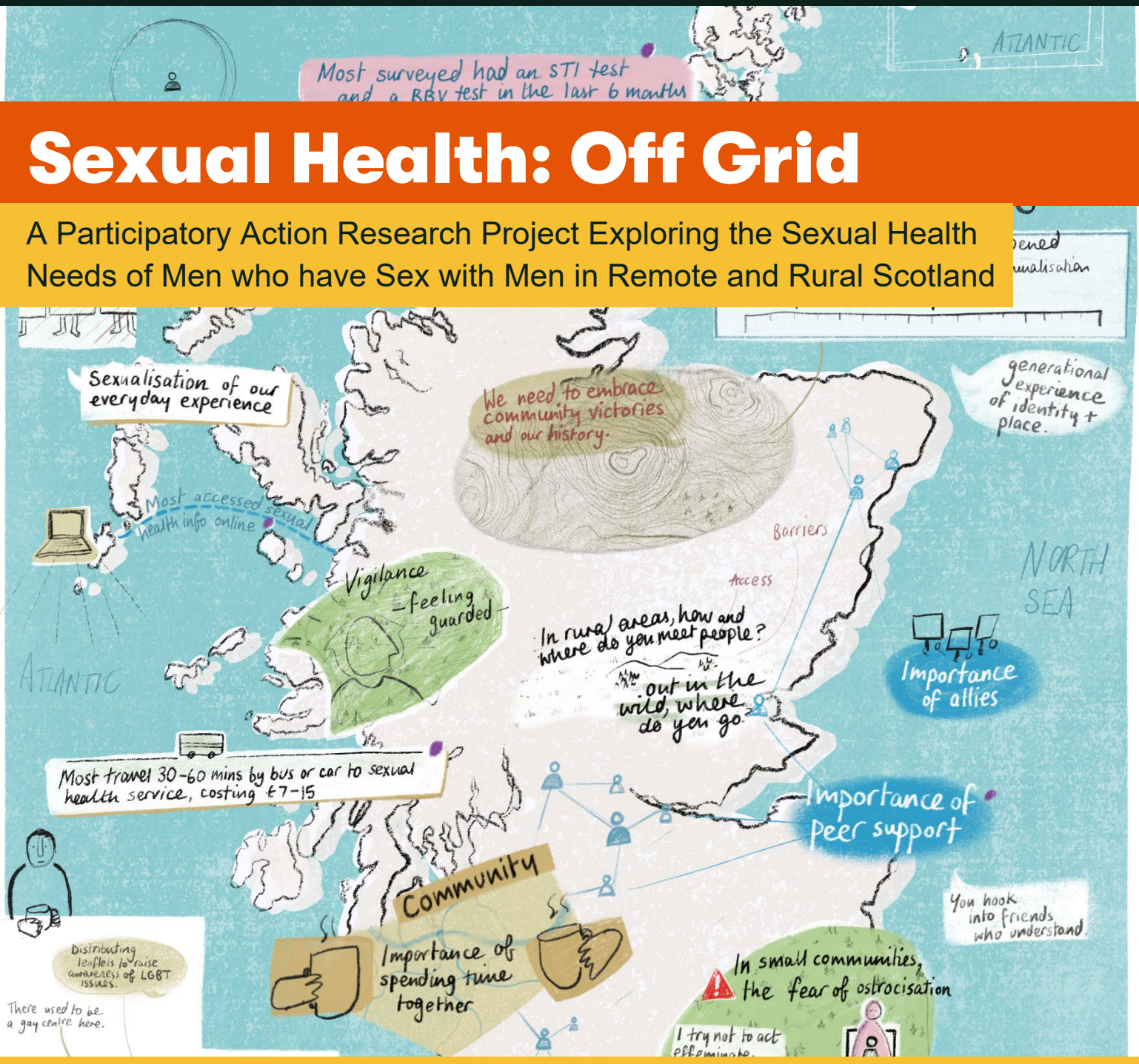
Waverley care

Sexual Health: Off Grid

A Participatory Action Research Project Exploring the Sexual Health Needs of Men who have Sex with Men in Remote and Rural Scotland



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CHAPTER 1: INTRODUCTION

1.1 About this Research

Waverley Care is funded by the Scottish Government to carry out research exploring the sexual health needs of men who have sex with men in remote and rural Scotland. This report describes the research findings gathered through:

- a national survey carried out in February – August 2022
- qualitative interviews carried out in August – September 2022

The research was designed using a person-centred informed participatory action research approach.

1.2 Context

Informing the research described in this report, we commissioned a bespoke analysis of data from SMMASH3 in 2020. SMMASH3 is a national bio-behavioural survey carried out with men who have sex with men by Glasgow Caledonian University. The analysis provided insight to the sexual behaviours and risks experienced by men who have sex with men living in remote and rural areas of Scotland, namely Forth Valley, Highland, Argyll & Bute, Western Isles, Orkney and Shetland. A summary of the key findings is detailed as follows.

Condomless Anal Sex

The data found that when it came to having condomless anal sex with regular partners:

- men living in Forth Valley, Highland, Argyll & Bute, Western Isles, Orkney, and Shetland had condomless anal sex with at least one regular partner in the past year.
- men living in Forth Valley had condomless anal sex with between 0 and 3.7 regular partners.

men living in Highland, Argyll & Bute, Western Isles, Orkney, and Shetland (HABWOS) had condomless anal sex with between 0 and 2.4 regular partners.

The data found that when it came to having condomless anal sex with casual partners:

- on average, men in Forth Valley were having condomless anal sex with 3.6 casual partners, however, at least half of participants did not engage in condomless anal sex with any casual partners.
- on average, men in HABWOS were having condomless anal sex with 4.1 casual partners, and at least half of partiipants have engaged in conomless anal sex with at least one casual partner.

High Risk Sex

The data explored the experience of engaging in high risk sex among men who have sex with men. ‘High risk’ was defined as reporting condomless anal sex with either partners who have an unknown HIV status, or partners who are HIV positive with an unknown or detectable viral load.

The data found that:

- 41.5% of men living in Forth Valley had engaged in high risk sex.

- 43.2% of men living in HABWOS had engaged in high risk sex.

STI and HIV Testing

The data on access to STI and HIV testing found that in Forth Valley:

- 42.6% of men accessed an STI test in the previous year, significantly below rates both nationally (55.3%) and in Lothian/Greater Glasgow and Clyde (62.2%).
- 81.7% of men believed they were HIV negative, while 52% of HIV negative/untested men had accessed HIV testing in the previous 12 months. This is significantly below rates both nationally (64.7%) and in Lothian/Greater Glasgow and Clyde (71.3%).
- The data on access to STI and HIV testing found that in HABWOS:
- 43.2% of men had accessed an STI test in the previous year, significantly below rates both nationally (55.3%) and in Lothian/Greater Glasgow and Clyde (62.2%).
- 92.5% of men believed they were HIV negative, while 62.2% of HIV negative/untested men had accessed HIV testing in the previous 12 months. This is slightly below rates both nationally (64.7%) and in Lothian/Greater Glasgow and Clyde (71.3%).

PrEP Use

In contrast to the access rates to STI and HIV testing, knowledge of PrEP among men in Forth Valley and HABWOS was high, with only 5.6% reporting having never heard of PrEP.

Intersectional Inequalities

In addition to the sexual behaviours and risks experienced by men living in Forth Valley and HABWOS, the SMMASH3 data highlighted a number of intersecting issues affecting this community, summarised as follows:

- 27.7% and 25% of those in Forth Valley and HABWOS respectively could be classed as hazardous drinkers, with higher rates of alcohol use among those experiencing financial worries or identifying as having a single relationship status.
- 43% and 30.6% of those in Forth Valley and HABWOS respectively reported having previously received a mental health diagnosis by a doctor, with higher diagosis rates among those experiencing financial worries or identifying as having a single relationship status.
- Men in Forth Valley experienced higher levels of sexuality related stigma compared to elsewhere in the country, while those in HABWOS experienced higher levels of personalised stigma but lower levels of concealment and overall stigma compared to Scotland as a whole.
- Men in both Forth Valley and HABWOS experienced considerably lower rates of resilience to stressful life situations when compared to comparable populations in Greater Glasgow and Clyde.
- 21.3% and 30% of those in Forth Valley and HABWOS respectively indicated that they had been victims of a form of physical, sexual or emotional abuse in the past year.

Overall, the SMMASH3 data indicates that men living in remote and rural Scotland have more risky sex than men living in central Scotland and do not test for STIs or HIV as frequently. The community continues to face multiple intersecting inequalities through high rates of problem alcohol use, poor mental health, and abuse, in addition to lower rates of resilience to stressful life events. These factors are further precipitated where men experience stigma socioeconomic challenges.

1.3 A Note on Definitions and Terminology

Definitions

The research uses the World Health Organisation (WHO) working definition of sexual health:

'Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.'

The Pan American Health Organisation, WHO and the World Association for Sexology (2000) have developed an overview of six sexual health needs and concerns, which further informed the research definition of sexual health. This includes sexual health relating to; body integrity and sexual safety, eroticism, gender, sexual orientation, emotional attachment and reproductive health.

Terminology

The research refers to men who have sex with men (MSM) throughout. While 'gay, bisexual and men who have sex with men' (GBMSM) continues to be a widely used term in the HIV and sexual health sector, the research takes an explicitly inclusive approach by using MSM. Although many MSM may identify with the labels of gay or bisexual, by stating 'G' and 'B', we inequitably prioritise recognising the identities of some men within the LGBTQIA+ community. This consequently reinforces an invisibility of those who identify in diverse ways while identifying within the broader group of MSM. Thus, the research refers inclusively to MSM, acknowledging the sexual health needs of all MSM, however they define their sexual orientation.

Relatedly, the research refers to 'men' as inclusive of trans men throughout. We nonetheless note there are specific barriers and facilitators experienced by trans men when accessing sexual health services. These barriers and facilitators are detailed in our earlier research exploring the access of trans and non-binary people to sexual health services in Scotland (Maund, McKenna & Wain, 2020).

CHAPTER 2: METHODOLOGY

The participatory action research (PAR) described in this report was conducted in two phases. The first phase included an online survey. The second phase included qualitative interviews. The design of both phases were informed by a person-centred attitudinal framework.

2.1 Participatory Action Research

PAR is an approach used in social research where communities usually the subject of research are empowered to take ownership over research carried out with the communities from which they are a member (Walter, 2009). Through PAR, traditionally researched communities are actively involved within all stages of research design (Chataway, 1997), valuing their experiential knowledge by providing a means to influence the development of policy, practice and societal perspectives that affect them (Baum, 2006).

The research described in this report uses a PAR approach as described by Baum (2006). Five Co-Researchers were employed by Waverley Care. The Co-Researchers participated in an action based cycle of learning about research, reflecting on the process of research,

exploring what the research meant in the context of their community identities, and determining what actions should follow. The process was supported by two research staff at Waverley Care, whose role was to provide resources and information determined as required by the Co-Researchers. In contrast to traditional linear processes in social research, PAR is an inclusive cyclical process where each step of reflective action informs the next (Wadsworth, 1998). This was mirrored in the process of designing the research described in this report, where the Co-Researchers and Researchers worked in partnership to shape the research scope, define the data collection strategies, analyse findings and define the consequential actions (Baum, 2006). An awareness of power dynamics was maintained throughout the process, with the Researchers implementing strategies to prevent the emergence of oppressive power dynamics often experienced by traditionally researched communities. Such strategies were informed by a person-centred attitudinal framework and are summarised in the following section.

2.2 Person-Centred Attiudinal Framework

The design of research described in this report was informed by a person-centred attitudinal framework (Proctor & Napier, 2004). The person-centred approach is a humanistic and relational psychotherapeutic model that involves an acute awareness of and sensitivity to power dynamics (Sanders, 2004). While the approach emerged as a clinical practice, the attitudes held within the person-centred approach facilitate the effective development of PAR by offering a framework of informative attitudes, namely empathy and unconditional positive regard (Rogers, 1957). When implemented as part of researcher practice, these attitudes can safeguard the power of traditionally researched communities when participating in the process of PAR design with Researchers.

In the context of this research, the person-centred attitudinal framework informed the PAR approach by facilitating the Researchers to implement power-aware safeguarding methods through reflective practice and integrated evaluation.

Reflective Practice

The Researchers participated in a process of reflective practice in tandem with the wider research process. This involved the Researchers participating in debriefs following each engagement session with the Co-Researchers. The Researchers explored their experience of the process during debriefs, as well as planning the implementation of any actions directed by the Co-Researchers.

The aim of reflective practice was to support the Researchers in offering empathy and unconditional positive regard (Rogers, 1957) to the Co-Researchers, thus preventing the displacement of power by maintaining a consistent awareness of its presence. By offering empathy as understood through the person-centred lens (Rogers, 1951), the Researchers were able to listen to the experiences of the Co-Researchers by stepping into their world while maintaining the ‘as if’ quality. In other words, by actively listening to the experiences of the Co-Researchers while refraining from taking power through interpreting their experience through the Researchers internal frames of reference (Proctor & Napier, 2004). In this way, the Researchers were equipped to more effectively act on the directions of the Co-Researcher.

Similarly, by offering unconditional positive regard, the Researchers prioritised a valuing of the phenomenological experience of the Co-Researchers, meeting them with warmth, but without possessiveness (Rogers, 1957) that may risk the displacement of power. Through

offering empathy and unconditional positive regard while maintaining an awareness of power, a relational environment of openness and collaboration was created between the Co-Researchers and Researchers, thus providing a safe space to experience the PAR approach while improving the subsequent quality of data gathered.

Integrated Evaluation

As part of effective PAR, opportunities for the Co-Researchers to evaluate the resources, approach and outputs were integrated throughout the process. This included both immediate opportunities to offer feedback during engagement sessions, subsequently actioned prior to the next contact point, as well as ongoing anonymous opportunities to offer feedback through a digital feedback box. The digital feedback box was hosted on a private website built by the Researchers to host information generated by the Co-Researchers throughout the process. Providing consistent opportunities for the Co-Researchers to offer feedback on any part of their experience, as well as actioning the feedback in a transparent manner, benefited the research in two ways. Firstly, the Researchers ensured the Co-Researchers were able to influence the process unaffected by the power dynamics experienced when feedback is personally identifyable. Secondly, by taking action on feedback provided by the Co-Researchers, a relationship of trust and collaboration was developed between the Researchers and Co-Researchers. Together these factors informed the effective use of PAR, as well as the subsequent data described in this report.

2.3 Phase One: Survey

An online survey was carried out to explore the sexual health needs of men who have sex with men in remote and rural Scotland. The survey design included a combination of qualitative and quantitative questions generated by the Co-Researchers. This method was chosen as the research was designed to include two phases. The first phase aimed to provide the Co-Researchers with broad data on the experiences of men living in remote and rural areas. The second phase focused on specific areas determined as requiring further exploration by the Co-Researchers. The findings of phase one are detailed in section 3.1 of this report.

The first stage of the survey findings were presented in the research project's preliminary report, published in May 2022. The survey was then extended until August 2022 and was promoted to engage a wider response. The extended survey was carried out via SurveyMonkey and gathered an additional 42 responses, with 176 responses in total and an 82% completion rate.

2.4 Phase Two: Qualitative Interviews

Phase two of the research was designed by the Co-Researchers to involve conducting focus groups with men who have sex with men in remote and rural Scotland. However, due to the challenges faced in recruiting participants (outlined in section 3.2.1) we redesigned the research to involve qualitative interviews with people who work with men who have sex with men in remote and rural areas of Scotland. We note that this participant group is referred to as 'community connectors' throughout this report.

Qualitative interviews are used to gather narrative data as a way of understanding a topic area in depth (Adeoye-Olatunde & Olenik, 2021). Using qualitative interviews offered us a way of exploring the perspectives of community connectors, providing a deeper insight into the challenges they experience engaging with men who have sex with men in remote and rural Scotland. The qualitative interviews were designed as semi-structured and therefore included some pre-set questions. However, using this method ensured we had the required

flexibility to allow conversation to develop according to the experiences shared by participants (Gilbert & Miles, 2005). The interviews lasted no longer than one hour. With participants consent (appendix 1), the interviews were audio recorded and transcribed. Participants were provided with a plain language information sheet (appendix 2) summarizing the research purpose, process of participation, and intended outputs.

We conducted five semi-structured qualitative interviews with community connectors. Four interviews were conducted by a Co-Researcher and Researcher, while one interview was conducted with a Researcher. The participant inclusion criteria was as follows:

- over the age of 18 and able to provide consent to take part
- working in a service located in or serving remote and rural areas of Scotland
- in contact with men who have sex with men as part of their role

2.5 Limitations

The limitations of this research include the challenges we encountered with phase one of data collection via an online survey. This was due to the survey being conducted online, and presented in two ways. Firstly, through attacks by bots that disrupted the data. Secondly, by its restricted reach to the remote and rural communities we were trying to engage. To mitigate the impact of these challenges, we cleaned the data of the online disruptions, presenting here only those genuine people who participated in the survey. These limitations informed our subsequent research methods as discussed in section 3.2.1.

CHAPTER 3: FINDINGS

3.1 Phase One: Survey

An online survey was carried out via SurveyMonkey and received 176 responses, with an 82% completion rate. The following data presents the findings of phase one of this research.

3.1.1 Respondent Demographics and Characteristics

The demographics and characteristics of survey respondents were as follows:

Age: Most respondents were aged between 25 and 54 (70%); with the highest number of respondents were aged between 25 and 34 (28%). 21% were aged 35–44; 19% were aged 45–54; 15% were aged 18–24; 13% were aged 55–64; 3% were over 65 and 1% were under 18.

Gender: 95% of respondents identified as male (including trans male); 2% identified as non-binary; 1% identified as female (including trans female); and 1% identified in another way, replying ‘male’ and ‘bi male’.

Transgender: 5% of respondents identified as transgender; 92% did not identify as transgender; 2% said they were ‘not sure’, and 1% preferred not to say.

Sexual orientation: 72% of respondents identified as gay; 18% identified as bisexual; 5% identified as heterosexual/straight; 3% identified in another way, describing themselves as ‘queer’ (4 responses), ‘pansexual’ (1 response) or ‘homosexual’ (1 response), 2% said they were ‘not sure’; and 1% preferred not to say.

Relationship status: 43% of respondents stated they were single; 31% were in a relationship; 22% were married or in a civil partnership; 1% were widowed; 1% divorced, and

2% described their status ‘in another way’, as ‘married (to a woman but gay)’, ‘complicated’, ‘I don’t define myself by romantic/sexual relationships’, and in an ‘open relationship’.

Relationship style: 51% of respondents stated they were in a monogamous relationship; 17% were in an open relationship; 9% were non-consensually non-monogamous (also known as cheating); 9% described in another way, as ‘single’ (11 responses), ‘I do not have a relationship style’ (1 response), ‘male & female’ (1), ‘just man sex’ (1), ‘not having a relationship style (1), and ‘lonely’ (1); 7% respectively were polyamorous or consensually non-monogamous (also known as ethically non-monogamous).

Health board: The highest number of respondents lived in NHS health boards Highland (20%), Grampian (15%), Dumfries and Galloway (14%), and Lothian (12%). The lowest number of respondents lived in Orkney (2%), Shetland (2%), and Fife (3%). All health boards were represented in the final survey data.

Education level: Education levels varied, with most respondents having obtained higher education – 28% with an ordinary or honours degree and 20% with a postgraduate degree; 38% had obtained highers; 9% nationals; and 6% none of the above.

Place of birth: 93% of respondents were born in the UK. Of the 7% who were not born in the UK, 66% were born in the EU and the remaining 34% born in the USA, Africa or Asia.

3.1.2 Local Sexual Health Services

We asked respondents a series of questions about their **use of sexual health services in their local area** to better understand their current experience of access.

Key Points:

A significant number of respondents have never been tested for an STI, HIV or another BBV.

Most respondents received an STI/HIV/BBV diagnosis in a sexual health clinic either in their nearest city or town. Considerably fewer had received a diagnosis from their GP, at a hospital, in a community testing service or from an online test.

Findings:

Most respondents had been tested for STIs in the last 6 months (36%). Significantly, **18% of respondents stated they had never been tested for an STI.**

More of the respondents had been tested for HIV or a BBV such as hepatitis C in the last 6 months (40%), with **similar numbers stating they had never been tested for HIV or a BBV (17%).**

65% of respondents had not been diagnosed with an STI in the last five years or had ever been diagnosed with HIV.

Of the 35% of respondents who had received a diagnosis for HIV or an STI, 54% had been diagnosed with an STI in the last five years; 38% had been diagnosed with HIV; 4% respectively had been diagnosed with hepatitis B or hepatitis C in the last five years.

Of the 35% of respondents who had received a diagnosis for HIV or an STI, 38% had been diagnosed in a sexual health clinic in their nearest city; 30% in a sexual health clinic in their nearest town; 14% by their local GP; 8% in a hospital in their nearest city; 4% in a community testing service; and 2% respectively at a hospital in their nearest town, by purchasing an online test or ordering a free online test.

3.1.3 PrEP

We asked respondents a series of questions about their **experience and knowledge of pre-exposure prophylaxis (PrEP).**

Key Points:

A significant majority of respondents had heard of PrEP and had previously taken it.

Some respondents noted the considerable distance either the clinic or the PrEP itself was from their homes, with one respondent noting that they travel 68 miles due to privacy concerns around accessing PrEP from the clinic in their home town.

Most respondents would prefer to order PrEP online or access it from a sexual health clinic in their nearest town. They would not like to access it at a hospital, and some respondents actively noted they would like to access it at a pharmacy.

Some respondents noted barriers to accessing PrEP at the current time.

Findings:

91% of respondents had previously heard of PrEP.

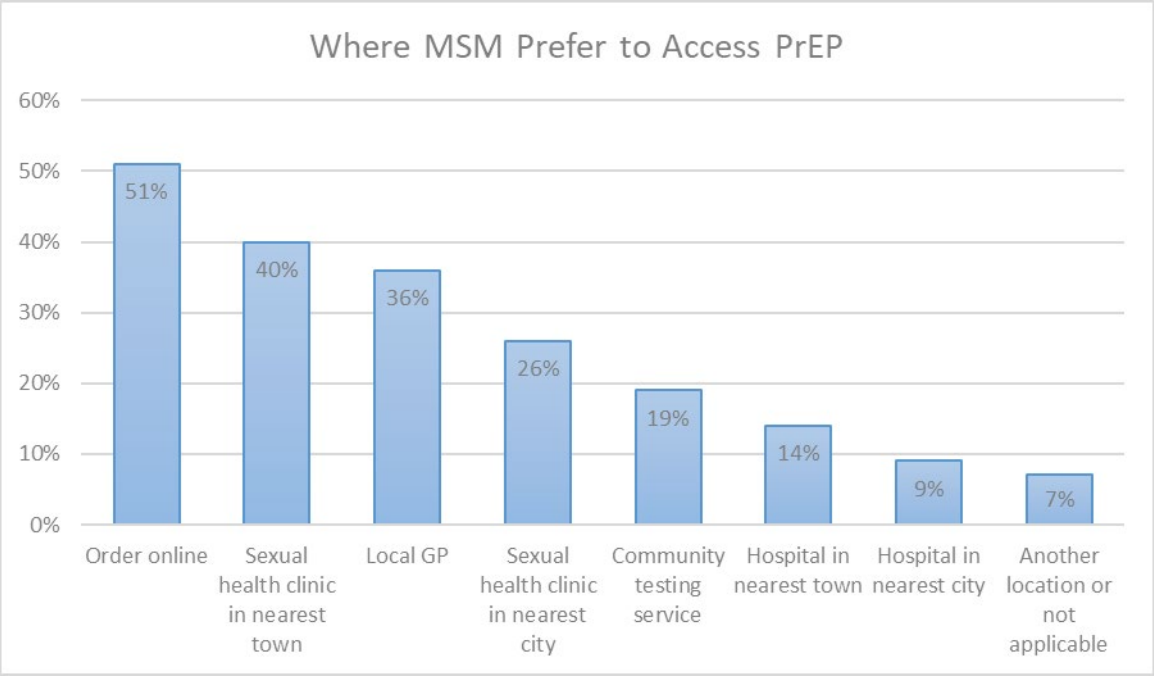
73% of respondents had previously taken PrEP.

Of those who had previously taken PrEP, a significant majority had accessed it from an NHS sexual health service either in their nearest town (37%) or in their nearest city (33%). The remainder either accessed it from an online pharmacy (17%) or from their local GP (2%).

Notably, the majority of the 11% who responded 'in another place' (4 out of 5 respondents) mentioned the considerable distance that it took for them to access PrEP:

> *'I attend a sexual health clinic in the next nearest town with a clinic but it's 68 miles away. I don't attend a clinic in my town due to privacy concerns'.*
>
> *'Appointment in my town but PrEP shipped up from Glasgow'.*
>
> *'In NHS clinic 150 miles from home'.*
>
> *'In the US. It is much more accessible there than on the NHS'.*

When asked where they would prefer to access PrEP, and asked to tick all that apply, respondents answered:



Of those who stated they would prefer to access PrEP in another location, respondents noted they would like to access PrEP at a pharmacy; while others noted accessibility issues in their local area:

> *'Anywhere that's on my island (I've been trying to access PrEP for months but I am unable to access it on my island)'.*
>
> *'All of the above. Hesitant to click GP because my GP is an old school Presbyterian, but I think he'd still provide the drugs, he just might be a bit mardy about it'.*

3.1.4 Sexual Health Information

We asked respondents a series of questions about where they would **find information about sexual health services**, for example, STIs or safer sex advice, to better understand the current availability of accessible information.

Key Points:

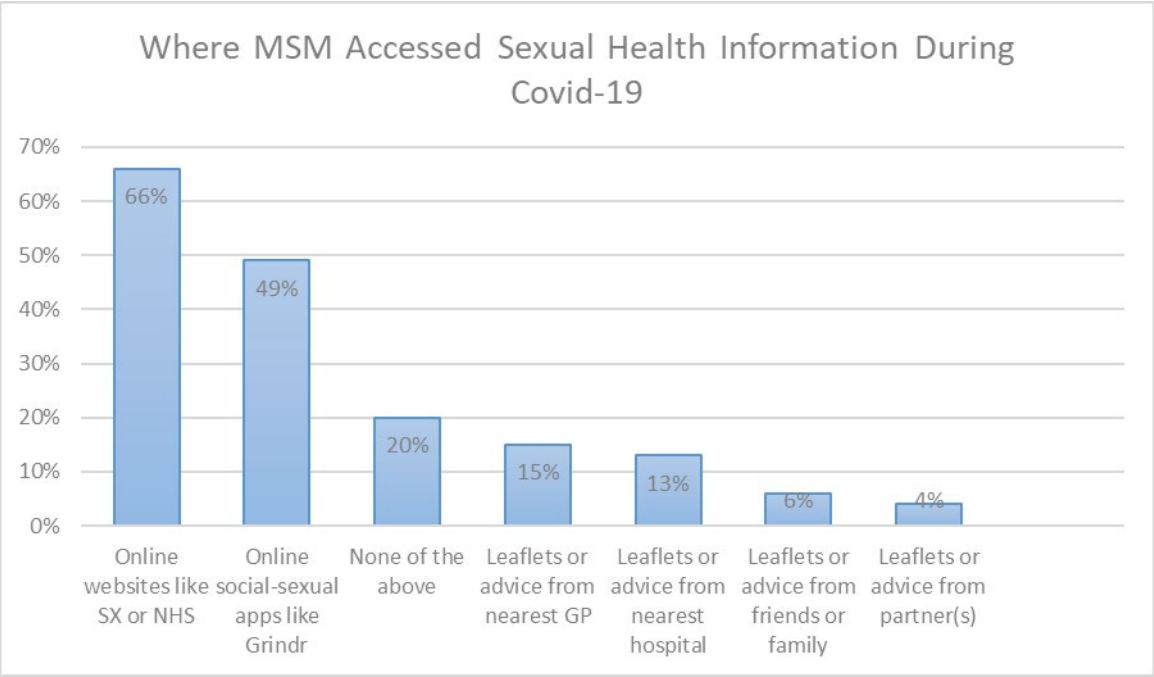
Most respondents have seen or become aware of sexual healthcare information from online sources in the past two years, rather than from leaflets or personal advice, with most saying that the Covid-19 pandemic has not changed this fact.

A significant majority of respondents would search online to find sexual healthcare information in the future, with very few saying they would ask people other than their GP or health professional.

However, 25% of respondents said they would not search online to access sexual healthcare information, a significant minority to consider when planning sexual healthcare information access.

Findings:

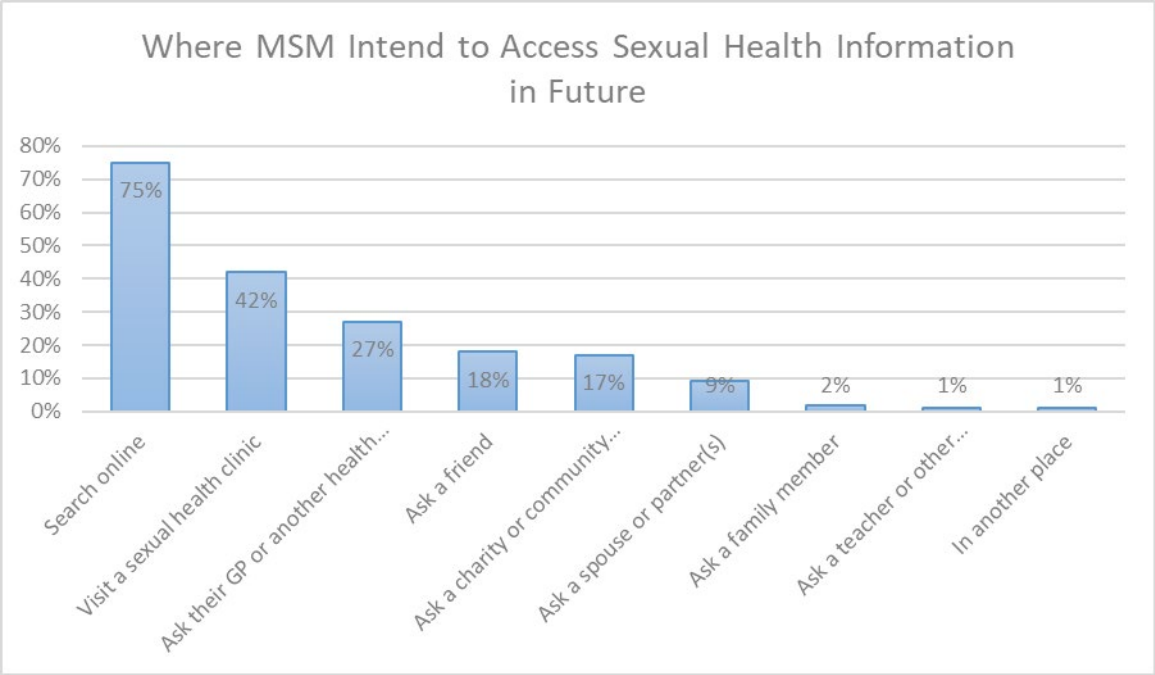
When asked what kind of sexual healthcare information they had seen or become aware of in the past two years, asked to tick all that apply, respondents answered:



61% of respondents said this had not changed since the onset of the Covid-19 pandemic; 20% said that it had changed; and 19% were not sure.

38% of respondents found it either difficult or very difficult to access sexual health information in their local area; 30% found it easy or very easy; and 32% were found it neither easy nor difficult.

When asked where they would find information about sexual health in the future (for example, STIs or safer sex advice), asked to tick all that apply, respondents answered:



'I'd go to Edinburgh sexual health clinic as I've been unable to find anything equivalent in Livingston area'.

3.1.5 Location and Transport

We asked respondents a series of questions about **where their local sexual health services were and how they would access them**, to find out whether living in a remote or rural area was a barrier to accessing sexual healthcare.

Key points:

Most respondents would travel for 30 minutes or less and would travel in their own car to their nearest sexual health service. But respondents noted that this fact depends on where the service is located – the time and mode of transport between a service located at the local GP or in the nearest sexual health clinic could differ considerably.

Respondents who would not travel to access a sexual health service noted time, convenience and stigma as the main reasons not to travel.

The cost of travel to a sexual health service also reflected the distance travelled, suggesting respondents would either live very close to, for example, their GP surgery or have to travel a considerable distance to a sexual health clinic.

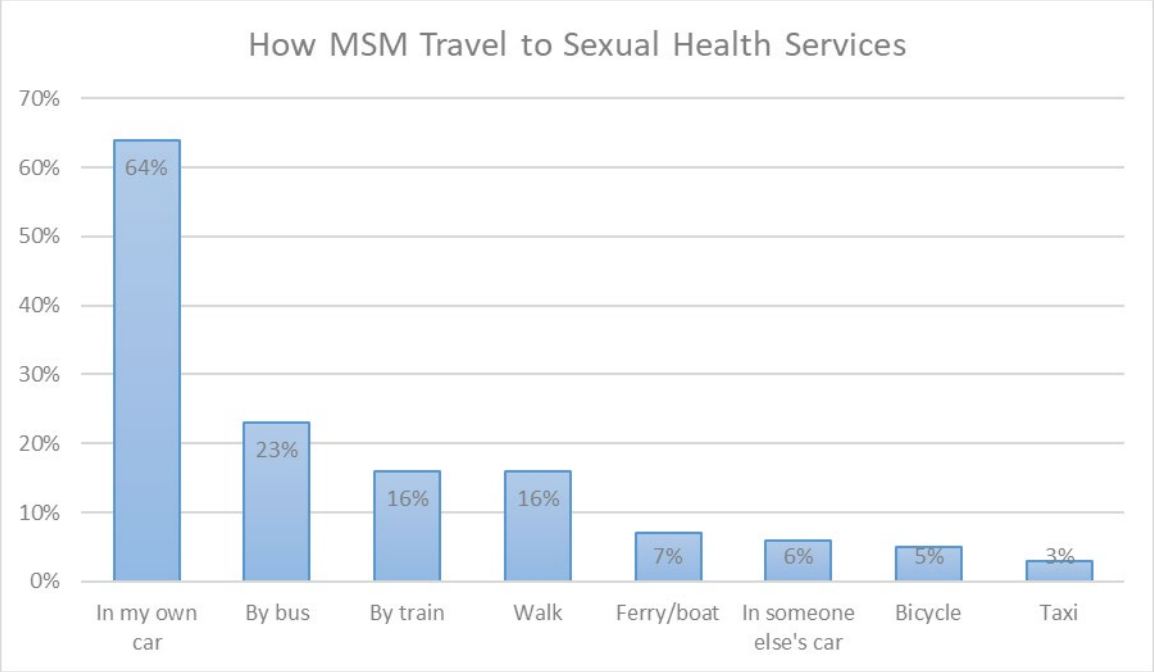
Findings:

Most respondents (36%) travelled for 30 minutes or less to travel to their nearest sexual health service; 27% travelled between 30 minutes and 1 hour; 18% between 1 and 1.5 hours; 10% between 1.5 and 2 hours; 4% 3 hours or more; 3% between 2 and 2.5 hours; and 2% between 2.5 and 3 hours.

Some respondents commented on the differing scale of travel and issues with accessibility:

> *'Depends what you mean. GP is ten minutes away. HIV clinic takes a three day round trip'.*
>
> *'If a clinic is running in Elgin 10 mins otherwise 1.5 hours to Aberdeen'.*

When asked how they would travel to their nearest sexual health service, asked to tick all that apply, respondents answered:



Those who said they would not travel were asked why. Respondents mostly mentioned time, cost, distance or convenience, as well as potential stigma around travelling to a sexual health service:

> *'Disruptions in ferry connections'.*
>
> *'Time, distance, I'd need to directly lie to my partner'.*
>
> *'Petrol prices'.*
>
> *'Too far. Edinburgh not car friendly and I'm still not comfortable with public transport in the midst of the pandemic'. 'Long time. No other need to go to Aberdeen'.*
>
> *'Cancelled ferry/bad weather'.*

'I would walk because I can't drive and I might feel embarrassed getting public transport such as a bus to a sexual health clinic'.

Cost of travel varied considerably. The majority of respondents would spend either £3–5 (16%); £0–1 (14%) or over £20 (15%). This variation reflects the previous responses that suggest respondents would either live very close to, for example, their GP surgery or have to travel a considerable distance to a sexual health clinic.

Most respondents said the travel costs would not stop them from attending a sexual health service (69%); with 18% saying the costs would stop them and 12% not sure.

3.1.6 Sexual Health Service Delivery

We asked respondents a series of questions on the **location and type of sexual health service delivery they would prefer to access**, to find out if there were any differences between their preferred and currently available services.

Key points:

Respondents preferred to access sexual health services from a qualified sexual health nurse at a GP surgery or at their nearest hospital.

Very few respondents would be happy to access sexual health services at a pharmacy or from a pharmacist.

Most people would speak to someone about their sexual health remotely, with telephone or online chat the preferred method; but 15% of respondents would not speak to someone about their sexual health if they had to do so online.

Respondents worried about privacy at home or about the security of speaking to someone online about their sexual health.

Most respondents found it unimportant whether the person they were getting sexual healthcare or advice from was the same gender, race/ethnicity or sexual orientation as them, but

Most respondents do not care if a sexual health practitioner lives in their local area or not, and they did not consider peer support an important part of sexual healthcare services.

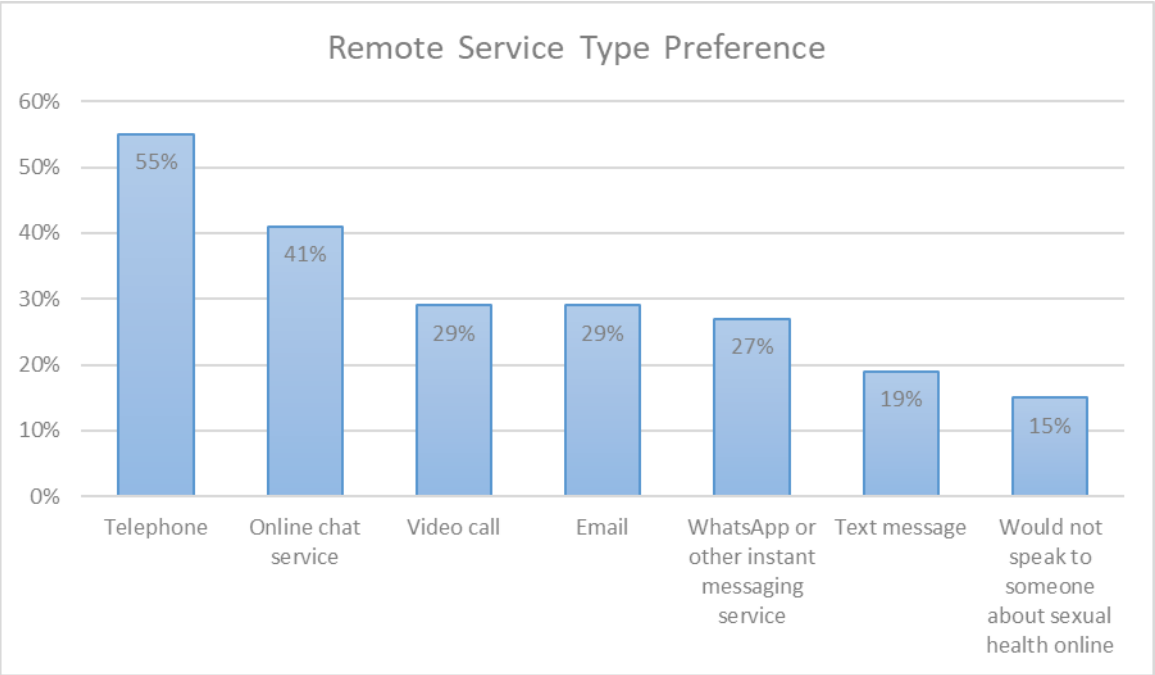
Findings:

Most respondents preferred to access their sexual health services at their local GP surgery (30%) or nearest hospital (20%); 13% respectively preferred a community venue or would access their sexual health services online rather than in any physical location; 11% preferred a combination of their nearest GP surgery, hospital and pharmacy; 9% would access their sexual health services outside of their local area rather than any of the local physical options; and 5% preferred their nearest pharmacy.

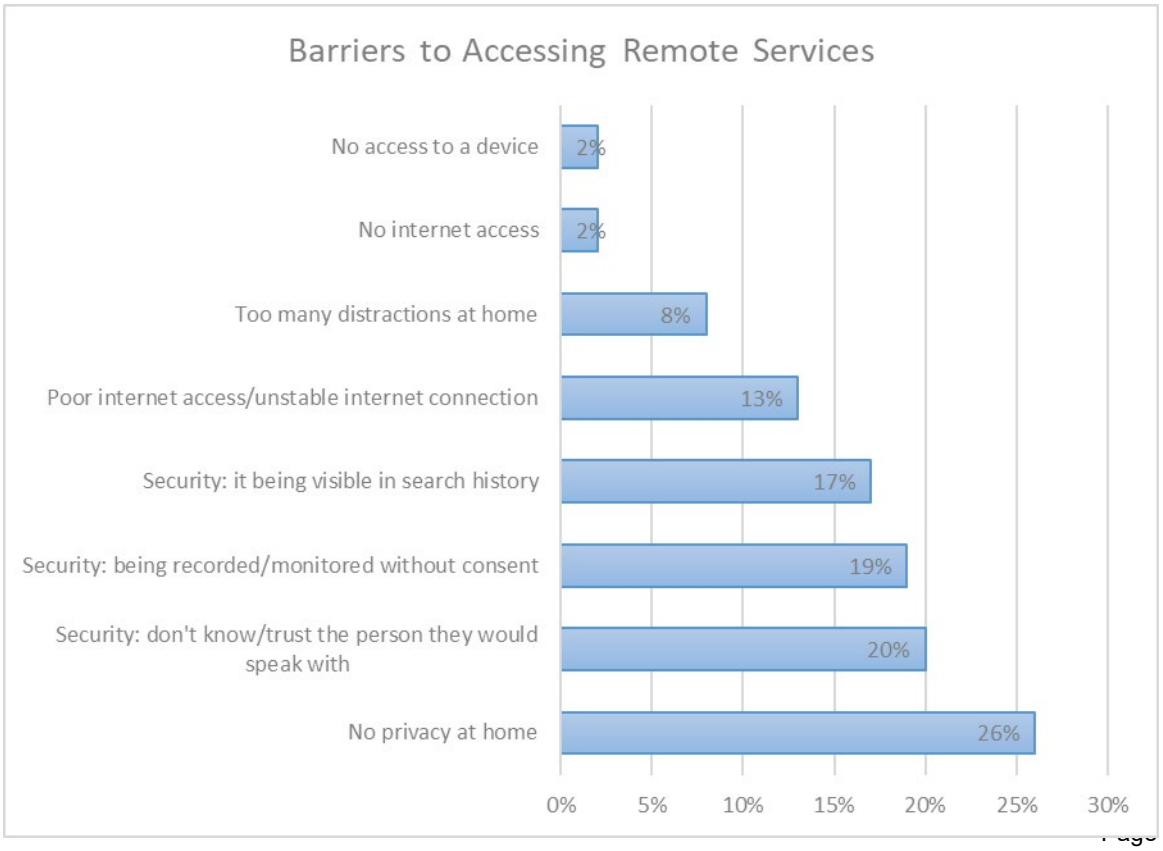
Most respondents preferred sexual health services be run by a sexual health nurse at a GP surgery (23%) or at a hospital (18%); 14% preferred them to be run by a doctor at a GP surgery; 12% from a sexual health practitioner from a charity; 9% would only get sexual health services online; 8% would only get sexual health services outside of their local area; 7% from a doctor at a hospital; 5% from a general nurse at a GP surgery; 2% respectively from a general nurse at a hospital or from a pharmacist. One respondent noted:

'We should have a cross-border arrangement to access the nearest neighbouring board's services'.

When asked which remote service they would be happy to speak to someone about sexual health on, asked to tick all that applied, respondents answered:



When asked what factors would stop them from speaking to someone about their sexual health remotely, asked to tick all that applied, most respondents stated that nothing would stop them and that they were comfortable speaking to someone online (54%), but of those factors that would stop them, respondents answered:



In answer to this question, respondents also mentioned issues such as:

> *'small community gossip'.*
>
> *'it's better in-person because of the tests there'.*
>
> *'I don't like talking about my health online'.*
>
> *'Professionalism of third sector/charitable organisations'.*
>
> *'I'm not comfortable discussing this online as I think a face to face consultation is important as it provides more confidence, provides a relationship between patient and care provider and permits an easier understanding of any issues as well as the opportunity to identify and discuss related issues'.*

Although preferences variation were small around the time to speak online about their sexual health, there was a slight preference to speak to someone online on weekday afternoons (+50%) and mornings slightly less preferred (-43%). The most preferred time was Monday PM (58%) and the least preferred Sunday AM (34%).

Most respondents (45%) found it unimportant to get sexual healthcare and advice from someone who is the same gender as them; although 35% found it important or very important; 12% found it moderately important; and 7% found it slightly important.

Most respondents (74%) found it unimportant to get sexual healthcare and advice from someone who is the same race/ethnicity as them; only 15% found it important or very important; and 10% found it moderately or slightly important.

Most respondents (42%) found it unimportant to get sexual healthcare and advice from someone who is the same sexual orientation as them; although 33% found it important or very important; 24% found it moderately or slightly important.

Most respondents did not care whether a sexual health service is provided by health practitioners who live in their local area or not (64%); 28% preferred them not to live in their local area; and only 8% preferred them to live in their local area.

Most respondents (36%) consider it unimportant to get peer support as part of their sexual health services; but 32% consider it very important or important to get peer support; 17% consider it moderately important and 16% consider it slightly important.

3.1.7 Gender, Sexuality and Engagement

We asked respondents a series of questions around their experiences of **gender and sexuality** as it relates to their engagement with sexual healthcare in their local area, to find out whether issues of identity influence their experiences.

Key points:

Most respondents are comfortable disclosing their sexuality in their local community and their nearest sexual health service.

Some respondents note that lack of awareness of how LGBTQIA+ identities intersect with the sexual healthcare among service providers adversely affects their access.

Findings:

Most respondents (60% total) were very comfortable (26%), somewhat comfortable (21%), or comfortable (13%) in disclosing their sexuality in their local community; but 24% were very

uncomfortable, uncomfortable or somewhat uncomfortable disclosing their sexuality; 11% were unsure.

Most respondents (74% total) were either very comfortable (40%), comfortable (19%) or somewhat comfortable (15%) disclosing their sexuality in their nearest sexual health service; 17% in total were uncomfortable (8%), somewhat uncomfortable (6%), or very uncomfortable (3%). 9% were unsure.

Most respondents (63%) did not feel their sexuality had ever prevented them from accessing sexual health services in their local area. However, when asked to comment, respondents voiced concerns about issues such as privacy and a lack of knowledge around providing sexual healthcare services to LGBTQIA+ people:

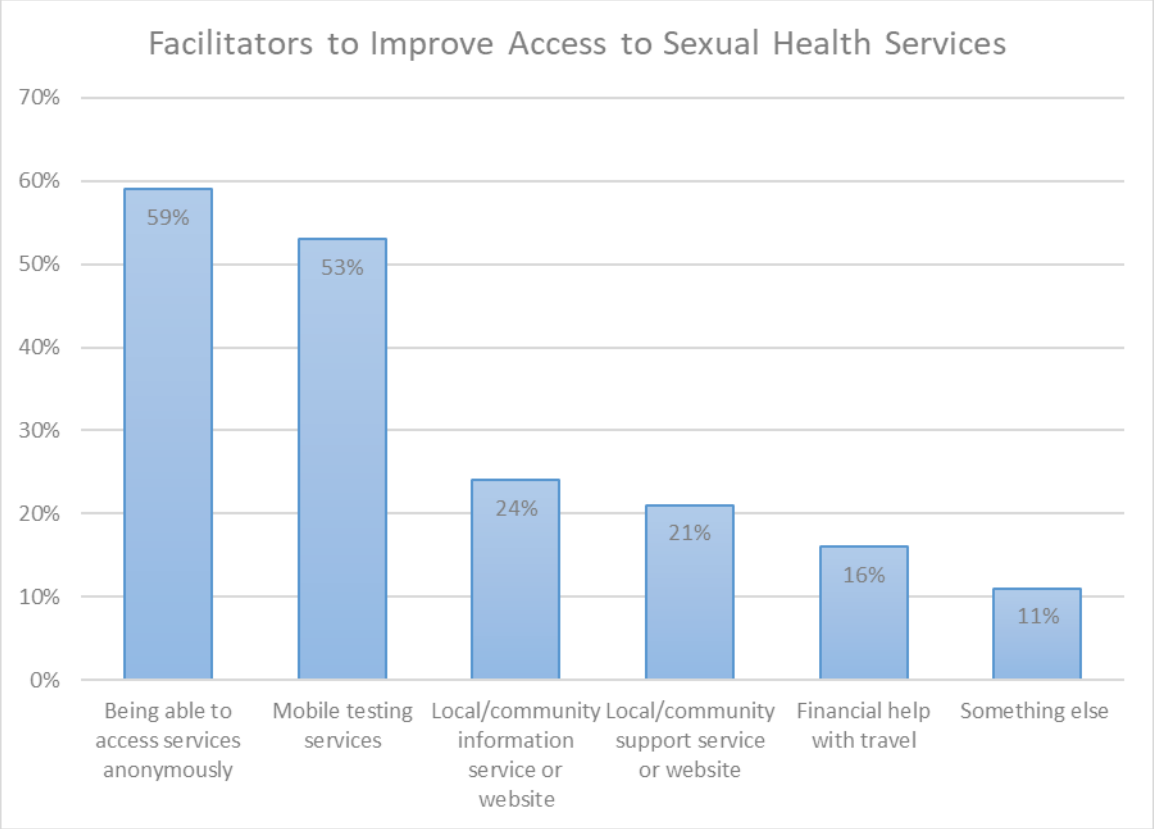
> *'We know that information from patient records has not always been kept confidential at our local GP practice. This is a concern in a small community'.*
>
> *'Lack of privacy. I'd trust the medical staff but not other people who attend the clinic. Whole town would be aware I was seen there within the hour'.*
>
> *'GP was reluctant to give treatment for PrEP and wanted me to travel over 100 miles via a ferry'.*
>
> *'I just received my first STI test since moving to the western isles. I don't think this rural GP practice was knowledgeable or equipped to cater to gay mens sexual health. There was no anal swab or throat swab. I think I was just tested as though I was a heterosexual patient. Also they are apparently unable to provide me with Prep and so I am very worried about HIV'.*
>
> *'Area is too small, I also didn't like the idea of setting in the doctor surgery with the clipboard which was quite clearly to fill out information for sexual health services'.*
>
> *'Shame & embarrassment'.*
>
> *'The local gum clinic is predominantly for heterosexual people, and the last time I was in hospital, for a urine retention caused by chronic constipation and an enlarged prostate, when I told the Dr I was homosexual I was lectured about bareback sex and felt humiliated. I do not trust heterosexual medics to treat me with respect'.*
>
> *'As a bi trans man it's difficult trying to explain to medical professionals what sort of help I need. I have been met with scepticism and discriminated against by doctors'.*
>
> *'working in nhs, knowing the staff who work there'.*
>
> *'I recently moved to Lewis. Before moving to Lewis, I was completely out and normalised my life and LGBTQ+ diversity. I love Lewis and want to settle here, but I'm a little more hesitant about the issues because I work with older Gaelic speakers who are often very religious and socially conservative. I'm not ashamed, but I am concerned about damaging important social networks'.*
>
> *'On NHS website heterosexuals can get STI face to face appointments however MSM appointments have to be over the phone first'.*
>
> *'People would know as word gets around'.*

Most respondents (80%) did not feel their gender had ever prevented them from accessing sexual health services in their local area. However, some respondents noted finding services were not available to them based on their gender:

> *'I had to go to my local GP for STI testing as I tried to access a sexual health clinic that apparently exists at the islands hospital, but I was informed that this was for women only'.*
>
> *'I feel the only thing available is for family planning which is not relevant to a gay man'.*
>
> *'There are no clinics in my local area which welcome trans or nonbinary people, so I would not feel comfortable as I would be misgendered in order to access the sexual health clinic nearest me'.*

3.1.8 Additional Considerations to Improve Engagement

We asked respondents two further questions to find out if there was anything else that would **help them access sexual health services** as an MSM living in a remote and/or rural area of Scotland. Respondents were directed to tick all that apply, and answered:



11% stated something else would help them access sexual healthcare, including:

> *'Everything being online is fine with me, I'd just like to see it widely advertised'.*
>
> *'Mobile private testing services at times after working hours as most people work 9–5'.*
>
> *'Better local service (not just via sexual health clinics)'.*
>
> *'Specific gay men's services where I won't face homophobic treatment from Doctors or nurses'.*
>
> *'Online testing and postal service'.*
>
> *'I would benefit from an STI testing facility for everyone being introduced to the Isle of Lewis and I would greatly benefit from being able to access PrEP through that service'.*
>
> *'Online kits would be the single, most effective thing that could be done for the rural communities. I've noticed they are available in cities but not out here, which seems insane. For blood borne tests (syphilis, HIV, etc.) I do not understand why they cannot be done through our local GPs surgery and sent away for testing'.*
>
> *'Sexual health clinic (not through our GP) closer to where I live. However, this will never be available as we are such a small community'.*

3.2 Phase Two: Qualitative Interviews

We conducted five semi-structured qualitative interviews with community connectors. The following data presents the findings of phase one of this research.

3.2.1 Difficulty in Recruiting Research Participants

> *"I find it quite hard to get into communities and people are so spread about and things that I would imagine that would be difficult"*

Participants echoed our experiences trying to recruit and connect with MSM people in rural and remote areas for the following reasons:

Poor Online Engagement

Interviewees had also experienced trying to advertise services and opportunities via social media but found that online groups in rural and remote areas tended not to have many members or that engagement had lapsed. They explained that this is likely because of the small number of community members in such areas and the issues MSM face around opening up about their sexuality in a public arena (see 'stigma' below).

Recruitment fatigue

Interviewees noted that those people who do engage with research or with LGBTQIA+ or sexual health services, such as Waverley Care, THT, or LGBT Health and Wellbeing, are asked regularly for their opinion, to take part in research or for other forms of engagement. This engagement has likely led to "recruitment fatigue", especially after the Covid-19 pandemic period where increasingly people are being asked to engage online.

Stigma

The main reason interviewees gave to explain the lack of engagement in the recruitment process was due to stigma around sexual orientation, sex and relationship practices in rural

and remote areas. Compared to more urban areas like Glasgow, Edinburgh or the Central Belt more generally, interviewees noted how sexuality or sexual preference is considered more private in remote and rural areas. One example given was around cruising sites in a rural area, which are historically situated in specific areas and times so are kept "hidden" from everyday life, or at least compartmentalised.

Another interviewee noted that within farming communities, people do not engage with a social sexual scene in their local area. If they do engage, they will travel to a city or to the Central Belt, again compartmentalising their sexuality.

These explanations led to conversations around how MSM in remote and/or rural areas in Scotland are a hidden or hard-to-reach community. Understanding how the community is formed and the barriers to MSM engaging fully in their local community therefore offers insight into how sexual health services can be better targeted.

3.2.2 Rural and Remote Communities

'There's not many people I know that come out in Stranraer'.

Rural and remote communities are socially organised in a particular way compared to urban areas. Some factors overlap with urban areas, such as age or demographic factors that cause social exclusion, but our interviews show that although communities are built where MSM can be open about their sexuality/sexual preferences, these can be marred by discrimination and social stigma. Small population sizes can also affect the kind of social organisation needed to sustain a community in a remote or rural area, which then tend to focus around towns rather than more remote and rural areas.

Social Exclusion

Digital Interaction

Multiple interviewees mentioned digital exclusion and the consequences of this exclusion in accessing people, especially in remote and rural communities.

Interviewees mentioned issues surrounding digital literacy and support. A person can have the technology to connect but not understand how to use it in a way to connect to people and resources. They mentioned a lack of resources in providing support services, in particular one service that provided laptops to people but were unable to support them in setting them up or teaching them digital skills.

Other interviewees mentioned the shift in social community for MSM from in-person, commercialised interactions such as gay pubs or clubs to online, social-sexual apps such as Grindr. This shift means that community is reduced to sexual interactions rather than broader community engagement; which limits anyone who is digitally excluded (see 'isolation' page 25).

One interviewee mentioned the prohibitive cost of publicising services anywhere other than online, such as printing and posting leaflets. Cost factors suggest that communities will increasingly be targeted online, further excluding those who do not or are unable to engage digitally.

Age

Age demographics also emerged as a factor that increased digital exclusion. One interviewee who works in a telephone service targeting over-50s LGBTQIA+ people stated

that nearly half of those they call do not have internet access. They tried to access these people via those who are online with a campaign that asked “do you know someone who may need a call?” but did not achieve much uptake.

However, another interviewee spoke of engaging an older demographic via social-sexual apps, saying that individuals in this group were more likely to hide their sexual activity in their everyday lives so preferred the anonymity of digital interactions and so were easier to communicate with about sexual health through these apps (see section 3.1.4).

Stigma and Discrimination

The main issue interviewees spoke of was the lack of an open LGBTQIA+ community in rural and/or remote areas and the subsequent difficulty MSM they knew had in finding community to engage with or even being comfortable enough to be open about their sexuality or sexual preferences.

Interviewees all talked about a hidden community of MSM/LGBTQIA+ people in remote and rural areas. People tend not to be open about their sexuality/sexual preferences because, as one interviewee noted, “if one person comes out, everyone knows about it”. This is especially prevalent in smaller villages and remote areas rather than towns, where an increase in Pride events in recent years and more established LGBTQIA+ communities mean that there is a difference again between towns such as Oban or Perth and even more remote and rural areas.

One interviewee talked about their awareness of cruising as being very common in remote and rural areas but because it is such a hidden activity, it is difficult to gauge how many people are in this demographic. They went on to say how difficult it makes them to engage with as this group of people are very different from those who are “out” and go to Pride festivals, for example.

One interviewee noted how being open about your sexuality in a remote and rural area could affect your life in significant ways:

‘Within the farming community … that would mean a lot of people would be prejudiced against you and would stop working with you, stop dealing with you, so your business could be impacted. … We know of a number of gay farmers who just cannot identify themselves as who they want to be or it would be their livelihood that would go’.

How Communities are Formed

In spite of this hidden number of MSM in remote and rural areas, communities are formed in these areas and understanding how they develop as well as the barriers to their development is very useful to create strategies in growing them further as a means of engagement.

Pride

Pride emerged as a significant form of community development that reduced stigma and encouraged MSM to be ‘open’ about their sexuality/sexual preferences, thus making them easier to find and engage with. One interviewee noted this connection and its link to sexual health service engagement:

> *‘Oban has a good community, they have got a really well established Pride, they do lots there and I think actually that’s why testing always goes so well there, it’s quite an open and accepting community’.*

Interviewees mentioned the work Pride festival organisers had undertaken in different regions across Scotland, going on tours around remote and rural areas to show a consistent presence and encourage those who are "out" to join in. One interviewee mentioned holding Pride events that were anonymous as being a significant first step in encouraging people to engage openly in their community. They mentioned a masquerade ball that was held during a Pride event that they noticed brought out people who were not known to services.

However, interviewees noted the need for a consistent scene in remote and rural areas, with one interviewee noting how there is still no gay bar or in Dumfries so people can be "out" during Pride but not the rest of the year.

Community Organisation

> *'The smaller the town, it seems to be the less service that the community are actually having or being offered to them or that they can access'.*

To be open about their sexuality/sexual preferences, people in remote and rural areas therefore generally need to engage with services or organisations. However, interviewees all noted the lack of consistent social organisations for MSM to interact with. One interviewee talked about working with someone who had recently moved to the area and was looking for social connections and there was only one group that he could join. This group had only started three weeks' previously and was based in a bar, so if anyone does not want to interact with an alcohol-based activity would not be able to engage.

One interviewee talked about the difficulties in up-to-date online resources for people to access local community organisation. They mentioned how finding groups online – through social media or on community listings – that do not respond or they find are no longer operating can create additional barriers to connecting to others:

'it takes a lot for someone to come forward for some support, people need to work themselves to point where they are willing to take that step, … and if when they try to do that … they don't get through to someone or they don't get a response, … that that will make it more difficult for them … to do it again because they will feel like I tried that and it didn't work for me, and that feels like a failing'.

Multiple interviewees noted that they generally have to point people towards Edinburgh or Glasgow for any meaningful form of social network, and that generally people move to the Central Belt rather than towns within remote and rural areas.

Differences in Areas

Interviewees also mentioned how their areas could not be treated as a whole when it came to community for MSM to engage with, in that, as noted above, there tends to be a considerable difference in how open individuals are in towns compared to more rural areas.

One person mentioned how Dumfries compared to Stranraer, especially in relation to poverty and the type of communities that live in these different towns that then created a space for openness and, subsequently, an ability to engage in services.

Another interviewee mentioned the difference between East and West Lothian. They used the same advertising for outreach clinics in both areas through social-sexual apps but had a very different response: a high uptake in West Lothian and almost no uptake in East Lothian. The interviewee explained this difference because West Lothian to them felt like it was "part

of the same corridor as Edinburgh and Glasgow", but as soon as you are out of that area engagement drops away.

3.2.3 Sexual Health Services

The findings around the difficulties MSM have in forming and sustaining community in remote and rural areas, combined with the difficulty service providers have in accessing individuals, frames how sexual health services are implemented in these areas. Interviewees discussed factors that affected their ability to deliver services and access people around accessibility, isolation, stigma, the lasting effect of the Covid-19 pandemic and the structures of NHS and support services in these areas.

Remote Services and Support

Interviewees all discussed both positives and negatives around current remote services and support, remote here meaning via post, telephone or online.

Interviewees all noted that people do tend to use postal services for testing or free condoms, and that they can work quite well considering people tend to avoid engaging with in-person services due to either the distances involved or the stigma of openly engaging with a sexual health service (see 3c below). One interviewee noted that people were more likely to engage with phone or postal services because:

> *'You are walking into the sexual health clinic, and there is only one every fortnight or something like that, somebody sees you going in they could make that assumption'.*

Another said:

> *'We have quite a lot of people … who would never dream of going to their local practice, even in a city let alone the country, and open up about their sexuality'.*

One interviewee also noted that they found social-sexual apps to work very well in accessing people. It is anonymous and people ask questions about testing, PrEP and STIs freely. The interviewee uses a GPS app so can move their status around different areas without physically being there.

However, some limitations to these services were noted. One interviewee had received lots of feedback to say that people found home testing too complicated; another noted that it was difficult to track the uptake of PrEP from the phone service they operate as people may talk about starting to take it but there is no way to check.

Multiple interviewees have found people very reluctant to engage with telephone services or support because they were worried about confidentiality or that they weren't confident speaking on the phone. Interviewees found a similar response to online services, where people were not comfortable speaking online due to the sensitive nature of the discussions.

Need for In-Person Services

The limitations to remote services are backed up by the contradictory responses to in-person services. As found in our survey responses, people wanted in-person services that are local and easily accessible, but that are anonymous.

All interviewees noted the need for drop-in services to be introduced or re-introduced after stopping during the Covid-19 pandemic (see section 3.c.i below). Drop-in services suit the nature of rural and remote areas, according to interviewees' experience. For example, one interviewee used to access a free drop-in clinic when working with young people. If they needed sexual health support, they could stop by the drop-in clinic when they needed to

without having to make an appointment, which suited the nature of interacting with a younger person. It is this group that the interviewee said were very reluctant to access similar services online or over the telephone, so they feel that this group now do not access sexual health support nearly as much as they used to when a drop-in service existed.

Interviewees also noted the need for mobile services that had multiple nearby stops so that individuals had a variety of times and sites to drop in to. It was noted that there is currently no mobile sexual health testing service in the Highlands.

3.2.4 Isolation

Impact of Covid-19

All interviewees mentioned the impact that the Covid-19 pandemic had had on services, as well as on the general health and wellbeing of service-users, with one interviewee mentioning how anxious people are about their health in general at the moment.

One interviewee was working as part of a telephone service that was started during the pandemic and that has continued to offer remote support to people.

Interviewees discussed services going from being regular, accessible and in-person, such as the drop-in services noted above, a long process with multiple barriers: first a person has to fill in a form on an NHS sexual health service website, then have a telephone consultation, then if appropriate being invited for an in-person appointment. This lack of easily accessible support and services means that fewer people are accessing services.

One interviewee noted that free drop-in clinics have stopped since Covid-19 emerged and have not been re-implemented, but that NHS sexual health workers are talking about super-strains of Chlamydia presenting in patients, but there is no discussion of re-starting a drop-in service.

Stigma

Although people prefer the accessibility and personal interaction that comes with an in-person service, the hidden nature of the MSM community as outlined in section 3.2.2 above complicates people's interaction with in-person services and support.

In-person services were also complicated by interviewees, with an interviewee who works on a telephone service stating that there is regular evidence of people not wanting to talk to their GP about issues that may reveal their sexuality or gender.

Interviewees from all four health boards repeated the same issue: people in remote and rural communities are reluctant to open up about their sexuality to health workers due to the close-knit communities they live in. They are likely to know the person they are speaking to so there is no possibility of accessing an anonymous service:

> *'I had somebody in Fort William who was looking for testing, so I thought "great I live in Fort William that's not a problem, where would you like to go and I'll book it, and we can do the test", and he refused. He would rather travel the hundred and thirty mile round trip to Inverness to get tested by one of the Inverness team because he was so worried that I would know him or something like that'.*

> *'It's the person that they have been seeing all their lives, that knows their whole family and the neighbours, and all of those, everybody knowing everyone else's business'.*

Interviewees noted especially issues around having to disclose health queries to receptionists before being able to access services, and that people felt deeply uncomfortable speaking to pharmacists about their sexual health.

> *'I think the real concern about turning up to a clinic and the receptionist there is your neighbour who can see your records, I can't imagine that working but going to a clinic in the centre of Glasgow has that. I am sure there is anxieties about it but I can't imagine it is the same level as somebody who lives in a town of a couple of thousand because it really is, it is that small a community'.*

Geographic Distance

Many interviewees discussed the barriers to accessing sexual health services that come from the distances involved in remote and rural areas of Scotland. One interviewee stated that "the whole system for sexual health just doesn't work" due to the distances people have to travel and how services are organised:

> *'For someone in Campbeltown who wants to access PrEP, they need to contact the sexual health nurse in Oban who covers the whole of Argyll and Bute, who then does the testing for PrEP, but PrEP is only accessed through Sandyford [in Glasgow] who do the consultation, so she will contact Sandyford to organise that'.*

Interviewees noted the amount of time it takes for a person to travel to access services:

> *'…that could be a whole day out of somebodies working life to travel to Inverness to get a test to travel back'.*

3.2.5 Spaces for Sexual Healthcare

A major issue that emerged from the interviews were in finding appropriate spaces to provide services and support. As already noted, people express concern about whether services can be accessed anonymously all while they would benefit from them being easily accessible and in-person. Two main themes came from discussions:

Service Visibility

Interviewees talked about their difficulty in finding appropriate locations to hold services, because they felt that people do not feel comfortable going to a service that is dedicated either as a sexual health space or as an LGBTQIA+ space.

One interviewee mentioned that holding a testing service in Oban worked well because they worked closely with Oban Pride and a local wellbeing hub. The service was held in a discrete location and Pride, the wellbeing hub and the local NHS services promoted it. Elsewhere in the Highlands, the interviewee had to hold services in local community halls, which have been unsuccessful in attracting service users.

Interviewees talked about the difficulty in finding a balance between being able to promote services whilst also not overly focusing on sexual health services or marking LGBTQIA+-specific spaces.

'It is treading that fine line between wanting to shout from the rooftops "We're here, HIV testing for GBMSM and you come you can get a HIV test that's great" but also wanting to make it discrete enough that people want to come and see us'.

Interviewees talked about the need for subtle, cleverly placed sites that do not cause anxiety or make people talk about their sex life on first meeting; places that are casual but that have strong boundaries. One example given is having a 'coffee social' as a relaxing space for

people to come and be themselves in, with the messages there but that aren't directly focused on sexual health or other health issues.

Some interviewees built on this idea talking about their experience as more of a community connector, being able to discuss multiple issues with a person and being able to direct them to the appropriate support for all kinds of social or health issues.

NHS Connection

Interviewees consistently talked about how people were reluctant to access services or support from the NHS, as well as problems they had experienced in working with local NHS services.

One interviewee noted that people they speak with generally stay away from NHS locations with regards to their sexual health, as "people have a lot of concerns about NHS sites in the Highlands regarding confidentiality". Another interviewee said they receive lots of questions on social-sexual app support services about confidentiality in the NHS and how the NASH system works.

'He point blank refuses to use the NHS service here … he would not go to the local hospital for sexual health testing, that would just be an absolute no because the fear is that the outpatient staff in the hospital or you know the hospital receptionist they see you coming in, they know it is a sexual health clinic that's on that day'.

One interviewee noted that although there are sexual health clinics within NHS health centres, people they talk to do not find them inclusive for LGBTQIA+ people.

Some interviewees also talked about problems to NHS services, where third sector organisations were providing more accessible services than the NHS were.

Another interviewee noted issues with getting information about their services into NHS sites; they said that GP surgeries are less likely to put out flyers or put up posters since the Covid-19 outbreak, but also they have to compete with NHS healthcare information so they are unlikely to get their publicity into NHS spaces – both a useful space for sexual healthcare information and a legitimising tool for a service.

CHAPTER 4: CONCLUSION

4.1 Phase One: Survey

Here we provide a concluding summary of the findings described in section 3.1 of this report.

4.1.1 How MSM are Currently Accessing Sexual Health Services in Remote and Rural Scotland

One in five respondents have never accessed STI or BBV testing.

Of those who have accessed testing, most have done so in a sexual health clinic in their nearest city or town. Less than 15% had accessed testing in their local GP surgery, hospital, in a community testing service or from an online test.

Two thirds of respondents travel to sexual health clinics in their own car, while a third travel 30 minutes or less to their nearest sexual health clinic.

Of those who have previously taken PrEP, most accessed it from an NHS sexual health service in their nearest town or city.

The barriers MSM currently face accessing sexual health services include: service availability; distance required to travel for services such as PrEP; concerns about privacy, security, and anonymity; stigma and discrimination.

4.1.2 How MSM would prefer to Access Sexual Health Services

One in two respondents want to access services anonymously, as well as having the option to engage with mobile testing services. Respondents also want more financial support and more clear information targeted towards them in their local community.

Most respondents prefer to access general sexual healthcare at their local GP surgery, while one in two would prefer to access PrEP online. 40% would prefer to access PrEP in a sexual health clinic in their nearest town, and 36% from their local GP.

Most people would speak to someone about their sexual health remotely. One in two respondents would prefer to speak to someone on the telephone. Less than half of respondents would prefer an online chat service.

While most respondents stated that nothing would stop them from accessing sexual health services remotely, 15% stated they would not speak to someone online. Security concerns were the most significant reason why respondents would not speak to someone about their sexual health online.

4.1.3 How MSM are Currently Accessing Sexual Health Information

During Covid-19, most respondents accessed sexual health information online or through social-sexual apps. Respondents therefore have considerably more access to information on sexual health online rather than via leaflets or information in person.

A significant number of respondents find it difficult to find sexual health information in their local area.

4.1.4 How MSM would prefer to Access Sexual Health Information

Three quarters of respondents would prefer to access sexual health information online, while less than half would access information by visiting a sexual health clinic. A surprising number of respondents would turn to their friends for information. Contrastingly, most would not ask their family members.

4.1.5 The Intersection between Identity and Sexual Health

Encouragingly, most respondents feel comfortable disclosing their sexuality in their local community and in their local sexual health service. However, respondents noted that lack of awareness of how LGBTQIA+ identities intersect with sexual healthcare among service providers nonetheless adversely affects their access.

Although most respondents do not care whether their sexual health practitioner lives in their local area, a significant majority of those who care one way or another prefer them to not live in their local area.

Questions about the demographic particularities of the sexual health practitioner were highly polarised, with equal numbers of respondents either feeling it very important or not important at all to have a sexual health practitioner who was the same gender and race/ethnicity. Responses were marginally less polarised around having a practitioner of the same sexual orientation, but still considerably polarised as either very important or unimportant.

4.2 Phase Two: Qualitative Interviews

We asked interviewees what their ideal sexual health service would look like in a remote and/or rural area, as well as interviewees offering solutions to issues that came up during conversation. Here we provide a concluding summary of the findings described in section 3.2 of this report. This includes interviewees' opinions of how a sexual health service could overcome the barriers outlined in 4.1.

4.2.1 Community-Centred Approaches

Services

Interviewees talked about the need to create a person-centred, or community-centred approach to services, based on the individual needs of each area – areas that can vary significantly even within a health board, as shown above in the interviewees' experiences.

Services need to be made available and easy to access, with a varied approach between postal, online, third sector and NHS.

Once the services are available, issues around confidentiality and visibility need to be addressed: making testing services visible yet discreet, and making sure that people know "yes, we are confidential".

Community

Interviewees talked about the work needing to be done around building community for MSM in remote and rural areas. To have a consistent LGBTQIA+ presence felt in communities not just based on Pride month.

> *'People need to be growing up in areas where they feel they can be themselves, where they can feel accepted, where can feel cared for and supported, and a large part of that is the networks that are around them, and if there is an absence of those networks then we run into issues in terms of people, their experience of that kind of internalised sense of shame around sexual identities and MSM.'*

4.2.2 Intersectional Support Spaces

A strong idea of intersectional support spaces emerged from discussions with interviewees. This kind of space is a stepping stone to building the kind of consistent community where MSM feel able to be themselves all year round and not separated from their everyday community.

Build Community and Network

Interviewees talked about the need for creating a support service in remote and rural areas that is for everyone and where people know they can go to for community advice – as much as to start a book group as for accessing sexual health services.

A partnership approach was also mentioned, where one interviewee mentioning how lots of organisations around mental health, carer support, among others, have asked for support when interacting with LGBTQIA+ people. People want to help and are looking for a space to ask questions.

Non-Identity-Based Spaces

Interviewees also recognise the need for spaces not to be solely based on identity, or "siloed by sexuality", as one interviewee put it. They find that people are more likely to interact with personal welfare services – they come in for one issue but there are often other issues that

are core to their welfare concerns. If a service is solely marked for LGBTQIA+ people, or to some extent, for sexual health, people can be put off.

Building on the partnership approach, interviewees also mentioned reaching people through other services to access people who would otherwise not engage with sexual health/LGBTQIA+ services in their local area.

4.2.3 Connections to NHS services

The issue of connecting to NHS sexual health services in remote and rural areas is one of the most difficult to solve, as this research has shown that people both need and want to engage with local NHS services but feel unable or uncomfortable doing so.

Interviewees talked about trying to find unmarked spaces like community halls or sports centres that a person could be entering for any reason, but if these spaces have been marked out for sexual health services they are again too obvious for a person to want to engage with.

Interviewees therefore felt that discretion was key in linking to NHS services. For example, utilising community healthcare services that may be more general such as ear syringing or community midwifery services.

However, this does not deal with the lack of trust in NHS services to maintain service-users' confidentiality. As a result, the interviewees suggested utilising NHS services such as their internal mail service to publicise information about sexual health services via GP surgeries so they are legitimised, while also keeping them separate to assure the service user of the service's confidentiality.

One interviewee commented on how all services should work together to provide the best sexual healthcare possible:

> *'There need to be the third sector, there needs to NHS, there needs to be postal testing. … It should all be there and it should all be available, and working in partnership is great with the NHS and we do want to work with them, and support them or have them support us. But we also have to be able to say to people we aren't the NHS, this isn't going on a formal record somewhere, this is just between us and the office, we can use different language, it's a different process'.*

4.2.4 Geographic Distances

Interviewees had clear views on how to overcome the problems of geographic distance in sexual healthcare access in remote and rural areas:

'You can't have sexual health clinics in every tiny town in the Highlands, it is just not possible. There is always going to be the barriers of distance and the challenges that that comes with but it come with the territory living up here as well, but we just have to make sure that things are accessible for people'.

Pop-Up Hubs

Many interviewees talked about the need for pop-up hubs and satellite clinics so that services can be offered that do not entail such long distances to access. These should be offered in clusters around different areas so that people have the option to attend services that are not in their immediate area but that remain relatively close by.

Services on Different Days

Additionally, services should be held in these clusters on a variety of days so that people have options to attend them.

Travel Support

Interviewees noted that travel support is desperately needed. As it stands, people still need to travel to Glasgow or Edinburgh for some services, even if it is not by choice, so until all services are readily available in all NHS boards (such as PrEP), financial or other support is needed.

4.2.5 Diversity Training

Interviewees noted that to overcome the stigma and discrimination that still exists in remote and rural communities in Scotland, networks and a sense of community resilience need to be built. Multiple interviewees noted that this process starts with education, encouraging diversity training in schools, as well as supporting local Pride and LGBTQIA+ groups to develop a year-round presence in remote and rural communities and ones that reach outside of towns.

4.2.6 Online Resources

Interviewees talked about how services and information varied considerably in different NHS boards. An overarching suggestion was therefore to centralise online resources, with the possibility of creating a customisable template for all online resources. These resources could be shared and updated regularly to ensure that MSM seeking support, advice or community could access up-to-date information that also presented a coherent, vibrant community back to them.

4.3 The Ideal Sexual Health Service

Based on the findings of phases one and two of this research, here we provide a recommended framework on which the ideal sexual health service can be developed for MSM in remote and rural Scotland.

*The ideal sexual health service is **flexible** because it:*

- can be accessed anonymously
- includes mobile testing services
- provides satellite clinics in varied locations at varied times/days
- offers remote services via telephone and online chat service
- offers postal testing and condom services

*The ideal sexual health service is **person-centred** because it is staffed with practitioners who:*

- are trained to be culturally competent in the sexual health needs of MSM
- understand how intersecting identities can influence sexual healthcare
- understand the role sexual health holds in wider health and wellbeing
- are comfortable talking about diverse sex and relationship practises
- are non-judgemental and empathetic

*The ideal sexual health service is **trustworthy** because it:*

- offers accessible information that addresses privacy and confidentiality concerns
- provides a comprehensive Scotland-wide online information service
- offers advocacy support when MSM experience barriers accessing sexual healthcare in wider health and social care services such as GP surgeries

*The ideal sexual health service is **connected within a trusted network** because it:*

- has established referral pathways with wider health and social care services for LGBTQIA+ communities
- offers LGBTQIA+ informed sexual health training, information and support to all health and social care services in remote and rural areas
- provides dedicated support, such as financial or travel support, to facilitate access for MSM disadvantaged by their socio-economic circumstances

APPENDIXES

Appendix 1: Phase One - Consent form

Sexual Health Needs of Men who have Sex with Men in Remote and Rural Scotland

1.	I understand what this research is about, why I have been asked to take part in an interview, and what my participation will involve.	X
2.	I have had the opportunity to ask questions.	X
3.	I voluntarily agree to take part in the research.	X
4.	I understand that I can leave the interview at any point, without giving a reason.	X
5.	I understand that Waverley Care will use the information I provide to write a report.	X
6.	I understand that I will not be identified in any materials resulting from this research.	X
7.	I understand that my name and contact details will be stored in a password protected document until December 2022, so that I can be contacted about developments in the project. I understand that they will be destroyed after this time.	X
8.	I agree that the interview can be recorded, and understand that the recording will be destroyed immediately after it is transcribed.	X

Participant signature Date

Researcher signature Date

Appendix 2: Phase One - Information Sheet

Information Sheet

Sexual Health Needs of Men who have Sex with Men in Remote and Rural Scotland

What is this project about?

This project explores the access of men who have sex with men to sexual health services in remote and rural Scotland. The research looks at the impact of living in a remote and rural area on access to sexual health services, such as STI testing and PrEP. The project includes a national survey and interviews with people who are community connectors.

Why are you doing this?

At Waverley Care, we provide support services to men who have sex with men across Scotland. Through our work, we have found that men who have sex with men living in remote and rural areas often have reduced access to sexual health services. For this reason, we are carrying out research exploring what sexual health support men who have sex with men need when living in a remote and rural area, as well as what makes it easier or more difficult to access sexual health services.

In addition to our national survey, we have sought to recruit participants for focus groups. However, we have been unable to recruit enough participants to conduct focus groups. As a result, we want to better understand why men who have sex with men in remote and rural areas may be less likely to engage in research methods that involve direct contact with Researchers. To explore this, we are carrying out interviews with people who are community connectors who may:

- identify as men who have sex with men, or;
- have contact with men who have sex with men in remote and rural areas

By community connectors, we mean people who are connected to networks, groups or organisations (informal or formal) that men who have sex with men engage with in remote and rural areas.

Who is running this research project?

The research is designed by a team of Co-Researchers, in other words people who identify as men who have sex with men. The research is facilitated by Dr Kirsty Kay (Research Officer) and managed by Jennifer Goff (Research and Engagement Manager).

What will taking part in an interview involve?

The interview will involve a one-to-one conversation with a Research Officer and Co-Researcher. They will ask you about your experience identifying as **and/or** engaging with, men who have sex with men in remote and rural Scotland. They will also ask you what you think an ideal sexual health service would be in remote and rural areas.

The interview will last no longer than an hour and will take place on Zoom.

How will you record information during the session?

With your consent, the interview will be recorded so that we have an accurate record of your views. However, if you would prefer not to be recorded, the interviewer will take notes. If you do consent to recording, the interview will be transcribed by a professional transcription service.

How will you protect my anonymity and confidentiality?

We will use the anonymised findings to produce a project report, which will be launched in November 2022. We may use the findings to inform other materials produced by Waverley Care, such as policy briefings. You will not be identifiable in any materials we produce.

What if I no longer want you to use what I have said in your report?

We can remove your comments from our report up until the point that we share it with other people, in November 2022. Up until then, you can contact us using the details below.

You can also withdraw from the interview at any point, without giving a reason. If you wish to leave the interview mid-way through, you can ask the interviewer to delete any information you have already provided.

What if I want to complain about this project?

In the first instance, you can speak to Jennifer Goff, Research and Engagement Manager, who is managing the project. Their contact details are:

jennifer.goff@waverleycare.org | 078 6070 3581

If you would like to speak to someone who is not involved in this research, you can contact Rachel Hughes, Head of Corporate Services. Her contact details are:

rachel.hughes@waverleycare.org | 07860 703579

If you have questions about the research, please contact Dr Kirsty Kay at kirsty.kay@waverleycare.org or Jennifer Goff at jennifer.goff@waverleycare.org

Appendix 3: Phase Two - Interview Pro-Forma

Sexual Health: Off Grid (semi-structured interview) - exploring the sexual health needs of men who have sex with men in rural and/or remote areas of Scotland

Section	Question
Pre-amble	Cover: Consent form Information sheet
Introduction	Can you tell me about the work you do? Experience of working in remote and rural areas – positives and barriers Experience engaging in sexual healthcare in r/r areas (or otherwise more generally) - barriers and accessibility Experience of gatekeepers to engagement in r/r areas Knowledge of how LGBTQIA+ communities operate in r/r areas (compared to cities) Opinions of what needs to be done to improve access to LGBTQIA+/hard-to-reach communities in r/r areas.
Background	Can you tell me about your role in X and how you came to take on the role? If appropriate - do you think being an LGBTQIA+ community member living in a remote and rural area in particular played a role in your choice to work in X?
Sexual healthcare in remote and rural areas	Do you think sexual healthcare today is different in rural and remote areas compared to cities? Why? What is your experience of sexual healthcare in r/r areas? For yourself If appropriate - what you know of it in your community?
Accessing remote and rural communities	We tried to create focus groups for this research project. We recruited to get men who have sex with men to talk in a small group about their experiences of sexual healthcare but we found it very difficult to get people to sign up, even though we offered payment and made the process as accessible as possible. We weren't able to get enough people together to form one focus group.

	We want to know what this says about MSM in r/r areas in a few different aspects: Why do you think we found it difficult to recruit people? What does it say about the visibility of LGBTQIA+ communities in r/r areas? How are communities structured in r/r areas? What brings MSM/LGBTQIA+ people together in r/r areas? Are MSM/LGBTQIA+ communities self-organised or are there gatekeepers to the community (in your experience)? Anything else you think is important to note? In your role as X, how do you engage vulnerable or hard-to-reach MSM?
Ideal sexual health service	We would like to know what your ideal sexual health service in your area/rural and remote areas would look like? What does it do? Why should it exist? Why should it be funded?

Appendix 4: Phase One – Survey

Preamble

Exploring the sexual health needs of men who have sex with men in Scotland's remote and rural areas

Welcome to My Survey

Thank you for participating in our survey. Your views are important to the development of sexual health services across Scotland.

What is this survey about?

This survey aims to find out how men who have sex with men access sexual health services when living in remote and rural areas ofScotland. At Waverley Care, we provide support services to men who have sex with men across Scotland. Through our work, we have found thatmen who have sex with men living in remote and rural areas often have reduced access to sexual health services. For this reason, weare carrying out research exploring what sexual heath support men who have sex with men need when living in a remote and rural area,as well as what makes it easier or more difficult to access sexual health services.

You can complete the survey whether or not you have accessed information, testing or support from Waverley Care's services before. All of the questions are optional and you can skip any that you do not want to answer.

Please note: this survey explores the experiences of men who have sex with men in remote and rural areas. By men, we mean anyonewho identifies as a man regardless of the gender they were assigned at birth.

Who is running the survey?

Waverley Care's Research and Engagement Team is running this survey. You can find out more about Waverley Care here. You can find out more about Waverley Care's dedicated service for men who have sex with men here.

What personal data will the survey collect?

The survey can be completed anonymously, or you can choose to enter personal data (your email address). We will only use your emai laddress to enter you into a prize draw to win a £250 Amazon voucher or to contact you about a follow up interview. If you include your email address, at the end of the survey we will ask you if you consent to it being used for both, or only one of, these purposes.

How will you use the information I provide?

Your survey response will be collated and analysed by staff from Waverley Care. We will use the information you provide as part of areport. We will share the survey findings publicly, including via social media and in published articles. We will also use the surveyfindings to develop our support services. We will not share any information that could identify you or other people.

How will you store the information I provide?

Your survey response will be stored using password protection. Your personal data will be deleted by 1st April 2022, and we will onlykeep your anonymised survey response.

Can I withdraw my survey response?

If you decide you do not want your survey response to be included in the evaluation, you can contact researchengagement@waverleycare.org. If you have completed the survey anonymously, we may not be able to identify yourresponse, but we will try to do this. If we can identify your response, you will be able to withdraw it until the point we publish the surveyresults, which will be around March 2022.

Who can I contact if I have questions about the survey or I want to make a complaint?

If you have questions about the survey, you can contact:

Jennifer Goff, Research and Engagement Manager, at: jennifer.goff@waverleycare.org

If you would like to speak to someone who is not involved in the survey, you can contact:

Rachel Hughes, Head of Corporate Services, at: rachel.hughes@waverleycare.org

Background

This section asks for some information about your background. You can skip any questions that you do not want to answer.

1. What is your age?

- Under 18
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65+

2. How would you describe your gender?

- Male (including trans male)
- Female (including trans female)
- Non-binary
- Prefer not to say
- In another way (please describe)

3. Do you consider yourself to be transgender?

- Yes
- No
- Not sure
- Prefer not to say

4. How would you describe your sexual orientation?

- Gay
- Lesbian
- Bisexual
- Heterosexual/straight
- Not sure
- Prefer not to say
- In another way (please describe)

5. How would you describe your relationship status?

- Single
- In a relationship
- Married or in a civil partnership
- Widowed
- Divorced
- Separated

In another way (please describe) OPEN TEXT BOX

6. How would you describe your relationship style?

- In a monogamous relationship
- Polyamorous
- In an open relationship
- Consensually non-monogamous (also known as ethically
- non-monogamous)
- Non-consensually non-monogamous (also known as
- cheating)
- In another way (please describe) OPEN TEXT BOX

7. What health board area do you live in?

- NHS Ayrshire and Arran
- NHS Borders
- NHS Dumfries and Galloway
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Greater Glasgow and Clyde
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS Orkney
- NHS Shetland
- NHS Tayside
- NHS Western Isles

8. What is your highest educational qualification?

- SCQF 1 (National 1, Access 1)
- SCQF 2 (National 2, Access 2)
- SCQF 3 (National 3, Access 3, Foundation Standard
- Grade)
- SCQF 4 (National 4, Intermediate 1, General Standard
- Grade, SVQ1)
- SCQF 5 (National 5, Intermediate 2, Credit Standard
- Grade, SVQ2)
- SCQF 6 (Higher, SVQ 3)
- SCQF 6 (Advanced Higher, Higher National Certificate,
- Certificate of Higher Education)
- SCQF 7 (Advanced Higher, Higher National Certificate,

- Certificate of Higher Education)
- SCQF 8 (Higher National Diploma, Diploma of Higher
- Education, SVQ 4)
- SCQF 9 (Ordinary degree, Graduate certificate)
- SCQF 10 (Honours degree, Graduate diploma)
- SCQF 11 (Master's degree, SVQ 5)
- SCQF 12 (Doctorate)
- None of the above

9. Were you born in the UK?

- Yes
- No

10. What is your country of origin?

OPEN TEXT BOX

11. How would you describe your ethnicity?

OPEN TEXT BOX

Sexual health services in your area

This section asks about your knowledge of sexual health services in your area. You can skip any questions you do not want to answer.

12. When did you last have a test for sexually transmitted infections (STIs), such as syphilis and gonorrhoea?

- Within the last 4 weeks
- Within the last 3 months
- Within the last 6 months
- Within the last 12 months
- Within the last 2 years
- Within the last 5 years
- Over 5 years ago
- Never

13. When did you last have a test for blood-borne viruses (BBVs), such as HIV or hepatitis C?

- Within the last 4 weeks
- Within the last 3 months
- Within the last 6 months
- Within the last 12 months
- Within the last 2 years
- Within the last 5 years
- Over 5 years ago
- Never

14. Have you been diagnosed with any **STIs** in the last five years ***or*** have you ever been diagnosed with **HIV**?

- Yes
- No

15. Which were you diagnosed with?

- HIV
- Hepatitis C in the last five years
- Hepatitis B in the last five years
- An STI in the last five years

16. Where were you diagnosed?

- Local GP
- A sexual health clinic in my nearest town
- A sexual health clinic in my nearest city
- A community testing service (a testing service not based in
- an NHS or private health facility, for example, a charity or
- community group)
- A hospital in my nearest town
- A hospital in my nearest city
- I purchased a test online
- I ordered a free test online

17. PrEP stands for pre-exposure prophylaxis.

PrEP is taken by HIV negative people before sex to protect against HIV. PrEP usually involves two HIV drugs combined in a single pill. For example, Truvada or Tenvir-EM. More information about PrEP is provided at the end of the survey.

Before taking this survey, had you heard of PrEP?

- Yes
- No
- Not sure

18. Have you ever taken PrEP?

- Yes
- No

19. Where did you get PrEP?

- From an NHS sexual health clinic in my nearest town
- From an NHS sexual health clinic in my nearest city
- From an online pharmacy
- From my local GP surgery
- In another place (please describe)

20. Where would you prefer to get PrEP? Please tick all that apply.

- Local GP
- A sexual health clinic in my nearest town

- A sexual health clinic in my nearest city
- A community testing service (a testing service not based in an NHS or private health facility, for example, a charity or community
- group)
- A hospital in my nearest town
- A hospital in my nearest city
- Order online
- Another location (please describe) OPEN TEXT BOX

Information about sexual health services

This section asks about the sexual healthcare information that is available in your area your experience and opinion of it. You can skip any questions you do not want to answer.

21. What kind of sexual healthcare information have you seen or become aware of in the past 2 years? Please tick all that apply.

- Online websites, like Sx or NHS website
- Online social-sexual apps, like Grindr
- Leaflets or advice from my nearest GP
- Leaflets or advice from my nearest hospital
- Leaflets or advice from my friends or family
- Leaflets or advice from my partner(s)
- None of the above

22. Has this changed since the onset of the Covid-19 pandemic?

- Yes
- No
- Not sure

23. How easy is it to get sexual health information in your local area?

- Very difficult
- Difficult
- Neutral
- Easy
- Very easy

24. If you wanted information about sexual health in the future, for example, STIs or safer sex advice, where would you find this out? Please tick all that apply.

- I'd ask my spouse or partner(s)
- I'd ask a friend
- I'd ask a family member
- I'd ask my GP or another health professional
- I'd visit a sexual health clinic
- I'd ask a charity or community organisation
- I'd ask my teacher or another education professional
- I'd search online
- In another place (please describe) OPEN TEXT BOX

Location and transport

This section asks about the location of sexual health services that you access and the transport available to reach them. You can skip any questions you do not want to answer.

25. Approximately how long does it take you to travel to your nearest sexual health service?

- 30 minutes or less
- 30 minutes - 1 hour
- 1 hour - 1.5 hours
- 1.5 hours - 2 hours
- 2 hours - 2.5 hours
- 2.5 hours - 3 hours
- 3 hours or more
- I would not travel (please tell us why if you feel comfortable doing so) OPEN TEXT BOX

26. How would you travel to your nearest sexual health service? Please tick all that apply.

- Public transport - bus
- Public transport – train
- Public transport – ferry/boat
- Taxi
- Walk
- Bicycle
- In my own car
- In someone else's car

27. Please tell us why you would not travel:

OPEN TEXT BOX

28. What would the cost be for a return trip to visit your nearest sexual health service?

- £0–1
- £1–3
- £3–5
- £5–7
- £7–10
- £10–15
- £15–20
- £20+

29. Would the travel costs involved stop you attending a sexual health service?

- Yes
- No
- Not sure

Sexual health service delivery

This section asks about the type of sexual health services you would prefer to access. You can skip any questions you do not want to answer.

A sexual health service is where you can get advice, testing, treatment and support with STIs, blood borne viruses like HIV (BBVs), PEP (post-exposure prophylaxis), and PrEP (pre-exposure prophylaxis).

30. Where would you **most prefer** sexual health services in your local area to be based?

- My nearest GP surgery
- My nearest hospital
- My nearest pharmacy
- My nearest GP surgery, hospital and pharmacy
- A community venue
- None of the above – I would get sexual health services online
- None of the above - I would get sexual health services outside of my local area
- Other (please specify) OPEN TEXT BOX

31. Would you **most prefer** sexual health services in your local area to be run by...

- Doctor at a GP surgery
- Doctor at a hospital
- General nurse at GP surgery
- General nurse at a hospital
- Sexual health nurse at GP surgery
- Sexual health nurse at a hospital
- Pharmacist
- Sexual health practitioner from a charity
- None of the above – I would only get sexual health services online
- None of the above - I would only get sexual health services outside of my local area

32. Due to the Covid-19 pandemic, sexual health clinics are offering reduced face-to-face services. If you could only speak to someone about sexual health remotely, in other words online, how would you prefer to do this? Please tick all that apply.

- Telephone
- Video call
- Email
- WhatsApp or another instant messenger service
- Text message
- Online chat (where you talk to someone using a chat window on a website)
- I would not speak to someone about sexual health if I had to do it online
- Another place (please describe)
- Other (please describe) OPEN TEXT BOX

33. What would stop you from speaking to someone about sexual health remotely, in other words online? Please select all that apply.

- I don’t have internet access
- I have poor internet access, in other words an unstable internet connection
- I don’t have access to a device, like a smartphone or
- Computer I don’t have privacy at home
- There are too many distractions at home
- I’m worried about security - I don’t know/trust the person I would be speaking with.

- I’m worried about security - being recorded or monitored without my consent
- I’m worried about security - it being visible in my search history
- Nothing would stop me - I’m comfortable speaking to someone online

34. If you could only speak to someone about sexual health remotely, in other words online, at what time of day would you prefer to do this? Please select all that apply.

- Monday AM
- Monday PM
- Tuesday AM
- Tuesday PM
- Wednesday AM
- Wednesday PM
- Thursday AM
- Thursday PM
- Friday AM
- Friday PM
- Saturday AM
- Saturday PM
- Sunday AM
- Sunday PM

35. How important is it that you can get sexual health help and advice from someone who is the same gender as you?

- Very important
- Important
- Moderately Important
- Slightly Important
- Unimportant

36. How important is it that you can get sexual health help and advice from someone who is the same race/ethnicity as you?

- Very Important
- Important
- Moderately Important
- Slightly Important
- Unimportant

37. How important is it that you can get sexual health help and advice from someone who has the same sexual orientation as you?

- Very Important
- Important
- Moderately Important
- Slightly Important
- Unimportant

38. I prefer knowing a sexual health service is provided by health practitioners who...

- do not live in my local area
- do live in my local area
- I don’t care

39. How important is it that you can get peer support as part of sexual health services?

Peer support is when people use their own experiences to help each other. People who carry out peer support may not have formal sexual health qualifications.

- Very important
- Important
- Moderately important
- Slightly important
- Unimportant

Gender, sexuality and engagement

This section asks about how your gender and sexuality affect the sexual health services you can get in your local area. You can skip any questions you do not want to answer.

40. How comfortable do you feel disclosing your sexuality in your local community?

- Very comfortable
- Somewhat comfortable
- Comfortable
- Not sure
- Uncomfortable
- Somewhat uncomfortable
- Very uncomfortable

41. How comfortable do you feel disclosing your sexuality in your nearest sexual health service?

- Very comfortable
- Somewhat comfortable
- Comfortable
- Not sure
- Uncomfortable
- Somewhat uncomfortable
- Very uncomfortable
- If you feel comfortable doing so, please explain your answer: OPEN TEXT BOX

42. Do you feel your sexuality has ever prevented you from accessing sexual health services in your local area?

- Yes
- No
- Not sure

43. Do you feel your gender has ever prevented you from accessing sexual health services in your local area?

- Yes
- No
- Not sure

44. Is there anything else that would help you access sexual health services, as a man who has sex with men living in a remote and/or rural area? Please tick all that apply.

- Financial help with travel, for example, a bus pass
- Mobile testing services
- Local/community information service or website
- Local/community support service or website
- Being able to access a service anonymously
- Something else would help (please describe) OPEN TEXT BOX

45. Is there anything else you would like to tell us about your experience as a man who has sex with men when it comes to sexual health and living in remote and rural areas of Scotland?

OPEN TEXT BOX

Thank you for taking part in this survey!

46. Thank you for taking the time to complete this survey. If you would like to be entered into a prize draw to win a £250 Amazon voucher, please provide your name and email address below.

OPEN TEXT BOX

47. This survey is part of a research project looking at how to improve the access of men who have sex with men living in remote and rural areas to sexual health services across Scotland. We also plan to carry out a follow up in-depth survey and interviews to explore some of the topics raised in this survey. You would receive £15 voucher for taking part. If you would be willing to take part in a follow up in-depth survey or interview please include your name and email address below.

OPEN TEXT BOX

If you would like to find out more information about any of the issues raised in this survey, you can visit our website here, or call us on 0131 556 9710.

You can find our service for men who have sex with men, Sx, here. Through Sx, we can provide you with sexual health support and advice.

Find out more about PrEP and PEP in Scotland here.

END OF SURVEY

Appendix 5: Glossary

Community Connector	By community connectors, we mean people who are connected to networks, groups or organisations (informal or formal) that men who have sex with men engage with in remote and rural areas.
LGBTQIA+	A term that refers to people of all genders and sexualities, such as lesbian, gay, bisexual, transgender, queer, intersex, and asexual
MSM	An acronym for 'men who have sex with men'. We note that by using the term 'men' we refer to all men, including trans men.
PrEP	An acronym for 'Pre-Exposure Prophylaxis' – a medication that prevents HIV transmission through sex
PEP	An acronym for 'Post-Exposure Prophylaxis' – a medication that is taken up to 72 hours after being at risk of HIV to prevent transmission through sex
U=U	U=U (Undetectable = Untransmittable) is a term used within the HIV sector to communicate that people with HIV who achieve and maintain an undetectable viral load by taking antiretroviral therapy (ART) daily as prescribed cannot sexually transmit the virus to others
HIV	An acronym for 'Human Immunodeficiency Virus' – a virus that damages the body's immune system
STI	An acronym for 'Sexually Transmitted Infection'
BBV	An acronym for 'Blood-Borne Virus'

Appendix 6: References

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