Guidelines for the Care of Lesbian, Gay and Bisexual Patients in Primary Care

RC GP NI
Royal College of General Practitioners

HSC Public Health Agency
Project supported by the PHA

Royal College of General Practitioners

Foreword

The Royal College of General Practitioners Northern Ireland (RCGPNI) developed these guidelines to assist general practitioners and other healthcare professionals to provide the best care possible to members of the Lesbian, Gay, Bisexual and Trans* community. Through the collaborative work of the Royal College of General Practitioners in Northern Ireland Lesbian, Gay, Bisexual &/ Trans* (LGB &/T) working group, it is hoped that these guidelines will create a positive change in the way LGB &/T people are cared for within the health service in Northern Ireland.

The RCGPNI would like to acknowledge the support received from the Public Health Agency NI which facilitated the development of this project.

The RCGPNI would also like to take this opportunity to recognise the Irish College of General Practitioners for the information and advice provided in the initial development stages of the Guidelines for the Care of Lesbians, Gay and Bisexual Patients in Primary Care.

Our Vision

Excellence in general practice for patients worldwide.

Our Values

The RCGP is the heart and voice of general practice.

- We promote the principles of holistic generalist care in partnership with other health professionals and our patients.
- We are committed to equitable access to, and delivery of, high-quality and effective primary health care for all.
- We are committed to the academic and practical development of high-quality general practice.

Our purpose and strategic aims

To promote the best possible quality of health and health care for the population by:

- setting the highest standards for general practice
- ensuring that GPs have the best possible training
- supporting GPs throughout their professional lives to deliver the best possible service
- leading the professionals and demonstrating the value of general practice
- developing general practice as the foundation of effective and sustainable primary care worldwide
- using resources efficiently to support our members and develop the College sustainability.

Contents

Terminology and Acronyms

- **Sexual Orientation** – A person's attraction, whether emotional, psychological and/or physical to people of the opposite and/or same gender
- **Gender Identity**- A person's innate, deeply felt psychological identification as a man, woman or some other gender, which may or may not correspond to the sex assigned to them at birth
- **LB** - Lesbian or Bisexual
- **LGB** - Lesbian, Gay, Bisexual
- **LGB &/T** - Lesbian, Gay, Bisexual &/Transgender
- **Trans*** - Transgender or Trans* is the umbrella term given to describe individuals, behaviours and groups whose gender identity is different from the sex assigned to them at birth and/or describes individuals, behaviours and groups whose gender identity does not conform to conventional notions of male and female. For more information on care of Trans* patients, please see the accompanying RCGPNI guideline.[1]
- **STI** - Sexually Transmitted Infection
- **MSM** - Men who have sex with other men
- **WSW** - Women who have sex with other women
- **GUM** - Genito-Urinary Medicine
- **BASHH** - British Association for Sexual Health & HIV
- **NICE** - National Institute for Health and Care Excellence

Introduction

Estimating the number of LGB people in the United Kingdom and Northern Ireland (NI) is difficult. It depends on people surveyed identifying as LGB and then feeling able to disclose this. In the Integrated Household Survey of 2013, 1.6% of UK adults identified as LGB.[2] This is thought to be an underestimate, with both Stonewall and the UK Treasury estimating 5-7%.[3] This means that a Northern Ireland general practice with a list size of 5000 patients will have 250-350 LGB patients. These guidelines have been designed to highlight the specific health needs of this patient population and go some way to identifying possible strategies for improving their care. Information specific to Trans* Patients can be found in the Guidelines for the Care of Trans* Patients in Primary Care.[1]

We hope that these guidelines will be useful to the entire primary care team.

Social Issues

LGB people can experience invisibility, violence, discrimination and prejudice throughout their lives. These experiences of intolerance can impact negatively on their emotional health and wellbeing.[4]

It is often during school years that people become aware of their minority sexual orientation and/or gender identity. The 'Through our Minds' study of the experiences of LGB &/T people in Northern Ireland asked people about their experiences of school. More than 60% reported being called hurtful names related to sexual orientation and/or gender identity.[4]

65.8% of LGB &/T people reported being verbally assaulted at least once due to their actual/or perceived sexual orientation and/or gender identity.

Through Our Minds – The Rainbow Project[4]

LGB &/T people were also found to have had negative experiences in their everyday lives related to their actual or perceived sexual orientation and/or gender identity. These negative experiences included being threatened with physical violence or discrimination when accessing goods, facilities or services. One third had been threatened with 'being outed' at least once.[4]

Social isolation can be a problem for LGB people. One study found that 41% of LGB people over the age of 55 live alone, compared to 28% of heterosexual people the same age.[5] Social isolation can be felt by LGB people of all ages and can be a particular problem in rural areas.[6]

50% of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of sixteen.

Gay and Bisexual Men's Health Survey – Stonewall[7]

Domestic abuse in LGB communities often goes unreported and may be in the form of verbal, emotional or physical abuse.[6 7 8]

Consultation Issues

Gay and bisexual men are more likely to be 'out' to their manager, work colleagues, family and friends than their GP.

Gay and Bisexual Men's Health Survey – Stonewall[7]

If patients feel able to disclose their sexual orientation to their GP, issues that disproportionately impact on their health can be identified and discussed. 'Coming out' is not a single event for LGB &/T people, it is something they are required to do repeatedly over the course of their lives.

There are a number of ways a practice can demonstrate an open and inclusive clinical environment to LGB &/T patients:

- Allow LGB &/T patients to self-identify on new patient enrolment forms if they choose to do so.
- Practices could consider how they record or code that patients are LGB &/T after gaining consent to do so from the patient.
- Reception staff should demonstrate positive attitudes and use sensitive language.
- Sexual orientation training could be considered for all primary care staff.
- Posters and leaflets reflecting LGB &/T issues can be displayed in the waiting room.
- Sexual orientation and gender should be included in the anti-discrimination policy and it should be clearly displayed.
- Include LGB &/T patients in patient participation groups.

During a consultation, it is important not to make assumptions about a patient's sexual orientation or to assume they are heterosexual. It is important to facilitate disclosure but also to respect non-disclosure. A GP can make it easier for patients to disclose or talk about their sexual orientation by:

- Assuring the patient that consultations are confidential.
- Adopting a non-judgemental attitude.
- Using open questions such as "Do you have a partner?"
- Using gender-neutral, inclusive terminology.

One third of gay and bisexual men, who had accessed healthcare services in the last year, had a negative experience related to their sexual orientation.

Gay and Bisexual Men's Health Survey – Stonewall[7]

Where a patient chooses to disclose their sexual orientation as LGB it is important that this is acknowledged and the terms they use clarified. They can then be offered information relevant to their sexual orientation and this should not focus solely on their sexual health. LGB patients report finding it difficult to bring a same sex partner to their consultation and should be encouraged to do so if they would find it helpful.[7 8]

When treating a child with same-sex parents, family diversity can be respected by involving the non-biological parent in the discussion.

GPs need to be aware of the need to support parents and other family members of teenagers who are 'coming out' as LGB (see additional resources page).

Health Screening

20% of LB women have been told they don't need a smear by a healthcare professional.

Prescription for change - Stonewall[8]

Lesbian and female Bisexual patients are also less likely to have had a cervical smear than women in general.[8] The Human Papilloma Virus (HPV) is sexually transmitted and HPV is a large causative factor in cell dyskaryosis and in the development of cervical cancer.[9][10] We know that WSW may or may not identify as L, G or B. LB women may be having penetrative sex with a man or have done so in the past. Other LB women may never have had sex with a man, but these patients can transmit HPV and STIs to their female partner from their sexual practice e.g. oral sex or sharing sex toys without use of a condom.[8][9] The Northern Ireland Cervical screening programme offers screening by cervical smear tests to all women aged 25–64.[9] The programme is inclusive of Lesbian and Bisexual women. Girls who identify as LB should also be included in the HPV vaccination programme.

GPs and GP employed nurses should:

- Offer all women aged 25–64 a cervical smear regardless of their sexual orientation.
- Offer women information about safer sex practices to reduce risk of acquiring HPV regardless of their sexual orientation.
- Ask inclusive questions when history taking around the smear test e.g. "Are you sexually active at present?" and if yes, "Do you have a regular partner?" making sure not to assume heterosexuality.

Lesbian and bisexual women aged 50-79 are more likely to develop breast cancer than women in general.

Prescription for change – Stonewall[8]

This is despite having similar rates of breast screening to the general population in that age group.[8][11] Breast cancer is the second most common form of cancer among women in Northern Ireland.[11] The Northern Ireland breast screening programme provides breast screening every three years for all eligible women in Northern Ireland aged 50 and over.[11]

GPs and GP employed nurses should:

- Educate all eligible women about breast screening and breast awareness, regardless of their sexual orientation.

For specific information relating to health screening for Trans* patients please refer to the Trans* specific guidelines.[1]

Smoking, Drug & Alcohol Addiction

Smoking

44% of LGB &/T people in Northern Ireland smoke compared to 24% of general population.

All Partied Out? - The Rainbow Project[12]
NISRA[13]

In the LGB &/T population, the ratio of women to men who smoke was approximately equal and 69% of LGB &/T smokers want to quit.[12]

Drugs

62% of LGB &/T people in Northern Ireland have taken an illegal drug in their lifetime, compared to 22% of the general population.

All Partied Out? - The Rainbow Project[12]
NACD & PHIRB[14]

There is a high risk behaviour becoming an increasing issue within the MSM community called "chemsex".[15] It is a term commonly used by gay or bisexual men to describe sex that occurs under the influence of drugs.[15]

Substance misuse is not, however, solely a problem of MSM. The LGB &/T population use all types of illegal drugs more than the general population.[12] These drugs include cannabis, sedatives and opiates as well as 'recreational' drugs such as poppers and ecstasy.[12]

The reasons for higher substance misuse appear to be multifactorial. The statistics challenge the belief that higher rates of substance misuse can be solely attributed to the 'gay scene'of bars and night clubs or chemsex.

The disparity between levels of substance misuse in the LGB &/T population and the general population are highest in the 15-24 year old age group. It can be speculated that this is due to these young people coming to terms with their sexual orientation and the stress of 'coming out' to family and friends.[12]

LGB &/T people are also less likely to access substance misuse services, often for fear of discrimination.[12]

GPs and GP employed nurses should:

- Be aware of the higher rate of substance misuse in the LGB &/T population.
- Be aware that LGB &/T people may find it more difficult to seek help and access services.

Alcohol

91% of LBG &/T people in Northern Ireland drank alcohol regularly compared to 74% of the general population.

All Partied Out? - The Rainbow Project [12]
DHSSPS [16]

13% of the LGB &/T population report daily drinking compared to 6% of the general population of Northern Ireland. 57% of LGB &/T respondents reported drinking to a hazardous level.[12]

GPs and GP employed nurses should:

- Be aware of the higher rate of alcohol use in the LGB &/T population and screen as felt appropriate.

Mental Health

Almost half (46.9%) of LGB &/T respondents disclosed a history of suicidal ideation.

Through Our Minds -The Rainbow Project [4]

Minority stress is a term used to describe the mental health consequences of stigmatisation, social exclusion, discrimination and harassment of minority groups. Research consistently shows that the LGB &/T population are at increased risk of depression, self-harm and suicide when compared to heterosexual people. One meta-analysis showed a twofold increase in suicide attempts in the preceding year in both men and women and a fourfold lifetime increase in gay and bisexual men.[17]

'Through Our Minds' was a study of the emotional health and well-being of the LGB &/T population in Northern Ireland.[3] Of those who responded:

- 70.9% had experienced or were experiencing depression
- 35.3% disclosed a history of self-harm
- 25.7% had attempted suicide at least once

It is worth noting that 78.2% of patients who sought help with their depression chose to present to their GP as did 54.4% of those who asked for help following a suicide attempt.[4]

Gay and bisexual men are more likely to suffer from eating disorders. One in seven (13%) have had a problem with their weight or eating in the last year compared to 4% of men in general.[7]

Being lesbian, gay or bisexual relates to sexual orientation. It is not a mental illness and cannot be 'cured'. Despite this, voluntary agencies in Northern Ireland still report meeting individuals who have been subjected to 'conversion therapy', also known as 'reparative' or 'gay-cure' therapy. A consensus statement prepared by the UK Council for Psychotherapy has condemned such practices.[18]

This is supported by the Royal College of Psychiatrists which states:

"The Royal College of Psychiatrists believes strongly in evidence-based treatment. There is no sound scientific evidence that sexual orientation can be changed. Furthermore, so-called treatments of homosexuality create a setting in which prejudice and discrimination flourish."[19]

GPs should:

- Be aware of the increased risk of depression, self-harm, and suicidal ideation in LGB &/T patients and screen patients for mental health risk factors if appropriate.
- Recognise that conversion therapy is ineffective, inappropriate and potentially damaging.

Sexual Health

44% of gay and bisexual men have never discussed STIs with a healthcare professional.

Gay and Bisexual Men's Health Survey – Stonewall[7]

Where does general practice fit in to sexual health services? RCGP have published a BASHH approved document 'Sexually Transmitted Infections in Primary Care 2013'.[20] It provides a practical approach to STI screening and management in primary care for all patients.

GPs providing sexual health services to LGB patients should:

- Only practice STI screening and management within their own level of competency and training. If GPs feel out of their depth – refer or sign post to GUM services.[20]
- Promote 'the safer sex message' to patients of all sexual orientations.
- Be able to take an appropriate and confidential sexual history to assess risk of STIs in patients of all sexual orientations.[21]
- Be mindful that WSW or MSM may not always identify as L, G or B.
- Offer STI testing on the basis of risk rather than sexual orientation.
- Be aware that if the patient is symptomatic they need to be offered a genital examination or referred to GUM.[22]
- Check if the patient needs assistance in accessing an appointment with GUM services and act as an advocate if appropriate.
- Make themselves aware of their local level 3 GUM service and community based services which can offer some STI testing – such as Brook NI clinic (male <25, female <20), The Rainbow Project (male only), outreach testing in Gay venues (GUM and Rainbow) and walk in MSM clinics in GUM. See **www.sexualhealthni.info*** for range of services.

When taking a sexual history you should consider the following guidance (see appendix 1):[21]

1. Ask to see the patient alone as this will reduce embarrassment and enhance disclosure.
2. Obtain consent and warn about the nature of the questions e.g. "I need to ask you some personal questions to help me advise you on the correct STI tests for you, would that be ok?".

*Pending launch April 2015

3. Normalise the process e.g. "We ask these questions to everyone with similar symptoms / difficulties".
4. Be non-judgemental and emphasise confidentiality.
5. Try not to make assumptions about sexual practice or risk of STIs before you ask the questions.
6. Avoid the terminology of LGB unless the patient identifies as such.
7. The language used should be professional but can be individualised for the patient or health practitioner.

STI screening should not necessarily be the first thing the clinician offers when a patient 'comes out'. In order to understand the risks a patient might be taking it is important to take a more holistic view of their health. Engaging in high sexual risk behaviour may be an indication of other underlying problems, such as deteriorating mental health, social exclusion or substance misuse. Being LGB is not a psychosexual problem; however some LGB patients may have a psychosexual problem or suffer with sexual dysfunction[7] The clinician may have to explore this in the same way as with their heterosexual patients and make appropriate referrals.

Men who have Sex with Men (MSM)

49.5% of gay men in Northern Ireland have never had an HIV test.

UK Gay Men's Sex Survey – EMIS[23]

MSM may be in long term relationships in which both partners have had repeated negative testing for STIs. Not all MSM will identify as Gay or Bisexual. MSM are disproportionately affected by STIs and HIV in Northern Ireland and STIs are on the rise here[24 25] Infectious Syphilis is endemic in Northern Ireland with highest rates in MSM.[24]

Table 1 - STIs in MSM in Northern Ireland 2013.[24 25]

STI	Percentage of new diagnosis in 2013 attributable to MSM.
HIV (male and female)	65%
Syphilis (male and female)	83%
Chlamydia (male)	12%
Gonorrhoea (male)	46%
Genital Herpes (male)	23%
Genital Warts (male)	9%

An estimated 1 in 5 people living with HIV in the UK are undiagnosed and it is believed that most HIV infections are transmitted by those as yet undiagnosed.[26] [27] MSM who have been surveyed by Stonewall about their sexual health have disclosed that they have not been tested for STIs, including HIV, for a variety of reasons including, 'I don't think I'm at risk', 'I'm too scared to test', 'I'm too busy to get tested', 'I have no symptoms of infections' or purely because they have poor access to services.[7] Conversely, MSM reported mostly being tested for HIV after an experience that they had classified as 'risky' or having symptoms that they attributed to an STI.[28]

BASHH standards for management of STIs recommend that all MSM STI screening and treatment should be managed at a Level 3 GUM service (consultant led), due to the sometimes complicated nature of the patient's needs.[22] GP surgeries should work with GUM services to provide screening if a patient declines GUM appointment or is having difficulty attending GUM. Community based services with strong links to GUM can also offer some services for these patients e.g. The Rainbow Project (rapid access HIV and syphilis testing service male only) and Brook NI (for <25s).

NICE guidance suggests that primary care providers should ensure annual HIV testing is offered to men who are known to have sex with men.[29] This is not necessarily easy to do at a practice population level and raises issues with coding of sexual practice and sexual orientation in GP records. Emphasis has been shifted away from pre-test counselling towards normalisation of the test and increasingly offering the test.[30] Thought should be given to the practice systems regarding HIV testing e.g. how should the test result be given to the patient? How should the result be coded?[31]

All MSM should be offered a 3 series course of Hepatitis A+B vaccinations (e.g. Twinrix Adult®) free on the NHS.[32] [33] [34] Accelerated courses should be offered initially to aid completion of the course. There are various accelerated schedules including 0, 7, 21 days with booster at 12 months and 0, 1, 2, 12 months.[35] This may cover MSM for up to 10 years, but titres need to be checked. It is important that GPs and GP employed nurses differentiate between these vaccinations schedules and travel vaccinations.

The Joint Committee on Vaccination and Immunisation (JCVI) has recently recommended that the HPV vaccine should be offered to MSM aged 16 to 40 in England.[36] Although not currently available in Northern Ireland, GPs should be aware that the HPV vaccination programme may be changed to reflect this recommendation in the future.

GPs should be aware that MSM patients:

- Should ideally be managed at a Level 3 GUM service (consultant led).[22]
- Could be offered opportunistic HIV testing in primary care.
- Having unprotected sex with casual or new partners should have an HIV/Hepatitis B+C/Syphilis/STI screen at least annually or every 3 months if changing partners regularly.
- May require triple site (urine, pharyngeal, anal) testing for Chlamydia and Gonorrhoea based on sexual practice.[22]
- Should be offered a free accelerated course Hepatitis A+B vaccination and booster based on immunity.

Post-Exposure Prophylaxis (PEP)

PEP is cost effective for high risk HIV exposure and unprotected anal sex in MSM.

PEPSE 2011 – BHIVA[37]

Post-Exposure Prophylaxis or PEP (sometimes referred to as PEPSE or Post-Exposure Prophylaxis after Sexual Exposure) is a 28 day course of antiviral tablets prescribed following high risk exposure to HIV.[37] Its aim is to prevent HIV becoming established in the T-memory cells if the virus has been transmitted. Treatment with PEP must be given within 72 hours, but the earlier after exposure it is commenced the more effective it will be.[37] PEP can only be accessed in GUM and A+E. When a patient presents requesting PEP a sexual history will be taken and the risks versus benefits of PEP will be discussed. If PEP is deemed appropriate, baseline tests including HIV, Hepatitis immunity and renal function will be taken before medication is provided.[37] Likely side effects and the importance of adherence to the regimen and attendance for follow up will be explained.

As a GP or GP employed nurse you should:

- Be able to assess the patient's risk of HIV exposure in the preceding 72hrs or contact GUM for advice. See appendix 2.[37]
- Refer at risk patients to GUM urgently for same day assessment if you believe PEP should be discussed.
- Refer the patient to A&E for PEP if it is out of hours for GUM.

Lesbian and Bisexual (LB) Women and Sexual Health

Less than half of lesbian and bisexual women have ever been tested for an STI.

Prescription for Change – Stonewall[8]

Lesbian and female bisexual patients often report they don't feel at risk of STIs, are too scared to get tested or have been told by a healthcare worker that they don't need tested.[8] Not all WSW will identify as L, G or B. Patients that identify as lesbian or bisexual may be having or have had sex with a man in the past.[8] Conversely, women who identify as heterosexual may be having sex or have had sex with a woman.

LB women have both oral and penetrative sex and can share fluids through hands, mouth and sex toys.[8] Although Bacterial Vaginosis (BV) can occur without sexual contact it is commonly sexually transmitted between LB women.[8] Thrush can also be transmitted by sexual contact in LB women.

All STIs can be transferred between women.[8] LB patients can get pelvic inflammatory disease (PID) most commonly from Chlamydia infection. Given the risks of untreated PID, suspected PID should be treated.[20]

Fertility Issues

LB women may present requesting referral to fertility clinics. The NHS can help with donor insemination or in vitro fertilisation (IVF) but this is very limited. To be eligible, you need to be trying to get pregnant without medical help for at least two years and it must be proven that you have a medical condition that makes conception difficult.[38] Private fertility clinics provide services such as intrauterine insemination (IUI) and IVF with donated sperm but this method can be very costly.[38] Many LB women choose self-insemination to conceive. This raises issues of safety and the health of the sperm donor.[38]

GPs and GP employed nurses should:

- Consider screening and treating female partners of women with BV.
- Offer women information about safer sex practices to reduce risk of acquiring STIs regardless of their sexual orientation.

Conclusion

LGB patients face minority pressure, stigmatisation and the pressure of 'coming out' on a daily basis. They have higher rates of depression, self-harm and suicide. They are more likely to smoke, take alcohol to excess and take illegal drugs. Their complex needs in primary care go far beyond STI screening. These guidelines aim to suggest ways in which practices can be more inclusive, allowing patients to self-disclose if they choose to and improve health outcomes as a result.

Additional Resources

The Rainbow Project: The Rainbow Project works to improve the health and wellbeing of LGB&/T people in Northern Ireland. They have offices in Belfast and L'Derry. The core services they provide are: counselling, health promotion, sexual health advice, education and training, support and advocacy and personal development. They are instrumental in influencing policy and lobbying policy makers in concerned campaigns. They provide sexual orientation awareness training to organisations.

W: **www.rainbow-project.org**
T: 02890 319030
E: **info@rainbow-project.org**

HERe NI: HERe NI specifically supports lesbian and bisexual women and their families. They have a range of peer support groups across the country. One to one support is also available on request. A range of information sessions are also provided throughout the year ranging from fertility information to LB women's legal rights. They provide sexual orientation training to organisations.

W: **www.hereni.org**
T: 02890 249452
E: **hello@hereni.org**

Cara-Friend: Cara-Friend was established as a voluntary counselling, befriending, information, health and social space organisation for the LGBTQ (questioning) community. They now bring together all ages, all genders and sexual orientations under one umbrella. They facilitate Gay Lesbian Youth NI and LGBTNI switchboard. They advocate on behalf of the LGBTQ community with the media, churches, government departments and politicians.

W: **www.cara-friend.org.uk**
T: 02890 890202
E: **admin@cara-friend.org.uk**

Want to find out what is going on across NI? Go to **www.lgbtni.org** for meetings and events.

Support for parents:
Family ties project: **http://www.familytiesproject.org.uk/whatproject.html**
Parenting NI: **http://www.parentingni.org/projects/parentingforum/documents/-Factsheet20GuidanceforParentsLGB.pdf**

Sexual Health Services in Northern Ireland: www.sexualhealthni.info*

***Pending launch April 2015**

Appendix 1

Minimum data for sexual history taking adapted from UK national guideline for consultations requiring sexual history taking (BASHH, 2013).[21]

Minimum sexual history for symptomatic female patient attending for STI testing.

- Symptoms / reason for attendance.
- Date of last sexual contact (LSC), partner's gender, anatomic sites of exposure, condom use and any suspected infection, infection risk or symptoms in this partner.
- Previous sexual partner details, as for LSC, if in the last three months and a note of total number of partners in last three months if more than two.
- Previous STIs.
- Last menstrual period (LMP) and menstrual pattern, contraceptive and cervical cytology history.
- Pregnancy and gynaecological history.
- Blood-borne virus risk assessment and vaccination history for those at risk.
- Past medical and surgical history.
- Medication history and history of drug allergies.
- Agree the method of giving results.
- Establish competency, safeguarding children / vulnerable adults.
- Recommend / consider recognition of gender-based violence / intimate partner violence.
- Alcohol and recreational drug history.

Minimum sexual history for symptomatic male patient attending for STI testing.

- Symptoms / reason for attendance.
- Last sexual contact, partner's gender, anatomic sites of exposure and condom use, any suspected infection, infection risk or symptoms in this partner.
- Previous sexual partner details as for LSC, if in the last three months, and a note of total number of partners in last three months if more than two.
- Previous STIs.
- Blood-borne virus risk assessment and vaccination history for those at risk.
- Past medical and surgical history.
- Medication history and history of drug allergies.
- Agree method of giving results.
- Establish competency, safeguarding children / vulnerable adults.
- Recommend / consider recognition of gender-based violence / intimate partner violence.
- Alcohol and recreational drug history.

Appendix 2

Table to assist clinicians in assessment for PEP, adapted from UK guideline for the use of post-exposure prophylaxis for HIV following sexual exposure (Int J STD AIDS 2011).[37]

Situations when post-exposure prophylaxis (PEP) is considered

	Source HIV status			
	HIV-positive			
	Viral load detectable	Viral load undetectable	Unknown from high prevalence group/area*	Unknown from low prevalence group/area
Receptive anal sex	Recommend	Recommend	Recommend	Not recommended
Insertive anal sex	Recommend	Not recommended	Consider†	Not recommended
Receptive vaginal sex	Recommend	Not recommended	Consider†	Not recommended
Insertive vaginal sex	Recommend	Not recommended	Consider†	Not recommended
Fellatio with ejaculation‡	Consider	Not recommended	Not recommended	Not recommended
Fellatio without ejaculation‡	Not recommended	Not recommended	Not recommended	Not recommended
Splash of semen into eye	Consider	Not recommended	Not recommended	Not recommended
Cunnilingus	Not recommended	Not recommended	Not recommended	Not recommended
Sharing of injecting equipment	Recommended	Not recommended	Consider	Not recommended
Human bite§	Not recommended	Not recommended	Not recommended	Not recommended
Needlestick from a discarded needle in the community			Not recommended	Not recommended

- *High prevalence groups within this recommendation are those where there is a significant likelihood of the source individual being HIV-positive. Within the UK at present, this is likely to be men who have sex with men and individuals who have immigrated to the UK from areas of high HIV prevalence (particularly sub-Saharan Africa)
- †More detailed knowledge of local prevalence of HIV within communities may change these recommendations from consider to recommended in areas of particularly high HIV prevalence
- ‡PEP is not recommended for individuals receiving fellatio i.e. inserting their penis into another's oral cavity
- §A bite is assumed to constitute breakage of the skin with passage of blood

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