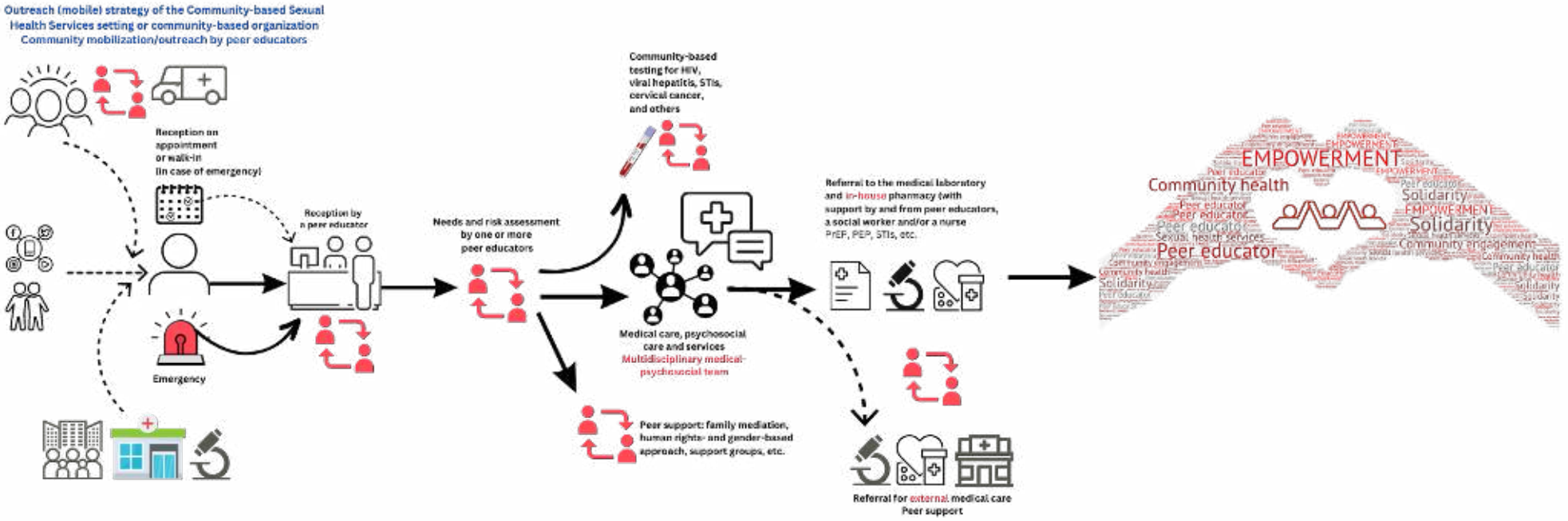
- In the four schemes, the **range of services evolves gradually over time as a result of regular changes in users' needs**. At Le Spot & L'Antenne, the idea of putting in place support for stopping use of psychoactive products in a sexual context emerged notably during a time of collective discussion between users at a Chillout Chemsex session. The focus groups put in place with users at the Access center in Douala have made it possible to identify, over time, needs such as assistance with cases of GBV, assistance in obtaining identity documents, and access to hormone treatment for transgender people (currently a topic under discussion). It is also as a result of these moments of discussion and exchange with users that the need for endocrinology services for transgender people as well as the demand for proctology consultations emerged at the Les Halles clinic. Always attentive to users, the Quito community center recently identified a need specific to migrants — psychological support — and put in place a service in response to this.

● In addition to the varied clinical and biological responses depending on the national system they supplement, the wellness dimension incorporated into the WHO definition of health – “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”83 – is taken into account by the four structures. The following components of their services are notably indicative of their consideration of the different socio-economic determinants and life context: adaptation of services to the schedules of key populations (night program adapted to sex workers; introduction of remote consultations, online) and their travel possibilities (mobile intervention strategy, outreach activities, location of centers in accessible places); emergency shelter/accommodation and family mediation, protection of key populations; free provision of services; social support and counseling, including support for access to social rights and job seeking; community mobilization and self-help for self-esteem and respect for human rights.

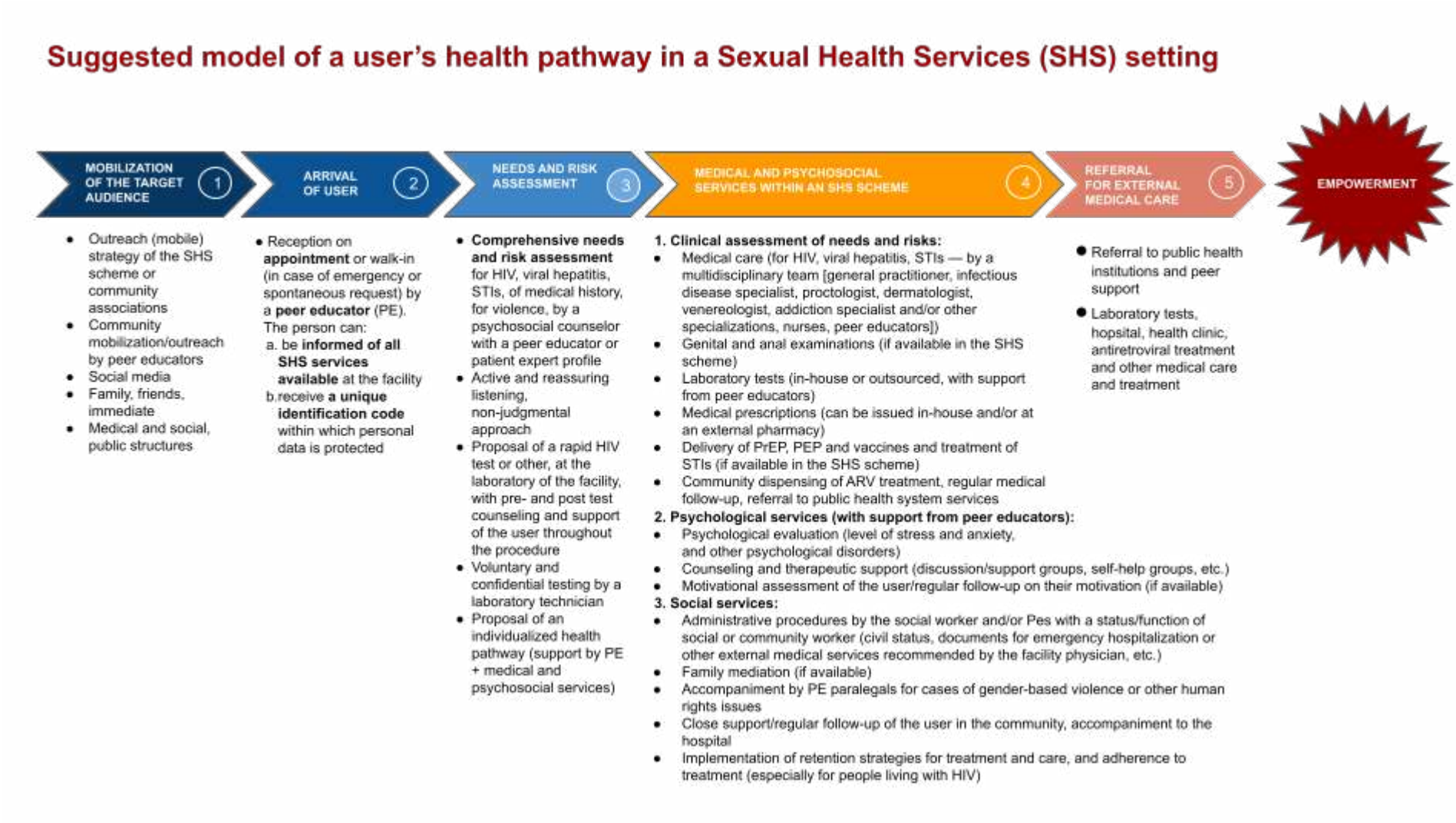
● The partnerships put in place by the four structures play an important role in the diversification of their services and/or user recruitment. In terms of resources for the diversification of services, we would recall **the partnerships of Le Spot & L’Antenne** with a feminist trans association to meet the specific needs of transgender users, the partnership with associations and an addiction treatment section of a hospital which make it possible to support users during their consumption severance; **the Douala Access center’s partnership** with a surgeon at a public hospital, which allows users to undergo free proctological procedures, or its collaboration with various partner associations for a joint response to violence based on sexual orientation or gender; **Kimirina’s partnerships** with human and LGBTQI+ rights associations in Ecuador, involving the implementation of joint prevention activities for the populations vulnerable to HIV and STIs. In terms of user recruitment, examples include the **partnerships with associations put in place by Les Halles clinic** within Les Halles market area of Bamako (youth associations, merchants association, key population associations), making it possible to refer people to the clinic.

[83] International Health Conference (2002). Constitution of the World Health Organization. 1946. Bulletin of the World Health Organization, 80(12), 983–984. https://www.who.int/fr/about/governance/constitution

User health care pathway in a community-based SHS setting (across the four structures)



Suggested model of a user's health care pathway in a SHS setting:



VI. Cross-cutting of the life paths[84] - treatment pathways of four users of the SHS settings

This section is intended first and foremost to provide a description of the experiences of users of the four SHS schemes – Le Spot & l'Antenne (AIDES and Le 190, France), Douala Access center (Alternatives-Cameroun, Cameroon), Les Halles clinic (ARCAD Santé PLUS, Mali), Quito community center (Kimirina, Ecuador) – from the users' point of view. To obtain this feedback, we conducted individual interviews with one user per scheme.

1. Life path before coming into contact with the SHS settings

Below is a snapshot view of their **life paths before coming into contact** with the SHS settings:

JC, age 51[85], came into contact for the first time with Le SPOT run by AIDES in 2021, after "20 years of substance use, ten years of partying, ten years of less partying and many more of addiction and notably chemsex"[86]. He tried several times over five years to quit his drug addiction himself. He also tried to get help and went to NA twice[87]. With a reasonably satisfactory job, surrounded by an open and loving family and kind friends, JC arrived at a critical point in November 2021 following "repeated absences and disappearances" due to his addiction and, in consequence, a loss of the social life he loves.

"I felt tired at work. And my job involved responsibilities (…). I managed people, but at the same time, I didn't realize at the time that it was a problem in my work. (…) I had been trying to quit by myself for five or six years already, so I would stop and then I'd start again and then I'd stop, then start again, etc. I never had the strength to get help though. What was funny was that while I was in a relationship, I didn't use in general or hardly at all, it was when I was single. That was the mechanism."

Oumarou, age 25[88], transgender, got in touch with the Alternatives-Cameroun Access center in Douala in 2015 after a painful and traumatizing journey due to the extensive stigmatization and discrimination he suffered. The serious consequences of these acts include: rejection by his father, no ID card, no housing, no job.

*"(…) When I talk, I talk like a woman, it's in my nature, it's who I am. It's something I can't change. (…). People started to beat me and ask me: 'Why do you do that?' And they drove me out of the district, but at that time I had nowhere else to go. I couldn't even go home because even my father had turned his back on me. And when my mother was living there, she couldn't take me in because she would have had problems with him. (…). It's a problem I'll have all my life... **rationally**, I need to prepare myself for the fact that people **will never love me**."*

Initially, Oumarou went to the Douala Access center because she wanted to "meet her soul mate", but returned two months after that first visit because she "became severely ill".

Seba, age 20[89], sex worker, came to Les Halles clinic for the first time in 2020 for a vaginal infection. Rejected by her family, she was living in a '*maquis*'[90] where she was sometimes robbed by clients or colleagues.

"I was a mess, I didn't know how to do things. Because I'm a sex worker, that's how I saw clients: once they offered me money, I did it without trying to find out their status."

Carlos, age 32[91], currently a user of the Quito community center, migrant, arrived in the country around six years ago *("important question to take into account")*, bisexual. Decided in 2020 in agreement with his partner to have an "open relationship". Following an accident (condom breakage), Carlos was exposed to a major risk of HIV infection.

"I've always been in the closet as a bisexual, I mean (...) I couldn't talk about it openly whether in a heterosexual couple or in a homosexual couple, I always felt questioned about it. For me, one of the

[84] A short sequential analysis that targets a limited period, that is to say the period prior to contact with the SHS settings and subsequent to the users' health pathways within the latter.
[85] Age at the time of the interview. This also applies to the presentation of the other individuals interviewed.
[86] Interview with J.C, June 7, 2022.
[87] Narcotiques anonymes, French branch of the association Narcotics Anonymous.
[88] Interview with O.Z, May 11, 2022.
[89] Interview with S.S, May 10, 2022.
[90] The name given in Mali to popular bars (sometimes with rooms used by sex workers).
[91] Interview with C.G., May 13, 2022.

most crucial things with regard to my sexual identity is being able to talk about it much more easily, openly, without constraints, and having information on sexual health."

2. How users came into contact with the SHS settings, their original motivation, the health services received in response to their urgent need and their immediate effects

User	How	Original motivation	Services received in response to users' urgent needs	Immediate effects observed
J.C.	Via a friend	**Internal factors:** Search for an effective program to quit drugs and a forum for discussion on sexual health issues **Factors connected to the SHS scheme** Attitude of the center's staff, accessibility in terms of appointment waiting times. The scheme's approach in itself (and its quality) to quitting drugs	Personalized follow-up/ Free psychological/ psychiatric consultations Group meetings and support groups	Better understanding of the 'mechanisms' of addiction Capacity-building for managing the risks of relapse *"I started putting words to things that I had completely pushed aside and that led me to [addictive] practices"*
Oumarou	Via a friend	**Internal factors:** Fear and urgent need to get treatment **Factors connected to the SHS scheme** **Free provision of services** – *"Alternatives, they helped me, they gave me all these medications (…) I didn't have any money, I had nothing"*	HIV testing and treatment Psychological counseling	*"I tried to put into practice the advice of the psychologist I met when I arrived here and that really helped me. Now, I live a positive life despite the fact that it's not what I want or what I'm looking for, but I don't have a choice."*
Seba	Via a friend	**Internal factors:** Urgent need to get treatment **Factors connected to the SHS scheme** **Free provision of services** – *"I didn't have the means to get medication"* **The proximity –** *"It only takes me 15-20 minutes to get to the Clinic"*	STI treatment HIV, STI testing	Better understanding of the importance of health and the need to protect yourself *"Before that, I didn't protect myself, my health wasn't even a concern for me before. But that's not true anymore."*

Carlos	He already knew about the center thanks to its visibility and public profile - *"They already have a reputation here, in Quito, for the work they do"*	**Internal factors:** Fear, anxiety **Factors connected to the SHS setting** Being able to **talk freely/openly**, in confidence **The accessibility of the services** – telemedicine makes it possible to receive all of the information requested at home	Virtual medical consultation/ information HIV testing PEP/PET[92] treatment and monitoring	*"The information given about the services gave me great confidence/a feeling of security and also a great deal of peace of mind."*

3. Personalized follow-up received by the users in response to health needs other than the initial needs

Following the critical period requiring an urgent response in terms of health services, the four SHS schemes continue to provide users with other services adapted to their lifestyle, to their sexual orientation, to their intimate relationships, and to their socio-economic situation, namely:

JC: support groups, participation in the *'apéros du vendredi'* [Friday aperitifs] get-togethers to overcome moments of solitude.

Oumarou: proctological services, family mediation and administrative procedures to obtain an identity card, temporary housing, help finding a job, filing complaints for GBV situations, advice provided by peer educators to reduce the risk of GBV and police arrests ("dress like a man, don't wear nail varnish", etc.).

Seba: HIV testing every 3 months, testing for cervical cancer every 6 months, hepatitis C and B testing, hepatitis B vaccination, input supply (condoms and gel), advice on avoiding being robbed by clients or colleagues, home visits by peer educators.

Carlos: access to PrEP, regular viral load monitoring and other periodic exams for hepatitis and STIs.

4. What users most appreciated in the SHS settings and enabled them to continue with treatment and their health pathway

The quality and efficacy of the services provided

J.C: the individual psychotherapeutic guidance, group therapy based on discussion and free expression (via support groups) and the whole drug dependency reduction approach. Unlike the NA approach which stopped at the exchange of experiences between peers, the approach at Le Spot goes one step further in terms of therapeutic intervention, in that users are guided, using specific techniques, to reach key moments of realization, to understand the 'why' and the 'mechanisms' of and how their dependency functions, to put words to the suffering or trauma, buried in the subconscious and unconscious.

*"It's a good approach that got me talking because I never thought that one day I'd be able to talk about myself. (…) There are **some really good techniques** here, particularly setting a framework with the group leader. You can tell that it's **really well thought out**."*

Carlos: *"(…) the information I was given at the time, which I really needed. Then, the help in accessing medication and the rapid medical attention. In my case, for example, I needed [the services to be provided] as early as possible."*

[92] Post-exposure prophylaxis (PEP) is an emergency treatment that consists of blocking the infectious process by exposing the virus to ARV medication as early as possible following a possible exposure to HIV (initiation of treatment, preferably within 4 hours, at the latest within 72 hours. This treatment must be taken for 28 days.

The quality of the human interactions, the kind, friendly and reassuring welcome, the non-judgment, the absence of discrimination and stigmatization, the confidence

Oumarou: *"I felt at ease, seeing people like me, who looked like me. I thought it was incredible to go to a place where you're welcomed, where no-one is judged."*

Seba: *"As soon as I arrived at the clinic, I felt at home. They were really cheerful with me."*

Carlos: *"One of the things I personally appreciated was the attention I received and the fact that they made me feel like someone they knew, familiar. (…) They make you feel welcome and accepted, and that's so important. (…) So it's truly the staff who make a real effort in how they receive beneficiaries, in how they listen to others. I think that it's not just because they've known me for two years now, it's a general attitude to the people who come to the center. (…) everything in the relationship with the center is built around trust."*

The quality and consistency of the various information provided

Carlos: *"The information is so important because the lack of knowledge, the ignorance of everything surrounding sexual issues and above all STIs, it's very important and I, there were things I didn't know, particularly PrEP, PEP, undetectable = untransmittable, I didn't know much or anything about it. They [also] gave me brochures. Each person who saw me started by giving explanations to the slightest question or slightest doubt I had about the medication, its interaction with food. There was* ***consistency*** *in all the information received from the different people, which really gave me confidence and a feeling of relief/security."*

5. Users' perceptions and representations of the SHS settings

One of the findings from the analysis of the user interviews is that the majority perceive the SHS schemes and their human dynamics, through the different interactions with the professionals, peers and other users, as a **"family"**:

J.C*: "It's like a close family. (…) It's a* ***real gift,*** *this center."*

Carlos: *"The way I'm treated, I feel like I'm almost part of the* ***family****, like a* ***cousin****, and I like that, how I'm treated."*

Seba: *"I feel like I'm part of a* ***family*** *here. The clinic has been a* ***truly amazing family*** *to me."*

The SHS schemes are also associated with an environment that facilitates freedom of expression, freedom to be yourself, non-judgment, security, a place where people feel good and where they like to go:

J.C: *"I* ***like*** *coming here"*

Oumar: *"(…) since here, it's the only place where I feel* ***free to express myself and where I feel comfortable****"*

Seba: *"(…) I really feel* ***safe*** *here. It's a* ***pleasure for me to come to the clinic often****."*

One interesting point to emerge from the analysis was the association of the SHS scheme with a **"gift" (JC).** Unlike a **"present",** a **"gift"** consists in giving without demanding anything in return and responds to a **lack of something, a specific need** (like the gifting or donation of blood or organs, for example). Our understanding of this, indirectly, is that the SHS schemes respond to specific needs, both medical and emotional.

6. Comparative overview of the users' experiences at other public and/or private health structures

User	Public system structures	Private system structures	SHS scheme vs other public/private health system structures
JC	Even though there is a very good relationship with the attending physician, sexual health issues and everything regarding sexual orientation are not discussed with him. *"Can you prescribe me that? I ask for a prescription for analyses, not medicinal, and he says OK. I don't talk about sexual health with him. I've known my attending physician for fifteen years. I go because I really think he's kind. I do regular tests"*	S.O	Being able to talk freely about problems connected with sexuality and drugs. Appreciation of the medical and psychotherapeutic follow-up, sharing with peers, free services *"I want to emphasize that for me, it's truly a gift that [such] organizations exist. I offered to pay, but they said no, not for now, no payment at all for the shrink, it's taken care of. It's incredible, because there are people who don't have the financial resources [to get treated]."*
Oumarou	Experience of discrimination and stigmatization on the grounds of sexual orientation and gender identity *"(...) when I arrived at the hospital, I had the nails, the varnish, all that, and the doctor refused to see me because he said that he didn't see homosexuals. Then my mom took me to another hospital, because here the hospitals are too stigmatizing towards people. Especially trans like us, they are too stigmatizing towards us, we have too many problems."*	S.O	*"In fact, the difference is that the Alternatives doctor smiles at me, talks to me like we already knew each other. It's two different worlds"* (in reference to the public health system)
Seba	Experience of discrimination and stigmatization on the grounds of socio-professional status *"They would call me all sorts of names, and judge me. (…). They would say why not find something better to do than be a sex worker. (…) I felt constantly uncomfortable when I went there"*	S.O	*"There's no comparison between the two (public system/SHS setting). I wonder if they've even had the same training. At the Clinic, there's no stigmatization, no discrimination, no judgment."*
Carlos	A difficult experience, marked by discrimination on the grounds of belonging to a migrant population: *"it was very unpleasant"* Explicit preference for the treatment of sexual health issues at other health structures, not within the public system:	Rapid access. And yet, very costly consultations and treatments on sexual health matters: *"For someone who earns the minimum wage*	Rapid access to treatment and care (faster than in the public or private health system). The cost of services is more accessible. Interactions with staff - a welcoming, friendly team.

	"I didn't go to the public system for sexual issues." Long waiting periods to resolve a sometimes urgent health problem: *"In the public system, it takes three months to get an appointment for a medical consultation."*	*here, it's something they can't even consider."* Inaccurate or inappropriate information on sexual health issues Touching on sexual health issues is not a simple matter in discussions with health professionals in this sector (neutral or, at best, more laid-back reactions) Resolving a problem requires consultations with several doctors until you find the right person.	*"The human kindness I receive at Kimirina is absolutely different from any other contact I've had, whether in the private or public systems. It's this human kindness in the way they treat others, the respect I feel from them. It's quite simply beyond compare."*

7. Users' engagement within the community-based health approach of the SHS settings

Another result of the interview analysis concerns user engagement as an indirect effect of the inter-relational dynamics within the community-based health approach and, at the same time, of what could metaphorically be called "the power of the gift received". Once the window of vulnerability had passed, the four users felt ready to share their knowledge gained from their experience and to help their peers. The examples of initiatives presented below demonstrate a relatively high level of empowerment with regard to their initial situation, but also of responsibility and empathy towards other users of the service:

JC: *"And then I took a different approach. So I thought about helping too. I looked into volunteering. I'd been coming here for years now and I'd never dared do it for lack of time (...). But, more and more, I realized that everything that being here has brought me, at some point in time, needs to be given back. I can't stand on the sidelines, there are messages, important things to pass on and I need to give my time. (…) During these meetings, we share our experiences (I share mine too). And in the group, the next week, someone will say to me: 'You said something last week that I liked, it got me thinking'. For me, it's the greatest thanks in this world. (…) Others are involved in other areas (people who distribute condoms, for example). (…) Prevention is important, but I don't have the illness, so I wouldn't have the right words to express myself. I prefer to talk about a subject I know, that I've lived through, to share my personal experience."*

Carlos: *"So I thought to myself: 'Why couldn't I be the spokesperson for that? Why not share with other [users] what I know now?' I set myself the goal of talking to them about the center, explaining things to them, helping them make appointments, encouraging them to get tested, get screened, telling them that they'd get information as well as condoms, etc. That's how I got started and that's why I'm a self-declared spokesperson still today."*

This commitment from the users interviewed is also reflected in the **recommendations and suggestions** they made/put forward during the interviews with regard to the health services and to the practices concerning them:

J.C: (1) organization of outings (walks, etc.) at weekends to prevent situations of solitude and depression among users in his support group *("the one thing we all have in common is solitude to different degrees")*, (2) drawing up a reference document to provide scientific/medical support for the psychotherapeutic approach to reduce/stop drug dependency, (3) working on promotion and communication surrounding this service so that it is easily identifiable by the people who need it and it attracts their interest resulting in them accessing it ("entry needs to be facilitated, because if people don't really want to, they don't come").

Oumarou: (1) a transgender doctor and psychologist, (2) facilities to obtain national ID cards for transgender people, (3) access to hormone treatment and the possibility of sex change.

Seba: (1) planning services, (2) vaccinations (hepatitis B, HPV, etc.)

Carlos: (1) in order to facilitate access to PrEP/PEP, a solution needs to be found so that the exams to confirm a HIV diagnosis can be carried out at the center (or at the Red Cross, as the price is half that of the private sector), (2) a psychologist for everyone coming to the center for testing (and this service should be provided at an accessible price), (3) "it would be great if lab analyses (e.g., viral load) could be done here", (4) finding ways to reduce the anxiety of people awaiting the result of testing, (5) more facilities in terms of prices for access to PEP/PET treatment.

8. The impact of the SHS settings on users' life paths

The SHS schemes have become essential to the users and are now an important trajectory in their life path.

Their testimonies to this effect fully confirm this:

JC: *"I don't think I've missed a Thursday since November 14 (2021), for that matter, and even though things are better today, I come back because it's like a crutch. It's just to remind myself, tell myself, that's it. And also I share information, these days I come with a much more positive message. And especially, I've fallen in love... and that hasn't happened to me in years."*

Oumarou: *"I can go twice a month [to the center] as it's the only place where I feel free to express myself and where I feel comfortable. [Apart from that,] they organize educational talks on different topics. The talks are really important to me, when I put them into practice it really helps. I've met people I've formed bonds with. We've become friends. I've learned that by protecting myself, I'm protecting others too."*

Seba: *"Sometimes I come four times a week to the clinic. I've made a lot of friends here. I've changed a lot."*

Carlos: *"Before, for me, coming to the center was about anxiety, now it's more about prevention. My friend is now someone who does not transmit the virus as they don't have a detectable viral load, and all that is thanks to the center."*

The different feedback regarding the community schemes underscores the important role that these schemes now play in the life of users. The perceptions and representations of the schemes, like feeling "part of a family" or wanting to get more involved in the association, demonstrate the engagement in the community-based approach (see sections 5 and 7 of this chapter). These factors demonstrate the development of a **feeling of belonging** within these schemes among users.

Since the 1990s, different theoretical contributions from social psychology have shown the important connections between the **need for social belonging** in individuals and (among others) their **health and**

well-being[93]. With this in mind, the community-based approach does not solely have an effect on the health of individuals but also on their psychosocial needs which are interconnected. This also lines up with Maslow's hierarchy of needs where social belonging follows **physiological, basic** needs (food, shelter, bodily comfort, sex, etc.) and **safety** needs (job security, stability, good health, etc.)[94]. In other words, satisfying the need for belonging – although it is an important determinant of health – is conditioned by/preceded by fulfillment of the two others.

The analysis of the health pathways of the four users, presented above, confirms Maslow's hierarchy of needs, in the sense that before the beneficiaries become empowered and demonstrate their need for involvement within the association and belonging to its community-based approach, they need first of all to see all their safety needs (health emergencies) fulfilled. In some cases (Oumarou), the fulfillment of safety needs is preceded by the fulfillment of basic needs (housing, physical comfort, money for medication, etc.), which shows that the process of empowering people with a higher degree of vulnerability is complex and needs to start from the same basis as the hierarchy of needs.

[93] Baumeister, R. & Leary, m. (1995). "The Need to Belong: Desire for Interpersonal Attachments as a Fundamental Human Motivation", *Psychological Bulletin,* 117(3), p. 497-529. http://dx.doi.org/10.1037/0033-2909.117.3.497. (PDF) The Need to Belong: Desire for Interpersonal Attachments as a Fundamental Human Motivation

[94] La pyramide de Maslow : la théorie des besoins [Maslow's hierarchy of needs]. Psychologue.net

Conclusion

The capitalization process, carried out on four SHS schemes run by AIDES (France), Alternatives-Cameroun (Cameroon), ARCAD Santé PLUS (Mali) and Kimirina (Ecuador), made it possible to identify: (1) the skills, expertise and main elements that the construction of a range of sexual health services is based on, differentiated and adapted to the needs of key populations particularly exposed to HIV, STIs and viral hepatitis; (2) the factors and strategies that have enabled this community-based model to mobilize vulnerable people from key populations to adapt the sexual health services to their needs; (3) consideration of users' life paths and the defense of human rights to facilitate access to health.

A comparative overview of the country information sheets, the comparative table of services, as well as user testimonies give an understanding of the way in which the three fundamental principles of the Coalition PLUS CBSHS referred to in the introduction are implemented within the four schemes:

1. The holistic approach centered on needs (users' interconnected health and social needs). The wellness dimension, incorporated into the WHO definition of health, is taken into account by all of the community sexual health centers analyzed. Another element common to the four CBSHS settings is the evolution of the services based on users' needs and the results of community-based research, and the involvement of users in the evaluation of the services. The quality of the services, meanwhile, is connected to staff training, the incorporation of specialized personnel, the multi-disciplinary dimension to the teams, and the partnerships with specialized structures, made aware in advance of how to receive populations. Other key aspects in terms of the accessibility of the services, such as their being free of charge for the users, the speed of access or the geographic proximity, are also encompassed at all the centers.

In the four settings, the users are welcomed by their peers, who are involved in the different steps of the centers' health circuits, depending on the case – for the evaluation of their needs once they arrive at the centers, HIV/STI counseling and testing, psychosocial support, referral to treatment and external care, home psychological and/or medical assistance services, family mediation, etc. Once the window of vulnerability has passed, some users get involved in the SHS settings by sharing their knowledge gained from their experience and helping their peers. They make recommendations with a view to adjusting or supplementing the existing health services to better meet needs.

One of the added values of these CBSHS schemes is primarily based on the holistic or global approach to users' needs through, among others, consideration of health determinants and, in particular, the family environment, the social support network, education, employment, income, housing, experiences of access to health services in other systems (public, private), habits/lifestyles, the level of vulnerability to the risks of infection and the capacity for resilience in this respect, etc. These determinants are, in fact, elements of a person's **life path and, more precisely, their status observed at the time of arrival** at the community sexual health center. Even sequentially, **this approach which takes into account the elements of a person's life path in order to build a differentiated and adapted health pathway, shows that taking action for a better state of health requires an adaptation of the health system, whatever the system and wherever it is, to users and not the other way round.**

2. The analysis of the information provided by the coordinators, as well as the user accounts, revealed that the **community-based approach to health** draws on a set of values and principles that are genuinely and systematically put into practice: the user is at the heart of all interventions and notably, to a greater or lesser degree in the decision-making, design, implementation and evaluation of health services. The fact that all members of the community have experience, knowledge and know-how to share as a resource to contribute to the collective effort is valorized by the four schemes as an important lever that allows users who want to become involved as peers to do so and to benefit from prior training and support in this area. The community-based approach, analyzed here, thus draws on a strong rooting in the community of the people concerned and targets the empowerment of vulnerable people, social change ('breaking taboos'), and health democracy (i.e., the participation of representatives of vulnerable people in the decisions surrounding the health topics that concern them).

Other important elements that make up the added value of the community-based health approach:

- community mobilization,
- the integrated range of services – prevention, medical care and psychosocial, economic and legal assistance,
- the constant search for innovations to increase access to services for key populations and offer them greater possibilities to improve their state of health,
- the quality and efficacy of the services,
- the multi-sectoral approach – different skills mobilized by multidisciplinary teams, peer educators, expert patients, lab technicians and community workers.

The changing dynamics of the health services is connected, among other things, to the results of community-based research projects and the involvement of users in the evaluation of the services. Consultations specific to anal and genital health, family mediation and mediation within the community and, for some SHS schemes, legal assistance in cases of GBV, are just some examples of services that have been gradually incorporated into the initial services available. Also in this regard, greater involvement of users in the process of joint construction of the service package and in decisions regarding services is without a doubt a line of action that the SHS schemes could further expand.

3. The defense of human rights and action against violence, stigmatization and discrimination (advocacy, legal assistance, but also the creation of a favorable environment at centers). Users associate the four CBSHS schemes with an environment that facilitates freedom of expression, the freedom to be yourself, non-judgment, safety, friendly human interactions, and trust. They are places where people can express themselves freely regarding issues related to sexuality, the risks of acquiring STIs, drugs, GBV, etc.

The advocacy actions put in place by the four Coalition PLUS member and partner associations in this area have made it possible to include key populations and their needs in the main public policy documents at national level (strategic guidelines or national plans for the fight against AIDS). In Cameroon, for example, the advocacy actions of Alternatives-Cameroun, founded, among others, on conclusive data from various research projects on the link between GBV and the spike in the HIV epidemic, have contributed to the inclusion of GBV in the 2018-2022 National Strategic Plan for HIV. Alternatives-Cameroun and ARCAD Santé PLUS have also included support for victims of GBV in their range of sexual health services. Mention should also be made of the different training courses put in place by Alternatives-Cameroun, Kimirina and ARCAD Santé PLUS for key actors in the public health system (doctors, authorities, etc.) which have placed the accent on discrimination and stigmatization as major barriers in the access of key populations to health services. Despite these successes, there is still a long way to go in the struggle against discrimination and violence against key populations, in order to ensure adequate and secure access to health services. The Cameroonian context is particularly sensitive in this regard: violence suffered by TP alienating them from care. In some cases, as one user confirmed, even community-based associations resort to invisibility advice (“dress like a man, don't wear nail varnish”, etc.) in order to safeguard their physical integrity. This reality is part of a global context where “to date, at least 13 UN member States worldwide explicitly criminalise trans persons”[95], “while others hide their discrimination behind (...) measures connected to public nuisance, indecency, morality, offenses related to sex work and to consensual activities between people of the same sex, among others”[96]. According to one of the most recent reports on the rights of TP around the world, a regression and even a stagnation of rights to the legal recognition of gender could be seen in 2019 in different Western countries, South America and Asia[97].

[95] ILGA World. (2020, September 30). Communique on “Trans human rights: ILGA World releases global research into legal gender recognition and criminalization”. https://ilga.org/fr/ilga-world-publie-trans-legal-mapping-report-troisieme-edition
[96] Droits des personnes trans dans le monde : une avancée des combats, mais aussi plus de crispations et de réactions violentes [Trans people’s rights around the world: progress, but also more tensions and violent reactions] neonmag.fr, 2020 [quotation translated from the original French]
[97] ILGA World: Zhan Chiam, Sandra Duffy, Matilda González Gil, Lara Goodwin, and Nigel Timothy Mpemba Patel, *Trans Legal Mapping Report 2019: Recognition before the law* (Geneva: ILGA World, 2020), p.7, Trans Legal

Although the four CBSHS settings originate in different countries and continents, the users' needs are practically the same. These converge on being able to benefit from health services – within the meaning of the WHO definition, that is to say "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" – in an environment that does not judge them or discriminate against them, where they are welcomed in complete safety, where they can express themselves freely, and where their opinions count and make a difference in the provision of health services. The services put in place and the advocacy carried out by the community-based associations also converge on the response to this fundamental need.

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