HIV PREVENTION

NEEDS ASSESSMENT OF MEN WHO HAVE SEX WITH MEN (MSM)

NHS CLINICAL STAFF INTERVIEWS

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1. INTRODUCTION

i. In 2011 NHS Greater Glasgow and Clyde and NHS Lothian both reviewed their HIV prevention work programmes targeting gay, bisexual and men who have sex with men (MSM) and agreed to jointly plan and undertake an HIV Prevention Needs Assessment of MSM. The Needs Assessment consists of several strands of work, including interviews with clinical staff, which is reported on here. This element of the Needs Assessment is described as follows:

'Clinical staff possess a unique insight into broad trends across their patient groups, and are therefore an often untapped source of information… Therefore the second area of the Needs Assessment will ask key clinical staff directly involved in sexual health and HIV service delivery to MSM in NHS Greater Glasgow and Clyde (NHS GGC) and NHS Lothian to participate in an individual interview which draws on their knowledge and experience of front-line service delivery to find out more about their perceptions and understandings of what MSM report around their sexual and social networks, risk behaviours and the motivators for their participation in unsafe sex… The aim then is to improve our understanding of the behaviours and motivators of MSM who are at highest risk of acquiring or transmitting HIV'.

ii. The work was given NHS Research Ethics and R&D approval (in both health boards). Part of Ethics/R&D approval was the requirement that staff in GU and HIV services were asked to volunteer for interview having seen information about the work. Information was shared with staff working in the following services:

- NHS GGC: The Brownlee Centre and Sandyford services
- NHS Lothian: Chalmers Sexual Health Centre and RIDU

iii. Staff who volunteered for interview were provided with a full information sheet and notice of questions in advance of interview. Interviewees were told that their views were understood to be individual, and not representative of their NHS Board or service. In interviews, participants were asked to draw on their knowledge and experience to ascertain the following about gay/bisexual/MSM at elevated risk of HIV transmission:

- Can you identify specific characteristics of men who you deem to be at elevated risk of HIV transmission?
- What can you tell us about the social and sexual networks utilised by men that might impact on risk of HIV transmission?
- What STI/HIV risk reduction strategies are currently employed by men?
- What motivates risk behaviour?
- Are current prevention interventions reaching men at highest risk of HIV acquisition?
- What could we do to enhance HIV prevention work in light of this information?

iv. The interviews were framed in the context of a shared view that our services are good, but we can always use our insight and do better. Interviews took place in July, August and September 2012.

2. CHARACTERISTICS OF MEN AT ELEVATED RISK OF HIV TRANSMISSION

i. Whilst being asked to discuss the characteristics of men at elevated risk of HIV transmission clinical staff have been keen to stress their view of all men as individuals, each with a unique set of experiences and attributes. However it has been possible to identify some characteristics of an individual that might be a marker for vulnerability in terms of HIV risk.

ii. Men who have poor self-esteem and self-worth are of concern where they indicate they do not feel they can, or have a right to state, what they want from sexual relationships. Men may not have ever worked out what their boundaries are, or what their priorities are in terms of pleasure. In such circumstances men may take risks because it fills a need for intimacy. Men may also then have poor negotiation skills, lack assertiveness and have little confidence and control in sexual situations.

iii. A different group of men who may also have issues with boundary setting and planning for sexual situations would be those who are led by intuition, who are less fact based in their assessment of others or of risk/situations, this poor understanding or pre-planning of boundaries and limits leads to risk. Services also engage with men who have risky/riskier sex when on holiday or on special trips to scenes elsewhere, for example London, Berlin, Barcelona.

iv. Interviewees also identified concerns for men who feel pressure to be sexually uninhibited, to be 'good at sex' and are unable to resist how others define this. Once in situations men may increasingly seek to 'turn the volume up' which leads to sexual adventurism and high partner numbers.

v. Staff interviewees identify the role of alcohol and drugs as key influences on men's sexual lives. In terms of drug use staff report use of ecstasy, ketamine, Viagra and increasingly use of crystal methamphetamine.

vi. Men who have been in heterosexual relationships, perhaps married, are thought to be at risk because they may lead secret sexual lives. There are concerns that men do not connect with their gay/bi selves, disassociating sex from other parts of their life, and may see HIV as something of the 'gay world' that they have nothing to do with. The places and spaces (online, public sex environments) where men lead these sexual lives might also be those within which they are unlikely to engage with good information or opportunities for support. For these men, concerns continue if/when they do 'come-out' because they may not have been exposed to sexual health messages or continue to not make connections between risk and their behaviour.

vii. Services also engage with men who have been sexually abused as children, this may involve experiences in care, and men who are at risk of sexual assault as adults because of their involvement in prostitution.

viii. Men in relationships can also be of concern and considered at risk of HIV acquisition. For men in relationships choices to stop using condoms with their partner can lead to risk when one or more of the partners has UAI out with the relationship; it seems that men can make an assumption that being in a relationship is in itself protective. Other men in relationships might agree one or both of them can have other sexual partners, but are not able to sustain condom use every time with those additional partners.

ix. Interviewees identify that services might not identify or be aware that learning disability might be impacting on the individual's understanding of information, risk and behaviour; men themselves might not be aware of how learning difficulties/disabilities might impact on their understanding or safety in certain environments.

x. Young men are a key concern across services:

- They can be poorly informed and educated about risk and HIV.
- Some young men are vulnerable due to low self-esteem, seek intimacy, this vulnerability is identified by other men, they do not choose the sex they have.
- It is a particular concern if they think UAI with other young men is safe because of assumptions that young men cannot be HIV positive.
- Young men coming to cities from out of town are perhaps rather naive and ill-informed.
- For some young men who have had a reasonably positive experience of coming out they just have not picked up messages about the risks associated with starting their sexual lives, there is no connection to HIV as a potential risk.

xi. Some staff interviewees have some concern about the role which treatment optimism can have on undermining intentions to stay safe. Interviewees recognise that as one interviewee put it, "downgrading HIV/AIDS", might have an impact on perceived seriousness and vulnerability and messages about the straightforward nature of treatment may characterise living with HIV as manageable.

xii. Finally, staff interviewees recognise that there are simply many men who have not yet connected with services, they may or may not access information, and they are not accessing testing/screening.

xiii. Two common threads ran through much of the discussion of the characteristics of men at elevated risk of HIV transmission; the dissonance or disconnect men might make between their sexual lives and other parts of who they are, and the importance of pleasure. The former issue allows men, however informed they are about risks of UAI, to locate sex/risk in a place that does not connect with understanding or who they are or what aspirations they have to be healthy, happy or safe; sex then is not guided by the logical, rational person they otherwise might be. The latter issue sees men focus on the moment and on gratification, any consideration of consequences or regret is dispelled until after the sexual encounter. As one interviewee said: "Discussion of sexual risks seems to happen in *post*-sex analysis, rationality is suppressed, sex takes place in the realm of the irrational, in the moment".

xiv. Interviewees have suggested that the following characteristics or issues are *not* thought to be relevant to risk:

- *Lack of information*: In broad terms a shared view is that men have information, whether they are able to apply it or not is the issue; although as stated earlier there are some concerns about men who have never identified as gay/bisexual and are using PSE or internet to connect with others.
- *Social deprivation*: risk appears to be an issue across men whatever their economic situation; *however* interviewees do identify that poor educational attainment is considered a risk factor and this is likely to be more common amongst men living in poverty.
- *Sero-discordant relationships*: the view is that services are good at support for men in established relationships where one partner is living with HIV and the other is not.

3. SOCIAL AND SEXUAL NETWORKS AND HIV TRANSMISSION

i. Across interviewees clinical staff highlighted the use of internet/apps as the biggest influence on how men meet others for sex. This is seen to facilitate increased partner numbers, limit opportunity or space for a potential dialogue about what men like or want, particularly so when it comes to negotiating condom use and safer sex. One interviewee summed up: "The apps aren't changing sex, they just make it easier to get what you want". There are also concerns about addiction issues in relation to web/apps usage.

ii. Staff report that the use of online places to meet others for sex facilitates the cognitive dissonance discussed earlier so that men's sexual lives are viewed apart from all other parts of their lives. Staff report that men will sometimes 'blame' the site/app they used to meet someone which led to risky sex/infection rather than see their behaviour as the issue.

iii. One further impact of more anonymised sex via sites/apps reported by staff is the complexity of partner notification.

iv. Staff report that men do not understand risks associated with concurrent relationships whereby they might believe that because they are having safe/safer sex with one partner that partner is also (always) having safe/safer sex with others.

v. Interviewees are aware of a developing sex party scene. For those who have heard of this from men it seems small, perhaps particularly attractive to positive men to assist sero-sorting and opportunities for UAI. However interviewees report concerns that negative men or those of unknown status are drawn to these parties.

vi. More men, particularly older men, report sex with friends as a regular part of their sexual lives; this is a shift from a notion of perhaps more anonymous 'fuck buddies' and there is a sense that men are not seeing 'sex with friends' as having potential risks; there may be a naive trust in them or a lack of negotiation about what they do.

vii. Saunas remain a venue for men, particularly older men and those who seek to assure anonymity that perhaps even website/apps can't offer. Other PSE seem much less used by men. Staff are concerned, based on reports from men, that more needs to be done to promote safe sex messages and condom provision in saunas and PSE.

viii. In interviews it has been reported that when engaging with men in clinical services it seems the focus is often on last/recent sexual activity and immediate risks rather than sexual lifestyle. Interviewees recognise value in engaging more around context of sexual behaviour but do not always have or create opportunities to make this happen.

4. RISK REDUCTION STRATEGIES EMPLOYED BY MEN

i. When asked about what men report in terms of risk reduction strategies the response from some interviewees is that some men do not adopt any and that frequently there is little reflection on behaviour in terms of risk of STI/HIV infection. There are particular concerns for men leading the 'secret sexual lives' discussed earlier, employing some degree of dissonance whereby sexual lives are poorly integrated into other parts of who they are.

ii. Most commonly though clinical staff report that men talk about condom use, however there are concerns that intentions can be undermined by a range of contextual issues including familiarity or 'knowing' the man and assumptions that they cannot be HIV positive, decisions based on beliefs that if someone looks 'healthy' they cannot be HIV positive, and that if a man is asked his status and he says he is negative then this will be taken at face value.

iii. Staff report concerns about assumptions of HIV status based on a lack of discussion. Men who are/think they are negative report that they believe that if someone is positive they will say, if they don't bring up HIV then they must be negative too, therefore condoms are not necessary. By contrast someone living with HIV may assume that a man who wants UAI who does not raise the issue of condom use or HIV must know they are positive and also be so.

iv. Interviewees report a range of other strategies men might adopt. Men talk about being a 'top' or only having oral sex; interviewees are concerned that these are not protective and ignore other STI risks. It is thought that HIV positive men are engaging in sero-sorting, some men will mention trying to identify other positive men but clinical staff report that this is concerning, that because men just don't talk enough this lacks efficacy. Negotiated safety, whereby partners have UAI within their relationship (usually when both are thought to be HIV negative) but expect additional sexual partners to be safe, is also considered a rather naïve strategy, with a partners behaviour out of your control.

v. Of course risk reduction strategies are employed by both negative and positive men. For interviewees there are concerns for men who on diagnosis, or when coming to terms with their HIV status, retreat from sex and relationships and feel their sexual lives are over. They may well view any sex as a risk for others, or feel that other men will not find them attractive. There are concerns about the consequences of this on the psychological wellbeing of the individual.

vi. Interviewees also discussed the value of how protective it is to consider when HIV positive men have a low viral load: some men understand they are unlikely to transmit HIV when well, managing medication and being monitored. However clinical staff view this is a sophisticated risk reduction strategy, it requires excellent management of treatment and monitoring. There are also concerns about other STI risks and consequences of undermining health/viral load because of STI infection. There is a concern that in seeking to support the positive person services might overstate the safety of this approach, rather we should be ascertaining whether *a partner* would be prefer the HIV positive person to use a condom for AI.

vii. Finally, in terms of men living with HIV there are concerns that some positive men seek to engage with services in ways which allow them to separate their HIV care and sexual health care. This may be made easier for them when some personnel within HIV services do not see the sexual health of the individual HIV patient as of relevance/interest to them. A lack of integration (by the patient and by the professional) is seen as undermining efforts to address risk/behaviours and promote sexual wellbeing.

viii. Clinical staff discussed the likely growth in the use of PrEP and PEP as a response to HIV acquisition; they expressed concerns that PrEP and PEP use might be seen as a strategy to protect from infection, and divert from the necessary focus on behaviour change.

ix. Interviewees appreciate that condom use is the end point of a long journey for some men so any harm/risk reduction should be supported; a problem is however is that although men are often being seen in a service following a high risk episode it may be some time before they are connecting again, this diminishes opportunities for discussion, planning and asserting commitments to safer sex.

5. UNDERSTANDING WHAT MOTIVATES RISK

i. The characteristics or context for risk have already been discussed, to summarise in terms of the question around 'what motivates risk' clinical staff report a concern for these key issues:

- Mood.
- Need to connect/for intimacy.
- Men using sex to make them feel better.
- Not taking care of myself/not worth taking care of.
- Assumptions that if HIV or condoms are not mentioned the other person is also negative/positive.
- Invulnerability or inevitability.

ii. Interviewees also identify that these other factors influence risk:

- For some men risk is normalised behaviour; perhaps for younger men who have never established safer sex norms.
- Men report that condoms get in the way of enjoyment/the moment.
- In clinical consultations men talk about use of pornography and there are concerns that what is viewed becomes normalised or expected (bareback sex, group sex).
- In relation to use of the internet there are concerns that fantasy from online chat seeps into real-time meets so that men who might lack language, skills or confidence for re-negotiation cannot do so.
- There are concerns for partner numbers but staff report that men are resistant to consideration of partner number reduction as a strategy to minimise risk.

iii. Interviewees also identify a key motivator for *not* taking risk as positive men's fear of transmission to others.

6. THE EFFECTIVENESS OF CURRENT HIV PREVENTION INTERVENTIONS

i. Interviewees were asked to consider the effectiveness of current HIV prevention interventions reaching men at highest risk of HIV acquisition. To assist with this conversation clinical staff were asked to comment on these approaches, each of which might be seen as having a role within HIV prevention efforts:

- *PROVIDING INFORMATION TO INCREASE KNOWLEDGE*
- *BUILDING SKILLS*
- *AFFECTING COGNITIVE FACTORS*
- *CHANGING EMOTIONAL STATES*
- *INCREASING SOCIAL SUPPORT TO INFLUENCE NORMS AND TO ENCOURAGE OR REINFORCE BEHAVIOUR CHANGE*

PROVIDING INFORMATION TO INCREASE KNOWLEDGE

ii. Interviewees state that men get information when they attend a service. Staff describe clinical services as , in the words of one interviewee, "very task oriented" with concerns that time is limited to both give and assess what the individual's information needs might be.

iii. Clinical staff are concerned that information on HIV has largely disappeared from bars/clubs, although condoms and lube might be available. While there is awareness of information and social marketing campaigns about HIV in the community there are doubts as to whether men personalise and internalise these, and are then able to use information/knowledge to influence choices regarding sexual behaviour. Whether men pick up information from clinical settings or in bars there are concerns whether it is understood and utilised.

iv. Amongst interviewees there is a lack of knowledge of what community based agencies do in terms of provision of information in commercial venues and worries that outreach done on the commercial gay scene by community agencies (as it is reported back in clinical settings) is seen as an annoyance by men.

BUILDING SKILLS

v. Building skills was discussed in terms of areas such as condom use or negotiation skills. Clinical staff report that while there is little formal assessment of need, where a skill deficit is identified this will be addressed. However interviewees recognise that men find it hard to say, or do not know, that their skills might be poor. Rather than a skills issue men will usually report risk as a mistake, but return some time later with the same issue. In terms of condom use there is some concern that men think they know how to use condoms but may not be as proficient as they think. Interviewees shared the view that clinical services could do more at supporting men in building skills.

AFFECTING COGNITIVE FACTORS

vi. In interviews cognitive factors were understood to be the attitudes and beliefs the individual man might hold in relation to their sexuality, sexual wellbeing and self; so that moving beyond providing facts or information men need time to think about what this means *to them*. Interviewees feel that clinical services do not address this area well, although interviewees recognise that they might refer on to colleagues who provide opportunities for

more personal reflection or more therapeutic interventions. Some interviewees identify that they work intuitively to help support and shift the individuals attitudes or beliefs and address ambivalence toward behaviour change and that over time, where relationships are established, men make progress.

vii. Motivational Interviewing, a model being introduced and used across clinical services, is seen as a way to change current clinical interventions, moving engagement from task oriented information provision to an opportunity to engage in discussion and reflection and support the individual in relation to behaviour change.

viii. Clinical staff report they are unaware if the community sector is working in this area of HIV prevention.

CHANGING EMOTIONAL STATES

ix. As has been highlighted earlier, clinical staff have a range of concerns about men where their emotional state, or mood, impacts on decisions and sexual behaviour. Again, although staff interviewees identify that they may refer on to others for specialist support they recognise that clinical services generally do not address these areas with most men. A shared view was that counselling or therapeutic support is more available to men *after* a positive diagnosis.

x. There are concerns that where men are referred on to specific programmes levels of engagement can be poor. For some interviewees 'brief interventions' are not attractive to men, for others they are seen as ineffective because they do not deal meaningfully with life experiences, others are concerned that efficacy is undermined because men feel they can make the change which may have been highlighted for them, but that continued awareness, commitment or capacity to do so then dissipates. One interview commented: "We need to do more than CBT because we don't dig deep enough, it's a revolving door".

xi. There is little knowledge of counselling or therapeutic services out with that provided within interviewees own setting.

xii. Interviewees see a connection between negative cultural factors, such as the language of church leaders in recent months, and the wellbeing of men living with a negative view of themselves.

xiii. Interviewees report that they meet men who are living sexual lives they appear to be unhappy with, but that men are unable to see a way out. Interviewees report that they/their service does not want to be perceived of as judgemental or trying to impose heteronormative relationship and sexual norms by addressing issues like sex with unknown men or partner numbers, but see that men want something different.

INCREASING SOCIAL SUPPORT TO INFLUENCE NORMS AND TO ENCOURAGE OR REINFORCE BEHAVIOUR CHANGE

xiv. Clinical staff recognise success in advances that have been made in testing rates. However too many men are still presenting late, this highlights that work remains to be done about testing and a culture of regular check-ups.

xv. Clinical staff interviewed identify that social isolation is underestimated as an influence on gay men's (sexual) lives. For acceptance of self, to feel worthy of good health, to feel in control, clinical staff see the need for men to build positive self-identity and this can be supported through social and community connectedness; interventions in this realm are seen as valuable in building protective factors.

xvi. There is a shared view across interviewees about the need to re-engage with the LGBT community on norms and behaviour in terms of sex and relationships. Interviewees are concerned that community based interventions are part of an overly/overtly sexualised view of gay men's lives. There are particular concerns that young men are sexualised, pornography defines what is expected, unrealistic body images in advertising, media and pornography results in negative body image from a young age, sex is expected to be anal sex. However interviewees do not see that clinical services are connected to this work and interviewees were left wondering: *who is doing it?* One interviewee stated "A lot of healing needs to be within the community; there needs to be a discussion about relationships, sex, and lifestyle, how people live their lives, responsibilities".

xvii. There are concerns that community based practice (using peer led work and community outreach) lacks an evidence based and should be evaluated for effectiveness so that it can be considered whether the model is best suited to current needs in terms of HIV prevention.

xviii. Finally, in terms of understanding the LGBT community context clinical staff recognised that there are very few positive men who can be seen as role models. One interview saw this as follows: "You get HIV and you keep your head down".

7. ENHANCING HIV PREVENTION

i. This final section of the report on NHS Clinical Staff interviews makes some suggestions as to a range of issues and areas which it would be useful to address further; through the development of policy, consideration of practice within clinical settings or in the context of inter-agency discussion and relationships.

The points which follow address:
The focus of HIV prevention
Meeting the needs of vulnerable men
Service design and delivery
Ethical and political considerations

THE FOCUS OF HIV PREVENTION

CONTINUE AN EMPHASIS ON TESTING

ii. Clinical staff recognise that there have been successes in terms of increasing HIV testing rates amongst gay, bisexual and MSM. They are also aware that untested positive men are a key concern and highest risk in terms of onward transmission of HIV. Testing is also viewed as important because it means engagement with a service and the beginning of a relationship. One interviewee commented: "Once men are in services there are intervention possibilities, sexual health check-ups can be instilled, particularly in younger men".

CONSIDERING THE CONDOM MESSAGE

iii. Interviewees identify that many men do not connect to the 'use a condom every time' mantra; and that for some men it has lost validity. Interviewees were of the view that there is no community norm on condom use; that it is a consideration for individuals rather than being an expectation in the places and spaces men inhabit and live their sexual lives. However, for some clinical staff interviewed the only appropriate HIV prevention message remains 'use a condom every time', and that compromising on the clarity of this message is a disservice to men to whom services have a responsibility. The challenge within clinical consultations however is that while staff want men to understand that condoms will prevent HIV transmission they also want to support men reduce risk if condom use every time is as yet unattainable. Interviewees appear to have different views on whether the message should be clear and unambiguous (use a condom) or a more staged/risk reduction approach dependent on the individual.

RISK AS A FOCUS

iv. Interviewees identify that opportunities are missed to address behaviour and risk, particularly when men attend for STI/HIV testing, so that the service spends time talking about what the HIV test means, preparing for it, giving results rather than discussing context and behaviour. For men who receive a negative HIV result an opportunity may be lost to engage in a dialogue (started at the point of testing and continued where necessary) that would be protective. Interviewees report that HIV testing is becoming normalised, but that discussion of behaviour and risk is not.

DISCUSSING PLEASURE

v. Interviewees report that there is little discussion of pleasure; so that even where sexual behaviour is discussed a failure to talk about pleasure means that the dialogue is focused on the service's agenda rather than connecting

to the man's perspective or drive in terms of certain behaviour. Some interviewees are concerned that discussion framed in this way might be embarrassing for some colleagues but that nonetheless there is a need to encourage discussion about 'what you want and what you like' as well as 'what you did'; reframing the idea of risk as a discussion about pleasure and safety.

CONCERNS ABOUT DOWNPLAYING OTHER STIS AND VIEWING HIV AS A TREATABLE CONDITION

vi. With the focus on HIV transmission staff express concerns that the importance or impact of other STIs is downplayed to the detriment of gay men's sexual health and HIV care. Further, there are concerns that viewing HIV as a 'chronic manageable condition' undermines the seriousness of the infection and subsequently intent and ability to encourage men to take effective measures to protect themselves from HIV infection.

PrEP, PEP AND HOME TESTING

vii. Interviewees identify that PrEP, PEP and home testing will play an increasing role in perceptions of HIV, how men access services and whether a key focus remains on prevention through enhancing protective behaviours. There are concerns that the HIV prevention agenda might be increasingly led by pharmaceutical companies; where treatment is seen as prevention, and behavioural interventions lose credibility and funding.

WORKING PRODUCTIVELY IN ONLINE ENVIRONMENTS

viii. In recognition of the increased use of online mediums and phone apps clinical staff identify the need to engage with the medium (and owners) so that the most productive and creative approach to HIV prevention can be developed.

MEETING THE NEEDS OF VULNERABLE MEN

IMPROVING EARLY INTERVENTIONS

ix. Interviewees identify that for too many men services become more accessible and more focused on individual need *after* a HIV positive diagnosis, rather than when risk or vulnerability is identified. One interviewee commented: "It's a positive diagnosis that leads to more intervention that has any depth… until then its average".

BUILDING RELATIONSHIPS AND TRUST

x. Interviewees recognise that for many men engaging with a clinical service this is, as one interviewee put it, "an awkward place". Clinical staff recognise that testing (or at least the context and worry that has led the man to the service) can be traumatic, men fear being judged or they are ashamed of the behaviour or risks they may have taken; in such contexts staff appreciate that it is difficult to be honest about sexual behaviour. When the patient and service are in this initial engagement staff understand that it is difficult to impact on behaviour and understanding of risk, rather interviewees report it may be three or four or more visits before relationships and understanding grow. In this sense staff see regular screening/check-ups as an important way to build trust and relationships.

USING ALL CONTACT AS AN INTERVENTION

xi. Interviewees talked about a range of contacts with HIV+ men who may access different parts of a services and staff. It seems however that contacts are not always viewed as an opportunity for an intervention which might address the man's broader health and wellbeing. Staff identify a need to improve individual planning around the man, where every contact meets immediate needs (for information, advice or service) but is also viewed as an interaction to progress other relevant issues or needs. One interviewee reported: "When you see people at annual review you can identify issues and concerns, and be struck by no-one having addressed core issues".

WORK WITH YOUNG MEN

xii. As has been identified earlier young men are a particular concern; interviewees share a view that clinical services and other service providers need to rethink their approaches. There was agreement across many interviews that services need to engage with young gay men before sexual debut and in childhood to build resilience, confidence and self-efficacy and as they grow into their teenage years; services need to support young men to understand how their sexual lives are in their control and connect to who they are. At an early age it was seen as crucial that young gay men see condom use as the norm. Interviewees suggest an aspiration for services should be to encourage young gay men to establish a commitment to regular sexual health check-ups.

xiii. Interviewees asserted that all children and young people need to hear positive affirming messages. While interviewees see the importance of sex and relationship learning in schools they also wonder whether we currently have a climate within schools where young gay and bisexual men can be supported; if we do not then alternative approaches need to be explored.

WORK WITH MEN ACCESSING PEP OR PRESENTING WITH OTHER STI INDICATIVE OF UAI

xiv. There is a view that men are poorly informed about PEP but that when it is accessed, (particularly where men are given a negative result or a positive result for another STI indicative of UAI) the engagement with the man may not be used as an intervention which could address concerns, exploring what has been happening for them *over* time rather than just *this* time.

THERAPEUTIC INTERVENTIONS

xv. Interviewees recognise that many of the men most at risk of HIV acquisition, and also men living with HIV who may be a risk for transmission, require therapeutic interventions. One service response has been the introduction of CBT models but there are concerns about the limits of CBT, its take-up and its impact on profound issues which are impacting on the men most at risk of HIV acquisition; trauma, addiction, depression. It is hoped that the introduction and use of Motivational Interviewing, as one interviewee put it, "changes the script… and the culture" in clinical interventions, moving from a focus on risk to more productive consideration of ambivalence and change.

xvi. A view across interviews is that therapeutic services are under resourced and need prioritising and that thresholds for services that could make a difference are too high. Interviewees also recognise that services need to rethink pathways into additional or specialist supports for men, so that rather than simply 'referring' the individual improved pathways need to be developed so that services (and men) can avoid stigma and resistance. It is unclear to interviewees how clinical services are doing across the Boards in terms of meeting the standards of psychological support for people living with HIV.

MEETING THE NEEDS OF POSITIVE MEN

xvii. Staff identify the need to improve support for men immediately after a positive diagnosis, which is recognised as a very difficult time for individuals. Post diagnosis is seen by staff as a time to establish new ways of living sexual lives and there are concerns that at this low point men can be vulnerable and find themselves in situations where they are unsafe and unhappy.

xviii. Interviewees identify that services do not take or create opportunities to reflect back with men, after their positive diagnosis, on their 'story'; when doing so might help us understand where opportunities for interventions may have been missed or could be enhanced for others.

xix. Positive men fear criminalisation; this can mean they are reluctant to have honest and open conversations about their sexual lives in clinical settings. Clinical staff recognise that both service and the HIV positive individual need to be aware of the legal context but that efforts to build trust will require the service to explain that questions asked are about enhancing the individuals sexual health and wellbeing, and not trying to trick or trap them into disclosing risk in relation to their sexual partners.

xx. Having identified the difficulties which a service might face in engaging with positive men interviewees also identify the need to improve interventions for positive men who are taking risks in terms of onward transmission of HIV and infection in terms of other STIs; this may mean supporting some men to better integrate their sexual lives and their HIV. Interviewees have recognised, discussed earlier, that some clinical staff choose to not address sexual health and wellbeing in HIV care, it has been suggested that where this happens a staff member within the service, not necessarily the primary physician, should be addressing this issue.

xxi. Interviewees also identify that in Scotland we currently do not make the most of positive men as a resource for HIV education and prevention, whilst there was some knowledge of peer activity connected to clinical services there was a hope that we could do more to engage positive men in educating others.

SERVICE DESIGN AND DELIVERY

LEARNING FROM COMMUNITY BASED OR ALTERNATIVE SETTINGS

xxii. In the context of interviews staff identify the need for clinical services to learn from new initiatives which make services more accessible , for example out of hours, locally based services including Point of Care testing which are seen as an important supplement to centrally based services. Interviewees also identify the usefulness of central services learning from, adapting and introducing elements of what works in these community based facilities.

STANDARDS ACROSS SERVICES

xxiii. Clinical staff see a positive shift for mainstream clinical services, so that in addition to men attending targeted or community based clinics, the main clinic services are also attracting more gay, bisexual and MSM. Interviewees also recognise that gay, bisexual and MSM may also use other services, but that in these contexts there is some concern that the particular vulnerability of men in terms of HIV risk may not be known or understood; as an example staff would like to see all blood samples, wherever taken, tested for HIV routinely, this is particularly important where men may be presenting with symptoms associated with HIV illness and this may not be considered by a clinician.

ETHICAL AND POLITICAL CONSIDERATIONS

CREATING OPPORTUNITIES FOR MEN TO DISCUSS ALTERNATIVES

xxiv. Clinical staff report that gay, bisexual, MSM discuss the pressure they feel to be something they might not want to be, or feel unable to be; about how men look, what kind of sex they should be having, to be hyper-masculine and have lots of sex. Rather than identifying with or within these parameters clinical staff hear that men want to be more content with who they are, perhaps to have a regular partner and to be happier with the sex they are having. Whilst some interviewees see the space to have these discussions might be in therapeutic contexts they would also like to see them as a public discourse, affirming alternatives for men and particularly for younger men.

A QUESTION OF RIGHTS AND RESPONSIBILITIES

xxv. For some interviewees there has been, as one interviewee said, "too overt a focus on the positive person" to the detriment of their partners (whether casual or regular). Staff understand this is difficult but some interviewees expressed concern that positive men might frame their 'right to sex' as a right to sex without condoms if they wish. One interviewee said: "This is a practical and a moral question. The negative person not mentioning condoms doesn't absolve the positive person. If there are rights, it's about care not sex. Promoting a general sense of personal responsibility can be a behavioural intervention".

A POLITICAL FRAMEWORK FOR HIV PREVENTION

xxvi. A consistent message from interviewees has been an interest in the social, political and cultural context within which gay, bisexual and MSM live their lives. Interviewees identify that vulnerable and marginalised men, and particularly young men, absorb destructive and discriminatory views and these impact negatively on wellbeing. Whether the work that needs to be done is focused directly on HIV prevention, or whether work is done across public services to support children, young people and vulnerable adults come to terms positively with their homosexuality, clinical staff are keen to locate work in the context of public health, equalities and human rights, resisting damaging socially conservative influences.