Waverley care

“More taboo than talking about drugs”

A qualitative assessment of the sexual health needs of people who inject drugs in Greater Glasgow and Clyde

Authors: Jennifer Goff, Kristin Hay, Kirsty Kay, Scott McMurray, Thomas Petersen, and Linda Robertson

To cite this report: Goff, J., Hay, K., Kay, K., McMurray, S., Petersen, T. and Robertson, L. (2023). ‘More taboo than talking about drugs’: A qualitative assessment of the sexual health needs of people who inject Drugs in Greater Glasgow and Clyde. Waverley Care

Acknowledgements

We would like to express our deepest thank you to all those who have made this research possible.

First and foremost, we extend our warmest thanks to the participants of this study for their time, willingness and cooperation, including both community members with experience injecting Drugs, and the Health and Social Care Practitioners, who each so kindly contributed. We know that talking about sexual health can be difficult, and that the topics we explored can touch on sensitive experiences in life. For these reasons, we appreciate each and every moment participants offered to this research. Their contributions have been invaluable to the findings this research and we promise to advocate for meaningful improvement to sexual healthcare on their behalf.

Thank you to each member of our steering group, Jo Zinger (NHS Greater Glasgow and Clyde), Becky Metcalfe (NHS/Glasgow Caledonian University), Trish Tracey (Turning Point Scotland), Matt Smith (Glasgow Caledonia University), Lynsey Boyd (NHS Greater Glasgow and Clyde), Adrienne Hannah (Scottish Drugs Forum), Scott Bissell (NHS Greater Glasgow and Clyde), Grant Sugden (Waverley Care) and Claire Kofman (Waverley Care). We are grateful for their guidance, encouragement and invaluable feedback throughout the duration of this project. Their expertise and ongoing support have been instrumental in shaping this research.

Thank you to Lindsay Boyd for generously offering her clinical support during data collection, as well as Dr Matt Smith for kindly offering his constructive feedback on the research design. Their insights and suggestions have greatly improved the quality of this research.

Thank you to our colleagues at the Simon Community Access Hub, who generously offered us space to carry out our research. Offering support to create new knowledge in this way is a form of community activism, so we sincerely appreciate the openhearted resourcing the Simon Community Access Hub team provided us with.

Thank you to our colleague Francis Osis for his support with proofreading, and to our communications team for designing this report.

Lastly, thank you to the Scottish Government for providing the financial support that made this research possible.

This research would not have been possible without the support and contributions of all those mentioned above. We are truly grateful for their help and support.

Contents

Executive Summary 3
Introduction 5
Literature review 6
Sexual Risk Taking and People who Inject Drugs 6
Risk taking behaviours, and types of drugs: 6
Women: 7
Sex Work: 8
Concurrent Risk Factors 8
Mental Health 9
Stigma 9
Methods 10
Phase 1: Participatory Action Research and Interviews 10
Phase 2: Semi-structured interviews with HSCPs 11
Findings - PWID 12
Sexual health awareness and perceived risk 12
Access to current services 13
Accessing future services 14
Findings – Health and Social Care Practitioners 15
Perceived knowledge and signposting 15
Knowledge of prevention 16
Support and training 17
Providing service specific information 18
Conclusion and Recommendations 21
Guidance Format 22
Concluding notes 23
Appendix - 24
Peer Researcher Training Programme 24

EXECUTIVE SUMMARY

'So, when you're going to see these people, it's all right them speaking about your addiction, a bit about your mental health, but what about your sexual health? I could be loaded up with something and that's affecting me in another way. If I had an infection it could be playing up things in my body, making me feel uncomfortable and I don't know. It could lead to other things, I'm trying to explain.' – Participant

This report describes the findings of qualitative research project, assessing the sexual health needs of people who inject drugs (PWID) in Greater Glasgow and Clyde. PWID face a number of intersecting inequalities, which affects risks to sexual health as well as access to services and information. Inconsistency in access to, and provision of sexual health services, has detrimental impacts on PWID, and heightens incidence of STIs and HIV – as witnessed through Glasgow's most recent HIV outbreak.

The research was conducted between September 2021 and September 2022, and through two phases of research, we heard from 30 people who inject drugs (PWID) – phase 1 - and 16 health and social care professionals employed within the area – phase 2.

As a group who are often considered hard to reach/easy to ignore, our findings indicate that PWID have a basic understanding of STIs, HIV, and contraception, but have little knowledge of preventative HIV treatments such as PrEP (pre-exposure prophylaxis) or PEP (post exposure prophylaxis). Much of what is known is also impacted upon by stigma. Through the research we found:

- Most PWID who took part in the research shared that they had a basic understanding of STIs, HIV, and contraception, but have little knowledge of HIV transmission methods and preventative medications such as PrEP (Pre-exposure Prophylaxis) or PEP (Post-exposure Prophylaxis)
- 70% of participants were unaware of what PrEP was
- 26% of participants reported having no knowledge of STIs, and 16% felt that they knew something but were unsure of what constituted a transmission risk.
- Most participants had either never accessed sexual health services, were unsure of when their most recent instance of access took place, or their most recent instance of access took place more than two years ago.
- When asked how they would normally access information about sexual health, 30% shared that they would get information through a general health service, such as their GP, a pharmacy, or the hospital. 40% would use a local community organisation, such as the Simon Community Access Hub, or a local homelessness service. 16% would access information online.

The findings from phase 2 of the research show that health and social care professionals (HSCPs) value sexual health as an important aspect of healthcare provision. However, many were unaware of key concepts related to HIV transmission prevention, such as the use of PrEP or the meaning of U=U.

- HSCPs value sexual health as an important aspect of healthcare provision, but many were unaware of key concepts related to HIV transmission prevention, such as the use of PrEP or the meaning of U=U.
- 56% of participants shared that they had accessed sexual health training in their current occupation.
- 25% had never accessed sexual health training.
- A number of barriers emerged, specifically around gaps in tailored training, and around limited targeted information for PWID.
- 68% of participants stated they would only be comfortable talking about sexual health with PWID if they had developed a working relationship

Areas of future work:

Both audiences were open to improving their sexual health literacy and awareness. PWID recognised the importance of managing their sexual health, but needed more information. This includes accessible sexual healthcare resources, provided for PWID through routes that account for varying literacy levels, digital exclusion. Attention within this information should also be given to the moralised perceptions that inform the assessment of STI and HIV risk. This must be developed alongside wider public health resources, including increasing access to PrEP and looking at opportunities like postal testing – following COVID models for PWID.

HSCPs shared their willingness to provide sexual healthcare with proper training and resources, but there were substantial gaps in training and information available to them, which affected their confidence to do so. We suggest therefore that tailored and specific guidance is developed to support HSCPs when talking about sexual health with PWID.

Specifically, guidance developed for HSCPs should:

- offer information on specific topics, such as trauma-informed sexual health support
- offer information on how the intersecting identities of PWID influence the sexual healthcare they need.
- include practical tips on talking about sex with PWID.
- include ways of accessing information aimed at PWID and Health and Social Care Practitioners.
- include ways of accessing training and further education.
- include what sexual health services are available for PWID and what their remit is.
- include referral pathways to clinical sexual health services where available.
- include information on how to signpost to all available sexual healthcare services.

The Scottish Government's aims to achieve zero HIV transmissions by 2030 reiterates the importance of attending to the needs of every group in society, to ensure that no-one is left behind in this mission. Our research highlights services, and information provision which should be considered in establishing a responsive system of sexual healthcare.

INTRODUCTION

Over recent years, Greater Glasgow and Clyde has seen significant developments in the provision of sexual healthcare as part of harm reduction measures for people who inject Drugs (PWID). In particular, these developments have been in response to the HIV outbreak in the area, where over 189 new HIV diagnoses were identified between 2014 and 2021 (National HIV PWID Oversight Sub-Group, 2021). The diagnosis rate marks a substantial increase when compared to an average of ten per year between 2006 and 2014 (Public Health England 2017; 2018). Thus, a renewed service, policy, and research focus has subsequently emerged, focusing on reducing injecting-related harms in Greater Glasgow and Clyde (Tweed and Rogers, 2016).

International evidence draws attention to the complex interrelated factors that increase the risk of HIV among PWID. A renewed focus in response to the HIV outbreak has generated evidence specific to the experience of PWID in Greater Glasgow and Clyde. PWID face a number of intersecting inequalities, compounding access to prevention and treatments, such as Scotland's national PrEP programme (Grimshaw et al 2021).

Although sharing injecting equipment is the main route of HIV transmission among this community, it is not the only one, and sexual transmission remains an avenue of transmission, albeit more overlooked (McAuley et al. 2019). Health Protection Scotland (2019) research, for instance, has similarly shown that PWID experience high levels of sexual risk-taking, as well as extremely low engagement with sexual health services. While the evidence available on the needs of PWID in Greater Glasgow and Clyde continues to grow, there remain notable gaps in service and information provision that continue to affect access to basic sexual healthcare.

The following sections of the report chart sexual health support, information and knowledge from the perspectives of PWIDs and HSCPs. Section 2 positions the research within wider literature and existing understandings around these audiences. The report then moves to discuss how the research was conducted (section 3), and what it found (sections 4 and 5). It finishes by outlining future recommendations within sexual health provision for PWID and associated training for HSCPs. In order to achieve the Scottish Government's (2020) ambition of reaching zero new HIV transmission by 2030, it is vital that no group is left behind and existing gaps in provision are attended to and remedied.

LITERATURE REVIEW

Sexual Risk Taking and People who Inject Drugs

"In February 2015, the West of Scotland Specialist Virology Centre (WoSSVC) in Glasgow reported to the Public Health Protection Unit that an unusually high number of HIV diagnoses had been made, via dry blood spot tests sent from drug treatment services in the city, in the latter part of 2014 and early 2015" (Metcalfe et al 2020).

Between 2014 and 2021, 189 PWID were diagnosed with HIV in Greater Glasgow and Clyde. This was identified as the Glasgow outbreak, during which a spike in HIV diagnosis and incidence was marked across data in the region. As part of this increase in incidence, it was also acknowledged that the populations affected found it difficult to engage with existing hospital models of care because of intersecting inequalities, and a number of social, physiological, and practical issues. Injecting drug use, or sexual contact with someone known to inject drugs, were identified as the main risk factors for HIV acquisition. Our research focuses specifically on the latter.

Work carried out by Health Protection Scotland (2019) has shown that PWID experience high levels of sexual risk-taking, as well as extremely low engagement with sexual health services. PWID are also not a homogenous group – those affected can vary, but there are some aspects such as gender and homelessness which can either increase risk or reduce readiness and access to care (and sometimes, both). For example, 34% of the HIV cases among PWID in the Glasgow outbreak are women – an overrepresentation compared with general HIV incidence amongst this group (24%). Similarly, 64% of the PWID cases in the Glasgow outbreak are unhoused, compared to 25% of the general population (National HIV PWID Oversight Sub-Group 2021).

Risk taking behaviours, and types of drugs:

The types of drugs which people use often impact upon behaviours – including sexual health and risk taking. In considering increased risk-taking behaviours, it is worth noting that injecting cocaine use has significantly increased in Glasgow over the last decade. Cocaine is thought to impact on sexual risk-taking (McAuley et al., 2019; Tweed and Rogers, 2016). Prevalence of cocaine injecting among this population increased from 37% in 2011 to 77% in 2018, with HIV infection more likely among people who had injected cocaine in the last six months (McAuley et al., 2019). While use of heroin and methadone is associated with increased sexual dysfunction in men (Teoh, 2017; Zhang et al., 2014), cocaine is associated with increased sexual arousal, reduced inhibitions, and greater levels of risk taking (Bellis 2008; Cheng 2016). In addition, the use of cocaine can lead to prolonged sexual intercourse, and as natural lubrication decreases, the likelihood of condoms breaking increases (Cheng, 2016). This then has a causal relationship with potential sexual health related infections.

Novel psychoactive Drugs (NPS), formally known as legal highs, are synthetically made drugs designed to replicate the effects of illegal drugs such as cannabis, cocaine and ecstasy. Their use has also increased considerably in recent years. One of the few studies

looking at the link between injecting NPS and hepatitis C infection found that in Scotland, the rise of hepatitis C infection in the Lothian NHS board could be partly attributed to the rise in NPS injecting (Dumchev, 2022). However, beyond this, there is currently a dearth of research which explores NPS use and high-risk behaviours. Those who inject multiple types of drugs (polydrug use) are found to report higher sexual risk behaviours than monodrug injectors (Tavitian-Exley et al., 2018).

Women:

Research shows that gender significantly influences PWID's life experiences, as well as the type and level of risk behaviour around sex, particularly for women. Women who inject Drugs (WWID) are at a higher risk of acquiring HIV, other blood-borne viruses (BBVs) and sexually transmitted infections (STIs) than their male counterparts (UNODC, 2016), with the global HIV prevalence among WWID at 13%, compared to 9% among men who inject drugs (MWID). In Europe and the USA, for WWID high-risk sex is a "more significant predictor of HIV than risky injecting practices" (The Global Coalition on Women and AIDS, 2011, 5). Studies show infrequent condom use by women who use drugs with long-term and casual partners, and a correlation between inconsistent condom use and the sharing of injection equipment (The Global Coalition on Women and AIDS, 2011).

There are multiple causes of WWID's higher risk of acquiring a BBV or STI. Some of these risks are due to socioeconomic and structural factors related to gender more broadly, such as intimate relationships (Tweed et al., 2018). Sexual coercion, for instance, is highly correlated with the risk of HIV transmission among women globally, and intimate partner violence makes it more difficult for women to negotiate safer sex practices (The Global Coalition on Women and AIDS, 2011). Intimate partner violence is approximately three times more likely in couples who use drugs, and a Canadian study found that HIV prevalence among PWID who had experienced sexual violence was 25%, compared to 19% among the general population who had never experienced sexual violence (Braitstein et al., 2003).

While there is limited published research on the impact of intimate partner violence on WWID in Scotland, there is evidence that drug-related deaths among women are increasing in Scotland (Tweed et al., 2018), and that gendered power dynamics in sexual relationships play a strong role in WWID's substance use practices and increased risk of HIV (MacRae and Aalto, 2000). MacRae and Aalto (2000) found that Scottish WWID's patterns of injecting and needle sharing were "strongly influenced by the nature and type of their sexual relationships", with the vast majority of WWID who had ever been in a sexual relationship with a MWID being predominately injected by their partner. However, in the context of their report on the rise in mortality among WWID in Scotland, there was no reference to high-risk sex behaviour such as coerced sex without a condom, multiple sexual partners or other gendered power imbalances within heterosexual relationships among PWID. There is additionally no available data on high-risk sex behaviour experienced by WWID, or more broadly PWID, who identify as LGBTQIA+.

In addition to the aforementioned socioeconomic and structural roots of poor sexual health among WWID, this population is also more likely to experience barriers to accessing sexual healthcare, in particular due to caring commitments and gendered life events. WWID are

more likely to lose child custody, which is closely related to a loss of motivation for recovery and engagement with services (Tweed et al., 2018, 36), and that the fear of losing child custody may influence a women's decision not to engage with healthcare services (IAPAC, nd). A report on drug-related deaths among women in Scotland notes that there is a lack of gender-specific services for WWID who experience a specific set of adversity, trauma and violence in their life events (Tweed et al., 2018, 39). WWID are also more likely to engage in sex work and experience more stigma than their male counterparts.

Sex Work:
In a recent report on service delivery for PWID and are engaged in sex work in Scotland, Matheson et al (2022) found the key theme when researching substance use, sexual behaviour and service use is vulnerability. They call for a gender-aware, rights-based approach to services for PWID who engage in sex work and note that although there is an awareness of trauma within substance use services, this awareness is lacking in sexual health services. Research participants in Scotland were often young when they were first introduced to drugs and/or sex work, often experienced challenging early life circumstances, and were often introduced to drugs and sex work by someone with more power over them or who had more experience with drugs and/or sex. Substance use and sex work were often intertwined for the women who were interviewed, and the two combined often led to an increased risk of sexual assault and rape, with reference to such events "widespread" among participants. Women who engaged in sex work described intermittent condom use, depending on their client's wishes, rape, or being paid extra to not use a condom. Although the women interviewed had some understanding of HIV, hepatitis C and unwanted pregnancy, there was less understanding about other STIs and the need for regular smear tests.

While WWID are more likely to engage in sex work than their male counterparts, there is a growing number of studies globally reporting MWID engaging in sex work, particularly for men who have sex with men (MSM) (Dumchev, 2022, 57). One study in the USA found that of those who had recently engaged in sex work, 74% was in exchange for drugs. It also found that those who reported receiving money, drugs or housing in exchange for sex were also considerably more likely to buy sex in exchange for money, drugs or housing (Javanbakht et al., 2019). One large European survey of MSM who engaged in sex work found that selling and buying sex were significant predictors of injecting drugs, being HIV positive and having STIs (Berg et al., 2019, 5).

Both Berg et al (2019, 7) and Matheson et al (2022, 10–11) recommend that comprehensive sexual and substance harm reduction services be combined, and that shared trauma-informed services will go some way to increase trust in services by these vulnerable groups.

Concurrent Risk Factors

The current literature points to wider issues around intersecting risk factors that are intimately connected in PWID's lives, but that may be treated individually by services working independent of one another. For example, PWID who engage in "dual-risk"

behaviour such as both sharing syringes and having sex without a condom are most at risk of acquiring HIV compared to PWID in general (Neagius et al., 2013). A study conducted among PWID in Iran found that the size of a person's social network for injecting and sex increased dual-risk behaviours, leading to an elevated risk of acquiring HIV (Noroozi et al., 2016). The same study aligned with other research that reported being unhoused and unemployment to negatively affect PWID's self-esteem and health service use, contributing to dual-risk behaviour (Noroozi et al., 2016, 191; Neaigus et al., 2013; Marshall et al., 2011).

Mental Health

Mental health is a clear contributing factor to PWID engaging in high-risk sex behaviour, which can be facilitated by insecure living and working conditions, among other vulnerabilities and trauma. Multiple studies have found that PWID have higher rates of mental illness than general populations (Goldner et al., 2014), and a study conducted in Vancouver, Canada found that rates of mental illness and their correlation to high-risk sex behaviour vary according to gender. WWID reported higher rates of depression than MWID, while WWID presenting with depressive symptoms were more likely to engage in sex without a condom and have multiple sexual partners than their male equivalents. The study also calls for integrated screening, counselling and treatment for mental illness within existing HIV prevention programmes for PWID, particularly noting the need for gender-specific interventions (Pettes et al., 2015).

Stigma

PWID experience stigma due to their substance use, combined with the stigma from overlapping social and health inequities such as sex work, intimate partner violence, mental health, social exclusion and being unhoused, stigma presents a significant barrier for PWID to access sexual healthcare and support.

A study about women on opioid substitution treatment in England identified intersectional stigma – gender, substance use, sex work, being unhoused and sexual health status – as crucial to explaining women's lack of condom use and lack of access to sexual health services (Medina-Perucha et al., 2019). Stigma has been reported by PWID in two ways: both as enacted experiences of discrimination and as anticipated stigma based on previous negative experiences. These twofold forms of stigma have been shown to make PWID distrustful of healthcare providers (Muncan et al., 2020). In his research on drug deaths in Scotland, McPhee (2021) found a key factor to be discrimination of PWID as they are presented in policy document and the media as "unproductive citizens". He also finds that PWID report experiencing shame and perceived discrimination at "micro-interactional" levels before and after drug treatment (McPhee et al., 2013). In 2021, the Scottish Drugs Forum conducted a survey of workers in the sexual health and BBV sector across Scotland, with one of their key recommendations being that stigma around sexual health and substance use needed to be tackled throughout society and that services should be trauma-informed. They called for decriminalisation and full regulation of the substance market to improve outcomes related to sexual health and BBVs (Scottish Drugs Forum, 2021).

METHODS

"We hope that the information gathered will be used to help access to testing and health services, normalise conversations surrounding sexual health between practitioners and supported individuals and challenge stigma surrounding blood-borne viruses. As a group, we wholeheartedly agree with the recommendations set out in this report.

We relished the opportunity to use our life experiences that haven't always been positive, to try to provide an understanding, safe space to speak openly, free from judgement. We all felt that the peer experience sparked an interest in us to try give voice to a section of society that often struggles to be heard."

- Reflections from Peer Researchers Scott, Thomas and Linda

Between September 2021 and September 2022, 30 PWID and 16 HSCPs shared their thoughts, experiences and knowledge around sexual health across two phases of the project. The first phase of used participatory action research (PAR), whereby people with lived experience of substance use and recovery were supported and trained to undertake qualitative semi-structured interviews as peers, with PWID. The second phase focused on interviews with HSCPs working in the area.

Phase 1: Participatory Action Research and Interviews

As an approach, PAR prioritises active community involvement in all aspects of research design and minimising power imbalances in knowledge generation by allowing people with first-hand experience to guide the research scope (Chataway, 1997; Proctor, 2010). This approach is grounded in the principle that people with lived experience of a topic should play a leading role in researching it (Neubauer, Witkop & Varpio, 2019). Four peer researchers were recruited to conduct the research we describe here, and trained accordingly – further information can be found in the appendix of this report.

Phase 1 of the research took place between X and X, during which time 30 interviews were carried out by the peer researchers, with PWID in Greater Glasgow and Clyde. Participants were recruited from an outreach service located in Glasgow city centre, the Simon Community Access Hub.

"[Participants] benefit by speaking to those who may have found themselves in similar situations, use similar language and show empathy towards how things are for them."

– Peer researcher, Thomas

Of the PWID who took part in the research, twenty-four identified as male, five as female, and one as non-binary. Almost 50% were aged 35-44, but there was an age range of 18 to 64. 60% of participants stated that they were actively injecting or using illicit drugs (Benzodiazepines, cocaine, heroin and cannabis were the most frequently cited), with the remainder stating they had recently or choosing not to answer this question. Finally, ten participants identified their housing status as unhoused and nine participants identified their housing status as homeless but in temporary accommodation. Only two participants

identified their housing status as previously unhoused but currently living in a secure tenancy.

Phase 2: Semi-structured interviews with HSCPs

The second phase of the research focused on the experiences and understanding of HSCP’s working in services located in Greater Glasgow and Clyde. Those who took part in the research held a range of roles from nursing to housing and emergency service managers. The focus of these interviews was to ascertain a greater understanding around current support, training and needs.

FINDINGS - PWID

This first findings section reports on results from interviews with PWID. It focuses specifically on sexual health awareness, risk, and barriers to provision.

Sexual health awareness and perceived risk

When awareness around sexual health was discussed, participants shared moderate levels of knowledge surrounding STIs, HIV and contraception. The attention given to the topic by PWID was sometimes linked to levels of activity - 40% of participants consider their sexual health generally, but a further 40% consider their sexual health only when sexually active. This suggests scope to support PWID in improving their awareness and management of sexual health.

People were also asked if they had ever been diagnosed with an STI or HIV. 50% reported having no STI or HIV diagnosis. 23% shared a diagnosis of an STI, and 13% stated that they had been diagnosed with hepatitis. Most participants felt that they had been at risk of HIV – largely reflected in comparative testing rates. Whereas most participants accessed STI testing more than a year ago, a third of participants had accessed HIV testing within the last three months (compared with 16% who had accessed STI testing in the last 3 months).

Participants highlighted mixed awareness and use of varying strategies to transmission risks associated with STIs and HIV. Notably, some participants assess their risk of STI and HIV transmission based on their perception of others sexual behaviour, reputation or HIV status. Only 53% of participants felt that they had a good knowledge of STIs and how they were transmitted.

"I know they can be conducted through saliva or sexual intercourse, of course. I know there's some very serious ones and there's some minor ones. But I know you have to get them dealt with right away because even the minor ones can mess your body up in the long term." Participant

26% of participants reported having no knowledge of STIs, and 16% felt that they knew something but were unsure of what constituted a transmission risk.

"STIs? Absolutely nothing. I don't even know what it stands for." Participant

"Well, obviously through sex. I don't know if you can catch it through blood-to-blood or whatever. I'm not really sure about it all, if I'm being serious. I'm not really sure, but I think you would catch it through blood-to-blood." Participant

Similar responses were found when asked specifically about HIV and associated risks of transmission. Here, 43% felt they had a good knowledge of HIV and its transmission.

"I know it's a blood-borne virus, I know you can't catch it from just touching someone or anything like that. As I say, it's a blood-borne, it's a liquid… bodily fluid to bodily fluid." Participant

30% felt that they had some knowledge of HIV, and 13% reported knowing nothing or very little about it.

"Not too much because I've got no intentions of getting it." Participant

For some, this risk was also tied up in gendered terms, with those identifying as men suggesting that their risk was aligned with their perception of current or previous sexual partners' sexual behaviour or 'reputation'. This also emphasises a reinforced stigma.

"I've never caught anything, so… I've always gone with hopefully quite sensible women in the past." Participant

"No, no. And I've not went with any working lassies in the town here." Participant

"Because I've not slept with any prostitutes or any dirty women." Participant

Access to current services

Most participants shared that they had never accessed sexual health services and fewer than one in four had attended a sexual health screening within the last two years. The impact of this was reflected in the uptake of therapies such as PrEP. While the preventative treatment of PrEP has been ground breaking in its success at reducing the risk of HIV, its use amongst PWID is woefully underrepresented. 70% of participants were unaware of what PrEP was, and only two participants had been prescribed PrEP.

Most generally expected to access sexual health information, advice and support through engagement with health and social care services. However, almost a third of those interviewed felt that they had not been provided with sexual health advice from HSCPs. Furthermore, 57% of participants stated that allied "support workers had not mentioned sexual health".

When asked how they would normally access information about sexual health, 30% shared that they would get information through a general health service, such as their GP, a pharmacy, or the hospital. 40% would use a local community organisation, such as the Simon Community Access Hub, or a local homelessness service. 16% would access information online.

Accessing future services

Despite relatively low uptake in sexual health support, 56% of participants shared that they did not experience any barriers which would decrease their likelihood of accessing sexual health services. Most would be likely to access services if they felt that they needed them.

"Nothing, because it's my health at the end of the day. I've got kids, so you need to look after yourself to care for your weans." Participant

23% of participants reported experiencing some or several barriers which might prevent them from accessing support. The barriers listed included having already received a previous negative STI or HIV test and feeling they did not need another. There were also worries around poor mental health and anxiety and fear of receiving a diagnosis, as well as practical aspects such as services existing in inaccessible locations or with busy waiting areas.

"Depression. Fear. In case I hear something I don't want to." Participant

Participants were also asked what facilitators exist that would increase the likelihood of accessing sexual health services. Convenience was an important facilitator. 60% of participants shared that they were more likely to access testing if it was available through a postal testing service.

"Yes. Because it's just at hand, isn't it? The same with the COVID tests, test myself twice a week. Just because I have them there at hand." Participant

Similarly, 36% of participants were more likely to access services if they were available to them remotely.

"I think anything that saves myself personally having to go into a populated place with people, like if I'm at home and one-to-one would be my first choice."

13% of participants felt that they would be more likely to access sexual health services if they were part of existing health and social care support individuals received. Two participants also felt that they would be more likely to access sexual health services if they were in a more accessible location, and if they had a bus pass. The potential of anonymity in sexual health services raised mixed responses from participants – one participant for example felt that they would be more likely to access services if they could do so anonymously, whereas another felt they would be more likely to access services if they were familiar with staff.

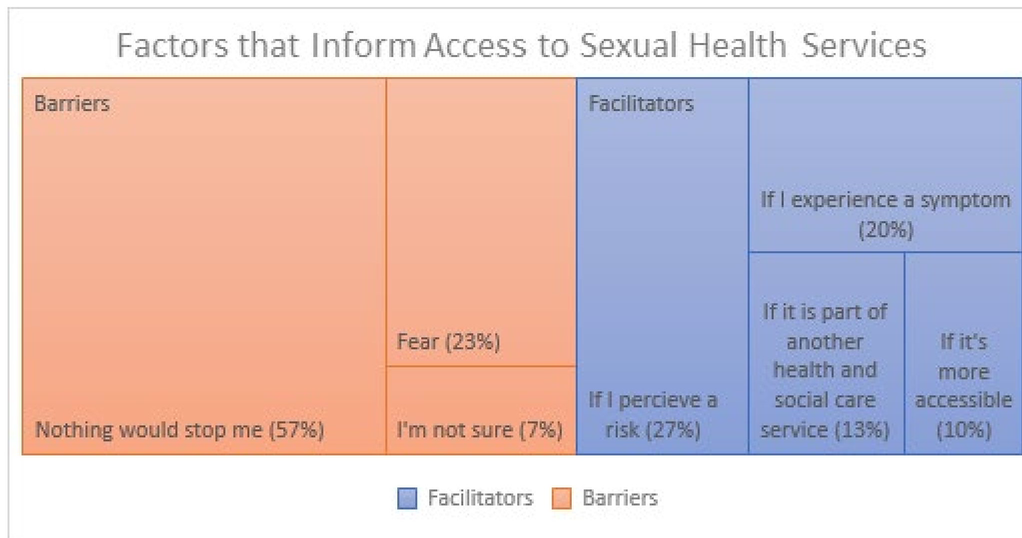

Figure showing barriers and facilitators of sexual health services

FINDINGS – HEALTH AND SOCIAL CARE PRACTITIONERS

The second findings section reports on outcomes from interviews with the 16 HSCP's conducted in phase 2 of the project. Particularly, it looks at perceived knowledge, existing information resources, and barriers and hurdles faced in confidently providing information about sexual health to PWID.

Perceived knowledge and signposting

The results suggest that there is mixed sexual health literacy among HSCPs. Over half of HSCPs had received some form of sexual health training as part of their current role. However, one in four HSCPs had never accessed sexual health specific training. In particular, those working in criminal justice or housing services were most likely to have lower knowledge levels, compared with other HSCPs. Only one participant felt that they were 'extremely confident' in their sexual health knowledge.

While participants were asked about their perceived knowledge levels, interviews were also assessed on a five-point Likert scale of 'not at all knowledgeable' (1) to 'extremely knowledgeable' (2). Each scale point was measured as follows:

- **Not at all knowledgeable (1)** – participant has no knowledge of sexual health.
- **Slightly knowledgeable (2)** – participant is aware of BBV risk, STI risk, and condom access.
- **Somewhat knowledgeable (3)** – participant is aware of BBV risk, STI risk, condom access, basic contraceptive options, and availability of NHS sexual health services. Participant is familiar with terms such as PrEP, PEP, and U=U, but does not understand the meaning of some or all of these terms.

- **Moderately knowledgeable (4)** – participant is aware of BBV risk, STI risk, availability of NHS sexual health services, availability of third sector sexual health and BBV services, contraceptive options. Participant understands the meaning of terms such as PrEP, PEP, and U=U. Participant has some awareness the influence of gender and sexuality on sexual health needs.
- **Extremely knowledgeable (5)** – participant is aware of sexual and reproductive health in depth, including wellbeing, pleasure, and relationships. Participants is aware of NHS sexual health services, as well as third sector sexual health and BBV services. Participant understands the meaning of terms such as PrEP, PEP, and U=U. Participant is aware of the influence of multiple intersecting identities on sexual health needs.

Based on this scale, participant's actual knowledge of sexual health was far higher than their self-reported knowledge, with the findings as follows:

- **Seven** participants were *moderately knowledgeable*
- **Five** participants were *somewhat knowledgeable*
- **Four** participants were *extremely knowledgeable*

Signposting and knowledge about signposting was an important component to perceived and actual knowledge. 75% HSCP's would signpost or refer to Sandyford if PWID required sexual health information. 30% would offer information based on their own existing knowledge – sometimes in conjunction with other signposting, and 30% would also signpost to Waverley Care. Only 25% stated that they would signpost to a GP.

'It's about having enough information to signpost, I'm not going to be the authority. I'm not going to be taking blood spot tests or anything like that, but I'm going to be informing people about what they can do and what they can expect, or if they go to Sandyford, what they can expect." HSCP

Knowledge of prevention

While uptake of PrEP is low amongst PWID, 15 of the 16 HSCPs interviewed as part of this research were familiar with the term PrEP. 50% of participants were able to describe what PrEP is and how it is used, while the remainder were either unable to describe PrEP, or how and who might use it. Comparatively fewer were familiar with PEP (Post exposure prophylaxis), with only 56% having heard of the term before. However, for those who had heard of the term, their understanding of what PEP is and how it is used was much higher than those who had heard of PrEP – all 56% were able to describe PEP and how and who might use it.

The phase U=U (Undetectable = Untransmittable) has garnered significant international prominence in HIV care as a way of explaining why people living with HIV who are on effective treatment, and with a fully suppressed viral load cannot pass HIV on. Only 31% of participants we spoke to as part of this research had heard of this term.

So I think it's always important as workers for us to be continually developing our awareness, whether it be around minority ethnic communities, people of colour, sexuality, women's rights.' HSCP

'It's great if people do know about different identities and understanding of it, I think that's great, but I do think the more important thing is to understand about being non-judgemental, because I've had people that know about identities but then when you talk about the specific sexual acts that they're having they get a riddy or they feel uncomfortable.' HSCP

Support and training

As part of interviews, participants were asked what sexual health training they had received. The purpose of this question was to explore whether sexual health training is included within professional development, and where gaps might sit.

56% of participants shared that they had accessed sexual health training in their current occupation. Of those, two participants described their sexual health training as being related to training on BBV risk. One described their sexual health training as focusing on women's sexual health, and one as training around including the experiences of Trans and non-binary people. 25% had never accessed sexual health training.

Participants were also asked how comfortable they felt talking about sexual health with PWID. 68% of participants stated they would only be comfortable talking about sexual health with PWID if they had developed a working relationship

'For me, talking about sexual health is about building relationships within the community so that they can feel comfortable to talk to me about it.' HSCP

'But I think what's key is the relationship you have with your clients and how you build that up over time for them to actually tell you something.' HSCP

Additionally, 62% stated they would be comfortable talking about sexual health if it was through a BBV lens.

'I think it's because maybe promoting the conversation about HIV, the increase, and that's maybe a good starting point as well, it's statistically out there, and I suppose we get fed that information as well, it's there to see. And I think that's maybe how I would go about it with my knowledge, and "have you ever been tested?" Because we should all be tested, at the end of the day, it's not just for the clients in the support, it's everybody.' HSCP

'So, the more we can break down and make people feel comfortable about their own experiences with a blood-borne virus then you actually can show them the rest of their life, it's the normality that happens in the rest of their life, and, as we said, that includes having a healthy sex life.' HSCP

Providing service specific information

1. STI Testing

Participants were asked to describe what actions they would take if PWID requested support accessing STI testing. 56% of participants shared that they would carry out STI testing ‘in house’ due to the availability of clinical services, and the integration of Sandyford drop-ins within their organisation. 43% would signpost to other services.

2. Cervical Smear Testing

Compared to STI testing, only 18% would carry of a cervical smear test ‘in house’. 68% would instead refer or signpost to other services including Sandyford and a specified GP.

3. Pregnancy Prevention

If PWID requested support with pregnancy prevention, 37% would signpost to services (namely Sandyford). The remaining participants would also signpost to Sandyford, or to GPs alongside providing information or resources like condoms or lube.

4. Abortion

Much like pregnancy prevention, responses to requests for abortion care were met with signposting and referrals. 75% of participants would signpost to services including Sandyford and GP’s. Two participants shared that they would be unsure of what actions they would take.

‘It’s providing options and providing information and seeking more advice from that medical professional, because I’m not a medical professional, I absolutely know that.’ HSCP

‘We’re human beings, most of the majority in the world have some sort of sexual relationships at some time or another, it shouldn’t be classified as a dirty secret we shouldn’t talk about, we should be able to freely open up. And then that way it becomes easier for maybe the minority to be able to come and talk to us and not have any fear. But equally, our reaction to them has to be in a very positive and welcoming and knowledgeable aspect of delivering that as well.’ HSCP

Barriers to provision

Similar to the conversations with PWID, HSCPs were asked about barriers they faced in having and giving information about sexual health and support. A number of barriers

emerged, specifically around gaps in tailored training, and around limited targeted information for PWID.

25% of respondents shared that there was no information targeted at men who inject drugs. Consequently, they felt ill equipped to raise sexual health as standard practice.

‘My experience coming from the males, I don’t feel that there’s enough training and possibly information shared specifically for males as it was for females.’ HSCP

‘There doesn’t seem to be direct organisations that I at this point could say “that’s who we would signpost”, other than the Sandyford. I can’t think of another organisation that we would signpost our males to.’ HSCP

A further 25% also mentioned feeling concerned that PWID may have experienced sexual violence. This left the HSCPs feeling under equipped at how to raise sexual health in a trauma-informed way. Two participants mentioned they needed a reason to raise sexual health as it is not a topic area raised as standard practice with PWID.

‘I think unless our clients talk to us, it’s not a thing in a curriculum for us that we are talking to them about. It’s not one of the first things, I think. I think it’s through working for maybe a wee bit of time, or an issue has come up and they’re worried about something, then I would find out where to go.’ HSCP

‘You can be sitting talking about a really serious subject, and say “right, what about your sexual health?” And they’d be like “what are you talking about? Where has this come from?’ HSCP

A further two participants also mentioned practitioners lack confidence talking about sex, with this making raising sexual health more difficult when supporting PWID. Similarly, three participants mentioned only feeling comfortable raising sexual health through a BBV risk lens.

‘I think in terms of confidence, I’m more confident on the BBV side of things than STI side.’ HSCP

There was also a range of bureaucratic challenges, around lacking of resourcing to offer sexual health support, as well as a lack of direct referral pathways. One participant also mentioned that condom distribution within prison settings also presents unique challenges in that there are currently no set distribution procedures in place.

'I think accessing is the key, quicker we access it. Because we can have women here, and then they'll just leave and it's not been dealt with and they're back out into the community by the time they're getting appointments.' HSCP

'There's so many problems come with the women and their sexual and reproductive health. We've got women just now, and have had women relatively recently, who were on hormone patches for menopause, so they have a different set of issues with their sexual health caused by menopause. So, there's a bigger wider scope, I think, for sexual and reproductive health.' HSCP

CONCLUSION AND RECOMMENDATIONS

PWID have the right to access good sexual health support. Throughout the first phase of the research that many whom we spoke to felt confident in accessing information and. However, there remain considerable gaps in knowledge around risk of STIs and HIV, much of which is perpetuated by stigma and public misconceptions. As a group, there are also missed opportunities to provide access to treatments like PrEP, and increased accessibility to testing and support. The popularity of postal testing, for instance, suggested by participants in this research illustrates the potential of exploring methods of testing and support which focus on convenience.

While HSCPs reported a low knowledge of STIs and HIV, our results showed that their knowledge levels were greater than those self-perceived. The importance of signposting across services, and having such up-to-date knowledge was emphasised as strengthening confidence and support which they were able to offer to PWID. However, challenges remained, particularly around gaps in training and in tailored information which could be offered to PWID. This in turn affected the confidence with which HSCPs felt they were able to engage and talk about sexual health.

The findings of this research build upon this evidence by identifying gaps and opportunities to improve the provision of a responsive sexual healthcare for PWID. Overall, PWID and HSCPs alike value sexual health, and most participants within both cohorts had some knowledge of sexual health. However, there is a need for topic-specific information, training, and resources to address mixed levels of confidence in providing sexual healthcare to PWID. In the same way, there is significant scope to improve the provision of sexual health education to PWID as a way of facilitating better access to services. Additionally, significant funding is required to adequately meet the sexual health resourcing needs of health and social care services that have high contact with PWID.

In Greater Glasgow and Clyde, there have been developments in the provision of sexual healthcare as part of harm reduction measures. However, the findings of this research indicate a lack of consistency in how sexual healthcare is approached. PWID are more likely to gain timely, informed access to sexual healthcare where there is integration within health and social care services; when there is no integration, they are more likely to experience sexual health provision as signposting to other services alone.

Regardless of the presence of integration, there are mixed practices among HSCPs when addressing the sexual health needs of PWID in the context of intersecting identities and experiences. These factors place the onus on individual HSCPs to navigate sexual healthcare without structural support or adequate resources. This consequently reinforces inequalities through the sustainment of inconsistent access to sexual healthcare for PWID. PWID therefore face heightened risk of STIs and HIV in tandem with wider harms associated with poor sexual health.

The findings reported throughout the previous two sections illustrate the perceived risks, barriers and facilitators to PWID accessing support. In particular, what both PWID and HSCPs highlighted was a need for consistent and accurate tailored information which was readily accessible and could inform decision making. The following recommendations are

focused upon the development of guidance for HSPCs to ensure that they have up-to-date information around sexual health for PWID, and are confident in being able to talk about this with people they may see or support.

HSCPs have a vital role to play in providing support and information to PWID. Throughout the research HSCPs asked for further guidance, specifically focused around:

- What sexual health services are available for PWID.
- How sexual health services can be accessed by PWID directly.
- How or if practitioners can refer directly to sexual health services.
- What emergency support is available should PWID require services such as PrEP access or abortion.

'A lot of our guys don't tend to attend the GPs or other services, we tend to be the service that they rely on the most. I think if they're going to have these conversations, it'll be with people from our service – or not our service, but people who work with people who use drugs.' HSCP

The findings suggest that this guidance should also include a number of specific topic areas, including information on:

- men's sexual health.
- trauma-informed sexual health.
- reproductive health.
- wellbeing, intimacy and pleasure.

'I think as well when it comes to sexual health for a lot of people there might be that element of talking about sex as a physical act, but we probably don't really get to talk so much about the conversations about the intimacy.'

Guidance Format

In order to cover these areas, participants within the research suggested including the following elements within the guidance - better facilitating integration of sexual health within practitioner practice.

- A tick list of sexual health questions or topics to address when supporting PWID. One participant mentioned using structures practitioners may be already familiar with, such as those used for Naloxone (Scottish Drugs Forum, 2018) or the WAND initiative (The Scottish Government, 2021).

- Links to trusted sources where sexual health information is available and guaranteed as up to date. Participants noted feeling unable to keep up to date with information, highlighting that having one place to seek this information would improve their confidence in raising sexual health with PWID.
- Include a manual that details the basic sexual health knowledge practitioners should have when working with PWID.
- Include information about further clinical and public health education available in Scotland.
- Include links to organisations offering training and workshops.
- Include the phone numbers of organisations who offer sexual health support to PWID. This should also include detail of what kind of sexual health support is offered.

Concluding notes

The development of this guidance provides opportunities for HSCPs to continue conversations around sexual health, and to do so confidently with PWID. The existing relationships established between individuals injecting drugs and key HSCPs are vital, and supporting the provision of information and resources enables opportunities for sharing knowledge and enhancing sexual health amongst a group often ignored. In order to increase equity in provision to HSCPs, further attention must be given to tailoring national programmes such as PrEP to be available and accessible for PWID. This should be done in conjunction with opportunities to increase accessibility of sexual health services – whether through options for postal testing, or the spaces through which support can be accessed. If targets around reducing transmission are to be realised, and everyone across Scotland is to have equitable access to sexual health support then it is crucial that no one is left behind.

'As I will say probably to my dying breath, especially in terms of HIV, the H stands for Human. It's Human, you have a human in front of you. So if you're talking as a healthcare professional, you talk about sex, you see the person not whatever else is going around them… but understand what's gone on around them.' HSCP

APPENDIX -

Peer Researcher Training Programme

The Peer Researchers participated in a bespoke PAR training programme designed by Waverley Care. The PAR training programme involved the Peer Researchers gaining research knowledge and skills through blended learning, including in-depth role play and practice interviewing. A blended learning approach was used to equip the Peer Researchers with the knowledge, confidence and skills to ethically design and carry out research.

The PAR training programme included the following topics:

- research methods
- ethics and informed consent
- confidentiality and boundaries
- interview design
- interview techniques and skills
- coding and analysing data
- talking about sexual health
- blood-borne virus awareness
- vicarious trauma and resilience

In addition to the PAR training programme, the Peer Researchers were provided with practical and psychological support from research staff at Waverley Care. This support was provided throughout the process of designing and conducting the research. Providing support as part of the PAR training programme ensured the Peer Researchers were able to take care of their health and wellbeing in the context of carrying out research within their community, as well as to ensure they were equipped to manage any accompanying risks.

Ongoing Support

Throughout the process of designing and carrying out research, the Peer Researchers participated in ongoing peer support sessions, where they met with the other Peer Researchers and research staff at Waverley Care to discuss the project and any issues arising. The Peer Researchers were also provided with one-to-one support from research staff at Waverley Care.

Safety when Conducting Interviews

During the process of conducting interviews, research staff from Waverley Care were on call to respond to any immediate issues experienced by the Peer Researchers. A peer researcher debrief was subsequently carried out no later than 24 hours after each interview. By providing on call support and debriefs, the Peer Researchers were supported to discuss issues that arose during interviews and any difficulties or distress they experienced as a result. Research staff from Waverley Care additionally maintained an open-door policy during working hours, where Peer Researchers were able to get in touch via telephone to discuss any emerging issues. To ensure the Peer Researchers were effectively supported, the research staff at Waverley Care also accessed regular support and supervision via their line managers at Waverley Care.