

The Manual for Sexual Health Advisers

Society of Sexual Health Advisers (SSHA)
www.ssha.info

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Section G

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Working with African people

DORINDA THIRLBY AND KATHRYN LEE

The high incidence of HIV in African communities in the UK require that policies need to be in place to specifically respond to this group of people with the aim of facilitating access to GUM services

A health adviser needs to be sensitive to the stigma of HIV and be aware of relevant cultural issues when African people seek HIV medical care/ testing

An example of a specific outreach/ health adviser post

INTRODUCTION*

Current statistics from the Public Health Laboratory Service (PHLS) show that African communities in the UK are the second largest group affected by and living with HIV. Those groups most seriously affected are from the Democratic Republic of Congo, Malawi, Kenya, Uganda, Tanzania and Zimbabwe.

The term African is used to describe a diverse group of people. People who are established in the UK, who are refugees, asylum seekers, students and others who may have migrated for employment or to be reunited with family. Other factors to consider are the many diverse educational, personal and religious beliefs within this group.

The majority of transmission is documented as occurring via heterosexual sex or transmission from mothers to babies.¹ There are evolving challenges facing the providers of HIV services as increasing numbers of people are being diagnosed with HIV within African communities in Britain. The Immigration and Asylum Act (2002)² and, in particular, the dispersal programme has led to African asylum seekers being redistributed to parts of the country with previously limited experience in providing services for this group. It is therefore important that health advisers are able to consider the specific needs of people from African communities. It is good practice that health advisers have an awareness of both local and national services so they can give relevant information to patients requiring specific services or support.

* In the absence of having an African healthcare worker involved in writing this chapter, it has been based on the relevant research undertaken to date and it is hoped when the manual is revised that this can be rewritten by someone from an African community.

SUPPORTING PATIENTS WITH INFORMATION

Health advisers can support patients by counteracting the stigma, myths and stereotypes experienced within African communities regarding sexual health and HIV. Studies suggest that on migration to the UK, many people may be at risk of contracting HIV because of social and community networks and low levels of perceived risk. There is also clear evidence showing that people within this group have a greater need for sexual health services, although they are less inclined to access them.³

Research undertaken by the Terrence Higgins Trust has found discussion of sex and sexual health matters is difficult, sometimes taboo for many African women. Especially where sex is associated with procreation and fertility it may be difficult for women to initiate condom use.⁴

Access to condoms and femidoms is vital in making the means of safer sex available without embarrassment. It is extremely important that health care providers do not reinforce the stigmatisation of any ethnic group. To do so may isolate that community further making health promotion more difficult. It is useful to consult with local African groups about where and how to target sexual health promotion.⁵ It is also important to prioritise sexual health promotion to Africans in an accessible format. Although there are regional variations within languages, there may be a standardised dialect within the same language. Community groups may be able to provide information on common dialects that are spoken locally.⁶ Making sexual health services accessible is essential, as early identification of STIs among African communities is necessary to improve sexual health and to help to reduce the transmission of HIV.⁷ (See Ch.36 -Working with interpreters)

FEAR OF DISCRIMINATION

Many people with HIV already experience problems such as isolation or rejection from family, friends and sometimes their own communities. Sigma research undertaken in 2001 suggested that up to 20% of people living with HIV had experienced some form of discrimination in the last 12 months.⁸ It is therefore worthwhile for the health adviser to discuss with African patients any experiences of discrimination and offer appropriate support and referral. Motivation to access services may be low and African refugees and asylum seekers will need clear information about the legal right to free and high quality medical and social services and encouraged to make use of these.⁹ 'Folk beliefs' held about HIV can make it more difficult for some people to make the most of available services and sometimes open discussion about HIV can be difficult. For some it may be more productive to talk about being sick as opposed to having HIV.

Peer education is considered to be an important aspect of sexual health promotion. This may provide a valuable opportunity to address any misconceptions held about safer sex and HIV. Single sex workshops are particularly useful.¹⁰ For example, in situations where one spouse lives in Africa and the other is in this country, then the management of long distance HIV prevention is particularly important when the spouses meet up. The most relevant intervention for those already aware of their HIV status is secondary prevention work. Acquiring the skills to negotiate safer sex is a priority in this situation as circumstances can change following a new diagnosis. This is good practice in all HIV care.

PERCEIVED RISK/ ACCESS TO SERVICES

Perceived risk of HIV is low, as is the motivation to access services for testing.¹¹ Research has shown that this group may be reluctant to use HIV testing services, and as a result, more work

needs to be done to dispel the stigma associated with HIV and testing. The advent of HAART seems to have had little impact on prognosis and AIDS diagnosis among this community. Again, this appears to be due to the poor uptake of testing services owing to social stigma. Consequently testing needs to be positively encouraged to reduce the proportion of undiagnosed infection and minimise the risk of onward or vertical transmission.¹² It is therefore important that clinics are promoted in the community as being free, confidential and open to all.¹³

However, information alone may not change an individual's perception of risk reduction. Negotiating safer sex challenges deeply rooted ideas about identity, gender, sexuality and power. Cultural beliefs may have a strong influence on this.¹⁴ Religion can also play an important role in shaping peoples understanding and in the information they receive about sexual health and HIV. There is concern that HIV positive individuals may make exclusive use of faith healing at the expense of orthodox anti-retroviral medication. Although the church is considered an important site of intervention and may constructively be used for prevention work with congregations, a supportive relationship needs to be cultivated between the churches and people living with HIV.¹⁵ By encouraging collaboration with outside agencies the health adviser can work on interventions aimed at prevention within target groups such as young people.

SEXUALITY

Evidence has shown that African men who have sex with men often face a double prejudice; homophobia from their communities and racism from the predominantly white gay community.¹⁶ This patient group needs to be managed supportively by the health adviser and referrals to other agencies are made appropriately. Accessing information relating to safer sex and risk reduction may have previously been difficult and fear of discrimination against homosexuality may have prevented any open discussion about sexuality. This fear of discrimination could have a negative impact on the health and well being of this group.

SPECIALIST HEALTH ADVISER POST

There are many different ways that the health advisers can foster good relationships with their local African communities. One such initiative is Acomo Oloya's post based at St George's hospital and in Merton Sutton and Wandsworth health promotion. Acomo works as a health adviser with a role as Outreach Co-ordinator (African Communities) in HIV and sexual health. The aims of her post are:

- To strengthen the links between statutory and voluntary agencies and to develop culturally appropriate HIV and sexual health services for black African communities
- To have an outreach remit that involves working with the black African communities to identify needs of services users and potential services users, explaining different ways of disseminating information, and promote greater understanding of UK medical culture and services to enable African people to access services confidently
- To work closely with African community organisations and groups to promote collaboration between sexual health services and community and to develop HIV prevention and sexual health promotion strategies
- To have health adviser drop-in sessions specifically for African people

- To provide training in the African communities to promote better understanding of STIs, their complications, and testing issues
- To provide training for healthcare professionals to enable them to work appropriately with African patients, and act as a point of consultation with these issues
- To look at the need for change in services to facilitate access¹⁷

C O N C L U S I O N

There are important points to consider when working with people from African communities needing HIV or sexual health care. African people come from diverse communities and it is important that the health adviser is aware of this when discussing prevention, treatment and care. The high incidence of HIV in this group means that increasingly health advisers may be involved in supporting individuals through pre and post test care. Being aware of specific needs, current issues and policy and the services available for referral will equip the health adviser to meet these new challenges.

I N T E R N E T R E S O U R C E S

www.blink.org.uk	Black information link.
www.blackhealthagency.org.uk	Information and helpline telephone numbers.
www.loveafrica.org	Sexual health information

R E F E R E N C E S

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 - 11 Fenton et al 2002. op.cit. Page 244
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 - 14 National AIDS Trust. op.cit. Page 12
 - 15 Ibid. Page 22
 - 16 Ibid. Page 8

Working with young people

DORINDA THIRLBY AND SANDRA JARRETT

The high incidence of sexually transmitted infections (STIs) in young people requires that policies be in place to specifically respond to this group of people with the aim of facilitating access to STI prevention, treatment and care.

The health adviser needs to be aware of the legal framework surrounding sex and young people and be alert for signs of sexual abuse and exploitation.

INTRODUCTION

The definition of a young person can range from those aged under 25, to under 16 years.¹ In English law a young person is a minor until they reach the age of 18 years. A young person can legally consent or refuse medical treatment once they are 16. However it is good practice to encourage parental involvement until they are 18 for serious or life threatening conditions. Within this guidance the focus is on the legal implications for young people under 16 in line with regional/ national guidance. However these principles can be applied to all young people accessing services.

Young people under 16 years are likely to access sexual health services for a variety of reasons. The principles to which health care personnel adhere to when providing services to this group are laid down in the Children Act 1989² (which applies to all under 18's) and the Fraser Ruling following the Gillick case in 1985.³ The ethos of the Children's Act is to listen to the child's wishes and feelings and to treat children with respect as individuals. The child's welfare is always the paramount consideration.

CONFIDENTIALITY AND CHILD PROTECTION ISSUES^{4 5}

The care of the young person must be guided by the standards laid down in statute for sexually transmitted disease (STD) services⁶, the Children Act 1989,⁷ the European Convention on Human Rights⁸ and the Human Rights Act.⁹ In the future consideration will have to be given to the recommendations of the Sex Offences Review "Setting The Boundaries"¹⁰ if this becomes law.

(See also Ch. 22: Law and the sexual health adviser)

The Sexual Offences Act 1956 ¹¹ states that it is an offence to have sexual intercourse with a girl aged under 16 years. However, a man has a defence in law if:

- He is under 24 years old and
- He has not previously been charged with a life offence, and
- He believed the girl was aged over 16 years

In practice, the police rarely take action in cases where the girl is 13 or over and has consented to sex. However, a girl of 12 years or under cannot give consent to sex in law, and sexual intercourse in this situation is automatically defined as rape. This is no legal defence and conviction results in a statutory life sentence. The legal age of consent to anal sex for gay men is 16 years.

FRASER RULING (FORMERLY - GILLICK COMPETENCE) ¹²

In 1985 a legal case was brought by Victoria Gillick who felt it should be illegal for doctors to prescribe contraception to girls under 16 years of age without parental consent. The Law Lords ruled that a girl under 16 could give valid consent for contraception if she were able to understand the proposed treatment and its implications. This principle has come to be known as Fraser Ruling, and this principle of competence has now been extended into most areas of clinical practice. The Fraser Ruling provides guidance for healthcare workers working with young people under the age of 16 in that they can give valid consent for medical examination and treatment – depending upon the nature and seriousness of the decision to be made, in conjunction with the child's mental and emotional maturity, intelligence and comprehension of the information they have been given. This requires a healthcare worker to make a judgement in each individual situation/ case.

Operational aspects of Fraser ruling

It is important that the healthcare worker makes a clinical judgement of the child's competence in each case. Certain criteria need to be met in order for a child to be deemed competent:

- The young person understands the potential risks and benefits of the treatment and the advice given
- The value of parental support is discussed. All healthcare workers are obliged to encourage the young person to inform their parents of the consultation. If s/he will not inform a parent, the healthcare worker must explore the reasons why. It is important that the young person seeking contraceptive advice is aware that although the healthcare worker is legally obliged to discuss the value of parental support, the healthcare worker will respect their confidentiality
- The young person's physical or mental health may suffer if s/he is not prescribed treatment / contraception

- The young person's best interests require the provision of medication / contraception without parental consent

It is good practice for the healthcare worker to record the factors taken into account in making the assessment of the young person's capacity to give valid consent. It is strongly recommended that s/he records what information has been given to the young person, including questions asked and the responses given. This is invaluable if the young person's ability to make decisions were to be questioned or where parents disagree with the decisions made. Any patient aged under 13 requires discussion with the consultant. Any patient under 16 who does not meet the Fraser guidance also needs to be discussed with the consultant.

GUIDELINES FOR WORKING WITH YOUNG PEOPLE UNDER 16

- It is recommended that health advisers, with other members of the multidisciplinary team have a written protocol on the management of young people in the clinic
- It is advisable to train reception staff in working with young people as they play a crucial role as the first contact in the clinic. It is important that they are as welcoming and non-threatening as possible
- Ideally, any person under 16 who walks in during advertised clinic hours would be seen even if s/he does not have an appointment
- Where possible it is advisable that the young person is 'fast tracked' through the service
- It is highly recommended that all under 16s see a health adviser. Where possible the health adviser may assist the young person with their registration, triage and make an assessment of their sexual health needs
- It is essential that recall/ follow up contact arrangements are discussed, and a 'safe' contact address and/or telephone number recorded, for example a mobile telephone number which will not compromise their confidentiality
- It is important that the young person is reassured at every opportunity that the service is confidential, as concern about confidentiality is the main reason for not accessing services. It is advisable to explain that their confidentiality will be respected, and information would not normally be given to a third party, for example parent, GP or school nurse, without their express permission. However, confidentiality is not absolute. If disclosure is necessary to protect the young person or a third party from significant harm, confidentiality may be broken. It is important absolute confidentiality of information is not stated
- All young people may be seen with a friend if they wish, at any point throughout the consultation and/or examination. Groups of young people may be seen together where this facilitates access to information on services and health promotion advice
- It is important the health adviser ensures that the young person understands the possible consequences of sexual activity and is aware of the law relating to underage

sex. Safer sex is discussed and condom use demonstrated to all under 16s who are sexually active or potentially sexually active

- It is advisable the health adviser document which school the young person attends, particularly if they are under 16. This also provides useful data for targeting health promotion
- It is important the healthcare worker is satisfied that the patient has sufficient understanding of what is involved in any investigations and treatment proposed to give valid consent. This is ideally a multi-disciplinary decision although as the prescriber, the doctor is legally responsible
- It is important the age of the young person's partner is documented in the notes
- It is good practice to offer a screen for sexually transmitted infections to all sexually active young people. Many will initially decline, but may agree to a screen at a later date when they have developed greater confidence in the clinic staff. Where urine tests or self-taken swabs are available, they can be offered to young people who decline a genital examination
- It is advisable the healthcare worker discuss and document follow-up arrangements
- It is important that any concerns about a young person are discussed with other staff involved in their care and further concerns discussed with the senior doctor or consultant. Any patient aged under 13 requires discussion with the consultant. Any patient under 16 who does not meet the Fraser guidance also needs to be discussed with the consultant.
- It is recommended health advisers work in their referral area with the relevant school nurses, practice nurses, young peoples services; and contraceptive services to facilitate access. Specific flyers for the service can therefore be used and suitable health promotion leaflets/ materials made available
- Consider developing a designated young person's service, where young people need not see other adult attenders. There can be appropriate music/ videos, leaflets and posters for younger patients to make a more welcoming environment. Sex and relationship education can be promoted from the start of the visit ¹⁵

CONTRACEPTION AND UNDER 16'S

- Any patient aged under 13 requires discussion with the consultant. Any patient under 16 who does not meet the Fraser guidance also needs to be discussed with the consultant.
- If the young person is 13 or over, make an assessment as to whether sexual intercourse was consensual or not. Discuss cases of possible abuse with a consultant
- Assess whether the young person is Fraser competent. If they are and there is no suggestion of abuse, contraception can be provided without involving a consultant
- Record discussion of the different methods of contraception have been discussed, including their relevant benefits, risks and side effects

- Give written information and record that it has been given
- Record whether the parent(s) are aware of the situation and discuss the value of parental support
- Record that discussion has taken place about notifying the GP and the outcome of this discussion

WORKING WITH YOUNG MEN

Boys tend to get less sex education in the family and from informed services such as health professionals;¹⁴. When young boys attend genitourinary medicine services (GUM) it is important they are targeted by health advisers for sexual health education which focuses on their concerns on sex and relationships in order to enhance their confidence, for example with safer sex and condom use. It is important to recognise boys tend to learn what they know about sex from male friends. Learning from their peer group may be complicated as often it is not acceptable that boys show ignorance and stories with other boys are often through real or imagined 'performance' stories.¹⁵ Boys may experience a lot of peer pressure to lose their virginity at an early age. Sexual intercourse may be seen as a way to become a man.

Boys may mask their vulnerabilities by behaving in a 'macho' way or by 'joking' or 'messing about' in the clinic, but it is important to be aware of this and their likely vulnerability. It is important to provide a safe environment, for example by seeing them with friends. Attendance of younger boys/ men may be encouraged by getting young girls attending the clinic to bring their boyfriends and male peers to the clinic. When young men attend there needs to be appropriate literature and resources for boys to give the message they are welcome. It is good practice to have male staff present in young person's services.

WORKING WITH YOUNG GAY MEN, LESBIANS AND BISEXUALS

It is important young person's services are able to discuss sexual orientation, behaviour and identity with young people who are gay, lesbian and bisexual. Specific issues on working with young gay men and lesbians are covered in the relevant chapters.

SEXUALLY TRANSMITTED INFECTIONS

Sexually active teenagers have higher rates of STIs¹⁶ The presence of a possible sexually transmitted organism, particularly in a young person, may indicate sexual abuse. Discuss all cases of STIs in a young person aged under 13 with a consultant. (The Royal College of Physicians has addressed the issue of confidentiality in this situation and discussion with a paediatrician does not constitute a breach of confidentiality in relation to VD regulations)

- If the young person is aged 13 or over and there is no suggestion of abuse, the young person can be treated as an adult if s/he is Fraser competent
- Ensure the young person understands the tests being taken and the reasons for the tests

- Ensure the method of contacting the patient with results is explicit and recorded in the notes

TERMINATION OF PREGNANCY (TOP) REFERRALS

- Sexual healthcare workers need to make themselves aware of their local referral procedures for termination of pregnancy in young people as some hospitals have 'fast track' service
- There needs to be discussion with the young person about the need for permission from the parent or person with parental responsibility prior to a TOP. If consent is not given, this needs to be made explicit in the referral letter
- In view of the high prevalence of STIs in this age group it is important to encourage uptake of sexual health screening prior to the TOP
- Future contraception needs to be discussed prior to the termination being carried out, and written details of local family planning services given

CHILD PROTECTION ISSUES

Although sexually active young people are likely to be involved in consensual sexual activity, other child protection issues need to be considered in the overall assessment of the young person including:

- Past and continuing sexual abuse/ assault (See guidelines below on suspected child abuse)
- Undiagnosed mental health problems, including self-harm, eating disorders, alcohol and substance misuse
- Risk or involvement in prostitution/ commercial sex work. Young people involved in prostitution are now considered in law to be victims of sexual abuse, even if they consent. Discuss all cases of suspected child prostitution with a consultant
- Vulnerability of those living away from home/ accommodated by the local authority
- Vulnerability of disabled young people/ or those with learning difficulties, irrespective of age

Suspected child abuse

It is important health advisers are aware of their local child protection policies and procedures and know how to contact the child protection team at any time. Each NHS trust has a named doctor and a named nurse or midwife who take a professional lead for child protection matters within a Trust.¹⁷

All staff working in genitourinary medicine (GUM) should:

- Be alert to the possibility of child abuse and neglect

- Be aware of local Area Child Protection Committee (ACPC) procedures and protocols
- Know the names of the relevant named and designated professionals
- Be familiar with local procedures for checking the child protection register
- Receive training and supervision needed to recognise and act upon child welfare concerns and to respond to the needs of the young person
- Be aware of the guidelines for the management of young people under 16 years attending GUM clinics
- Know the ‘Chain of Evidence’ procedure”¹⁸

The first responsibility of health care workers is to the young person when abuse or potential abuse is suspected. The effective management of child abuse demands a multidisciplinary and inter-agency approach. If an under 16 year old discloses abuse, or a health care professional suspects that abuse may be occurring, it needs to be made clear to the young person that this information may need to be discussed with other colleagues in the interest of their health and well being. In this first instance discuss the case with senior health adviser/ professional and consultant/ senior doctor in the department.

The following are associated with an increased risk of abuse:

- History of physical or sexual abuse
- Partner more than 3 years older than patient
- Low self esteem
- Learning difficulties
- History of social services care
- Communication difficulties
- Early age of first intercourse

If a child discloses information about abuse, it is best practice to involve a community paediatrician, preferably with the consent of the young person. If consent is given, an examination should **only** be carried out by a forensic medical examiner or evidence may not be admissible in court. A forensic medical examination will only be needed urgently if:

- There has been a recent sexual act and there may be evidence such as semen
- The child sustained physical injuries necessitating urgent medical assistance
- The perpetrator is likely to abscond and evidence secures arrest and detention
- The child requests immediate treatment

In any situation where there are concerns, staff members involved in the care of the young person need to discuss their concerns with each other and their senior team member as appropriate. Confidentiality may need to be breached if consent is not given, but this is only after careful consideration and discussion with a consultant. If further advice may be sought from the local designated doctor for child abuse. Advice can also be sought from the child protection team without disclosing the young person's identity.

In practice it is an extremely rare occurrence that confidentiality needs to be breached, but if it is necessary then it is important the young person is informed of the decision. Other issues to consider prior to breaching confidentiality is if the young person is not willing to co-operate they may deny the disclosure to the outside agency. They may have also given a false name and address to the clinic. A breach of confidentiality might result in other young people not accessing the service in future.

Before contacting a paediatrician or child protection team, collect the following details:

- Name
- Date of birth
- Address including postcode
- Who they live with, and relationship to them
- School
- Nominated social worker, if the patient has one

B I B L I O G R A P H Y

The Marlborough Clinic protocol written by Sarah Bell & Dawn Whittaker

The Roehampton Clinic protocol written by Dr Emma Fox.

Physical signs of sexual abuse in children - Royal College of Physicians, 2nd edition. The Royal College of Physicians of London, 'Physical Signs of Sexual abuse in children. 2nd edition (1997).

Inter-agency Borough Guidelines on Child Protection – Wandsworth Area Child Protection Committee 1997.

'Someone with a smile would be your best bet': What young people want from sex advice services. Brook Publications.

Promoting sexual health services to young people. Brook Publications.

'You think they won't tell anyone, well you HOPE they won't: Do young people believe sex advice is confidential? Brook Publications.

Teenage Pregnancy. Social Exclusion Unit June 1999.

Confidentiality and people under 16. Guidance issued jointly by the BMA, HEA, Brook Advisory Services, FPA and RCGP.

Mental health history			
Drug use	Past	Current	Never
If yes, what?			
Involvement with drug services	Y	N	N/A
General information			

In my opinion, this patient is sufficiently mature to give consent to examination and treatment, and understand advice given to them:

Signature
Print name
Position
Date

APPENDIX 2

Suggested Proforma for Health Advisers

Clinical Effectiveness Group (Association of Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases)
National Guideline on the Management of Suspected Sexually Transmitted Infections in Children and Young People

Date						
RISK ASSESSMENT FORM FOR PATIENT UNDER 16 YEARS						
Reports	Past	Ongoing	Other young people at risk	Parent/ Guardian/ Care unit aware	Social Services aware	Police aware
Sexual Contact						
Involuntary						
Voluntary partner age<23						
Voluntary partner age>24						
Family member						
Substance Abuse						
Alcohol						
Heroin						
Crack						
Speed						
Ecstasy						
Cannabis						
Temazepam						
Other						
Solvents						
IV route						
Prostitution						
Street						
Sauna						
Escort						
Abuse						
Physical						
Emotional						
Neglect						

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- 8 European Convention on Human Rights 1950
- 9 British Medical Association. The impact of the Human Rights Act 1998 on medical decision-making BMA: London. 2000
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- 12 Gillick v West Norfolk and Wisbech AHA. Op cit
- 13 Adams J. Sex Education Forum fact sheet. London: National Children's Bureau. Fact sheet 25. 2001.
- 14 Sex Education Forum, fact sheet 11, National Children's Bureau London: National Children's Bureau. Fact sheet 11. 1996.
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Working with gay men

MIKE JONES

Gay and bisexual men and men who have sex with men (MSM) are a diverse population of individuals who reflect every social and ethnic group in the UK. The sheer size and diversity of this population makes any attempt to cover all of the relevant issues in depth somewhat problematic.

This section therefore aims to cover core issues relevant for sexual health advisers working with this client group. For a more detailed analysis of some of the subjects covered a reading list is provided at the end of the chapter.

INTRODUCTION

The sexual health needs of gay men are of course both similar to and different from those of their heterosexual counterparts. Much of the advice and information provided in the general sections of this handbook will also apply to gay men. There are however two unique factors which continue to mark out gay men as different from their heterosexual peers and which affect the work we do with gay men/MSM.

Firstly, in the UK and elsewhere there is a historical background of social and institutional disapproval of male to male sexual contact and relationships.

Most gay men grow up in an environment where there continues to be both overt and covert hostility towards men who are sexually attracted to other men.

These negative messages not only affect and influence gay men but also those working with them on sexual health issues.

Secondly, the advent of HIV in the last 20 years and its disproportionate impact upon gay men in the UK has profoundly influenced contemporary gay male sexuality and culture. From the mid 1980s to the mid 1990s sexual health education aimed at gay men/MSM tended to be defined by HIV prevention messages. This might be viewed as sometimes being to the exclusion of other sexual health concerns for both HIV negative and positive men. More recently, sexual health educators have responded by placing HIV within the broader context

of gay men's sexual, physical and emotional wellbeing. A reflection of the growing realisation that for safer sex and risk reduction messages to be effective other factors like self esteem, mood, general sexual health, alcohol and drug use have to be taken into account.

WHO ARE GAY MEN / WHOSE DEFINITION?

In working with gay/bisexual and MSM it is important to respect and understand an individual's identification of his sexuality.

Though the patient in front of you might be behaviourally homosexual, bisexual or heterosexual it is the patient's perception of his sexuality which should guide you in the work you do with him and the language you use.

Gay men are men who have sex with men..... but not all men who have sex with men identify as gay .

In these guidelines the term **gay man/MSM** will be used to describe all men who have or who have had male sexual partners. Generally the term 'gay' means more than 'a man who has male sexual partners'. To self identify as gay in our society suggests (to varying degrees) an acceptance and awareness of shared experience and identification with other homosexual men. It also suggests a perception of difference from the experience of heterosexual males.

The use of the word gay might therefore be seen as partly descriptive of a cultural and community identity as well as of sexual identity.

A bisexual man is usually defined as a man who is sexually attracted to both women and men. Though a bisexual man is someone who behaviourally might have sex with both men and women his choice might be to identify his sexuality as either bisexual or gay.

A man who has sex with men (MSM) is a term that has come into more recent usage to describe the broad spectrum of men who do not identify as gay or bisexual but who nevertheless have sex with men. Sexual behaviours in this group can range from men who usually have sex with women but who occasionally have sex with men, to men who are almost exclusively behaviourally homosexual.

The reasons why MSM do not identify as bisexual or gay are as diverse as the individuals involved. Some MSM from ethnic minority and other socio/cultural groups do not identify with the mainstream gay scene and 'out' gay men

This might be because of issues around race and exclusion^{1 2} or because they come from cultures where identities like gay or lesbian do not have equivalent words or concepts.^{3 4 5} For some men sexual identity is more fluid than 'straight, gay or bi'. Sometimes sex between men or certain types of sexual activity like mutual masturbation are defined as 'playing' or not perceived to be 'real' sex.

In some cultures or in some male only environments sexual identity might be defined by role during penetrative sex mirroring attitudes around heterosexual sex .The 'penetrator' retains a heterosexual identity but the 'penetrated' is perceived as homosexual.⁶

Other reasons for not identifying as gay or bisexual include internalised homophobia. Some MSM have internalised society's negativity about homosexuality to the degree where they reject any communality with openly gay identified men. There are also men who are

'situationally homosexual' in male only environments or institutions where female partners are unavailable, in prisons for example.

Another important group in the MSM category are some male sex workers.

Not all male escorts or 'rent boys' (that is, men who sell sex to men) identify as gay or bisexual. Some identify as heterosexual and may have female sexual partners.

The examples above present situations where the health adviser needs to be extremely sensitive to the personal circumstances of the patient.

Men who have sex with men but who do not identify as gay or bisexual are frequently wary of disclosing their sexual activity with men to medical staff.

This can also be true of gay or bisexual men who are just starting to explore their sexuality and men who are new attenders at your clinic. They might be anxious about how they will be treated by medical staff if they disclose their true sexuality. Some men might describe male partners as female or not mention male partners in a consultation. This is more likely to happen if the doctor, health adviser or nurse does not specifically ask a patient if he 'has or has ever had male partners'? It is advisable to ask this question as a routine part of sexual history taking.

Images, posters and leaflets, which portray same sex couples and information about sexually transmitted infections (STIs) written for gay men/MSM can be displayed in all sexual health clinics. These convey the message to patients that the clinic is a safe environment for gay men/MSM to discuss sexual health concerns and that staff are aware of health issues specific to these patients.

THE LAW AND GAY MEN

Prior to the late 19th century sex between men might or might not be prosecuted under a variety of laws depending on the zeal or whim of the authorities of the time ⁷ *

The offence of gross indecency (any consensual sex between men other than anal sex) came onto the statute books in 1885 and this was used with the offence of buggery (anal sex) to criminalise all sexual activity between men.

Following the Wolfenden report gay sex was only partially decriminalised under the sexual offences act of 1967. The age of consent was set at 21, the law stating that no more than two men were to be involved and the sex had to take place in a 'private' not 'public' area. Definitions of what constitutes private or public space continue to be open to interpretation and legal debate.

In 1994 the age of consent for sex between men was lowered to 18.

In November 2000 the government invoked the Parliament Act to force through legislation to make the age of consent 16 in England, Scotland and Wales and 17 in Northern Ireland. This means that the age of consent is now the same for heterosexuals and homosexuals across the UK.

* The Stonewall website at www.stonewall.org.uk provides useful information on the history behind legislation affecting gay men.

The legal concepts of buggery and gross indecency (male to male sexual contact in a 'non private' space) remain in place. Gay men can still be prosecuted for having consensual sex. There has been recent discussion at government level on changing the law on gross indecency to a new offence of public indecency. This would apply equally to both homosexual and heterosexual sex. If this happens it will effectively end the legal discrimination against gay men inherent under the existing law.

THE HEALTH ADVISER INTERVIEW

Sexual health, HIV, risk reduction and gay men

20 years into the HIV /AIDS epidemic and with the advent of anti-retroviral drugs sexually experienced gay men are making increasingly complex choices around sexual health and risk taking.

Some writers ⁸ refer to a 'post AIDS ' generation of gay men in Europe, the U.S.A and elsewhere for whom the HIV/AIDS epidemic is no longer viewed as a crisis but as a fact of life, to be lived with and managed like many other risks.

The content of your interview with your patient/client will of course depend upon his knowledge base and needs. Working with someone just beginning to explore his sexuality can be very different to working with someone who is sexually experienced.

There are several key areas that it is important to discuss with any gay man/MSM attending a GUM service, particularly a new attender.

The following areas for discussion will depend upon why he has been referred to the health adviser or has requested to see the health adviser and should be tailored to the needs of the patient.

The interview

As with any patient, in order to establish trust and confidence it is first important to find out what he may already know, what he perceives his needs to be and to build on these.

In the interview, especially with young or sexually inexperienced patients, any or all of the following topics are relevant:

- General sexually transmitted infections (STIs) information
- Risk reduction/safer sex and condom use
- HIV transmission
- Knowledge of HIV status and that of partners
- Hepatitis A and B status and vaccination
- Hepatitis C status and knowledge of transmission and health risks, particularly if patient is HIV positive

- If the patient is HIV positive it is important to address any concerns he might have around risk reduction with partners of either positive or negative/unknown HIV status

Awareness of STIs, transmission and symptoms

If the patient has been referred with a diagnosis of an STI firstly ascertain his knowledge and understanding of the infection and of how it has been transmitted

It may be important to clarify whether the patient is aware of which STIs have a higher incidence amongst gay men/MSM and why this is.

If there is a local or national increase in the incidence of an STI amongst gay men (for example, syphilis) then it is important the health adviser check that the patient is aware of this.

If the patient is HIV positive he may have some different concerns around STIs. Frequently asked questions include whether or not STIs are more serious for positive men and are they harder to treat or likely to increase viral load?

HIV transmission and risk reduction.

The first step in any HIV risk reduction discussion is to understand the patient's knowledge base, his awareness of and assumptions about sexual risk taking.

A key part of the health adviser role is to provide the patient with the information necessary for him to make informed choices about his sexual wellbeing. This means addressing gaps in the patient's knowledge and challenging any assumptions not based on fact or evidence. This will guide the patient towards developing a personal sexual risk reduction strategy that makes sense and is workable for him.

Questions for your patient

- Does he understand how HIV is transmitted?
- Does he have concerns about being infected or of infecting others with HIV?
- Does he already have a personal risk reduction strategy?
- Does he ever have sex, which is less safe than he would like it to be?

Most gay men/MSM in the UK are aware of primary routes of transmission of HIV even if relatively sexually inexperienced. However, perceptions of risk of HIV transmission vary considerably from person to person.

When discussing sexual activity it is important to ascertain whether the patient 'ever has sex which is more risky than he would like it to be'?

This can be a more helpful question for opening a discussion about risk reduction with a patient than 'do you ever have unsafe sex'. If he voices concern about his risks then it is probable he will be open to further discussion.

HIV health promotion and risk reduction messages for gay men/MSM have evolved from the early 1980s to the present in response to the realities of sexual choices and risk taking. The original 'safe' sex message of "never have unprotected anal intercourse (UAI)" has evolved

into the 'safer' sex message of "never have UAI with someone of unknown or different HIV status".

This is in response to the fact that many gay men have incorporated HIV testing and HIV status into their personal risk reduction strategy.^{9 †}

Gay men often prefer not to use condoms with a regular partner of the same HIV status for reasons of love, trust and intimacy. Therefore being absolutely certain of a partner's HIV status via testing is recommended to any couple not using or considering not using a condom. They can also be advised to set some ground rules about safer sex with other sexual partners and to be open with each other if unsafe sex has occurred outside of the relationship.¹⁰

A more controversial issue is whether an HIV positive man having unprotected anal intercourse with another positive man can be infected with another strain of HIV. This could mean being (re) infected with a strain of HIV, which is more aggressive or drug resistant than his current strain of virus. There is evidence to support the view that superinfection can occur.^{11 ‡}

Some HIV positive men argue that the evidence for superinfection is somewhat limited and that low viral load reduces this risk considerably. They might choose to have UAI with other positive men for both personal and political reasons.

Therefore they feel they are making an informed choice about risk taking in order to enjoy genuine intimacy with other positive men, particularly regular partners.

It is vital that we as Health Advisers are aware of current debates within the gay community about sexual risk taking and have access to accurate information about STIs and health risks for HIV positive gay men. We are then in a position to have a useful dialogue with our patients and to ensure that their sexual choices and strategies are informed by the best available evidence.

HIV negative and positive gay men have been making increasingly complex decisions around sexual risk taking as the nature of HIV transmission became clearer. Sexual health surveys show that at any one time around 30% to 40% of gay men are not using condoms for anal intercourse.¹² This does not necessarily mean that 30% to 40% of gay men are always having high risk sex. This figure includes HIV negative men who are only having UAI with a regular partner who is also known to be negative (low risk UAI) through to men who are unsure of their status who are having UAI with other men of unknown status (high risk UAI).

Men who are most at risk of contracting or transmitting HIV are those who have UAI with partners of different HIV status. Anonymous testing of blood taken at GU clinics reveals that up a third of HIV positive gay men/MSM may be unaware of their HIV status. Evidence suggests that these are not men who have never tested for HIV. They are often men who do not perceive themselves to have been at risk since their last test or who were not offered a test at their last sexual health screen.¹³

Therefore in working with gay men/MSM who are having UAI who do not perceive themselves to be at risk it is important to ascertain if they are certain of their HIV status. If

† Project Sigma (Tel: 020 7737 6223) have surveyed Gay Men's sexual behaviour since 1993. From 1997 these surveys have taken place nationally and yearly. For survey reports and other publications on gay men's sexual behaviour and attitudes contact

‡ A very readable précis of this report can be found on AIDSMAP www.aidsmap.com Under Fieldhouse R. First unequivocal case of HIV superinfection.

not it is appropriate to raise the issue of HIV testing as part of their personal risk reduction strategy.

R I S K R E D U C T I O N

If the patient wants to reduce the level of risk he is taking it is worth exploring patterns in mood, behaviour, environment or choice of partner when risky sex happens.

- Does risky sex happen with regular or casual partners? Does he have risky sex when depressed, anxious or stressed?
- Does it happen when he is drunk or taking recreational drugs? Or at a particular venue?
- Is he having risky sex because he feels unable to discuss HIV status or testing with a new or regular partner?

It might be possible to help him reduce risk by exploring ways of changing factors in his life which impact on his sexual choices. This might involve several counselling sessions to identify potential changes that can be made.

Any changes should be realistic rather than idealistic. Some men feel they have failed if they cannot maintain safer sex with every partner. It is therefore important to emphasise that **any** reduction in higher risk sex will reduce his statistical chances of being infected with or transmitting HIV.

The health adviser should be wary of being viewed as punishing or policing around safer sex. By using positive and affirming language about the patients desire to reduce risk and by identifying factors likely to increase risky behaviour he can be encouraged to return for further discussion after risky sex occurs.

Other options for men who want to reduce risk but are finding change difficult can include referral for ongoing counselling or psychology support if available.

Some cities in the UK have counselling organisations specifically for gay men and MSM, which are a valuable resource and can link people into their communities. Several gay men's and HIV organisations run groups and courses for gay men exploring issues like relationships, assertiveness, risk reduction and sexual wellbeing. Many men have found sharing their experiences with other gay men in a workshop or groupwork setting to be very useful.^{14 §} Some agencies providing these services are listed at the end of the reading list.

P U B L I C H E A L T H A N D R I S K R E D U C T I O N V E R S U S P A T I E N T A D V O C A C Y A N D C H O I C E ?

Some gay men have felt or fear pressure to HIV test before ready from clinic staff. Some have felt judged by clinic staff around sexual practices and personal risk reduction strategies. HIV positive men have reported feeling unable to discuss their sexual health needs with clinic staff because of previous negative responses to their sexual activity.^{15 **} It is therefore important to

§ Reports containing research and information on needs of HIV positive people when seeing sexual health care professionals.

** An analysis of research relevant to primary prevention in relation to people with HIV. Contact THT London. Tel 020 7831 0330

ensure that in any discussion with this client group, health advisers are sensitive to and respectful of the individual needs and choices of the patient.

Health advisers are in a difficult position because we have a public health as well as patient advocate role. The laudable aims of improving public health are not always easily applied to the complexities of human sexual behaviour.

Good risk reduction work is not only about providing information. Helping the patient to identify and address factors in his life which affect his ability to reduce risk, is a fundamental part of developing a workable risk reduction strategy appropriate to his needs.

A patient who knows that the health adviser is providing him with clear and unbiased information and is listening to and addressing his needs is probably more likely to feel able to discuss his sexual activity and to return for further advice and counselling. The patient who feels that the health adviser, irrespective of that patient's needs or concerns, is imposing an agenda and who feels judged or patronised may not be open to future discussion. Always ask the patient to clarify any terminology he uses that is new or confusing and always check that the patient understands the information you are giving him.

Covering all of the above in one session may prove difficult given pressure of time. In addition the patient will only retain a percentage of any information given.

Too much in depth description of STI and HIV transmission to the exclusion of more positive messages can prove alarming and off putting. This is particularly true of anyone just starting to explore his sexuality. If a good working relationship has been established between the health adviser and the patient he can be encouraged to return if he feels this would be helpful.

A health adviser can also back up verbal information with leaflets written specifically for gay men. It is important to remember that a patient may be living with others who do not know about his sexuality and where privacy might be a problem.

He may be wary of taking leaflets that could identify him as a gay man/MSM. Sometimes general sexual health leaflets are more acceptable and it is always worth checking this out with the patient first.

PARTNER NOTIFICATION AND GAY MEN

Guidelines given elsewhere in this handbook on partner notification for STIs and HIV are also of course applicable to gay men.

The most significant difference is that gay men/MSM are likely to have more sexual contacts than heterosexual men and women¹⁶. Furthermore, because of the opportunities for casual sex in clubs, bars, saunas and cruising areas it is likely that a higher proportion of these contacts will be casual or anonymous and therefore untraceable.¹⁷

Cities like London Manchester and Brighton have large populations of gay men and many venues and places where casual sex is available. Also many men using the scene in these cities are from other parts of the UK or tourists from abroad.¹⁸

This poses particular problems for partner notification resolution and clinics with a high proportion of gay male attenders in urban areas will find that they have higher numbers of 'untraceable' contacts reported. Different approaches to disease control and public health

have been adopted where effective PN is difficult or impossible in the midst of an STI epidemic. Targeted club and venue based information campaigns about infections can be extremely effective at raising awareness and encouraging men to attend GU services for screening.

Recent examples of these are outreach and venue based campaigns to raise awareness of syphilis amongst gay men in London and Manchester. This has involved collaboration between GU clinics / health advisers, gay men's outreach organisations and the Public Health Services.

Patients with early syphilis have mentioned particular sex venues, Internet chat rooms or cruising grounds as places where they suspect they encountered the partner or partners who infected them. This has been fed back to public health and gay men's outreach organisations who have targeted those sites with advice and information about the infection and how to access screening and treatment.

Through the collation of up to date information about local syphilis epidemics appropriate interventions to reduce incidence have evolved where PN has been difficult.

WORKING WITH YOUNG GAY AND BISEXUAL MEN

Young gay men, particularly those aged 18 and under, form a smaller percentage of clinic attenders than heterosexual men or homosexual men above 18. Many young gay men do not become sexually active until after their teenage years. Those who are sexually active as teens frequently find it hard to disclose their sexuality. As a result those who do attend usually do so with an acute medical problem.¹⁹

Sexual Health clinics are ideally suited to meeting the needs of this group. The confidentiality, anonymity and non-judgmental approach of clinics should make them an ideal venue for young gay men to seek advice and help on issues of sex and sexuality.

To attract this client group clinics have to make determined efforts through appropriate advertising, tailoring services to their needs and focussed staff training.^{20 ††}

PSYCHOSEXUAL AND EMOTIONAL NEEDS OF YOUNG GAY MEN

Young gay men frequently experience major difficulties coming to terms with their sexuality as a result of the stigma that much of society still attaches to homosexuality. Young gay men are at a greater risk of violence than their heterosexual counterparts. A 1994 study by Stonewall found that one in two gay identified under 18 year olds surveyed suffered at least one violent assault and one in four received some form of harassment from members of their own family.

They may find it very difficult to approach any adult or authority figure (for example teachers or GP's) for advice and help, expecting to encounter the homophobia and negativity they experience around them. Younger gay men may view homosexual sex as abnormal having internalised the messages received from family and society. It is therefore important for the

†† Axis is a sexual health clinic specifically for gay and bisexual men aged under 26. The report contains useful information on setting up a gay men's service and on issues specific to young gay men.

health adviser to normalise homosexual sex and to place it in context as part of a range of human relationships.

It is not therefore surprising that young gay men can suffer from low self esteem and may be wary of any interventions that may focus on their sexuality. Many deny both to themselves and others their sexual attraction to other men, preferring to view themselves as heterosexual or bisexual.

In addition many young gay men may be unclear about the age of consent, legal issues around gay sex and the confidentiality of GU services. All of these factors can make it difficult for a worker in a GU clinical setting to establish the trust and confidence of some gay men.

The pressures on young gay men are reflected in suicide rates, which are proportionally higher than in equivalent heterosexual age groups.²¹ Young gay men from ethnic and religious minorities can face particular pressures and problems when familial and religious identity and duty conflicts with sexual identity and desire.^{22 23 24} This is especially true in communities where arranged marriages are the norm and where adult identity and family honour is inextricably bound up with marriage and children.

Referral to counselling and support organisations aware of the specific problems faced by young gay men/MSM in this situation should be offered. ‡ Staffs at sexual health clinics thus need to be aware of the potential vulnerability of young gay men and the anxieties they will have in attending the service. It is important not to use language that could be construed as judgmental when working with any patient. This is particularly important in the case of young gay men and in any initial consultation it is also important to emphasise the confidential nature of sexual health clinics.

HEALTH EDUCATION NEEDS

For whatever reason young gay men attend the clinic it is an ideal chance for health educational work, as they will all be in the early stages of their sexual lives. Even if they have received some sex education at school it is unlikely that much, if any, will have covered homosexual sex. Like most young people many young gay men learn about sex from peers or sexual partners and the information they have may be incomplete or inaccurate.

Like any young person a young gay man may find it embarrassing and difficult to discuss sex, particularly homosexual sex, with an older person so it might be advisable to keep language as neutral or clinical as possible. Always ask the patient to clarify any terminology he uses that is new or confusing to you and always check that the patient understands the information that you are giving him.

LEGAL ISSUES WHEN WORKING WITH YOUNG GAY MEN

For information on this subject on men aged 16 and over please read the previous section on the Law and Gay Men. Much of the law relating to consent, treatment, under 16's, sexual

‡ Naz Project London. Works with men from South Asian, Turkish, Iranian and Arab backgrounds. 020 8741 1879. PACE. Lesbian and Gay counselling service which can advise on local services. 020 7837 6768

abuse and rape applies irrespective of the sexuality or gender of the young person involved. The most relevant law here is that relating to the offence of 'buggery'.

In theory even if a 15 year old is having consensual anal sex with a partner of the same age both could be prosecuted for buggery. In practice sex between consenting males of the same or similar ages if under 16 is unlikely to be followed up by the police. This is similar to police practice around consensual under age heterosexual sex. There is a common law presumption that a boy under the age of 14 cannot commit the offence of buggery.

The sections in this handbook on working with young people, under 16's and child protection provide further information on legal issues which are also relevant for young gay men.

GAY MEN/MSM AND ACCESS TO GU SERVICES

All clinics can ensure that gay men are able and willing to access their services. If gay men are not using their local GU service and are travelling elsewhere for treatment then questions need to be asked about why that might be.

There are several ways to monitor whether or not gay men are making use of a GU service and to improve access:

- Are data on clinic attendances by gay men captured? For example by 'diagnosis acquisition'
- Are data on gay male attendance analysed or audited?
- Does the clinic have any links with local health promotion services working with gay men? Or with voluntary sector organisations working with gay men or people with HIV?
- Is the clinic advertised in places where gay men meet or socialise, for example posters or leaflets in bars, clubs, and saunas? Is the clinic advertised in any gay media covering your area?
- Does your clinic have guidelines/protocols for doctors working with gay men so that a standardised service is offered?
- Does your clinic have clear policies on Hepatitis B (and Hep A) vaccination for gay men?
- Does your clinic screen all HIV positive gay men for Hepatitis C?
- Are there training needs for health advisers, doctors or nurses?

USEFUL LITERATURE AND RELEVANT ORGANISATIONS

NB This list is far from comprehensive but most of the literature listed here contains advice on further reading and sources of help and information. Organisations listed here are those that have a national or high profile role in gay men's sexual health, support or counselling. They can usually advise on services in your area:

Making it count: A collaborative planning framework to reduce the incidence of HIV infection during sex between men. Second edition. Sigma Research 2000.

For information on organisations providing advice, counselling support and group work for gay men/msm contact;

- Terrence Higgins Trust (THT) - National organisation. Central Helpline THT Direct tel 0845 12 21 200
- London Lesbian and Gay Switchboard - Can provide info on local lesbian and gay services across UK including local lesbian and gay helplines. Tel 020 7837 7324
- National AIDS Helpline Free 24 hour advice and help on HIV related issues. Tel 0800 567 124

USEFUL WEBSITES

www.tht.org.uk THT provides information on national services for gay men as well as other groups.

www.mesmac.co.uk Provides information on services across the UK offering support and advice for men who have sex with men. There are also regional mesmac websites.

www.metromate.org.uk Provides information on the wide range of groups for gay men provided by

Gay Men Fighting AIDS (GMFA) and BIG UP at GMFA. Some groups specifically for men from Caribbean and African backgrounds. London based.

www.freedoms.org.uk Provides information on condoms, safer sex and links to national services for gay men. London based.

www.naz.org.uk Provides information for gay men/msm of South Asian, Turkish, Iranian and Arab backgrounds.

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Working with lesbians

KATHRYN LEE

This chapter aims to examine common barriers that some lesbians may face when attending a sexual health service. Making the service more accessible may help to reduce misconceptions held by both service provider and service user.

INTRODUCTION

There is no standard definition of what constitutes a 'lesbian'. Sexual orientation is most often described through behaviour and identity. It is important to note that views of sexual behaviour and sexual identity may vary significantly across differing cultures and ethnic groups.¹ Lesbians and women who have sex with women (WSW) are found among all sub-populations of women and are represented in all ethnic and racial groups, all ages and all socio-economic strata.

Lesbians and WSW have some specific sexual health needs. A number of surveys have highlighted that misconceptions about the health risks of lesbians need to be addressed. Lesbians and health care providers often hold these misconceptions alike. In a survey conducted in Manchester, lesbians did not consider themselves at risk of STI and HIV. There were a large number of women who felt reluctant to disclose their sexuality to health care professionals due to fears of discrimination and a perceived lack of confidentiality within health care settings.²

SEXUAL RISK

As with all patients it is important to remember that the care given by the health adviser should be individualised and based on patient need. A number of factors influence the sexual health of WSW. Namely the nature of sexual activities, the number of partners, a history of having sex with men and previous exposure to STI. Traditionally WSW have been perceived as a low risk group and have been largely over-looked in terms of sexually transmitted infections and cervical cytology screening initiatives. This is clearly demonstrated by the lack of acknowledgement of WSW in the National strategy for sexual health and HIV.³ However, studies of prevalence of STI in WSW have shown significant numbers of WSW diagnosed with genital herpes, bacterial vaginosis, hepatitis A, B and C and genital warts⁴

High percentages of women in all studies gave a history of having previous or current sexual contact with men. Research highlights the risk behaviour profile of WSW as significantly more likely to have sex with men who identify as gay or bisexual. This demonstrates that a woman's sexual identity is not always an accurate predictor of her sexual behaviour, with women who define themselves as lesbian sometimes engaging in high-risk sexual contact with men. For a case of 'heterosexual' transmission to occur, neither person need be heterosexual.⁵ Research shows that WSW who believe themselves to be in a low risk group for STI and HIV are less likely to practise safer sex than heterosexual women with partners from high prevalence groups, such as gay men.⁶

An accurate sexual history is paramount when assessing risks and intervention. Sensitive sexual history taking is now judged to be an element of good practice in any sexual health service.⁷ There is relatively little data regarding the risk of female to female transmission of HIV, although available research suggests the risk to be very low. Other factors must be taken into account, such as the use of intravenous drugs or sexual contact with men. Viral STI (such as herpes and genital warts) are diagnosed in women who have had exclusively lesbian sexual experiences. Woman to woman transmission of trichomonas is also well documented. However the reason for the high rates of bacterial vaginosis amongst lesbians is unclear.⁸

Studies have demonstrated the prevalence of STI but evidence of transmission between women is lacking, all studies cited highlighted a need for further research in this area. Evidence suggests that risk behaviour is high amongst WSW but these risks are related to factors outside their experiences of sex with women.⁹

S A F E R S E X

Advice about safer sex is common to all sexual orientations, but clear advice should be given to WSW regarding the use of sex toys and condoms; risks from oral sex; and the transmission risks of digital penetration. Studies reinforce that the promotion of dental dams is unwarranted and unacceptable.¹⁰ As with all patients, the health advice given needs to be clear, current and non-judgmental. It is essential that the health adviser is familiar with common sexual practices among WSW, and is able to openly discuss with patients any sexual health risks which may be relevant to them.

C Y T O L O G Y

Studies show abnormal cervical cytology to be as prevalent in WSW as their heterosexual counterparts. Historically, WSW have been discouraged from attending for cervical cytology screening as the risk of abnormality was perceived to be low. Research has clearly demonstrated cervical cytological abnormalities in WSW, including those who report never having had male sexual partners.¹¹ Lesbians should therefore be encouraged to attend for cervical cytology.

P A R E N T I N G A N D C O N C E P T I O N

A survey showed that almost one quarter of WSW attending sexual health services wanted more information about parenting and conception.¹² For WSW the issue of conception raises dilemmas in relation to the potential exposure to STI/HIV. Lesbian women may attend sexual health services to seek advice on donor insemination, HIV /STI testing, pre-conceptual care or adoption. The health adviser should have the resources available to make relevant

referrals to local and national services and be equipped to discuss the options available to them, especially with regard to STI and HIV.

IMPROVING ACCESSIBILITY TO SERVICES

Access to health care services may be adversely affected because of assumed discrimination or stigmatisation. WSW may have already encountered negativity in a health care setting associated with their sexual orientation, and been affected by prejudice and homophobia. Studies have shown that many women identifying as lesbian felt they had endured bad experiences in sexual health services because of their sexuality.¹³

Revealing ones lesbian identity for some is an understandably difficult task. Many WSW do not feel safe disclosing their sexuality in healthcare settings, and often neither they nor the health care worker initiate any discussion regarding sexual practice.¹⁴ Assumptions of heterosexuality can lead to a lack of disclosure and this invisibility of lesbian service-users may contribute to exclusion and poor utilisation of services by WSW. By failing to disclose or discuss sexuality, appropriate health interventions may be overlooked.¹⁵

It is important to remember that there are real concerns for lesbians about confidentiality. Disclosing sexual orientation may leave some patients feeling vulnerable so it is vital to be clear about how the information will be used, where it will be documented and who will have access to it.¹⁶ The health adviser should have a comprehensive awareness of local and national resources and support networks available to WSW.

Young lesbians particularly may need support and reassurance when confronting issues about coming out to family or peers and self-esteem issues around acceptance of their own sexuality.

CLINIC ENVIRONMENT

The clinic should be a positive environment, displaying inclusive material in the waiting areas and reception. Patients should be asked gender-neutral questions about partners or personal circumstances when booking in at reception. The waiting room should display a mission statement outlining the services position on equality and this should specifically identify lesbians as being part of that commitment. Finding relevant information about sexual health may be difficult for some WSW.¹⁷ There is a need for current, understandable and appropriate written information for WSW, with clear guidance about sexual risks and the need for cervical screening. The clinic could be profiled in the local or national lesbian press to promote an inclusive service and raise awareness about sexual health matters affecting WSW.

The health adviser has some responsibility for ensuring that members of the multidisciplinary team are adequately trained and aware of the specific needs of WSW clients. Sexual history taking and the language used should make the consultation conducive to disclosure.

Evaluating the views of lesbian service-users is an important factor in establishing if clinic services are lesbian-friendly. The feedback given by clients can be used to adopt inclusive strategies and raise the expectations of WSW using the service by dispelling fears associated with disclosure, visibility and vulnerability. By developing an understanding of the barriers lesbians face when using sexual health services, access can be improved and a more relevant, sensitive and successful service can be provided.

RECOMMENDED RESOURCES

- Saffron L. Lesbian parenting from all angles. Pinkparents (UK) Ltd.
- www.pinkparents.co.uk (Information and advice about parenting.)
- Feeling Good, Feeling Sexy. Manchester Health Promotion Specialist Service. Tel: 0161 291 3642 (Lesbian Sexual Health information for clients.)
- www.fflag.org.uk (Support for families and friends of lesbians and gays.)
- www.lesbianstd.com (information about sti)
- www.dcnetwork.co.uk (Parenting/pregnancy.)
- Witon T. Good for you: a handbook on lesbian health and wellbeing. Cassell. 1997
- Sullivan S, Palmer P. Lesbians talk safer sex. Scarlet Press. 1992
- Boston Women's Health Book Collective. Our bodies, ourselves-for a new century. Simon & Schuster. 1998
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Working with interpreters

CHRIS FALDON

Sexual health advisers will need to work effectively with interpreters to break down communication barriers. This is not always an easy task and requires careful planning.

INTRODUCTION

Many people in the UK use a first language that is not English, or a dialect not readily understood by others. Others may be deaf and English is a second language. This may mean that their understanding of abstract concepts, grammar and complex words may be limited.¹ This can create barriers to accessing health services. In GUM settings even when English is the first language of service users there are many potential barriers to good communication such as fear, shame, anger and embarrassment. A genuine attempt is needed to overcome these when conducting a sexual health interview. When an interpreter is required, it is to be acknowledged that this is often a socially, culturally and politically complex and skilful activity.² It requires careful planning at both an interpersonal and institutional level. Health advisers may often be the key professionals involved in facilitating the interpreting service for a client. This chapter sets out to provide some basic advice on how to work productively with an interpreter.

The function of interpreting in health care settings has evolved greatly over recent years as the inadequacies of using family members (including children), non-medical staff and sometimes other patients have come to light. Such practices ran the high risk of patient misdiagnosis and incorrect treatment with potentially catastrophic consequences. Untrained interpreters are likely to have little or no understanding of medical concepts or terminology and the primacy of ensuring that any messages conveyed are complete and accurate.

Many public sector services including the National Health Service have relied on a service provision model that supplements established approaches to communication with specialist provision. The use of interpreters in interviews, leaflet translation, special telephone and computer technologies are problematic in these services and are regarded as expensive and difficult to obtain. It is argued that a social inclusion model starts from the perspective that everyone has a right to the information and support that will enable participation in the social and cultural life of their community. Alternative approaches to communication in public life need to be built in to provision at the outset.³ Clients are therefore entitled to a professional interpreting service. This is enshrined in legislation for deaf people under the Disability

Discrimination Act with businesses and organisations being legally obliged to look at how they provide access.⁴

GUM clinics as part of a much larger public service may well struggle to shift the emphasis from language to communication but it is in the best interests of everyone to ensure that communication is enhanced through using an interpreter when required.

Services will vary considerably across the country but the following principles are to be noted:

- Professionally trained interpreters working to a code of ethics⁵ are capable of maintaining a neutral and independent position. Their use is to be encouraged where at all possible
- Using a friend or family member to interpret is fraught with difficulties and is to be discouraged unless the client insists

ASSESSMENT OF NEED

It may not be obvious that someone requires an interpreter due to them having grasped sufficient English to communicate basic information. Often they will present to reception and the health adviser may be requested to assist with registration. To elicit their comprehension of English it may be helpful to ask the following:

- Questions that demands more than a Yes/No response
- To repeat a message you have given in their own words

There can be a temptation to struggle through a consultation if the person has made an effort to attend and has got so far through the system. However it is to be noted that the health adviser has a professional obligation to ensure that any tests and procedures performed require fully informed consent. This may not be possible if there is a communication barrier and therefore the input of an interpreter is just as much for the benefit of the professional as well as the client.

Identify which language the person speaks before requesting an interpreter. This may be conveyed in advance or the patient/client brings a card naming the language required. If this however is to be established it may be helpful to request that an interpreter service provides a printed list of languages they offer with a translation of the following:

“Please indicate which language you speak and we will try to obtain an interpreter to help us.”

A British Sign Language (BSL) /English interpreter can make it easier for a Deaf sign language user and a hearing person to communicate with each other. An interpreter interprets from one language to the other. In the UK this will usually be from BSL to spoken or written English, or spoken or written English to BSL.⁶ In Ireland this will be Irish Sign Language. As in spoken English there are regional variations. Some however will use Sign Support English or finger spelling. Deafblind people have a combined sight and hearing loss. Although many deafblind people still have a little useful sight and hearing, and can therefore use speech and hearing aids to communicate, some will require manual communication in the form of the deafblind alphabet. If the booking of a communication service is required for someone who is deaf or deafblind, it is vital their communication needs are assessed before making it.⁷

BOOKING AN INTERPRETER

It is important that local policies are adhered to, though the following information will be universally applicable:

- Try to give notice to the interpreting service when booking the appointment e.g. one week, unless there is an urgent need. Some areas may need even longer. This is often true when booking an interpreter for a Deaf patient. If this results in an unacceptable delay then it may be necessary to arrange the use of a telephone interpreting service. The London based service 'Language Line' (0800 169 2879) is expensive but can usually provide an interpreter within minutes to participate in a 3-way conference call. They handle over 120 languages on a regular basis⁸
- Make a provisional appointment time and date with the patient and discuss the easiest way to contact them if there is a need to rebook. Document how to contact them in the notes
- Stipulate the length of time that the interpreter will be required
- Confirm what language(s) they speak and what dialect
- Consider whether you can maximise the use of the interpreter, it may be possible to get the patient's partner in at the same time, or consider if they need other appointments arranged to see another member of staff; for example if the person is coming for an HIV test it may be useful to offer a GU screening appointment at the same time

WORKING WITH THE INTERPRETER

The following guidelines will assist the health adviser in how to work more effectively with an interpreter:

- When the interpreter arrives the member of staff who is seeing the patient may be informed that the interpreter has arrived
- Prior to seeing the patient it is good practice that the member of staff working with the interpreter has a discussion with them about what is required. Give permission for the interpreter to interrupt the interview where necessary. The interpreter is unlikely to be an expert in cultural issues but may provide some guidance on factors that could affect the interview
- Time spent with the interpreter explaining briefly what is known of the case may be valuable. Specific information could be given with regards to the nature of the clinic
- Check with the interpreter how to correctly use and pronounce the clients name
- Brief them about the type of questions they need to translate. Some common terms and vocabulary may need to be explained

- Information could be made available about clinic confidentiality. For example if there is a known recent casual contact that this should not be made known to the other partner
- Does any of the above cause any concern for the interpreter?

Time invested in such a discussion will ensure that the interpreter is suitable. If there seems to be a conflict of interests then this is to be made explicit and the health adviser may consider cancelling the appointment and write a complaint or provide feedback to the interpreting service. Such circumstances should be rare if the interpreting service offers training to its staff. There may be opportunity for the health adviser to provide input into this training programme.

T H E I N T E R V I E W

The following guidelines will help the health adviser, patient and interpreter to get the most out of the interview:

- Arrange a place where the interview can be conducted in private
- Arrange the seating to allow for easy communication. It is important for the interpreter to be placed between the two parties since this is a more neutral position.⁹ However in the case of working with a Deaf client position the interpreter close to the main speaker if possible, and clearly visible to the Deaf person. The interpreter is to be well lit, but not from behind - not in front of a bright window¹⁰
- Provide a glass of water to the interpreter – they will be speaking twice as much as anyone else
- Establish that the interpreter and client speak the same language or dialect
- Allow extra time for the interpreter to introduce himself or herself to the client and explain their role
- Stress the confidential nature of the interview
- Check if they are acceptable to the client
- Introduce the health adviser and roles
- Look at the client and not the interpreter. Maintaining good eye contact will reinforce the feeling of direct communication
- Use simple language as free from jargon as possible
- Speak clearly at a normal pace. Interpretation is almost simultaneous, but there will be a slight delay as the interpreter picks up the meaning of a phrase. Break up speech into short sections. A message may be lost if more than four or five sentences are delivered at one time
- Listen actively to the interpreter and the client. Allow time for the client to respond or ask questions

- Check if the client has understood everything at the end of the interview

COMMONLY ENCOUNTERED DIFFICULTIES

Using an interpreter is not without its problems and they may fall into the category of:

- The interpreter does not speak the clients language and English fluently
- The client feeling uncomfortable with the interpreter which may hinder open communication
- The interpreter not translating exactly what is being said
- The interpreter losing their neutral stance and acting as an advocate for the client
- Not allowing sufficient time for the interview
- Overuse of complex vocabulary
- Discomfort of the interpreter with the sexually explicit nature of the interview

If these are identified and cannot be easily rectified then the interview may be terminated and rescheduled.

POST INTERVIEW

Following a consultation the interpreter could be offered advice/ feedback about the session. It is necessary to document the interpreters name and agency in the patient's notes.

Arrange a suitable appointment with the patient if follow up is required. Check if the interpreter is available. Should the interpreter not be available then rearrange the follow up appointment directly with the interpreting service. Any difficulties encountered during the whole process are to be reported directly to the interpreting agency.

CONCLUSION

Health advisers are well placed to facilitate high quality communication between the client and clinic professionals through the use of an interpreter. There are many obstacles to achieving this but if overcome through paying attention to detail, then the sexual health of the client can be significantly enhanced.

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