

# HIV PREVENTION

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

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For reference purposes the study is

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## GLOSSARY

AI: Anal intercourse

CD4: Cluster of Differentiation 4 cells are part of the human immune system and used as a measure of stage of infection in relation to HIV disease progression. At diagnosis a CD4 cell count of less than 350 per mm<sup>3</sup> is defined as a late diagnosis with CD4 cell count less than 200 cells per mm<sup>3</sup> being very late.

CNR: Case Note Reviews

BDSM: Bondage, Domination, Sadomasochism

GBL/GHB: GHB (gammahydroxybutrate) and GBL (gammabutyrolactone), are closely related, dangerous drugs with similar sedative and anaesthetic effects.

GPS: Global Positioning System.

LGBT: Lesbian, gay, bisexual, transgender

MSM: 'Men who have sex with men' is a term utilised in Scotland's sexual health and HIV services and across policy & planning arenas. It focuses attention on a man's sexual behaviour with another man or men rather than the sexual identity of the individual. MSM includes men who identify as gay, bisexual, heterosexual or who may not associate with any of these identities. It is acknowledged that this is not a term utilised directly by men and some may find it reductive in its description, however it is used here acknowledging these limits and is not intended to cause offence.

NHS GGC: NHS Greater Glasgow and Clyde

PEP: Post-exposure prophylaxis

PLWHIV: People living with diagnosed HIV

PN: Partner notification

PSE: Public sex environment

RIDU: Regional Infectious Disease Unit

SSPS: Predictive analysis computer software

STI: Sexually transmitted infection

UAI: Unprotected anal intercourse, i.e. anal intercourse which does not involve condom use.

VL: Viral load

## KEY MESSAGES

The Needs Assessment has generated a wealth of rich information about the needs of MSM and the steering group considers the totality of the findings to be of significant value. Through a process of reflection, the following “key messages” have been selected as summarising the main issues that our HIV prevention efforts need to focus on for MSM.

### VULNERABLE MEN

From the case note review 28% of men newly diagnosed with HIV had 2 or more vulnerabilities, including problematic alcohol use, low self esteem, mental health problems and experience of violence and childhood sexual abuse. The risks they are taking with their sexual health may be a symptom of these wider syndemic affects. The diagnosis of a rectal STI (and particularly repeat diagnosis) should trigger an intensive package of HIV prevention support for the individual which must include an assessment for other overlapping vulnerabilities experienced.

Having a high risk of STI acquisition, infrequent HIV testing, or never being tested for HIV appears to be associated with social deprivation and with not accessing MSM specific services. We must significantly extend the reach of all interventions to involve generic services including generic young people’s services and general practice to address the needs of men who are not currently served.

### ANAL SEX

For those men who have anal sex, it is a marker of trust and intimacy and source of pleasure. For men that do not have anal sex or for whom anal sex is of less importance, their sexual decision making takes place within a wider context in which there is an expectation from others of anal sex. So anal sex forms an important and central aspect of many men’s sexual lives and they would welcome discussions about what it means to them within clinical settings. The perception from men is that condomless anal sex is problematised by services purely in relation to HIV/STI transmission. Services must have conversations with men about anal sex, and understand the meaning of it and reduce the stigma associated with it. If anal sex is only obliquely referenced in terms of condom use we cannot successfully and meaningfully engage men around effective HIV/STI prevention (within which condoms have a role).

### HIV STATUS AND HIV TESTING:

Men rarely talk explicitly about HIV status with potential sexual partners yet men tell us that knowing a partner’s HIV status is an important component of sexual decision-making. Men make assumptions about HIV status, their own and that of other men. There needs to be a continued focus on regular HIV testing, stressing the benefits of knowledge of HIV status. There is also a need to support men (both population wide and as individuals) to be more open in their conversations about testing, re-testing and HIV status in order to inform sexual decision-making. This requires support and education both for men disclosing HIV positive status and men hearing such disclosure.

### CONCERNS ABOUT SPECIFIC POPULATIONS OF MEN

Men who have sex with both men and women are less likely to engage with services. Men in relationships can be vulnerable to HIV infection as a high proportion of men report concurrent sexual activity with other men, either individually or together with their primary partner. Men need to be informed about the heightened risk of concurrency and supported to make informed decisions about reducing their risk.

Younger men (aged <26) are also less likely to engage with services and have distinct HIV prevention needs; they are very sexually active with higher partner numbers and condomless anal sex episodes. They appear less aware of risk and are less equipped to reduce their risk. They need to be engaged in discussion and learning about anal sex before they first have sex and be supported to delay first experience of anal sex until they are ready.

### **MEN LIVING WITH HIV**

HIV services are not currently meeting the sexual health and well-being needs of all men living with HIV (MLWHIV). These men experience a high burden of sexual ill health with 1 in 5 of all rectal STIs in MSM found in MLWHIV, rising to 1 in 4 in the over 25 year olds. . Among MLWHIV who acquired a recent rectal STI, nearly half had a detectable HIV viral load and were therefore potentially infectious to others. Men living with diagnosed HIV continue to have the need for sexual health care and STI prevention. Their sexual health needs should be met within HIV and sexual health services where HIV treatment and care is integrated with sexual health care. Services should be realigned to support men to maintain good sexual health which includes empowering men to maintain effective risk reduction strategies. Men newly diagnosed with HIV and those diagnosed with rectal STIs should be a focus for services.

### **STAFF KNOWLEDGE, SKILLS AND INTERESTS**

Men want and need services where they can build a relationship with staff. The needs assessment has demonstrated through its high level of engagement that men will talk about sex and relationships when the opportunity is framed positively. A cohort of staff within existing HIV and sexual health services is equipped with the knowledge, skills and interests to deliver excellent care, but clinic staff in large part are not starting the broader conversation about sexual health. Services should employ existing expertise where it is most needed while undertaking a programme of continuing professional development, across services, for others. We must significantly extend the reach of all interventions to involve generic services including generic young people's services and general practice to address the needs of men who are not currently served.

### **CULTURE AND SOCIETY**

MSM (whether they identify as gay, bisexual or not) told us that they experience discrimination and prejudice throughout their lives. When this results in feelings of isolation and powerlessness this impacts on all aspects of life including decision making and risk relating to sex and relationships. Men living with HIV bear an additional burden of rejection, stigma and discrimination. HIV prevention, treatment and care must also address the cultural context within which men live their lives. On a positive note, the methods of engagement used in the FAQ work show that men are willing to engage in discussions about a host of issues that affect sexual health.

# 1. INTRODUCTION

## 1.1 BACKGROUND TO THE NEEDS ASSESSMENT

In the summer of 2011 NHS GGC and NHS Lothian began a process of review of their HIV prevention work aimed at MSM. This involved reviewing the most current evidence of effectiveness of HIV prevention interventions, intelligence on the sexual behaviours of MSM and up to date HIV epidemiology in both Health Boards.

It was agreed that both Health Boards had developed and delivered HIV prevention interventions based on current evidence and local need for almost a decade. At this point both Health Boards delivered a breadth of HIV prevention interventions which included: motivational interviewing; cognitive behavioural therapy; outreach commercial gay venues; condom provision; social marketing; and partnership work with third sector agencies in areas such as promoting HIV testing. These activities defined the 'combination approach' delivered to date. Despite some significant success in increasing HIV testing rates and reducing the proportion of undiagnosed HIV infection among MSM, both Health Boards had failed to see a reduction in new HIV infections amongst MSM, as detailed above. Both Boards had also witnessed rises in risk behaviours reported by MSM over the last decade, specifically reports of unprotected anal intercourse (UAI).<sup>2</sup>

The intelligence on the sexual behaviour of MSM was mostly based on the triennial Gay Men's Sexual Health Survey from the MRC Social and Public Health Sciences Unit (MRC SPHSU). This has collected intelligence on a growing group of MSM who reported high risk sexual behaviours for HIV transmission. High risk behaviours are defined as: reporting UAI with more than one partner in the past twelve months; having had UAI with casual partners in the past twelve months; or having had UAI with men of a different or unknown HIV status in the past twelve months.

Although there was a good understanding of the types of interventions that were likely to have a positive effect on reducing HIV transmission from the published literature, there were considerable gaps in knowledge around how to effectively deliver these interventions in a Scottish context. There was some understanding of the increase in HIV risk behaviours amongst some MSM, however there was poor intelligence on the characteristics of these men and how to target them with appropriate HIV prevention interventions. This was illustrated by the fact that most of the prevention work to date utilised a broad brush community level approach to reach men who may be at risk and encouraged them to engage with services or adopt behaviour change, with some limited highly targeted interventions aimed at specific groups considered high risk such as men involved in prostitution and men living with HIV.

It was therefore agreed that there was a need to increase understanding of the demographics and behaviours of these high risk MSM and to use this knowledge to inform the development of effective targeted HIV prevention interventions. It was agreed that this could best be delivered jointly across both NHS GGC and NHS Lothian. The Scottish Government provided additional funds to support this project.

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<sup>1</sup> Combination HIV prevention programmes aim to select the optimal mix of interventions that will have the greatest impact on reducing HIV transmission, individuals' susceptibility and vulnerability to HIV, and the infectivity of the virus. Combination prevention programmes have considered local epidemiology and target population demographics and have chosen the most appropriate mix of biomedical, behavioural and structural interventions which best meet local population need.

<sup>2</sup> Knussen, C., Flowers, P., McDaid, L., Hart, G. (2011): 'HIV-related sexual risk behaviour between 1996 and 2008, according to age, among MSM (Scotland)'. *Sex Transm Infect*, 87:257-259.

A Health Needs Assessment is a Public Health tool which involves a systematic review of the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. It provides detailed evidence about a population's demographics and behaviours to inform planning of services and to address inequalities. Providing an opportunity to engage with specific populations and key stakeholders, it enables them to contribute to targeted service planning and the design of creative and effective interventions.

This HIV Prevention Needs Assessment of MSM was developed in partnership between NHS GGC and NHS Lothian, with additional funding from the Scottish Government Public Health Division Sexual Health and Blood Borne Virus team with support from the Minister for Public Health. The Needs Assessment was designed to answer the following questions:

**THE PRINCIPAL RESEARCH QUESTION:**

What factors can be identified that will influence the design of future interventions to reduce HIV incidence amongst MSM?

**SECONDARY RESEARCH QUESTIONS:**

1. What can we learn about the social and sexual networks utilised by men?
2. What STI/HIV risk reduction strategies are currently employed by men?
3. What characterises MSM most at risk of HIV?
4. What motivates risk behaviour?
5. Are current prevention interventions reaching men at highest risk of HIV acquisition?
6. What might a combination approach to HIV prevention look like in light of this information?

The key components of the MSM HIV Needs Assessment are outlined below



**FIGURE 3. STRUCTURE OF THE MSM HIV NEEDS ASSESSMENT**

A Public Health Researcher specifically recruited for the study undertook the Case Note Reviews. TASC Scotland was commissioned to undertake the staff interviews and community engagement. Lisa McDaid, MRC SPHSU, was commissioned to provide additional analysis of the MRC Gay Men's Sexual Health Survey. Health Protection Scotland was asked to perform additional analysis of national epidemiology.

The learning from all strands of work has been collated to inform recommendations for the future design of HIV prevention services and the development of effective and targeted HIV prevention interventions aimed at MSM in both NHS GGC and NHS Lothian. Learning will also be shared across Scotland to support service redesign where needed.

The case note reviews, clinical staff interviews and earlier phases of the community engagement and received ethical approval from the West of Scotland Research Ethics Committee.<sup>3</sup> Agreement was reached that the latter stages of the community engagement process did not require ethical approval.

<sup>3</sup> REC Reference: 12/WS/0040

## 1.2 EPIDEMIOLOGY AND POLICY CONTEXT IN SCOTLAND

In the thirty years since the first cases of Human Immunodeficiency Virus (HIV) were identified in Scotland, there has been significant progress in understanding the condition and treating individuals living with the virus and also some advances in our understanding of efficacy of prevention interventions.

Treatment advances have largely transformed HIV infection from a fatal disease into a long-term chronic condition, however it remains one of the most important communicable diseases. It is associated with serious long term morbidity, premature loss of life, increasing treatment and care costs and those affected experience profound levels of stigma and discrimination.

Since 2001 the rates of new diagnoses of HIV in Scotland have more than doubled from an average of 160 reports per year in the late 1980s and 1990s to an average of 350 per year. This is a trend witnessed in all Western countries.

This rise in new diagnoses has occurred almost exclusively through sexual transmission. Although the increase was observed across the whole population, sex between men has been the route of transmission for 71% of all new diagnoses acquired within Scotland since 2004. Men who have sex with men are therefore the population of primary concern in Scotland.

Between 2001 and 2011 the observed rise in new infections among MSM appears to have plateaued at a higher level.<sup>4</sup> This rise is consistent with wider UK and international trends.

The estimated prevalence of HIV among MSM in Scotland is now 4.5%.

Around 100 MSM in NHS Greater Glasgow and Clyde (GGC) and NHS Lothian are found to have HIV infection. This represents the vast majority of all new diagnoses amongst MSM in Scotland. NHS GGC and NHS Lothian are responsible for the treatment and care of 70% of all MSM living with diagnosed HIV in Scotland, equating to approximately 1000 men.<sup>5</sup>

HIV prevention work targeting MSM has been identified as a key and growing priority in successive sexual health and HIV policy documents developed by the Scottish Government:

- Respect and Responsibility (2005)
- Standards for Sexual Health Services (2007)
- Outcomes for Respect and Responsibility (2008-2011)
- HIV Action Plan (2009-2014)
- HIS Standards for HIV Services (2011)
- The Sexual Health and Blood Borne Virus Framework (2011-2015)

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<sup>4</sup> Health Protection Scotland <http://www.documents.hps.scot.nhs.uk/bbvsti/annual-data-tables/2012/hiv-cases-number-2012.pdf>

<sup>5</sup> Health Protection Scotland <http://www.hps.scot.nhs.uk/bbvsti/hivandaids.aspx?subjectid=27>

### 1.3 LOCAL EPIDEMIOLOGY OF HIV

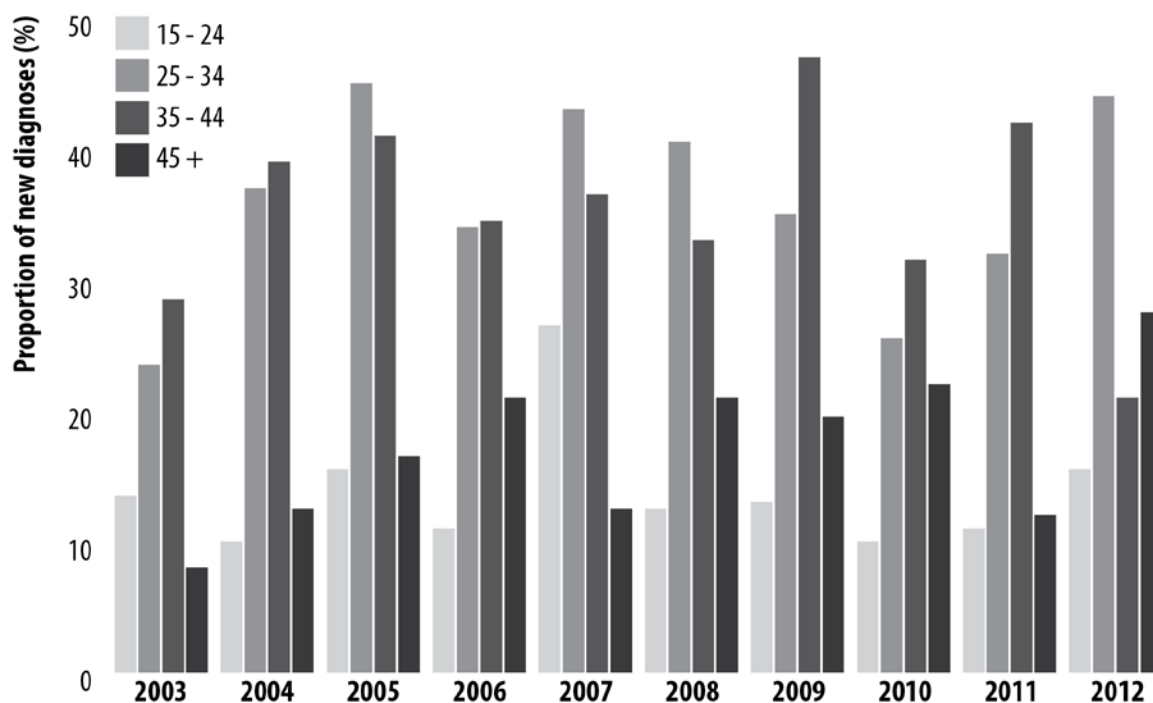
In both health boards over the last 10 years, new cases of HIV in MSM average at 100 a year. As with the national picture, most men acquire their HIV indigenously.

**TABLE 1: NEW DIAGNOSIS OF HIV IN MSM IN GGC AND LOTHIAN**

	<b>GGC Exposure within Scotland</b>	<b>GGC Exposure outwith Scotland</b>	<b>GGC Total</b>	<b>Lothian Exposure in Scotland</b>	<b>Lothian Exposure outwith Scotland</b>	<b>Lothian Total</b>	<b>Combined Total</b>
2003	24	11	35	19	21	40	75
2004	27	12	39	44	15	59	98
2005	36	21	57	39	24	63	120
2006	34	13	47	25	29	54	101
2007	36	21	57	38	25	63	120
2008	34	12	46	32	30	62	108
2009	44	32	76	20	20	40	116
2010	33	12	45	26	21	47	92
2011	36	16	52	28	20	48	100
2012	34	26	60	27	24	51	111
<b>Total</b>							<b>1,041</b>

#### 1.3.1 AGE RANGE

In the last ten years (2003 - June 2013), the majority of men were in the 35-44 age category at diagnosis, however, in recent years there has been increases in younger men (15-24 and 24 -34 age range) being diagnosed.

**CHART 1. NEW DIAGNOSIS OF HIV IN MSM IN GGC AND LOTHIAN BY AGE GROUP**

### 1.3.2 COHORT OF MSM ATTENDING FOR TREATMENT AND CARE

A total of 1383 patients attended for care in the period 1 April to 31 March 2013 in Greater Glasgow and Clyde. The proportion who acquired HIV through sex between men is 46.7% (n=646) with 9.6% (n=62) men infected outwith the UK.

A total of 1,212 patients attended for care for the year up to September 2013 in Lothian. The proportion who acquired HIV through sex between men is 46.7% (n=558) with 16.5% (n=92) men infected outwith the UK.

## 1.4 SEXUALLY TRANSMITTED INFECTIONS

Since 2001, the increase in HIV diagnoses in MSM has been mirrored by rises in other sexually transmitted infections, notably syphilis, gonorrhoea and chlamydia.

### 1.4.1 SYPHILIS

In 2001 outbreaks of syphilis began occurring in larger cities with higher densities of MSM residents as occurred in other Western nations. There is a high proportion of co-infection with HIV observed with MSM. Although it appeared that the epidemic had peaked and a decline had been observed, the last three years saw the figures increase once more. In 2012, 84% of all syphilis diagnoses were in GGC and Lothian and 80% of all Scottish syphilis cases were in MSM.

**TABLE 2 – NEW CASES OF INFECTIOUS SYPHILIS IN MSM IN GGC AND LOTHIAN**

Year	GGC	GGC coinfection (%)	Lothian	Lothian coinfection (%)	Total
2005	54	15 (28)	93	16 (17)	147
2006	87	19 (22)	62	10 (17)	149
2007	89	14 (16)	72	22 (31)	161
2008	79	17 (22)	70	21 (30)	149
2009	42	5 (12)	53	13 (24)	96
2010	26	7 (27)	62	13 (21)	88
2011	53	23 (43)	61	22 (36)	114
2012	63	11 (18)	74	26 (35)	137

#### 1.4.2 GONORRHOEA

The incidence of rectal gonorrhoea, an indicator of condomless anal sex among MSM increased for a fourth successive year in 2012, and accounted for 28% of male gonorrhoea diagnoses in Scotland, the highest proportion recorded in the past ten years.

**TABLE 3 – NEW CASES OF GONORRHOEA IN MSM IN GGC AND LOTHIAN**

Year	GGC male	GGC rectal (%)	Lothian male	Lothian rectal (%)
2005	294	27 (9)	193	38 (20)
2006	261	42 (16)	178	48 (27)
2007	267	29 (11)	133	41 (31)
2008	216	38 (18)	152	25 (16)
2009	260	76 (29)	150	35 (23)
2010	469	117 (25)	167	69 (41)
2011	442	140 (32)	256	86 (34)
2012	516	152 (30)	322	111 (34)

Taken together these data demonstrate an increase in pathogens associated with sexual risk.

Both NHS GGC and NHS Lothian were using the Abbott m2000 Real Time PCR CtNg dual test during the period of interest for simultaneous detection of *Chlamydia trachomatis* and *Neisseria gonorrhoea*. In NHS GGC rectal swabs are only offered to individuals who disclose receptive anal sex, whereas in NHS Lothian all men who have sex with men are routinely offered rectal swabs. The majority of HIV testing across both Health Boards during this period was via venipuncture blood sample tested using automated 4th generation assay. There was also a small amount of near patient testing, mainly limited to community/outreach clinics.

### 1.5 CURRENT SEXUAL HEALTH AND HIV SERVICES

Figures 1 and 2 below illustrated the current sexual health and HIV treatment and care services provided across both NHS GGC and NHS Lothian.

**FIGURE 2: SERVICES PROVIDED TO MSM BY NHSGGC**

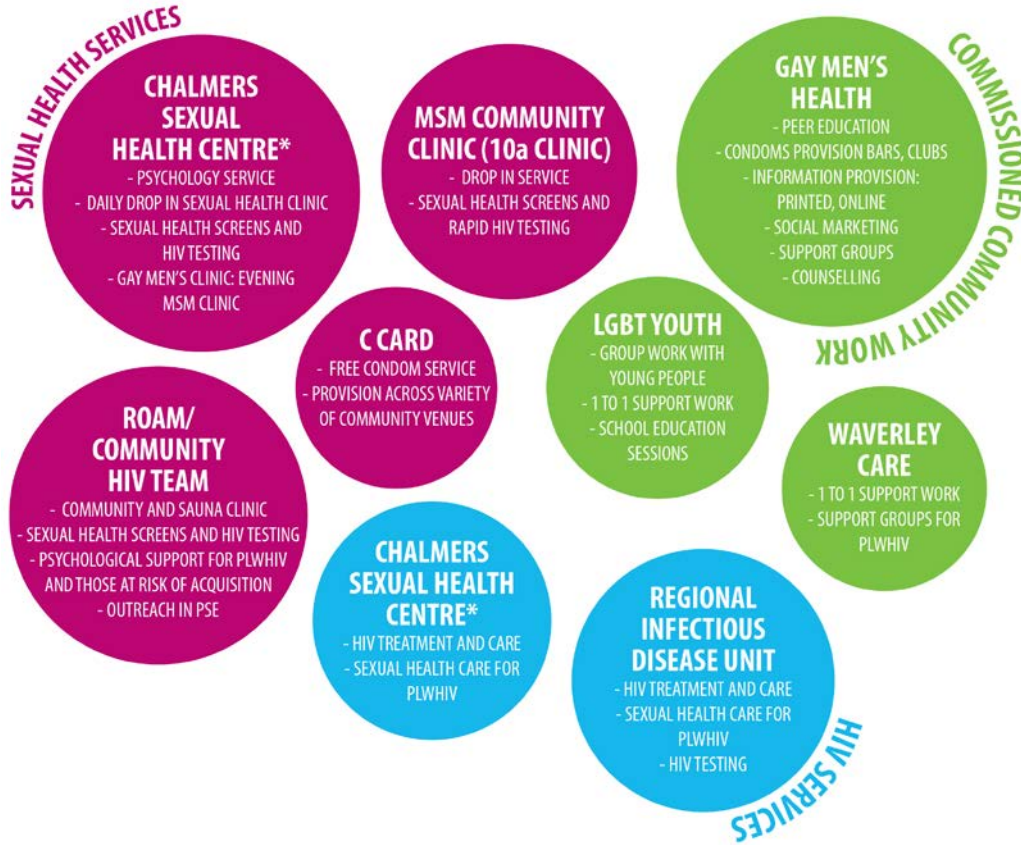
**NHS GREATER GLASGOW AND CLYDE**  
SRP @GHM PROVIDED SINCE NOVEMBER 2012



**FIGURE 3 - SERVICES PROVIDED TO MSM BY NHS Lothian**

**NHS Lothian**

\*PRIOR TO JUNE 2011 SERVICES WERE PROVIDED WITHIN THE GENITOURINARY MEDICINE CLINIC AT THE LAURISTON BUILDING





## 2. METHODOLOGY

This chapter will cover the methodological approaches to each of the needs assessment components included in this report.

### 2.1. MRC GAY MEN'S SEXUAL HEALTH SURVEY ANALYSIS

The MRC Gay Men's Sexual Health Survey is a cross-sectional survey conducted in gay bars and saunas every three years since 1996 in Glasgow and Edinburgh. A form of time and location sampling is used to recruit representative samples of men. The questionnaires are anonymised and self completed, gathering information on sexual behaviours. Men are also asked to provide oral fluid samples to be tested for HIV antibodies.

The Needs Assessment Steering Group requested some additional analysis be conducted using the three most recent surveys and focusing on a sub group of men considered at high risk of HIV transmission. Three surveys were included in the analysis: the 2005 and 2008 MRC Gay Men's Sexual Health Surveys and the 2010 Make Your Position Clear evaluation survey<sup>6</sup> (Glasgow only).

Ethical approval was granted by the University of Glasgow, Faculty of Medicine Ethics Committee (2005 and 2008) and the Psychology Ethics Subcommittee at Glasgow Caledonian University (2010).

A total of 4080 men participated in the survey over the three years, with a response rate ranging from 66-71%. 1271 men (32.8% of the total sample) were categorised as at high risk of HIV transmission and were included in the main analyses. Men at high risk of HIV were defined as those who reported UAI with more than one partner, UAI with casual partners, or UAI with partners of unknown or discordant HIV status in the previous 12 months.

Data were analysed using SPSS 15.0 for Windows. Univariate and bivariate results are presented and for bivariate comparisons, the Pearson  $\chi^2$  Test was used. A P value of less than 0.05 was considered to be statistically significant. The learning from this analysis is summarised in Chapter 3.

#### 2.1.1. LIMITATIONS

The MRC Survey has several limitations which should be remembered when considering the findings. Caution should be taken when generalising to the wider MSM population as although cross-sectional in design, only men who visited the venues surveyed could participate. The definition of high risk was based on reported UAI, however risk can also be affected by frequency of sexual acts and risk reduction strategies, but this data was not available. Comparison of the 2005, 2008 and 2010 surveys are observed at a community level; they are descriptive and do not control for any demographic differences between the surveys. Finally, the cross-sectional nature of the data precludes any analysis of causality, but they do provide markers of, and trends in, the level of risk of HIV transmission and acquisition in order to identify men at potentially greater need of further sexual health promotion.

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<sup>6</sup> The 2010 MYPC Survey was commissioned by a partnership of NHS Ayrshire and Arran, NHS GGC and NHS Lanarkshire to evaluate an HIV prevention social marketing campaign produced jointly by these Health Boards called Make Your Position Clear. The evaluation was carried out by researchers from Glasgow Caledonian University and the MRC SPHSU using similar methodology to the MRC Gay Men's Sex Survey and using some of the same questions.



## 2.2. ENGAGEMENT WITH CLINICAL STAFF

It was acknowledged that clinical staff working in sexual health and HIV services possessed a unique insight into broad trends across their patient groups and were therefore an untapped source of information which could inform HIV prevention work. This component of the needs assessment aimed to tap this source of intelligence via in depth interviews. Twenty clinical staff, with experience of working directly with MSM in both sexual health and HIV services, were recruited from the following four clinical services:

- NHS GGC: The Brownlee Centre and Sandyford Sexual Health Services.
- NHS Lothian: Chalmers Sexual Health Centre and the Regional Infectious Disease Unit (RIDU).

Staff volunteered to be interviewed by researchers from TASC Scotland, either in person or by phone. Staff were asked to draw on their clinical experience to reflect on the following questions about 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 behaviours?
- 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?

Interviews were conducted from July to September 2012.

## 2.3. CASE NOTE REVIEWS (CNR)

The CNR strand had three components which focused on three distinct groups of MSM who attended for sexual health or HIV care in NHS GGC and NHS Lothian and presented with clinical indicators of HIV transmission risk:

- **Group A:** MSM who were not known to be HIV positive, but who had been diagnosed with STIs indicative of HIV risk behaviours (rectal *Chlamydia trachomatis* or rectal *Neisseria gonorrhoea*) in a specialist sexual health service<sup>7</sup>. The aim was to improve our understanding of the demographics, sexual behaviours and service use of MSM at risk of acquiring HIV.
- **Group B:** MSM who had been newly diagnosed with HIV, with the aim of improving our knowledge of the MSM who become HIV positive and their previous behaviours and service use patterns.
- **Group C:** MSM who had been living with diagnosed HIV for more than 12 months, when diagnosed with either rectal *Chlamydia trachomatis* or rectal *Neisseria gonorrhoea*, which indicated UAI. The aim was to understand the ongoing sexual health and HIV prevention needs of MSM living with HIV over time to inform sexual health improvement.

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<sup>7</sup> Men diagnosed with rectal Lymphogranuloma venereum (LGV) were included in the analysis as rectal Chlamydia diagnoses and not disaggregated. However the numbers were small over the review period.

### 2.3.1. CASE NOTES

The case notes for review included both paper notes and also electronic patient records. NaSH, the National Sexual Health IT System for the management of electronic clinical records, was introduced in 2008 for sexual health/GUM clinics. Each individual accessing a NaSH using sexual health service is assigned a unique NaSH number, which can be unlinked from other health records. NHS GGC introduced NaSH in December 2008 and NHS Lothian in June 2011. The different types of case notes available for the review period in each service are summarised in Table 3 below.

For CNR Group A only the specialist sexual health service case notes were reviewed, including the notes for community clinics when available. However for Groups B and C both HIV and sexual health service notes were reviewed, when available.

**TABLE 3: FORMATS OF CASE NOTES HELD IN GGC AND LOTHIAN**

<b>Service</b>	<b>Type of case notes</b>	<b>Review period covered</b>
Sandyford services (including community clinics)	Electronic	Entire review period
Chalmers sexual health clinics	Paper	Pre- June 2012
	Electronic	June 2012 onwards
Chalmers HIV clinics	Paper	Entire review period
	Electronic	Limited use since June 2012
RIDU	Paper	Entire review period
ROAM (Spittal St and 10A clinics)	Paper	Entire review period
Brownlee Centre	Paper	Entire review period

### 2.3.2. IDENTIFYING CASES FOR INCLUSION

Given the differences in the monitoring of HIV and STI diagnoses, different approaches to identifying men eligible for inclusion were required in both Health Boards, outlined in Table 4 below. Interrogation of the various databases was supported by database managers, clinical coders and the microbiology laboratories in both health boards.

**TABLE 4: DATABASES UTILISED FOR CNR**

Health Board	CNR Group	Databases interrogated
NHS GGC	A	NaSH
	B	NaSH Brownlee service database
	C	NaSH Brownlee service database Microbiology laboratory database
NHS Lothian	A	NaSH STISS Roam community test tracker
	B	NaSH STISS
	C	NaSH Lothian HIV database Microbiology laboratory database GUM@RIDU clinic database

As described above, for some of the CNR Groups multiple lists of possible eligible men were generated and needed to be cross checked. On review of the notes men were also excluded when it was found they did not meet the inclusion criteria. Table 5 below details the selection criteria, review periods and final sample size for each of the CNR Groups.

**TABLE 5: CNR SELECTION CRITERIA**

CNR Group	Selection criteria	Review period	Sample size
<b>A</b>	Men not known to be HIV positive on 30/06/12, who were diagnosed with rectal <i>Chlamydia trachomatis</i> or rectal <i>Neisseria gonorrhoea</i> , between 01/07/11 and 30/06/12	01/07/10 to 30/06/12	GGC: n=131 Lothian: n=78
<b>B</b>	Men newly diagnosed with HIV GGC: between 01/07/11 and 30/06/12 Lothian: between 01/02/11 and 30/06/12	Two years prior to HIV diagnosis and first twelve months post diagnosis	GGC: n=39 Lothian: n=39
<b>C</b>	HIV positive men who were diagnosed with rectal <i>Chlamydia trachomatis</i> or rectal <i>Neisseria gonorrhoea</i> , between 01/07/10 and 30/06/12, and had also been diagnosed with HIV for at least twelve months at STI diagnosis	01/07/10 to 30/06/12	GGC: n=48 Lothian: n=26

### *2.3.3. DATA COLLECTION AND ANALYSIS*

Data collection tools were designed for each of the 3 CNR Groups, which collected information on demographics, behaviours, and engagement with sexual health and HIV services (Appendix 1). These data collection tools were used to construct Access 2003 databases for data collection and storage.

As illustrated in the data collection tools, many of the variables were already categorised and coded at the point of data collection. These were then extrapolated to SPSS 20 for analysis. Further thematic analysis of the qualitative notes the researcher had also collected on individuals generated some additional variables which were coded in SPSS. Univariate and bivariate results are presented and for bivariate comparisons, the Pearson  $\chi^2$  Test was used unless otherwise stated. Independent T tests were used for numeric variables. Due to small sample size for some cross tabulations Fisher's exact test was also used in place of the Pearson  $\chi^2$  Test, which will be noted in the analysis section. A P value of less than 0.05 was considered to be statistically significant. Given the design of the study it was not possible to investigate causality.

### *2.3.4. LIMITATIONS*

The use of rectal STI diagnoses as an indicator of risk, assumes that all men have acquired their STI through UAI, whereas it is feasible that some men may have become infected through another form of anal penetration, such as shared sex toys. There will also be men who had UAI over the review period and either did not acquire a rectal STI or remained undiagnosed who were not included.

There are differences across services and individual staff in what is routinely asked and subsequently recorded about clinical interactions. Therefore the information recorded about individuals will vary. The depth of information available for individuals will also be influenced by how often they engaged with clinical services over the periods of review.

Another concern relates to the self reporting of information and how this may be influenced by fear of criminalisation, and by both setting and the individual health care worker that the patient is engaging with.

For NHS Lothian the two year period selected for review coincided with some major service changes, in particular a service relocation for sexual health and HIV service which was fully integrated with sexual and reproductive health services; a change in how new diagnoses were reported for epidemiological monitoring; and a transition from paper to electronic patient records. The majority of sexual health case notes and older volumes of HIV case notes are now stored off site. However some of these notes were not easily accessible and as a result some of the available records were limited for individuals.

Although all attempts were made to identify eligible men, some men living with HIV may have been inadvertently excluded. For the most part HIV and Sexual Health Service records are unlinked, although attempts are made to communicate STI diagnoses amongst HIV patients to their HIV care team. There is a chance some men living with HIV attending for care at a sexual health service may have been mistakenly included in Group A. Given the anonymous service provided at sexual health services, some positive men may have also presented for care under pseudonyms, and therefore been included in Group A.

With these limitations in mind the findings discussed in this report should be considered as indicative rather than wholly representative of these men's lives and caution should be used when extrapolating to wider populations of men.

## **2.4 COMMUNITY ENGAGEMENT**

To find out what the experiences, thoughts, feelings and needs of MSM were, the social research company TASC Scotland was engaged. TASC Scotland devised an innovative approach to engage with MSM which was known as FAQ.

### *2.4.1 MEN HAD TWO WAYS TO TAKE PART IN FAQ*

#### **TELEPHONE INTERVIEWS**

To make contact with men and to invite them to be interviewed, FAQ placed adverts on a number of apps and sites that men use to meet other men (this is how most men who took part got in touch). Sexual health clinics and voluntary sector agencies also shared information with men about FAQ.

The purpose of the FAQ interviews was to learn more about men's sexual lives, knowledge and attitudes towards HIV, and their experience of engaging with services about their sexual health.

154 men took part in telephone interviews over three phases of recruitment: 118 men were recruited in the first phase, a further 18 men in phase 2 and again a further 18 in phase 3. In all, FAQ undertook 243 detailed semi-structured interviews over the phone (23 men took part in three interviews, 43 men took part in two interviews and 88 men in one interview). Interviews lasted between 20 minutes to over one hour, on average 40 to 45 minutes.

#### **FAQ ONLINE**

Two phases of online work took place.

- The Diary Room was a broad based survey completed by 427 men in October and November 2012.
- The second phase was a number of thematic surveys called 'quickies'. There were 24 quickie surveys and these attracted a total of 2,423 responses. The surveys were available for men to complete from mid-June to mid-July 2013.

There is more about the men who took part in both elements of FAQ available on the FAQ site at [www.faqscotland.co.uk](http://www.faqscotland.co.uk)

### *2.4.2 WORKING WITH THE DATA*

During the telephone interviews with men the FAQ interviewers took detailed notes. Immediately after each interview they reviewed and clarified, or when necessary, extended the notes. Interviewers shared and read all interviews, and through a process of reflection, discussion, distilling and checking, they organised the men's stories into themes. By working manually from the notes FAQ interviewers were able to remain faithful to the variety, richness and individual character of each man's contribution.

To collect and store the data from FAQ online the project used a provider called Survey Gizmo. All of the survey returns reside on the Survey Gizmo's highly secure servers. All survey entries received as part of the project will be securely deleted from the servers upon completion of the project.

The data from the surveys was downloaded from the website and then loaded in SPSS version 20. Before analysing survey data every response was checked and all the missing data coded out. Due to the online nature of the surveys it was necessary to examine each participant's response to ensure there were no discordant answers or ambiguities. Analysis looked for associations between clinic attendance, age and sexual orientation with the relevant thematic variable that the particular survey focused on.

## 3. FINDINGS

This chapter summarises the key findings of the five research strands.

### 3.1. MRC GAY MEN'S SEXUAL HEALTH SURVEY ANALYSIS

#### 3.1.1. PROFILE OF MEN AT RISK OF HIV TRANSMISSION

High risk men were relatively young, with two thirds (67.3%) aged under 35 years old and almost a third (31.7%) aged under 25 years old. They were mostly employed (83.0%) and relatively well educated, with 44.5% having a further or vocational qualification and 36% having a degree or post-graduate qualification. They were predominantly white (95.4%) and gay (94.5%). Half lived in Glasgow (51.7%) a quarter (24.1%) in Edinburgh, and a fifth (19.5%) in the rest of Scotland, however the sample was biased by the 2010 survey which was only conducted in Glasgow.

When compared to men deemed not high risk who completed the surveys, high risk men were significantly younger ( $p < 0.001$ ); less likely to have a degree or post-graduate qualification ( $p < 0.001$ ); and more likely to be an ethnic minority ( $p = 0.047$ ) and identify as gay ( $p < 0.001$ ).

High risk men were active on the gay scene; over half (54.7%) went to a commercial gay venue at least once a week and almost a fifth (18.0%) went out 4-5 times a week.

HIV-positive men at risk of transmitting HIV tended to be older than the HIV-negative or untested men at risk ( $p < 0.001$ ). Untested men were more likely to live in the rest of Scotland than Glasgow or Edinburgh ( $p = 0.009$ ).

High risk men sampled in Glasgow tended to be younger than high risk men in Edinburgh ( $p < 0.001$ ), and were less likely to report higher education qualifications ( $p = 0.002$ ). The Glasgow sample also contained a higher proportion of men non-resident in the city ( $p < 0.001$ ), whereas the Edinburgh sample had a higher proportion of ethnic minorities ( $p = 0.007$ ).

#### 3.1.2. SEXUAL BEHAVIOURS OF MEN AT RISK OF HIV TRANSMISSION

Just under half (47.5%) of the high risk men were in a relationship, and 46.1% of those were long-term (three years+). Over a third (38.1%) did not know their partner's HIV status.

Eight out of ten (82.5%) men reported two or more sexual partners in the previous twelve months. Over one third reported eleven or more sexual partners and 14.6% reported 11 or more anal sex partners. Two-fifths (42.5%) reported UAI with two or more partners, 64.0% reported UAI with a casual partner, and two-thirds (67.0%) did not always know the HIV status of their partner.

In the 2005 survey men were asked about how they met recent partners. As would be expected, most (80.8%) had met a sexual partner at a bar or a club in the previous twelve months. Over a third (37.9%) had met a sexual partner over the internet, a third (33.5%) through private party or friends, under a quarter (23.6%) in a sauna or backroom and a fifth (19.6%) through work or college. A smaller proportion had met a partner in a public sex environment (PSE) (14.4%) and chat lines or personal ads (11.2%). A significantly higher proportion of HIV-positive men reported

use of internet chat rooms ( $p=0.031$ ), saunas ( $p<0.001$ ) and cruising areas ( $p=0.003$ ) than HIV-negative or untested men.

The proportion of high risk men who reported that they always knew their UAI partners' HIV status significantly increased from 30.5% in 2005 to 39.0% in 2010 ( $p=0.04$ ).

HIV-positive men were more likely to report higher numbers of sexual ( $p<0.001$ ), anal ( $p<0.001$ ) and UAI partners ( $p<0.001$ ) in the previous twelve months than HIV-negative or untested men, but there was no difference in knowledge of partners' status by HIV status.

High risk men surveyed in saunas reported significantly more sexual ( $p<0.001$ ) and anal sex ( $p<0.001$ ) partners than men surveyed in bars, but there were no significant differences between the two groups in sexual risk behaviour.

High risk men who had never had an HIV test reported fewer sexual partners ( $p<0.001$ ) and were more likely to report knowing their UAI partners' HIV status ( $p=0.017$ ), although they were unaware of their own.

### *3.1.3. HOW DO HIGH RISK MEN ENGAGE WITH CURRENT SERVICES?*

When HIV positive men were excluded, just under half (45.0%) of the high risk men had had an HIV test in the previous twelve months, however 35.3% had never had an HIV test.

Never-tested men were younger ( $p<0.001$ ); more likely to live out with the two survey cities ( $p=0.014$ ); more likely to report fewer sexual partners ( $p<0.001$ ); and were more likely to report knowing their UAI partners' HIV status ( $p=0.017$ ), even though unaware of their own. They were also less likely to have had a sexually transmitted infection (STI) test ( $p<0.001$ ) or report having an STI ( $p<0.001$ ) in the previous twelve months.

Over time, an increasing proportion of at risk men reported having an HIV test in the previous twelve months ( $p<0.001$ ), but there was no corresponding increase in STI testing. This may indicate the rise in HIV testing was attributed to the introduction of the opt-out testing policy in sexual health services.

Half (51.8%) of the high risk men reported having an STI test in the previous twelve months, and almost one in five (18.0%) had an STI during that time. The proportion of high risk men who reported having an STI in the previous twelve months varied significantly between the surveys: in 2005, 20.6% men reported having an STI, in 2008 this declined to 12.9%, before increasing again to 21.2% in 2010 ( $p=0.003$ ).

Three-quarters of HIV-positive men had been tested for STIs during the previous twelve months, compared to two thirds of HIV-negative men and 12.8% of untested men. Almost half (46.8%) of HIV-positive men reported having had an STI in the previous twelve months, compared to 20.6% of HIV-negative men and 10.1% of untested men.

Health improvement interventions appeared to reach the men at risk, with 86.3% coming into contact with some intervention in the previous 12 months. Almost eight out of ten (79.5%) had picked up free condoms in a bar, club or sauna; two-fifths (42.6%) had picked up a sexual health leaflet in a bar, club or sauna; and over a third (36.0%) had looked for safer sex or sexual health information on the internet. One in ten (11.1%) had been to group or one-to-one sexual health or HIV counselling.



HIV-positive men were the most likely to have had contact with any intervention ( $p=0.032$ ); picked up a sexual health leaflet ( $p=0.014$ ); talked to an outreach worker ( $p=0.005$ ); or been to sexual health or HIV counselling ( $p=0.001$ ). The difference was greatest in counselling use: 30.8% of HIV-positive men reported counselling, compared with 11.9% of HIV-negative men and 6.3% of untested men.

#### *3.1.4. Identified needs and implications for planning, prevention and services.*

The analysis of MRC Gay Men's Sexual Health Surveys identified a demographic and behavioural profile of men at high risk of HIV, which could guide future targeting of HIV prevention interventions.

- There were clear differences between HIV-positive, HIV-negative and untested men at risk of HIV, and while in general, HIV prevention should include all three groups, interventions could and should be tailored to the specific needs of each.
- By means of definition, sexual risk behaviour was high among high risk men and it is clear that reductions in such behaviours should continue to be a focus for intervention.
- Such interventions should target those locales and situations where and when men meet their sexual partners. In particular the future role of the internet for HIV prevention interventions seems an important focus.
- Sex on premises, in venues and outdoor cruising areas were a particular locale for HIV-positive men to meet partners, and as such could be considered for specifically targeted interventions.
- HIV testing, and STI screening more generally, have to remain central to sexual health improvement and more must be done to meet the minimum testing levels recommended for MSM at high risk.
- Consideration should also be given to boosting recall systems for high risk men who test positive for STIs.
- A third of the high risk men had never tested for HIV. This group was characterised by being younger, non-city residents, and also being less likely to report risk behaviours. However they were also less likely to have tested for STIs, suggesting this group is not engaging with current sexual health services.
- The barriers to testing and engagement with services need to be understood for this group of men.
- Health improvement interventions appeared to reach high risk men and accessing free condoms was by far the most commonly reported of all the interventions measured; it is a key prevention activity that should continue.
- Regular and frequent sexual health screens present secondary opportunities for first, HIV testing, and second, HIV prevention (through, for example, risk reduction counselling provided by Sexual Health Advisors).

## **3.2. ENGAGEMENT WITH CLINICAL STAFF**

### *3.2.1. PROFILE OF MEN AT RISK OF HIV TRANSMISSION*

During the interviews clinical staff were keen to stress their view that all men are individuals, each with a unique set of experiences and attributes. However across the interviews it was also possible to identify some characteristics which may be markers for vulnerability in terms of HIV risk.

Men with poor emotional wellbeing, who reported low self-esteem or self worth and loneliness, were described as feeling less able to negotiate what they wanted from sexual encounters or within relationships, as they lacked confidence, skills or assertiveness. Some may have never defined their own boundaries or priorities in terms of pleasure and may take risks as it fills a need for intimacy. Others may be influenced by perceived peer or cultural pressure to be more sexually adventurous and uninhibited, which may lead to riskier sex.

Men who identify as heterosexual and may be married were described as leading secret sexual lives, disconnected and disassociated from other parts of their lives. It is believed that these men may not view themselves or their behaviours as a risk for HIV, as they do not connect themselves with gay culture which may be associated with HIV risk. This may in part be due to lack of information or engagement with current HIV prevention work.

Young men were identified for being at higher risk due to a mix of factors. They were more likely to be poorly informed about HIV risk and to make assumptions about the relative 'safety' or 'risk' of individuals and behaviours. The experience of coming out was also viewed as contributing to poor emotional wellbeing, vulnerability and an inability to negotiate the sex they want. In particular young men from more rural areas were seen as less informed.

Clinical staff also identified men in relationships as at risk. This was due to misconceptions of sex within a relationship as safe, as men were either unaware of concurrent sexual partners or of the risks their partners took with other men, even if agreements about condom use with casual partners had been made.

Men who reported other risk behaviours, such as excessive alcohol and recreational drug use, or involvement in prostitution, were also viewed as at higher risk. There was recognition of the link between experience of childhood abuse and current involvement in prostitution which also increased an individual's vulnerability.

Staff did not view social deprivation as a factor associated with elevated HIV risk, although they did identify poor educational attainment as a risk factor, which may be more common in men living in poverty.

### *3.2.2 SEXUAL BEHAVIOURS OF MEN AT RISK OF HIV TRANSMISSION*

Alcohol and drug use were viewed as a key influence in some men's sexual risk taking. In particular ecstasy, ketamine, Viagra and increasingly crystal methamphetamine, were commonly reported.

The cruising websites and smart phone applications are viewed as playing a major role in facilitating anonymous casual sexual encounters. Staff also reported that men will sometimes blame the website or cruising app for their risk taking rather than acknowledging their own behaviour as the issue. There were also concerns raised about sex addiction linked to these technologies.

With the increase in mobile technologies, staff have witnessed a decline in reports of PSE use. However saunas are viewed as still being an important venue for men, in particular older men, and they are also viewed as facilitating anonymous encounters.

The prevalence of concurrent sexual partners reported by men was also a concern. In particular staff raised concerns that men do not appear to understand the increased HIV risks associated with this behaviour. Often men in relationships may report having agreements to always use condoms with partners outside of their relationships, but fail to appreciate that this is not easily maintained.

An increasing number of men, particularly older men, report that they regularly have sex with friends. However this in turn is associated with assumptions that these interactions are low risk, as they know their partner and may decide to not use condoms or may find it difficult to negotiate what they want.

Staff also described a growing trend for sex parties, although it appears small. It is believed to be attractive to men living with HIV as a means of facilitating serosorting and opportunities for UAI. However there are concerns that HIV negative or status unknown men may also be attracted to this scene.

Interviewees expressed concern about how men make risk assessments which influence condom use, in particular how men interpret a lack of discussion or disclosure of HIV status. There is a prevalent belief amongst men that if a partner is living with HIV they will disclose their status. Risk assessments are also based on how well they know and trust a partner, physical appearance and if someone tells them they are negative there is no further discussion of when their last test was.

Some men reported riskier sex abroad whilst on holiday or when visiting scenes in other large cities.

### *3.2.3. HOW DO HIGH RISK MEN ENGAGE WITH CURRENT SERVICES?*

There is a belief that some men living with HIV seek to separate their HIV and sexual health care, which is further facilitated by an inconsistent approach to sexual health care within HIV clinics. The concern that this serves to undermine efforts to promote sexual wellbeing and efforts to address risk and behaviour was raised.

The interviewees also recognised that there were a substantial group of men who were not engaging with clinical, community or voluntary services and who may also not have accessed any information on HIV. These men may therefore be unaware of HIV risks and risk reduction strategies.

### *3.2.4. IDENTIFIED NEEDS AND IMPLICATIONS FOR PLANNING, PREVENTION AND SERVICES.*

- The impact of social isolation on sexual behaviour was felt to be underestimated.
- Staff felt there was a need to help men build positive self-identity, supported through social and community connectedness.
- Staff articulated the pressures that some men felt to conform to perceived behaviours or stereotypes, such as body image, promiscuity or sexual adventurism.
- There were particular concerns about the needs of young men, who appear to be overly sexualised via current gay media, pornography and through some approaches to HIV prevention, which perpetuate an

- overly sexualised view of gay men's lives and community norms. It was felt there was a need to address these issues both for individual men and also a need for a more public discourse which affirmed alternative gay identities.
- Staff acknowledged that clinical services did not engage men about pleasure or the wider context of their sexual behaviour and risk taking. Engagement with clinical services is primarily driven by the service's agenda rather than being centred on the individual.
  - It was felt there was a need to provide a space for men to discuss their behaviour in terms of what they want or need from sex and relationships, and their wider sexual behaviour patterns. However there wasn't space during clinical interactions to do this.
  - The successes in increasing HIV testing rates were acknowledged, however staff were aware of continued high rates of late HIV diagnoses.
  - It was felt that more work was needed to promote HIV testing, and to foster a culture of regular screening. Clinical services were felt to have an important role, in particular for younger men, in instilling regular sexual health check ups.
  - For HIV services, staff raised concerns about the lack of integration of sexual health care with HIV care, which led to inconsistent level of care for individuals across HIV services.
  - Further integrating or more consistently incorporating sexual health care with HIV care would support effort to promote sexual wellbeing among men living with HIV, and provide a consistent approach to addressing sexual risk behaviours.
  - Staff raised questions about the reach and success of current HIV prevention efforts in community settings, unsure of whether they still engaged men and impacted on behaviour. It was felt there was a need for a review.
  - It was acknowledged that there was little assessment of HIV prevention skills, such as condom use or negotiation skills, for men using clinical services.
  - It was also felt that men were reluctant to acknowledge or disclose a skills deficit.
  - Staff agreed that clinical services could do more to support men in building skills.
  - Interviewees felt that clinical services did not address cognitive factors such as attitudes, behaviours, emotional and mental health which may impact on sexual wellbeing and HIV risk. It was recognised that they might refer on to colleagues who could provide opportunities for personal reflection and therapeutic intervention.
  - There was a shared view that there was a greater opportunity for counselling and therapeutic support after an HIV diagnosis. Although there was acknowledgement that more could be done to support men newly diagnosed with HIV.

- For negative men however there was a lack of similar therapeutic services or that thresholds for existing services were set too high due to lack of investment.
- Some staff identified that the promotion of 100% condom use may no longer resonate with men and that the community norm around condom use has eroded. There was a tension expressed about how to respond to this observation, in particular on how to discuss risk reduction with men if they could not commit to consistent condom use. It is clear that services should address this tension and seek consensus on the issue.
- There was a view that all contacts with men should be viewed as an opportunity for an intervention. It was highlighted in particular for men living with HIV and for addressing wider health and well being issues.
- As staff had identified the unique needs of younger men, they also expressed an opinion that young men needed to be reached earlier, before sexual debut, to build resilience, confidence and self-efficacy. It was felt crucial that young men adopted condom use norms and commitment to regular screening.
- Staff recognised that more could be done to gather information on missed opportunities or previous engagement with services from newly diagnosed men. This would serve to evaluate and enhance prevention services.

### 3.3. CASE NOTE REVIEW GROUP A

Group A men were not known to be HIV positive and were diagnosed with either rectal gonorrhoea or Chlamydia, which was assumed to indicate UAI and therefore behaviour considered high risk for HIV transmission.

#### 3.3.1. PROFILE OF MEN AT RISK OF HIV TRANSMISSION

As demonstrated in Table 6 below the sample were mostly urban dwelling, of white Scottish ethnicity, relatively young and the majority reported sex with men only over the two year review period.

**TABLE 6 . DEMOGRAPHICS OF MEN IN CNR GROUP A**

		<b>Frequency</b>	<b>Valid percent</b>
<b>Local Authority of residence</b>	City	148	72.9
	Non-City	55	27.1
	Missing	6	
<b>Health Board of residence</b>	GGC	116	56.9
	Lothian	72	35.3
	Other	16	7.8
	Missing	5	
<b>Gender of current sexual partners</b>	Male	192	91.8
	Male and female	17	8.1
<b>Age band</b>	16-25	92	44.0
	26-35	72	34.4
	36-45	35	16.7
	46+	10	3.8
<b>Ethnicity</b>	White Scottish	148	74.1
	Non-white Scottish	49	24.9
	Missing	12	
<b>SIMD</b>	1	67	34.0
	2	30	15.2
	3	31	15.8
	4	41	20.8
	5	28	14.2
	Missing	12	

Thematic analysis of the psycho-social and behavioural trends reported by the sample identified a number of concurrent commonly recognised health determinants or risk factors. Some of which the men reported directly or indirectly impacted on their sexual behaviours. Once identified some of these factors were coded on SPSS.

A significant proportion of the sample reported experience of psychological concerns. 9.1% reported a mental health concern over the two years which required a form of intervention, including prescription drugs, engagement with a psychologist, psychiatrist or counsellor. 18.7% reported poor emotional wellbeing over the two year review period, which included low self esteem, low mood, loneliness, or an acute episode linked to bereavement or the end of a relationship. Many of these men reported how these feelings impacted on their sexual behaviours, such as having a

'reckless' period in response to the end of a relationship, or that their need for intimacy or fear of rejection prevented them from negotiating condom use. 23.1% (n=9) of the men with poor emotional wellbeing over the two years also reported a more serious mental health concern requiring intervention.

22% of men self identified as having problematic alcohol use frequently linking this to their sexual behaviour. Alcohol was described as impeding intentions and decision making, reducing men's ability to make objective risk assessments or to negotiate the sex they wanted. Some men also reported alcohol-related memory loss during sexual encounters.

A minority of men (12.4%) reported experience of sexual, physical or emotional abuse, the majority of whom described intimate partner violence in adulthood. Smaller numbers of men in the sample reported homelessness, involvement in prostitution, financial or employment problems over the review period.

During the thematic analysis it became apparent that a significant group of men reported a clustering of several concurrent psycho-social and behavioural factors alongside their HIV risk behaviours. On review of their notes their sexual behaviours seemed symptomatic of their underlying complex needs, marking these men out as having increased vulnerability. A new variable was constructed to identify this 'vulnerable' group, and found that a quarter of men (24.4%) reported two or more concurrent psycho-social and behavioural risk factors over the review period.<sup>8</sup> This group were more likely to reside in NHS GGC, but this was likely due to the deprivation profile, with a much larger proportion of GGC residents residing in SIMD 1 (most deprived quintile).

### 3.3.2. SEXUAL BEHAVIOURS OF MEN AT RISK OF HIV TRANSMISSION

When recent (previous three months) sexual behaviour at rectal STI diagnosis was reviewed 86.4% reported they had at least one new sexual partner and 65.8% had two or more sexual partners in the previous three months<sup>9</sup>. Almost two fifths (39.8%) reported being in a relationship at the point of STI diagnosis.

Again thematic analysis was used to review the notes on men's reported sexual behaviours over the two year review period, and this was used to identify and code more common behaviours. 42.1% reported having concurrent sexual partners; just over half of these men (55.7%) reported concurrency whilst in a relationship; and almost a third (30.7%) reported group sex (13.9% of overall sample reported having group sex). The most commonly reported ways of meeting partners included when travelling/holidaying in other countries (25.4%), cruising websites or phone applications (17.7%) and gay saunas (9.1%). However it is likely this is under-representative as men were not routinely asked how they met partners.

Little could be learned about possible sexual networks from the case notes, however when the partner notification notes were reviewed it was evident that a sizeable group of men reported sex with men with a significant age gap. This was defined as encounters between young men (aged under 26 years old) and men who were at least ten years older. This was reported by 18.2%.

<sup>8</sup> Men were coded as belonging to this vulnerable group if they reported two or more of the following risk factors: residing in SIMD 1; reporting mental health concern or poor emotional wellbeing; problematic alcohol consumption; experience of physical, emotional or sexual abuse; homelessness; joblessness or financial worries; or involvement in prostitution. Bivariate analysis found significant associations between these variables.

<sup>9</sup> There was large variance in the number of partners reported over the previous three months. Although the mean was 4.0, the media was 2.0 with a range of 0-60 and standard deviation of 5.8.

The most common HIV prevention strategy reported by men was still condoms, however 72.6% of men reported inconsistent use. Those men who reported concurrency whilst in a relationship often reported having agreements with their partner to always use condoms outside of the relationship or to regularly screen for STIs, however it was apparent many men struggled to maintain this. A smaller number of men reported testing for HIV before commencing condomless sex with a partner, or routinely screening for HIV and STIs whilst they could not commit to consistent condom use but these did not seem popular behaviours.

More concerning was the finding that 36.4% of men reported less robust risk reduction strategies based on how well they knew or trusted a partner rather than discussion of HIV status when deciding to have UAI.

### *3.3.3. HOW DO HIGH RISK MEN ENGAGE WITH CURRENT SERVICES?*

Over the two year review period 60.8% of the men had at least one rectal gonorrhoea diagnosis and 52.6% had rectal Chlamydia. A fifth of the men had two or more STI episodes involving one of these rectal infections over the two years, suggesting ongoing risk. Having multiple rectal STIs over the two years was associated with residing in deprivation (SIMD 1 and 2,  $p=0.045$ ); reporting poor emotional wellbeing ( $p=0.009$ ); reporting sauna use ( $p=0.001$ ); and having five or more sexual partners in the previous year ( $p=0.029$ ).

When the reason for the men's first or only indicative STI episode of care were reviewed, 43.3% were prompted to attend due to symptoms, 26.9% were prompted by partner notification and 29.8% attended when asymptomatic, but possibly prompted by something else which was not always recorded e.g. some men gave change of partner as a reason. This suggests that a minority of men display a proactive approach to their sexual health, such as the routine screening (annually as a minimum) currently recommended by both Health Boards. The majority seem to display reactionary behaviours.

At their first rectal STI diagnosis over the review period 14.9% had been previously diagnosed with rectal chlamydia or rectal gonorrhoea, prior to the 1<sup>st</sup> July 2010 and 74.2% were already known to sexual health services having a record of previous engagement.

When the men's engagement with specialist sexual health services over the two year review period was considered they recorded on average 2.1 HIV tests (standard deviation 1.6, range 0-9); 2.0 sexual health screens (standard deviation 1.4, range 1-7) and a median of 5.0 visits to a specialist sexual health service (standard deviation 3.6, range 1-31).

At their first or only indicative STI diagnosis 20.1% had no record of a previous HIV test (never testers); a further 28.7% had last tested more than one year before (infrequent testers). Being a never tester was associated with being aged under 26 years old ( $p=0.001$ ) and they were less likely to engage with specialist MSM clinical services ( $p<0.001$ ). Infrequent testers were more likely to reside in non-city local authorities ( $p=0.003$ ), to be aged 26 years or older ( $p=0.029$ ) and were more likely to exclusively use generic sexual health services over the two year period ( $p=0.001$ ). A very small number of men (less than 5) remained untested, despite engagement with sexual health services by the end of the review period.

When the circumstances for having an HIV test over the review period were categorised it was clear that the vast majority had one as part of a sexual health screen rather than specifically requesting an HIV test.



Men's point of engagement for each episode of care over the two year review period was analysed. The most popular initial point of engagement for a new episode of care was via centrally-based services. 87.9% of men initially engaged this way for one episode of care during the two years, as walk-in patients (89.6%) and via a generic sexual health clinic (82.1%). However, a reasonable proportion of men (47.8%) were recorded as using an MSM specific service as their first point of contact (e.g. the SRP in Glasgow or the Gay Men's Clinic in Edinburgh). At their first or only indicative STI diagnosis over the two years the majority (66.5%) of men engaged via a generic sexual health clinic, with a quarter attending a specialist MSM clinic (28.7%).

Exclusively using generic sexual health services (recorded for 52.2% of Group A men) was associated with reporting bisexual behaviour ( $p=0.015$ ); inconsistent condom use ( $p=0.009$ ); requesting symptomatic sexual health screens ( $p<0.001$ ); and never having tested for HIV prior to diagnosis with indicative STI ( $p<0.001$ ).

By far the most common recorded intervention over the two year review period was the offer of condoms and lube (offered to 68.6% of men); followed by a 1-2-1 risk reduction or motivational interviewing (31.1%); and an offer of referral to further psychological support (25.4%). It is important to note that these figures only reflect what was recorded within the clinical notes and may not therefore be a true reflection of the clinical interaction.

#### *3.3.4. IDENTIFIED NEEDS AND THE IMPLICATIONS FOR PLANNING, PREVENTION AND SERVICES*

A clear demographic profile of HIV negative men at risk of acquiring HIV has emerged: younger men, who reside in urban areas, with white Scottish ethnicity and who have male only partners. This may be useful for planning community level HIV prevention interventions such as social marketing. However the analysis also highlights there are sub groups of men who have distinct HIV prevention needs which should be considered.

Men in relationships emerged as an important sub group. Men in relationships are more likely to stop using condoms with their partner as a sign of trust, intimacy and commitment. However it is clear that some men require support to reduce the risks associated with this decision, such as supporting men to adopt a 'test, test, trust' approach with their partners.<sup>10</sup> A large proportion of men in relationships also reported having concurrent partners. Sometimes this included having threesomes with their regular partner or having an agreement to have an open relationship. Often men had agreements to use condoms with concurrent partners, however it was clear that some men did not maintain this or had a poor understanding of the increased risks of having concurrent partners. There is a need to support men in relationships to make informed decisions and choose the most effective risk reduction strategies for themselves and their partners.

Alcohol and poor emotional wellbeing emerge as important factors which contribute to HIV risk behaviours for a significant proportion of men. Alcohol is discussed as impeding intentions and decision making, reducing ability to make objective risk assessments or to negotiate the sex they want. Poor emotional wellbeing is also described as a barrier to negotiating the safer sex men want or where their need for intimacy overrides their need to minimise HIV risk. These themes suggest that current services are not meeting the needs of these men, perhaps because thresholds for alcohol and psychological support services are set too high. It may be more appropriate to locate interventions which support these men within sexual health services, given men already engage via these services.

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<sup>10</sup> 'Test, test, trust' was a HIV prevention campaign developed and delivered in New South Wales, Australia. It aimed to encourage gay and bisexual men entering new monogamous relationships to both test for HIV prior to ceasing condom use.

A group of vulnerable men with complex needs as a result of multiple co-occurring psycho-social and behavioural risk factors were identified. Given the complexity of their needs, these men would likely benefit from more intensive one-to-one support which focuses on the concurrent issues which are impacting on sexual risk taking.

Men who were diagnosed with multiple rectal STI infections over the two year review period should be considered a higher risk group. In particular as these men were more likely to also have a recorded rectal STI prior to the period covered by the review ( $p=0.021$ ). Having repeated rectal STIs is a marker of ongoing UAI, and it was associated with high partner numbers (5 or more in previous three months) ( $p=0.029$ ), sauna use ( $p=0.001$ ), group sex ( $p=0.052$ ), poor emotional wellbeing ( $p=0.009$ ) and social deprivation (residing in SIMD 1 or 2,  $p=0.045$ ). Repeated rectal STI diagnoses could be used by clinical services as a marker for identifying higher risk MSM and offering targeted intensive interventions.

On thematic analysis of the case notes young men (under 26 years) within the sample reported low awareness of HIV risk and poor knowledge of HIV prevention. In particular young men reporting sex with a significant age gap were more likely to report other vulnerabilities, including homelessness, financial concerns and involvement in prostitution. They were also unaware of the increased HIV prevalence amongst older men. For younger men in the sample their diagnosis with the indicative STI was frequently their first ever engagement with a specialist service. This clearly points to an important role that services can play in engaging, educating, and empowering these men to make informed decisions relating to their sexual health and also in identifying and supporting more vulnerable young men.

There is still work needed to encourage men to test for HIV more frequently as of men that had previously tested ( $n=148$ ), 39.9% demonstrated infrequent testing patterns (more than 12 months since last HIV test at indicative STI diagnosis). Infrequent HIV testing was associated with living in rural areas and attending generic sexual health services. This may indicate that accessibility of testing services is creating a barrier to more frequent testing. However considering the sample there was little evidence that the men were adopting proactive health seeking behaviours as the majority were diagnosed with the indicative rectal STI when they were symptomatic or following partner notification. More work is needed to both facilitate and encourage routine asymptomatic screening amongst these men.

Generally across services there was inconsistent recording of the wider context in which men live their sexual lives, suggesting inconsistent discussion within clinical settings. The wider context, such as how men meet partners, and why they may decide with specific partners or in specific situations to have UAI are important not only to better understand the needs of individuals but it also allows a better understanding of the wider patterns and context of men's sexual lives.

There was also poor recording of the behaviour change discussions that occurred with men. As services move to introduce motivational interviewing, the electronic patient records provide a useful means of recording these discussions for tracking progress or revisiting discussions at subsequent visits. It could be used to support men on their journey towards behaviour change and risk reduction.

Partner notification is clearly a very useful method of targeting this group of men, as 26.9% were diagnosed with their indicative STI as a result of a notification. It may be worth considering opportunities to enhance existing partner notification in services, focusing in particular on rectal STIs.

It also became apparent that there are a group of highly skilled staff who can successfully engage men in meaningful discussions about their behaviours, build relationships with men over time and refer men on to more specialist support when this is indicated in both Health Boards. The future role of this group of staff should be reviewed and opportunities to expand their capacity to engage with higher risk men investigated.

### 3.4. CASE NOTE REVIEW GROUP B

Group B were men were newly diagnosed with HIV between 01/07/2011 to 30/06/2012 in NHS GGC and between 01/02/2011 to 30/06/2012 in NHS Lothian.

#### 3.4.1. PROFILE OF MEN AT RISK OF HIV TRANSMISSION

Like men in the CNR group A, men newly diagnosed with HIV were mostly city dwelling, reported sex with men only and were of white Scottish ethnicity. The group had a slightly older age profile, with a peak in age band 36-45yrs and were significantly older than Group A men ( $p=0.001$ ). Table 7 below provides further details. Of note over half of the 'non-white Scottish' men were of white UK/Irish ethnicity.

**TABLE 7: DEMOGRAPHICS OF MEN IN CNR GROUP B**

		Frequency	Valid Percent
<b>HIV Service</b>	Brownlee	39	50.0
	Chalmers	30	38.5
	RIDU	9	11.5
<b>Local Authority of residence</b>	City	60	78.9
	Non-City	16	21.1
	Missing	2	
<b>Health Board of residence</b>	GGC	34	43.6
	Lothian	35	44.9
	Other	9	11.5
<b>Gender of sexual partners</b>	Male	69	88.5
	Male and female	9	11.5
<b>Age band</b>	16-25	18	23.1
	26-35	23	29.5
	36-45	29	37.2
	46+	8	10.2
<b>Ethnicity</b>	White Scottish	54	72.0
	Non-white Scottish	21	28.0
	Missing	3	
<b>SIMD</b>	1	15	20.5
	2	19	26.0
	3	13	17.8
	4	13	17.8
	5	13	17.8
	Missing	5	

As with Group A men (who had been diagnosed with a rectal STI but were not known to be HIV positive at 30/06/2012), on thematic analysis of the reported wider health concerns, a similar range of psycho-social and behavioural concerns emerged and were subsequently coded in SPSS for men newly diagnosed with HIV (Group B). These were categorised by when they were recorded in the case notes, at or in the two years prior to HIV diagnosis or in the first twelve months after diagnosis.

At or prior to diagnosis similar proportions of Group B men, as Group A men, reported poor emotional wellbeing<sup>11</sup> (20.5%); experience of physical, emotional or sexual abuse (12.8%) and self-identified problematic alcohol consumption (11.5%). However significantly more Group B men (28.2%) reported a historical or ongoing mental health problem which required intervention than Group A men ( $p < 0.001$ ).<sup>12</sup> Group B men were also more likely to have been recorded as using illicit drugs at diagnosis compared to Group A men ( $p < 0.001$ ). It isn't clear whether these differences are explained by different level of more holistic enquiry triggered by an HIV diagnosis.

Once again thematic analysis revealed a group of men experiencing a clustering of these psycho-social and behavioural factors (28.3%), who again may be at heightened vulnerability.<sup>13</sup>

When available the first twelve months post diagnosis was reviewed for each man. 52.6% of the men reported poor emotional wellbeing during this period. Sometimes this was directly linked to HIV diagnosis with men reporting fear and anxiety about disclosure; describing feelings of isolation; experiencing low mood; having fears for their future; or that HIV was causing relationship problems. Those men who appeared to cope better after their diagnosis appeared to be those who disclosed their status earlier and had an identified support network of partners, family and friends, particularly if they knew someone who was living with HIV.

12.8% reported more serious mental health concerns requiring intervention. Again these were often linked to their diagnosis and included suicide ideation, self harm and clinical depression. However these men were significantly more likely to have had a previous mental health concern which required intervention ( $p = 0.004$ ).

### *3.4.2. SEXUAL BEHAVIOURS OF MEN AT RISK OF HIV TRANSMISSION*

Generally there was poor recording of men's sexual behaviour prior to diagnosis, partly due to the large proportion of men who had never previously engaged with a sexual health service (46.2%).

At diagnosis with HIV 43.6%,  $n = 34$  of the men reported that they were in a relationship. 54.5% of the men in relationships had been with their partners for more than one year at this point. 30.5% of all men reported that they had concurrent partners at some point during the two years prior to diagnosis. At HIV diagnosis, a third of the men who reported they were in a relationship also reported concurrent partners (35.3% of men in relationships,  $n = 12$ ).

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<sup>11</sup> Poor emotional wellbeing included low self esteem, low mood, loneliness, or an acute episode linked to bereavement or the end of a relationship.

<sup>12</sup> A historical or ongoing mental health concern which required a form of intervention, which could include prescription drugs, engagement with a psychologist, psychiatrist or counsellor. Eight individuals reported both a mental health concern and poor emotional wellbeing at or prior to HIV diagnosis, which was 36.4% of men with a serious mental health concern.

<sup>13</sup> Men were coded as belonging to this vulnerable group if they reported two or more of the following risk factors: residing in SIMD 1; reporting mental health concern or poor emotional wellbeing; problematic alcohol consumption; experience of physical, emotional or sexual abuse; homelessness; joblessness or financial worries; or involvement in prostitution. Bivariate analysis indicated there were associations between these variables.

At diagnosis 60.0% of men reported that they had at least one new sexual partner in the previous three months and 46.5% reported having two or more partners during this same period.

When recorded the most common HIV prevention strategy employed by men prior to HIV diagnosis was condoms, however the majority reported inconsistent use (65.2%). Worryingly 41.0% reported that they had decided to have UAI in the previous two years based on how well they knew or trusted a partner rather than knowledge or discussion of HIV status or testing.

Thematic analysis found that substantial proportions of men described having anonymous or untraceable partners (28.2%) in the two years prior to diagnosis, or meeting partners outside of Scotland (34.6%). Only 14.1% of the men were recorded as having previous sexual partners known to be HIV positive.

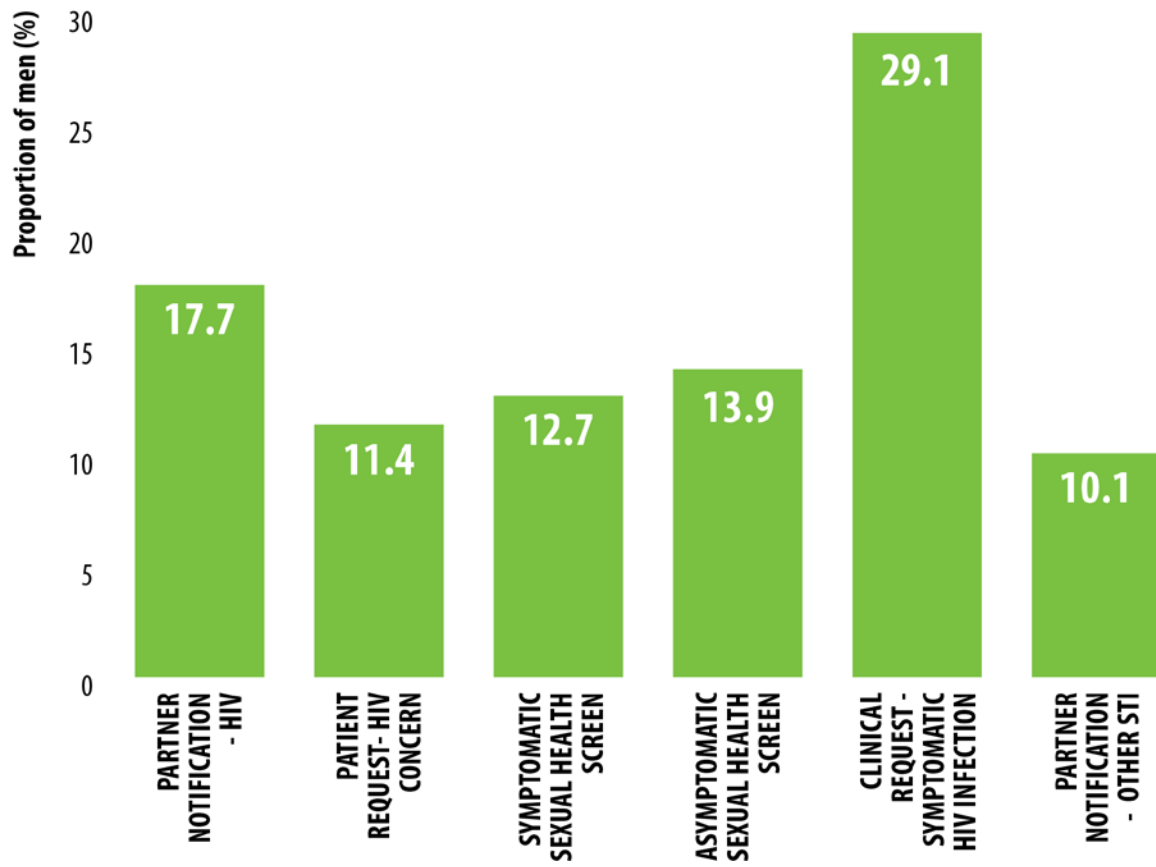
When sexual behaviour during the first twelve months post diagnosis was reviewed, 41.7% of the men reported that they were not sexually active. Most commonly this was an active choice, as men described needing time to adjust to their diagnosis or that fear of disclosure or onward transmission of HIV prevented them from meeting new partners.

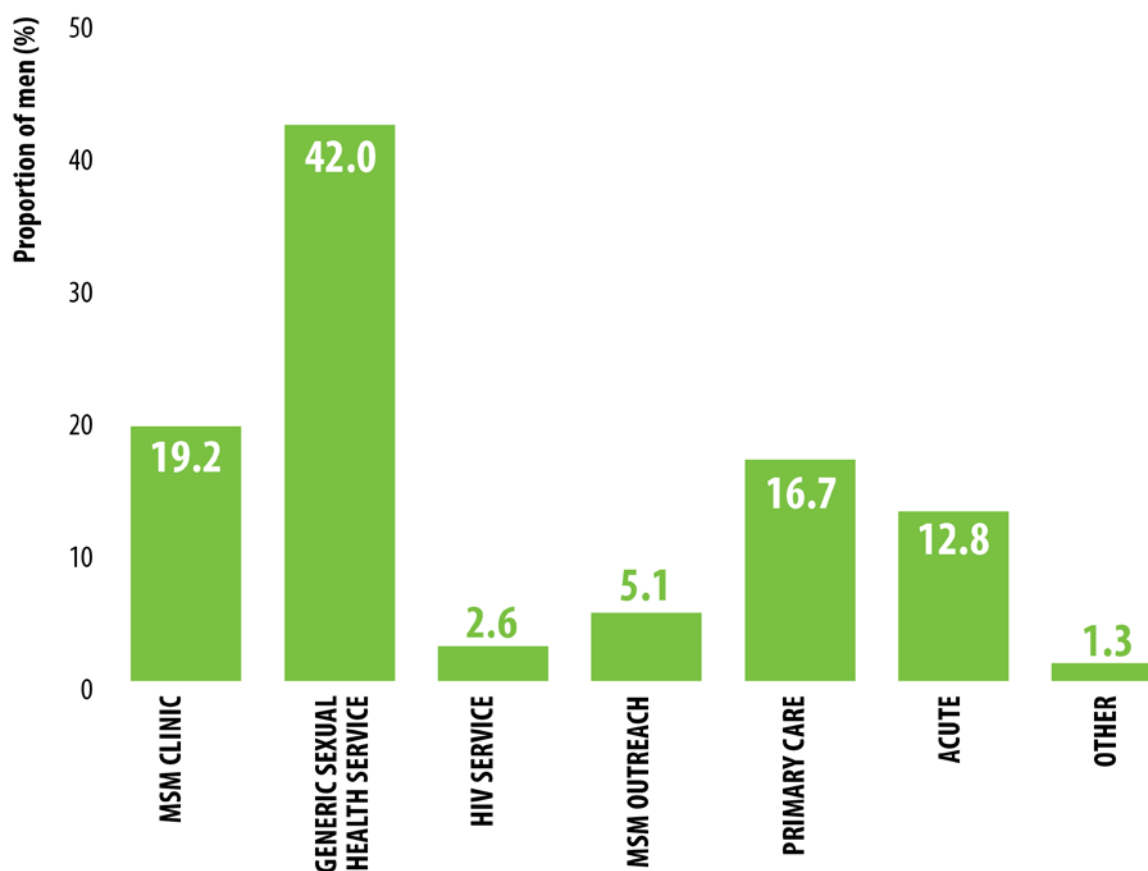
Of those who were sexually active 60% reported always using condoms and 28.6% reported trying serosorting during the first 12 months after diagnosis.

### *3.4.3. HOW DO HIGH RISK MEN ENGAGE WITH CURRENT SERVICES?*

As Figure 3 below illustrates the most common reason for having the diagnostic HIV test was following clinical suspicion that a patient was symptomatic for HIV (29.1%). The majority of men had their diagnostic HIV test in a specialist sexual health setting, including community/outreach services, accounting for two thirds of all new diagnoses amongst MSM (see Fig 3 below).

**FIGURE 3. REASONS FOR HIV TEST IN CNR GROUP B**



**FIGURE 4: LOCATION OF DIAGNOSTIC HIV TEST IN CNR GROUP B**

At HIV diagnosis 32.1% of men were concurrently diagnosed with an STI, most commonly syphilis (12.8%), rectal Chlamydia (12.8%), and rectal gonorrhoea (10.3%). In total 17.9% of men were diagnosed with either/both rectal gonorrhoea or Chlamydia at diagnosis with HIV.

46.8% of Group B were classed as a late diagnosis, with CD4 counts less than 350. This is higher than the UK late diagnoses rate for MSM which was 34% in 2012.<sup>14</sup> Half of the late diagnoses (23.4% of overall sample) were classed as a very late diagnosis, with CD4 less than 200. Being a late diagnosis was associated with never having tested for HIV ( $p=0.002$ ) and being diagnosed with HIV in an acute or primary care health setting ( $p=0.034$ ).

At diagnosis with HIV 46.2% of the men had no previous engagement with a specialist sexual health service and 26.9% had not engaged for more than two years. Those who had never accessed a service were more likely to report bisexual behaviours ( $p<0.001$ ) and less likely to report having a new sexual partner in the three months prior to diagnosis ( $p=0.014$ ).

Of the previous attendees over half had last attended a sexual health service over two years prior to HIV diagnosis. These infrequent attendees were more likely to report current or historical mental health problems which required

<sup>14</sup> HIV in the United Kingdom: 2013 Report (Public Health England)

intervention ( $p=0.010$ ) and were less likely to report having a new partner in the three months prior to HIV diagnosis ( $p<0.001$ ).

A similar picture emerged when the HIV testing history of these men was reviewed with 32.5% reporting never having a previous HIV test and 37.6% last testing more than two years prior to diagnosis. Never having tested for HIV was associated with reporting bisexual behaviour at HIV diagnosis ( $p=0.027$ ) and being diagnosed late ( $p=0.003$ ).

Of those who had previously tested negative for HIV 55.8% had last tested over two years prior to diagnosis. Men who last tested more than two years ago were more likely to reside in more deprived areas (SIMD 1 and 2,  $p=0.013$ ); to report current or historical mental health problems requiring intervention ( $p=0.037$ ); and current or historical self-reported problematic alcohol consumption ( $p=0.012$ ).

Of the thirty previous testers where details of previous tests were available: 26.7% mostly/only tested before when having a symptomatic sexual health screen; 33.3% mostly/only when part of an asymptomatic sexual health screen; and 30% previously tested following a specific risk, such as UAI.<sup>15</sup>

Of those who had previously engaged with a specialist sexual health service in NHS GGC or Lothian ( $n=42$ ): 59.5% had tested at a central sexual health service before; 40.5% had tested at an MSM specific service/clinic; 11.9% tested at an MSM outreach service/community clinic.

During the two years preceding diagnosis with HIV, for those who had engaged with a specialist sexual health service, ( $n=21$ ) the mean number of visits was 3.2 (median 2.0, SD 3.3, range 1-15).

Very little was recorded about HIV prevention interventions offered to the men who had previously engaged with a specialist sexual health service, however offer of condoms was the most commonly recorded.

#### *3.4.4. IDENTIFIED NEEDS AND IMPLICATIONS FOR PLANNING, PREVENTION AND SERVICES.*

During the review of case notes it was apparent that staff and services had an inconsistent approach to recording the sexual behaviours and wider psycho-social factors experienced by men newly diagnosed with HIV. This may suggest an inconsistent approach to discussing these topics and therefore an inequity of care being provided. If this is the case then there are clear missed opportunities to not only gather intelligence which would inform HIV prevention efforts, but also inconsistent assessment of the wider psycho-social needs of men newly diagnosed. A more consistent approach to inquiry and recording of emotional wellbeing, mental health, experience of sexual abuse and violence, alcohol and drug for men newly diagnosed with HIV is required. A system of feeding this intelligence back into HIV prevention planning would also be useful.

The high degree of inconsistent recording of recent sexual behaviour at diagnosis, suggests there is still scope to expand and improve partner notification, which already accounts for 29.4% of the prompts for the diagnostic HIV tests in this group.

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<sup>15</sup> Men were classified as mostly/only having tested due as part of an asymptomatic or symptomatic screen if 75% or more of their previous HIV tests met this criteria.



A significant proportion (28.3%) of the men reported experiencing a number of concurrent psycho-social and behavioural factors at HIV diagnosis which are known to impact on engagement with HIV care and adherence to treatment. These more vulnerable men experiencing more complex issues may benefit from intensive case-management or one-to-one support.

The majority of men newly diagnosed with HIV reported that problems adjusting to their diagnosis, fear of disclosure and criminalisation of transmission all prevented them becoming sexual active in the months following diagnosis (41.7%). This highlights an important area of need amongst this group to provide support adjusting to HIV diagnosis and sexual relationships.

Emotional wellbeing and mental health issues remain the most common concurrent concerns for men newly diagnosed with HIV. Like men in Group A, men reported experiencing a range of issues from low self esteem and loneliness through to more serious mental health concerns such as depression and suicide ideation, often describing how these issues impacted on sexual behaviours, such as their ability and desire to negotiate or maintain condom use for anal sex, or to engage with HIV testing services. Clearly these issues need to be considered in the design and provision of prevention services.

As with Group A, 43.6 % of men newly diagnosed with HIV were in a relationship at diagnosis. The case notes also indicated that concurrency whilst in relationships is a common behaviour. It is clear that men in relationships and also men with concurrent sexual partners should be an important focus of future HIV prevention interventions.

Men who had never previously tested for HIV or engaged with sexual health services were more likely to be diagnosed late and are therefore an important group to target with future HIV prevention interventions. However little is known about the sexual behaviours of these men, although a higher proportion of men with bisexual behaviour fall within this group. More work is needed to understand why these men had never previously tested for HIV.

Infrequently testing/engaging with services was associated with social deprivation, problematic alcohol consumption and experience of serious mental health problems. Interventions which target this group of men may seek to address these concurrent health and wellbeing needs. Few men display proactive regular screening patterns so much work is also needed to increase frequency HIV test amongst all MSM. Given that these men do engage with sexual health services, these services have an important role in future work increasing frequency of testing.

Little was recorded about interventions these men received during previous engagement with specialist sexual health services or any engagement with the voluntary sector. Again this highlights a missed opportunity to gather data on the impact of current services and interventions.

13.5% of men newly diagnosed with HIV had a record of a previous chlamydia/gonorrhoea infection and 17.9% had a concurrent rectal STI at HIV diagnosis. This indicates rectal STI diagnoses may be a useful marker for targeting men at risk of HIV engaging with services.

The vast majority of men with late diagnoses had never previously tested for HIV or engaged with a specialist sexual health service. They mostly commonly presented to primary care or acute settings with symptomatic HIV infection. Very little could be learned about the sexual behaviours of these men, which may have put them at higher risk, or the barriers this group may have experienced to engaging with prevention, testing and sexual health services. However it would appear that bisexual identity/behaviour and experience of deprivation may be important factors associated

with late diagnosis. More work is therefore needed to understand how to reach this group, reduce their risk of acquiring HIV and encourage them to engage with existing services.

### 3.5. CASE NOTE REVIEW GROUP C

Group C is men living with HIV who were diagnosed with rectal *Chlamydia trachomatis* or *Neisseria Gonorrhoea* between 01/07/2010 and 30/06/2012 and had been diagnosed with HIV for at least twelve months at diagnosis.

#### 3.5.1. PROFILE OF MEN AT RISK OF HIV TRANSMISSION

The case note review suggests that these men share a similar profile to the men in the two other CNR groups: predominantly white Scottish ethnicity; urban dwelling and reporting mostly male only partners. When compared to HIV negative men who acquired rectal STIs, positive men were more likely to be older ( $p < 0.001$ ) and although not significant, they are less likely to report mixed gender partners or reside in rural areas.

**Table 8 – Demographics of Men in CNR Group C**

		Frequency	Valid Percent
<b>Health Board responsible for HIV care</b>	NHS GGC	48	64.9
	NHS Lothian	26	35.1
<b>HIV Clinic responsible for HIV care</b>	Brownlee	48	64.9
	Chalmers	20	27.0
	RIDU	6	8.1
<b>Local Authority of residence</b>	City	63	85.1
	Non-City	11	14.9
<b>Health Board of residence</b>	GGC	43	58.1
	Lothian	24	32.4
	Other	7	9.5
<b>Sex of current sexual partners</b>	Male	73	98.6
	Male and female	1	1.4
<b>Age band</b>	16-25	5	6.8
	26-35	27	36.5
	36-45	26	35.1
	46+	16	21.6
<b>Ethnicity</b>	White Scottish	53	72.6
	Non-white Scottish	20	27.4
	Missing	1	
<b>SIMD</b>	1	18	25.0
	2	18	25.0
	3	14	19.4
	4	10	13.9
	5	12	16.7
	Missing	2	

<b>Years diagnosed with HIV</b>	Less than 5yrs	44	60.3
	5 to 10yrs	19	26.0
	10yrs or more	10	13.7
	missing	1	

As with the other review groups, Group C men reported a number of concurrent psycho-social and behavioural concerns. These men reported higher levels of poor mental health and wellbeing, with 36.5% reporting mental health concerns requiring intervention and 29.7% reporting poor emotional wellbeing over the two year review period (five men reported both poor emotional wellbeing and mental health concerns requiring intervention). 29.7% of Group C men also reported recreational drug use or excessive alcohol consumption. Group C men were also more likely to report other social issues such as homelessness, employment and financial concerns than the other CNR groups. 50.0% of the Group C men reported a clustering of two or more concurrent issues, which alongside HIV diagnosis may increase their vulnerability to poor health.

The majority of Group C men (60.3%) had been diagnosed with HIV for less than five years when diagnosed with the indicative STI.

### *3.5.2. SEXUAL BEHAVIOURS OF MEN AT RISK OF HIV TRANSMISSION*

As with CNR groups A and B there was generally inconsistent recording of men's sexual behaviours and how they met sexual partners. However qualitative analysis suggested that use of saunas and public sex environments were popular amongst this group of men. Some men described how these settings and spaces facilitated anonymous sexual contact without the need for disclosure, and also facilitated safer serosorting.

Serosorting for both regular and casual contacts appears to be very prevalent amongst this group (at indicative STI diagnosis 32.4% reported their regular partner was HIV positive and 29.7% reported that all of their casual contacts were HIV positive in the last three months). However the underlying motivations for such behaviour often suggested poor emotional wellbeing, as men described feeling 'damaged' or 'tainted' and therefore undesirable to HIV-negative men, while others harboured anxiety about possible transmission, criminalisation or disclosure which limited their partner choice to other men living with HIV.

There was some evidence from partner notification notes of networks of men living with HIV who routinely have casual sex with each other. For some this involved parties, recreational drugs and alcohol. 45.9% (n=34) of the men reported that knowing their partner was HIV positive was the reason they chose to have UAI (45.9% reported UAI with casual or 37.8% with a regular when that partner was HIV positive).

Concurrency was also prevalent in this group, including men involved in the HIV positive networks of 'friends' or 'fuck buddies' who regularly had casual sex but also for men in relationships (52.7% reported concurrency over the two year review period and over three quarters of these men were in relationships). Concurrency was also associated with UAI with casual and regular partners, and although associated with reporting HIV positive partners, not all men exclusively serosort.

Over the two year review period this group of men recorded 94 events which included at least one indicative STI diagnosis. At each new diagnosis men were asked about their sexual behaviours over the previous three months. In

77.1%, (n=74) of these diagnoses, men reported they had at least one casual contact in the previous three months. Of these 74 diagnoses: 96.2% reported this involved at least one new contact; 62.8% reported having UAI with one of these casual contacts; 35.1% reported they also had a concurrent regular partner/were in a relationship; and 29.5% reported that their casual contacts were all HIV positive. Of the men reporting casual contacts in the previous three months 68.9% reported having two or more, with a mean of 6.0 casual contacts (median 2.0).

### *3.5.3. HOW DO HIGH RISK MEN ENGAGE WITH CURRENT SERVICES?*

50.0% of the men in Group C had a record of a rectal gonorrhoea or Chlamydia infection prior to the beginning of the review period and 21.6% had two or more indicative STI events during the year review period, indicating that a large proportion of the men are having ongoing UAI. Having a previous rectal STI was associated with having repeated rectal infections during the review period ( $p=0.005$ ), having a more varied approach to accessing sexual health care via both HIV clinic and sexual health clinics ( $p=0.003$ ), and reporting casual sexual contacts in the three months prior to indicative STI diagnosis ( $p<0.001$ ), having casual contacts of mixed serostatus ( $p=0.018$ ) and reporting sauna or PSE use ( $p=0.012$ ).

At diagnosis with the indicative STI 64.6% of the men were on anti-retroviral therapy and of those on therapy 79% had achieved an undetectable viral load prior to STI diagnosis. The men on anti-retroviral therapy and those who had achieved an undetectable viral load did not appear different to the rest of the sample when their sexual behaviours were compared.

Interestingly Group C men had a mixed approach to seeking sexual health care over the two year review period. One subgroup predominantly received sexual health care via their HIV clinic (44.6%), most commonly recording asymptomatic screens. This group did appear to present with a slightly lower sexual risk behaviours, being less likely to report UAI with a casual contact ( $p=0.044$ ), and less likely to have been diagnosed with a previous rectal STI ( $p=0.010$ ) or to have repeated rectal STIs over the review period ( $p=0.004$ ). It was not always clear if the men requested sexual health screens or were offered, but whatever the motivations these men were choosing not to seek sexual health care independently of HIV care.

Another sizeable subgroup (37.8%) had a mixed approach, seeking sexual health care via specialist clinics and their HIV clinic. There appeared to be a pattern emerging, with men attending generic services more likely to present as symptomatic at that service than at their HIV service. Seeking sexual health care predominantly via specialist sexual health clinics was less common (17.6%).

46.9% of Group C men were diagnosed with their indicative STI during an asymptomatic screen, compared to 29.9% of HIV negative men (Group A). This is unsurprising given that the majority of the asymptomatic screens were performed at HIV services, and indicates the higher engagement with services of men living with HIV and perhaps the opportunistic nature of the asymptomatic screens. Qualitative analysis also suggested that men were more likely to attend generic sexual health services when they were symptomatic.

Group C men were also significantly less likely to request screens following partner notification. Whilst reviewing the partner notification notes, it was also evident that men living with HIV were less likely to engage with partner notification, frequently refusing to provide names or stating that all of their partners were untraceable. There may be benefit in further investment in partner notification for this group and also in dispelling any barriers to men's engagement with the process.

It was worryingly to note that 21.6% showed a degree of disengagement from HIV care over the 2yr period<sup>16</sup>, and this was associated with repeated rectal infections over the review period (Fisher's Exact test,  $p=0.034$ ).

Given the higher reporting of poor mental health and wellbeing it was good to find a high record of referrals on to further psychological support for these men (85.2% of men who reported serious mental health concern had an offer of a referral and 81.8% of men who reported poor emotional wellbeing). Condom distribution was the most common sexual health and HIV prevention intervention with 90.5% of men having at least one recorded offer over the two year period. However overall the detail of the interventions or offers of intervention or referral provided within clinics and the outcomes of these was inconsistent. It was therefore difficult to get an impression of the reach, acceptability and impact of the current approach.

#### *3.5.4. IDENTIFIED NEEDS AND IMPLICATIONS FOR PLANNING, PREVENTION AND SERVICES*

Again the inconsistent recording of the wider psycho-social and behavioural factors affecting this group may indicate an inconsistent approach to discussing individual's overall wellbeing in services. Yet these men seem to be at higher risk of poor mental and emotional health and other social problems such as alcohol and drug problems, and homelessness, which are known to impact on engagement and adherence to HIV care. Steps should be taken to ensure a consistent approach to enquiry and supporting men who disclose these issues is in place.

The researcher encountered difficulty generating an accurate list of HIV positive men diagnosed with rectal STIs. Both Health Boards need to address the need to record HIV specific STI morbidity along with other sexual health issues.

There was little evidence that men were routinely reminded about existing support service available locally for them, or of any new developments in the services available. It seemed that men more recently diagnosed were more likely to have a record of information provision, whereas longer term diagnosed men had little. This suggests a missed opportunity to remind men of the services available, which may now be of use, and also to keep them informed of any new developments.

As with the other review groups there was poor recording of offers and outcomes of interventions or referrals. It was therefore difficult to assess the awareness, reach and uptake of current interventions. But there also seemed to be missed opportunities to follow up, for example discussions from a previous motivational interviewing discussion or the outcome of a referral to a counsellor.

The inconsistent recording of sexual behaviour and individual risk reduction strategies in particular again suggests clinics do not routinely discuss these issues with men. This may suggest a lack of confidence, awareness or skills amongst clinical staff which should be addressed. If men living with HIV are seeking UAI, then it is important that they have reliable information to make informed choices about risk reduction. The one exception to this observation was the high degree of discussion about PEP.

There was a high degree of concurrent sexual partners reported by this group of men living with HIV. Most men reporting concurrent partners were in relationships, and either reported group sex or having an open relationship. However there was also evidence of small networks of friends, who were all HIV positive and routinely had sex with

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<sup>16</sup> Disengagement was defined as not attending 2 or more consecutive appointments at their HIV clinic.

each other and attended sex parties, which often involved drug taking. Concurrency was also associated with UAI with casual and regular partners, putting both these men and their partners at high risk for STIs.

The majority of men in this group reported serosorting at some point over the two year review period. Although this appeared to be a valid and informed risk reduction strategy for HIV, it was associated with UAI both in relationships and with casual contacts. This puts these men at much higher risk of acquiring STIs. The case notes also indicated for many men this behaviour was also an indication of poor emotional wellbeing, with men describing feeling like they had limited choice, as they were no longer desirable to HIVnegative men, or that they were so overwhelmed by fear of disclosure or criminalisation that this was their only means of having sex.

Public sex environments, online cruising tools and saunas appear popular amongst this group of men, in particular for the facilitation of casual, anonymous sex and serosorting. It is important that our services feel able to discuss the motivators and risks involved with these approaches to finding new partners.

Given the high rates of reported UAI and also the high degree of repeat rectal gonorrhoea and Chlamydia diagnoses amongst this group, it is clear that a high proportion of these men struggle to or choose not to use condoms consistently. Services should create opportunities to discuss risk reduction with men, which may include supporting men to use condoms or to adopt alternative risk reduction strategies as necessary.

It was positive to find that men living with HIV were more likely to have been diagnosed with the indicative rectal STI via their HIV clinic and via an asymptomatic sexual health screen. It was unclear if the motivator for these diagnosing screens was a patient request or an offer from clinical staff. A significant proportion of the men also only accessed sexual health care via their HIV clinic. This demonstrates the importance of the routine offer sexual health care and discussion of sexual health within HIV services.

On review of partner notification notes for these HIV positive men, it was also clear they were less likely to engage in partner notification, frequently preferring not to disclose names or stating that all of their partners were untraceable. Given the higher prevalence of STIs amongst HIV positive men, and the fact that the majority of men in this sample reported serosorting further investment in partner notification within HIV services, and also improved linkage between sexual health services and HIV services may prove valuable for this group of men, by curbing STI infection and improving linkage to treatment.

It was worrying that approximately one in five of men in the sample showed a degree of disengagement from HIV care over the two year review period. Men who disengaged were more likely to have repeated rectal STI infections and to present at specialist sexual health services when symptomatic, highlighting a high degree of need. Disengagement from care could be used as a means of selecting men for more intensive support with the factors influencing these behaviours.

### 3.6 COMMUNITY ENGAGEMENT WITH MEN

FAQ Scotland is the community engagement part of the HIV Needs Assessment.

The purpose of FAQ was to make contact with gay and bisexual men and hear from them about their sex and relationships and sexual health.

#### 3.6.3 REPORTING BY THEME/ISSUE

FAQ has reported online at [www.faqscotland.co.uk](http://www.faqscotland.co.uk). Each thematic chapter starts with an overview of findings, identifies what findings mean to HIV and sexual health services and then offers a number of reflective questions for practitioners. The following themed sections of this report draws on these elements of the FAQ chapters. For a full account of findings please go to the FAQ site.

### ALCOHOL

#### *ALCOHOL: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- Across their interactions with FAQ, men identify that alcohol plays a significant role in the social and sexual lives of gay and bisexual men.
- Men recognise that alcohol impairs decision making, sometimes explaining decisions they might not otherwise make; in some circumstances they report not remembering decisions made or risks taken.
- Men who drink alcohol while having sex report higher partner numbers.
- Even in the context of heavy alcohol use some men remain committed to condom use for anal sex.
- For some men there is sense of regret about decisions which have been influenced by alcohol, which impacts on their sense of mental wellbeing.
- Alcohol has also been identified by men as a factor in making decisions about condom use in a relationship. Rather than making a decision to stop condom use as a result of discussion, condoms might be dispensed with in the moment.
- Alcohol use is prevalent as a form of currency when men are paid for sex.
- Alcohol use also features in the experiences of violence men have reported.
- When men are asked if they have ever discussed alcohol/their drinking with someone at a sexual health clinic and would they ever do so few men report ever having such a discussion, but many more would do so.

#### *ALCOHOL: WHAT THE FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- Reflecting the fact that alcohol plays a significant role in the social and sexual lives of gay and bisexual men consideration of alcohol use must play a part in the assessment of HIV/STI risk and the development of individualised, person-centred approaches to improve outcomes for men.
- Individualised care should provide an opportunity to discuss and plan risk reduction strategies that are particular and appropriate to the individual's circumstances and their relationship with alcohol.
- Where men require more intensive alcohol dependency services, they should be supported to access these. Specialist alcohol services must have the confidence and skills to address the needs of gay and bisexual men who are referred to them.
- Reflecting on the needs of gay and bisexual men, consideration should be given to the potential of developing specific alcohol services for them as part of community sexual health improvement services.

#### *ALCOHOL: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- Have I considered the role that alcohol plays in the lives of men I work with?



- How do I approach a conversation with a man about his alcohol use?
- Should my service routinely ask men about alcohol use?
- Am I clear in my engagement with men that my service is more than a pragmatic 'test and treat' service, that I provide a holistic service which has a concern for all aspects of wellbeing?
- In the consulting room, do I make space for individuals to pause, reflect, and talk about alcohol use?
- If a man needs further information or specialist services regarding alcohol use, do I know where they can go and do I support them to get there?
- How might I/my service work across the LGBT community to encourage reflection and dialogue on the part alcohol plays in the community and in personal and sexual relationships?

## **ANAL SEX, CONDOMS AND CONDOMLESS ANAL SEX**

### *ANAL SEX, CONDOMS AND CONDOMLESS ANAL SEX: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- Men have anal sex because they find it pleasurable and a marker of intimacy with a sexual partner.
- While accepting that men have anal sex it is important to remember there is a spectrum of enjoyment or centrality that it plays in their sex lives. Engagement (rather than assumptions) with men will ascertain what part it plays for them.
- Most men who have engaged with FAQ report first experiences of anal sex as teenagers; many young men are curious, some feel it is expected of them, others see it as a rite of passage. Early experiences can be enjoyable but can also be characterised by secrecy and a lack of control.
- With little chance to talk or learn about anal sex positively, pornography, jokes and homophobic 'banter' can be the only sources of information. No men received information about anal sex at school. Men's views of anal sex can also be informed or negatively influenced by societal views that anal sex is taboo, shameful, disgusting or unmanly.
- Via FAQ online only 55% of men report always using condoms for anal sex when a 'top' and 58% when a 'bottom'.
- A minority of FAQ respondents have discussed anal sex or condomless anal sex when attending a sexual health clinic; however a majority are interested in doing so.
- Bisexual men are significantly less likely to attend sexual health services, and when they do, less likely to want to discuss anal sex.
- A significant challenge in fostering a dialogue about anal sex is that men themselves rarely talk about it at all. Some men report they are upfront about expectations or desire for anal sex (although not always face-to-face, perhaps intentions are stated online or through messaging) while for others it can be difficult to raise the issue. Rather than talk about anal sex, men themselves might only have some cursory dialogue about condom use, although again it is sometimes unclear how condom use will pan out.
- Many men do not like using condoms or find they get in the way of pleasure, intimacy and spontaneity. FAQ online found that men under 35 are more likely to report problems with condom use including losing erection, problems with fit and putting the condom on.
- Choices to have condomless anal sex can be based on assumptions (that a sexual partner 'looks' HIV negative, that his professional status means he would know he is HIV negative, that he is young or bisexual and so less likely to be HIV positive) or a belief that a sexual partner will simply know and report his HIV status accurately.
- For men in relationships dispensing with condoms is a marker of trust and intimacy. Yet agreements about sex with others can be broken, putting men in relationships at risk of HIV/STI infection.



- Men report that they adopt alternative or additional strategies to condom use which offer (or they believe offer) degrees of protection from HIV/STI acquisition and transmission. Few men report experience of discussing personal HIV risk reduction strategies within clinical settings, beyond condom use for anal sex.
- Around three-quarters of men responding to FAQ online indicate that they worry to some extent about HIV; this would indicate an opening to discuss HIV, choices and addressing risk in the clinic setting.

*ANAL SEX, CONDOMS AND CONDOMLESS ANAL SEX: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- HIV/Sexual Health clinical staff need to talk with men about anal sex. Useful conversations about anal sex should be framed by an acceptance of anal sex as a regular and important part of gay and bisexual men's sexual behaviour. Discussions about anal sex must be within the context of pleasure, intimacy and trust as well as risk reduction.
- If we frame anal sex as problematic, only or mostly as the means of HIV/STI transmission, then we fail to understand its importance, role and meaning.
- If we talk (only) about condoms rather than anal sex (which is what men tell us most clinic staff focus on) we are at risk of engaging men in the realm of logic, reason and pragmatic management of sexual behaviour as if it were easy to prepare, plan and practise safer sex and use condoms 100% of the time. It is not.
- Men recognise that difficulties talking about anal sex are informed by negative societal attitudes towards it. There is a challenge to ensure that these are not views that men will encounter when they engage with a HIV/Sexual Health clinical service.
- With bisexual men less likely to attend services or talk about anal sex this group of men needs to be considered explicitly when services consider approaches to discussing anal sex.
- Young men need to be engaged in discussion and learning about anal sex before they first have sex, engagement should begin in their early teenage years. Young men need to be supported to avoid regret, to make decisions which mean sex is pleasurable and safe, and to delay first experience of anal sex until they are ready.
- The development of conversations about intimacy and pressure which might inform new approaches to work with younger gay and bisexual men might be usefully informed by current services and approaches to work with young women.
- Information about anal sex and HIV prevention/risk reduction (including, but not solely focused on condom use) needs to be available to young men across a range of sex and relationship education materials and programmes.
- For men who come out later in life there remains a need to engage in conversations, where this is possible, before first experiences of anal sex; again with a focus on pleasure, choice and safety.
- Decisions made by men in relationships to dispense with condom use might be recognised as putting men at risk of HIV infection but engagement with men on these issues needs to be personalised and respectful of their choices which are often informed by a view that condoms are a barrier to intimacy.
- Men who do not want to have anal sex might need services to support them to build confidence to challenge assumptions, expectations or demands of sexual partners.
- When men experience problems with condom use they are unlikely to be convinced by attempts to eroticise their use. In such circumstances individual approaches to other strategies which minimise risk should be looked at in clinic settings. This is especially important for men under 35 who are more likely to report problems with condom use.

- When men adopt alternative or additional strategies to condom use (being a top, withdrawal, using knowledge of viral load) services need to create opportunities to discuss such choices and strategies openly, then men can be given best information, advice and support.
- There needs to be a dialogue across the community about the meaning and importance of anal sex, framed by our understanding that it is practiced by most gay and bisexual men. The discussion should balance the pleasure men experience with the understanding that it is the means of HIV transmission men should be most aware of. This community conversation needs to be had while rejecting judgement, guilt, shame and disgust.

*ANAL SEX, CONDOMS AND CONDOMLESS ANAL SEX: REFLECTIVE QUESTIONS FOR PRACTITIONERS:*

In terms of the faq findings reported in this chapter we pose these questions for practitioners:

- What are my personal feelings about anal sex?
- How have negative societal views on anal sex affected me personally and professionally?
- How do I approach a conversation with a man about anal sex?
- If a man is resistant to talking about anal sex, perhaps because of feelings of embarrassment or shame, how do I raise it and engage him in the discussion?
- In my conversations with men what is the focus: Condoms or anal sex? Risk or pleasure?
- How do I ensure my conversations about anal sex and condoms are individual and personalised, based on what I know or need to know about the man in front of me?
- How do I respond (verbally and in my body language) to reports of condomless sex or ambivalent attitudes towards condom use?
- How do I engage a man in conversation about condom use that supports him to plan a shift in behaviour towards more effective use of condoms when that is to his benefit?
- How ready am I, or is my service, to talk about anal sex with young men in their early teenage years?
- What role can I and my service play in fostering a refreshed and constructive dialogue about anal sex and condom use among gay and bisexual men?

## **BISEXUAL MEN/MEN WHO SEX WITH MEN AND WOMEN**

*WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES:*

- In interviews and online, an important message from bisexual men has been their experience of labelling, stereotyping and discrimination. In the on line responses, men talk about bisexual men being viewed as indecisive, greedy, confused or promiscuous. FAQ interviewees sense that others are often unaccepting or dismissive of their bisexuality.
- Experiences of discrimination and negativity impact on relationships and feelings of self-worth.
- FAQ contributors experience living as bisexual men in different ways. This can be positive and affirming. But some men find their desires at odds with the life they can lead publicly, leaving them conflicted about the sex or intimacy they want with men.
- For bisexual men in long-term relationships with women, having sex with men requires them to make decisions about the extent to which they can share this with a partner; for many men in such circumstances sex with men remains undisclosed. In such circumstances men can have a specific worry about STI/HIV risk.
- Bisexual men may think differently about the sex they have with men and with women; for some bisexual men sex with men might be seen as more casual, 'rougher' or less engaged emotionally.
- Bisexual men are less likely to engage with sexual health services; the most significant barriers are reported as concerns about privacy and a lack of discretion alongside fears that staff will be judgemental.

- As younger men are also less likely to attend clinics, younger bisexual men may be particularly vulnerable to not accessing sexual health services.
- Bisexual men recognise that when attending a sexual health service some men may not want to discuss their bisexuality because they are embarrassed or ashamed or have experienced (and fear) stigma.
- When they do attend, a minority report they discuss their bisexuality but a majority would do so if barriers to engagement are addressed.
- Bisexual men will come to services, and will discuss their sexuality, when staff are open-minded, non-judgemental and clear in acceptance of bisexuality. Information about services welcoming bisexual men is required.
- When bisexual men engage with a community-based, outreach or clinical service it may be the first opportunity they have had to discuss the role sexuality has in their lives.
- Bisexual men engaging with FAQ have indicated an interest in talking further about the pressures bisexual men face, highlighting the need to have a safe space in which to explore sexual identity and talk about how bisexuality is shared and discussed with a partner.
- Bisexual men engaging with FAQ express a preference for a general sexual health clinic for men, or for both men and women, or indicate that they had no preference. A minority of bisexual men express an interest in a clinic specifically for gay and bisexual men.

### **WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES**

- Services should review and refresh their efforts to attract bisexual men. Services need to make it clear that bisexual men are welcome.
- Clinic staff need to build an understanding of the discrimination or negative messages bisexual men can receive across society. Services need to understand how this might impact on how bisexual men access and use HIV/Sexual Health services.
- Bisexual men will have developed individual approaches to talking about their bisexuality with sexual partners. Men in long term relationships with women who have sex with men too may have to navigate a complex set of choices. With this in mind clinical staff need to ensure an individualised approach with time to build an understanding of each man's circumstances.
- As bisexual men do not necessarily want to attend a targeted gay/bisexual men's clinic, services must consider how generic services understand and meet their needs.
- Services should ensure that staff who work with bisexual men have the skills, knowledge, language and confidence to be effective. Part of any engagement with a bisexual man should begin with an understanding that experiences of discrimination and negativity can impact on relationships and feelings of self-worth.

### **REFLECTIVE QUESTIONS FOR PRACTITIONERS**

Throughout FAQ reporting we ask individual practitioners, teams and services to read the detail of findings and then take time to reflect on important questions. In terms of the FAQ findings reported in this chapter we pose these questions for practitioners:

- Have I reflected on why a bisexual man would be less likely than a gay man to use my service?
- When I think of bisexual men, do I consider them first: As male? As bisexual? Do I ask or expect the man to name his sexual identity? How do I discuss sex with men if the man does not use the term bisexual?
- How ready am I, or is my service, to talk about the sex bisexual men have with partners of both sexes?

- What can I do in my engagement with bisexual men to assure them of the key things they want from a service: a friendly welcome, reassurance that they will not be judged, and a service which is discreet?
- In the consulting room, do I create a space for reflection and dialogue?
- In my engagement with bisexual men how do I consider and address their feelings of shame and embarrassment about attending services?
- If my service is more than a 'test and treat' service, what role do I/we have in building confidence, self-esteem and self-worth in bisexual men who need such support?
- What role does my service have in addressing the labels, stereotypes and discrimination bisexual men experience in society in general and also in the LGBT community?

## DRUGS/CHEMS

The numbers of men who talked with FAQ about drug use are relatively small but point to some experiences and needs which should be considered in terms of HIV prevention and the provision of services. The term 'chems' is also used to describe drugs.

### *DRUGS/CHEMS: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- From contributions to FAQ, information on drug use would suggest that a range of recreational, illegal substances are used by a minority of men: one in twelve of Diary Room respondents use drugs/chems when having sex and one in five of our FAQ interviewees talk about drug use in the context of recent sex.
- Men also report that drugs/chems are often taken in combination with each other.
- With nearly half of men reporting alcohol and poppers use, it is likely that drug/chems are used in association with these other drugs.
- Some men report that decisions they make when having sex are affected by drugs/chems, and particularly so when taken with alcohol.
- In the context of FAQ interviews, men discuss drug use in terms of increasing sexual pleasure and ability to perform with multiple partners. Drugs mentioned in this context are GBL/GHB and Viagra or generic versions of it.
- Older, HIV positive men may be more likely to engage with multiple partners while using a mix of drugs/chems.
- Online respondents indicate that drug/chems use is rarely addressed while attending a service, but that there is willingness for some men to do so.

### *DRUGS/CHEMS: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- With a minority of men reporting using drugs/chems, some recognising that their use can affect choices or decisions about anal intercourse and condom use, services should consider how to introduce discussion of drugs/chems in consultations.
- Individualised care should provide an opportunity to discuss and plan risk reduction strategies that are specific and appropriate to the individual's circumstances and use of drugs/chems.

### *DRUGS/CHEMS: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the faq findings reported in this chapter we pose these questions for practitioners.

- Have I considered the role that drugs/chems plays in the sex men have? In particular do I consider the link with alcohol and poppers use?
- How do I approach a conversation with a man about his use of drugs/chems?

- If we talk about drugs/chems what is the starting point or focus: Health risks? Pleasure? Why drugs are used? Men's own questions?
- With a relatively small number of men inputting on drug use to FAQ, does my service need to do more to ascertain how drugs/chems are impacting on individuals and risk?
- Is there a need for a refreshed and constructive dialogue about drug use among gay and bisexual men/across the community?

## **FEELING DOWN/MENTAL HEALTH**

For the purposes of the FAQ community engagement process, mental health was considered in more everyday language, so we talked with men about feeling down or feeling low, feelings or experiences of depression and about feeling/being anxious.

### *FEELING DOWN/MENTAL HEALTH: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- Men interviewed as part of the FAQ community engagement process describe experiences of mental health problems; this includes low self-esteem, loneliness, panic attacks, anxiety, depression and thinking about suicide. They also talk about how these experiences can happen at different ages and ebb and flow depending on circumstances, sometimes triggered by difficult situations.
- Some interviewees connect being HIV positive or having a partner who is HIV positive to mental health problems.
- Bisexual men also fear reactions to their bisexuality; this impacts on confidence and isolates the individual.
- For some men, anxiety or low mood means they do not want to have sex or feel unable to have sex; this might also be influenced by medication, and can have a particular impact on relationships with a partner.
- Body image is an issue of concern for some men who identify pressures on them to look a certain way; muscular, fit, 'masculine'. Sex can also be used to address low self-esteem and a negative view of one's body.
- FAQ contributors identify the impact of mental health problems on risk taking; sex might be used to try to feel better or experience intimacy. Some men describe themselves as being less discriminating in who they will have sex with. Others may look to an increased number of sexual partners. Medication for a given condition, used alongside alcohol, might also affect behaviour and choices. On reflection, men see these behaviours as further influencing low mood.
- Responses to the FAQ online Feeling Down survey show a higher proportion of gay men tend to engage in riskier sex when they feel down, relative to bisexual men. Similar proportions of gay and bisexual men report that feeling down makes them feel more inclined to isolation.
- Men report that mental health problems may not be spoken about when attending a clinic.
- The Feeling Down survey tells us that men who associate feeling down with riskier sex do attend sexual health services in response to risks taken, however when at the clinic only one in five men with a mental health problem say they have spoken about their mental health.
- Further, only one in six of FAQ interviewees who experience mental health problems, use sexual health services for support or onward referral.
- Some FAQ interviewees perceive a lack of interest in their mental health in the clinic. Other FAQ interviewees would not choose a sexual health clinic as a service in which to discuss or seek help. Others might seek help if the nurse, doctor or health advisor was explicitly interested in their mental health. Half of respondents to the FAQ Feeling Down survey say they would discuss mental health at a sexual health clinic;

- gay men are more likely to say that they would be willing to discuss their mental health compared to bisexual men, as were older men aged over 45.
- When it comes to seeking and accessing support elsewhere, FAQ interviewees report poor experiences of support from GPs (where they are often just offered or prescribed medication) and positive experiences from specialist psychiatric services and counselling services.
  - FAQ interviewees living with HIV think that counselling support should be available from a professional person who understands what it is like to live with HIV, even if the focus of support is not directly about HIV.
  - Men tell us that they would value counselling and mental health services with specialist knowledge of gay and bisexual men's needs and lives.
  - Men point to a positive rapport with the sexual health service provider as a necessary precursor to any successful engagement around mental health. They also want to sense that the sexual health service would welcome the discussion, being open and not overtly directed towards a certain outcome.
  - Men have questions about mental health that could be addressed in the context of HIV/sexual health service provision. Most commonly these are about how to manage and stop mental health problems as well as where and how to get help and support. Men want to know more about how mental health problems impact on the decisions they make about sex and relationships.
  - FAQ contributors who experience mental health problems report real isolation and a lack of support, alongside concerns that poor mental health impacts negatively on choices and experiences in personal and sexual relationships.

#### *FEELING DOWN/MENTAL HEALTH: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- With men reporting that mental health problems lead to isolation and increased risk in sexual behaviour, HIV/sexual health services need to respond by building individualised and person-centred relationships with men, to better understand each man's needs and risks.
- Services need to consider why they miss opportunities to talk with men about their mental health. This might include reviewing prompts or questions used by staff, but this also highlights the need to clarify for men that they can talk about how they feel/their mental health.
- With bisexual men and younger gay men less likely to talk about their mental health in a clinic setting the needs of these men must be considered explicitly when services consider approaches to discussing mental health.
- Insights given to HIV/sexual health services via FAQ, in relation to the mental health and wellbeing of gay and bisexual men, should be shared with colleagues in primary care so they can improve care and treatment for gay and bisexual men in those settings.
- With men identifying a need for mental health support and interventions that have specialist knowledge of gay and bisexual men's needs and lives, including those of men living with HIV, services should explore what this means in terms of staff skills, knowledge and understanding and broader issues of service capacity.
- There needs to be a dialogue across the LGBT community about the meaning and importance of mental health and how feelings of low mood, isolation, feeling down, anxiety or depression impact on the decisions that an individual makes about sex and relationships.
- This community conversation needs to take place while recognising and rejecting any stigma associated with mental health problems.

*FEELING DOWN/MENTAL HEALTH: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the faq findings reported in this chapter we pose these questions for practitioners.

- How ready am I, or is my service, to talk about mental health?
- In the consulting room, do I make space for individuals to pause, reflect, and talk about how they feel?
- Is my service more than a pragmatic 'test and treat' service: do I provide a holistic service which has a concern for all aspects of sexual health and wellbeing?
- How does fear and stigma about mental health problems affect me personally and professionally?
- How do I approach and engage a man in a conversation about his mental health?
- If a man is resistant to talking about his mental health, perhaps because of embarrassment or shame, or concerns about stigma, how do I raise it and engage him in the discussion?
- If a man needs further information or specialist services regarding mental health problems, do I know where he can go and do I support him to get there?
- What role can I and my service play in fostering a refreshed and constructive dialogue about mental health and wellbeing for gay and bisexual men across the LGBT community?
- Discussing mental health can make me reflect on my own experiences and needs: is support in place for me should I need it?

**FETISH, BDSM AND SEX TOYS**

Words like fetish and kink can have a wide range of meanings to different people. For the purpose of FAQ the term fetish indicates a sexual interest with objects, body parts, or situations not conventionally viewed as being sexual in nature. The term BDSM means use of dominance and submission and includes a variety of role play and restraint. The term sex toy refers an object or a device which is used for sexual pleasure.

*FETISH, BDSM AND SEX TOYS: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- While many people perceive fetishes as outside the norm of sexual activity, when asked, FAQ contributors express varying degrees of interest in a range of fetish activity.
- For some men, initial experimentation can lead to more common engagement with the activity, and then heightened pleasure and intensity of the experience.
- Men report different strategies to minimise risk of HIV/STI transmission; most commonly this means using condoms and gloves, not sharing toys, cleaning toys, and care not to exchange body fluids.
- When considering their fetish interests, men express some degree of worry about HIV/STI transmission, but men may be unclear about the level of HIV/STI risk actually associated with a fetish they enjoy. Few men express worry about HIV/STI transmission when discussing their use of sex toys.
- Alcohol and drugs can undermine intentions to play safe.
- For some men, the line between fetish and violence or abuse within relationships can be difficult to distinguish.
- While very few men have discussed sexual fetishes and sex toys in the context of a sexual health clinic, many more would be interested in doing so.
- Men highlight that clinic staff need to be informed, need to normalise the discussion, raise the issues explicitly, and ensure a non-judgemental attitude.
- The facilitation of sexual fetishes can be part of 'paid for sex' work.

*FETISH, BDSM AND SEX TOYS: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*



- With some men interested in particular fetishes, BDSM or sex toys, services should consider how to introduce discussion in consultations.
- With few men reporting discussion of this nature, clinic staff should consider how more individualised care can provide an opportunity to discuss and plan risk reduction strategies specific and appropriate to the individual's needs.

#### *FETISH, BDSM AND SEX TOYS: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the faq findings reported in this chapter we pose these questions for practitioners.

- Have I considered the role that sexual fetishes and sex toys play in the sex men have?
- How do I approach a conversation with a man about this aspect of sexual behaviour?
- How do I respond (verbally and in my body language) to reports of sexual fetish and sex toys?
- If I talk about sexual fetishes and sex toys what is the starting point or focus: Risks? Pleasure? Men's own questions?

## **HIV STATUS/TALKING ABOUT HIV**

### *HIV STATUS/TALKING ABOUT HIV: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- FAQ participants paint a complex picture in terms of knowing about and talking about HIV status.
- It is not common to ask a direct question about the HIV status of another man. There is little evidence of men discussing HIV status of partners prior to anal sex and men make assumptions about HIV status, yet men tell us that knowing a partner's HIV status is an important component of sexual decision making.
- There is an expectation amongst HIV-negative/untested/presumed negative men that HIV-positive men would and should disclose their status in all sexual encounters.
- Young men in particular say HIV status matters and they want to know the status of a sexual partner. Men who attend sexual health services are more likely to report that HIV status does not matter.
- Without talking and without the availability of accurate information about status, men make decisions about sex based on assumptions: some men will assume a sexual partner's HIV-negative status (40% of online respondents); others assume all sexual partners are HIV-positive (26% of online respondents).
- Other assumptions about HIV status are also at work. Men might base assumptions (of negative status of a sexual partner) on professional status, how fit the man looks or educational attainment. HIV-positive men might assume a sexual partner is HIV positive when the man wants condomless anal sex (bareback).
- Conversations about condom use (if they take place) act as a proxy to indicate HIV status or the risk associated with having sex with this individual. A general commitment to condom use is also seen as making the discussion about HIV status either irrelevant or avoidable.
- Social media can facilitate conversations about status, providing a space for direct or indirect questions or statements about HIV status.
- Across FAQ interviews and in online responses, men often use the term 'clean' to describe HIV-negative status.
- Men living with HIV take different approaches to sharing HIV status; some men are unequivocal and want to ensure partners make informed choices to have sex; others do not feel an obligation to share and use knowledge of low/undetectable viral load while maintaining a commitment to condom use as protective.
- FAQ interviewees express concern that younger men are less likely to enquire about HIV status (although our surveys suggest younger men are more likely to want this information) or consider condom use in the absence of such information. Some view this as young men perceiving HIV as a condition affecting only older men.



- Men reporting HIV-negative status have different levels of 'worry' about HIV. Men who know people living with HIV and view it as a treatable/manageable condition have less worry.
- Some FAQ interviewees identify a need for further awareness-raising about HIV; others express ambivalence or a sense of resignation about HIV acquisition.
- Around half of FAQ online respondents agree with the statement: I would not have sex with someone if he is HIV positive. Many FAQ interviewees agree; others say knowledge of HIV positive status would only affect choices made about anal sex. Interviewees also acknowledge that they may already have sex with men without being aware of the man's HIV positive status.
- An important aspect of men's attitudes toward sex with a man living with HIV is described as the need to be 'at ease' with HIV; while men understand that condom use is a barrier to transmission, worries it seems are founded in a less rational place.
- Across FAQ interviews men express a commitment to condom use for anal sex, recognising that this is the most important protective behaviour in terms of HIV risk. When it comes to sex with a partner who may be HIV positive, this is emphasised by men who adapt what might be a 'don't ask/don't tell/play safe' approach which depends on condom use every time.
- For some men, living with HIV means a preference or exclusivity for sex with other HIV-positive men.
- Men who state or presume they are HIV-negative will sometimes seek or consent to condomless anal sex without information about the HIV status of a sexual partner.
- The most common response from HIV-negative men about the prospect of a positive diagnosis was that they would be fearful of what this would mean to their physical and mental health, and their relationships with others. Some would be anxious about onward transmission, perhaps they could no longer consider having sex, or might only be able to have sex with other HIV positive men.
- When FAQ interviewees (HIV-negative or presumed so) reflect on what life might be like living with HIV they recognise that an HIV diagnosis means managing discriminatory attitudes and behaviours, perhaps being judged by others, many men used the term stigma.
- FAQ interviewees living with HIV talk about the impact of diagnosis on mental health and an increased sense of isolation; sex or relationships can feel out of reach. For men with late diagnosis there can be an immediate impact on physical wellbeing; time is needed for recovery. For some positive men sex now tends to be with other HIV-positive men and/or includes a commitment to condom use or other protective strategies. Men report that the impact of medication varies.
- HIV-positive men see many HIV-negative (or presumed negative) men as having no or little information; they then make poorly informed choices about looking after themselves.
- Men living with HIV experience enduring stigma and discrimination from HIV-negative/untested men and risk rejection if they disclose to sexual partners.

#### *HIV STATUS/TALKING ABOUT HIV: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- While hoping to encourage men to discuss HIV status, or to develop effective strategies to reduce their risk of HIV infection, engagement with men needs to include some discussion of the assumptions they might make about the HIV status of a sexual partner.
- If men do not ask or want to know the HIV status of a sexual partner they need to be supported to identify risk reduction strategies that will be protective; this might include work to strengthen commitments to condom use.

- Clinic staff need to have a good understanding of men's use of social media in order to mitigate risk in this key space where men live their sexual lives.
- An expression of 'worry' about HIV provides an opportunity to explore men's behaviour and build protective behaviours. Men who express ambivalence or a sense of inevitability about HIV need services to build a personal relationship so that they can address their hopes and needs.
- Men who state or presume they are HIV-negative who sometimes seek or consent to condomless anal sex should be a key concern for services. Individualised approaches are required. Helpful questions to put to men might include: Do you assume a partner is HIV positive or HIV negative? Do you expect a man to tell you his HIV status? How do you ask? How do you decide if not? If a man does not want to use a condom, what does that mean to you? What does it say on your profile on (name of app) about your HIV status or your interest in the status of sexual partner? Do you worry about HIV? Would you have sex with a guy who said he was HIV-positive?
- Support for men living with HIV needs to consider the impact on their psychological wellbeing as a consequence of an HIV diagnosis, long-term life with HIV, the expectation of disclosure to sexual partners and the negative or discriminatory response this might get when they do.
- In the context of relationships with individual men, and with the LGBT community, HIV prevention and HIV/sexual health clinical services need to give continued consideration to their role in education and prevention which tackles ignorance, discrimination, and stigma about HIV.

#### *HIV STATUS/TALKING ABOUT HIV: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- How do I respond (verbally and in my body language) to reports of condomless anal sex or ambivalent attitudes towards HIV risk?
- How do I engage each man in a conversation which allows me to understand the assumptions they might make about HIV status of sexual partners?
- If men are resistant to unambiguous discussion about HIV status (their own or that of others) what other protective attitudes or behaviours can I help them develop?
- How do I work with men to raise awareness of HIV risk without unduly worrying them?
- Do I know enough about the social media men use and understand how discussions about HIV status (including the language used such as 'clean') or condom use play out in this space?
- Do I know enough about the experience of living with HIV? Can I learn anything from those who do? In the consulting room, do I make space for individuals living with HIV to pause, reflect and talk about how they feel? Do I know what support, advice or information a man living with HIV wants and needs, to be able to manage discussions about his status?
- How do I feel about and respond to prejudicial views expressed about men living with HIV?
- How do I respond to the use of terms such as 'clean'? How do I encourage men to reflect on the use of language that contributes to HIV stigma and discrimination?
- What role does my service play in tackling HIV stigma?
- Discussing HIV status can make me reflect on my own experiences and needs if I am living with HIV too: is support in place for me should I need it?

## HIV TESTING

### *HIV TESTING: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- The men involved in the FAQ community engagement process represent a range of regular testers (tested within the last twelve months), infrequent testers (more than one year since their last test) and never testers.
- Regular testers have established a pattern of regular attendance at a sexual health service. This commitment to testing might be backed up by regular advice or information that promotes testing.
- Irregular attenders do not maintain such adherence to a timetable of testing; this may be because they do not perceive they are exposed to HIV risk.
- Men who have never tested may not yet engage in any way with a sexual health service, they may have concerns about doing so; they may decline HIV testing or fear a positive result.
- Men who have never tested at a sexual health clinic may have been in situations where HIV testing could have been undertaken, but was not; for example at their local GP practice or attending another specialist service within the NHS.
- Regular clinic attendees have established a pattern of testing; for many men the most common trigger is an episode of 'risky' sex.
- Men report that concerns about other STIs, not necessarily HIV, might trigger a visit to a service which can then involve HIV testing.
- Men in relationships often choose to test when they want to confirm HIV- negative status, perhaps as a precursor to stopping condom use with a partner.
- Men living with HIV report that their first HIV test may have been at the point of diagnosis.
- While most gay and bisexual men who have engaged with FAQ have tested in a sexual health service in Scotland, FAQ online surveys (two different surveys) find that between one in three and one in four men were last tested in another part of the UK or in another country and so, although they have tested, they are not connected to or regularly attending a local sexual health service.
- Men identify that HIV home testing and enhanced access to clinical services would encourage them to test more regularly.
- Men's questions about home testing – in terms of the current model of home-sampling or thinking ahead to home testing which gives instant results – focus on accessing test kits, accuracy, confidentiality, reassurance about ease of use, how often HIV home testing can be used and support for someone receiving an HIV positive result.

### *HIV TESTING: WHAT THE FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- While HIV testing rates among men are good, further improvements need to be made, both in terms of getting men who have never tested to do so, and to encourage men who test irregularly to test more regularly.
- HIV testing should be promoted as part of regular health check-ups for gay and bisexual men, rather than just a response to a 'risky' episode.
- Information about testing should address men's concerns about doing so and promote the benefits of knowing HIV status.
- HIV/sexual health clinical services should engage with colleagues across the NHS to ensure that HIV testing is undertaken in other settings, including primary care, where this would benefit the patient.
- When men in relationships use HIV testing to inform decisions about condom use in the relationship this is a key opportunity to discuss choices and support other HIV prevention strategies.

- Services should consider how to extend access to home sampling/home testing and focus on responding to men's questions and concerns about how this works.

#### *HIV TESTING: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- What role does HIV testing play in a broad and holistic approach to gay and bisexual men's health?
- How do I engage with men who attend my service after an episode of risk, to try to establish a more positive risk/harm reduction relationship with my service?
- What can my team and I do to ensure we offer a flexible, accessible and welcoming service?
- How can my service motivate men who have never engaged with a sexual health service to attend?
- Has my service considered what acts as barriers to testing among irregular testers and men who have never attended a sexual health service?
- Does my service have a plan as to how we engage those men who have never connected with a local sexual health service?
- How can my service engage with other NHS services – primary care/GPs and others specialisms – to make sure that HIV testing is undertaken where and when necessary?
- How do I envisage HIV home testing as a future option for gay and bisexual men; as it develops, what role does my agency have in this emerging service?

### **MEN LIVING WITH HIV**

The views on men living with HIV are addressed across FAQ chapters. In this thematic chapter (in full at [www.faqscotland.co.uk](http://www.faqscotland.co.uk)) this chapter pulls together findings and poses specific questions for practitioners.

#### **REFLECTIVE QUESTIONS FOR PRACTITIONERS**

- Do I know enough about the experience of living with HIV? Can I learn anything from those who are?
- In the consulting room, do I make space for individuals living with HIV to pause, reflect, and talk about how they feel?
- Do I know what support, advice, or information a man living with HIV wants and needs to be able to manage discussions about his status?
- Do I provide opportunities for the man living with HIV to talk about what a safe, happy, healthy sex life means to him?
- Does my service provide an appropriate balance between sexual health support and advice and HIV treatment and care?
- How do I feel about and respond to prejudicial views HIV negative/untested men express, and how men living with HIV experience them?
- Discussing HIV can make me reflect on my own experiences and needs if I am living with HIV or putting myself at risk: is support in place for me should I need it?

### **ORAL SEX**

*ORAL SEX: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES:*

- Men report that giving and receiving oral sex is part of most sexual encounters.
- While 60% of men responding to our FAQ online survey express some level of worry about STI transmission during oral sex, the remainder do not or have not thought about it. Men who have not attended a sexual

- health clinic report less worry about the risk of STIs from oral sex. In general, men consider oral sex as low risk for HIV transmission.
- Men (across all ages and sexual orientation) report that they generally do not and would not consider using condoms for oral sex.
  - Some men are aware of the risks of STI and HIV transmission due to cuts or bleeding gums, others avoid taking ejaculate in their mouths. Men consider HIV risk increases in terms of oral sex with a partner who is HIV positive.
  - When it comes to discussing oral sex only one in four online respondents had discussed the issue at a clinic, but three in four men would do so.
  - While gay and bisexual men are equally willing to discuss oral sex, gay men are more likely than bisexual men to have done so in the past.
  - FAQ contributors want accurate information about STI and HIV risk but reject any suggestion by clinical staff that men should wear condoms for oral sex. The suggestion of condom use for oral sex is often perceived of as a marker of how out of touch a member of staff must be with gay and bisexual men's sexual experiences and enjoyment.
  - While men generally believe oral sex is 'safer' than anal sex, and that condom use for oral sex is not a serious consideration, they remain concerned about STI/HIV risk and seek assurances and good information on the matter.

*ORAL SEX: WHAT THE FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES:*

- HIV/sexual health clinical staff need to talk with men about oral sex.
- Useful conversations about oral sex should be framed by an acceptance of oral sex as a regular and important part of gay and bisexual men's sexual lives.
- In the context of men rejecting condom use for oral sex, clinic staff need to talk with men so that they can be aware of the concerns men have about HIV/STI risks, answer questions, and provide the best advice to minimise risk of infections.
- Men who do not attend sexual health services also need to access information about oral sex and minimising risk; other means of engaging with these men should be identified so that accurate information is available to them.

*ORAL SEX: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- How do I approach a conversation with a man about oral sex?
- In my conversations with men what do I focus on: risk or pleasure?
- How do I ensure my conversations about oral sex are individual and personalised, based on what I know or need to know about the man in front of me? For example, would my advice on condom use be the same for a man in a relationship as for a man having oral sex with multiple partners?
- How do I respond (verbally and in my body language) to a rejection of condom use for oral sex?
- Knowing that men reject messages about condom use for oral sex, what other strategies to minimise STI/HIV risk am I aware of? And which ones am I comfortable in promoting?

## **PAYMENT FOR SEX**

### *PAYMENT FOR SEX: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES:*

- In the course of FAQ it has become clear that there is a culture of offering men, particularly younger men, payment for sex.
- Young men tell us that such approaches are most often made on social networking sites but also happen in bars and clubs or in the street.
- Decisions to take money for sex are often based on financial difficulties. Men may also accept alcohol, drugs, gifts or a place to go in return for sex.
- For some younger men, agreement to having sex for pay might be spur-of-the-moment or influenced by alcohol.
- Some men who have been paid report the experience as something to be regretted. For some the occasional experience of being paid for sex can become normalised through contact with a regular man who pays.
- The need for money might be a driver for future possible occasions when payment for sex will be agreed.
- The entry of young men into prostitution can be facilitated by acquaintances, friends or approaches from agencies providing escort services.
- FAQ contributors also report that they have paid for sex. This is often a one-off or infrequent experience; some men report they enjoy the experience, others regret it.
- Paying for sex is described as pragmatic, as making sex accessible, particularly to younger men who might not choose to have sex with the older man paying.
- Paying for sex can ensure that sex is disconnected from emotions and the experience is in the control of the man paying.
- Men who are paid for sex may also have a female partner whose knowledge of their work can vary. Men report concerns about their partners HIV/STI risk as a consequence of the decisions they make when paid for sex.
- Men report that they assess HIV risk on an individual basis.
- The man paying for sex might be a regular contact.
- The men being paid report they will believe that the man paying will know his HIV status and be honest with them about it.
- FAQ interviewees also report that some men will offer more money for condomless anal sex. Men might also offer condomless anal sex for more money.
- For some men, alcohol and drug use/addiction can drive the need to make money in this way. Sometimes alcohol and drugs are also supplied by the men paying for sex. On occasions drug use can leave the individual at very high risk of violence and HIV/STI infection.
- There can be a desire to get out of prostitution but money, addiction and stigma can make that difficult.
- Men who are paid for sex can be exposed to violence.
- While some men recognise that prostitution is about power and that involvement can be driven by alcohol, drug addiction and isolation, other men view prostitution as the provision of a service.
- FAQ asked online respondents if they would ever discuss payment for sex within a consultation: one in three men would never discuss it, a similar number were not sure, with the remaining one in three open to discussing this issue, clearly indicating that there is some way to go to convince and enable men to talk about this issue when attending services.

*PAYMENT FOR SEX: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES:*

- When men talk about payment for sex they rarely use the term prostitution; rather they might use the term escort or possibly sex work/sex worker.
- As with findings across the FAQ project this points to the need for sensitivity to the man's preferred language in clinic consultations.
- With young men indicating that they can be offered payment for sex, there is a need to explore how services identify vulnerable young men and support them to make choices.
- Assessing vulnerability means sexual health services need to give some consideration to the financial circumstances and other support systems around a young man.
- Men who pay for sex may also be at increased HIV/STI risk, particularly if sex involves condomless anal sex.
- Men who are paid for sex need support so that they can build better strategies to protect themselves from HIV/STI infection. The female partners of men involved in prostitution have specific health needs.
- For some men who are paid for sex there is a need for support around alcohol and drug addiction.
- Services need to engage with men on these issues through routine questioning about payment for sex.

*PAYMENT FOR SEX: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- How ready am I, or is my service, to talk about payment for sex?
- Do I provide a space within which a young man might be able to reflect on any past experience of being paid for sex?
- How do I approach and engage a man in a conversation about payment for sex, particularly in light of feelings of embarrassment, shame or concerns about stigma?
- Is my service more than a pragmatic 'test and treat' service: do I provide a holistic service which has a concern for all aspects of sexual health and wellbeing?
- With a holistic view, is the social or financial circumstance of a vulnerable young man relevant?
- If a man needs further information or specialist services as a result of involvement in prostitution, do I know where he can go and do I support him to get there?
- How might I/my service work across the LGBT community to encourage reflection and dialogue on the issue of payment for sex?
- Does my service have a role in engaging with social network providers to address the practice of young men being approached by other men or by escort agencies to accept payment for sex?

**PEP***PEP: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES:*

- Awareness of PEP among gay and bisexual men remains low.
- There is some confusion among men as to when an experience of condomless anal sex requires PEP as a response.
- When men know about PEP they might make their own assessment about whether condomless anal sex has been risky enough to consider its use.
- Men report poor experiences of attempting to access PEP via hospital based Accident and Emergency services.
- Some men can experience difficulties using PEP because of side effects.
- FAQ participants support further efforts to raise awareness of PEP.



*PEP: WHAT THE FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- Further work needs to be done to raise awareness of PEP.
- Education about PEP should support gay and bisexual men to understand when they should seek professional advice about the appropriateness of PEP.
- If men are advised to attend Accident and Emergency services for PEP then these services need to have appropriate knowledge, skills and attitudes toward providing this service.

*PEP: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

- What role should I play in raising awareness of PEP with individuals at risk of acquiring HIV?
- How does knowledge or use of PEP sit alongside other risk reduction work with the individual?
- Do I know enough about PEP, its recommended use and its management?
- What needs to be done with colleagues in Accident and Emergency services to improve the service they provide when it comes to accessing PEP?

**POPPERS***POPPERS: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES:*

- Poppers use by gay and bisexual men is common, yet it does not appear to be discussed in the context of HIV/Sexual Health Service engagement with men.
- In the first wave of online FAQ work (the Diary Room) two fifths of men report that they like to use poppers; men 35+ are more likely to use them.
- In the second wave of FAQ online the Poppers survey shows that one in five men use poppers most times when having sex, similarly around one in five often when having sex, with a further two in every five men sometimes using them when having sex. This means that of these respondents only one in five men never use poppers.
- In reports of recent sex, approximately 20% of men interviewed by FAQ report use of poppers.
- From analysis of our surveys there is no difference between gay and bisexual men's use of poppers.
- Men report that the most common reasons for using poppers are that they increase sexual feelings and pleasure and help men relax for anal sex.
- Men also report that using poppers disinhibits the individual; this can affect choices or decisions about anal intercourse and condom use.
- From the FAQ Poppers survey fewer than one in twenty men have spoken to someone at a sexual health clinic about poppers while three in five would be happy to do so, or might do so. This willingness to talk about poppers is true for gay and bisexual men and across all ages.
- Men's questions about poppers are predominantly about safety and both short and long term health impacts.

*POPPERS: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES:*

- With many men reporting using poppers, some recognising that their use can affect choices or decisions about anal intercourse and condom use, and very few men reporting that this is discussed in the context of a sexual health clinical engagement, services should consider how to introduce discussion of poppers in consultations.
- Individualised care should provide an opportunity to discuss and plan risk reduction strategies that are particular and appropriate to the individual's circumstances and their use of poppers.
- Services need to provide basic health information about poppers and the health impacts of their use.



*POPPERS: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- Have I considered the role that poppers plays in the sex men have?
- How do I approach a conversation with a man about his use of poppers?
- If you talk about poppers what is the starting point or focus: Health risks? Pleasure? Why poppers are used? Men's own questions?
- Is there a need for a refreshed and constructive dialogue about poppers use amongst gay and bisexual men/across the community?

**RELATIONSHIPS**

This chapter considered relationships in terms of open relationships, sex with friends and the issue of concurrency.

**WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES***RELATIONSHIPS: OPEN RELATIONSHIPS*

- Open relationships are seen by many men as a positive choice.
- Most men in open relationships report these have been agreed with their partner; however when it comes to what sex they have with other men, agreements might not always be explicit.
- Most men in open relationships would welcome discussions about their relationship in a sexual health service, but may not talk about it for fear of judgemental attitudes.
- Men stop using condoms for anal sex in a relationship for several reasons; this can include trust, a commitment to monogamy, that condomless anal sex is more intimate, or a preference for condomless sex.
- Men are concerned that clinic staff do not understand the meaning of ceasing condom use within relationships.
- In some relationships men use HIV testing as an integral part of decisions about discontinuing condom use; others may not, preferring to discuss the issue and base decisions on a belief that a partner knows his HIV status.
- Men will make decisions to stop condom use with their partner at different stages of a relationship; some men months after being together; some men considerably longer.
- For some men a commitment to condoms for anal sex remains, even in context of a monogamous relationship; this might reflect a long term commitment or preference for anal sex with condoms. Or they may view it as a pragmatic self-protection strategy in case a partner has sex with someone else without their knowledge.
- Decisions about condom use with a partner can also change; not using condoms on some occasions might be influenced by alcohol or desire for intimacy.
- FAQ participants gave a common description of open relationships as one in which both men have sex with others, they have talked about and agreed rules about how this works, they have anal sex with men other than their partner, condoms are not used when having anal sex within the relationship but they are used with other men.
- Compared to other age groups taking part in the FAQ project, men aged 26 to 35 are most likely to be in an open relationship.
- Sustaining agreements about condom use with other men can be difficult.
- Some FAQ participants who have considered or attempted contact with services as a couple have found this is not possible.

- Men are interested in discussing their open relationships. They would like to reflect on how they feel about them, how others view them and make sure they have best advice and information on HIV/STI testing and prevention.

### **SEX WITH FRIENDS**

- A theme across FAQ interviews has been sex with men who are considered friends.
- Men describe on-going contact with a sexual partner who they do not consider a partner/ boyfriend but someone with whom a relationship has been built, the central part of which is sex.
- Sex with friends is a considered choice for men, sometimes in the absence of a relationship and sometimes in addition to a relationship.
- Men also identify that sex can be with one friend or with several.
- Social media plays an important role in establishing and maintaining relationships and arranging contact.
- The importance of testing and trust (including being open about HIV status) is of importance to men making decisions about condom use.
- Condom use for anal sex with a friend might be dispensed with when there is a trust that the friend knows his status and he says he is not having condomless sex with others.
- Men living with HIV report that sex with friends is a means by which they can be open about their HIV status.
- FAQ interviewees also describe 'sex with friends' which is perhaps less clear, and in the emerging relationship – potentially from friends to partners – there can be a lack of clarity about condom use and expectations about sex with others.

### *RELATIONSHIPS: CONCURRENCY*

- Concurrent sexual partnerships are situations in which an individual has overlapping sexual relationships with more than one person.
- Concurrency is only an HIV risk if one or more of the individuals is HIV positive and has condomless anal sex with a partner.
- Men in open relationships or men having sex with friends would meet this definition of concurrency.
- Men who split from one partner while starting another relationship, men who have concurrent sexual partners at the beginning of a relationship and men who have sex with more than one man in a given period would also meet this definition of concurrency.
- With this broad picture of concurrency in mind, and given the different arrangements or behaviours men might have with concurrent sexual partners, circumstances are often individual to the man concerned.

### *RELATIONSHIPS: WHAT THE FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES:*

- HIV/sexual health services are well placed to support men in defining the parameters of their relationships and planning for risk reduction in different contexts.
- Clinic staff need to engage with men on an individual basis to understand how they frame and describe concurrent sexual relationships; this might include sex with a partner and other men, or sex-only relationships with a number of men (fuck buddies), or sex with friends.
- Given different arrangements or behaviours it is important for clinic staff to ascertain a full picture of a man's sexual behaviour and relationships to discuss HIV risk and prevention.
- Clinic staff should use discussions around intimacy, trust and monogamy as a starting point for safety in relationships.

- Men should be helped to incorporate decisions around HIV testing and negotiated safety into their existing approaches for risk reduction.
- Men in open relationships who have not discussed with their partner that they have sex with other men, or who have not agreed rules for sex outside the relationship, should be helped to initiate such discussion.
- Clinic staff should not routinely recommend condom use within relationships as this risks alienating men and devalues the establishment of trust within a gay relationship.
- Services should respond to MSM couples that wish to stop using condoms with the same positive and facilitative approach that would be offered to a heterosexual couple making the same decision.
- Services should consider how they can offer services to couples without compromising individual client confidentiality. Services should develop an approach to work with couples and support them to negotiate and agree the parameters of their relationships and how to manage situations where commitments are not kept.
- Services need to be better at explaining the purpose and management of Partner Notification; as they do so, men will need assurance that they will not be judged if they honestly discuss concurrency and numbers of partners.

#### *RELATIONSHIPS: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- What are my personal feelings about monogamy and open relationships?
- What are my personal feelings about a man having sex with friends?
- What are my personal feelings about a man having overlapping sexual relationships with more than one person?
- How do societal views, which see open relationships or concurrency as taboo, affect me personally and professionally?
- How do I approach a man about his relationships?
- If a man is resistant to talking about his personal and sexual relationships, perhaps because of feelings of embarrassment or shame, how do I raise it and engage him in the discussion?
- How ready am I, or is my service, to talk to men about their decisions regarding open relationships, sex with friends, or concurrency and their intentions to minimise HIV risk.
- How ready am I or is my service to accept men's decisions on these issues?
- Do I have a clear understanding of and empathy toward men's decisions about condom use?
- How do I respond (verbally and in my body language) when men report open relationships or sex with friends?
- How does or can my service work with couples?
- What role can I and my service play in fostering a refreshed and constructive dialogue about HIV risk among gay and bisexual men in open relationships or who report sex with friends?

## **SAUNAS**

### *SAUNAS: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- There is a long history of men meeting other men for sex in the setting of saunas. Saunas operate in both Edinburgh and Glasgow.
- For some FAQ contributors saunas are perceived of as places where condomless anal sex is more likely to happen, generally that they are 'riskier' places.

- For other men they can be seen as places to meet men who do not identify as gay who they perceive to be at reduced risk of HIV infection.
- Many FAQ interviewees and online contributors talked about saunas as a setting for increased risk of condomless anal sex and so HIV transmission.
- Sex in saunas might also include multiple partners.
- Despite concerns about condomless anal sex FAQ interviewees report that condoms and lube are available in most saunas.
- Saunas might also be a setting where men in open relationships meet others for sex.
- As sex takes place on premises, vulnerable men may be at increased risk in this setting.
- For some FAQ contributors risk of HIV/STI infection is increased by a lack of communication about safer sex (or condom use) and HIV status in the sauna setting.
- Men report that some men do not identify as gay or bisexual and that they might dissociate the person they are before heading to the sauna from the man who wants sex when there; in such circumstances choices and behaviour can put men at increased risk of HIV/STI infection.
- Saunas can be a setting for sexual violence.
- FAQ interviewees report that sexual health services are present in saunas in both Glasgow and Edinburgh, providing condoms and lube and sexual health screening.
- One in four men who responded to the FAQ Saunas survey do not attend sexual health services and only one in ten have engaged with an outreach service in a sauna.
- Only one in five men who use saunas have ever discussed this at a sexual health service but just over half of men say they would do so.
- Men recognise that discussing saunas in a sexual health service setting might be difficult if they expect to encounter stigma which they perceive to be attached to the practice.

*SAUNAS: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- HIV/sexual health clinical staff need to talk with men about their use of saunas.
- Useful conversations should be framed by an acceptance of saunas as a regular and important part of some men's sexual behaviour.
- Men are willing to discuss their use of saunas with clinic staff, but only when they can be sure that the response they receive will be open and non-judgmental.
- Services should explore how they can reach more men in the setting of saunas by providing HIV prevention information and testing.
- With bisexual men less likely to attend sexual health services, connecting with men in the setting of a sauna might be a key opportunity to engage them with services they can trust.

*SAUNAS: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- What are my personal feelings about men having sex in sex-on-premises venues such as saunas?
- How do I approach a man about his use of saunas?
- If a man is resistant to talking about using saunas, perhaps because of feelings of embarrassment or shame, how do I raise it and engage him in the discussion?
- How do I respond (verbally and in my body language) to reports of men with female partners using saunas to meet men for sex?
- How do I engage a man in conversation about condom use and other risk reduction strategies?

- What role does my service have in maintaining an open and constructive dialogue with sauna owners to develop a shared agenda for HIV prevention?

## **SOCIAL MEDIA/APPS**

### *SOCIAL MEDIA AND APPS: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- A growing number of social network GPS apps and social media websites target gay and bisexual men who use them to facilitate contact.
- Across their interactions with FAQ, men identify that apps and websites play a significant role in their social and sexual lives.
- Men can have a presence across multiple social media platforms, FAQ interviewees report using between one and twelve apps or sites to meet other men.
- Most FAQ online respondents report daily use.
- The basic information provided in an online profile can be the only exchange of information men might have about HIV status or condom use; others will use chat/messaging to explore these issues further before any meeting is finalised.
- Men living with HIV can use this continuing online conversation to discuss status.
- The apps/sites ask new users if they are 17 years of age but there are no checks other than the affirmation of the user.
- Apps and websites can also be used to facilitate payment for sex. This might be the case for men who are seeking payment for sex but social media can also be a place where men are approached and offered payment for sex.
- FAQ interviewees highlight positive aspects of their use of social media. The social aspects of being online are of real benefit.
- The apps/sites men use are the key means by which they can identify and meet others for sex.
- Online contact also gives the individual a sense of control about interaction and it can feel safer than using public sex environments to meet men for sex.
- A common complaint among FAQ interviewees is that many men with whom they engage are 'time-wasters', men who engage in conversation, possibly suggest sex, but do not follow through.
- Men are also aware that an online identity might not be real.
- Some men have concerns about how a presence on social media can lead to the commodification of sex.
- Men can also experience rejection and be treated badly by others in online environments.
- Few men report discussing their use of social media at an HIV/sexual health service but a majority would do so.
- Men identify that conversations about social media might help them consider personal safety, negotiate safer sex and reflect on worries about using the medium.

### *SOCIAL MEDIA AND APPS: WHAT THE FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- HIV/sexual health clinical services should ensure that staff who engage with gay and bisexual men (and men who do not identify as gay or bisexual but use the medium to meet other men for sex) have a good understanding of how social network GPS apps and social media websites work.
- Staff understanding of social media needs to reflect the positive view men have about its use, as well as concerns about HIV/STI risk that might be associated with the sexual contact which it facilitates.

- With men reporting that social media plays an important part in their social and sexual lives, consideration of this must play a part in the assessment of HIV/STI risk and the development of individualised, person-centred approaches to improve outcomes for men.
- Individualised care should provide an opportunity to discuss and plan risk reduction strategies that are specific and appropriate to the individual's use of social media to meet others for sex.
- Staff engagement with younger men should pay particular attention to the support they need to navigate their use of social media.
- Services should consider how they engage with companies who own the apps/sites which provide a service to gay and bisexual men and consider how a shared commitment to HIV prevention might best be served.

#### *SOCIAL MEDIA AND APPS: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- As a user of social media, what benefits and what concerns do I have?
- Do I understand the growing market which targets gay and bisexual men and facilitates social and sexual contact?
- Should my service be routinely asking men about their online lives?
- Do I understand the benefits of social media, the social connections it facilitates and remain non-judgemental at all times?
- Do I create space in a consultation to find out about how a man uses social media to facilitate sexual contacts?
- Am I informed and confident enough to speak with younger men in their teenage years about how they engage with targeted gay and bisexual apps/sites?
- Do I help men to pose questions or worries they might have about their online lives?
- What role does my service play in engaging directly with the private sector companies who own and manage the apps and sites men use? Are there ways to work together?

## **VIOLENCE**

#### *VIOLENCE: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- When men experience physical, emotional and sexual violence and/or childhood sexual abuse these experiences impact on the quality of their relationships and on sexual health and wellbeing.
- Men can struggle to understand that violence is unacceptable; they may not know or understand what is normal, particularly where a level of consensual aggressive or violent behaviour is established as part of sex. This is particularly true for younger men.
- Men identify exiting a violent relationship can be a difficult or protracted process.
- Problematic alcohol use features in the violence men experience.
- Sexual violence can happen in a relationship as well as in one-off sexual contacts; experiences often leave men feeling isolated and responsible and are rarely reported to others.
- Men working in prostitution are also vulnerable to violence.
- Men who experience childhood sexual abuse report having to cope alone, that these experiences had not been talked about with others (as a child or as an adult) or that as a child (when they told someone) they were not believed.
- Men also recognise the experience of childhood sexual abuse can be woven into the experience of coming out, causing confusion for the child's emerging understanding of their sexual identity.

- While some FAQ interviewees describe childhood sexual abuse as such, FAQ questions about childhood sexual abuse led some men to talk about sexual experiences as children which they do not necessarily frame or name as sexual abuse. A common perspective was for men to describe themselves as curious or precocious although as adults they now see these experiences as something to question.
- In discussing adult experiences of violence many men identify that they do not know who to go to for support or advice, or that they feel that reporting is not worthwhile. Seeking support can be problematic when it also requires the man to 'come out'.
- Men might not discuss experiences of violence at a sexual health service because they see clinics as a pragmatic 'test and treat service', men also highlight a need for clinical services to show an interest and open a dialogue.

*VIOLENCE: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES:*

- With men reporting that experiences of violence and abuse impact on relationships and sexual health, HIV/sexual health services need to respond by building individualised and person-centred relationships with men, to better understand each man's experiences, needs and risks.
- When men require more intensive services to help them address experiences of violence, they should be supported to access these.
- Specialist services must have the confidence and skills to address the needs of gay and bisexual men who are referred to them.
- Staff in HIV/sexual health services should know where to refer gay and bisexual men who wish to report violence.
- When services engage with women they undertake routine enquiry about domestic abuse and childhood sexual abuse; this needs to be done with men.

*VIOLENCE: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- Should my service be routinely asking men about their experience – current and past – of physical, emotional and sexual violence and childhood sexual abuse?
- Am I clear in my engagement with men that my service is more than a 'test and treat' service, that I provide a holistic service which has a concern for all aspects of sexual health and wellbeing?
- In the consulting room, do I make space for individuals to pause, reflect and talk?
- How might I/my service work with individuals and across the LGBT community to encourage reflection and dialogue on the part violence plays in men's relationships?
- How close are the associations of being a man, physicality and aggression?
- Can I/we help men to question violence as the norm? Or as something a man 'deserves'? Specifically, how might I/my service work with young men to establish what they want from sex and relationships – with the specific intent to build resilience and refusal to accept violence?
- If men discuss childhood sexual experiences, but do not understand or frame these as abuse, how do I engage?
- What role can I and my service play in fostering a dialogue about sexual relationships between men of considerably different ages, ensuring that men understand the law as it relates to sexual activity before the age of 16?
- What is in the best interests of young men who engage in sexual relationships out with their peer group?



- If a man needs further information or specialist services, do I know where they can go and do I consider the support they need to get there?
- Do I know and understand how men can report violence to the Police and what they will experience as a part of these procedures?
- Do I understand the role alcohol plays in men's lives and have I considered how men need to be and can be supported?
- Discussing physical, emotional and sexual violence and childhood sexual abuse can make me reflect on and remember my own experiences: is support in place for me should I need it?

## VISITING THE CLINIC

### *VISITING THE CLINIC: WHAT WE LEARNED FROM MEN ABOUT THEIR EXPERIENCES*

- Attending a sexual health service is often prompted by worry, it can feel stressful.
- Despite this, FAQ interviewees share many positive experiences when engaging with services.
- Men recognise that services have come a long way in recent years, now becoming more welcoming and capable of attending to gay and bisexual men's needs.
- Positive experiences help the individual to build a relationship with a service and with individual clinic staff and to establish a pattern of attendance.
- While generally positive, some engagement with services can feel like a 'tick box' experience, structured around set questions and lacking a focus on the individual's experience and needs.
- On occasion men report contact in which staff can be judgemental or lecturing.
- Men are especially sensitive to any impression that clinic staff are uncomfortable or embarrassed in the discussion of gay sex.
- Staff who have the skills, knowledge and language and are comfortable talking about the sexual lives men lead are able to deliver a positive clinical experience to gay and bisexual men.
- In addition to the skills and qualities of staff other key features attract men to services, these are: a discreet outward appearance; convenient locations with a choice of local or city centre; provision of free condoms and lube; a mix of appointments and drop-in clinics (daytime, weekend and evening); good advice and support; and minimal waiting times. Young men identify the most important aspects which draw them to a service are the quality and skills of staff and a commitment to provide a service which is confidential, anonymous and discreet. However, as with men of all ages, younger men may also be motivated to come to services only after perceived risk or with symptoms.
- Young men also report important blocks to accessing services: a lack of privacy and concerns about being seen attending a service; they might be fearful of the experience of HIV/STI tests or a positive result; feelings of embarrassment and shame are also significant hurdles to overcome.
- Bisexual men identify the most important characteristics which draw them to a service are the quality of staff (they should be open-minded, non-judgemental, conversational) and by privacy and discretion. Bisexual men also report that fear of discrimination and stigma about being bisexual can act as a barrier to engaging with a service.
- A majority of gay men like the option of attending a specialist gay/bisexual men's clinic.
- However, younger men express a preference for a targeted younger gay and bisexual men's service or for a generic young people's service and bisexual men indicate a preference for generic/open clinics rather than a gay/bisexual men's service.
- Men support the development of new aspects of clinic provision (as options and not mandatory requirements) which FAQ has proposed to them. Text and email reminders to make or keep appointments



- and pre-consultation questionnaires are generally welcomed. Telephone and online consultations and services for couples may be explored further and were seen by men as having both potential benefits and disadvantages. Point of care/rapid HIV and STI testing receives overwhelming support from those gay and bisexual men who have engaged with FAQ.
- Men reject the use of condoms for oral sex; continuing this advice contributes to men disengaging with all discussions of risk reduction because they consider the service/staff member as out of touch.
  - Men report that sexual health services need to improve the focus and support they give in terms of mental health.
  - Some men express a preference to engage with male or gay/bisexual staff however when it comes to their engagement with a service, most men want staff who are knowledgeable, non-judgemental and interested in them; continuity and building a relationship with a member of staff also matter.
  - FAQ interviewees living with HIV identify the opportunity to talk openly and frankly about sex and sexual health as a positive feature, however HIV- positive men also recognise that a 'tick-box' experience can mean not enough time and care is taken to speak in detail about sex, relationships and sexual health.
  - HIV-positive men report that HIV/sexual health services should not assume that an HIV-positive man has the information or knowledge or skills he needs to maintain a healthy approach to sex.
  - While HIV-positive men tell FAQ that they think HIV/sexual health services are good they might also choose to limit the information they are willing to share, particularly when it comes to partner numbers or instances of condomless anal sex.
  - HIV-positive men identify the need for better integration across HIV treatment and care services and sexual health services when it comes to meeting their sexual health needs.
  - HIV-positive men report that they can still encounter negative attitudes towards their HIV status when engaging with other parts of the NHS.
  - While practical arrangements and issues of access are important what really defines a service and ensures that men return is the relationship built between people.
  - Two key messages emerge from men (across ages, sexual orientation and HIV status). First, clinic staff should remember that men might be nervous or anxious, either when first approaching a service or when they attend with a worry about their sexual health. Second, men need clinic staff to be non-judgemental, respectful, informative, interested, friendly and professional.

#### *VISITING THE CLINIC: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- Too many gay and bisexual men come to services only when they are concerned about an episode of risky sex or have symptoms; services need to consider how they engage with men more effectively as preventative services, and not just reactive.
- When they engage with a man, clinic staff should focus on building a relationship and delivering individualised, person-centred care, while taking steps to make routine data collection less mechanical/tick box.
- Services should ensure that it is staff with the skills, knowledge, language and confidence to work with gay and bisexual men who do so.
- Individualised care should provide an opportunity to discuss and plan risk reduction strategies that are particular and appropriate to the individual's circumstances; this might include condom use for anal sex.
- With men rejecting condoms for oral sex clinical services and HIV prevention interventions should reconsider how they discuss the risk of HIV transmission through oral sex.

- Younger men and bisexual men do not necessarily want to attend a targeted gay/bisexual service, with this in mind services must consider how generic young people's services or open clinics understand and meet their needs.
- The sexual health needs of HIV-positive men may not be met consistently or adequately and should be given more consideration.
- Services must consider how the mental health and wellbeing of service users is understood and addressed in the context of a HIV/sexual health service.
- Consideration should be given as to how staff training can support staff to focus on whether they are giving verbal or non-verbal signals that suggest judgemental attitudes to men or their behaviour.
- Staff training is required to educate staff about gay/bisexual culture and sexual practices to ensure staff are equipped to have detailed conversations with men.
- Services should consider piloting text and email reminders for routine sexual health screens, online or telephone consultations, pre-consultation questionnaires for triage, and couples clinics. Recognising that men like Point of Care/rapid HIV and STI testing, services should explore how this can be expanded.

#### *VISITING THE CLINIC: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- Personally, am I ever anxious when using a public service?
- What characterises a good public service for me?
- Do I understand the worry or anxiety a gay or bisexual man (or a man who does not identify as gay or bisexual) might feel when engaging with my service?
- How do I approach my conversations with a man? Are they my focus? Or am I guided by a list of questions and risk assessment I must undertake?
- How do I respond (verbally and in my body language) to reports of condomless sex or ambivalent attitudes towards condom use?
- Do I show empathy and patience in my manner and language?
- In the consulting room, do I make space for individuals to pause, reflect and talk?
- Am I aware of how my gender and sexual orientation might affect how I work or how I am perceived by a gay or bisexual man using my service?
- How do I and my service engage with men living with HIV in the realm of sexual health and wellbeing?
- Do I place an equal value on trust established in a regular gay relationship to that within a heterosexual relationship, recognising that the difference in HIV risk between the two is primarily a function of higher HIV prevalence in MSM and the biology of transmission?
- Am I clear in my engagement with men that my service is more than a pragmatic 'test and treat' service, that I provide a holistic service which has a concern for all aspects of sexual health and wellbeing?
- What can my service do to meet expectations that services should be discreet, welcoming, accessible and flexible?

## **YOUNGER MEN**

For the purposes of reporting in this chapter we consider younger men as those in their teenage years.

#### *WHAT WE LEARNED FROM YOUNGER MEN ABOUT THEIR EXPERIENCES:*

- Findings from a number of aspects of FAQ remind us that gay and bisexual men become sexually active as teenagers.

- Looking at what age first anal sex takes place, nearly half of online respondents and three in every five FAQ interviewees report anal sex as teenagers; for a significant minority first anal sex happens aged 13 to 15 years old (14.4% of FAQ interviewees and 16.5% of online respondents).
- Younger men have little engagement with services or supports. This means they may have no contact with information and advice about sex, relationships or sexual health from an informed, professional source.
- Younger men identify the most important aspects which would draw them to a service are the quality and skills of staff and a commitment to provide a service which is confidential, anonymous and discreet.
- However, as with men of all ages, perceived risk or symptoms may be the motivator for younger men to come to services.
- Important blocks to accessing services, younger men report, are a lack of privacy and concerns about being seen attending a service. Younger men might fear the experience of HIV/ STI tests or a positive result. Feelings of embarrassment and shame also pose significant hurdles to overcome.
- FAQ online teenage respondents indicate a preference for a targeted younger gay and bisexual men's service or for a generic young people's service rather than a clinic for all gay and bisexual men or a generic clinic for everyone.

#### *YOUNGER MEN: WHAT FINDINGS MEAN FOR HIV PREVENTION AND HIV/SEXUAL HEALTH CLINICAL SERVICES*

- Services should review and refresh their efforts to attract younger gay and bisexual men.
- When they engage with young men, clinic staff should focus on building a relationship and delivering individualised, person-centred care.
- Services need to understand and recognise that gay and bisexual men become sexually active as teenagers, and their sexual lives include anal sex.
- A number of young men have anal sex before they are 16, giving further impetus to the need to engage with young men about HIV prevention.
- Services should ensure that staff with the skills, knowledge, language and confidence to work with young gay and bisexual men are the ones who do so.
- With young men indicating they might first come to services after perceived risk or with symptoms, services should consider how they engage with younger men more effectively as preventative services.
- As younger men do not necessarily want to attend a targeted gay/bisexual clinic, services must consider how generic young people's services understand and meet their needs.

#### *YOUNGER MEN: REFLECTIVE QUESTIONS FOR PRACTITIONERS*

In terms of the FAQ findings reported in this chapter we pose these questions for practitioners.

- Have I reflected on why my service attracts so few gay and bisexual men in their teenage years?
- When I think of younger gay and bisexual men do I consider them first: As young? As male? As gay or bisexual? How might this matter?
- Do I provide the same level of care in assessing the quality of young men's relationships in the same way I would do for young women?
- Is my service engaging with young men in the realm of social media, where many of them live their personal and sexual lives?
- How ready am I, or is my service, to talk about sex (including anal sex) with young men in their teenage years?
- What can I do in my engagement with young men to assure them of the key things they want from a service: confidentiality, a friendly welcome and reassurance that they will not be judged?

- In my engagement with young men how do I consider and address their feelings of shame and embarrassment about attending services?
- In the consulting room, do I create a space for reflection and dialogue?
- How does my service build relationships and establish patterns of regular attendance? Can we do this in the teenage years?

## 4. DISCUSSION

### 4.1 PROFILE OF MEN AT RISK OF HIV TRANSMISSION

**FIGURE 5. EVIDENCE MATRIX: PROFILE OF MEN AT RISK**

	MRC Gay Men's Survey	Clinical staff engagement	CNR Group A	CNR Group B	CNR Group C	FAQ
<b>Younger men (25yrs old and under) of particular concern</b>						
<b>Majority white (Scottish) ethnicity</b>						
<b>Majority gay/male only partners</b>						
<b>Urban dwelling</b>						
<b>Poor emotional wellbeing/mental health</b>						
<b>Problematic alcohol use</b>						
<b>Illegal drug use</b>						
<b>Social problems (homeless, jobless, financial)</b>						
<b>Experience of violence/abuse</b>						
<b>Bisexual/mixed gender partners</b>						
<b>Vulnerable group (experience cluster of risk factors)</b>						

As the evidence matrix above indicates there was a high degree of consistency in the characteristics of men at higher risk of HIV transmission across the six strands of work. A broad demographic profile of men at risk emerges marking them as mainly urban dwelling, of white (Scottish) ethnicity and identifying as gay or reporting male only partners. This profile likely reflects the wider MSM populations and will be useful when considering the planning and evaluation of broad brush community level interventions. However the research also uncovered sub groups of men with differing risk profiles which will need to be considered when planning more targeted interventions.

Young men (25 years old and under), who were HIV-negative, were described as being a particular concern. Young men were reporting high numbers of sexual partners, but low awareness and perception of HIV risk. They presented with poor knowledge of HIV prevention and in particular described deciding to have UAI with partners based on intimacy rather than knowledge of their own or partner's HIV status. They were less likely to have tested for HIV and to have previously engaged with specialist sexual health services. Further, the HIV epidemiology suggests a slight growth in new diagnoses amongst this group and the high proportion of late diagnoses may also indicate a burden of undiagnosed infection amongst younger MSM in their 20s.

Although the majority of men at risk identified as gay or reported male only partners, men who behaved bisexually emerged as an important sub group amongst HIV negative men at risk. There were concerns that these men were perhaps less well informed and less likely to engage with current services and that HIV prevention work to date may not be reaching this group. The Case Note Reviews and the FAQ community engagement work found that men who behaved bisexually were more likely to have never tested for HIV or engaged with sexual health services.

Men reporting poor emotional wellbeing or mental health were identified across the Case Note Reviews, by clinical staff and in the FAQ community engagement work. Emotional wellbeing concerns included low mood, low self-esteem or self-worth and loneliness. Men reported that their poor emotional wellbeing made it difficult for them to negotiate the safer sex they wanted or that their need for intimacy overrode their need to minimise HIV risk. Some men described how risky sex was used as a way of self harming to cope with wider mental health issues. Although causality cannot be inferred, in the Case Note Reviews reporting emotional wellbeing concerns was associated with ongoing risk behaviour demonstrated by repeat rectal STI infections, reporting never using condoms for anal sex and poor/infrequent engagement with specialist sexual health services.

Reporting other risk behaviours, such as problematic alcohol consumption and illegal drug use, was found to be an indication of increased HIV risk. A high proportion of men in the Case Note Review were reporting that problematic alcohol consumption was linked to sexual risk taking, as alcohol contributed to a loss of sexual inhibition, impaired ability to make objective risk assessments or to negotiate the sex that they wanted. Some men also reported that alcohol led to memory loss relating to sexual encounters. A smaller proportion of men, and HIV positive men in particular, attributed similar experiences to illegal drug use.

A number of risk factors were also reported by higher risk men which included involvement in prostitution, experience of abuse or violence and homelessness. On review of the three sets of case notes it emerged that a significant proportion of men were experiencing a clustering of psycho-social and behavioural risk factors which may be increasing their risk of HIV acquisition. These included experience of social deprivation (residing in SIMD 1); poor emotional wellbeing or a mental health disorder requiring intervention; experience of abuse or violence; problematic alcohol consumption; homelessness; joblessness or financial worries; involvement in prostitution; behavioural or learning disabilities. Men were coded as belonging to this vulnerable group if they reported two or more of these issues. Men in this vulnerable group were more likely to reside in NHS GGC and to report intergenerational sex, use of public sex environments and saunas, and were more likely to report never using condoms.

## 4.2 SEXUAL BEHAVIOURS OF MEN AT RISK OF HIV TRANSMISSION

**FIGURE 6. EVIDENCE MATRIX: SEXUAL BEHAVIOURS**

	MRC Gay Men's Survey	Clinical staff engagement	CNR Group A	CNR Group B	CNR Group C	FAQ
<b>Concurrency</b>						
<b>UAI and intimacy</b>						
<b>UAI with casual or anonymous contacts</b>						
<b>Sex parties</b>						
<b>Serosorting</b>						
<b>Sex with a significant age gap</b>						
<b>PSEs and saunas</b>						
<b>Internet cruising</b>						
<b>Sex abroad and UAI</b>						
<b>High partner numbers</b>						
<b>Low awareness of partners' HIV status</b>						
<b>Newly diagnosed with HIV</b>						

There were a number of sexual behaviours associated with men at higher risk of HIV transmission, some of which were unique to men living with diagnosed HIV. From the evidence matrix above it is clear that most of these behaviours emerged across several of the strands of research.

Reporting concurrent sexual partners was one of the more prevalent behaviours reported by men regardless of serostatus. Concurrency included both men with and without partners. Men with partners often reported having agreements with their partner about having an 'open' relationship, which allowed for concurrent casual partners. Most men describe also agreeing risk reduction strategies with their partners that condoms must always be used with

these casual contacts or that both partners will routinely screen for STIs and HIV. However from the case notes and from FAQ interviews it is apparent that many men struggle to maintain these risk reduction strategies.

For men not in relationships concurrency could take the form of having 'friends' with whom they regularly have sex, whilst also having concurrent casual contacts. Other men reported group sex, most commonly threesomes, or having multiple partners during a sex party. Threesomes were also common amongst men in relationships, whereas sex parties were predominantly reported by men living with HIV. The sex parties described by men living with HIV were also linked to alcohol and illegal drugs. Although currently considered a small scene, staff felt that it has been growing in popularity.

Concerns were also raised about the circumstances in which men report having UAI. Some men believed that sex within relationships or with someone that they knew like a friend was safe, regardless of whether they had discussed HIV testing and status, and therefore agreed to UAI. Other men continue to report that they make assumptions about how someone's physical appearance, their character or their lack of any disclosure, implies they are HIV-negative and therefore decide to have UAI. There are also those men who report inconsistent condom use with all contacts and the minority who report never using condoms. There appears little appreciation about the risks of such assumptions or that a significant proportion of men with HIV remain undiagnosed.

Across the research strands men reported a variety of spaces that facilitate meeting new partners and were often associated with UAI. These included PSE, saunas, cruising websites and phone applications and also when abroad on holiday or travelling for work. Some of these spaces facilitated serosorting for men living with HIV, and it appeared that the dominant current method across all groups of men was the use of internet based technologies.

Almost 20% of the HIV negative men diagnosed with a rectal STI (CNR Group A) reported sex with a partner with an age gap of more than 10 years. Considered together with the high number of partners and reports of UAI amongst men under 26 years old in this sample, and the fact that HIV prevalence is higher in older men, this may indicate a subgroup of men at particular risk of HIV acquisition.

Serosorting was a very common behaviour reported by men living with HIV who were also reporting high levels of UAI. Although a valid means of reducing the risk of HIV transmission, it carries other risks such as super-infection with other strains of HIV and STI acquisition. It is also of concern that many of the men reporting serosorting reveal their motivations relate to poor emotional wellbeing or mental health, often aggravated further by this behaviour which may reinforce feelings that they are undesirable to most men due to their HIV status.

A large proportion of men newly diagnosed with HIV abstained from sex for a period post diagnosis and for some men this was associated with needing time to adjust to their diagnosis, fear of disclosure or onward transmission of HIV. Of those who were sexually active post diagnosis the majority reported always using condoms and just over a quarter reported trying serosorting.



### 4.3. HOW DO AT RISK MEN ENGAGE WITH CURRENT SERVICES?

**FIGURE 7. EVIDENCE MATRIX: ENGAGEMENT WITH CURRENT SERVICES**

	MRC Gay Men's Survey	Clinical staff engagement	CNR Group A	CNR Group B	CNR Group C	FAQ
Never engagers/testers						
Infrequent engagers/testers						
Late diagnoses						
Men w/repeated rectal STIs						
Reactive approach to STI testing						
Poor record of interventions						
Engagement with sexual health care by serostatus						
Use of generic versus MSM targeted sexual health services						

Men who had never tested for HIV emerged as a group of concern across several strands of the Needs Assessment. The majority of these never testers had also never engaged with a specialist sexual health service or had a sexual health screen. Over a third of high risk men in the MRC Gay Men's Survey had never tested for HIV and these men tended to be younger (under 26 years) and live in rural areas. A fifth of men in CNR Group A had never previously tested for HIV at diagnosis with the rectal STI, and again these men tended to be younger, and to have engaged via a generic sexual health clinic. Only a small number of men (less than 5 men) had not agreed to a HIV test during the two year review period. A third of CNR Group B men were diagnosed with HIV at their first HIV test, these men were more likely to be bisexual and to be diagnosed late.

It was evident from the MRC surveys, the CNR and the FAQ community engagement work that there are a group of men who have/do test and engage with services but do not engage or test as frequently as we would like. Current testing policies in NHS GGC and NHS Lothian state that MSM should be encouraged to test for HIV at least annually, but up to three monthly if at ongoing risk. Of the men who had ever tested for HIV, the percentage who had tested more than twelve months previously was 30.4% of high risk men in the MRC survey; 39.9% of CNR group A men (HIV negative diagnosed with rectal STI); and 67.9% of CNR group B men (newly diagnosed with HIV). From the FAQ work we know that 29% of men who were interviewed have never tested or whose last test was more than 1 year ago. From FAQ online work relating to HIV testing surveys showed a range of 37% to 57.9% of men who have either never tested or whose last test was more than 1 year ago. This presents evidence that a substantial proportion of men do not follow current recommendations for minimum HIV testing.

For CNR Groups A and B men were classed as infrequent HIV testers if at diagnosis with rectal STI/HIV it had been more than one year since their last HIV test. Being an infrequent tester was associated with living in a rural local authority and being aged 26 years or older in CNR Group A, whereas infrequent testing in Group B was associated with social deprivation (residing in SIMD 1 or 2).<sup>17</sup> Infrequent HIV testers were also more likely to be infrequent attendees at specialist sexual health services, and to report infrequent screening for STIs.

Reduction of the proportion of individuals diagnosed late with HIV is a UK and Scottish target. Of the men newly diagnosed with HIV included in the Case Note Review (Group B) just under half were classed as a late diagnosis, with CD4 counts less than 350. This is higher than the UK late diagnoses rate for MSM which was 35% in 2011.<sup>18</sup> Half of the late diagnoses (23.4% of overall sample) were classed as a very late diagnosis, with CD4 less than 200. Men with late diagnoses were more likely to have never previously tested for HIV and to have been diagnosed in primary care or an acute setting.

Rectal Chlamydia and gonorrhoea infections were used as indicators of HIV risk assuming that the majority will have been acquired via UAI. It then follows that men presenting with repeated rectal infections should be considered as displaying ongoing HIV risk. A fifth of CNR Group A men were diagnosed with two or more rectal STIs over the two year review period and these men were more likely to live in areas of social deprivation (SIMD 1 or 2), to have experienced poor emotional wellbeing and report using saunas. A similar proportion of Group B men (17.9%) were co-infected with rectal Chlamydia or gonorrhoea at HIV diagnosis. A fifth of the high risk men living with HIV (CNR Group C) were diagnosed with two or more rectal infections over the two year review period. When prior STIs for this group were reviewed 50% of the men in Group C had a rectal STI prior to the start of the two year review period. This subset of men were more likely to go on to have multiple STI infections over the two year review period; to report having casual partners prior to STI diagnosis; to have partners of mixed serostatus; and to report use of saunas or PSEs.

Despite attempts to foster a culture of minimum twelve monthly sexual health screening amongst gay and bisexual men in both Health Boards in recent years, there was little evidence that this behaviour had been adopted by the high risk men identified in the case note reviews. In CNR Group A 43.3% of men were diagnosed with the indicative STI after symptoms prompted them to attend for screening. A similar proportion of men in CNR Group B were diagnosed with HIV following symptoms of HIV or STI infection prompted a HIV test or sexual health screen. Partner notification also played an important role in encouraging men to engage with services for testing, with just over a quarter of men in Group A diagnosed with their rectal infection following partner notification and almost a third of men diagnosed with HIV as a result of partner notification. These observations indicate that a large proportion of high risk men, who consider themselves to be HIV-negative, are displaying more reactive approaches to their sexual health. From the FAQ work men also report that attendance at a sexual health service is also related to a perceived STI risk rather than a proactive regular attendance.

Men living with HIV, however, were more likely to be asymptomatic at diagnosis of their rectal STIs and less likely to have been prompted to screen following partner notification. This difference is likely due to the higher level of engagement with services and the move to offer sexual health screens routinely to people living with HIV via their HIV clinics. The staff interviews, case note review and FAQ work also raised concerns that the provision of sexual

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<sup>17</sup> These associations were found when infrequent testers were compared to men who had a record of a recent HIV test within the year prior to diagnosis with rectal STI/HIV.

<sup>18</sup> Health Protection Agency [http://www.hpa.org.uk/webc/hpawebfile/hpaweb\\_c/1317137200016](http://www.hpa.org.uk/webc/hpawebfile/hpaweb_c/1317137200016)

health care in HIV clinics was inconsistent and opportunities were being missed to facilitate discussions and to support men with their concerns about relationships, risk reduction and sexual health.

Across the CNR there was inconsistent recording of the offer, uptake and outcome of interventions, thus making it difficult to assess the current impact and acceptability of current interventions. For motivational interviewing and risk reduction in particular there was a lack of detail of the outcome of discussions, which led to missed opportunities for staff to revisit or continue discussions about planned behaviour change at subsequent visits.

There was a mixed approach to engaging with sexual health care across the three CNR groups. Men diagnosed with a rectal STI but who were HIV negative (Group A) mostly attended centrally located generic sexual health services/clinics over the two year period, with half of Group A men exclusively attending generic sexual health services over the two years. Exclusively attending generic sexual health services was associated with bisexual behaviour; reporting inconsistent or no condom use for anal sex; requesting a sexual health screen when symptomatic; and never having tested for HIV prior to diagnosis with the indicative rectal STI. Whereas men who exclusively attended targeted MSM services tended to be older and report high numbers of sexual partners.

Men living with HIV and diagnosed with a rectal STI (Group C) had the option of receiving sexual health care via their HIV service, and this appeared popular with two fifths mostly/always receiving care this way. However a further two fifths of Group C men took a mixed approach using both their HIV clinics and specialist sexual health services over the two years. In general these men were more likely to attend a specialist sexual health service when they were symptomatic, and most of the HIV clinic care concerned asymptomatic screening.

#### **4.4. IDENTIFIED NEEDS AND IMPLICATIONS FOR PLANNING, PREVENTION AND SERVICES**

On review of the five strands of research a number of sub groups of men and behaviours were identified which should serve to influence the design and targeting of future HIV preventions interventions. The research also highlighted a number of practice points that services could consider introducing in future. This section will discuss the needs of the sub groups of men which have been identified; the behaviours which appear to be influencing HIV risk and need to be addressed; and finally the practice points raised across the strands of research which should be considered.

## 4.4.1. SUB GROUPS OF MEN AT RISK

**FIGURE 8 – SUBGROUPS OF MEN WITH INCREASED RISK**

	MRC Gay Men's Survey	Clinical staff engagement	CNR Group A	CNR Group B	CNR Group C	FAQ
Never engagers/testers						
Infrequent engagers/testers						
Men living with HIV						
Men newly diagnosed with HIV						
Young MSM						
Bisexual/report mixed gender partners						
Men in relationships						
Men with poor emotional wellbeing/mental health						
Vulnerable men with complex needs						
Men with repeated rectal STIs						

It would appear that the current specialist sexual health services are successful in encouraging men who access services to test for HIV. However there are a significant group of men who have yet to engage with our sexual health services, and therefore yet to test for HIV. Never testing or engaging with services was associated with late HIV diagnosis, highlighting why this group of men should be a priority for future prevention work. The research has provided some indication of the demographics of never testers, suggesting they are more likely to be younger (under 26 years old), reside in rural areas and to report bisexual behaviour. This may suggest that they experience structural barriers to accessing services, or that poor knowledge contributes to low perceptions of their risk of acquiring HIV. However more work is needed to better understand what prevents or delays these men from accessing sexual health and HIV services, so that these factors can be addressed.

There is a small minority of men who engage with sexual health services but have yet to test for HIV. However it is clear that staff in clinical services are attempting to support these men to take their first HIV test.

A second group of men of concern are those men who do engage and have tested for HIV but who do not test as frequently as we would wish. These infrequent testers were more likely to reside outside of the cities; to be older (over 26 years old); and to reside in areas of social deprivation (SIMD 1 and 2). Although we can not infer causality it is possible that these factors may influence men's engagement with testing and may need to be considered for future interventions. There is a clear need for future prevention work to foster a culture of routine sexual health/HIV screening amongst MSM. Specialist sexual health services have an important role in this task as these men do engage with these services, if infrequently. Services could consider reviewing and improving existing recall systems. However community level interventions such as social marketing would reach men not engaging and would reinforce the work in services.

A subgroup of men living with HIV were shown to have ongoing sexual health needs which are not currently being adequately met by services. These men report high numbers of sexual partners, concurrency and UAI, and use of saunas, cruising areas and internet technologies to meet sexual contacts, and a large proportion of them are diagnosed with repeated rectal STIs. Although many report serosorting and that this is the most common facilitator of UAI, many of these men report that this behaviour is linked to poor emotional wellbeing, feelings of low self worth or fear of disclosure or criminalisation. There was little evidence in the Case Note Reviews that HIV services were consistently discussing sexual health, relationships and risk reduction with HIV-positive men despite the finding that two fifths of the high risk HIV-positive men almost exclusively receive sexual health care via their HIV clinic. Staff also raised concerns about the low prioritisation and inconsistent approach to sexual health within HIV services. HIV clinics have a clear role to play in supporting men living with HIV to maintain good sexual health and wellbeing, to feel confident in reducing their risks of onward transmission and supported to have fulfilling sexual lives.

There was also an inconsistent approach to the recording of risk reduction, sexual health and relationships with men newly diagnosed with HIV. Two fifths of new diagnoses were in relationships at the time and two fifths reported that they felt the need to abstain from sex as they struggled to adjust to their diagnosis and the anxieties of disclosure, onward transmission and criminalisation.

There is a clear need to inform newly diagnosed men about risk reduction, to address these anxieties and to support them to have sexual relationships if they wish to have them.

Across sources young men (less than 26 years old) were identified as in need of some attention. Young men reported high numbers of sexual partners and UAI but low awareness or perception of HIV risk and poor knowledge of HIV prevention. In particular young MSM in the case note reviews were more likely to report having UAI based on how well they knew a partner and associated assumptions, rather than knowledge of their own or partner's HIV status. Young men were more likely to have never previously tested for HIV at diagnosis with the indicative rectal STI or HIV. Future HIV prevention work should target young MSM, in particular before sexual debut, to raise awareness of HIV risks, and to equip young men with the skills to negotiate the sex and relationships they want, to reduce risk of acquiring HIV and to instil a culture of regular sexual health screening, which includes HIV testing. Sexual health services have an important role in identifying young MSM at their first engagement with services, however other young people's services could be recruited or new interventions designed to reach younger men before sexual debut.

Clinical staff raised particular concerns about bisexual men and men who may not claim that identity but report sex with both men and women. There were concerns that these men were poorly informed about HIV and poorly equipped to reduce risks. Men who behaved bisexually were more likely to have never previously tested for HIV or

engaged with services at diagnosis with rectal STI or HIV, and yet accounted for one in ten of new HIV diagnoses. The FAQ community engagement process has gone some way to identify the needs of men who have sex with men and women and the barriers they identify to engagement to HIV prevention and sexual health services for these men, however ongoing consultation and engagement with bisexual men will provide further useful information

Men in relationships were found to report ceasing condom use with a partner as a symbol of trust and commitment however few men reported testing for HIV prior to this decision. A sizeable proportion of men at risk in relationships reported that they had concurrent sexual partners. Often this was within the context of an open relationship with their partner, or that as a couple they had threesomes with casual contacts. Men usually described a risk reduction agreement that condoms would be used with these casual contacts, however also reported that in reality these agreements were hard to maintain. Future HIV prevention services should aim to reach men in relationships, to encourage HIV testing prior to ceasing condom use, possible via couple's testing clinics, and also by facilitating discussions about the risks of current risk reduction strategies for those with open relationships, supporting men to increase the effectiveness of their agreements with partners.

Poor emotional wellbeing was reported by a substantial proportion of men at higher risk of HIV transmission across the case note reviews, and was raised as an important factor by clinical staff. Low mood, poor self esteem and loneliness were described as impeding men's ability to negotiate condom use, or that a need for intimacy overrode a desire to reduce HIV risk. Men reporting poor emotional wellbeing were more likely to be diagnosed with repeated rectal STIs, to report never using condoms for anal sex and to have infrequent engagement with specialist sexual health services. Men living with HIV disclosing poor emotional wellbeing or mental health concerns were more likely to be offered a referral to further psychological support. However there is a lack of services to refer HIV-negative men on to, and the thresholds of current psychological support services are too high. There is a need to consider the impact of poor emotional wellbeing in the design of future HIV prevention services. Services should seek to routinely enquire about men at risk's overall wellbeing both in specialist sexual health and HIV services.

A group of vulnerable men with complex needs as a result of multiple co-occurring psycho-social and behavioural risk factors were identified. These factors included experience of intimate partner violence or other forms of abuse; mental health concerns; homelessness; involvement in prostitution; joblessness and learning disabilities, and others. There was evidence from NHS Lothian that an individualised case work approach, whereby services worked together to support an individual by ensuring they were linked to appropriate support both within and outside specialist sexual health and HIV services, was successful. Given the complexity of their needs, these men would likely benefit from more intensive one-to-one support which focuses on the concurrent issues which are impacting on sexual risk taking.

A significant number of both HIV-positive and negative men were diagnosed with repeat rectal STIs, and indication of ongoing UAI. Repeat rectal STIs amongst high risk HIV-negative men were associated with social deprivation, poor emotional wellbeing, high numbers of sexual partners and use of saunas, whereas men living with HIV diagnosed with repeated rectal STIs were more likely to report casual partners, partners of mixed serostatus and to report using saunas or cruising areas. Repeated rectal STI infections could serve as a marker for clinical services to identify men at ongoing risk who could be offered targeted intensive HIV prevention interventions.

## 4.4.2. SEXUAL BEHAVIOURS INFLUENCING HIV RISK

**FIGURE 9 – EVIDENCE MATRIX: SEXUAL BEHAVIOURS INFLUENCING HIV RISK**

	MRC Gay Men's Survey	Clinical staff engagement	CNR Group A	CNR Group B	CNR Group C	FAQ
<b>Concurrency</b>						
<b>UAI related to intimacy</b>						
<b>UAI and travel</b>						
<b>Sex with a partner with an age gap of more than 10 years</b>						
<b>Serosorting</b>						
<b>Group sex and sex parties</b>						
<b>Saunas, cruising areas and internet technologies</b>						

Reporting concurrent sexual partners was a common behaviour amongst HIV- positive and negative men, and among men in and out of relationships. Men in relationships often describe having risk reduction agreements with partners to always use condoms with casual contacts, however many find this difficult to maintain. Other men, in particular men living with HIV and older men, report regular sex with 'friends' alongside casual partners. Sex with 'friends' is viewed as low risk and therefore often condomless. Alongside the low levels of consistent condom use reported amongst high risk men these behaviours are of concern. Men need to be informed about the heightened risk of concurrency, and supported to make informed decisions about reducing their risk. Clinical services have a role in facilitating such discussions.

Intimacy was found to play a role in men's decisions about the use and non-use of condoms for anal sex. Men in relationships were found to report that ceasing condom use symbolised trust, intimacy and commitment within their relationships, yet few reported HIV testing prior to this move. As noted above it was also common for men to report sex with 'friends' and describe the assumptions that are made that this is low risk as they trust their friend, but again they do not report any discussion about HIV status or recent testing. Men also continue to make assumptions based on someone's appearance, character or the non-disclosure of being HIV positive, as the basis for condomless sex. There is a need to encourage men to question the safety of these assumptions, and equip them to find more effective ways of reducing their risks. In particular men in relationships should be encouraged to view joint HIV testing before ceasing condom use as cementing trust and commitment and an accepted stage of gay relationships.

High-risk men also reported having higher numbers of partners and UAI when travelling. Often this was whilst on holiday, in particular in Spain, but also whilst travelling for work. Other large European cities were popular destinations. Men seemed unaware of the higher prevalence of HIV amongst these urban European MSM communities.

Given the assumed difference in HIV prevalence amongst different age groups, the observation that at least a fifth of men in the Case Note Review Group A reported sexual encounters with a partner with a significant age gap may be of concern, when considered alongside the high rates of UAI.

Although serosorting is believed to be a valid HIV transmission risk reduction strategy for men living with HIV, when partnered with high rates of UAI, it is still high risk for other STIs. The men living with HIV reporting high rates of UAI were found to also report high levels of serosorting in our samples. They were also diagnosed with high rates of repeat rectal STIs. More concerning was the finding that serosorting was often attributed to poor emotional wellbeing rather than positive informed choices. Men living with HIV require ongoing access to high level sexual health care, which considers the emotional impact of life with HIV and supports men to have the sex and relationships they want, whilst reducing the risks of acquiring STIs or onward transmission of HIV.

Group sex, in particular threesomes, seemed popular amongst men in relationships. Men described meeting these casual contacts online or in bars or clubs, and that this was a routine component of some men's sexual relationships. Amongst men living with HIV there were reports of a growing trend for sex parties, again often facilitated by the internet, and offering a safe means of serosorting, often involving multiple partners in one night, alongside illicit drug use and alcohol consumption. Clinical staff should be aware of the prevalence of these behaviours and be equipped to discuss the risks involved with men, to support them to maintain their sexual health.

Staff view cruising websites and smart phone applications as playing a major role in facilitating anonymous casual sex. These technologies are also believed to be contributing to sex addiction and for some men the disassociation from their behaviour, instead blaming the technology for risk taking. Alongside the rise in popularity of internet cruising, staff have witnessed a decline in use of PSEs. Saunas are thought to have remained popular, in particular with men living with HIV and older men. Men living with HIV are also more likely to report use of saunas, PSE and internet based technologies, reporting that they facilitate anonymous sexual encounters, without the need for serostatus disclosure and also that they are a safe means of facilitating serosorting. These environments remain important foci for HIV prevention work. As they become better equipped to discuss how venue or mode of meeting partners may influence HIV risk there is also a need to ensure that an interest in these issues does not come across to men as ill-informed or judgemental.

#### *4.4.3. PRACTICE POINTS FOR HIV/SEXUAL HEALTH SERVICES*

Offer of and access to free condoms was reported as having the most reach with men at risk of HIV. This service should be continued and its reach with MSM at risk of HIV transmission enhanced.

Staff recognised that the focus of clinical discussion with men is usually on last or most recent sexual activity and also information on tests, which can sometimes prevent discussion of the individual's sexual lifestyle and ongoing behaviour. This was also evident in what was recorded in case notes. It was generally agreed there was value in exploring and attempting to address the context of risk, pleasure and behaviours, however there wasn't always space to do this within clinical services. It is suggested that this should be rebalanced.



For HIV services, staff and the CNR raised concerns about the lack of integration of sexual health care with HIV care, which led to inconsistent level of care for individuals across HIV services. Further integrating or more consistently incorporating sexual health care with HIV care would support effort to promote sexual wellbeing amongst men living with HIV, and provide a consistent approach to addressing sexual risk behaviours.

There is little assessment of HIV prevention skills, such as condom use or negotiation skills, for men using clinical services. Clinical services could do more to support men in building skills. From the FAQ community engagement work we also know that condom use is impacted upon by loss of erection and so in addition to skills men may also need to discuss pleasure, intimacy and what condom use means to them.

There was a view across both the staff interviews and Case Note Reviews that all contacts with men should be viewed as an opportunity for an intervention. Sexual health services in both Health Boards have introduced motivational interviewing as a behaviour change intervention. There was poor recording of the detail of such discussions, such as outcomes or planned behaviour change. This created missed opportunities to revisit or reinforce these discussions at subsequent engagements. It is clear that NaSH is a useful tool for making this information accessible for future engagements.

More generally across the CNR there was poor recording of offers and outcomes of interventions or referrals. It was therefore difficult to assess the current reach and uptake of interventions and referrals. Mechanisms which would accurately gather this information should be considered.

Given the higher incidence of poor emotional wellbeing and mental health HIV positive men require ongoing discussion about their overall mental health and wellbeing, so that they can be signposted to appropriate support.

Partner notification was a useful tool for engaging men at high risk with sexual health services, as demonstrated in CNR Group A. However amongst men newly diagnosed with HIV and those living with HIV and displaying ongoing risks, there is potential to expand this intervention. It seems that men living with HIV encounter barriers to engaging with partner notification which should be investigated and addressed.

During the CNR, staff interviews and the FAQ community engagement work it became apparent that both sexual health services have a group of highly skilled and experienced staff who can successfully engage men in meaningful discussions about their behaviours, build relationships and identify men requiring referral on to more specialist support. The future role of this group of staff should be reviewed and opportunities to expand their capacity to engage with higher risk men investigated.

The difficulty encountered generating an accurate list of HIV positive men diagnosed with rectal STIs highlights a need to review how the sexual health of men living with HIV is accurately monitored.

There was great variation in recording of sexual behaviours of newly diagnosed HIV positive men prior to diagnosis. Men who had never previously engaged or tested for HIV would be of particular interest. This intelligence would be an invaluable source of information for HIV prevention planning and for the evaluation of the reach and impact of existing prevention services. It seems that HIV services have a role to play in collating this information and feeding it back into the planning structures in each Health Board.

#### **4.5. REMAINING UNANSWERED QUESTIONS**

Although we have gained a far richer knowledge of the prevalence of behaviours, risk reduction strategies and psycho-social factors reported by men, the inconsistent approach in clinical services to exploration and recording of these factors in case notes, means there is scope for improving our knowledge further.

Never testers/engagers remain a key target of future HIV prevention work, it is important that we build on the picture we now have from across the Needs Assessment about barriers to testing and sexual health services, particularly for more vulnerable men. In particular there would be great benefit in routinely exploring what prevented men newly diagnosed with HIV from testing or engaging with specialist sexual health services prior to HIV diagnosis.

The research to date has focused on men at high risk but it has been unable to explore how these men, their behaviours and engagement with services may differ from men at lower risk of HIV transmission. Further, there may be benefit in investigating the traits, behaviours and resiliencies which contribute to reduced HIV risk for some men.

## 5. CONCLUSIONS AND RECOMMENDATIONS

### CONCLUSIONS

#### FACTORS THAT IMPACT ON HIV RISK BEHAVIOUR

- MSM experience discrimination and prejudice throughout their lives because of their sexual identity. This can result in feelings of isolation and powerlessness which impact on all aspects of life, including decision making and risk in relation to sex and relationships.
- **Men living with HIV** bear an additional burden of stigma and discrimination relating to their HIV status which compounds earlier experiences of discrimination in relation to sexual identity.
- **Mental health problems** are associated with social isolation and ongoing risk behaviours. We do not deal with this adequately within current sexual health services.
- **Alcohol**, for a large proportion of men, and drugs, for a smaller number of men, impacts on men's intentions and abilities to look after their sexual health.
- **Deprivation** is associated with a range of poor emotional wellbeing, problematic alcohol consumption, experience of abuse or violence, less frequent HIV testing and engagement with specialist sexual health services. However, there appears to be no association between socio-economic deprivation and *acquiring* HIV. There is some evidence however, that men from areas of socio-economic deprivation have poorer outcomes once diagnosed.
- Men who have experienced **violence and childhood sexual abuse** report that these experiences impact on their adult sexual lives. Sexual health services do not appear to enquire about this with the same level of care as when these issues are reported by women.
- Men who experience **more than one of the factors** described above, such as mental health problems, drug and alcohol use, and a history of violence and abuse, have complex needs and require intensive support. These needs become more pronounced the more these experiences overlap. For men with overlapping vulnerabilities, the risks they are taking with their sexual health are a symptom of wider needs.
- During the course of the needs assessment, the researchers became aware of wider international research describing '**syndemics**' of similar factors relating to MSM which our findings appear to support.
- Thus, a holistic approach to the sexual health and sexual rights of gay and bisexual men (whatever their HIV status) is necessary and means that services need to understand the context within which men live their sexual lives.

#### ANAL SEX AND CONDOMS

- An understanding of **anal sex and its meaning for men** is crucial in understanding the motivations for condomless anal sex. Most - but not all - MSM have anal sex.
- For most men that have anal sex, it forms an important and **central aspect** of their sexual lives and they would welcome discussions about what anal sex means to them within clinical settings
- For men that do not have anal sex or for whom anal sex is of less importance, their sexual decision making takes place within a wider context in which there is an **expectation from others** of anal sex.
- Some men report they have only ever had information about anal sex from **pornography** rather than (factual) information from a trusted source which is specific to their needs.
- Men report that they rarely discuss anal sex openly with each other because of **embarrassment, shame or taboo** around anal sex.

- The need for **intimacy** and other emotional factors influence the choices men make around condom use for anal sex.
- There is little evidence of men discussing HIV status of partners prior to participating in condomless anal sex.
- The FAQ online work found that only 55% of men report always using condoms for anal sex when insertive and 58% when receptive.
- A significant proportion of men report **problems with condom use**, particularly those younger than 35. While some problems indicate a skills or knowledge gap around condom use, a significant reason given for not using condoms is loss of erection.

### HIV TESTING

- The majority of men who engaged with FAQ (in interviews and online) had previously tested for HIV; however their HIV testing patterns and motivators to test were varied.
- A minority of men reported routine testing, but common motivators for most men included a recent episode of sex deemed 'risky' or symptoms of an STI.

### CULTURE

- From the FAQ community engagement work we know that men make **assumptions about HIV status**, yet report that knowing a partner's HIV status is an important component of sexual decision-making.
- There is an expectation among HIV negative/untested/presumed negative men that men living with HIV should disclose their status in all sexual encounters, however, **men living with HIV experience stigma** if they do disclose it.
- Young men in particular say HIV status matters and they want to know the status of a sexual partner, however there is no evidence that they have discussions about HIV status with partners.
- **Apps and social networking sites** play a considerable role in facilitating men's sexual lives.

### YOUNGER MEN AGED 25 AND YOUNGER

- Younger men were shown to be a vulnerable group with distinct HIV prevention needs; they are **very sexually active** with high numbers of partners and condomless sex episodes. They appear **less aware of risk** and less well equipped to reduce their risk.
- Most men report that their **first experience of anal sex** was as a teenager, with around 15% of men who engaged with FAQ reporting being aged 15 or younger the first time they had anal sex.
- Many young men are curious about anal sex; some feel anal sex is expected of them; others see it as a rite of passage. Early experiences can be enjoyable but can also be characterised by secrecy and a lack of control particularly where there is a significant age difference.
- The majority of men report they **lacked information on anal sex** prior to their first experience, particularly if their first experience was at a younger age.

### MEN IN RELATIONSHIPS

- For many men in relationships, **condomless anal sex is an expression of intimacy and trust** in that relationship; in the same way that condomless sex can be for heterosexual couples. However, there is a high proportion of men in relationships reporting concurrent sexual relationships with other men, either individually or together with their partner.

- 43.6% of MSM newly diagnosed with HIV were **in a relationship at the time of their diagnosis**. In addition 39.8% of HIV negative men diagnosed with a rectal STI were in a relationship at the time of diagnosis (Group A men).
- Most men in open relationships report that they made **sexual agreements** with their partners about sex with other men; however in many cases the agreements are not clear or are not spoken about after the initial agreement.
- There are also men in relationships whose concurrent relationships have **not been agreed** with their primary partner and are covert.
- Men in relationships often report condomless sex within their relationship and view this as low risk, yet also report **being unaware of their partner's HIV status** or that of other (concurrent) sexual partners.
- Men in relationships report that agreements about condom use with men other than their partner can be difficult to sustain.
- Most men in open relationships would be happy to discuss their relationships when attending a sexual health service but may not do so for **fear of judgemental attitudes and responses from clinic staff**. In particular men fear that clinic staff will not understand or support their decisions about condom use (where they do not use condoms with a partner but do with other men).

#### **BISEXUAL MEN AND MEN WHO HAVE SEX WITH MEN AND WOMEN (MSMW)**

- MSMW are **less likely to attend** sexual health services.
- MSMW are less likely than other MSM to wish to talk about anal sex at sexual health services.
- **MSMW face discrimination, stigma and unhelpful assumptions** about their sexual identity, not only from wider society but also from gay men.
- Men who have sex with men and women form **11% of new diagnoses of HIV in MSM**. There is a broad spectrum of identities and behaviours for men who have sex with men and women and we do not fully understand the unique range of needs this group has. We know, however, that there is a lack of engagement from these men with services, and that services themselves are not sufficiently informed about what these men specifically require.

#### **MEN NEWLY DIAGNOSED WITH HIV**

- MSM living in Greater Glasgow and Clyde and Lothian NHS Board areas are, on average, diagnosed with HIV at a **later stage of infection than MSM in the rest of the UK**.
- The men most likely to be diagnosed with HIV are **white, urban dwelling and aged 26 to 45**, although there is a growing number of younger men acquiring HIV who form a quarter of new diagnoses.
- Two fifths of men newly diagnosed with HIV had **never previously engaged** with specialist sexual health services and a third had **never previously tested** for HIV prior to diagnosis.
- Two fifths of men newly diagnosed with HIV were **in a relationship** at the time of their diagnosis.

#### **MEN LIVING WITH HIV (MLWHIV)**

- MLWHIV experience a disproportionately high burden of rectal STI's. **1 in 5 of all rectal STI in MSM** occur in MLWHIV; 1 in 4 occur in those men aged 26 and older.
- Among MLWHIV who acquired a recent rectal STI, **nearly half had a detectable HIV viral load** (*Viral load was taken as the last reading potentially known to the men, i.e. their last viral load check prior to their diagnostic screen*) and were therefore potentially infectious to others. Further work is required in order to understand why viral load has not been suppressed in these men who have already been diagnosed: for

- example, these men may be at an early stage of HIV infection and not yet receiving treatment, or may have fallen out of care and returned to care due to acute rectal symptoms.
- MLWHIV diagnosed with an indicative STI were significantly **younger** (43.3% of the Group C men where aged 35yrs or under compared to 18.8% of all MSM who attended HIV treatment and care Jul 12 to Jun 13) and had been **living with HIV for less time** than the wider HIV positive MSM cohort.
  - MLWHIV report that they experience **enduring stigma and discrimination** from other MSM and risk rejection if they disclose to sexual partners.
  - Men who are HIV negative/presumed HIV negative/untested can use the term 'clean' to describe an HIV negative status; this language is indicative of **ignorance or prejudicial views**.
  - A large proportion of MLWHIV attempt **serosorting**. For some, the motivations for this behaviour indicate social isolation, poor emotional wellbeing and the experience of rejection and discriminatory attitudes expressed by negative or presumed negative MSM.

## ABOUT SERVICES FOR MEN WHO HAVE SEX WITH MEN

### STAFF UNDERSTANDING AND SKILLS IN DISCUSSING ANAL SEX AND CONDOMS

- For those men who have anal sex, it is a marker of intimacy and source of pleasure but the perception from men is that **services generally problematise it around HIV/STI transmission**.
- There is potential to improve our discussions with men in services around condomless anal sex. **Engagement with men** will ascertain the importance that anal sex represents for them. Men who do not wish to have anal sex may need services to support them to build confidence to challenge assumptions, expectations or demands of sexual partners.
- Few men report experience of discussing **personal HIV risk reduction strategies** within clinical settings, beyond condom use for anal and oral sex.
- The intervention most frequently offered to men by services is to use **condoms**.
- Men report that they **do not use condoms for oral sex**.
- Men told us that services continued to suggest condoms for oral sex as a prevention strategy for HIV
- Focussing on oral sex as a route of transmission for HIV; this is misleading and diverts attention away from effective risk reduction strategies.

### STAFF UNDERSTANDING AND SKILLS IN DISCUSSING SEX WITHIN RELATIONSHIPS

- Men are concerned that sexual health service staff do not understand **the meaning of ceasing condom use** within relationships, which can symbolise intimacy, trust and commitment between partners.
- Routinely recommending condom use within relationships when men want to stop, risks alienating men and is perceived as **devaluing a method of establishing trust within a relationship**.
- Men would be happy to and would welcome **discussions about open relationships** in sexual health services, although some fear judgemental attitudes and responses from staff.

### STAFF UNDERSTANDING AND SKILLS IN RELATION TO DISTINCT GROUPS OF MEN

- High levels of **problematic alcohol use** were found which impairs men's intentions and abilities to look after their sexual health. Services do not appear to have considered how to respond to this and current thresholds which trigger intervention may be too high.

- There is growing concern that a small number of men are using drugs such as crystal meth and new generation **recreational drugs**. This can have a major impact on individuals and services are not currently geared up to respond adequately to this.
- There is inadequate discussion about men's **mental health** and services are responding poorly to this area of need.
- Rectal STI diagnosis, in particular **repeat rectal STI diagnosis**, can serve as a useful marker of men at higher risk in need of more targeted interventions.
- When rectal STI diagnosis was compared by serostatus, MLWHIV were more likely to have screened asymptotically and within their HIV clinic. This suggests that **sexual health screening within HIV clinics** is an important service for early detection and treatment of STIs and for engaging men who may not seek sexual health care independent of their HIV clinic.
- There is a need for increased awareness among staff of the needs of **young gay men** as it is evident that services do not respond to the needs of young men as they respond to young women. For examples, discussion about **coercion and pressure** that take place routinely with young women are unlikely to take place with young men.
- The needs of **bisexual men** or men who have sex with men and women are not well understood.
- MLWHIV report that they may **limit the information they share** with sexual health and HIV services for fear of judgement. Staff can also make assumptions that MLWHIV are sufficiently informed about how to maintain a healthy approach to sex when, in fact, there are considerable sexual health needs which are not met consistently.
- There is no evidence from men participating in FAQ of services enquiring about experiences of **childhood sexual abuse in services**.
- Staff can have a poor level of knowledge and understanding of the **apps and websites** men use to facilitate sexual contacts.

## RECORDING

- Gaps remain in our understanding of need. This could be addressed through **improved recording** and appropriate sharing of anonymised information.
- The sexual health needs of men newly diagnosed with HIV and STI diagnoses amongst MLWHIV are **inconsistently recorded**. This reduces the ability to inform planning and service delivery and provide person centred care.
- There is a tension between the need to record the detailed clinical interactions with individuals and the need to provide a client centred experience. Via the FAQ community engagement process, men report concerns that some clinical engagement can feel like a **'tick-box' experience**. Other men feel more positively about an engagement when staff are more evidently talking and listening to them. Further exploration of ways to **manage recording without detriment** to the patient experience should be explored.

## MEN'S ENGAGEMENT WITH SERVICES

- On the whole, men report **positive experiences** of engaging with specialist sexual health services and value them highly. However, some do report judgemental, lecturing or rude experiences or that staff may have a poor understanding of gay and bisexual men's culture and sexual practices.



- Positive experiences help the individual to **build a relationship with a service** and with individual clinic staff and establish a pattern of attendance. Focussing on the individual's experience and needs, with a personalised, detailed discussion avoids the 'tick box' experience.
- Men endorsed the development of new aspects of clinic provision (as options and not mandatory requirements), which FAQ proposed to them. **Text and email reminders** to make or keep appointments and pre-consultation questionnaires are generally welcomed.
- **Telephone and online consultations** for men and a clearer welcome to the services for couples were seen by men as having both potential benefits and disadvantages.
- **Point of care/rapid HIV and STI testing** receives overwhelming support by gay and bisexual men who have engaged with FAQ.
- Current services do not reach a significant proportion of men at high risk. **Ongoing community engagement**, research, service reflection and evaluation will continue to build our understanding of barriers men continue to face regarding HIV testing and engagement with specialist sexual health services.
- Men tell us that they would value **counselling and mental health services** with specialist knowledge of HIV and gay and bisexual men's needs and lives.
- A majority of gay men like the option of attending a specialist gay and bisexual men's clinic.
- However, from the FAQ community engagement process, younger men express a preference for a targeted **younger gay and bisexual men's service** or for a generic young people's service. Bisexual men express a preference for services for all men or mixed gender generic services.
- MSM at high risk of HIV are likely to present to **mainstream sexual health services and general practice** and to seek help only when symptomatic. Interventions to support those at high risk must, therefore, extend beyond specialist MSM services to address the needs of men who are not currently served.
- Men at risk of acquiring HIV do not test for HIV as frequently as services currently advise and there was little evidence of high risk men displaying a proactive approach to their sexual health.
- Having a high risk of STI acquisition, infrequent HIV testing, or never being tested for HIV appears to be associated with **social deprivation** and with not accessing MSM specific services.
- **Partner notification for rectal STIs** is a useful process for engaging men at high risk with specialist sexual health services.
- Men newly diagnosed with HIV and MLWHIV diagnosed with other **STIs appear to experience challenges with partner notification** and were more likely to have declined to provide details of partners when compared to negative men, perhaps because they don't understand how it works, embarrassment and worries about personal confidentiality.
- The FAQ work identified that **talking out loud about their own risk behaviours has a therapeutic effect** for some men. 31 men who had described an incident of UAI with someone other than a long term partner, within the 12 months prior to interview one were interviewed a second time. Of these, 13 reported no UAI in between interview one and interview two, and described it as a deliberate effort to stay safe. 5 of the 13 referenced the phone interview as a catalyst for the change in behaviour. Additional to the 13, 4 men reported efforts to stay safe, but were not 100% successful.



## RECOMMENDATIONS

### ADDRESSING THE VULNERABILITIES WHICH CAN LEAD TO HIV RISK

- There is a need to consider the **impact of poor emotional wellbeing** in the design of future HIV prevention services.
- Sexual health and HIV services should **routinely assess the mental and emotional health of men** who report regular, unplanned condomless anal sex.
- Services should ensure a **tiered model of care** is in place to support men with mental and emotional health support needs.
- Sexual health and HIV services should implement **case management approaches** to support for men with multiple vulnerabilities.
- Both sexual health and HIV services should have the facility to offer **alcohol brief interventions** and, where necessary, refer men into more intensive alcohol dependency services.
- Both sexual health and HIV services should begin the process of gathering and monitoring information on the use of **novel psychoactive substances** in individuals.
- Services should ensure that **routine enquiry into experience of violence from sexual partners**, domestic abuse and childhood sexual abuse is provided equally to MSM as it is to women.
- The **diagnosis of a rectal STI** should trigger a more intensive package of HIV prevention support for MSM, which should include assessments for alcohol, mental and emotional health issues, and a shorter period of recall for follow up screening and for HIV negative men.
- Consideration should also be given to a **home supply of PEP** particularly for men in sero discordant relationships.
- A **holistic approach to the sexual health** and sexual rights of gay and bisexual men requires sexual health services to understand the context within which they live their lives, especially the impact of prejudice, discrimination and stigma.

### HIV PREVENTION INTERVENTIONS IN NON CLINIC SETTINGS

- The offer of, and access to, **free condoms** was reported as having the most reach with men at risk of HIV and this should continue. When condoms are being provided, the service should also talk about practical issues of fit and use, particularly with younger men.
- More needs to be done to work with men on an individual basis to explore the **psychological impact or meaning of condom use** as well as the perceived impact condom use may have on pleasure and intimacy.
- All health boards should consider including targeted and evidence based **emotional and mental health interventions in non-clinical settings**. Future HIV prevention services should aim to reach men in relationships and to encourage HIV testing prior to ceasing condom use, with the option of couple's services. They should also facilitate discussions about the risks of current risk reduction strategies for those in open relationships, supporting men to increase the effectiveness of their agreements with partners.
- There is a need to encourage men to **question the safety of the assumptions they make about open relationships**, and to equip them to find more effective ways of reducing their risks. In particular, men in relationships should be encouraged to view joint HIV testing before ceasing condom use as cementing trust and commitment and an accepted stage of gay relationships in the same way that screening is encouraged within heterosexual relationships.

- To match the shift in emphasis required within clinical services to **equip staff to discuss anal sex more openly** with men, social marketing approaches should be utilised to facilitate greater discussion, informed by the principles of pleasure, intimacy, trust and safety.

## IMPROVING ENGAGEMENT WITH SEXUAL HEALTH AND HIV SERVICES

- A significant proportion of men at risk of HIV **do not engage with specialist sexual health or HIV testing services**. Services need to keep finding new ways to better understand who these men are and what would overcome the barriers they face to engagement.
- Efforts to address the **barriers to attending services** should be undertaken with men who have never tested or who are infrequent testers for HIV. *A combination of social marketing, community engagement and community based outreach/services* should be utilised to support this.
- The FAQ approach has shown that **men are willing to engage** in both online and telephone discussion of sexual health and HIV issues. These models should be developed and evaluated within services.
- Services should also consider piloting and evaluating text and email reminders for routine sexual health screens, pre-consultation questionnaires for triage and couples appointments.
- Given their widespread use, apps and social networking sites should be considered a setting to improve reach as part of a combination prevention approach.
- Services need to **actively adopt community engagement** and outreach methods for younger MSM in order to address their barriers to engagement with HIV prevention and sexual health services.
- **Repeated rectal STI infections** should serve as a marker for clinical services to identify men at ongoing risk and who could be engaged in **targeted intensive HIV prevention interventions**.
- Services should be **discussing anal sex with men**, in the context of its meaning to men, not solely in reference to condom use. This will better allow services to successfully and meaningfully engage with men around effective HIV/STI prevention strategies.
- There needs to be a greater **focus on sexual health and relationships for MLWHIV**; this is particularly important in newly diagnosed men but is also an important part of ongoing HIV care.

## IMPROVING THE SKILLS AND UNDERSTANDING OF STAFF IN SEXUAL HEALTH & HIV SERVICES

- The case note reviews showed that sexual health services have a group of **highly skilled and experienced staff who can successfully engage men** in meaningful discussions about their behaviours, build relationships, and identify men requiring referral to more specialist support. The future role of this group of staff should be reviewed and opportunities to expand their capacity to engage with higher risk men investigated.
- Services should seek to **explore the context within which men have sex**, by discussing risk alongside pleasure and how and why a partner or setting may influence behaviour in order to provide more meaningful and personal discussions with men. This would require building staff confidence and capacity which will require staff training.

- **Services need to specifically talk with men about anal sex.** Conversations about anal sex should be framed by an acceptance of anal sex as a regular and important part of gay and bisexual men's sexual behaviour - if they choose to take part in it.
- Services should enhance their support to men in building HIV prevention skills, such as condom negotiation and addressing barriers to condom use.
- Staff training should focus on the verbal and non-verbal signals that may suggest judgemental attitudes towards men and their behaviour.
- Clinical interactions should focus on building potentially lifelong **relationships between men and their services** and delivering individualised person-centred care, whilst taking steps to make routine data collection less mechanical/tick box.
- Staff in services should **support men in relationships** to discuss and help make agreements about boundaries for themselves and for the relationship.
- Staff in services should use **discussions around intimacy**, trust and monogamy as a starting point for safety in relationships. Men should be helped to incorporate decisions around HIV testing and negotiated safety into their existing experiences.
- **Men in open relationships** who have not discussed sex with other men with their primary partner, or who have not agreed rules for sex outside the relationship, should be helped to initiate such discussion.
- Men need to be informed about the **heightened risk of concurrency**, and supported to make informed decisions about reducing their risk. Clinical services have a role in facilitating such discussions.
- **Partner notification for rectal STIs** should be enhanced and further work is needed to understand and address the barriers that men experience in relation to partner notification.
- Staff in services should incorporate discussion of apps and social media networks when exploring what men want from their relationships and sexual encounters and how these media may help or hinder their goals.
- Services should support men to reconsider some of the assumptions they make about **HIV status**.
- Services also have a role to play in discussing the language used in relation to HIV status and STI diagnoses to ensure that concepts of 'clean' (where men assume HIV status according to how a person looks) are actively challenged.

### IMPROVING SERVICES FOR YOUNGER MEN

- Services should seek to engage with young MSM **prior to their first sexual experience**.
- Services should **support school-based sexual health and relationship education** as well as encourage individual support from Pastoral Care staff who should support young gay/bisexual men to access the information and support they need.
- Services have a role to inform young men of the **pleasure, meanings and risks involved with anal sex**. They need to equip young men with the skills to negotiate the sex and relationships they want, to reduce risk of acquiring HIV and to instil a culture of regular sexual health screening, which includes HIV testing.

### IMPROVING SERVICES FOR BISEXUAL MEN AND MEN WHO HAVE SEX WITH MEN AND WOMEN

- Further **research and engagement** is required to inform service delivery and scope the potential for non-clinical service provision, specifically for bisexual men.

### IMPROVING SERVICES FOR MEN LIVING WITH HIV (MLWHIV)

- HIV services should do more to understand and meet the sexual health and wellbeing needs of men living with HIV. Services should be realigned to support **men living with HIV to maintain good sexual health**, which includes both reducing STIs and empowering men to have positive relationships and to maintain effective risk reduction strategies. Men newly diagnosed with HIV and those diagnosed with rectal STIs should be a particular focus for services.

### IMPROVING RECORDING WITHOUT COMPROMISING CARE

- There is a tension between the need to record the detail of behaviour change interventions within services, such as outcomes or planned behaviour change, and the ability to provide a **person centred package of care**. Further exploration of ways to manage both should be explored.
- The benefits of recording the detail of such discussions to facilitate **continuity of prevention related care** is evidenced in the case note reviews and attempts should be made to improve these. Services should consider utilising NaSH to facilitate reflection and follow up of behaviour change interventions at subsequent service visits.
- In undertaking the case note reviews it proved challenging to locate the case notes for men living with HIV diagnosed with rectal STI's. Electronic case note systems for men living with HIV should be reviewed and modernised to ensure up to date sexual health care needs are recorded and followed up.
- There was great variation in recording of sexual behaviours of newly diagnosed MLWHIV prior to diagnosis. Men who had **never previously engaged or tested for HIV** would be of particular interest. This intelligence would be an invaluable source of information for HIV prevention planning and for the evaluation of the reach and impact of existing prevention services. HIV services should collate this information to inform planning in each Health Board.

### STRATEGIC PLANNING FOR HEALTH BOARDS

- All health boards should ensure that their programmes of **mental health promotion interventions** include targeted work aimed at their LGBT populations that is relevant to the needs of MSM.
- All health boards should ensure that they utilise their partnerships with statutory and voluntary agencies to contribute towards **addressing homophobia and HIV stigma** in society with a priority focus on schools (and in terms of younger gay/bisexual men) parents and families.

### FUTURE RESEARCH

- The research to date has sought to focus on men at high risk of HIV infection but it has not specifically explored how these men, their behaviours and engagement with services may differ from men at low risk of HIV transmission. There may be benefit in investigating the traits, behaviours and resiliencies which **contribute to reduced HIV risk** for some men by acting as protective factors.