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Investigating health services for sexual and gender minorities in France: a qualitative study protocol

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SCHOLARONE™
Manuscripts

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3 1 **Title** : Investigating health services for sexual and gender minorities in France: a qualitative study
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2
3 29 **ABSTRACT:**
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5 30 **Introduction:**
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7 31 Discrimination and structural violence experienced by sexual and gender minorities are the source of
8
9 32 social inequalities in health. The last decade has been marked by major developments in the provision
10
11 33 of sexual health services for these minorities in France. This paper presents the research protocol of
12
13 34 the SeSAM-LGBTI+ study which aims to document the health, social and professional challenges in the
14
15 35 organization of current health services for sexual and gender minorities in France.
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18 36 **Methods and Analysis:**
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20 37 The SeSAM-LGBTI+ study relies on a multidisciplinary qualitative study. It has two objectives: 1. To
21
22 38 analyze the history of the development of LGBTI+ health services in France, through interviews with
23
24 39 key informants and rights activists and through a study of archives; 2. To study the functioning and
25
26 40 challenges of a sample of health services currently offered to LGBTI+ people in France, through a
27
28 41 multiple case study, using a multi-level and multi-sited ethnography.
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31 42 **Ethics and Dissemination:**
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33 43 The study protocol has undergone a peer review by the *Institut de Recherche En santé Publique's*
34
35 44 scientific committee and has been approved by the research ethical committee of Aix-Marseille
36
37 45 University (registration number: 2022-05-12-010). The project has received funding from 12/2021
38
39 46 through 11/2024. The results of the research will be disseminated from 2023 onwards to researchers,
40
41 47 health professionals and community health organizations.
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44 48 **Keywords :**
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46 49 LGBTI+; Community Health; Sexual and Gender Minorities; Health Services; Qualitative study
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51 51 **Strengths and limitations of this study :**
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- 53 52
- 54 53 • This protocol will be the first in depth analysis of current health services for LGBTI+ people in
55 54 France
 - 56 55 • The study relies on multidisciplinary approach: public health, sociology, history and archives
57 56 studies
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- The study conducts a multi-level and multi-sited ethnography of LGBTI+ health services
- The study diversifies the ethnographic sites in order to avoid the bias of over-representation of territories where sexual and gender minority services are concentrated
- The study employs the term “sexual and gender minorities” to overcome the difficulties in including the full range of experiences within the LGBTI+ population

For peer review only

1. INTRODUCTION

1.1 Sexual and gender minority health issues in France

Discrimination and structural violence experienced by sexual and gender minorities (SGM) are the source of social inequalities in health (1). These inequalities are related to the relatively high prevalence and incidence of STIs (2), suicide attempts and mental health problems (3), psychoactive substance use (4–6), and cancers (7) observed in this population. The lack of training for health professionals on the realities and specific needs of SGM contributes to these challenges (8). Presuming that patients are heterosexual can impact how diagnoses are made (9). These various inequality elements create a syndemic context (10) in which the aggregation of health problems and situations of discrimination and violence affect the living conditions of lesbian, gay, bisexual, transgender, and intersex (LGBTI+) people.

Inequalities and discrimination have prompted SGM to develop community-based health interventions. In France, health interventions for SGM have historically been structured around responses to HIV/AIDS. The specific socio-behavioral and epidemiological characteristics of this population have led to increased prevention and screening activities, particularly for gay and bisexual men - often categorized by public health organizations as 'men who have sex with men' (MSM) - and for transgender people, especially sex workers. However, two populations have remained on the margins of these health interventions. The first are women who have sex with women (WSW), a group that has never been a target for public health; the second are bisexuals and their sexual partners; these persons are often lumped together under the MSM category, with the resulting risk that their different identity and sexual behaviours is invisibilised (11).

The prolonged focus on interventions concentrating on HIV/AIDS and individual prevention and screening behaviours started to show its limitations during the 2000s. More specifically, the continued high incidence of STIs (12) and HIV (13) despite these interventions demonstrated the need for a more comprehensive approach to sexual health issues that took into account structural barriers to access to

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2
3 87 health services (14). Furthermore, it would appear that a lack of epidemiological data led to the
4
5 88 invisibilization of sexual health issues other than HIV, and to lesbians and bisexual women being
6
7 89 overlooked in SGM public health programs (15). This particular issue led to a number of more
8
9 90 comprehensive and inclusive community-based initiatives, despite the low level of funding dedicated.
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11
12 91 In the last decade, France has seen major developments in the provision of sexual health services for
13
14 92 SGM, including the creation of several sexual health centers in Paris, the development of community-
15
16 93 based rapid HIV testing, the spread of pre-exposure prophylaxis and follow-up services (particularly
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18 94 online), the structuring of self-support initiatives for transgender people, and the development of
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20 95 sexual health programs for lesbians (16). Often driven by collaborations between associations, health
21
22 96 professionals, and researchers, these services - inspired by initiatives in other countries (e.g.
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24 97 Switzerland, the United Kingdom, the United States and Canada) - mostly combine traditional health
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26 98 care with community resources, complemented by digital tools. However, given the absence of any
27
28 99 specific public policy and no official research agenda, the field of SGM health is poorly structured, with
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30 100 services often being provided by local instead of national mobilization. This situation weakens the
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32 101 potential for these services to expand.
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102 To our knowledge no study to date has analyzed current interventions for SGM in a comprehensive
103 and comparative manner in the French context. Moreover, unlike in English-speaking countries, the
104 health of SGM is an underexplored subject in the field of social sciences in France (17,18), and most of
105 the published work is gay-centric. Some of the few French studies that have explored SGM health
106 focused on the subjective experience of this population in the medical care context (19). Dimensions
107 related to access to health services remain understudied. In light of these shortcomings, SeSAM-
108 LGBTI+ will focus on the organization of current services for SGM and the related activities of health
109 care actors.

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111 2. STUDY AIMS AND HYPOTHESIS

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3 112 This paper presents the research protocol of the SeSAM-LGBTI+ study (health Services for Minorities-
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5 113 Lesbian Gays Bisexuals Transgender Intersex +), which will explore the social and professional
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7 114 challenges in the organization of existing health services for sexual and gender minorities in France.

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10 115 SeSAM-LGBTI+ has two main objectives:

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12 116 *Objective 1.*

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15 117 The first objective is to investigate the social and political conditions influencing the development of
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17 118 health services for SGM in France over the last two decades, the inclusion of these conditions in public
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19 119 health policy, and the tensions related to their concrete implementation.

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23 121 *Objective 2.*

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26 122 The second objective is to analyze the functioning of existing health services and interventions
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28 123 targeting SGM in order to better understand how they are organized, how well they meet the needs
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30 124 of the populations concerned, problems related to training health care professionals, collaborations
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32 125 and coordination between different actors, the participation of users (e.g., in a board of directors), and
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34 126 the development of a burgeoning new field of health promotion which lies at the frontier between
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36 127 public health intervention and community-based intervention.

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40 128 The research is based on three hypotheses:

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42 129 *Hypothesis 1:* The notion of 'community health', which is omnipresent in the field of SGM health, is
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44 130 polysemous and subject of controversy in France. It covers divergent interests within the LGBTI+
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46 131 populations, but also among the associations and health professionals involved. The project will focus
47
48 132 on the differing definitions of 'community' and 'community health' by all SGM health actors and in
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50 133 related public debates. It will show how these variations reflect differences in local contexts,
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52 134 intellectual influences, training of health care providers, and socio-professional trajectories.

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56 135 *Hypothesis 2:* The current provision of health services for SGM highlights tensions between
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58 136 intervention paradigms (universal / community-based), professional skills (generalist / specialist), the

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3 137 types of knowledge used to study the population concerned (medical / lay knowledge), and
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5 138 categorizations of gender and sexuality. These tensions help shape the field of SGM health care in
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7 139 France.

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10 140 *Hypothesis 3:* As is the case for most health care services, services for SGM are structured by social
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12 141 power relations (gender, race, and social class dynamics). The consequence is the differential
13
14 142 treatment of patients by health professionals and community workers. We aim to analyze whether or
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16 143 not these dimensions of intersectionality are taken into account in the development and provision of
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18 144 services for SGM.

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22 23 146 **3. METHODS**

24 25 147 **3.1 Theoretical Approaches**

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27 148 This study is rooted in the field of sociology of health, and uses a multi-level and multi-sited
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29 149 ethnography. The theoretical approach mobilized is inspired by the critical sociology of power
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31 150 relations, and more particularly by feminist and intersectional theorizations of social relations (20). In
32
33 151 this perspective, we consider that gender and sexuality identities are socially and historically
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35 152 constructed (21). They are the result of socially determined power relations – in society as well as
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37 153 within the communities concerned – that can be transformed. Feminist and intersectional analyses of
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39 154 health (22,23) help us to better understand the way in which current LGBTI+ health services are
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41 155 structured in France, and aspects that have not been considered in this structuring.

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45 46 157 **3.2 Study Population**

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48 158 Data collection will target three distinct populations.

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53 160 1. **Key informants/experts in the field of SGM health.** A total of 20 researchers, policy makers,
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55 161 national-level healthcare providers and LGBTI+ rights activists will be interviewed. They will be
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57 162 pre-identified during the literature review will be the first persons interviewed. Using a

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3 163 snowball technique (by asking at the end of these interviews: “Who do you think are the key
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5 164 people in this field?”), we will then interview others. Interviews with 15 lesbian and bisexuals
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7 165 in the field of HIV activism will also be conducted.
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10 166 2. **Service providers/local health service staff.** We plan to interview up to 60 people working in
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12 167 a professional or volunteer capacity in diverse LGBTI+ health service settings (type of structure
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14 168 (community-based/medical), geographical location (urban/rural/Paris region/other regions),
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16 169 types of services offered, and target public). Our aim to ensure a diversity of sociological
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18 170 profiles (age, career path, gender identity, race, and sexual orientation). Recruitment will
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20 171 happen during the ethnography of health services, in order to identify the most relevant
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22 172 people to interview within a given service.
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25 173 3. **Users of health services.** We will conduct focus groups with LGBTI+ people who use dedicated
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27 174 health services. These persons are not the priority target of this study but their experience of
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29 175 these services is a key element in understanding the quality of care currently provided. We
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31 176 plan to hold ten focus groups, with a total of 50 people, and to ensure their profiles are diverse
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33 177 in terms of age, gender identity, race and sexual orientation. Recruitment will be based on the
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35 178 ethnography.
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41 180 **3.3 Patient and Public Involvement**

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43 181 The LGBTI+ patients were not involved in the research design.
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47 48 183 **3.4 Study Design**

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50 184 SeSAM-LGBTI+ is a qualitative research study, conducted by a multidisciplinary team of social science
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52 185 researchers: sociologists, socio-demographers, and archivists. Our complementary skills (ethnography,
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54 186 history and archival studies) will allow us to meet the study’s two objectives.
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3 188 The study will use a multi-level and multi-sited ethnography. We will analyze the history of the
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5 189 development of LGBTI+ health services in France, through interviews with key informants, a study of
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7 190 archives, and retrospective interviews with lesbian and bisexual rights activists from the 1980s to the
8
9 191 2000s. This part of the ethnography will be multi-level, as the study of activist archives, the interviews
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11 192 with activists, decision makers and researchers, and the analysis of public policies will be all performed
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13 193 at different geographical scales (local, regional, national). We will also study the functioning and
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15 194 challenges of a sample of health services currently offered to SGM in France, through a multiple case
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17 195 study (24,25). This second part of the ethnography will be multi-sited, as the case studies will be
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19 196 selected to reflect the diversity of profiles of SGM health services in France in terms of geography, the
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21 197 target population, the type of structure, etc.
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27 199 We chose to perform an ethnography as we aim to create an original database on the health of
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29 200 SGM in France, which includes the documenting of several dimensions that have been understudied
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31 201 in these populations until now. More generally, outside of sexual health, LGBTI+ health is not very well
32
33 202 known and often invisibilized. Given the fact, as mentioned above in the Background section, that
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35 203 WSW have been marginalized in terms of interventions over the years, we decided to focus one section
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37 204 of our study on the history of lesbian mobilizations in HIV activism since the 1980s.
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206 **3.5 Data collection**

207 A variety of data collection methods will be used; they are presented below in relation to the two main
208 study objectives (Figure 1.).
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210 To meet **the first objective of the study**, the ethnographic data collection will include:

211 a) Scoping interviews with key informants

212 20 semi-structured interviews with actors in the development of SGM health in France: association
213 activists, health professionals, policy makers.

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b) Grey literature and public policy documents in the field of LGBTI+ health

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Collection of grey literature and public policy documents: public health plans, national sexual health strategy between 2000 and 2022.

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c) Archives and retrospective interviews on the involvement of lesbians and bisexuals in the fight against HIV/AIDS sexual health

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Collection of archives on the involvement of lesbians and bisexuals in the fight against HIV/AIDS in France (Lesbian Archives, Research and Culture - ARCL) between the 1980s and 2000s and 15 semi-structured interviews with female activists of lesbian associations, focusing on their involvement in the fight against HIV/AIDS since the 1980s.

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With regard to the second objective of the study, one of the first elements of the study is to

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decide which case studies to include. In this context, we already performed an exploratory mapping of the main LGBTI+ health services in France, by combining our knowledge with an internet search. This revealed a large concentration of services in Paris. Accordingly, we opted to use a definition criterion, specifically, that each case refers to a structure offering health services to LGBTI+ persons (i.e., as opposed to a territory, etc.).

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Given that we to analyze a diversity of configurations in terms of geography, services offered

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and target audiences, and that each case includes an analysis of the network of actors with whom

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collaborative links exist (patient referrals, training of service providers, partnerships, etc.), we finally

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chose four case studies, reflecting a diversity of geography (Paris, Grenoble, Toulouse and Saint-

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Brieuc), city size, and target audiences. This selection is not representative, but illustrates the plurality

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of GSM health service profiles currently available in France.

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For each case study, there will be five phases of data collection (Table 1.):

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PHASE	METHOD	TIMING	TARGETS (POPULATION/MEDIA/ACTIONS)	DATA COLLECTION
1	Online Ethnography	Continuous	Websites of LGBTI+ community health facilities	Public Information, public image
2	Interviews	Months 4-16	Professionals in LGBTI+ health facilities	Experience, perceptions
3	Observations	Months 4-16	Actions within the LGBTI+ health facilities (Working meetings, public events)	Internal functioning, work environment
4	Focus Groups	Months 6-18	Users of LGBTI+ community health services	Evaluation, needs, expectations, feedback
5	Interviews	Months 8-18	Professionals within the facility's network	Network functioning

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243 Table 1. Multiple Case Study Data collection

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245 Phase 1: Online ethnography

246 This will consist in consulting public documents (reports, articles, websites) and grey literature
 247 (meeting minutes, internal reports, evaluation tools used by the structure) in order to understand the
 248 context in which the service in question emerged and developed. It will be necessary to understand
 249 and locate all the actors involved, the initial objectives, and the evaluation procedures envisaged at
 250 the outset. This phase will provide detailed knowledge of the structure studied and its activity
 251 statistics. In this first phase, we shall pay particular attention to online-based interventions, through a
 252 detailed investigation of their modalities and scope.

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254 Phase 2: Interviews with professionals in LGBTI+ health facilities

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3 255 We will conduct interviews with the actors of the service studied, aiming to include diverse points of
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5 256 view (employees/volunteers, years working in the structure). These will focus exclusively on the
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7 257 professional and/or activist background and practices of the interviewees. The number of interviews
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9 258 will vary according to the size of the structure (between 5 and 10 interviews).
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14 260 Phase 3: Observations

16 261 We will perform observations of work meetings in the service studied, with prior agreement from the
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18 262 structure. The objective is to study the organization of the related work, the challenges encountered
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20 263 and how they are overcome, as well as the role of each actor. Between 5 and 10 observation sessions
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22 264 (each approximately 2 hours long) are planned for each case study. The aim is not to focus on individual
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24 265 logics, but rather on more general social logics (professional relations, gender, race and class relations,
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26 266 etc.).
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32 268 Phase 4: Focus groups

34 269 We will organize two focus groups per case study with LGBTI+ service users. An analysis of users'
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36 270 perceptions of the service offered (evaluation of the quality of reception in the structure, the service
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38 271 offered, user expectations, etc.) will be conducted. The organization of these focus groups will be
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40 272 based on information disseminated on social networks and to the users of the services concerned. The
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42 273 information notice and the study consent form will be sent to people who contact the research team
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44 274 indicating their interest in participation. The focus groups will comprise between 5 and 10 people, and
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46 275 will be facilitated by the study's research team.
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52 277 Phase 5: Interviews with professionals working in structures' partner networks

54 278 Finally, we will conduct interviews with actors working in the particular structure's (i.e., that is
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56 279 providing the health service studied) partner network. The objective is to analyze collaboration
57
58 280 between the structures studied. Interviewees will include health professionals, association-based
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3 281 rights activists and LGBTI+ community members. The number of interviews will vary depending on the
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5 282 case (between 5 and 10 interviews), and will focus exclusively on the professional and/or activist
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7 283 background and practices of the interviewees.
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12 285 These different data collection operations will constitute the case study for each service included. In
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14 286 total, the local reports will include between 15 and 25 interviews, and between 10 and 20 focus group
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16 287 participants. The overall number of interviews will therefore be between 90 and 150, while the overall
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18 288 number of participants in the focus groups will be between 60 and 80.
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22 23 24 290 **3.6 Data Analysis**

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26 291 The archives collected in Phase 1 will be classified and grouped in a database created specifically for
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28 292 SESAM-LGBTI+. This database will be accessible to all the team's researchers. Audio-recorded data
29
30 293 from interviews, focus groups and field notes will be transcribed verbatim for analysis. Data will then
31
32 294 be interpreted based on the theoretical approaches employed by the study (see above). For the key
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34 295 informant interviews, we will conduct an inductive analysis. The aim is to identify the main themes
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36 296 which emerge from their discourses by condensing the results into a summary format. For this
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38 297 summarization stage, we will use a categorical thematic analysis. We will iteratively read all the
39
40 298 transcripts to identify emerging themes, and will use NVivo software to systematize our observations.
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42 299 Data will then be interpreted based on the theoretical approaches employed (see above). At the end
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44 300 of the data collection, we will be able to propose an analysis of the challenges involved in developing
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46 301 health services for SGM in the French context. This summary will be based on both the socio-historical
47
48 302 analysis and the cross-sectional analysis of the case studies, and will lead to a final activity report.
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54 304 The analysis process will not be limited to the final phase of the study. Intermediate analyses will be
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56 305 produced during the course of the study, particularly around the local reports of the different cases
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58 306 studied. These analyses will be shared with the members of the steering committee, the scientific
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3 307 committee, and actors involved in the case studies.. This phase will consist in presenting our
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5 308 preliminary analyses to the health service actors and beneficiaries. This exchange will allow us to verify
6
7 309 the soundness of the analyses, to improve them, to clarify any gray areas, and to plan knowledge
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9 310 transfer actions. This process will require the organization of collective feedback meetings.
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14 312 In addition to the preparation of articles and scientific communications, the data analysis phases will
15
16 313 be devoted to the preparation of activities and tools for knowledge transfer (good practice guide,
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18 314 training, summer schools, etc.).
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22 23 316 **4. ETHICS AND DISSEMINATION**

24 25 317 **4.1 Ethics approval and consent to participate**

26
27 318 The study protocol has undergone a peer review by the *Institut de Recherche En santé Publique's*
28
29 319 scientific committee and has been approved by the research ethical committee of Aix-Marseille
30
31 320 University (registration number: 2022-05-12-010). The study has received funding from the "Institut
32
33 321 de Recherche En santé Publique" (IRESP) from 1 December 2021 to 30 November 2024.

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35 322 Details on the protection of the data collected will be specified in an information letter given to each
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37 323 person invited to participate. All key informants and respondents will be over 18 years old and will
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39 324 participate voluntarily with no monetary compensation. However, considering ethical
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41 325 recommendations, participation will be at no cost for participants; for instance transportation fees will
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43 326 be reimbursed. All participants will provide written informed consent.
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48 327 The interviews will be recorded with the oral consent of the participants, and will be fully transcribed
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50 328 and anonymized. A number will be assigned to each interviewee (Health L 01, etc.); all identifying
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52 329 information (names of people, places) will be erased. Only the following socio-demographic
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54 330 information will be reported in the analysis and publications: age range, gender, and level of education.
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56 331 Observations will be recorded in situ and will be systematically anonymized (Structure X 01, etc). The
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58 332 anonymised transcripts will be made available to all the members of the research team.
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4.2 Data deposition and curation

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7 335 Data will be stored in encrypted form on a secure server in Aix-Marseille University cloud, will be
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9 336 accessible only to authorized researchers. The data processing implemented for the needs of this study
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11 337 will be performed in compliance with MR 004 and declared to the DPO registry of Aix-Marseille
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13 338 University.
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4.3 Dissemination plan

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20 341 Study findings will be disseminated from 2023 onwards to various audiences. We will communicate
21
22 342 our findings to researchers at scientific gatherings and publications in peer-reviewed journals.
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24 343 Dissemination events will be organized for health professionals and community based services. In
25
26 344 addition, results will be used as pedagogical material for training courses and summer schools aimed
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28 345 at health professionals.
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5. DISCUSSION

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36 348 Since the early stages of this planned study, specific challenges have necessitated discussions within
37
38 349 the research team. The first challenge concerns the spatial dimension of SGM health. The
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40 350 overrepresentation of LGBTI+ populations in urban areas translates into an uneven distribution of
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42 351 health services for sexual and gender minorities throughout France: dense and concentrated in the
43
44 352 Paris region and in some metropolises with over 400,000 inhabitants, more disparate in cities with less
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46 353 than 300,000 inhabitants, and rare in working-class neighborhoods of large cities and in rural areas. To
47
48 354 ensure diversity in our investigations, we decided to implement the study by using the type of facility
49
50 355 (community/medical-community/medical), geographical area (Paris region/ non-Paris region) and
51
52 356 intervention area (urban/rural) as three variables.
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56
57 357 The second challenge concerns the heterogeneity of experiences covered by the acronym LGBTI+ and
58
59 358 the different realities and experiences of lesbian, gays, bisexuals, transgender and intersex people.
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359 One of the objectives of SeSAM-LGBTI+ is to analyze how existing health services for LGBTI+ in France
360 meet the diversity of health needs these populations have, and what the barriers and limitations are
361 to their accessing health care. For scientific reasons, we therefore chose to use the term 'sexual and
362 gender minorities' (SGM), which in our opinion is more inclusive of the diversity of identifications and
363 their evolution, and better reflects our critical approach to analyzing the processes of essentialization
364 of minority identities.

365
366 To conclude, SESAM- LGBTI+ will provide the first in-depth analysis of health services for LGBTI+ people
367 in France. We hope that the results of this work will help inform the development of professional
368 training and health promotion approaches in this area.

369 **6. AUTHOR CONTRIBUTIONS**

370
371 All co-authors except MR and LV designed the research protocol. LV and GG wrote this paper and all
372 authors participated in reviewing and approving the final text.

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377 **8. COMPETING INTERESTS STATEMENT**

378
379 No conflict of interest to declare.

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10. LIST OF ABBREVIATIONS

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3 446 AIDS: Acquired Immunodeficiency Syndrome
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5 447 ARCL: Lesbian Archives, Research and Culture
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7 448 HIV: Human Immunodeficiency Viruses
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10 449 LGBTI+: Lesbian Gays Bisexuals Trans Intersex and other sexual and gender identity minorities
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12 450 MSM: Men who have Sex with Men
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14 451 SGM: Sexual and Gender Minorities
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16 452 STIs: Sexually Transmitted infections
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18 453 WSW: Women who have Sex with Women
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23 455 **11. LEGEND: FIGURES**
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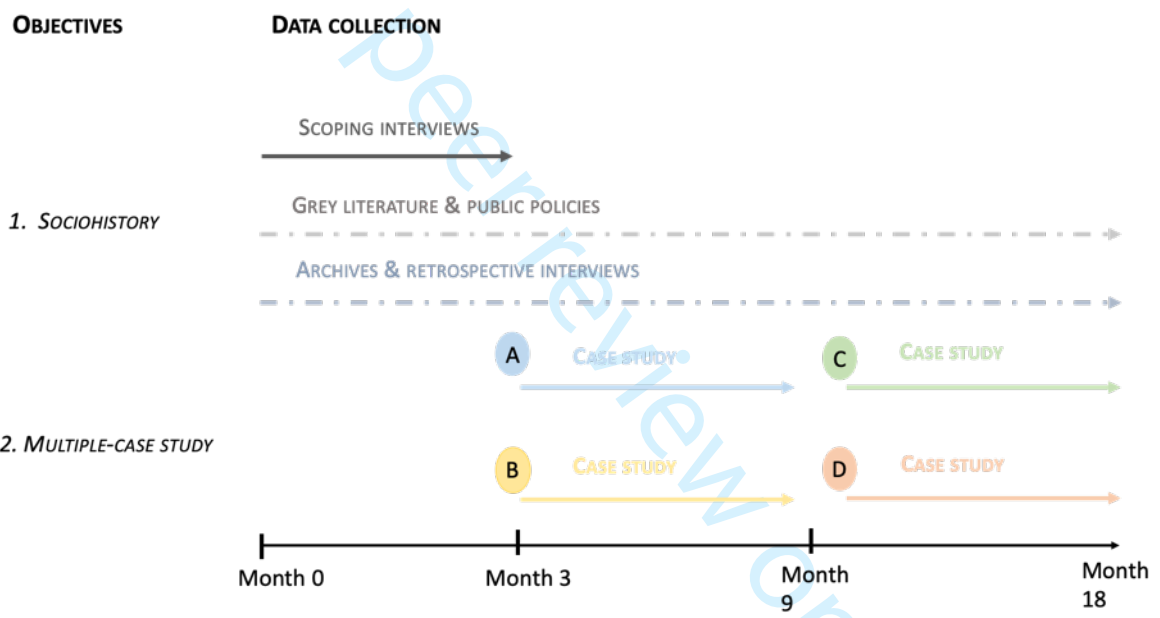
25 456 Figure 1:
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27 457 - Title: "Data collection"

28 458 - Legend: Data collection stages of the SeSAM-LGBTI+ project
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BMJ Open

Investigating health services for sexual and gender minorities in France: a qualitative study protocol

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Secondary Subject Heading:	Qualitative research, Sexual health, HIV/AIDS
Keywords:	Organisation of health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, QUALITATIVE RESEARCH, SEXUAL MEDICINE, SOCIAL MEDICINE

SCHOLARONE™
Manuscripts

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2
3 1 **Title** : Investigating health services for sexual and gender minorities in France: a qualitative study
4
5 2 protocol
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2
3 15 **ABSTRACT:**
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5 16 **Introduction:**
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7 17 Discrimination and structural violence experienced by sexual and gender minorities are the source of
8
9 18 social inequalities in health. The last decade has been marked by major developments in the provision
10
11 19 of sexual health services for these minorities in France. This paper presents the research protocol of
12
13 20 the SeSAM-LGBTI+ study which aims to document the health, social and professional challenges in the
14
15 21 organization of current health services for sexual and gender minorities in France.
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17

18 22 **Methods and Analysis:**
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20 23 The SeSAM-LGBTI+ study relies on a multidisciplinary qualitative study. It has two objectives: 1. To
21
22 24 analyze the history of the development of LGBTI+ health services in France, through interviews with
23
24 25 key informants and rights activists and through a study of archives; 2. To study the functioning and
25
26 26 challenges of a sample of health services currently offered to LGBTI+ people in France, through a
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28 27 multiple case study, using a multi-level and multi-sited ethnography. The study will rely on
29
30 28 approximately 100 interviews. The analysis will be based on an inductive and iterative approach,
31
32 29 combining socio-historical data and the cross-sectional analysis of the case studies.
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36 30 **Ethics and Dissemination:**
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38 31 The study protocol has undergone a peer review by the *Institut de Recherche En santé Publique's*
39
40 32 scientific committee and has been approved by the research ethical committee of Aix-Marseille
41
42 33 University (registration number: 2022-05-12-010). The project has received funding from 12/2021
43
44 34 through 11/2024. The results of the research will be disseminated from 2023 onwards to researchers,
45
46 35 health professionals and community health organizations.
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48

49 36 **Keywords :** (3-10)
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51 37 LGBTI+; Community Health; Sexual and Gender Minorities; Health Services; Qualitative study
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58 39 **Strengths and limitations of this study :**
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- 60 40
 - The study conducts a multi-level and multi-sited ethnography of LGBTI+ health services

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- 41 • The study diversifies the ethnographic sites in order to avoid the bias of over-representation
- 42 of territories where sexual and gender minority services are concentrated
- 43 • The study employs the term “sexual and gender minorities” to overcome the difficulties in
- 44 including the full range of experiences within the LGBTI+ population

For peer review only

1. INTRODUCTION

1.1 Sexual and gender minority health issues in France

Discrimination and structural violence experienced by sexual and gender minorities (SGM) are the source of social inequalities in health (1). These inequalities are related to the relatively high prevalence and incidence of Sexually Transmitted Infections (STIs) (2), suicide attempts and mental health problems (3), psychoactive substance use (4–6), and cancers (7) observed in this population. The lack of training for health professionals on the realities and specific needs of SGM contributes to these challenges (8). Presuming that patients are heterosexual can impact how diagnoses are made (9). Moreover, the difficulties encountered by LGBTI+ people can be related to mechanisms of internalized LGBTI+phobia (10) and to minority stress (11). These various inequality elements create a syndemic context (12) in which the aggregation of health problems and situations of discrimination and violence affect the living conditions of lesbian, gay, bisexual, transgender, and intersex (LGBTI+) people. In several countries, university curricula have begun to include training on the health realities of LGBTI persons (13). In France, such training remains sporadic and is an active process on the part of service providers and essentially by community-based organizations.

Inequalities and discrimination have prompted SGM to develop community-based health interventions. In France, health interventions for SGM have historically been structured around responses to HIV/AIDS. The specific socio-behavioral and epidemiological characteristics of this population have led to increased prevention and screening activities, particularly for gay and bisexual men - often categorized by public health organizations as 'men who have sex with men' (MSM) - and for transgender people, especially sex workers. However, two populations have remained on the margins of these health interventions. The first are women who have sex with women (WSW), a group that has never been a target for public health; the second are bisexuals and their sexual partners; these persons are often lumped together under the MSM category, with the resulting risk that their different

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3 70 identity and sexual behaviours is invisibilised (14). Appropriate care for transgender men remains less
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5 71 developed, but has improved over the past decade thanks to the mobilization of transgender activists.
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8 72 The prolonged focus on interventions concentrating on HIV/AIDS and individual prevention and
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10 73 screening behaviours started to show its limitations during the 2000s. More specifically, the continued
11
12 74 high incidence of STIs (15) and HIV (16) despite these interventions demonstrated the need for a more
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14 75 comprehensive approach to sexual health issues that took into account structural barriers to access to
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16 76 health services (17). Furthermore, it would appear that a lack of epidemiological data led to the
17
18 77 invisibilization of sexual health issues other than HIV, and to lesbians and bisexual women being
19
20 78 overlooked in SGM public health programs (18). This particular issue led to a number of more
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22 79 comprehensive and inclusive community-based initiatives, despite the low level of funding dedicated.
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26 80 In the last decade, France has seen major developments in the provision of sexual health services for
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28 81 SGM, including the creation of several sexual health centers in Paris, the development of community-
29
30 82 based rapid HIV testing, the spread of pre-exposure prophylaxis and follow-up services (particularly
31
32 83 online), the structuring of self-support initiatives for transgender people, and the development of
33
34 84 sexual health programs for lesbian and bisexual women (19). Often driven by collaborations between
35
36 85 associations, health professionals, and researchers, these services - inspired by initiatives in other
37
38 86 countries (e.g. Switzerland, the United Kingdom, the United States and Canada) - mostly combine
39
40 87 traditional health care with community resources, complemented by digital tools. However, given the
41
42 88 absence of any specific public policy and no official research agenda, the field of SGM health is poorly
43
44 89 structured, with services often being provided by local instead of national mobilization. This situation
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46 90 weakens the potential for these services to expand. This results in a lack of awareness of LGBTI+ issues
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48 91 among health providers, which has consequences in terms of early detection of STIs, certain cancers
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50 92 and mental health issues.
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56 93 To our knowledge no study to date has analyzed current interventions for SGM in a comprehensive
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58 94 and comparative manner in the French context. Moreover, unlike in English-speaking countries, the
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3 95 health of SGM is an underexplored subject in the field of social sciences in France (20,21), and most of
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5 96 the published work is gay-centric. Some of the few French studies that have explored SGM health
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7 97 focused on the subjective experience of this population in the medical care context (22). Dimensions
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10 98 related to access to health services remain understudied. In light of these shortcomings, SeSAM-
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12 99 LGBTI+ will focus on the organization of current services for SGM and the related activities of health
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14 100 care actors.

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102 **2. STUDY AIMS AND HYPOTHESIS**

103 This paper presents the research protocol of the SeSAM-LGBTI+ study (health Services for **Minorities-**
104 **Lesbian Gays Bisexuals Transgender Intersex +**), which will explore the social and professional
105 challenges in the organization of existing health services for sexual and gender minorities in France.
106 SeSAM-LGBTI+ has two main objectives:

107 *Objective 1.*

108 The first objective is to investigate the social and political conditions influencing the development of
109 health services for SGM in France over the last two decades, the inclusion of these conditions in public
110 health policy, and the tensions related to their concrete implementation.

111

112 *Objective 2.*

113 The second objective is to analyze the functioning of existing health services and interventions
114 targeting SGM in order to better understand how they are organized, how well they meet the needs
115 of the populations concerned, problems related to training health care professionals, collaborations
116 and coordination between different actors, the participation of users (e.g., in a board of directors), and
117 the development of a burgeoning new field of health promotion which lies at the frontier between
118 public health intervention and community-based intervention.

119 The research is based on three hypotheses:

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3 120 *Hypothesis 1:* The notion of ‘community health’, which is omnipresent in the field of SGM health, is
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5 121 polysemous and subject of controversy in France. It covers divergent interests within the LGBTI+
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7 122 populations, but also among the associations and health professionals involved. The project will focus
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9 123 on the differing definitions of ‘community’ and ‘community health’ by all SGM health actors and in
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11 124 related public debates. It will show how these variations reflect differences in local contexts,
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13 125 intellectual influences, training of health care providers, and socio-professional trajectories.

16
17 126 *Hypothesis 2:* The current provision of health services for SGM highlights tensions between
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19 127 intervention paradigms (universal / community-based), professional skills (generalist / specialist), the
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21 128 types of knowledge used to study the population concerned (medical / lay knowledge), and
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23 129 categorizations of gender and sexuality. These tensions help shape the field of SGM health care in
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25 130 France.

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29 131 *Hypothesis 3:* As is the case for most health care services, services for SGM are structured by social
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31 132 power relations (gender, race, and social class dynamics). The consequence is the differential
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33 133 treatment of patients by health professionals and community workers. We aim to analyze whether or
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35 134 not these dimensions of intersectionality are taken into account in the development and provision of
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37 135 services for SGM.

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41 42 137 **3. METHODS**

43 44 138 **3.1 Theoretical Approaches**

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46 139 This study is rooted in the field of sociology of health, and uses a multi-level and multi-sited
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48 140 ethnography. The theoretical approach mobilized is inspired by the critical sociology of power
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50 141 relations, and more particularly by feminist and intersectional theorizations of social relations (23). In
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52 142 this perspective, we consider that gender and sexuality identities are socially and historically
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54 143 constructed (24). They are the result of socially determined power relations – in society as well as
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56 144 within the communities concerned – that can be transformed. Feminist and intersectional analyses of
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3 145 health (25,26) help us to better understand the way in which current LGBTI+ health services are
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5 146 structured in France, and aspects that have not been considered in this structuring.
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10 148 **3.2 Study Population**

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12 149 Data collection will involve three distinct populations.

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14 150 1. **Key informants/experts in the field of SGM health.** A total of 20 researchers, policy makers,
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16 151 national-level healthcare providers and LGBTI+ rights activists will be interviewed. They will be
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18 152 pre-identified during the literature review will be the first persons interviewed. Using a
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20 153 snowball technique (by asking at the end of these interviews: "Who do you think are the key
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22 154 people in this field?"), we will then interview others. Interviews with 15 lesbian and bisexual
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24 155 women in the field of HIV activism will also be conducted.
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27 156 2. **Service providers/local health service staff.** We plan to interview up to 60 people working in
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29 157 a professional or volunteer capacity in diverse LGBTI+ health service settings (type of structure
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31 158 (community-based/medical), geographical location (urban/rural/Paris region/other regions),
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33 159 types of services offered, and target public). Our aim to ensure a diversity of sociological
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35 160 profiles (age, career path, gender identity, race, and sexual orientation). Recruitment will
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37 161 happen during the ethnography of health services, in order to identify the most relevant
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39 162 people to interview within a given service.
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41 163 3. **Users of health services.** We will conduct focus groups with LGBTI+ people who use dedicated
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43 164 health services. These persons are not the priority target of this study but their experience of
44
45 165 these services is a key element in understanding the quality of care currently provided. We
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47 166 plan to hold ten focus groups, with a total of 50 people, and to ensure their profiles are diverse
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49 167 in terms of age, gender identity, race and sexual orientation. Recruitment will be based on the
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51 168 ethnography.
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57 169 The study will be conducted from December 2021 to November 2024. Data will be collected from
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59 170 October 2022 to December 2023. Data analysis will take place during 2024.
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172 3.3 Study Design

173 SeSAM-LGBTI+ is a qualitative research study, conducted by a multidisciplinary team of social science
174 researchers: sociologists, socio-demographers, and archivists. Our complementary skills (ethnography,
175 history and archival studies) will allow us to meet the study's two objectives.

176

177 The study will use a multi-level and multi-sited ethnography. We will analyze the history of the
178 development of LGBTI+ health services in France, through interviews with key informants, a study of
179 archives, and retrospective interviews with lesbian and bisexual rights activists from the 1980s to the
180 2000s. This part of the ethnography will be multi-level, as the study of activist archives, the interviews
181 with activists, decision makers and researchers, and the analysis of public policies will be all performed
182 at different geographical scales (local, regional, national). We will also study the functioning and
183 challenges of a sample of health services currently offered to SGM in France, through a multiple case
184 study (27,28). This second part of the ethnography will be multi-sited, as the case studies will be
185 selected to reflect the diversity of profiles of SGM health services in France in terms of geography, the
186 target population, the type of structure, etc.

187

188 We chose to perform an ethnography as we aim to create an original database on the health of
189 SGM in France, which includes the documenting of several dimensions that have been understudied
190 in these populations until now. More generally, outside of sexual health, LGBTI+ health is not very well
191 known and often invisibilized. Given the fact, as mentioned above in the Background section, that
192 WSW have been marginalized in terms of interventions over the years, we decided to focus one section
193 of our study on the history of lesbian mobilizations in HIV activism since the 1980s.

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195 3.4 Data collection

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3 196 A variety of data collection methods will be used; they are presented below in relation to the two main
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5 197 study objectives (Figure 1.).
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10 199 To meet **the first objective of the study**, the ethnographic data collection will include:

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12 200 a) Scoping interviews with key informants

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14 201 20 semi-structured interviews with actors in the development of SGM health in France: association
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16 202 activists, health professionals, policy makers. Interviews will take place online or in person, lasting
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18 203 approximately one hour. Participants will be asked about their experiences and thoughts around
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20 204 LGBTI+ health. At the end of the interview, they will be asked to draw a personal map of the field of
21
22 205 LGBTI+ health actors in France.
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28 207 b) Grey literature and public policy documents in the field of LGBTI+ health

29
30 208 Collection of grey literature and public policy documents: public health plans, national sexual health
31
32 209 strategy between 2000 and 2022.
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37 211 c) Archives and retrospective interviews on the involvement of lesbian and bisexual
38
39 212 women in the fight against HIV/AIDS sexual health

40
41 213 Collection of archives on the involvement of lesbian and bisexual women in the fight against HIV/AIDS
42
43 214 in France (Lesbian Archives, Research and Culture - ARCL) between the 1980s and 2000s and 15 semi-
44
45 215 structured interviews with activists of lesbian associations, focusing on their involvement in the fight
46
47 216 against HIV/AIDS since the 1980s.
48
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50 217

51
52 218 **With regard to the second objective of the study**, one of the first elements of the study is to
53
54 219 decide which case studies to include. In this context, we already performed an exploratory mapping of
55
56 220 the main LGBTI+ health services in France, by combining our knowledge with an internet search. This
57
58 221 revealed a large concentration of services in Paris. Accordingly, we opted to use a definition criterion,
59
60

222 specifically, that each case refers to a structure offering health services to LGBTI+ persons (i.e., as
223 opposed to a territory, etc.).

224 Given that we to analyze a diversity of configurations in terms of geography, services offered
225 and target audiences, and that each case includes an analysis of the network of actors with whom
226 collaborative links exist (patient referrals, training of service providers, partnerships, etc.), we finally
227 chose four case studies, reflecting a diversity of geography (Paris, Grenoble, Toulouse and Saint-
228 Briec), city size, and target audiences. This selection is not representative, but illustrates the plurality
229 of GSM health service profiles currently available in France.

230

231 For each case study, there will be five phases of data collection (Table 1.):

232

233

PHASE	METHOD	TIMING	TARGETS (POPULATION/MEDIA/ACTIONS)	DATA COLLECTION
1	Online Ethnography	Continuous	Websites of LGBTI+ community health facilities	Public Information, public image
2	Interviews	Months 4- 16	Professionals in LGBTI+ health facilities	Experience, perceptions
3	Observations	Months 4- 16	Actions within the LGBTI+ health facilities (Working meetings, public events)	Internal functioning, work environment
4	Focus Groups	Months 6- 18	Users of LGBTI+ community health services	Evaluation, needs, expectations, feedback
5	Interviews	Months 8- 18	Professionals within the facility's network	Network functioning

234

235 Table 1. Multiple Case Study Data collection

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1
2
3 237 Phase 1: Online ethnography
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5 238 This will consist in consulting public documents (reports, articles, websites) and grey literature
6
7 239 (meeting minutes, internal reports, evaluation tools used by the structure) in order to understand the
8
9 240 context in which the service in question emerged and developed. It will be necessary to understand
10
11 241 and locate all the actors involved, the initial objectives, and the evaluation procedures envisaged at
12
13 242 the outset. This phase will provide detailed knowledge of the structure studied and its activity
14
15 243 statistics. In this first phase, we shall pay particular attention to online-based interventions, through a
16
17 244 detailed investigation of their modalities and scope.
18
19
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21 245

22
23 246 Phase 2: Interviews with professionals in LGBTI+ health facilities
24

25 247 We will conduct interviews with the actors of the service studied, aiming to include diverse points of
26
27 248 view (employees/volunteers, years working in the structure). These will focus exclusively on the
28
29 249 professional and/or activist background and practices of the interviewees. The number of interviews
30
31 250 will vary according to the size of the structure (between 5 and 10 interviews) (**Interview guide:**
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33 251 **supplementary file 1**).
34
35

36 252

37
38
39 253 Phase 3: Observations
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41 254 We will perform observations of work meetings in the service studied, with prior agreement from the
42
43 255 structure. The objective is to study the organization of the related work, the challenges encountered
44
45 256 and how they are overcome, as well as the role of each actor. Between 5 and 10 observation sessions
46
47 257 (each approximately 2 hours long) are planned for each case study. The aim is not to focus on individual
48
49 258 logics, but rather on more general social logics (professional relations, gender, race and class relations,
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51 259 etc.).
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57 261 Phase 4: Focus groups
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3 262 We will organize two focus groups per case study with LGBTI+ service users. An analysis of users'
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5 263 perceptions of the service offered (evaluation of the quality of reception in the structure, the service
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7 264 offered, user expectations, etc.) will be conducted. The organization of these focus groups will be
8
9
10 265 based on information disseminated on social networks and to the users of the services concerned. The
11
12 266 information notice and the study consent form will be sent to people who contact the research team
13
14 267 indicating their interest in participation. The focus groups will comprise between 5 and 10 people, and
15
16 268 will be facilitated by the study's research team. The focus groups will take place in person, in a venue
17
18 269 independent of the health services studied. We will aim for a diversity of profiles and experience of
19
20
21 270 the services (**Focus group guide: supplementary file 2**).

22
23 27124
25 272 Phase 5: Interviews with professionals working in structures' partner networks26
27 273 Finally, we will conduct interviews with actors working in the particular structure's (i.e., that is
28
29 274 providing the health service studied) partner network. The objective is to analyze collaboration
30
31 275 between the structures studied. Interviewees will include health professionals, association-based
32
33 276 rights activists and LGBTI+ community members. The number of interviews will vary depending on the
34
35 277 case (between 5 and 10 interviews), and will focus exclusively on the professional and/or activist
36
37 278 background and practices of the interviewees.
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3940
41 27942
43 280 These different data collection operations will constitute the case study for each service included. In
44
45 281 total, the local reports will include between 15 and 25 interviews, and between 10 and 20 focus group
46
47 282 participants. The overall number of interviews will therefore be between 90 and 150, while the overall
48
49 283 number of participants in the focus groups will be between 60 and 80.
50
51

52 284

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54
55 285 **3.5 Data Analysis**56
57 286 The archives collected in Phase 1 will be classified and grouped in a database created specifically for
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59 287 SESAM-LGBTI+. This database will be accessible to all the team's researchers. Audio-recorded data

1
2
3 288 from interviews, focus groups and field notes will be transcribed verbatim for analysis. Data will then
4
5 289 be interpreted based on the theoretical approaches employed by the study (see above). For the key
6
7 290 informant interviews, we will conduct an inductive analysis. The aim is to identify the main themes
8
9 291 which emerge from their discourses by condensing the results into a summary format. For this
10
11 292 summarization stage, we will use a categorical thematic analysis. We will iteratively read all the
12
13 293 transcripts to identify emerging themes, and will use NVivo software to systematize our observations.
14
15 294 Data will then be interpreted based on the theoretical approaches employed (see above). At the end
16
17 295 of the data collection, we will be able to propose an analysis of the challenges involved in developing
18
19 296 health services for SGM in the French context. This summary will be based on both the socio-historical
20
21 297 analysis and the cross-sectional analysis of the case studies, and will lead to a final activity report. Data
22
23 298 triangulation techniques (combination of interviews, observations, and archives) will help to limit
24
25 299 memory bias, especially regarding sociohistorical dimensions of our study.
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31 300
32 301 The analysis process will not be limited to the final phase of the study. Intermediate analyses will be
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34 302 produced during the course of the study, particularly around the local reports of the different cases
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36 303 studied. The data analysis process will be based on research team workshops, repeated at several
37
38 304 stages of the study. These workshops will allow us to cross-read the raw data and produce a collective
39
40 305 interpretation by sharing perspectives. Following the quality assessment principles, we will proceed by
41
42 306 parallel coding of interviews, as well as by triangulation of the collected data. These analyses will be
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44 307 shared with the members of the steering committee, the scientific committee, and actors involved in
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46 308 the case studies. This phase will consist in presenting our preliminary analyses to the health service
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48 309 actors and beneficiaries. This exchange will allow us to verify the soundness of the analyses, to improve
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50 310 them, to clarify any gray areas, and to plan knowledge transfer actions. This process will require the
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52 311 organization of collective feedback meetings.
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3 313 In addition to the preparation of articles and scientific communications, the data analysis phases will
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5 314 be devoted to the preparation of activities and tools for knowledge transfer (good practice guide,
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7 315 training, summer schools, etc.).
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9

10 316 **3.6 Patient and public involvement**

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12
13 318 None.

14
15 319

17 320 **4. ETHICS AND DISSEMINATION**

20 321 **4.1 Ethics approval and consent to participate**

21
22 322 The study protocol has undergone a peer review by the *Institut de Recherche En santé Publique's*
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24 323 scientific committee and has been approved by the research ethical committee of Aix-Marseille
25
26 324 University (registration number: 2022-05-12-010). The study has received funding from 1 December
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28 325 2021 to 30 November 2024.

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30
31 326 Details on the protection of the data collected will be specified in an information letter given to each
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33 327 person invited to participate. All key informants and respondents will be over 18 years old and will
34
35 328 participate voluntarily with no monetary compensation. However, considering ethical
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37 329 recommendations, participation will be at no cost for participants; for instance, transportation fees
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39 330 will be reimbursed. All participants will provide written informed consent.

40
41
42 331 The interviews will be recorded with the oral consent of the participants, and will be fully transcribed
43
44 332 and anonymized. A number will be assigned to each interviewee (Health L 01, etc.); all identifying
45
46 333 information (names of people, places) will be erased. Only the following socio-demographic
47
48 334 information will be reported in the analysis and publications: age range, gender, and level of education.
49
50 335 Observations will be recorded in situ and will be systematically anonymized (Structure X 01, etc). The
51
52 336 anonymised transcripts will be made available to all the members of the research team.
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58 338 **4.2 Data deposition and curation**

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3 339 Data will be stored in encrypted form on a secure server in Aix-Marseille University cloud, will be
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5 340 accessible only to authorized researchers. The data processing implemented for the needs of this study
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7 341 will be performed in compliance with MR 004 and declared to the DPO registry of Aix-Marseille
8
9 342 University.
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14 344 **4.3 Dissemination plan**

16 345 Study findings will be disseminated from 2023 onwards to various audiences. We will communicate
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18 346 our findings to researchers at scientific gatherings and publications in peer-reviewed journals.
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20 347 Dissemination events will be organized for health professionals and community based services. In
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22 348 addition, results will be used as pedagogical material for training courses and summer schools aimed
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24 349 at health professionals.
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30 351 **5. DISCUSSION**

32 352 Since the early stages of this planned study, specific challenges have necessitated discussions within
33
34 353 the research team. The first challenge concerns the spatial dimension of SGM health. The
35
36 354 overrepresentation of LGBTI+ populations in urban areas translates into an uneven distribution of
37
38 355 health services for sexual and gender minorities throughout France: dense and concentrated in the
39
40 356 Paris region and in some metropolises with over 400,000 inhabitants, more disparate in cities with less
41
42 357 than 300,000 inhabitants, and rare in working-class neighborhoods of large cities and in rural areas. To
43
44 358 ensure diversity in our investigations, we decided to implement the study by using the type of facility
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46 359 (community/medical-community/medical), geographical area (Paris region/ non-Paris region) and
47
48 360 intervention area (urban/rural) as three variables.
49

51
52 361 The second challenge concerns the heterogeneity of experiences covered by the acronym LGBTI+ and
53
54 362 the different realities and experiences of lesbian, gays, bisexuals, transgender and intersex people.
55
56 363 One of the objectives of SeSAM-LGBTI+ is to analyze how existing health services for LGBTI+ in France
57
58 364 meet the diversity of health needs these populations have, and what the barriers and limitations are
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60

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3 365 to their accessing health care. For scientific reasons, we therefore chose to use the term 'sexual and
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5 366 gender minorities' (SGM), which in our opinion is more inclusive of the diversity of identifications and
6
7 367 their evolution, and better reflects our critical approach to analyzing the processes of essentialization
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9
10 368 of minority identities.

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12 369
13
14 370 To conclude, SESAM- LGBTI+ will provide the first in-depth analysis of health services for LGBTI+ people
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16 371 in France. We hope that the results of this work will help inform the development of professional
17
18 372 training and health promotion approaches in this area.

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22 374 6. REFERENCES

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7. LIST OF ABBREVIATIONS

- AIDS: Acquired Immunodeficiency Syndrome
- ARCL: Lesbian Archives, Research and Culture
- HIV: Human Immunodeficiency Viruses
- LGBTI+: Lesbian Gays Bisexuals Trans Intersex and other sexual and gender identity minorities
- MSM: Men who have Sex with Men
- SGM: Sexual and Gender Minorities

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3 453 STIs: Sexually Transmitted infections
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5 454 WSW: Women who have Sex with Women
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10 456 **8. LEGEND: FIGURES**

11
12 457 Figure 1:

13 458 - Title: "Data collection"

14 459 - Legend: Data collection stages of the SeSAM-LGBTI+ project
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16 460
17 461

18 462 **9. Contributorship statement**

19 463
20 464 G. Girard, E. Marsicano, E. Beaubatie, Y. Eched, M. Le Bris and L. Porée designed the research protocol.

21
22 465 L. Virole and G. Girard wrote this paper and G. Girard, E. Marsicano, E. Beaubatie, Y. Eched, M. Le Bris,
23

24 466 L. Porée and M. Raz participated in reviewing and approving the final text.
25
26 467

27 468 **10. Competing interests**

28 469
29 470 None declared.
30
31 471

32 472 **11. Funding**

33 473
34

35 474 The project has received funding from the Institut de Recherche En santé Publique (IRESP) from
36

37 475 12/2021 through 11/2024. The project was evaluated twice, through an independent scientific
38

39 476 committee commissioned by IRESP: once on the basis of a letter of intent (September 2020), and a
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41 477 second time on the basis of a full project (January 2021). The results were formalized in June 2021, and
42

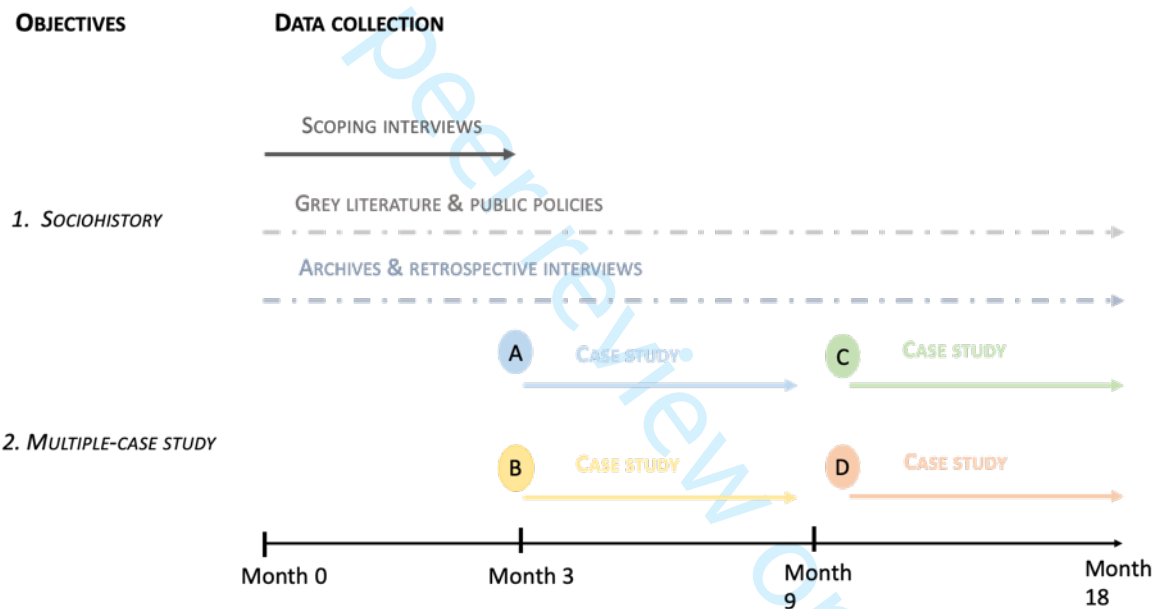
43 478 the funds were disbursed in December 2021.
44
45 479

46 480 Award/Grant number: NA.
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48 481

49 482 **12. Data sharing statement**

50 483 Not applicable.
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SESAM - LGBTI+

Interview guide

Instructions for the interviewer:

- At the beginning of the interview: presentation of the research and the ethical framework (anonymity, confidentiality)
- Presentation of the research.
- Your name will be anonymized, as well as the name of the service
- Signature of consent to participate in the research.

- Initial question: Could you tell us how you came to work in this structure?

- At the end of the interview: contacts for future interviews?

- After the interview: write a summary sheet and include in it the picture of the network drawing (or the Zoom screen shot) and the contacts given by the person.

Issues	Questions
Career	<ul style="list-style-type: none"> • Could you introduce yourself? Age, social origin, education, professional background, activist background • How did you come to work here? Why did you choose to work in an LGBTI+ health service? Could you describe your current position?
Health service background	<ul style="list-style-type: none"> • Could you tell us more about the structure and its evolutions since its creation? Its status, its functioning, its financing, its main actions, the team and the organization of the work, the internal training
Public	<ul style="list-style-type: none"> • Could you describe your target public (have these definitions changed over time?) • What are the social characteristics of your public? • What are their needs (specific needs of L/G/B/T/I + ; Different from the general population)?
Access to care	<ul style="list-style-type: none"> • How do people access your structure? (What about non-French speakers, isolated or remote people, without medical coverage?)
Care	<ul style="list-style-type: none"> • What is the care or support relationship you put in place? Would you define it as safe/friendly? If so, what is your definition of LGBT-friendly? How do you train on it?
Communication	<ul style="list-style-type: none"> • How do you promote yourself to the LGBT public? (Communication adapted to the target audience)
Evaluation	<ul style="list-style-type: none"> • How do you collect feedback from users? • In your opinion, what are the issues/challenges/difficulties facing the facility? • How do you think the facility should evolve in the future?
Community health services	<ul style="list-style-type: none"> • Would you define your service as community-based? If so, what definition? What inspirations (international)? What are the difficulties in defending this approach (universalism...)? • Do you recruit professionals from the LGBT community? How are users included in the decision making process?
LGBTI+ health field	<ul style="list-style-type: none"> • What are the other LGBT health structures in your territory? (+In France?) What are their funds? • What partnerships have you developed (network)? LGBT associations, GP, hospitals... • What are the conflicts and tensions in this field? What needs to be improved?
Network drawing	<ul style="list-style-type: none"> • Could you draw the actors you are connected with in the field of LGBT health? • Could you describe what you are drawing? • (once drawn): How have these connections changed since the facility was created/since you came to the facility?
Contacts	<ul style="list-style-type: none"> • Would you be willing to give us the contact information of the members of your network so that we can contact them for our research?

SESAM - LGBTI+

Focus groups facilitation guide

Process: questions and focus group facilitation

Number of expected participants: 5-12

Duration: 2 hours

2 Sesam LGBTI+ team members facilitators. A facilitator takes notes to identify who is speaking.

General guidelines for facilitators:

- Introduce the research ethic framework: confidentiality and anonymity. Respect of the view of other participants.
- Explain that the content of each focus groups will be translated and analyzed and compared to other focus groups
- Be attentive to the interactions between participants, their disagreements.

Step of the focus group:

1. Introductory tour (and expectations) of each participant and presentation of SESAM-LGBTI+ study (10 min).
2. Questions (1h10):
 - What is your personal experience with LGBTI+ health services?
 - Where have you been and how did you hear about these services?
 - How easy was access (financial, geographic, disability, availability)?
 - What fears or hesitations did you have before consulting them?
 - How was the reception?
 - How were the appointments/consultations with the service providers?

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 - Did they meet your expectations?
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 - What ideas would you have for improving this offer?
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 - What does LGBTI+ community health mean to you?
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 - Does it add value?
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 - Did the service providers belong to the LGBTI+ community?
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 - Does it matter?
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3. Collective activity (sub-groups, 2-3): Imagine the ideal service for LGBTI+ people: give it a name and a slogan on a poster, a sentence that explains what we do there, and a small story of a lived experience (atmosphere, posture...) = 25 min + 15 min of presentation by group, summarize the common points.
4. Conclusion and feedback from participants + Quick anonymous questionnaire at the end: socio-demographic characteristics, and satisfaction with the FG.