

Guidance on HIV Prevention in Men who have Sex with Men (MSM).

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Good
Practice
Guidance.

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Table of Contents

Acknowledgements	iv
Comments on the published guidance	iv
Abbreviations	v
Prologue	1
Section A – Context, Evidence and Engagement	2
A1. Aim of the Guidance	2
A2. Summary of Recommendations	2
Structural	2
Behavioural	3
Biomedical	3
A3. HIV Prevention Approaches for MSM	3
A4. The MSM Population: Data and Diversity	4
A5. Policy and Service Improvement Context	7
A6. Key Performance Indicators and Evaluation Outcomes	8
A7. Engagement of MSM in Intervention Development and Delivery	10
Section B - The Guidance Recommendations	10
B1. Recommendations on Structural Interventions	11
B2. Recommendations on Behavioural Interventions	13
B3. Recommendations on Biomedical Interventions	15
Appendix 1: Key Guidance, Policy and Standards Influencing the Development of Interventions	19
Appendix 2: Methodology Employed in Guideline Development	20
Appendix 3: Evidence Statements in support of Guidance Recommendations	22
Appendix 4: Guidance Development Group Membership	26
2018 Guidance update	26
2012 Guidance	26
Associate Members of Writing Group	26
Reference Group members	27

Appendix 5: Guidance Consultation List	27
Guidance consultation, 2018	27
Guidance consultation, 2012	28
Further Groups Contacted in Professional Consultation, Jan-March 2012	28
Glossary	29
References	31

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Comments on the published guidance

Comments on this guidance should be sent to the SHPN Guidance Group by emailing NSS.SHPN@nhs.net.

Abbreviations

ART	Antiretroviral Therapy
BASHH	British Association for Sexual Health & HIV
BBV	Blood Borne Virus
BHIVA	British HIV Association
BME	Black and Minority Ethnic
CAI	Condomless Anal Intercourse
CBT	Cognitive Behavioural Therapy
CEL	Chief Executive's Letter (guidance from Scottish Government)
GBL	γ -butyrolactone
GBV	Gender Based Violence
GHB	γ -hydroxybutyrate
GDG	Guidance Development Group
HIV	Human Immunodeficiency Virus
HPS	Health Protection Scotland
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
KPIs	Key Performance Indicators
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex
MSM	Men who have Sex with Men
NICE	National Institute for Health and Care Excellence
NPS	Novel psychoactive substance
PeP	Post-exposure Prophylaxis
PePSE	Post-exposure Prophylaxis for Sexual Exposure
PHE	Public Health England
PrEP	Pre-exposure Prophylaxis
PWID	People Who Inject Drugs
RCT	Randomised Control Trial
RSHP	Relationship, Sexual Health and Parenthood education
SIGN	Scottish Intercollegiate Guidelines Network
SIMD	Scottish Index of Multiple Deprivation
SHBBV	Sexual Health and Blood-borne Virus
STEI	Sexually Transmitted Enteric infection
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
WHO	World Health Organisation

Prologue

The transmission of HIV amongst Men who have Sex with Men continues to be a concern. Much has changed since the first edition of the Good Practice Guidance on HIV Prevention in MSM was published in 2012, however the number of MSM newly diagnosed with HIV shows no sign of sustained decline.

There have been numerous advances in the intervening six years, including the introduction of PrEP through the NHS in Scotland and UNAIDS' 90-90-90 target which has helped focus attention on treatment as prevention, and the crucial role of people living with HIV in the conversation about HIV prevention.

This document continues to place the model of combination prevention at its core. The three constituent elements of the model have been thoroughly revised and reordered with structural, behavioural and biomedical interventions presented in that order. Wellbeing in sexual health and the prevention of HIV cannot be produced and performed by any one single agent or agency, be that individual MSM, the NHS, or the third sector. A reduction in health inequalities is the foundation upon which further and individualised interventions are anchored.

The Guidance Development Group wishes to thank all those organisations who have contributed their support to produce this updated document. We hope it proves to be a useful guide and reference point for anyone planning HIV prevention services or activities.

Julian Heng

Chair of the Guidance Development Group

Section A – Context, Evidence and Engagement

A1. Aim of the Guidance

Men who have sex with men (MSM) continue to be a key population of concern in the epidemiology of Human Immunodeficiency Virus (HIV) in Scotland. They experience major inequalities with regard to HIV incidence.

This guidance is founded on the best available evidence on HIV prevention in MSM as well as expert opinion. It is intended to facilitate pathways to improve HIV prevention interventions, whether they are provided by statutory services or commissioned and subsequently delivered by either statutory or third sector organisations.

Implementing this guidance will:

- strengthen the commissioning and delivery process;
- inform service review and planning processes;
- inform policy development;
- ensure that interventions are evidence informed;
- ensure an authentic local approach (i.e. informed by a comprehensive, rigorous needs assessment and consultation process including a representative sample of MSM);
- strengthen the skills and expertise already in place within the third sector both locally and nationally; and
- aid accountability and audit to focus more attention on evaluation of intervention processes and outcomes.

The primary audience of this guidance is local NHS commissioners and those who deliver HIV prevention services and activities in clinical and non-clinical settings. It has been written to dovetail with other key Blood Borne Virus (BBV) and Sexual Health documents (See Section A5)

This guidance should also have influence beyond HIV prevention. It is noted that many MSM experience the burden of a syndemic effect upon their health and this guidance should also be considered within non HIV prevention services, for example, alcohol and drug, mental health, homelessness and Gender Based Violence (GBV) services.^{1:2}

A2. Summary of Recommendations

Structural

1. Ensure structural interventions are provided to address and redress health and societal inequalities which reinforce and perpetuate vulnerability. These are intersectional in nature, and require partnership working to create opportunities and achieve change.

A focused programme of Health Improvement is recommended which contributes to culture change.

2. Ensure that service design and intervention delivery take into account any barriers and vulnerabilities experienced by MSM, and have due regard to a range of structural interventions to ensure equity.

Behavioural

3. Ensure a range of behaviour change interventions are available, which are tailored to patient need and focus upon HIV risk reduction, for example, behavioural interventions to increase condom use, behavioural interventions to ensure compliance with pre-exposure Prophylaxis (PrEP), or behavioural interventions to arrange and seek regular HIV testing. Such interventions should include brief motivation-based interventions where applicable, delivered face to face by appropriately trained staff. More intensive psychological interventions should be provided for those with more complex needs such as those involved in chemsex, with experiences of addiction and/or poor levels of mental health.
4. Ensure that behaviour change interventions are grounded in evidence and theory and that the content and intensity of interventions are proportionate to need.
5. Ensure that behaviour change interventions are developed to increase HIV testing and address heterogeneity within the MSM population and the patterning of distinct barriers to testing.
6. Ensure that behaviour change interventions are delivered in ways which maximise population reach and minimise health inequalities amongst MSM.

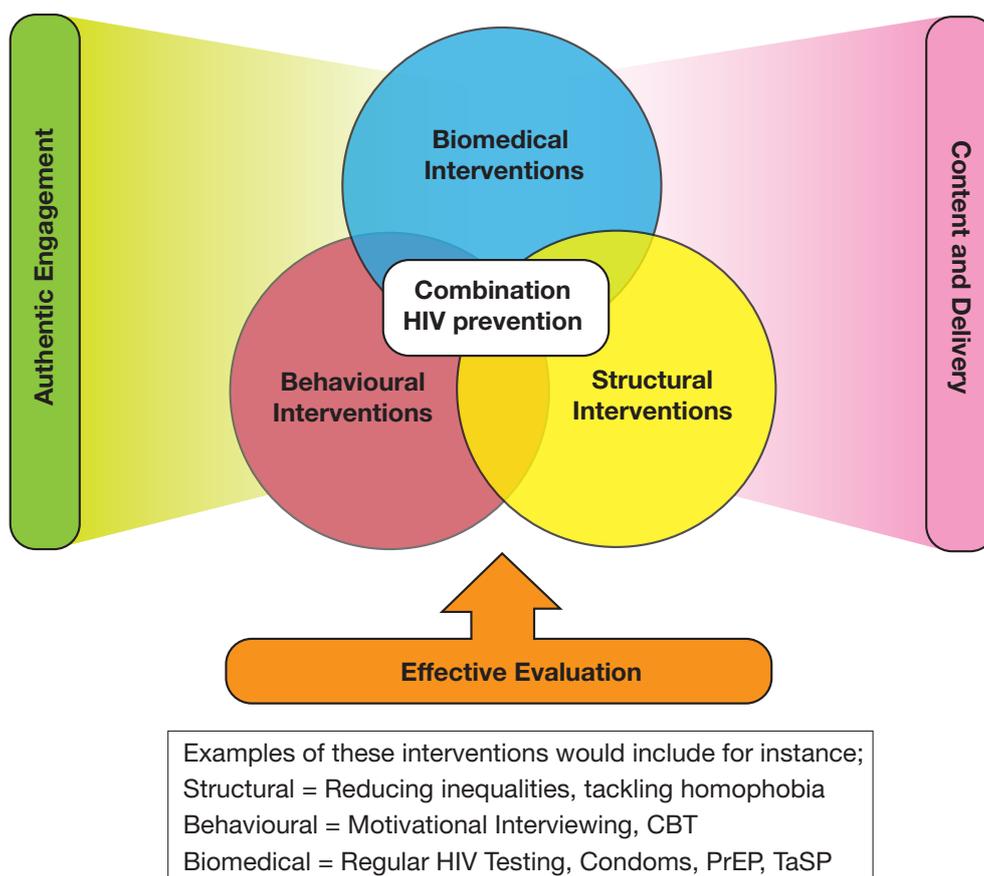
Biomedical

7. Ensure a range of HIV testing opportunities are available which meet the diverse needs of the entire MSM population.
8. Ensure that PrEP is readily available to all MSM at high risk of HIV acquisition
9. Ensure that a range of condoms and lubricant are provided and are made available in a variety of settings.
10. Ensure that HIV treatment as Prevention (TasP) and support for antiretroviral treatment adherence is provided as a key part of prevention.
11. Ensure MSM have access to routine comprehensive sexual health care.

A3. HIV Prevention Approaches for MSM

There is no single intervention - no 'magic bullet' - capable of eliminating onward transmission of HIV. Needs and skills can vary among MSM, as can the setting and level of intervention. Therefore, using a 'Combination HIV Prevention' approach is integral to this guidance (see Figure 1).

FIGURE 1: Combination HIV Prevention



Adapted from: Coates, Richter & Caceres (2008) Behavioural strategies to reduce HIV transmission: how to make them work better, Lancet, Published online August 6, 2008

In Scotland and elsewhere, MSM are a diverse population, with diverse needs. Critically, health inequalities between MSM vary by the intersection of other health determinants (e.g. deprivation, ethnicity, sexual identity, behaviour, HIV status, age, disability). Sexual ill health, HIV risk behaviours, HIV vulnerability and the locations used for meeting sexual partners are also patterned by these inequalities.

It is anticipated that a variety of approaches both across and within each of the three categories below represents a minimum standard of appropriate combination prevention. The cost and ease of implementation of the approaches outlined here varies considerably.

A4. The MSM Population: Data and Diversity

HIV transmission among MSM remains a serious public health concern and evidence from behavioural surveys and other infection data indicate that rates of casual unprotected sexual intercourse remain high.

Scottish national HIV surveillance data indicate that MSM comprise the largest number and proportion (50%) of annual HIV diagnoses. At the time of publication in 2018 there has been an average of 175 newly identified HIV positive individuals per year (over the past five years), two thirds of whom are newly diagnosed. Of those newly diagnosed, one in three has evidence of acquiring their infection within the last three to four months indicating ongoing

transmission in this population. While there was a noted decline in new diagnoses in 2016, this has not been sustained in 2017 and the data indicate a return to a similar number as that reported in previous years. The HPS website provides the [latest data](#).

While the annual number of HIV diagnoses remains stable, there has been a notable increase in other sexually transmitted infections (STIs) particularly infectious syphilis and gonorrhoea. The emergence of sexually transmitted enteric infections (STeIs) caused by *Shigella* species and Hepatitis A has also been reported. However, there is no evidence that these STeIs have increased in Scotland despite outbreaks in other UK and European countries. Since 2014, diagnoses of infectious syphilis and gonorrhoea, particularly rectal gonorrhoea, have increased reaching the highest levels recorded for several decades. These sustained high levels of infection are concerning as the likelihood of HIV transmission during untreated acute infection is increased in the presence of another STI,^{3,4} particularly ulcerative infections and rectal infections.

Furthermore, in a survey of a community sample of MSM in gay bars and clubs in Glasgow and Edinburgh, (unpublished) data from the 2014 MRC Gay Men's Sexual Health Survey⁵ indicate that a higher proportion of HIV negative men (19%) reported CAI with two or more partners in the previous year compared to that reported in 2011 (14%).

Knowing the needs of the local MSM population is crucial to effective intervention targeting. Needs assessment should be carried out as a standard methodical process by commissioners as they would with any local minority or vulnerable population to inform planning and improve effectiveness.

One key element to consider is the location in which, or mode by which, MSM meet each other for sex, for example:

- commercial LGBTQI venues and community events;
- the internet and mobile phone apps;
- public sex environments and venues (such as saunas, parks, beaches and lay-bys);
- private sex parties, including chemsex parties;
- instances of sex exchanged for payment.

The HIV Prevention Needs Assessment of Men Who Have Sex With Men¹ and the Social Media, Men Who Have Sex With Men, Sexual and Holistic Health (SMMASH 2)² documents together provide a detailed account of the various sub-populations of MSM with their attendant and particular HIV risk factors and broader life circumstances. It is important to think of MSM as a diverse population (not only as 'out' gay men) and acknowledge that use of these locations/modes is patterned by this segmentation, for example:

- younger men;
- men who have sex with men and women;
- men in a regular relationship with a man;
- men experiencing high risk condomless anal intercourse (CAI);

- men who test infrequently for HIV;
- men living with HIV;
- men with multiple vulnerabilities;
- men living in rural areas;
- black and minority ethnic (BME) men;
- asylum seekers and refugees; and
- transgender men.

To describe high risk CAI, it is important to note that the literature defines this as men who have had condomless anal intercourse in the last year with a serodifferent partner⁶ and without a suitable biomedical intervention to reduce the risk of HIV transmission such as PrEP or TasP. In addition, the SMMASH2 study² defined greatest HIV transmission risk as associated with:

- i) CAI with at least two partners, or
- ii) CAI with a casual partner, or
- iii) At least one CAI partner whose HIV status is unknown or serodiscordant to their own in the last 12 months.

To describe multiple vulnerabilities, it is also important to be aware of the following²:

- i) men living in areas of poverty (those living in the areas within quintiles one and two of the Scottish Index of Multiple Deprivation (SIMD) data);
- ii) men with one or more mental health problem;
- iii) men with behavioural or learning disabilities;
- iv) men experiencing problematic alcohol/drug use;
- v) men experiencing relationship abuse;
- vi) men experiencing homelessness;
- vii) men experiencing financial worries or unemployment;
- viii) men involved in prostitution.

These vulnerabilities can reduce an individual's resilience and ability to minimise harm to themselves, contributing to an increase in HIV transmission risk.

An appreciation of the diversity of MSM and its relevance for commissioning can be further developed through literature review, exploratory research, local engagement with MSM, and the agencies that represent them, as well as owners of settings and moderators of sites where MSM make contact.

A5. Policy and Service Improvement Context

The Sexual Health & BBV (SHBBV) Framework Update 2015-207 explicitly includes MSM as a population of focus within a wider context of sexual health, Hepatitis B and Hepatitis C. Continued focus on MSM through local interventions will therefore be a requirement by NHS Boards in meeting the framework objectives and indicators, to reduce BBV and STI incidence and prevalence, challenge stigma towards key minority populations and to reduce inequalities in health. Key performance indicators focused on HIV include:

- a reduction in HIV and STI incidence;
- a reduction in the number of people newly diagnosed with advanced HIV disease;
- an increase in the proportion of diagnosed HIV infected people receiving treatment; achieving a culture where sexual well being, sex free from coercion, harm, and sexual regret exist.

This guidance is intended to provide a useful contribution to ensure that local approaches can work towards delivering many of these key performance indicators; through guiding service content and delivery which targets MSM and ensure that wherever possible it is evidence informed. These indicators also compliment the wider context of viral hepatitis prevention and sexual health improvement.

HIV Testing Guidance by National Institute for Health and Care Excellence (NICE)⁸ is intended to increase focus and effectiveness of testing through a range of settings and approaches and makes specific recommendations on:

- offering and recommending HIV testing in different settings;
- increasing opportunities for HIV testing;
- promoting awareness and uptake of HIV testing;
- reducing barriers to HIV testing.

Parallel public health guidance by NICE on the most appropriate means of generic and specific interventions to support attitude and behaviour change^{9;10} and their assessment of community engagement and community development approaches¹¹ are also relevant wider guidance documents to consider when designing and delivering interventions.

In summary, this guidance should be considered in conjunction with:

- Healthcare Improvement Scotland's HIV Standards¹² (as it does not duplicate the relevant quality statements);
- British HIV Association (BHIVA)/British Association for Sexual Health and HIV (BASHH) Guidelines on HIV Testing¹³;
- BHIVA/BASHH/FSRH guidelines for the sexual and reproductive health of people living with HIV 2017¹⁴;
- BHIVA/BASHH guidelines on the use of HIV pre-exposure prophylaxis 2017¹⁵;

- BASHH Safer Sex Advice Guidance¹⁶;
- BASHH Guidelines on Sexual Health Care of MSM¹⁷;
- NICE Guidance on HIV Testing: Increasing Uptake Among People Who May Have Undiagnosed HIV⁸;
- The Sexual Health and Blood Borne Virus Framework 2011-15/2015-20 Update^{7;18};
- Chemsex healthcare guidance detailing effective interventions, pathways and support for men with experience of chemsex.¹⁹

It also complements British Psychological Society Standards on Psychological Support for People Living with HIV,²⁰ UNAIDS 90-90-90 target and their Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations,²¹ WHO Recommendations on HIV Prevention Approaches for MSM and Transgender People,²² and PHE's Promoting the Health and Wellbeing of Gay, Bisexual and other MSM Action Plan.²³

A6. Key Performance Indicators and Evaluation Outcomes

Given the shared goal of sexual health improvement within this guidance and the Sexual Health and Blood Borne Virus Framework,^{7;18} and the resulting commissioned interventions, it is important to consider the KPIs/outcomes (Table 1) that can be employed within intervention design and evaluation.

The outcomes selected will be determined by the needs of the local MSM population, the content of the chosen intervention and what it is expected to affect. While some interventions may conceivably set behavioural outcomes as their goal, for the most part, only large-scale, resource intensive combination HIV prevention approaches can expect to achieve measurable changes in biological outcomes.

Reducing HIV incidence at a population level requires the combination of behaviour change and biomedical interventions e.g. frequent HIV testing to enable early detection, initiating and maintaining PrEP or good adherence to antiretroviral therapy (ART) in those diagnosed with HIV to deliver wider TasP.

Table 1: Sexual Health and Blood Borne Virus Framework outcomes

Sexual Health and Blood Borne Virus Framework Outcome	Representative indicator
Outcome 1: Fewer newly acquired BBVs and STIs	Diagnosis of rectal gonorrhoea in MSM Rates of transmission of HIV in Scotland Delivery of Relationship, Sexual Health and Parenthood education (RSHP) and BBV education in line with Curriculum for Excellence
Outcome 2: A reduction in the health inequalities gap	Rates of regular HIV testing Rates of PrEP therapy prescribed Proportion of individuals, diagnosed with HIV, attending specialist HIV services
Outcome 3: People affected by BBVs lead longer, healthier lives	Proportion of new HIV diagnoses with advanced disease HIV infected individuals, eligible for HIV therapy, receiving it HIV infected individuals eligible for therapy: uptake of, and response to ART
Outcome 4: Sexual relationships are free from coercion and harm	Level of sexual regret Level of sexual wellbeing Level of gender based violence
Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive	Acceptability of services to those living with, or vulnerable to, poor sexual health and/or BBVs Awareness and understanding in the general population of the positive and life enhancing aspects of sex and good sexual health Awareness and understanding in the general population of BBVs including transmission, treatment and complex long-term health outcomes Positive portrayal of sexual health and BBVs in the media

A7. Engagement of MSM in Intervention Development and Delivery

Balancing evidence informed ideas for interventions with direct involvement of MSM is crucial to effective design, delivery and acceptability of local interventions. Secondary and tertiary level specialist clinical services, social marketing materials and policy development will all be improved and be person-centred if the intended target audience inform the intervention content and delivery. This can occur at early or advanced stages of development and can also be a crucial aspect of evaluation. Methods to achieve this may include research, robust partnerships with local third sector organisations and peer engagement with a broad and representative cross-section of the target population. Further to the public health guidance on community engagement by NICE stipulated above, a range of guidance, policy and standards contextualise and strengthen this involvement at every stage of intervention design, delivery and evaluation. [Appendix 1](#) outlines details of key documents.

Section B - The Guidance Recommendations

Across the ‘combination prevention’ approach outlined in Figure 1, the quality of evidence on effectiveness varies considerably across the types of intervention. Some interventions have no high level quality evidence illustrating their effectiveness but are nonetheless logical, plausible and necessary (see Table 6 for detail). As a result the recommendations detailed below can be considered as pragmatic; they are ‘evidence-informed’ rather than strictly ‘evidence-based’.²⁴

When planning local approaches it is important to acknowledge that there are difficulties in distinguishing between categorisation of HIV prevention interventions. Implementing interventions requires a multi-level process and a holistic understanding of intervention delivery.²⁵ For example, implementing biomedical approaches necessarily involves engaging with an array of psychosocial, behavioural and structural processes (e.g. the acceptability of condoms, or beliefs around an individual’s capacity to take a HIV test).

The recommendations below can all be considered as acceptable and are likely to be effective amongst diverse populations with the majority of them requiring regular audit or evaluation. Due consideration for the transferability of interventions across international contexts is also required.

Using the Evidence

This guidance utilises a framework based upon the Scottish intercollegiate Guideline Network (SIGN) 50: A guideline developer’s handbook. See [Appendix 2: Methodology Employed in Guideline Development](#) for further information.

Although this guidance is ‘evidence informed’ rather than ‘evidence based’, where possible the degree of evidence available to support recommendations is provided. Supporting evidence statements for each recommendation can be found in [Appendix 3: Evidence Statements in support of Guidance Recommendations](#).

B1. Recommendations on Structural Interventions

The evidence supporting a broad range of structural interventions which encompass a wide variety of cultural, social, economic and political determinants is presented. (See Appendix 3 for supporting evidence tables).

Structural interventions often rely on different evidence compared to biomedical and behavioural interventions, which are less amenable to Randomised Control Trial (RCT) designs for ethical and pragmatic reasons.

Structural interventions work primarily at a whole population level and are broadly community facing, minimising and reducing the societal factors which contribute to vulnerability. In this way, some aspects of structural interventions are for everyone, i.e. to combat homophobia and heterosexism, wider Scottish culture has to change. Structural interventions aim to redress the social inequalities which create vulnerability such as poverty, poor literacy, gender based violence, substance use, homelessness, poor mental health, stigma and discrimination, thus allowing the individual to better manage any risk.

1. Ensure structural interventions are provided to address and redress health and societal inequalities which reinforce and perpetuate vulnerability. These are intersectional in nature, and require partnership working to create opportunities and achieve change. A focused programme of Health Improvement is recommended which contributes to culture change.

EXPERT SUMMARY 1

Structural interventions need to address the wider social and cultural determinants of HIV risk-related behaviour amongst MSM (e.g. through challenging heteronormativity and homophobia whilst simultaneously acknowledging the heterogeneity of MSM populations and promoting social inclusion and well being).

Structural interventions to reduce inequalities should commence in early years, with appropriate parenting programmes and early protective messages, such as consent and respect. RSHP education in schools should be inclusive of LGBTQI identities and contain information and advice which is both identity appropriate and age/stage appropriate. A recent report by LGBT Youth Scotland details a range of structural factors which impact on this population.²⁶ A range of campaigning work is recommended to actively challenge HIV stigma and homophobia across all sectors.

Services working with either adolescents or adults should incorporate learning about the health and wellbeing of MSM within their core staff training on health and equalities. Key messages should be consistently articulated to staff within sexual health, mental health, alcohol and drug and criminal justice services. Content should include harm reduction information, pathways to local treatment and care services, pathways to local social support, as well as the socio-cultural factors which contribute to vulnerability and influence poor health.

2. Ensure that service design and intervention delivery take into account any barriers and vulnerabilities experienced by MSM, and have due regard to a range of structural interventions to ensure equity.

EXPERT SUMMARY 2

The SMMASH2² study highlighted that 44.9% of the sample reported multiple vulnerabilities (498 men), where these were defined as:

1. Living in the poorest areas of Scotland
2. At least one mental health issue
3. Behavioural or learning disabilities
4. Problematic alcohol consumption
5. Relationship abuse
6. Homelessness
7. Unemployment
8. Involvement in prostitution.

Additionally, the HIV Prevention Needs Assessment of Men Who Have Sex with Men¹ highlighted (from a case note review of men who attended treatment and care services within Greater Glasgow & Clyde and Lothian NHS board areas) that 28% of MSM newly diagnosed with HIV had two or more vulnerabilities, including problematic alcohol use, low self esteem, mental health problems and experience of violence and childhood sexual abuse. This phenomenon is conceptualised as a syndemic effect.

Access for MSM most in need can be achieved through appropriate service design and a programme of health improvement which encompasses:

- Challenging stigma, discrimination, homophobia and gender based violence
- Contributing to cultural change, allowing effective communication around sexual health and relationships
- Service redesign and delivery within the community, which utilises local population data to target vulnerable MSM
- Comprehensive programme of staff training on the sexual health needs and priorities for MSM, including training on the determinants of vulnerability.

B2. Recommendations on Behavioural Interventions

Structural interventions are largely concerned with equality of opportunity for HIV prevention. Behavioural interventions focus upon the uptake and maintenance of other HIV prevention approaches (e.g. seeking regular HIV testing, using condom or compliance with PrEP). Behavioural approaches also detail how biomedical approaches should be implemented - ensuring that efficacy is translated into effectiveness often through the behaviour change of staff involved in HIV prevention. These recommendations relate firstly to general principles of behaviour change, and secondly, where evidence is available (See [Appendix 3](#)), to more specific areas of HIV prevention.

3. Ensure a range of behaviour change interventions are available, which are tailored to patient need and focus upon HIV risk reduction, for example, behavioural interventions to increase condom use, behavioural interventions to ensure compliance with pre-exposure Prophylaxis (PrEP), or behavioural interventions to arrange and seek regular HIV testing. Such interventions should include brief motivation-based interventions where applicable, delivered face to face by appropriately trained staff. More intensive psychological interventions should be provided for those with more complex needs such as those involved in chemsex, with experiences of addiction and/or poor levels of mental health.

EXPERT SUMMARY 3

Behaviour change interventions that focus upon HIV risk reduction are effective, although evidence of long-term effectiveness is lacking. A range of behaviour change interventions of varied intensity is likely to be useful to capitalise on the reach of structural interventions and maximise the use of biomedical interventions. In this way once people are in touch with services their engagement with biomedical interventions can be enhanced through behaviour change interventions delivered across a range of modalities and various staff. There is evidence to suggest that interventions which are theoretically based are more effective than those that are not. Evidence suggests that behaviour change techniques associated with goals and planning, feedback and monitoring, identity and social support may represent particularly important intervention content. Effective interventions should also clearly demonstrate cultural competencies with regard to MSM sub-cultures.

4. Ensure that behaviour change interventions are grounded in evidence and theory and that the content and intensity of interventions are proportionate to need.

EXPERT SUMMARY 4

Behaviour change interventions are known to be successful and cost effective at reducing HIV risk behaviours. Behaviour change interventions must address the inequalities that exist within the MSM population. HIV prevention is enacted and maintained in different ways across MSM, with younger men, men with lower educational qualifications, BME men, men from rural areas and men who do not use the gay scene often displaying increased HIV risk. In this way, targeting different groups of MSM with diverse behaviour change interventions, ranging in focus and intensity, may reduce these health inequalities and enable all men to access services and the full range of biomedical prevention approaches.

NICE guidance¹⁰ on behaviour change interventions provides a comprehensive approach to planning, commissioning and delivering behaviour change interventions. This includes the need to consider commissioning high quality, effective behaviour change interventions; (i) using proven behaviour change techniques when designing interventions; (ii) ensuring interventions meet individual needs; (iii) delivering very brief, brief, extended brief and high intensity behaviour change interventions and programmes, and (iv) commissioning training for all staff involved in helping to change people's behaviour.

5. Ensure that behaviour change interventions are developed to increase HIV testing and address heterogeneity within the MSM population and the patterning of distinct barriers to testing.

EXPERT SUMMARY 5

Interventions to increase HIV testing amongst MSM should target diverse groups of MSM in relation to different barriers to testing (e.g. fear of positive result following a perceived risk event; low perceptions of risk because of low HIV literacy and geographic factors reducing access to clinics), choices of testing approach (e.g. self-testing; self-sampling and point of care) and distinct sub-populations (e.g. first time testers and those who haven't tested for a while²⁷). Social marketing interventions engaging MSM with testing should include the segmentation and targeting of these MSM populations to enable wide reach and engagement amongst diverse MSM. For some populations, self-sampling or self-testing may overcome particular barriers to HIV testing.

6. Ensure that behaviour change interventions are delivered in ways which maximise population reach and minimise health inequalities amongst MSM.

EXPERT SUMMARY 6

The ways in which HIV prevention behaviour change interventions are delivered can impact upon their effectiveness. Key decisions in implementing these interventions relate to the form of intervention delivery, particularly whether multiple modes of delivery can be used to maximise reach and engage those experiencing the greatest health inequalities. Particular attention should be paid to variation in digital literacy, health literacy and HIV literacy. The full range of delivery options should be considered (online, face to face and provision of clinical outreach) and the positioning of intervention materials within appropriate environments. Multi-modal interventions may be the most appropriate but will require the most resource.

Although biomedical prevention is available across Scotland, it is currently under-utilised and improvements are needed. Behaviour change interventions must ensure MSM are informed about HIV and use the wide range of HIV prevention services. Data from surveys in Scotland between 2011-2013 show appropriate testing is reported by less than a quarter of MSM.²⁸ Equally data from the SMMASH2² study shows 37% of the sample reported high risk condomless anal sex. Furthermore 6% of the whole SMMASH2 sample reported sexualised chemsex drug use in the last year. Little data is currently available about the underuse of PrEP as a HIV prevention intervention for those who are eligible to use it.

B3. Recommendations on Biomedical Interventions

These recommendations relate to the main biomedical interventions used within HIV prevention in developed countries. A number of interventions have a substantial evidence base of the highest level (RCT based evidence) to support their utility. Others are not supported by high level evidence of effectiveness, but are recommended on the basis of being robustly ‘tried and tested’, or simply both logical and plausible.

7. Ensure a range of HIV testing opportunities are available which meet the diverse needs of the entire MSM population.

EXPERT SUMMARY 7

The UNAIDS 90-90-90 strategy to help end HIV transmission recommends that 90% of people living with HIV are aware of their status. Early diagnosis offers the individual clinical benefits but also the possibility of treatment as prevention. The BASHH UK National Guideline on the sexual health care of MSM summarizes the evidence for frequency of HIV testing in MSM.

Annual STI testing including HIV is recommended to all sexually active MSM other than those with one long-term mutually exclusive partner of more than two years. There is insufficient evidence to suggest a more frequent testing interval should be applied to all MSM and risk-factor based testing is likely to be more clinically and cost-effective than universal interval testing^{29;30}. Subgroups of MSM in which three monthly STI testing including HIV should be offered include (for strength of recommendation and evidence see references):

- CAI with partners of unknown or serodiscordant status over the last twelve months
- More than ten partners over the last twelve months
- Use of methamphetamine or inhaled nitrates during sex over the last six months
- Use of γ -butyrolactone (GBL), ketamine or other novel psychoactive substance (NPS) over the last six months
- Multiple or anonymous partners since last tested.

A range of testing interventions should be available to address the heterogeneity of MSM. Opt-out testing is the appropriate approach for MSM in all settings. Opportunities for additional HIV testing in MSM in settings other than sexual health services should be expanded. Additionally, point of care testing for HIV in community settings should be developed and made available. HIV self-testing and home sampling may be recommended as a supplementary strategy to combat some of the recognised barriers to testing. However, in respect of self-testing, consideration should be given to the need for confirmatory testing, prevention, and linkage to treatment and care services.

8. Ensure that PrEP is readily available to all MSM at high risk of HIV acquisition.

EXPERT SUMMARY 8

PrEP (on demand or daily oral PrEP, or other options as available) should be offered to HIV negative MSM who are identified as being at high risk of HIV acquisition through CAI. PrEP should also be offered to HIV negative MSM whose regular partners are newly diagnosed with HIV infection until the partner's serum viral load reaches undetectable levels.

The PROUD and IPERGAY studies both showed an 86% reduction in HIV seroconversions with oral tenofovir/ emtricitabine in clinical trials.

PrEP eligibility criteria for MSM in Scotland are defined as:

- You are 16 or over
- You test HIV negative in a clinic
- You can attend for regular reviews every three months
- You are willing to stop taking PrEP if you become no longer eligible in the future
- You live in Scotland.

And also one of the following:

- Your sexual partner is HIV positive and has a detectable viral load
- You have had a rectal STI in the last year or you have had CAI with more than one person in the last year and are likely to do so again in the next three months.
- You are at an equivalent high risk of HIV acquisition, as assessed by two specialist clinicians.

Information and advice on the availability of PrEP prior to sexual exposure should be available to all MSM at high risk of HIV acquisition through all services providing sexual health care. PrEP provision should also include condom provision, regular HIV testing and behavioural support, thus providing a range of preventative benefits, including:

- Targeting and screening of the highest risk PrEP candidates.
- Initiating of care and subsequent retention within specialist sexual health services.
- Optimal adherence to drug regime to maximise HIV prevention, and motivation to persist with PrEP use as long as it is clinically indicated.

Demand for Post Exposure Prophylaxis for Sexual Exposure for HIV (PEPSE) is likely to reduce with increasing PrEP uptake. However it remains an important prevention intervention and may offer a gateway to services and to follow-on PrEP provision in men who do not meet the full eligibility criteria for PrEP on presentation and are at high risk due to an infrequent episode of CAI, or who may have other vulnerabilities and who present acutely at times of crisis. In these circumstances, PEPSE should continue to be offered as an emergency measure, rather than as a regular method of preventing HIV transmission. As with PrEP, PEPSE does not protect against other STIs.

9. Ensure that a range of condoms and lubricant are provided and are made available in a variety of settings.

EXPERT SUMMARY 9

There is a vast amount of high quality evidence available to indicate that the use of condoms reduces the risk of HIV transmission amongst heterosexual couples and a comparable effect has been observed for MSM. Use of non-oil based lubricants has been shown to decrease the chance of condom tearing during anal intercourse.

Free condom distribution schemes are known to be effective in increasing condom use uptake. Although no strong evidence is available for condom distribution via postal delivery schemes, this may be considered as an additional option for increasing condom uptake. Condoms should be made available in a variety of settings e.g. where sex takes place, as well as in gay venues and at events.

It is also suggested that a range of condom types and sizes are provided, as well as non-oil based lubricant.

10. Ensure that HIV treatment as Prevention (TasP) and support for antiretroviral treatment adherence is provided as a key part of prevention.

EXPERT SUMMARY 10

When ART results in viral suppression, defined as less than 200 copies/ml or undetectable levels, it prevents sexual HIV transmission. Across three different studies, including studies of MSM having anal sex without the use of condoms or PrEP, no HIV transmissions to an HIV-negative partner were observed when the HIV-positive person was virally suppressed. This means that people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2017, BHIVA and the SHPN SHBBV HIV Clinical Leads endorsed the Undetectable Equals Untransmittable (U=U) Consensus Statement produced by the [Prevention Access Campaign](#).

All MSM who are newly diagnosed with HIV should be offered TasP. This relies upon MSM being able to readily access opportunities for testing and diagnosis, and timely linkage with treatment and care services. Increased rates of HIV testing combined with initiation of TasP at diagnosis would be likely to lead to substantial reductions in HIV incidence. Increased condom use should be promoted to avoid the erosion of the benefits of treatment and to prevent other STIs.

11. Ensure MSM have access to routine comprehensive sexual health care.

EXPERT SUMMARY 11

Given the high rate of HIV transmission occurring immediately after STI acquisition, comprehensive sexual health care provides opportunities both to detect HIV infection and to test for and treat other STIs including Syphilis and Hepatitis C, which could otherwise

increase the risk of both HIV transmission and HIV acquisition. It also confers further opportunities for prevention through the offer of vaccination for Hepatitis A, Hepatitis B, and the Human Papilloma Virus (HPV) for eligible MSM, minimising the risk of co-infection and facilitation of HIV transmission. Routine comprehensive sexual health care also provides an opportunity to discuss a range of risk factors which can contribute to HIV transmission, including participation in chemsex and also group sex, recreational drug use, and hazardous binge drinking.

Clinical services that are identified as MSM-specific can contribute to increased attendance at specialist sexual health services alongside approachable core services and the provision of services by a range of other stakeholders including the voluntary sector.

Appendix 1: Key Guidance, Policy and Standards Influencing the Development of Interventions

- **The Equality Act, UK Government, 2010**
<https://www.gov.uk/guidance/equality-act-2010-guidance>
- **The Scottish Health Council's Public Involvement and Participation Standard**
http://www.scottishhealthcouncil.org/patient_public_participation/participation_standard/participation_standard.aspx
- **The NHS Scotland Quality Strategy**
<https://www2.gov.scot/Topics/Health/NHS-Workforce>
- **The Scottish Community Development Council's National Standards for Community Engagement**
<http://www.scdc.org.uk/what/national-standards/>
- **The NHS QIS Clinical Governance and Risk Management Standards (CGRM)**
http://www.healthcareimprovementscotland.org/previous_resources/archived/clinical_governance_and_risk_m.aspx.
- **The Scottish Government's CEL on 'Informing, engaging and consulting people in developing health and community care services'**
https://www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf
- **Better Together: Scotland's Patient Experience Programme**
<https://www2.gov.scot/Publications/2009/07/08114927/0>
- **Visioning Outcomes in Community Engagement (VOiCE)**
<http://www.scdc.org.uk/what/voice/>
- **Checking for Change: A Building Blocks Approach to Race Equality in Health**
<http://www.healthscotland.com/equalities/race.aspx>
- **The Patients' Rights (Scotland) Act**
<http://www.legislation.gov.uk/asp/2011/5/contents/enacted>

Appendix 2: Methodology Employed in Guideline Development

The 2012 guidance represented the view of a multidisciplinary group convened in Scotland under the auspices of the Health Protection Network (HPN). The guideline development group (GDG) followed a systematic development framework proposed by the HPN in line with the principles of SIGN methodology. The grading of evidence is detailed in Appendix 3 by use of evidence statements to support this guideline's recommendations. As part of this methodology, the evidence level of each source of literature was also categorised as detailed in Table 2 and collectively graded for each recommendation as per Table 3.

For consistency, the 2018 guidance followed the same methodology, with a review being conducted by a reformed GDG, convened under the SHPN. This document has been labelled as Good Practice Guidance (GPG) – Category B, in the [SHPN Framework for Health Protection Guidance Development](#) – as it is based, primarily, on good practice recommendations. It is accepted that these recommendations are determined from scientific evidence, colloquial evidence (particularly, expert opinion) and other types of non-scientific evidence.

TABLE 2: Evidence level criteria as per SIGN 50 Guideline Developer's Handbook

Evidence Level	Sign 50 Criteria
1++	High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+	Well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
1 -	Meta-analyses, systematic reviews, or RCTs with a high risk of bias
2++	High quality systematic reviews of case control or cohort studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2 -	Case control or cohort studies with a high risk of confounding or bias and significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series, qualitative research
4	Expert opinion

TABLE 3: Recommendation grading criteria, SIGN 50 Guideline Developer’s Handbook

Grading	SIGN 50 Criteria
A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+
X	Good practice points

Recommended best practice based on the clinical experience of the guideline development group.

Recommendations given in this guideline resulted after careful review and consideration of the evidence available and principles of best practice. It is ‘evidence based’ where possible and ‘evidence informed’ where necessary.

For the 2012 guidance the evidence base was synthesised from three sources.

- 1) A systematic review of reviews commissioned specifically for this guidance development;³¹
- 2) the United Kingdom National Guideline on safer sex advice (2012)¹⁶; and
- 3) additional focused searches and evidence scoping within the grey literature by the GDG.

The GDG agreed that given problems with extracting directly useful and transferable knowledge from some of the review level evidence, the proportion of recommendations which are not supported by high level evidence but that do relate to common sense, logic or inherent problems with operationalising interventions within an evidence-based framework, the GDG made a pragmatic decision not to grade individual recommendations, but to grade the supporting evidence statements utilising a framework based upon SIGN 50: a developer’s handbook.

For the 2018 review, literature searches concentrated primarily on review level evidence where available, as well as information from key guidance documents published since 2012.

Appendix 3: Evidence Statements in support of Guidance Recommendations

Table 4: Structural Recommendations Evidence Statements

These evidence statements relate to **Recommendations 1 and 2**.

Related Evidence Statement	Grade	Reference/s
<p>Combination prevention relies on evidence informed, strategic and simultaneous use of complementary behavioural, biomedical and structural prevention strategies.</p> <p>Particular attention should be paid to the roles of income inequality, stigma and discrimination, violation of human rights, and social marginalisation. National plans should include specific population and geographic priorities, articulate causal pathways, describe how synergies among different prevention strategies will be captured and maximized, and set clear, time-bound targets for coverage, quality and impact.</p>	(D)	32
<p>Immediate and sustained attention to guaranteeing the scale-up of sustainable HIV and STI prevention structures for MSM is needed to enable and empower communities of men to access the services and information needed to maximise their sexual health and to reduce HIV and STI acquisition and transmission. In addition to the provision of the combination of interventions, national activities will be most effective if implemented alongside interventions to eliminate structural barriers, the reduction of stigma and discrimination, and involvement of the men that the services intend to reach.</p>	(D)	33
<p>There are three distinct but overlapping areas in which MSM bear a disproportionate burden of ill health: sexual health and HIV, mental health and in the use of alcohol, drugs and tobacco. By identifying and tackling the structural and direct determinants behind these areas, it is considered that specific inequalities can be reduced and the general health and wellbeing of MSM can be improved.</p>	(D)	34
<p>The Needs Assessment highlighted several areas that HIV prevention services need to focus and outlined numerous recommendations relating to improving:</p> <ul style="list-style-type: none"> • HIV prevention interventions in non clinic settings • Engagement with sexual health services • Services for younger men, bisexual men and men who have sex with men and women • Staff training working in sexual health services • Strategic planning for health boards, particularly in relation to mental health promotion interventions and those helping to address homophobia and HIV stigma. 	(D)	1

Table 5: Behavioural Recommendations Evidence Statements

Related Evidence Statement	Grade	Reference/s
RECOMMENDATION 3		
A range of behavioural interventions should be made available, which are tailored to patient need and focus upon HIV risk reduction (e.g. condom use, PrEP or regular HIV testing). These should include brief motivation-based interventions delivered face-to-face by appropriately trained staff and more intensive CBT for those with more complex needs such as those involved in chemsex.	(A)	9;31;35-37
RECOMMENDATION 4		
Behavioural interventions are known to be successful and cost effective at reducing HIV risk behaviours.	(A)	38-40
Behavioural interventions should address the inequalities that exist within the MSM population.	(A)	36;41-43
RECOMMENDATION 5		
Behavioural interventions should aim to increase HIV testing heterogeneity within the MSM population and reduce testing barriers.	(B)	8;27;44-48
RECOMMENDATION 6		
Behavioural interventions should be delivered in ways which maximise population reach and minimise health inequalities amongst MSM.	(A)	25;49-52

Table 6: Biomedical Recommendations Evidence Statements

Related Evidence Statement	Grade	Reference/s
RECOMMENDATION 7		
Annual HIV testing is considered beneficial for groups with high HIV prevalence, and more frequently for individuals at higher risk of HIV acquisition.	(D)	8;17
Testing those at high risk every 3 months is considered to result in cost saving when compared with annual testing.	(D)	29;30
Provide a range of interventions to promote testing to accommodate differences in populations, choices of testing approaches and differences in barriers to testing.	(D)	27
HIV self-testing is associated with increased uptake and frequency of testing. Such increases, particularly among those at risk who may not otherwise test, will likely identify more HIV-positive individuals as compared to standard testing alone.	(B)	53

Related Evidence Statement	Grade	Reference/s
Self-sampling kits may be considered for people in groups and communities with a high rate of HIV. Home sampling should be made available as an option for testing to all MSM.	(D)	8;17
For further specific information on various aspects of testing see: 2016 United Kingdom national guideline on the sexual health care of men who have sex with men.	N/A	17

RECOMMENDATION 8

PrEP has been shown to be effective in a number of studies. See 2016 United Kingdom national guideline on the sexual health care of men who have sex with men for further details.	(A)	17;54
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RECOMMENDATION 9

The male latex condom reduces the transmission of HIV in heterosexual couples, including those who have anal sex.	(A)	55
There is also evidence for a comparable effect in MSM.		56
Female condoms confer as much protection from STIs as male condoms.	(A)	57-60
Thicker condoms are no less likely than standard condoms to break or slip off during anal sex.	(B)	61
Non-oil based lubricant and condoms should be used for anal sex.	(B)	61
Free condom distribution to settings where sex takes place increases condom use.	(B)	62
Condom by post delivery schemes increases condom use.	(X)	No specific evidence, but logical, good practice and theoretically plausible.
Providing a range of condom sizes is a quick and more practical alternative to formal condom sizing.	(X)	No specific evidence, but logical, good practice and theoretically plausible.

RECOMMENDATION 10

HIV transmission from HIV-infected study participants to their partners was not observed when viral replication in the treated individual was stably suppressed by ART.	(A)	63
Much higher rates of HIV testing combined with initiation of treatment at diagnosis would be likely to lead to substantial reductions in HIV incidence. Increased condom use should be promoted to avoid the erosion of the benefits of treatment and to prevent other STIs.	(C)	64

Related Evidence Statement	Grade	Reference/s
RECOMMENDATION 11		
<p>For further details see 2016 United Kingdom national guideline on the sexual health care of men who have sex with men which outlines recommendations on:</p> <ul style="list-style-type: none"> • Access to sexual health care • Identification of problematic recreational drug and alcohol use • Testing for asymptomatic STI's 	N/A- various	17

Appendix 4: Guidance Development Group Membership

2018 Guidance update

Colin Anderson Senior Health Promotion Officer for Blood Borne Viruses and Sexual Health, NHS Lanarkshire (Chair February 2017- August 2017)

David Bingham Health Promotion Manager, Terrence Higgins Trust

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Catherine Courtney Sexual Health Team Leader, NHS Lanarkshire

Julian Heng Health Improvement Lead, Sexual Health, NHS Greater Glasgow & Clyde (Chair August 2017-June 2018)

Paul Flowers Professor of Sexual Health Psychology, Glasgow Caledonian University

Lesley Wallace Principal Healthcare Scientist, (Blood Borne Virus and Sexually Transmitted Infection team), Health Protection Scotland

Fraser West, Healthcare Scientist for the Scottish Health Protection Network, Health Protection Scotland (From 28th May 2018)

Adriana Zalewska, Healthcare Scientist for the Scottish Health Protection Network, Health Protection Scotland

2012 Guidance

Primary Authorship

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Colin Anderson Senior Health Promotion Officer for Blood Borne Viruses and Sexual Health, NHS Lanarkshire

Nick Putnam Learning Development Officer, HIV Scotland (from Jan 2011)

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Marion Henderson Programme Leader for Sexual Health, MRC/CSO Social & Public Health Sciences Unit, Glasgow (Until March 2011)

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Steve Bagley GUM Consultant, NHS Grampian

Dan Clutterbuck GUM Consultant, NHS Borders / NHS Lothian

Noel Gill Health Protection Agency (Until Dec 2010)

Nick Kennedy Infectious Diseases Consultant, NHS Lanarkshire / Clinical Advisor, Healthcare Improvement Scotland

Roy Kilpatrick Chief Executive, HIV Scotland (until Dec 2010)

Martin Murchie Senior Sexual Health Adviser, The Sandyford Initiative, NHS Greater Glasgow & Clyde

Jim Sherval Consultant in Public Health Medicine (HIV), NHS Lothian

Kate Templeton Consultant Microbiologist, NHS Lothian

Lesley Wallace Epidemiologist, Health Protection Scotland

Appendix 5: Guidance Consultation List

Guidance consultation, 2018

SHBBV Executive Leads Group

HIV Clinical Leads Group

BBV Prevention Leads Group

Scottish Sexual Health Promotion Specialists Group

Sexual and Reproductive Health Lead Clinicians Group

SHBBV Coordination Network

Scottish Sexual Health Strategy Lead Nurses Group

Health Protection Scotland

Scottish Health Protection Network Guidance Group

Consultants in Public Health Medicine

Health Protection Nurses Network

Scottish Microbiology and Virology Network

British Association for Sexual Health and HIV British HIV Association

Terrence Higgins Trust Scotland

Waverley Care

HIV Scotland

Scottish Drugs Forum

Guidance consultation, 2012

Pre-consultation and preview of Brief Guidance Liaison with Local and National Networks

Health Protection Network Board

Scottish Sexual Health Improvement Specialists Group

Scottish Sexual Health Lead Clinicians

Scottish HIV Voluntary Sector Forum

NHS Greater Glasgow & Clyde MSM Planning Forum NHS Lothian HIV Prevention MSM Planning Group NHS Lanarkshire BBV Prevention Planning Group

Further Groups Contacted in Professional Consultation, Jan-March 2012

Sexual Health & BBV Executive Leads

Sexual Health Clinical Leads

Sexual Health Improvement Specialists

HIV Voluntary Sector Forum

British Psychological Society

National AIDS Trust

Terrence Higgins Trust

British Association for Sexual Health and HIV

British HIV Association

Glossary

Combination HIV Prevention

This term was coined by Prof K Holmes,

University of Washington School of Medicine, Seattle, WA, USA.
Lancet Infect Dis 2007; 7: 516–20.

Coats et al. (2008) state: “Advances in biomedical HIV prevention... provide substantial opportunities to re-invigorate behavioural approaches to HIV prevention and challenge us to advance structural approaches so that these advances can get to those who need them the most. All prevention approaches contribute to effective HIV prevention within communities, and thus behavioural strategies need to be used in combination with biomedical and structural approaches that are combined strategically to address local epidemics.”

Chemsex

Chemsex is the term used to describe sex under the influence of psychoactive drugs, mostly among men who have sex with men. It refers particularly to the use of mephedrone (mcat), γ -hydroxybutyrate (GHB), γ -butyrolactone (GBL), and crystallised methamphetamine (Tina). Ketamine and cocaine are also sometimes used. These drugs are often used in combination to facilitate sexual sessions lasting several hours or days with multiple sexual partners. However some men use these drugs to have chemsex with one other partner.

Commissioning

The design, development and funding of interventions to improve health.

Heteronormativity

A cultural bias in favour of opposite-sex relationships of a sexual nature often leading to assumptions of monogamy. It therefore it is essential to value relationship choice in MSM.

Men who have sex with men

This is an epidemiological and behavioural classification and reflects men who report having had sex with other men. It relates to the behaviour of people who have a gender identity as male and does not relate to sexual identity.

Syndemic

A syndemic is the occurrence of multiple health inequalities which combine to create a burden of ill health. This term is cited from Santos G-M, Do T, Beck J, et al. Sex Transm Infect 2014;90:250–253, who state that “intertwining syndemics that may operate synergistically to increase HIV risk among MSM globally. To curb HIV effectively and advance the health of MSM, multiple conditions must be addressed concurrently using multi-level approaches that target both individual and structural risk factors”.

Trans

The Scottish Transgender Alliance state “In Scotland, it is currently common to use the terms transgender people or trans people as an ‘umbrella’ to cover the many diverse ways in which people can find their personal experience of their gender differs from the assumptions and expectations of the society they live in”. The Trans umbrella includes Trans Men, Trans Women, Trans Non-Binary People and Cross Dressing People. Separately, the Intersex Umbrella includes Intersex Men, Intersex Women and Intersex Non-Binary People.

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