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AYMARA Social Enterprise	Guideline	General	General	There are some topics which are missing attention, as they are ignored or simply off the radar of the organisations trying to tackle HIV, including public bodies and local authorities, as follows: - The word innovation is missing in the document. Both innovation in the delivery of services to reach the most vulnerable and retain them into care, and innovation in the commissioning of services to ensure that funds are properly spent by community organisations so people living with HIV or in need of PrEP will receive the help they need. The sector still needs auditing mechanisms for quality assurance, as the delivery of quality outputs not only involves results but also the use of funds in the most efficient manner. The use of tools and techniques, and standards to comply with agreed by all stakeholders, for impact measurement and management might be the beginning of a solution - Retention is also missing in the document. Retention is much more cost effective than engagement and reengagement into care, however retention is not part of any commissioning exercise. Therefore, the cost of retention is not included in any healthcare model, not even in outcome based payment models. Dedicated reengagement is not enough, it's just a quick fix and temporary solution if there is not a clear retention strategy to maximise the value of the funds available. Retention can only be enabled by an integrated care	Thank you. The committee considered that the guideline includes examples of innovation, particularly in its approach to co-producing interventions with groups with greater sexual health or access needs. The committee also anticipated that this co-production may foster the development of innovative services in terms of their design and delivery. Retention is addressed in one of the recommendations about co-production (1.1.8) and specifically references having a plan for follow up and repeated contact. Recommendations 1.1.4 and 1.1.5 are specifically about invisible individuals through recognising and targeting the groups with greater sexual health needs and the factors that prevent them from accessing services.

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				system that can offer added value health and wellbeing services to vulnerable individuals, so they are more likely to keep engaged into the healthcare system and follow treatment if needed - Invisible individuals are also missed in the document. Invisible people are those who do not want to be identified because they are terrified by stigma, discrimination or the idea of being deported. Community organisations are still only testing or offering PrEP in areas of controlled risk (e.g. Soho in London), where most individuals know their status, positive ones are in treatment, and negative ones are taking PrEP. Invisible individuals can only be found in the most depressed areas, slums and ghettos. If we do not identify this group, we'll be missing a meaningful proportion of people living with HIV not following treatment	
British Association for Sexual Health and HIV (BASHH)	Guideline	General	General	Q1 - Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why: Access – challenging for clinicians as determined by commissioners/local councils and dependant on budget	Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned.
British Association for Sexual Health and HIV (BASHH)	Guideline	General	General	Q2 - Would implementation of any of the draft recommendations have significant cost implications? Offer people without symptoms remote self-sampling STI services	Thank you for your comment. The committee agreed that most local areas are already providing some kind of asymptomatic remote self-sampling service, often as part of larger collaboratives. However, they noted that recommendations to widen access to this might have a cost impact. Although remote self-sampling is a cheaper method of testing than in clinic, the extra positive cases detected mean there will be an overall increase in costs.

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					They were, however, satisfied that the evidence supported a strategy of offering remote self-sampling as being cost effective compared with clinic only testing, and that therefore these additional costs would represent good value for money. That noted, however, that cost-effectiveness was very sensitive to the return rate of the self-sampling kits, and therefore as part of implementing the recommendations it would be important to monitor return rates for kits and positive test result rates to determine whether broader testing was identifying more people with STIs.
British Association for Sexual Health and HIV (BASHH)	Guideline	General	General	Q3 - What would help users overcome any challenges?: National self sampling STI service?/reduce inequalities in access	Thank you for your response. The committee discussed inequalities in access at length and made several recommendations to help address this, particularly by focussing on groups with greater sexual health or access needs. The committee did not consider a national self-sampling STI service but this suggestion will be considered by NICE where relevant support activity is being planned. .
British Association for Sexual Health and HIV (BASHH)	Guideline	005	018 - 019	Access to services here indicate people can access services outside of their area of residence. Though I support this concept as it meets the need of the individual, it would be helpful to have a standard (eg. %) that should be from within area. For example, a service could design itself to not meet the needs of their population and that those individuals who require care seek it elsewhere outside of their area residence and	Thank you for your comment. Setting standards for service delivery is beyond NICE's remit for this guideline. However, the committee recognised the challenges with service delivery that you describe, particularly the strain placed on some services when a large number of the people accessing care are from outside that area of residence. They acknowledged that

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				therefore their need remains hidden from the service within their area of residence and place additional strain on the neighbouring service	this is one of the limitations of open access but not one that could be resolved in this guideline.
British Association for Sexual Health and HIV (BASHH)	Guideline	005	018 - 019	"open access to sexual healthcare regardless of the location of the service or their area of residence". This places focus on staff to allow people to access but it may be that limits have been placed by commissioners ie not to see pts out of area. Do we need a minimum expectation of what should be seen out of area? Or priority groups?	Thank you for your comment. Setting standards for services is beyond NICE's remit for this guideline so it is not possible to specify minimum expectations or priority groups. The committee recognised some of the challenges of open access but agreed that this was not something that could be resolved in this guideline. The committee also noted that cross charging and reciprocal agreements are often in place so that limits do not have to be placed on seeing patients.
British Association for Sexual Health and HIV (BASHH)	Guideline	008	001 - 002	Delivering interventions to reduce STIs : worth mentioning Young Person services? Maternity services?	Thank you. The services listed are given as examples and not designed to be exhaustive.
British Association for Sexual Health and HIV (BASHH)	Guideline	009	007 - 008	What tests should be available for self-sampling? To be consistent BASHH HIV testing guidance this should include HIV and, to be consistent with BASHH guidance on STI testing (2015), syphilis, as the offer for non-clinic attendance with those without symptoms should provide an equal service.	Thank you. The committee agreed that the tests offered via self-sampling should be the same as those offered in clinic to ensure an equitable service and added this to recommendation 1.2.2 and in the rationale and impact section.
British Association for Sexual Health and HIV (BASHH)	Guideline	011	021	"confirm" – in reality how? What would be deemed acceptable? A text message with evidence that it has been delivered? If not, call patient? How many attempts before accepting lost to follow up?	Thank you. This sentence has now been removed from recommendation 1.4.5
British Association for Sexual Health	Guideline	012	019	Identifying persons not returning for follow up vaccines – this can be difficult depending on provider software.	Thank you. The committee discussed some of the challenges of contacting patients and verifying whether they have received reminders. They agreed that it is

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and HIV (BASHH)				Some software can only tell you that message has been delivered, not necessarily received by person.	generally routine practice to send at least 2 reminders, but that issues such as incorrect contact details or records not being up to date can mean it is not always possible to contact all patients. This is a broader issue about patient contact that cannot be addressed within this guideline.
British Association for Sexual Health and HIV (BASHH)	Guideline	015	006 - 007	As comment number 3	Thank you for your comment. Setting standards for services is beyond NICE's remit for this guideline so it is not possible to specify minimum expectations or priority groups. The committee recognised some of the challenges of open access but agreed that this was not something that could be resolved in this guideline. The committee also noted that cross charging and reciprocal agreements are often in place so that limits do not have to be placed on seeing patients.
British Association for the Study of the Liver (BASL) / British Viral Hepatitis Group (BVHG)	Guideline	General	General	The guidance makes no mention of HCV as a sexually transmitted disease in people who have greater sexual health needs due to high risk sexual behaviours, particularly men who have sex with men and we do think this should at least be recognised somewhere in the document and appropriate advice and management given	Thank you. The guideline does not refer to any STIs specifically and is intended to cover all sexually transmitted infections. The exception to this is section 1.4 where the committee were specifically asked to look at uptake of HPV, Hep A and B vaccinations in men who have sex with men.
British Association for the Study of the Liver (BASL) / British Viral	Evidence Review F	General	General	We felt that greater emphasis could be provided on vaccinations against hepatitis A and B viruses. The vast majority of the current draft focuses on human papillomavirus vaccination. Both hepatitis A and B viruses can lead to acute liver failure and death. I would suggest greater emphasis on these vaccines and in	Thank you. NICE guidelines are based on published evidence and the majority of the evidence found related to HPV vaccinations in the specified groups. The guideline has been amended to refer to the importance of finishing the course (recommendation 1.4.5). A link has also been added to NICE guidelines on vaccine uptake in the general population.

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Hepatitis Group (BVHG)				particular completion of the hepatitis B vaccine course with measurement of anti-HBs antibody titres.	
British HIV Association (BHIVA)	Guideline	General	General	There is a gap around making recommendations around asking about alcohol and recreational drug use in the context of sex and the impact on consent as well as making competent decisions about sex. In addition, intimate partner violence is recognised as a risk factor for HIV, but there is no specific recommendation to ask about this.	Thank you. Looking at risk factors for STIs and HIV was beyond the remit of this guideline. Please see the scope document on the NICE website. Recommendation 1.1.14 partially addresses your comment by focussing on self-worth and empowerment in relation to sexual decision making, and recommendation 1.1.8, which talks about the content of interventions and specifically talks about risk assessment and risk reduction activities. A new sentence has been added to the rationale and impact section to highlight the importance of sexual history taking, which may help to identify issues such as sexual violence, coercion, and drug and alcohol use in the context of sex. Reference has also been made to the BASHH 2019 UK National Guideline for consultations requiring sexual history taking in the rationale and impact section, and to the NICE guidelines on domestic violence and abuse in recommendation 1.1.10.
British HIV Association (BHIVA)	Guideline	001	012	Rec 1.4 – Other individuals who might be at risk of Hepatitis B and who would therefore benefit from vaccination include sexual partners of people diagnosed with Hepatitis B, sex workers, people who inject drugs and those who have Hepatitis C infection.	Thank you. The committee were asked to look at HPV and Hep A and B vaccination only for gay, bisexual and other men who have sex with men, so the evidence reviews were for this population only. Please see the scope document on the NICE website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations.

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British HIV Association (BHIVA)	Guideline	004	General	Rec 1.1.2 – It might be worth specifically mentioning migrants in this section. This is not a homogenous group but there are often specific needs where people come from areas of e.g. high HIV prevalence, endemic viral hepatitis and low access to or absence of vaccination. These people may also have lower understanding of how STI services are structured in the UK, open access and the absence of charging. Undocumented migrants might have particular fears here and might be overlooked in JSNA.	Thank you. The committee were very keen to avoid naming particular groups as this has the potential to be stereotyping and stigmatising, and therefore referred throughout the document to 'groups with greater sexual health or access needs.' This would include migrants. The 'Terms used in this guideline' section explains that people having greater sexual health or access needs can be because they have higher rates of sex partner change or because they have less contact with services. This definition refers to people who are refugees or asylum seekers, who may find it more difficult to access sexual health services because they may not understand that they are eligible for free sexual health services. Recommendation 1.1.3 discusses entitlements to services and open access to sexual healthcare, but this has been reiterated in recommendation 1.1.8 where we have added a bullet to include "information about sexual health services available, including that they are free and open access."
British HIV Association (BHIVA)	Guideline	005	016	Rec 1.15 - It is not only staff that represent a barrier here. The open access nature of sexual health services has proved very challenging to reconcile with funding arrangements per local authority – the latter bodies receive population based funding, but clinics located in their borough can attract many residents who are "out of area". Cross-charging mechanisms were never satisfactorily resolved following the Health and Social	Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned

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				Care Act. In addition, different boroughs may make different decisions about which services will be commissioned, e.g. restricting some contraception to certain age groups, which can result in conflicts when the service user attends a service with a different contract.	
British HIV Association (BHIVA)	Guideline	006	008	Rec 1.16 - Public and service user involvement in sexual health services has proved very challenging. This is perhaps due to the perceived stigmatising nature of the service and because they are mainly used on an episodic basis by younger people who are more concerned with "getting in and getting out".	Thank you. The committee discussed this and acknowledged that it may be more difficult to engage with some groups. Although they recognised the challenge of public and service-user involvement, they emphasised its importance and agreed it should be done. A sentence has been added to the rationale and impact section to acknowledge this.
British HIV Association (BHIVA)	Guideline	006	021	Rec 1.17 – I particularly welcome the mention of motivational interviewing based approaches. There are challenges in implementation with these – if staff are temporary or turnover (e.g. with doctors in training), ensuring consistency of provision is difficult. Time pressures, given the high and increasing activity in sexual health services and challenging funding position also represent barriers to more time-consuming conversations.	Thank you. Your comments will be considered by NICE where relevant support activity is being planned.
British HIV Association (BHIVA)	Guideline	007	013	Rec 1.19 – I would suggest clarifying that interventions targeting higher risk groups are likely to produce the greatest impact and be most cost-effective, but that these are not the only groups that should access testing. As per previous public health guidance from PHE, sexually active individuals who change partner, or are setting out on a new relationship should also test for STIs, with the frequency of future testing depending on further partner change. The latter groups might	Thank you. Recommendation 1.1.9 (now 1.1.10) is about tailoring interventions to reduce the transmission and acquisition of STIs, not about access to STI testing or STI testing frequency. The committee were only asked to look at interventions to increase STI testing uptake; guidance on testing frequency is outside the scope of this guideline.

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				particularly benefit from signposting to online services or e.g. primary care testing.	
British HIV Association (BHIVA)	Guideline	009	001	Rec 1.2 – Testing is a key intervention to identify STIs with rapid access to treatment so that onward transmission can be avoided. There are a number of other areas where testing can be improved, other than through self-sampling. It should be made clear what tests are indicated in a sexual health screen, e.g. by reference to BASHH standards. This is key to improving service quality in settings other than specialist services, e.g. primary care. Specific mention should be made of opt-out testing for HIV in all service offers when STI testing is requested, as well as opt-out testing in a range of healthcare settings in higher HIV prevalence areas. Please reference the BHIVA guidelines on HIV testing and refer to previous NICE guidance around HIV testing in particular groups, as well as opt-out HIV testing in services outside specialist services and in clinical indicator conditions. These interventions are likely to be increasingly important in identifying those with undiagnosed HIV who are not accessing specialist services and may not perceive themselves, or be perceived as being at higher risk.	Thank you. Specific STI tests and what constitutes a sexual health screen are clinical decisions and are outside the scope of this guideline. Opt-out testing for HIV and clinical indicator conditions are covered in the NICE guideline on HIV testing (NG60)
British HIV Association (BHIVA)	Guideline	009	004	Rec 1.2.1 – Self sampling services are not specified in any national service specification and therefore are subject to individual decisions by local authorities, restricting access by post code. There is an argument that people making use of self-sampling is cost-saving	Thank you for your comment. The cost of an individual home test is less than an in-clinic test, so per test there is likely to be a cost saving, but home testing also results in increases in the number of tests undertaken. It is unclear what the exact balance between these reduced and additional costs is, but the cost-effectiveness work

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				through diversion from specialist services, but I am unsure if evidence to support this is in the public domain.	undertaken for the guideline demonstrated that the provision of self-sampling is likely to be a cost-effective intervention overall, as a result of the increased number of asymptomatic STIs detected and appropriately treated.
British HIV Association (BHIVA)	Guideline	021	007	Recs for Research If increasing use of self-sampling happens in people who are recognised as being at risk for STIs, are they effectively signposted to interventions such as PrEP and is the uptake the same as in those accessing face to face services?	Thank you. The committee recognised not being able to direct people to other services as a limitation of self-sampling. This is discussed in rationale and impact section of the guideline. They also stressed the importance of exploring possible adverse outcomes in the research recommendation about self-sampling.
British Pregnancy Advisory Service (BPAS)	Guideline	General	General	There is nothing in this guideline about the availability and accessibility of treatment for STIs once they are detected. Prompt treatment ensures that STIs are not passed on, but too often women report to us that waits at GP surgeries and lack of capacity at sexual health clinics mean they are unable to access timely appointments to minimise the risk of transmitting an STI that has been detected. We recommend that provision of and access to treatment be included in 1.1	Thank you. The committee agreed that prompt STI treatment is an important part of STI prevention and reducing onward transmission, and have added a sentence to the rationale and impact section to reflect this and included a reference to the BASHH guidelines on the management of STIs which specifies that people should be offered an appointment within 2 days of contacting the service.
British Pregnancy Advisory Service (BPAS)	Guideline	General	General	Although 'other services' are mentioned, these mostly refer to drug, alcohol, and GIDS clinics. There is little consideration (or request for research) regarding other groups. We suggest that 'other services' could include reference to maternity and abortion services to reflect the variety of need and areas where particularly women's STI needs are catered for.	Thank you. The committee agreed to add abortion care services to the 'Who is it for?' section of the guideline on page 1, and added abortion care services to recommendation 1.1.11.

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British Pregnancy Advisory Service (BPAS)	Guideline	009	002	In the section on testing, there is no reference to what STIs should be tested for. As a national provider, we are aware that this varies substantially between commissioners, making delivery complex and resulting in funding which does not reflect client needs. We would suggest clarity on what standard testing should include and be funded by CCGs and LAs.	Thank you. Specific STI tests and what constitutes a standard sexual health screen are clinical decisions and are outside the scope of this guideline.
British Pregnancy Advisory Service (BPAS)	Guideline	009	002	In the section on testing, there is no mention of the restrictions on funding for routine testing by age, which mean in some areas that testing for eg chlamydia or gonorrhoea are only funded for under 25s in abortion services, and over 25s are not eligible for opportunistic testing. This guideline should recognise that there was people with higher sexual health needs that present to many services, no matter their age, and that test funding should not be restricted by age.	Thank you. There is no restriction by age on testing in sexual health services, as long as the person is able to consent to testing. Recommendation 1.1.11 refers to offering sexual health services within other services and includes abortion services as an example. The committee hope that this will make services more equitable.
British Pregnancy Advisory Service (BPAS)	Guideline	009	004	BPAS strongly supports remote self-sampling as an accessible way to provide STI testing	Thank you for your support.
British Pregnancy Advisory Service (BPAS)	Guideline	009	016	In the course of our advocacy, we have heard about issues in many areas where a limited number of self-sampling kits are released at a certain time of day/week/month. This limits access to those who are able to be available at this specific time, and is likely to discriminate against certain groups on the grounds of eg disability or maternity status. We suggest adding to this point. 'Ensure that self-sampling kits are available without time- or day-based restrictions.'	Thank you. The committee discussed issues relating to regional variations in the availability of test kits and 'capping' of the number of test kits available. As this is a commissioning decision, we are unable to say anything specific about this but your comments will be considered by NICE implementation where relevant support activity is being planned.

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British Pregnancy Advisory Service (BPAS)	Guideline	009	016	We recommend including 'via the internet' as another example to avoid telephone being the only remote option offered – which is likely to reduce accessibility for younger people who prefer to use online tools.	Thank you. 'Online' has been added to recommendation 1.2.5.
British Pregnancy Advisory Service (BPAS)	Guideline	017	001	BPAS supports the overarching message regarding groups with greater sexual health needs, and supports the use of this language, in which women who have abortions may be more likely to see themselves in a way they do not associate with (or appreciate) being called 'high risk'. However, this messaging should continue through the document – messaging should be consistent and avoid the pejorative use of 'high risk' or 'risky'.	Thank you. The term 'high risk' has been avoided where possible and instead the guideline refers to groups with greater sexual health or access needs. Where necessary, 'higher risk' has been used rather than high risk.
Company Chemists' Association	Guideline	General	General	Q3 - What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) A common challenge to patients accessing care (particularly sexual health services) is uncertainty in expectations and variation in process. Sexual health services in community pharmacies are commissioned by local authorities and vary widely in design, patient inclusion, and process creating uncertainty and barriers to access. Patients who live and work in different local authorities or live near boundaries may find significant variation in available care. The creation of standards for services of this nature would greatly improve both community pharmacy provision (through operational simplicity), but also patient confidence in the care available.	Thank you. The committee discussed issues relating to regional variations in services and acknowledged that at the local level there can be significant variation in the standard of care provided. They recognised the value of sexual health services in community pharmacies and acknowledged the need for service standards but agreed that this was beyond the remit of this guideline. Your comments relating to implementation issues will be considered by NICE where relevant support activity is being planned.

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Company Chemists' Association	Guideline	004	004	We agree with the use of JSNAs as a useful source for identifying local needs. Although 'other data sources' is broad in scope, we would suggest there is value in specifically referencing the Local Authority produced Pharmaceutical Needs Assessments.	Thank you for your suggestion. Variation in local data sources and the ways JSNAs are put together mean we don't want to be specific about other data sources; this is for local areas to decide.
Company Chemists' Association	Guideline	005	002	At present there is significant variation in the availability of EHC services across England, ranging from issues surrounding eligibility criteria to operational restrictions. A single national specification should be adopted for EHC services by all local authority commissioners in England. A standardisation of care is necessary to ensure groups and populations with greater sexual health needs, as compounded by existing social barriers, have access to contraception and high-quality advice/support.	Thank you. Emergency hormonal contraception is outside the scope of this guideline. The decision about what to include in this guideline was made during the scoping phase and consulted on in August/Sept 2019. Please see the scope document on the NICE website.
Company Chemists' Association	Guideline	005	002	Creating a network of services that are all aware of each other and the relevant inclusion/exclusion criteria is essential to good patient care. This network should include community pharmacies as key part of the sexual health provision in a location. Learnings from integrating community pharmacy into networks in other clinical areas have shown the importance of digital referral where possible, and local agreements on expectations. 'Blind referral' (i.e., informal referral to a without patient identifiable information provided, or to an assumed service availability, risks patients being lost in their journey and treatment being delayed. Lists of service availability must be kept up to date by commissioners, accessible by all providers, and where relevant contain contact numbers. This is particularly important in sexual health	Thank you. The committee agreed that community pharmacies are an important part of this network. They also agreed that it is essential that all services in the network are aware of each other and that information about service availability is kept up to date, so they added an additional bullet to recommendation 1.1.1 to emphasise this.

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				recognising the myriad of commissioners, and NHS and non-NHS services.	
Company Chemists' Association	Guideline	007	013	Another consideration of service design is location. Particularly relevant in more deprived communities, the distance required to travel to health services can act as a significant barrier. Community pharmacies are located within the communities they serve, with 90% of the population within a 20-minute walk of a pharmacy. They are often staffed by people who live within the community, helping break down barriers to access.	Thank you. The committee considered that service location is covered in recommendation 1.1.2, which talks about determining the most appropriate settings in which to deliver services and interventions to increase access and uptake.
Company Chemists' Association	Guideline	009	004	Commissioners should maximise the capacity of community pharmacies to offer testing and self-sampling kits. In particular, recognising the relationships inherent between community pharmacy teams and the local communities, to boost rates of returned kits amongst groups less likely to do so. Accessing STI kits through 'medical settings' can present barriers, as can home test kits where the home environment is not safe. Community pharmacy offers a neutral location with a clinically trained team to offer support where needed.	Thank you. The committee agreed that community pharmacies are a crucial component of local sexual health service networks and added reference to them in 1.2.1 as a possible service for supporting STI testing options. A sentence was also added to the rationale and impact section to reflect that while community pharmacies may be an integral part of test kit provision in some areas, there were potential commissioning issues to address.
Company Chemists' Association	Guideline	014	009	Communities, particularly those experiencing high deprivation, could benefit from the expansion of fully-funded PrEP services within pharmacies since frontline community engagement is integral to prevention.	Thank you. Current rules only allow PrEP to be prescribed in specialist sexual health services.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guidance	General	General	Ensure schools are able to get accurate information about local STI services available for young people to support schools with their statutory requirements around Relationships, Sex and Health Education in line with the relevant national Relationships and sex education (RSE) and health education - GOV.UK (www.gov.uk). *By the end of secondary school children and young people*	Thank you. This guideline is for people aged over 16 years. This has been clarified in the guideline. While the guideline may also be relevant to younger people who contact or use sexual health services and are considered to be Gillick competent, interventions delivered in schools or as part of RSE were excluded.

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				should know how to get further advice, including how and where to access condiential sexual health and reproductive health advice and treatment (pp 29, Relationships Education, Relationships and Sex Education and Health Education guidance (publishing.service.gov.uk)*.*	
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	General	General	Having STI testing within termination of pregnancy service is understood to have the potential to have a **big impact** on STI testing coverage and identification of STIs considering18 and 25 year olds make up the largest volume of terminations of service users and this age group is at disproportionate high risk of STIs. Early STI testing and treatment can also reduce the risk of complications for the Termination of Pregnancy procedure. And if the service user decides to keep the pregnancy it is still important that they are offered a STI test to reduce the risk of complications for the unborn baby. Due to the split commissioning of Sexual Health Services and terminations of pregnancy this may be a **challenge** in some areas of the country, which is why it is important that this guidance clearly highlights that it is also for Terminations of Pregnancy commissioners and providers to help **overcome challenges** that exist in many local areas.	Thank you. The committee agreed to add abortion care services to the 'Who is it for?' section of the guideline on page 1, and added abortion care services to recommendation 1.1.11.
English HIV & Sexual Health Commissioner	Guideline	001	006	It is good that GPs are referenced, but it would be good to stipulate on page one under 'who is this for?' (either under Providers or Healthcare professionals) that the guidance is for Termination of Pregnancy / abortion	Thank you. The committee agreed to add abortion care services to the 'Who is it for?' section of the guideline on page 1, and added abortion care services to recommendation 1.1.11.

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s Group (EHSHCG)				providers. It is important to note that STI can increase complications post abortion.	
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	001	006	As well as commissioners of sexual health services, this guidance is also relevant to commissioners of reproductive health services, terminations of pregnancy and vasectomy services who may not recognise themselves as a sexual health commissioner.	Thank you. The committee agreed to add abortion care services to the 'Who is it for?' section of the guideline on page 1, and added abortion care services to recommendation 1.1.11.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	004	003	'Behavioural insights' is a fundamental to 'meet the needs of groups with greatest sexual health needs'. Exploring where their needs are being met and maximise on this intelligence is also important. As part of workforce development for commissioners and services, the Behaviour Change Development Framework (developed by Health Education England) may help **overcome challenges** relating to professionals' ability to maximise on behavioural insights and behaviour change tools to strengthen resources available.	Thank you. The committee believe this is covered in the current wording of the recommendation.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	005	007	With reference to accessing sexual health services, there should be reference to the option of 'remote access' or 'telemedicine'?	Thank you. The committee agreed to add 'include online and non-clinical settings' to 1.1.2
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	005	010	With reference to accessing sexual health services, there could be mention of 'easy access to information available about STIs and STI testing services' as this is an important part of facilitating access? For example, many services are have videos available online of what to expect when patients access their	Thank you. The committee agreed to add 'information about sexual health services available' to 1.1.8. They did not consider it necessary to add anything further as they recognised that services should already be adhering to the NHS accessible information standard, which includes identifying the information and communication

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				building / service. This is especially useful for people who are neurodivergent and people with autism to reduce barriers related to access. This has to potential to address barriers for other professionals signposting / referring into sexual health also.	needs of people that use the service and making sure the service meets those needs.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	007	019	**Opportunity to overcome barriers and reduce local financial challenges**: signposting to a national training resource / training framework to provide non clinical peers a baseline of knowledge (and skills) to supporting the ambition to reduce STI transmission. This could be facilitated by a local resource on local trends (e.g. STI section in SPLASH) and Making Every Contact Count training	Thank you. Your comments will be considered by NICE where relevant support activity is being planned.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	013	004	Encouraging the take up of PrEP should be done within the relevant guidance, including Advertise your medicines - GOV.UK (www.gov.uk) and PrEP-Health-Promotion-Campaign-Guidance.pdf (hivpreventionengland.org.uk)	Thank you. The guideline does not make any specific recommendations about encouraging the uptake of PrEP – the focus is on raising awareness, facilitating access, and supporting people. The committee agreed to add a reference to the PrEP Health promotion campaign guidance in the rationale and impact section.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	014	019	It is really good to see recommendations for protected time for health care professions who have day to day contact with people eligible for PrEP to have training on relevant issues. To help users of the guidance implement this recommendation it would be beneficial to receive advice or guidance on what is required within that learning. It would be even better to have a central training resource supported by updated communications	Thank you. The content of health professionals training is beyond NICE's remit. Royal colleges and professional bodies are responsible for setting standards of training required to perform professional tasks.

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				a)for sexual health professionals providing PrEP b) for other professionals signposting to PrEP c) for peers promoting PrEP. The later two could be supported by communications from local services about how to access PrEP locally.	
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guidance	015	009	It may be advisable to reiterate under 'prescribing PrEP' that HPV and Hep vaccinations should also be recommended for gay, bisexual and other men who have sex with men on PrEP.	Thank you. Recommendation 1.4.3 recommends that HPV, Hep A&B vaccines are recommended to MSM opportunistically. This would include during PrEP prescribing or monitoring appointments.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guideline	017	004	We advise to avoid the term 'risky sex' as the term is stigmatising and ambiguous. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6953392/ provides a list of precise and neutral language to avoid the use of ambiguous or stigmatizing language.	Thank you. This term has been removed.
English HIV & Sexual Health Commissioners Group (EHSHCG)	Guidance	018	010	Currently it is hard to evidence precisely about positive results within or signposted to remote testing from other settings, such as terminations of pregnancy, drugs and alcohol services. They can get accumulated under 'other settings' or 'remote access' using the data available. Therefore it would be really good to explore how to ensure that national recording is able to compare settings clearly and compare across local areas.	Thank you. Data management is outside the scope of this guideline. Please see the scope document on the NICE website.
English HIV & Sexual Health Commissioners Group (EHSHCG)]	Guideline	006	012	Extend sentence to 'information and education about STIs, including the services available'	Thank you. The committee agreed and have added 'information about sexual health services available, including that they are free and open access' as a new bullet for 1.1.8.

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European Cancer Organisation (ECO)	Guideline	General	General	No mention of HPV in terms of being an STI priority. The recommendations all need to reflect access to HPV in conjunction with public health policy guidance. GUM services should allow access to catch up vaccination for those who may have missed out on school programmes. Importantly, there is a need for STI guidelines to address vaccine hesitancy and factors that may promote HPV vaccine uptake (plus other relevant vaccines). The European Cancer Organisation has just completed an umbrella review (review of reviews) that provide insight into the most effective ways to educate and promote vaccine uptake as part of sexual health promotion. This issue needs to be more evident in the new guidance on STIs.	Thank you. The guideline committee were asked to look specifically at increasing the uptake of HPV vaccine in MSM. Broader issues about HPV vaccination are outside the scope of this guideline. Please see the scope document on the NICE website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations. Issues relating to vaccine hesitancy and ways to promote vaccine uptake are also covered in the NICE guideline on vaccine uptake in the general population. A link to this guideline is provided at the end of section 1.4.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	004		Section 1 accessing sexual health services – I feel this is missing some mention of refugees/asylum seekers and defining their 'entitlement' to free screening/care	Thank you. The committee **were** aware that some population groups such as refugees and asylum seekers may not be aware of their entitlement to free sexual health services**.** The 'Terms used in this guideline' section explains that people having greater sexual health or access needs can be because they have higher rates of sex partner change or because they have less contact with services. This definition refers to people who are refugees or asylum seekers, who may find it more difficult to access sexual health services because they may not understand that they are eligible for free sexual health services. Recommendation 1.1.3 discusses entitlements to services and open access to sexual healthcare, but this has been reiterated in recommendation 1.1.8 where we

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					have added a bullet to include "information about sexual health services available, including that they are free and open access."
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	004	011	Replace 'deprivation' with 'geographical and infrastructure barriers'	Thank you. The committee did not consider geographical and infrastructure barriers to be the same thing as deprivation so have retained the original terminology.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	005	002 - 006	Consider rewriting clumsy sentence	Thank you. This recommendation has been amended so the sentence should now be clearer.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	005	010	Sentence doesn't make sense	Thank you. This error has been corrected.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	005	016 - 019	Recommend editing this statement and clarification on entitlements.	Thank you. The statement on entitlement to services in 1.1.3 has been clarified and a bullet has been added to recommendation 1.1.8 on providing information about sexual health services available, including that they are free and open access.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	005	021	Elaborate on wider support: from whom or for what?	Thank you. The committee agreed that 'wider support' was vague and removed this from the recommendation.

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Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	006	021 - 022	Sentence unclear suggest rewriting.	Thank you. This sentence has been edited.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	007	008 - 009	Needs specific guidance on follow-up; type, how often, what form, needs to be client/patient focused	Thank you. The evidence was not sufficiently specific about how often and what format follow-up should take; it likely depends on the individual and the type of intervention they have received.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	007	010 - 012	Needs to include specialist therapy services in this co-design	Thank you. Everything referenced in 1.1.8 was evidence based and there was no evidence identified for specialist therapy services.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	012	006	1.4.2 could include importance of tests to confirm immunity after hepB vaccination	Thank you. The Green Book doesn't recommend tests to confirm immunity and topic experts noted that even if tests indicated no immunity, no further action would be taken in terms of patient care so it is not necessary to add this suggestion to the recommendation.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	025	012	suggests those who access sexual health services can be regarded as high risk for STI. With the integration of SRH/contraceptive services and GUM many contraception seekers will be in stable monogamous relationships where STI risk is extremely low – needs to be a disclaimer here, much like earlier statements that not all gay men are at high risk.	Thank you. As you note, this is about those who access sexual health services, not contraceptive services. In integrated services this would be those who present for a sexual health screen rather than those who present for contraceptive advice.
Faculty of Sexual and Reproductive	Guideline	026	005 - 006	sentence doesn't make sense: no one has a greater sexual health need of STIs	Thank you. This has been amended.

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Healthcare (FSRH)					
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	028	016	re digital divide this also applies to people who are homeless and those for whom delivery of a test kit to an address might be difficult eg in an abusive relationship	Thank you. This has been added to the equality impact assessment.
Faculty of Sexual and Reproductive Healthcare (FSRH)	Guideline	029	019	end of paragraph needs clarification or punctuation as not easy to work out meaning	Thank you. This has been edited for clarity.
GIRES (Gender Identity Research and Education Society)	Guideline	General	General	Aside from the concerns noted above, this is an excellent guideline document with well-reasoned recommendations. Thank you for preparing it.	Thank you for your support.
GIRES (Gender Identity Research and Education Society)	Guideline	005	011	Remove "populations" to improve clarity.	Thank you. This error has been corrected.
GIRES (Gender Identity Research and Education Society)	Guideline	005	018 - 019	Clarify whether the guideline is recommending that sexual healthcare should be provided regardless of issues related to residency vs the location of the service. Please also provide some more specific examples. A particularly important one may be transgender people, for whom sexual health services can at times be very	Thank you. The wording of this recommendation has been amended to make it clearer that services should be accessible to everyone. The committee discussed the difficulties trans people face in accessing services at length and were very careful to make recommendations that considered this.

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				inaccessible, particularly when services are arranged around an assumption of binary/cisgender sex.	This included using inclusive language (1.1.14), recognising a range of relationships and sexual behaviours (1.1.14), being identity positive and respectful of their sex life (1.1.14). The recommendations on co-production (1.1.6), engaging with people with greater sexual health or access needs (1.1.5), and tailoring interventions to the needs of specific groups (1.1.10) would also apply to trans people.
GIRES (Gender Identity Research and Education Society)	Guideline	005	General	Recommendation 1.1.5 would be of more value if specific recommendations were provided based on the specific barriers faced by particular groups with greater sexual health needs.	Thank you. The committee did not consider it necessary to specify the barriers faced by particular groups because they felt that different people within particular groups may experience different barriers, and the degree of intersectionality could influence the type and degree of barriers faced. They preferred to refer to a range of barriers to access in recommendation 1.1.5 but these are given as examples rather than an exhaustive list.
GIRES (Gender Identity Research and Education Society)	Guideline	006	007	Add "and therefore discretion may be particularly important for some groups"	Thank you for your suggestion. The recommendation has been reworded to: "This includes recognising that people may be engaged in activities that are stigmatised by their communities, and discretion may be particularly important for them."
GIRES (Gender Identity Research and Education Society)	Guideline	006	013	change "to explain" to "and explain" – it may also be worthwhile to add a remark about how this information can help counteract stigma (internalised or otherwise) and thereby increase uptake of care by the affected community. If information is delivered in a way that increases rather than decreases internalised stigma,	Thank you. The evidence suggested that using information about STI prevalence was a good way to communicate risk and to help people realise that they belong to a group with high rates of STIs.

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				patients will disengage and behaviour-change will have been delayed rather than hastened by the service.	
GIRES (Gender Identity Research and Education Society)	Guideline	007	017	This recommendation (1.1.9) would be more effective if the role of stigma in preventing healthcare engagement (and indeed self-care more generally) were explicitly mentioned.	Thank you. A new bullet has been added to recommendation 1.1.8 ("Information about the impact of stigma") so we think your suggestion is captured in this change. The committee also made a research recommendation about methods of reducing the stigma associated with accessing sexual health services.
GIRES (Gender Identity Research and Education Society)	Guideline	009	020	What is the intended meaning of 'highlight' here? Presumably, 'identify to enable more targeted interventions' or something similar? In either case, please be more explicit.	Thank you. The wording of recommendation 1.2.6 has been amended to "Monitor provision and return rates of kits to identify any groups that have low rates of accessing or returning them. Take action to try to address the reasons for the low rates."
GIRES (Gender Identity Research and Education Society)	Guideline	009	General	Recommendation 1.2.4 could be broken into 'inclusive' and 'accessible', and more detail or an external reference provided regarding what that means in practice for the full range of groups/protected characteristics.	Thank you. The recommendation currently provides a number of examples of how to ensure accessibility and inclusivity. It is not intended to be an exhaustive list.
GIRES (Gender Identity Research and Education Society)	Guideline	009	General	Recommendation 1.2.5 could also mention explicitly the value of ordering online (no need for contact with a person, making access easier for people who experience embarrassment or anxiety in the sexual health context) and then point out that for many people a phone is more accessible (e.g. if they don't have an internet connection or the website is unforeseeably inaccessible/inflexible)	Thank you. 'Online' has been added to recommendation 1.2.5.
GIRES (Gender Identity	Guideline	010	003	Total inclusivity is sometimes not possible simultaneously within a single setting. For example, in a lecture, the needs of hard-of-hearing people who	Thank you. Recommendation 1.2.7 has been amended to 'where possible, ensure that interventions are

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Research and Education Society)				cannot/do not use BSL or lip-reading (amplification of voices they need to hear) directly conflicts with the needs of people who experience auditory hypersensitivity (a relatively low maximum level of sound). Please rephrase this to recognise that conflicts can occasionally occur, but remain clear that de-facto exclusion of a group on this basis is impermissible (e.g. the lecture theatre above should seek to install a loop system to resolve the conflicting accessibility needs, rather than continue to allow the individual with auditory hypersensitivity to be unable to access the service).	available for other groups who may be excluded by this targeting."
GIRES (Gender Identity Research and Education Society)	Guideline	010	010	Please make sure privacy considerations are mentioned alongside this example.	Thank you. The committee agreed that there may be safety / privacy concerns with personalising messages so added "Be aware of any potential risks of personalising messages, for example where there may be safety concerns," to recommendation 1.2.9. A sentence has also been added to the rationale and impact section to note that safety concerns should be taken into account when personalising messages.
GIRES (Gender Identity Research and Education Society)	Guideline	011	General	Recommendations 1.3.3 and 1.3.4 need to make clear that there will be situations in which notification is not possible or appropriate and that excessive pressure to notify sexual partners could lead the patient to notify partners where doing so endangers them (e.g. domestic violence, sexual assault, 'trans panic'…)	Thank you. The committee discussed issues relating to patient safety and recognised that there may be situations where PN is not possible. This is reflected in the rationale and impact section: "The committee recognised that partner notification could lead to negative responses from partners, including the potential for violence. Although experiences of violence or compromised patient safety were not reported in any of the included qualitative studies, the committee agreed that they remain a potentially adverse consequence that needs to be taken into account. They therefore discussed the need for recommendations about patient

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					safety and patient choice, and acknowledged that there may be situations in which partner notification is not appropriate."
GIRES (Gender Identity Research and Education Society)	Guideline	012	General	Recommendations 1.4 relate to vaccinations that are of relevance to other groups than MSM. In particular, while trans women and other trans people assigned male at birth have often been lumped in with MSM despite significant differences, this particular recommendation may be broadly relevant for sexually-active LGBTQ+ people, especially those whose sexual encounters often involve (a) penis(es).	Thank you. The guideline committee were asked to look specifically at increasing the uptake of HPV vaccine in GBMSM. Broader issues about HPV vaccination or access for other eligible groups are outside the scope of this guideline. Please see the scope document on the NICE website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations.
GIRES (Gender Identity Research and Education Society)	Guideline	013	General	1.5.1 could specifically mention the possibility of using appropriate geospatial networking apps commonly used to find sexual partners, as a means to spread information, destigmatisation etc related to PrEP use; to advertise a local service where PrEP can be obtained, making clear that it is free/subsidised (when that is the case).	Thank you. There was no evidence found on the importance of geospatial networking apps as an effective intervention so the committee were unable to add this to recommendation 1.5.1. 1.5.4 talks about targeting specific information gaps and causes of stigma, and 1.5.5 also discusses ways to reduce stigma.
GIRES (Gender Identity Research and Education Society)	Guideline	014	General	Item 1.5.6 is very important and we welcome its inclusion in this document	Thank you for your support.
GIRES (Gender Identity Research and	Guideline	014	012 - 013	"Ensure that that tailoring services to specific communities does not exclude or alienate other groups." We agree with this point but would caution that some groups, for example anti-LGBT religious organisations or individuals, or anti-trans "gender critical feminists" may	Thank you. 'Eligible' has been added to this recommendation to clarify.

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Education Society)				claim to be excluded and/or be alienated by LGBT inclusion and/or tailoring of services – and that while those feelings may be sincere, complaints may be predicated on unjustifiable ideological sentiments and/or dis/mis -information.	
Hywel Dda University Health Board	Guideline	004	011	Consider reviewing terminology- deprivation consider using geographical and infrastructure barriers	Thank you. The committee did not consider geographical and infrastructure barriers to be the same thing as deprivation so have retained the original terminology.
Hywel Dda University Health Board	Guideline	005	002 - 004	Consider re-writing sentence to make it clearer.	Thank you. This recommendation has been amended so the sentence should now be clearer.
Hywel Dda University Health Board	Guideline	005	005 - 006	Clarity on what 'traditionally underserved' means	Thank you. This has been amended to 'underserved communities.'
Hywel Dda University Health Board	Guideline	005	010 -011	Clarity of sentence meaning.	Thank you. This error has been corrected.
Hywel Dda University Health Board	Guideline	005	016 -019	Review statement and clarification on entitlements	Thank you. The statement on entitlement to services in 1.1.3 has been clarified and a bullet has been added to recommendation 1.1.8 on providing information about sexual health services available, including that they are free and open access.
Hywel Dda University Health Board	Guideline	005	021	Clarity on wider support- from whom or for what?	Thank you. The committee agreed that 'wider support' was vague and removed this from the recommendation.
Hywel Dda University Health Board	Guideline	006 - 007	021 - 022 & 001 - 002	Re-review and consider rewriting sentence	Thank you. This sentence has been edited.

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Hywel Dda University Health Board	Guideline	007	005	Terminology 'broader' should this be broaden or develop?	Thank you for the suggestion. This is about activities to increase sexual self-efficacy as a specific type of self-efficacy, but also broader aspects of self-efficacy like self-esteem, so broader is correct here.
Hywel Dda University Health Board	Guideline	007	008 - 009	Specific guidance on follow-up; type, how often, what form…needs to be client/patient focussed.	Thank you. The evidence was not sufficiently specific about how often and what format follow-up should take; it likely depends on the individual and the type of intervention they have received.
Hywel Dda University Health Board	Guideline	007	010 -012	Needs to include specialist therapy services in this co-design.	Thank you. Everything referenced in 1.1.8 was evidence based and there was no evidence identified for specialist therapy services.
Hywel Dda University Health Board	Guideline	016	005	'people' – include everyday vs alternative regimes ie. Event based.	Thank you. The definition of PrEP has been updated to clarify this.
Hywel Dda University Health Board	Guideline	016	012 -013	Consider adding 'as per BASHH guidance' and consider guidance on bones aswell.	Thank you. This is stated clearly in the preamble to these recommendations. Measuring bone density is also included in the BASHH/BHIVA guidelines. Recommendation 1.5.17 has been amended to read "Follow up people taking PrEP in line with the good practice points and monitoring recommendations in the BHIVA/BASHH guidelines".
LGBT Foundation	Guideline	General	General	Limited focus on physical accessibility to services, including for disabled people.	Thank you. The committee agreed that physical accessibility is a known barrier but one that applies to all services and is not specific to sexual health. They agreed that as this is a legal obligation, it does not need to be included in the recommendations, however they added reference to physical accessibility in the glossary definition of greater sexual health and access needs. .
LGBT Foundation	Guideline	General	General	Limited acknowledgement of multiply marginalised groups and the increased and conflicting need	Thank you. The committee discussed intersectionality at some length. Their discussion is reflected in the

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				individuals may experience if they have conflicting identities.	rationale and impact section on meeting the need of groups with greater sexual health needs and their avoidance of labelling specific groups within the guideline. The committee acknowledged concerns that by avoiding naming specific groups it may lead to a lack of action for those groups, but agreed that on balance it was better to be generic and refer to groups with greater sexual health or access needs due to the potential for stigmatising or stereotyping specific groups by naming them.
LGBT Foundation	Guideline	006	015	1.1.7 We fully support a broader view of sexual health and in particular wider discussion of sexual orientation, gender identity, and pleasure. 'Sex Positivity' is a term which might not consider more neutral or negative experiences of sex and which may alienate those who are unable	Thank you. Sex positive approaches are defined in the glossary and this definition recognises diversity in sexual experiences Taking a sex positive approach refers to the overall perspective taken by the service. It does not mean ignoring people's neutral or negative experiences of sex.
LGBT Foundation	Guideline	008	011	1.1.3 Using gender neutral language as a baseline (before you have the opportunity to identify appropriate language for each person) is a good idea, however it is important to ask questions which allow you to acknowledge and affirm a person's identity. This includes while speaking to them in consultations, as well as on electronic records/paperwork/forms. Using appropriate language to refer to peoples body parts, identity, partners, and experiences will create a more culturally competent and inclusive service.	Thank you. The committee agreed to add "use inclusive language (until the person expresses a preference)" to recommendation 1.1.14 and have added further detail on this issue to the rationale and impact.
LGBT Foundation	Guideline	010	009	1.2.9 Clarify consent-gaining procedures if tailoring recall messages to ensure safety of vulnerable people. For example, if an LGBT person experiencing domestic	Thank you. The committee discussed issues relating to automated recall messages and agreed that most services use 'opt-in' systems where consent for text messaging is obtained. The committee agreed that there

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				abuse receives a tailored message containing their name, is this more likely to 'out' them if the perpetrator has access to phones?	may be safety / privacy concerns with personalising messages so added "Be aware of any potential risks of personalising messages, for example where there may be safety concerns," to recommendation 1.2.9. A sentence has also been added to the rationale and impact section to note that safety concerns should be taken into account when personalising messages.
LGBT Foundation	Guideline	012	006	1.4.2 Also include trans people who may be eligible for HPV/Hepatitis vaccination	Thank you. The guideline committee were asked to look specifically at increasing the uptake of HPV vaccine in GBMSM. Broader issues about HPV vaccination or access for other eligible groups are outside the scope of this guideline. Please see the scope document on the NICE website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations.
LGBT Foundation	Guideline	013	015	1.5.2 When working with community groups to share sexual health messaging, it is important to appropriately remunerate them for their time, skills, knowledge, and existing community buy-in. Commissioning should include a focus on third sector/charity partners in sexual health to help fund this activity.	Thank you. This is a local commissioning issue. The support offered to local community groups could include financial support. .
London School of Hygiene & Tropical Medicine	Guideline	010	General	I wonder why the recommendation is not narrowed down to a certain list of STIs; and why there seem to be no ranking of STIs. As an example: partner notification for syphilis is extremely important as the disease (particularly in women and MSM, ie. vaginal, oral, and anorectal manifestation) has a high chance to be unnoticed, and, unlike eg. Gonorrhoea is unlikely to clear spontaneously. In my view, PN for syphilis has	Thank you. Recommendation 1.3.5 references the BASHH statement on partner notification for STIs which includes detailed information on partner notification processes by STI type.

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				highest priority and may never be missed; missing syphilis PN in my view is medical malpractice. PN for HPV and HSV-1/2 on the other hand does not make any sense to me as it has no clinical consequences for the informed partners. Finally, PN for non-bacterial, non-viral STIs such as pubic lice or scabies however have a high chance of effectively reducing transmission.	
London School of Hygiene & Tropical Medicine	Evidence review A	General	General	I suggest replacing "high-risk groups" with "high-prevalence groups" because high-risk typically implies (or is at least perceived as) risk arising from individual behaviour (such as partner numbers, concurrent sexual contacts, sexual practices, etc.). However, there are many other factors for increased prevalence that are independent from individual behaviour, namely the position in the sexual network, the size of the sexual network, and the density of the sexual network (*i.e.* the number of possible sexual connections between all members of the sexual network). Mathematically, one can easily model that when increasing the individual number of partners and leaving everything else including STI prevalence constant, MSM have a twofold risk of STI acquisition because the number of possible sexual connections is twice as large as in heterosexual networks.	Thank you. 'High risk' has been changed to 'higher risk' throughout the guideline.
London School of Hygiene & Tropical Medicine	Evidence review A	General	General	See comment 1 I suggest replacing "high-risk groups" with "high-prevalence groups" because high-risk typically implies (or is at least perceived as) risk arising from individual behaviour (such as partner numbers, concurrent sexual contacts, sexual practices, etc.). However, there are many other factors for increased prevalence that are	Thank you. 'High risk' has been changed to 'higher risk' throughout the guideline.

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				independent from individual behaviour, namely the position in the sexual network, the size of the sexual network, and the density of the sexual network (*i.e.* the number of possible sexual connections between all members of the sexual network). Mathematically, one can easily model that when increasing the individual number of partners and leaving everything else including STI prevalence constant, MSM have a twofold risk of STI acquisition because the number of possible sexual connections is twice as large as in heterosexual networks.	
London School of Hygiene & Tropical Medicine	Evidence review A	005	015	I would suggest a shift of focus from "People engaging in so-called chemsex" to "people engaging in group sex, particularly when under the influence of stimulant drugs (also known as 'chemsex') – because (1) most definitions of chemsex are specific to MSM, and my suggestion allows the inclusion of e.g. trans people engaging in the same sexual context; (2) the most important aspect is not that a drug is taken, but regards the fact that multiple sexual partners are involved simultaneously and/or in close sequence over an EXTENDED PERIOD OF TIME (several hours to a few days); (3) in sexual history taking, asking for 'chemsex' might not result in good identification of people at risk.	Thank you. This has been changed in the guideline as you suggest.
London School of Hygiene & Tropical Medicine	Evidence review A	005	017	An annual increase of 5% in my view is not a good argument for changing intervention. What is needed in my view is evidence that there is a long-term (e.g. 5 years or more) increase in true incidence, which is independent from a rise in testing. As there is no reference given to support the stated 5% increase in annual incidence, I am not even sure if it is really	Thank you. This sentence has been amended.

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				incidence and not absolute or relative number of new diagnoses… (Is it clear enough to which geographical entity the 5% relate? I suppose it is England?).	
London School of Hygiene & Tropical Medicine	Evidence review B	025	003 - 009	Incidence data are noted as important, but the increase in private test providers who do not need to report to national surveillance programmes mean that there will be an increasing issue with regards to quality and quantity of data to use this measure.	Thank you. This is outside the scope of this guideline. Please see the scope document on the NICE website.
London School of Hygiene & Tropical Medicine	Evidence review B	102	002	2c Wonderful that there is desire to normalise STI testing, with barriers noted of cost, stigma, etc. but consideration needs to be made somewhere (perhaps with links on populations asking for information on where to get tested) to providers (especially private providers) who provide services not in-line with national standards, thus providing patients with a fee-paying, sub-standard, service	Thank you. This is outside the scope of this guideline. Please see the scope document on the NICE website.
London School of Hygiene & Tropical Medicine	Evidence review C	008	005	1.1.10 R Given the lack of evidence (Noted page 8, line 1), it is surprising only one research recommendation was made.	Thank you. The committee discussed the lack of evidence and agreed that many of the recommendations they had made about strategies to increase STI testing uptake would also apply to increasing the frequency of testing in very high risk groups.
Merck Sharp & Dohme (UK) Limited	Guideline	General	General	MSD is very impressed with the high-quality draft guidelines and evidence review pack. The key areas we would like to see the impact and as a company are committed to support are: – Reduction in sexually transmitted infections, increase in vaccination rates, screening, and consultation attendance across the population. The guideline focuses on the high-risk groups. However, we would like to see acknowledgment	Thank you. - The text in the 'who is it for?' section has been amended to state that the guideline is for sexually active people to make it clear that the guideline is not just for high risk groups. - The committee agree that the guidelines are important and need to be widely disseminated. It is

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				and applicability of these recommendations for all eligible population and state that the guidelines focus on the high-risk groups. – We would like to emphasize the importance of the guidelines and the need of dissemination more widely. This should be inclusive of Sexual Health services which in turn are better able to reach and serve the HIV community through delivery of accessible, rapid STI treatment and accessible strategies for STI prevention. – The guideline did not elaborate but we consider pointing out the importance of data connectivity between various service providers. Data linkage between sexual health clinics and GP IT systems is crucial. Usually , GPs are unaware of vaccinations and screening/testing outcomes carried out in sexual health clinics. This would support capturing missed opportunities/people, provide support and engage in more productive ways. We would like this guideline to encourage various preventive and screening activities that would lead reduction in sexually transmitted infections, HPV related cancer and disease elimination, and HIV. Hepatitis C elimination work provided positive learnings including but not limited to examples of interventions and people who has first-hand experience (Peers).	hoped that they will support the delivery of accessible, rapid STI treatment and accessible strategies for STI prevention. - The committee acknowledged some of the issues relating to data connectivity but emphasised that sexual health clinics by design have separate health records that purposefully aren't linked in order to maintain anonymity and confidentiality. This is a policy position.

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Merck Sharp & Dohme (UK) Limited	Guideline	005	010 - 011	This recommendation has to involve new locations and potentially new types of practitioners being enabled to deliver advice and potentially services (including prescription). The people and places currently offering service are a barrier themselves (often due to stigma or cultural impacts) and no matter how friendly they are unlikely to be able to just "welcome" some underserved groups in. Outreach may go towards this, but unlikely to solve for "non-approach". An alternative approach could be development of champions or Peers within underserved communities. Ref: Zoe Ward, Linda Campbell, Julian Surey, Steven Platts, Rachel Glass, Matthew Hickman, Alistair Story, Peter Vickerman, The cost-effectiveness of an HCV outreach intervention for at-risk populations in London, UK, *Journal of Antimicrobial Chemotherapy*, Volume 74, Issue Supplement_5, November 2019, Pages v5–v16, https://doi.org/10.1093/jac/dkz451	Thank you. The recommendations hope to address this partly by having networks of services (1.1.1) to direct people to the service that is best for them, services delivered within other services (1.1.11) and peer interventions as you describe (1.1.13).
Merck Sharp & Dohme (UK) Limited	Guideline	005	013 - 015	Translator or interpreter should receive training on people's entitlements and how to approach sensitive topics.	Thank you. The training of NHS translators and interpreters is outside the scope of this guideline.
Merck Sharp & Dohme (UK) Limited	Guideline	005	016 - 021	It is vital that Services remain open access and free at the point of use - and that this is actively promoted to all potential service users. This is not always the case for some communities (i.e., migrant communities, refugees) and it is vital that this is addressed in order to meet zero-thirty goals for HIV transmissions and improvements in	Thank you. The statement on entitlement to services in 1.1.3 has been clarified and a bullet has been added to recommendation 1.1.8 on providing information about sexual health services available, including that they are free and open access.

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				sexual health overall. (See National AIDS Trust response on this for further evidence). Furthermore, it needs to be very clear what is meant by 'open access' in terms of minimum levels of service provision. Since 2014/15 there has been over £700 million in cuts to the public health budget. There has been a 14% real terms reduction in local authority spending on sexual health between 2013/14 and 2017/18. This has coincided with increased demand for sexual health services. National AIDS Trust provided their feedback on this point. We would like to emphasize the importance of this point and support their statement. Ref: National AIDS Trust, Cuts to public health are cuts to the NHS. The need for continued investment in public health and prevention services	
Merck Sharp & Dohme (UK) Limited	Guideline	005	020 - 021	Suggestion to add "Encouragement to use those services".	Thank you. The committee did not consider this a necessary addition as this is already captured in the recommendation.
Merck Sharp & Dohme (UK) Limited	Guideline	005	022 - 023	Suggestion to leverage experience and success in outreach from the Hepatitis C Elimination - vans, buses, HCPs going out to homeless hostels and services. Unfortunately, publications are still under development but if needed we are happy to organize meetings with relevant teams.	Thank you for your support and examples of good practice. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date and will identify any relevant publications when they become available.

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Merck Sharp & Dohme (UK) Limited	Guideline	007	013 - 018	Welcome that services and offers should be tailored - but concerned at the language around 'risk' Language matters: 'risk' is not an absolute term and doesn't mean the same to everyone. It could also be playing into perpetuation of stigma - as the term could be perceived as judgemental to people's lifestyles. Stigma plays a key role in the barriers to testing in sexual health (and in HIV - and needs to be addressed) A number of key concerns with the 'risk' terminology are summarised in the article by Marcus et al. Ref: Marcus JL, Snowden JM. Words Matter: Putting an End to "Unsafe" and "Risky" Sex. Sex Transom Dis. 2020 Jan;47(1):1-3. doi: 10.1097/OLQ.0000000000001065	Thank you. The term higher risk has now been used throughout the guideline to clarify that risk is a relative value. The guideline should now also make it clear that membership of a 'higher risk group' does not automatically mean that an individual is at higher risk.
Merck Sharp & Dohme (UK) Limited	Guideline	007	019	Reduction of STI transmission is dependent on all stakeholders involved in the provision of services to align, agree, coordinate, and integrate initiatives. This should avoid duplication, over-testing and provide more accurate data.	Thank you. It is hoped that this guideline will reach all stakeholders involved in the provision of services. Recommendation 1.1.1 addresses the need for networks of services to work together to align and coordinate initiatives.
Merck Sharp & Dohme (UK) Limited	Guideline	008	001 - 002	Experience from working with D&A services as part of HCV elimination is that they are very focussed on addiction elements (rightly so). They are often stretched. The guidelines and teams implementing these recommendations need to consider the capacity realistically and how do you keep it high on their agenda.	Thank you. This is an implementation issue so your comments will be considered by NICE where relevant support activity is being planned.
Merck Sharp & Dohme (UK) Limited	Guideline	008	007 - 009	It is welcome to have peer support raised, however this point should be strengthened from 'if possible' to a	Thank you. This recommendation has been strengthened by removing 'if possible,' as the evidence

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				recommendation that services ensure peer support is an integrated part of testing, care and outreach support. Hepatitis C Peer work is highly applicable here but only directly comparable in the drug use setting. In the UK, the "at risk" person for STI or HIV is unlikely to be associated with drug use and any targeted intervention via Peers must therefore be far more sophisticated and more comprehensive of other at-risk groups. The research by Stagg et al demonstrated that providing patients with a peer advocate increased their absolute likelihood of successfully engaging with healthcare systems by 18.1%.This translated into 2.55 times the odds of a successful outcome. In hepatitis C treatment and care pathways, Peer to Peer working has been demonstrated as highly effective at uncovering and navigating HCV infected or at-risk clients towards positive health outcomes because the strength of the "Lived Experience" of Peer workers can cut through lifestyle and social demographic factors that would otherwise prevent some clients from engaging with the treatment and care pathways. Therefore, Peer working should be seen as an integral part of services commissioned to support and address STIs in marginalised communities. Ref: Stagg, H.R., Surey, J., Francis, M. et al. Improving engagement with healthcare in hepatitis C: a randomised controlled trial of a peer support	and committee agreed that peer led approaches were effective.

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				intervention. BMC Med 17, 71 (2019). https://doi.org/10.1186/s12916-019-1300-2	
Merck Sharp & Dohme (UK) Limited	Guideline	008	010 - 017	This limited focus may in fact prejudice against heterosexual males and females who are not involved in drug use but do find themselves at risk of STIs including HIV. About 50% of all new HIV diagnosis is related to heterosexual contact and only a miniscule amount respectively associated with "problem" drug use therefore the absence of any up scaling of GP delivery seems remiss. Ref: Department of Health, HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report The annual official statistics data release (data to end of December 2020)	Thank you. Recommendation 1.1.13 (which is now 1.1.14 due to guideline edits) does not refer to drug use or sexual orientation / identity and emphasises not making assumptions about people. The recommendation would apply to everyone, including heterosexual males and females who are not involved in drug use.
Merck Sharp & Dohme (UK) Limited	Guideline	009	003	Suggestion to make better use/increase awareness of commissioned sexual health online portals: • https://www.shl.uk • https://sh24.org.uk • https://thenorthernsexualhealth.co.uk/order-a-home-sti-test-kit The guidelines have to be in line with objectives of raising awareness of the availability of different self-sampling options to increase uptake. Uptake may be low due to lack of awareness.	Thank you. The committee chose not to reference these online portals as they do not have universal geographical coverage. Recommendation 1.1.1 emphasises the importance of networks of services and keeping those networks up to date in terms of service offer and availability. This may help to raise awareness of sexual health services available. Similarly, recommendations 1.2.1, 1.2.2 and 1.2.3 all focus on making sure a range of different testing and self-sampling options are available, and that people have up-to-date information on the options available to them.

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Merck Sharp & Dohme (UK) Limited	Guideline	009	007 - 008	In 2020, almost half of people testing did so online – showing significant increased demand for online testing services and making the case for year-round access to online testing in all areas, especially in the deprived and remote areas. With this in mind, this recommendation should be strengthened. Furthermore, please consider specifying a broader range of services to offer such testing - including community and advocacy groups.	Thank you. The guideline already emphasises the importance of offering online testing for asymptomatic people (recommendation 1.2.1 specifies remote self-sampling should be one option in a range of testing options, and recommendation 1.2.2 makes it clear that remote self-sampling should be offered as an option for people without symptoms). The committee agreed to add 'community pharmacy' to the range of services that offer STI testing in recommendation 1.2.1.
Merck Sharp & Dohme (UK) Limited	Guideline	012	003 - 005	Suggestion to rephrase that vaccination should be discussed with all eligible population. Green book lists much wider eligible population that will benefit from this recommendation: males and females in cohorts eligible for vaccination in the national programme until their 25th birthday, MSMs, transgender and other individuals like sex workers, and men and women living with HIV infection. Ref: Green Book, 18a Human papillomavirus (HPV)	Thank you. The guideline committee were asked to look specifically at increasing the uptake of HPV vaccine in GBMSM. Broader issues about HPV vaccination or access for other eligible groups are outside the scope of this guideline. Please see the scope document on the NICE website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations.
Merck Sharp & Dohme (UK) Limited	Guideline	012	006 - 010	Suggestion to consider rephrasing to 'actively promoting' vaccinations for all eligible individuals including gay, bisexual and other men who have sex with men who are eligible for the vaccines. By focussing only on MSMs here is there a risk of missing an opportunity to vaccinate other eligible men and women (e.g. women <25 who are still eligible for HPV under the NIP). This could cross-reference NICE guideline on Vaccine uptake	Thank you. The wording of recommendation 1.4.3 has been changed to 'opportunistically promote…' The guideline committee were asked to look specifically at increasing the uptake of HPV vaccine in GBMSM. Broader issues about HPV vaccination or access for other eligible groups are outside the scope of this guideline. Please see the scope document on the NICE

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				in the general population, Green Book (chapters on Hepatitis A, Hepatitis B and HPV) and BHIVA guidelines for PLWHIV after a diagnosis. Ref: NICE draft guideline on Vaccine uptake in the general population British HIV Association guidelines on the use of vaccines in HIV-positive adults 2015 UK Health Security Agency, Green Book	website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations. Reference to the NICE guidelines on vaccine uptake in the general population has been added to this section after recommendation 1.4.5.
Merck Sharp & Dohme (UK) Limited	Guideline	012	016 -018	Could this be offered for all individuals accessing sexual health services?	Thank you. Accessing sexual health services would be included in attending routine health appointments.
Merck Sharp & Dohme (UK) Limited	Guideline	012	019 - 021	Suggestion to add to the reminder text that highlights the need to complete the course of vaccinations to be fully protected.	Thank you. The committee agreed with this suggestion and have added it to recommendation 1.4.5
Merck Sharp & Dohme (UK) Limited	Guideline	014	014 - 020	We support the recommendation regarding improving training but would suggest this recommendation is expanded to include awareness of the benefits of PrEP for all communities, understanding and awareness of U=U and TasP in HIV - and the need for healthcare professionals to ensure equitable uptake of PrEP beyond just gay and bisexual men. See HIV Action Plan recommendations around training healthcare professionals on U=U and Tap - *"Action 9: we will tackle stigma and improve knowledge and understanding across the health and care system*	Thank you. U=U and TasP are both outside the scope of this guideline. Recommendation 1.5.1 specifically talks about raising awareness of PrEP in groups where uptake is lower. Recommendation 1.5.8 recommends similar awareness raising among healthcare professionals.

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				about transmission of HIV and the role of treatment as prevention *OHID will work with national organisations, including HEE, to include information on HIV transmission, U=U and infection control as an element of every healthcare worker's standard induction and regular mandatory training. OHID working with NHSEI will examine ways to assess the level of HIV awareness among healthcare staff. OHID will also request that NHSEI (and/or other relevant NHS organisations) consider including relevant questions in relation to HIV awareness and stigma in their annual staff survey and take appropriate action on the findings."* Ref: Department of Health, Policy paper: Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025.	
Merck Sharp & Dohme (UK) Limited	Guideline	018	008	There are learnings from the hepatitis C elimination activities. The Supermarket vouchers have worked for Hep-C testing. For this model - be careful when you give the voucher. You either need to split it e.g., £'x' to do the test £'x' for coming back for the result and/or follow-up. Or alternatively only give the full value when they come back for result/follow-up.	Thank you. This research recommendation was made because the evidence about incentives is very sparse and did not give the committee enough detail to be able to make recommendations.
Merck Sharp & Dohme (UK) Limited	Guideline	021	001 - 003	MSD agrees that this is an area that further research is required to address the knowledge gaps. PrEP is a prevention drug, and it should not be a requirement for people to put themselves at risk of getting HIV before they are deemed eligible for a preventative drug. It	Thank you for confirming that this is an important area for research.

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				seems to be unethical to put people at risk first to qualify for a preventive measure. We agree with the National AIDS Trust' suggestion for the research would look into insights about the healthcare professional knowledge and attitudes to PrEP in different settings, including their understanding of risk and currently practices in recommending PrEP and promoting it to difference communities.	
Merck Sharp & Dohme (UK) Limited	Guideline	033	007 - 008	We suggest widening the population scope and if needed to call out the listed groups. The considerations should be given to other groups like the ones that are eligible for HPV vaccination who might access STI clinics regularly. Examples include sexual health workers, PLWHIV and opportunistic recommendation of vaccination to immunocompromised individuals. Monitoring and surveillance of other groups accessing vaccination would also support the evaluation of vaccine impact on other groups other than MSMs.	Thank you. This is outside the scope of this guideline, which was only asked to look at these vaccines for gay, bisexual and other men who have sex with men. Please see the scope document on the NICE website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations.
Mesmac and Shine Newcastle	Guideline	General	General	No inclusion in the guidelines of sexual exploitation/transactional sex/survival sex/sex work Chemsex and the sex choices/ needs of other populations are also not included. More consideration of how people have sex, including LBI women and Trans and Non-Binary people. Further focus on additional ways to avoid STI, other barrier methods etc. Also to consider more inclusive screening processes rather than male kit/female kit/MSM kit etc.	Thank you. The committee were very keen to avoid stereotyping and stigmatising particular groups and therefore referred throughout the document to 'groups with greater sexual health or access needs' rather than naming specific groups. They also avoided using the term high-risk where possible, recognising that risk is relative. The 'Terms used in this guideline' section explains that people having greater sexual health needs can be because they have higher rates of sex partner change or

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					because they have less contact with services. The guideline encourages local areas to define their local groups with greater sexual health needs, but to avoid the assumption that everyone in a particular group is at higher risk. For further details see the 'Terms used in this guideline' section of the guideline. Recommendation 1.1.8 refers to the correct and consistent use of barrier methods and cross refers to NICE guidance on condom distribution schemes. Recommendation 1.1.14 notes the importance of using gender affirming language, and recommendation 1.2.4 specifies that testing kits need to meet the needs of trans and gender diverse people.
Mesmac and Shine Newcastle	Guideline	General	General	We agree the wider approach of working with people in their communities is vitally important and the impact community-based interventions have. Further consideration can be given as to why people do not access services and the importance of peer interventions and co-production.	Thank you. Co-production and peer intervention are both integral parts of section 1.1 of the guideline. Please see particularly the section entitled 'co-producing interventions to reduce STI transmission' and 1.1.13 on peer intervention.
Mesmac and Shine Newcastle	Guideline	005	002	No specific mention of the importance of nonclinical interventions and settings	Thank you. The committee agreed to add 'including online services' to 1.1.1 and 'Include online and non-clinical settings' to 1.1.2
Mesmac and Shine Newcastle	Guideline	005	013 /014	Professional translator/interpreter, inclusion of 'professional' necessary to distinguish between family members/friends/neighbours etc. Consider training for interpreters.	Thank you. 'Professional' has been added to this recommendation. The training of NHS translators and interpreters is outside the scope of this guideline.

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Mesmac and Shine Newcastle	Guideline	006	004	All staff must be culturally competent across the staff team, receptionist, consultant etc	Thank you. The committee acknowledged the need for all staff to be culturally competent and highlighted that all NHS staff receive training in equality, diversity and inclusivity, although they recognised that despite this training there can still be issues with cultural competency across NHS services. They were unable to make a specific recommendation about further staff training on this as it is beyond the remit of this guideline, but recommendation 1.1.14 emphasises the importance of avoiding making assumptions about people or judging them, and being sex and identity positive, and this would apply to all staff across the service.
Mesmac and Shine Newcastle	Guideline	016	041	Choice of how to order and receive, online, postal etc	Thank you. The committee felt that it was important for people to attend for their 3 monthly HIV testing and STI screening (recommendation 1.5.15) and agreed that PrEP would usually be prescribed at these appointments.
Mesmac and Shine Newcastle	Guideline	017	004	"risky sex" is blaming and stigmatising, "types of sex" or "ways of having sex" as alternative	Thank you. This term has been removed.
Mesmac and Shine Newcastle	Guideline	018		Sex positive approaches – include choice and pleasure. Language must be non-stigmatising and inclusive to all	Thank you. The committee agreed and reflected this throughout the guideline.
Mesmac and Shine Newcastle	Guideline	041	020	We would hope to see increased PreP equity and greater representation of groups accessing PrEP, and at minimum having the awareness and information so they are able to make informed choices. Access to PrEP needs to be quicker, and easier. More nurse led clinics?	Thank you. The committee agreed that much of section 1.5 focuses on exactly these issues: Recommendation 1.5.1 cover raising awareness of PrEP for groups with greater sexual health and access needs.

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					Recommendation 1.5.2 discusses information and awareness raising Recommendation 1.5.4 focuses on targeting information gaps Recommendation 1.5.8 talks about raising awareness of groups eligible for PrEP.
METRO Charity	Guideline	005	007	Preventing people getting and transmitting STIs: Meeting the needs of groups with greater sexual health needs 1.1.4 We believe the use of the words 'appropriate settings' should be clarified and suggest adding 'including online' so that physical settings are not the only ones considered. Many communities only meet online, and therefore it's imperative that virtual platforms are assessed as possible settings to deliver services.	Thank you. The committee agreed to add 'include online and non-clinical settings' to 1.1.4 (now 1.1.2)
METRO Charity	Guideline	005	010	**Accessing sexual health services** 1.1.5 We believe that meeting the You're Welcome quality criteria should be mandatory for providers delivering sexual health services to young people, particularly those who are at increased risk of poor sexual health outcomes. "Taking into account" is not strong enough language.	Thank you. This guideline is for people aged over 16 years so the You're Welcome quality criteria are only partially relevant. Furthermore, there was no evidence relating to the You're Welcome quality criteria and its' inclusion was based on committee consensus, so it is not possible to strengthen the recommendation beyond 'taking into account'. Additionally, the committee was aware that it can be costly and time consuming to implement the You're Welcome criteria and that some

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					organisations would find it too difficult to implement them.
METRO Charity	Guideline	006	005 - 007	**Co-producing interventions to reduce STI transmission** 1.1.6 Further clarification is required of the statement: 'This includes recognising that people may be engaged in activities that their culture or peers would not approve of.'	Thank you. The purpose of this statement was to reflect that some cultures or peer groups may have strong expectations about sexual behaviour and people not conforming to those expectations may be stigmatised by their communities. The wording of 1.1.6 (now recommendation 1.1.7) has been amended to better capture this.
METRO Charity	Guideline	006	005 -007	**Co-producing interventions to reduce STI transmission** Inclusion of risk mitigation practices in relation to this issue of potentially covert behaviour.	Thank you. The committee agreed to amend the wording of this recommendation to "This includes recognising that people may be engaged in activities that are stigmatised by their communities, and discretion may be particularly important for them."
METRO Charity	Guideline	006	008	**Co-producing interventions to reduce STI transmission** 1.1.7 We believe that when co-producing interventions for the groups identified that '**Information about stigma and how this impacts communities**' should be an included component. Stigma can play an important role in how well an intervention is received or not by the community and therefore needs to be discussed at the production of the intervention.	Thank you. The committee agreed with this suggestion and have added it as an additional bullet to 1.1.8. Stigma is also already discussed in 1.1.10.

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METRO Charity	Guideline	006	015 - 016	**Co-producing interventions to reduce STI transmission** Add 'by people of all genders' so that the sentence reads: "sex positive approaches to consistent and correct use of barrier methods by people of all genders…', to reinforce the message that women, trans-women, and non-binary people should also have equality of access and know how to use condoms etc.	Thank you. The committee agreed that this was a useful suggestion but preferred to reference internal and external condoms rather than gender.
METRO Charity	Guideline	008	011 - 013	**Delivering and evaluating interventions to reduce STI transmission** 1.1.13 We believe the word 'different' here could be othering (who are they different to?) and suggest this rewording: 'recognising a range of relationships and ensure that all training and resources delivered alongside interventions use imagery and language that is familiar to the target populations'.	Thank you. The committee agree so have replaced 'different' with 'a range of relationships and sexual behaviours.' Reference to training or resources was not added as that is not the intended focus of this recommendation.
METRO Charity	Guideline	011	016	**Partner notification** 1.3.5: Include 'anonymous (if requested)' before 'partner notification'.	Thank you for your suggestion but this was not considered a necessary addition.
METRO Charity	Guideline	036	005 - 018	**Service design for PrEP services** We are concerned that the recommendation of restricting the delivery of pre-exposure prophylaxis for HIV (PrEP) to genito-urinary medicine (GUM)/sexual health care settings is limited in scope. We do not feel this approach will sufficiently reach out to existing populations which have little or no uptake of PrEP but	Thank you. NICE does not recommend restricting delivery of PrEP services to GU settings. National guidance restricts the prescribing of PrEP to specialist sexual health services. Recommendation 1.5.1 discusses raising awareness of PrEP among groups with greater sexual health and

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				clearly should be prioritised. For example, your own evidence suggests groups such as Black African cis women should be prioritised. It is more likely that these cis women will need to be supported in a primary healthcare setting, and more likely that if they access PrEP in this setting in tandem with acquiring other methods of contraception and STI prevention methods, that they are likely to learn about PreP and become better informed about it. In our experience of service delivery, many Black African cis women do not perceive themselves to be at high risk of acquiring HIV, however, the data suggests otherwise. These women are not catered for in sexual health settings, and regularly not given offers of HIV testing in primary or secondary care. Whilst it is to be applauded to recognise that primary care staff need training on PrEP, secondary care staff also need training in GUM settings on at-risk groups such as Black African cis women. Based on our experience, unless Black African cis women hear about PrEP in a range of community settings and are able to access prescriptions from community locations – such as voluntary and community settings, pharmacies, and primary care – they are unlikely to follow through and access PrEP from secondary care settings or GUM settings.	access needs, and in particular groups such as cisgender women and people with a Black African or Caribbean family background. 1.5.2 refers to raising awareness in community groups 1.5.8 talks about raising awareness among healthcare professionals about who is eligible for PrEP The section also links to NICE guidelines on HIV testing which makes recommendations about offering and recommending HIV testing to people at higher risk in a variety of settings.
METRO Charity	Guideline	036	General	**Service design for PrEP services**	Thank you. Currently PrEP can only be prescribed in specialist sexual health services.

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				As a voluntary sector agency, currently providing on site and mobile HIV fast test finger prick testing, we would value an expansion of the guidelines to include prescribing rights for primary care settings.	
National Aids Trust (NAT)	Guideline	004	007 - 010	We welcome the recognition that there are barriers to some people accessing sexual health services and services need to both be aware of these barriers and actively seek to overcome them. Specifically, a group not highlighted which has specific needs beyond those stated is those born abroad – migrant communities. Regarding HIV, we know this is a large group of those at risk and living with HIV in the UK. Services should specially engage with and seek to meet the needs of these communities if they are to be effective. In 2019, 62% (2195/3552) of all new HIV diagnoses in the UK (including people previously diagnosed abroad) were among migrants (PHE data, provided upon request in email dated 21 April 2021). New diagnoses have declined over the past 10 years for people born in the UK and abroad, and rates of late diagnosis were similar, but slightly higher for migrants with HIV (51%, 541/1051) compared to people born in the UK (46%, 461/1000). Recent research by National AIDS Trust looking at the needs of migrant communities living with and at risk of HIV found that there are often numerous barriers for migrant communities beyond those faced by those when viewed with simply an ethnicity, gender, age etc. lens. Specifically, concerns about confidentiality of data, links	Thank you. The committee were very keen to avoid stereotyping and stigmatising particular groups and therefore referred throughout the document to 'groups with greater sexual health or access needs' rather than naming specific groups. The 'Terms used in this guideline' section explains that people having greater sexual health or access needs can be because they have higher rates of sex partner change or because they have less contact with services. This definition refers to people who are refugees or asylum seekers, who may find it more difficult to access sexual health services because they may not understand that they are eligible for free sexual health services. Recommendation 1.1.3 discusses entitlements to services and open access to sexual healthcare, but this has been reiterated in recommendation 1.1.8 where we have added a bullet to include "information about sexual health services available, including that they are free and open access."

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				between health services and the Home Office (data sharing), insecure migration statuses, concerns about healthcare charging for sexual health testing was prevalent (even though services are free people often were not aware of this) and broader barriers of language, poor knowledge of health services and structures in the UK, and deprivation preventing access to testing (National AIDS Trust, 2021, HIV and migration: Understanding the barriers faced by people born abroad living with HIV in the UK). It is vital services actively seek to overcome these barriers for this important population group.	
National Aids Trust (NAT)	Guideline	005	016 - 019	Regarding entitlement to services, it is vital that services actively promote open and free access to all to sexual health services. It cannot be taken as a given that people understand that sexual health testing is exempt from migrant charging or people believe that follow-up treatment is also without cost. Our research demonstrated that migrants often have poor understanding of NHS charging and people can be incorrectly informed by services. Most found out that HIV testing and treatment was free through a friend, HIV support service, or doctor once they had been admitted to hospital for an illness often related to advanced HIV infection. There is a lack of awareness among migrants about how to test. Similarly, there is a lack of information for migrants already diagnosed with HIV who want to access treatment.	Thank you for your comment. A bullet has been added to recommendation 1.1.8 which is designed to make people aware of what sexual health services are available to them, including that they are free and open access.

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				Many people we interviewed as part of our research spoke about how hard it had been to find information about access to HIV testing, treatment and care in the UK. Some who had already been diagnosed with HIV before they arrived tried to find out about their healthcare entitlements in the UK but struggled. A male in his 50s born in Latin America, said that he had to find all the information for himself when he arrived. Nothing was accessible or provided to him. Most people used the internet for information, but said it was tricky finding reliable sources especially as some said their level of English was not good when they first arrived. Equally, address requirements on seeking appointments or registration with services can be off putting for migrants, with people fearing referral to the Home Office, and that accessing sexual health services for things like HIV testing, diagnosis and treatment may impact their visa applications. It is important that reception staff, online forms and clinic staff are clear that such information as GP registration or address information can be sensitive to migrants for this reason and is not a reason to stop access to open access services.	
National Aids Trust (NAT)	Guideline	005	020 - 021	We welcome the commitment to supporting people to attend appointments and engage with treatment and care, but feel more detail is needed in this recommendation about practically what this commitment involves, giving services greater clarity about expectations and service users clear understanding of service expectations.	Thank you. The committee agreed that 'wider support' was somewhat vague, so this has been removed from recommendation 1.1.3. Many of the recommendations address issues relating to ensuring easy access to services and emphasise the importance of offering a range of appointment types:

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				As a minimum, this should include providing a range of appointment types – including online and telephone access to services. Demand for these services has significantly increased during COVID both due to necessity, as services have restricted face to face access, but we also know that there is demand for telehealth from some groups and this can widen access to some groups who face barriers to travelling for appointments. Cost of travel and rurality can prevent frequent face to face appointments. At present there is not uniform access in all areas to online sexual health testing or phone/online appointments – the guideline should specifically address this here. Whilst it is welcome that the recommendation seems to ensure people can continue to experience open access to services in any area no matter where their home address is, the range and scope of services available is important. Since 2014/15 there has been over £700 million in cuts to the public health budget. This funding backdrop has had real impacts on local sexual health budgets, with a 14% real terms reduction in local authority spending on sexual health between 2013/14 and 2017/18. This has coincided with increased demand for sexual health services. It is important to recognise that in recent years access to services has become more challenging to access in many locations due to public health cuts, and there is no specific recommendation here for services to offer a range of appointment types and to provide continuity of access,	1.1.1 and 1.1.2 reference a range of services, including non-clinical and online; and 1.1.3 discusses a range of ways to reduce barriers to access, including outreach activities. Recommendations in the STI testing section also emphasise the importance of having a range of appointment types and testing options available, including remote self-sampling, clinic attendance, community settings and outreach services (1.2.1), and a range of ways to access self-sampling kits including online, by phone, through pop-up or outreach services (1.2.5).

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				including to pre-booked and drop-in arrangements for urgent or higher risk groups. A mix of available services is important and helpful as well as outreach-based activities. Ensuring easy access to services is vital as we have seen drops in overall levels of testing and increases in late diagnosis rates for HIV during COVID (UKHSA data 2021 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf).	
National Aids Trust (NAT)	Guideline	007	003 - 007	As well talking about sexual consent and condom negotiation in general terms, it is vital that services ask attendees if they are able to apply these in their own lives – in other words, if people are safe and free from harm/domestic abuse. Where this is not the case, support should be provided to refer people to relevant support services. Whilst general inclusion of these concepts is welcome, without specific tailored application and support, this commitment is of low impact and needs amending.	Thank you. A new sentence has been added to the rationale and impact section to highlight the importance of sexual history taking, which may help to identify issues such as sexual violence, sexual exploitation and coercion. Reference has also been made to the BASHH 2019 UK National Guideline for consultations requiring sexual history taking in the rationale and impact section, and to the NICE guidelines on domestic violence and abuse in recommendation 1.1.10.
National Aids Trust (NAT)	Guideline	007	013 -018	007 (and general comment too) This section, as well as much of the guidance more broadly, addresses groups as 'higher risk'. It is helpful here to include wider context of groups at risk and patterns and trends in diagnoses. As it currently stands, we worry the focus throughout this guideline on 'higher risk groups', and regular reference only to groups like	Thank you. The overall focus of the guideline is all sexually active people and the committee felt that the recommendations, particularly those on STI testing and partner notification, apply to all people at risk of an STI. Some of the evidence reviews were focused on higher risk groups or people eligible for PrEP, so the recommendations that are based on those reviews are

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				'gay men', could unhelpfully reinforce views that only certain groups should be encouraged to proactively test. We have seen major gains amongst gay and bisexual men in terms of decreases in new infections of HIV and increased rates of diagnosis, and falls in late diagnosis. However progress is more limited elsewhere. There are stubbornly high rates of late diagnosis and undiagnosed HIV amongst older groups, those outside of London and amongst heterosexual communities. Rates of transmissions are reducing more slowly in groups not traditionally seen as 'high risk'. It is vital that all those who are sexually active are encouraged to test regularly, that testing is normalised, and a narrow focus only on those deemed 'at high risk' could simply reinforce preconceptions and stigma amongst people and healthcare staff about who should test. We know that far too many people leave sexual health service without testing for HIV. Overall coverage of HIV testing in sexual health services was 65% in 2019. Of those who did not get tested, 46% were not offered a test and the remainder declined. Worryingly, the number of people being tested for HIV at sexual health clinics decreased 30% in 2020. This was particularly high for heterosexual people and Black African communities, which is very concerning as rates of undiagnosed HIV and late HIV diagnosis remain stubbornly high amongst this group.	more specific to higher risk groups, such as those in sections 1.1 and 1.5.

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				One of the HIV Commission report's headline recommendations was for a significant increase in HIV opt-out testing in the NHS in a range of settings. Every contact with the health system is an opportunity, and every blood test where an HIV test is not offered is an opportunity missed. Sexual health services are at the frontline of the goal to end new HIV transmission, and everyone attending should be offered an HIV test.	
National Aids Trust (NAT)	Guideline	008	007 - 009	It is welcome to have peer support raised. However, this point should be strengthened from 'if possible' to a recommendation that services *ensure* peer support is an integrated part of testing, care and outreach support.	Thank you. This recommendation has been strengthened by removing 'if possible,' as the evidence and committee agreed that peer led approaches were effective.
National Aids Trust (NAT)	Guideline	009	004 - 006	Welcome the mention of self-sampling services, however this point could be clearer and stronger making it clear that there is need in all areas for a range of service options including self-sampling being available in all areas. This would make this guideline consistent with the recently published HIV Action Plan which also made this commitment. In 2020, almost half of people testing did so online – showing significant increased demand for online testing services and making the case for year-round access to online testing in all areas.	Thank you. Recommendation 1.2.1 makes it clear that self-sampling services should be offered as one option in a range of service provision options, and recommendation 1.2.2 makes it clear that remote self-sampling should be offered as an option for people without symptoms.
National Aids Trust (NAT)	Guideline	012	016 - 018	This language should be strengthened, from 'considering' to actively promoting vaccinations for all eligible individuals, ensuring that everyone attending has had the option to receive a vaccination in these areas.	Thank you. It may not always be possible for providers to give vaccinations at all routine health appointments, so 'consider' is appropriate here. Recommendation 1.4.3 has been amended to say 'opportunistically promote' HPV, Hep A and B vaccinations which may capture your suggestion.

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National Aids Trust (NAT)	Guideline	012	019 - 021	We welcome the mention of follow-ups and text reminders being used for those who do not return for vaccinations, but suggest that this could be strengthened and encouraged to be used proactively to ensure people consider vaccinations if they have not already had them, and proactively encourage them to attend ahead of vaccination due dates. This is a tried and tested tool for various aspects of the health system and is a good practice strategy for ensuring ongoing engagement in care.	Thank you. This is covered in section 1.3 of the NICE guideline on vaccine uptake in the general population, which is referred to after recommendation 1.4.5.
National Aids Trust (NAT)	Guideline	013	010 - 014	We strongly support the inclusion of this recommendation and broader content which encourages the wider use and consideration of PrEP, which has been a vital tool in reducing HIV transmissions. We know, however, that the vast majority of those accessing PrEP remain gay and bisexual men, and disproportionately white men. Data released last year from 2017 to 2020 showed that 24,000 people had access to the HIV prevention drug PrEP in England through the Impact Trial. However, access was low amongst many groups. 96% accessing the drug were gay and bisexual men, 76% were white and the median age 33 years. More action is needed to reach all communities. This recommendation could be stronger/clearer and we would suggest rather than wording of '*pay particular attention to*...' this should more clearly indicate that there should be equitable provision and promotion of PrEP in clinics, and that services should actively promote PrEP to *all* groups including	Thank you. The committee agreed and have added "to promote equal access to PrEP" to the end of recommendation 1.5.1. to clarify.

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				those listed as underserved by PrEP to date. This would help ensure equitable take-up. We know that awareness of PrEP is currently low amongst certain groups, and services are not always promoting PrEP to all communities as effectively as could be the case. This is in line with the HIV Action Plan's commitment to, '*support the system to continue to improve access to PrEP for key population groups and monitor progress through a monitoring and evaluation framework'*.	
National Aids Trust (NAT)	Guideline	014	014 -018	We support the recommendation regarding improving training and awareness amongst healthcare professionals about PrEP but would suggest this recommendation is expanded to include the need for this training to include awareness of the benefits of PrEP for all communities, and the need for healthcare professionals to ensure equitable uptake beyond just Gay and bisexual men.	Thank you. Recommendation 1.5.1 specifically talks about raising awareness of PrEP in groups where uptake is lower. Recommendation 1.5.8 recommends similar awareness raising among healthcare professionals.
National Aids Trust (NAT)	Guideline	015	001 - 008	This section should also make recommendations for services to consider facilitating access to PrEP outside of sexual health clinics, including through outreach for groups at high risk, for example, via services working with people injecting drugs/rough sleepers.	Thank you. Currently PrEP can only be prescribed in specialist sexual health services so the committee were unable to say anything about access to PrEP outside of sexual health clinic settings. However, they made a research recommendation on the effectiveness and cost effectiveness of providing PrEP outside of sexual health services.
National Aids Trust (NAT)	Guideline	017	001 - 009	Whilst it is correct that people are at varying degrees of relative risk depending on the type and frequency of sexual activities, we recommend this narrative does	Thank you. The definition you refer to is specifically for people with greater sexual health or access needs.

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				highlight that one sexual contact (if unprotected) is enough to get an STI/HIV. It is vital that if we are to make progress in lowering infections and ending all HIV transmissions, everyone sexually active knows their STI and HIV status. People may not know the actions of their partner(s), and assumptions should not be made that deem only certain groups 'high risk'. Unfortunately, there are still persistent attitudes amongst the public and even some of the healthcare workforce, that certain groups are at risk of HIV, and certain groups are not. We know, however, the data does not support this and all groups can and do get STIs and HIV. At present the narrative in this section seems to reinforce the view that gay and bisexual men are a high-risk group being the only group specially mentioned. More contextual information would be helpful in clarifying this.	
National Aids Trust (NAT)	Guideline	017	010 -012	For those less familiar with PrEP, slightly more detail may be welcome about what PrEP is, and that generally PrEP can be taken as one pill daily and that there are event-based options too.	Thank you. This has been added to the definition of PrEP.
National Aids Trust (NAT)	Guideline	018	002 - 005	We would suggest that this research area is expanded to also include research into which specific health/community settings are most effective for different groups to receive PrEP, rather than more general research into the general effectiveness of access to PrEP broadly beyond sexual health services. We know there is strong interest for PrEP to be available in a range of settings in community pharmacy, maternity and	The recommended research is intended to examine the effectiveness of offering, providing and monitoring PrEP in non-sexual health services, and therefore may include a range of non-SHS settings such as community pharmacy, GPs and online, if evidence is available on these different settings. Further details can be found in

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				termination services, GPs and online, and it would be helpful to have specific research into which settings are most effective for different communities currently underserved by access to PrEP only being via sexual health services. Research by NAT showed public acceptance of this, with more than 8 in 10 respondents supporting PrEP being made available via GP settings, for example.	the full research recommendation in appendix L of review G.
National Aids Trust (NAT)	Guideline	019	005 - 006	We would recommend that this research area is expanded to include addressing not only stigma that prevents people accessing sexual health services, but also how stigma currently prevents people when they do have access to sexual health services from being offered or taking an HIV test. We know many hundreds of thousands of people are accessing services already, but not being either offered or taking an HIV test, and whilst this may be due to a range of reasons, it is clearly also due to HIV stigma amongst the public and also healthcare staff. Addressing this stigma is a key priority for the HIV Action Plan in order to ensure we improve diagnosis rates, particularly amongst women and the black community, where these rates of attendance without testing are higher.	Thank you. Stigma around HIV testing is addressed in NICEs guideline on HIV testing: increasing uptake among people who may have undiagnosed HIV
National Aids Trust (NAT)	Guideline	021	002 - 003	PrEP is a prevention drug. It should not be a requirement for people to put themselves at risk of getting HIV before they are deemed eligible for a preventative drug. We would not, and do not, require people to have condomless sex before offering them	Thank you. NICE is not responsible for limitations on prescribing of PrEP, either in terms of who it can be prescribed to or where it can be prescribed. The research recommendation is intended to test the cost-effectiveness of PrEP in populations who do not report

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				condoms, or offer the contraceptive pill to women only once they may be at risk of becoming pregnant. The same principle should apply for PrEP. The intention / possibility of unprotected sex should be enough to provide PrEP. We feel this area of research is not only unnecessary, but also reinforces unhelpful views and stigma about PrEP. We understand that the current guidelines for PrEP are being updated and this will also hopefully address these issues, and seek to move beyond the current scope of the guidelines to help promote wider access. A helpful area of research would be healthcare professional knowledge and attitudes to PrEP in different settings, including their understanding of risk and current practices in recommending PrEP, and promoting it to different communities. This would help us identify barriers and training needs in order to ensure equitable access.	condomless sex, not to make a judgment on whether it should be provided to those groups.
NHS England & NHS Improvement	Guideline	General	General	We are content that there isn't anything contentious and the recommendations don't present a new burden or unmanageable workload for primary care, community services or clinics. The guidance also takes into consideration equity of access and service provision. There will be a need for commissioners to consider social marketing to raise public awareness of PrEP and to commission local pathways to access PrEP.	Thank you for your support.
NHS England & NHS Improvement	Guideline	General	Guideline	There is a missed opportunity to further support marginalised groups such as people with Learning Disabilities. The guidelines should make the use of Annual Health checks (Learning disabilities - Annual	Thank you for your comment. The committee discussed this suggestion but agreed that annual health checks were not the best place for these interventions. This was partly because the annual health check is already very

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				health checks - NHS (www.nhs.uk) as a way to tailor sexual health interventions within an annual health check. Some autistic people and people with a learning disability may not easily access mainstream services	busy, and also because staff undertaking the health check would not necessarily have the skills and expertise to deliver sexual health interventions. However, they discussed at length some of the barriers to accessing mainstream services that may be faced by some autistic people and people with a learning disability, and made a number of recommendations that focus on making services accessible and meeting the needs of groups with greater access needs.
Portsmouth City Council	Guidance	General	General	Ensure schools are able to get accurate information about local STI services available for young people to support schools with their statutory requirements around Relationships, Sex and Health Education in line with the relevant national Relationships and sex education (RSE) and health education - GOV.UK (www.gov.uk). *By the end of secondary school children and young people should know how to get further advice, including how and where to access condiential sexual health and reproductive health advice and treatment (pp 29,* Relationships Education, Relationships and Sex Education and Health Education guidance (publishing.service.gov.uk)*.*	Thank you. This guideline is for people aged over 16 years. This has been clarified in the guideline. While the guideline may also be relevant to younger people who contact or use sexual health services and are considered to be Gillick competent, interventions delivered in schools or as part of RSE were excluded.
Portsmouth City Council	Guideline	General	General	Having STI testing within termination of pregnancy service is understood to have the potential to have a **big impact** on STI testing coverage and identification of STIs considering18 and 25 year olds make up the largest volume of terminations of service users and this age group is at disproportionate high risk of STIs. Early STI testing and treatment can also reduce the risk of complications for the Termination of Pregnancy	Thank you. The committee agreed to add abortion care services to the 'Who is it for?' section of the guideline on page 1, and added abortion care services to recommendation 1.1.11.

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				procedure. And if the service user decides to keep the pregnancy it is still important that they are offered a STI test to reduce the risk of complications for the unborn baby. Due to the split commissioning of Sexual Health Services and terminations of pregnancy this may be a **challenge** in some areas of the country, which is why it is important that this guidance clearly highlights that it is also for Terminations of Pregnancy commissioners and providers to help **overcome challenges** that exist in many local areas.	
Portsmouth City Council	Guideline	001	006	It is good that GPs are referenced, but it would be good to stipulate on page one under 'who is this for?' (either under Providers or Healthcare professionals) that the guidance is for Termination of Pregnancy / abortion providers. It is important to note that STI can increase complications post abortion.	Thank you. The committee agreed to add abortion care services to the 'Who is it for?' section of the guideline on page 1, and added abortion care services to recommendation 1.1.11.
Portsmouth City Council	Guideline	001	006	As well as commissioners of sexual health services, this guidance is also relevant to commissioners of reproductive health services, terminations of pregnancy and vasectomy services who may not recognise themselves as a sexual health commissioner.	Thank you. The committee agreed to add abortion care services to the 'Who is it for?' section of the guideline on page 1, and added abortion care services to recommendation 1.1.11.
Portsmouth City Council	Guideline	004	003	'Behavioural insights' is a fundamental to 'meet the needs of groups with greatest sexual health needs'. Exploring where their needs are being met and maximise on this intelligence is also important. As part of workforce development for commissioners and services, the Behaviour Change Development Framework (developed by Health Education England)	Thank you. The committee believe this is covered in the current wording of the recommendation.

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				may help **overcome challenges** relating to professionals' ability to maximise on behavioural insights and behaviour change tools to strengthen resources available.	
Portsmouth City Council	Guideline	005	007	With reference to accessing sexual health services, there should be reference to the option of 'remote access' or 'telemedicine'?	Thank you. The committee agreed to add 'include online and non-clinical settings' to 1.1.2
Portsmouth City Council	Guideline	005	010	With reference to accessing sexual health services, there could be mention of 'easy access to information available about STIs and STI testing services' as this is an important part of facilitating access? For example, many services are have videos available online of what to expect when patients access their building / service. This is especially useful for people who are neurodivergent and people with autism to reduce barriers related to access. This has to potential to address barriers for other professionals signposting / referring into sexual health also.	Thank you. The committee agreed to add 'information about sexual health services available' to 1.1.8. They recognised that services should already be adhering to the NHS accessible information standard, which includes identifying the information and communication needs of people that use the service and making sure the service meets those needs.
Portsmouth City Council	Guideline	006	012	Extend sentence to 'information and education about STIs, including the services available'	Thank you. The committee agreed and have added 'information about sexual health services available, including that they are free and open access' as a new bullet for 1.1.8.
Portsmouth City Council	Guideline	007	019	**Opportunity to overcome barriers and reduce local financial challenges**: signposting to a national training resource / training framework to provide non clinical peers a baseline of knowledge (and skills) to supporting the ambition to reduce STI transmission. This could be facilitated by a local resource on local trends (e.g. STI	Thank you. Your comments will be considered by NICE where relevant support activity is being planned.

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				section in SPLASH) and Making Every Contact Count training	
Portsmouth City Council	Guideline	013	004	Encouraging the take up of PrEP should be done within the relevant guidance, including Advertise your medicines - GOV.UK (www.gov.uk) and PrEP-Health-Promotion-Campaign-Guidance.pdf (hivpreventionengland.org.uk)	Thank you. The guideline does not make any specific recommendations about encouraging the uptake of PrEP – the focus is on raising awareness, facilitating access, and supporting people. The committee agreed to add a reference to the PrEP Health promotion campaign guidance in the rationale and impact section.
Portsmouth City Council	Guideline	014	019	It is really good to see recommendations for protected time for health care professions who have day to day contact with people eligible for PrEP to have training on relevant issues. To help users of the guidance implement this recommendation it would be beneficial to receive advice or guidance on what is required within that learning. It would be even better to have a central training resource supported by updated communications a)for sexual health professionals providing PrEP b) for other professionals signposting to PrEP c) for peers promoting PrEP. The later two could be supported by communications from local services about how to access PrEP locally.	Thank you. The content of health professionals training is beyond NICE's remit. Royal colleges and professional bodies are responsible for setting standards of training required to perform professional tasks.
Portsmouth City Council	Guidance	015	009	It may be advisable to reiterate under 'prescribing PrEP' that HPV and Hep vaccinations should also be recommended for gay, bisexual and other men who have sex with men on PrEP.	Thank you. Recommendation 1.4.3 recommends that HPV, Hep A&B vaccines are recommended to MSM opportunistically. This would include during PrEP prescribing or monitoring appointments.
Portsmouth City Council	Guideline	017	004	We advise to avoid the term 'risky sex' as the term is stigmatising and ambiguous.	Thank you. This term has been removed.

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				https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6953392/ provides a list of precise and neutral language to avoid the use of ambiguous or stigmatizing language.	
Portsmouth City Council	Guidance	018	010	Currently it is hard to evidence precisely about positive results within or signposted to remote testing from other settings, such as terminations of pregnancy, drugs and alcohol services. They can get accumulated under 'other settings' or 'remote access' using the data available. Therefore it would be really good to explore how to ensure that national recording is able to compare settings clearly and compare across local areas.	Thank you. Data management is outside the scope of this guideline. Please see the scope document on the NICE website.
Preventx Ltd	Guideline	General	General	There are some significant advantages to remote testing that the document could highlight – including the potential to take a highly adaptive and regional approach to local epidemiology, responding at pace to outbreaks or additional testing requirements.	Thank you. The guideline makes a strong recommendation to offer remote self-sampling for STIs.
Preventx Ltd	Guideline	009	007	Rec 1.2.2 – online testing for asymptomatic service users has become the widely accepted standard of care for those unable or without access to clinic-based services. The guidelines should state that any area that is not providing access to online testing is failing to provide adequate level of service.	Thank you. The guideline already emphasises the importance of offering online testing for asymptomatic people (recommendation 1.2.1 specifies remote self-sampling should be one option in a range of testing options, and recommendation 1.2.2 makes it clear that remote self-sampling should be offered as an option for people without symptoms).
Preventx Ltd	Guideline	009	011	Rec 1.2.4 – Preventx has survey data from thousands of self-sampling service users about their requirements for accessibility and translation services when accessing remote STI testing. We have found that the greatest impact comes from creating guidance that is simple, clear and uses visual aids (in the form or diagrams, photos and videos).	Thank you. The committee agreed to add that instructions and guidance for testing kits should be available in different formats such as diagrams, photos or videos to recommendation 1.2.4.

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Preventx Ltd	Guideline	009	016	Rec 1.2.5 – Ofcom Report 2020 that 89% of people access the internet. Community outreach for self-sampling should be aimed at people who are reluctant to test. Preventx has been involved with projects such as PEasy, handing self-sampling kits directly to people in the community. Our goal is to prioritise mitigating inequalities through effective outreach services.	Thank you for your comment.
Preventx Ltd	Guideline	011	005	Rec 1.3.3 – electronic patient notification should be an integral part of these recommendations, as it increases confidentiality and accessibility for a wide range of service users, as well as increasing the ease of measuring the success of PN and outcomes. This kind of automated system should be built into whatever platform is used for PN.	Thank you. Recommendation 1.3.1 talks about discussing the different methods of partner notification with people but does not specifically mention the different types of PN so the committee did not consider it necessary to explicitly reference ePN in the recommendations, although they agreed to reference online PN in the rationale and impact section. In addition, the evidence indicated that online partner notification was not the preferred approach and was generally only considered as acceptable in specific circumstances such as when anonymity was particularly important.
Preventx Ltd	Guideline	011	016	Rec 1.3.5 – this recommendation should mention the ease of ePN. Additionally, this type of seamless notification should be built into any remote testing platform.	Thank you. The committee discussed the potential of online PN but did not consider it necessary to explicitly mention online PN in the recommendations, although they agreed to add reference to online PN in the rationale and impact section.
Preventx Ltd	Guideline	016	003	Rec 1.5.14 – online testing can be a way of facilitating prompt access and commencement of PrEP (pre-exposure prophylaxis). Many services offer potential PrEP users an initial appointment for assessment and "baseline tests" and then they might still need to reattend for a review appointment days/weeks afterwards before they can then commence PrEP. This	Thank you. The guideline makes many references to remote self-sampling and the committee did not think it was helpful to add it here. They did not see any evidence about the effectiveness of remote self-sampling in improving access to PrEP.

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				might lead to drop out/failure to initiate and also potential for ongoing risk of HIV before they take their first dose. By signposting potential users to online testing at first contact they can then order a test kit (with possible baseline PrEP renal testing) and then those results could be available at the initial clinic visit to enable them to be start PrEP immediately.	
Preventx Ltd	Guideline	016	005	Rec 1.5.15 – again the role of online testing is hugely important here. Automated reminders, and ease of online testing makes this approach to testing a vital tool for people taking PrEP (pre-exposure prophylaxis).	Thank you. The committee did not think it was helpful to refer to online testing here as it is highlighted in so many other places in the guideline.
Preventx Ltd	Guideline	019	001	Online services can be easily tailored to service users – for example, Preventx has worked on a project specifically targeting Black heterosexual men, with a dedicated website, phrasing and approach – all while still using the same reliable tech platform and lab that services the rest of the UK.	Thank you. This is exactly the kind of research that this research recommendation is trying to promote. We would encourage you to publish any results you have from any evaluations of your service.
Preventx Ltd	Guideline	019	004	Suggestion that online testing is specified as an area of research and focus when reducing stigma. Online testing is key to overcoming the stigma associated with accessing services. We have data that shows that many online users have never attended sexual health services and feedback from users shows that stigma is a huge issue preventing users attending physical services - fear of the "walk of shame" or seeing someone they know in clinic. Online testing offers the greatest anonymity and sampling in the comfort of the user's own environment.	Thank you. Online testing may be one effective way of reducing the stigma associated with STI testing, however we would not wish to pre-empt the research.
Preventx Ltd	Guideline	021	007	Preventx has significant data and research in preparation for publication on the outcomes of people with symptoms when they use remote self-sampling services. We presented research findings at the BASHH	Thank you. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure

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				(British Association for Sexual Health and HIV) 2021 conference, comparing outcomes from symptomatic and asymptomatic cohorts, (n= 596,637 test kits), showing the positivity rates for chlamydia (5.8%) in returned mild symptomatic results (67,171) is higher when compared to asymptomatic results (4.4%). However, the positivity rates for gonorrhoea were lower in the symptomatic orders (1.4%) compared to asymptomatic orders (1.8%). Preventx is the largest provider of remote sexual health testing services in the UK, working in partnership with the NHS and local authorities to run publicly funded services Freetest.me, SH.UK and SHL.UK – and has sent more than 3.5 million test kits to service users across the country. The Preventx online triage has been carefully crafted with clinical teams to ensure that we ask service users detailed information about their symptoms, allowing for a nuanced approach to whether remote self-sampling is appropriate for someone. Only those with symptoms that are classed as 'mild' are handled through the service, anyone with more serious symptoms is either called back or referred to a clinic. This approach allows for careful mitigation of risk or adverse outcomes.	that they are up to date so that they can monitor for publication of this study.
Preventx Ltd	Guideline	028	014	Given the Ofcom Report 2020 that 89% of people access the internet, and self-sampling kits can be sent to any address, we know that the overwhelming majority of people can use this service to access testing. Current data suggests that online testing is penetrating well into areas of highest deprivation across the UK. Preventx has presented data at BASHH (British Association for	Thank you for the information. The committee agree that access to self-sampling kits online is an important option amongst a suite of STI testing options available to people.

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				Sexual Health and HIV) to show that health inequalities are not widened when people use online testing services.	
Preventx Ltd	Guideline	028	018	Please clarify what this means – why can't people who are eligible get a test?	Thank you. This sentence has been amended to clarify that it is because demand for tests can outstrip supply.
Preventx Ltd	Guideline	028	021	Remote testing services do not need to charge for kits that are not returned. Based on the Preventx services, in the event a user doesn't return part of a kit (swab, urine, bloods) or this is damaged, insufficient, haemolysed, or HIV testing is skipped as they are already living with HIV, the commissioner should not be invoiced for pathology associated with these samples.	Thank you for this useful information. The rationale section is reflecting the committees experience of some areas capping number of tests available. They made a recommendation about monitoring kit provision and return to enable local commissioners to understand the take-up of remote testing and to be able to promote and target self-sampling better.
Preventx Ltd	Guideline	029	001	This section should emphasise the need for expert and specialist remote sampling services, with laboratories dedicated to handling small blood samples. For example, they can carry out up to six tests on a single finger-prick blood sample, plus confirmatory testing and assays such as quantitative RPR for syphilis. Postal kits for blood testing should be well designed to reduce haemolysis rates. Currently, based on 3.5 million test kits, Preventx sees that 85% of service users who are sent a blood test kit are able to return a usable sample to the lab. Additionally, compared to no testing at all, any testing is better and most users will test negative and have their needs met with good quality remote testing.	Thank you. This is outside the scope of this guideline. Please see the scope document on the NICE website.
Preventx Ltd	Guideline	029	003	This highlights the need for a high-quality remote service. With an end-to-end integrated service, triage questions can add/remove tests so this risk is almost entirely mitigated where users know they've had an	Thank you. This is outside the scope of this guideline. Please see the scope document on the NICE website.

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				infection. With syphilis, by testing the specimen with an RPR assay instead of a specific antibody test a negative result can reduce the need for most to attend clinic for repeat testing.	
Preventx Ltd	Guideline	029	008	Preventx has been presenting data and research to BASHH (British Association for Sexual Health and HIV) for the last year on the safety and quality of remote testing for patients with symptoms. This research is in the process of being published but has been presented at scientific conferences as it's being developed. The Preventx online triage has been carefully crafted with clinical teams to ensure that we ask service users detailed information about their symptoms, allowing for a nuanced approach to whether remote self-sampling is appropriate for someone. Only those with symptoms that are classes as 'mild' are handled through the service, anyone with more serious symptoms is either called back or referred to a clinic. This approach allows for careful mitigation of risk or adverse outcomes. Remote testing is fast, and the total process is often quicker than someone attending clinic and then waiting for subsequent lab results. Additionally, we have presented data that shows that access to symptomatic testing could help reach sections of the population who otherwise test less. As presented at the BASHH (British Association for Sexual Health and HIV) conference: analysis on 596,637 kit orders, by users who were asymptomatic (n=484,139) and mildly symptomatic (n=112,498), placed between 26 March	Thank you. The committee agreed that the safety of self-sampling for symptomatic people is an important area for further research and made a research recommendation about the use of remote self-sampling combined with telephone or online triage. We will pass your comment to the NICE surveillance team who will monitor for publication of your paper.

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				2020 and 30 June 2021. We found a higher proportion of symptomatic to asymptomatic users in testing kit orders from deprived areas (deciles 1, 2 and 3) compared with affluent areas. There was a higher proportion of symptomatic females testing (74.4% [83,731/112,498]), compared to the proportion from the asymptomatic cohort (53% [256,491/484,139]). Whereas, there was a lower proportion of men in the symptomatic cohort (25.2% [28,311/112,498] of symptomatic orders were from men) compared to the proportion of men in asymptomatic cohort (46.2%, [223,467/484,139]). With ethnicity, there was a higher proportion of symptomatic Black Caribbean and Black African individuals testing, compared to asymptomatic orders. When looking at age, 10.5% (50990/484,139) of asymptomatic orders were from 18-21-year-olds, whereas they made up 16% (18049/112,498) of orders in the symptomatic cohort.	
Preventx Ltd	Guideline	029	012	Clinical support for remote sampling services is crucial to service users understanding their results. Preventx partners with local sexual health services and clinics, so the clinical support is managed at a local level. For example, if someone receives a reactive result for HIV, their local clinical team will call them, explain the result and invite them to the local clinic for a re-test. This model ensures clarity and continuity of care.	Thank you. Your comments will be considered by NICE where relevant support activity is being planned.
Preventx Ltd	Guideline	029	013	A well-designed online triage is crucial for ensuring people receive the right testing kit for their anatomy. Working with clinicians and service users to develop an appropriate set of questions minimises the risk that an inappropriate testing kit will be sent out.	Thank you. The committee agreed this was important. They highlighted in recommendation 1.2.4 that kits need to be inclusive and this is further explained in the rationale and impact section and makes specific

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					reference to people getting the right tests for their anatomy.
Preventx Ltd	Guideline	029	016	When talking about symptomatic testing, it might help to take the example of a Trust that uses the SH.UK remote testing service. In March 2020 Kent implemented an innovative approach to online sexual health testing through two new pathways: one for mild symptomatic testing and a complex symptomatic testing pathway to support an unmet demand. This complemented the existing sexual health services provided at the then seven clinics they had in place across the county. The implementation of COVID-19 social distancing restrictions, which came into place in March 2020, meant that many of the face-to-face services were unable to operate in their usual capacity. Maidstone and Tunbridge Wells NHS Trust (MTW) took the decision to undertake a forward-thinking service change, which allowed them to increase the range of online testing available so that individuals had access to the services and care they needed. Preventx worked with MTW to introduce a mild symptomatic pathway which was created in collaboration with the consultants from the Trust who developed a bespoke algorithm which enabled users with defined mild symptoms to order a test with no clinical intervention. Amidst the pandemic onset, the service was quickly adapted to allow those reporting higher risk symptoms to enter their phone number on the SH.UK platform and receive a call back from one of MTW's clinicians for	Thank you. The committee agreed that the safety of self-sampling for symptomatic people is an important area for further research and made a research recommendation about the use of remote self-sampling combined with telephone or online triage.

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				further assessment. At this point, the clinician could then decide if the user should test online or arrange if they should be seen in clinic. Lesley Navaratne is Clinical Director for sexual health services at MTW: *'The simplicity and ability for symptomatic users to test online has meant that 93.3% of people who wanted to test online were able to, with clinicians only triaging 6.7% of users with the most complex symptoms into clinic. Previously, only 69% of these users could have tested online. Patients will sometimes ask about the accuracy of results from online testing but as clinicians it is our responsibility to be confident of the safety and accuracy of and then reassure them of the safety and accuracy of online testing."* Remote testing has meant different population groups can have different testing regimes; for example, men who have sex with men are able to undertake monthly testing. Capacity in the face-to-face clinics would be unable to cope with this level of testing and if this were to be offered appointments would quickly run out. *"Kent is a big area and it's not always easy for people to get to a clinic so remote testing saves people having to travel. It's a private, quick and rapid way to get screened. 45% of the people who access our services are over the age of 45 and many of them don't want to come into clinic. And with other populations such as men who have sex with men, although they may have come into to see us occasionally before remote testing, they are now able to test monthly at home. Remote testing*	

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				has increased access, widened availability and it's really brought testing out into the open." The service is liked and trusted by those using it. Of patients testing in Kent, 98.8% said they would recommend remote sexual health testing.	
Preventx Ltd	Guideline	029	019	Preventx has undertaken significant research into attitudes to online testing. A recent survey of 250 service users found that if they had symptoms, 80% said that they are either very likely or somewhat likely to use home STI tests and nearly half, 46% said that next time they have symptoms they would prefer to carry out an STI test at home.	Thank you. The committee noted that remote self-sampling with telephone/online triage had been used during the COVID-19 pandemic and agreed that further research needs to be undertaken to establish the safety and effectiveness of this. They made a research recommendation to that effect.
Preventx Ltd	Guideline	030	006	We are not sure if this conclusion makes sense. Finding positive cases helps reduce the spread of STIs, reducing costs overall. Only a small % of users testing need follow up care and the costs of self-sampling are substantially cheaper.	Thank you for your comment. Based on the published randomised trials identified in the guideline, the increase in the number of tests undertaken with remote self-sampling is such that it increases the overall costs of the service (due to increases in treatment costs for those additional people identified, as well as test costs). However, the extra health generated through appropriate treatment of those additional asymptomatic cases identified is such that remote self-sampling was estimated to be a cost-effective intervention.
Preventx Ltd	Guideline	030	011	This highlights the need for clarity around costs for remote testing services. Providers who don't load cost into the kits, have an incentive to push for good return rates.	Thank you for your comment, and we agree that the sensitivity of the cost-effectiveness results to return rates of kits means that ensuring return rates are as high as possible should be aim for commissioners and providers of services.
Preventx Ltd	Guideline	036	017	We want to highlight the potential for online PrEP (pre-exposure prophylaxis), including medication and monitoring. This would be a significant improvement on	Thank you. Currently PrEP can only be prescribed in specialist sexual health settings. The committee made a research recommendation about the benefits of prescribing PrEP in other settings.

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				the large number of those who buy PrEP online in the absence of any testing or monitoring.	
Royal College of General Practitioners (RCGP)	Guideline	General	General	The Royal College of General Practitioners has reviewed the guideline for Reducing sexually transmitted infections [NG10142] and has no comments to submit. We believe this guideline will be a welcome addition to clinical practice.	Thank you for your support.
Royal College of Nursing	Guideline	General	General	We do not have any comments to add on this consultation. Thank you for the opportunity to contribute.	Thank you for your support.
Royal College of Physicians (RCP)	Guideline	General	General	The RCP is grateful for the opportunity to respond to the above consultation. In doing so we would like to endorse the response submitted by The British Association for Sexual Health and HIV (BASHH). We have also liaised with our JSC for Genitourinary Medicine and would like to comment as follows.	Thank you for your comments.
Royal College of Physicians (RCP)	Guideline	General	General	The introduction states 'This guideline … aims to reduce the transmission of chlamydia and other STIs, including HIV … Our experts note that in view of the soaring rates of syphilis and gonorrhoea infections perhaps these infections should be named specifically alongside chlamydia as they have significant pathology too.	Thank you. The committee agreed that it seems odd to only mention chlamydia by name and have amended this to read "transmission of all STIs".
Royal College of Physicians (RCP)	Guideline	005	010 - 027	**Section 1.1.5** Our experts note that ensuring face to face appointments remain available as a choice, and for those where remote testing is difficult or misses	Thank you. Recommendations 1.1.1 and 1.1.2 highlight the importance of offering a range of services and settings. 1.2.1 also emphasises the importance of offering both remote and in-person options so patients

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				opportunities for safeguarding, vaccination, contraception etc	have a choice. Currently remote testing is only recommended for asymptomatic people (1.2.2). Face to face appointments are required for people with symptoms. There is a broader question about the configuration of services during a pandemic which is beyond the remit of this guideline.
Royal College of Physicians (RCP)	Guideline	005	016	"Ensure staff are aware"……. Our experts believe that sexual health services should not refuse an appointment to an individual if the patient is unable or unwilling to provide their address, GP name or NHS number. It is imperative that services remain having open access.	Thank you. The recommendation already states that staff should not refuse access to someone who is entitled to the service. A bullet has been added to recommendation 1.1.8 which is designed to make people aware of what sexual health services are available to them, including that they are free and open access.
Royal College of Physicians (RCP)	Guideline	005	General	Section 1 accessing sexual health services The NICE standard for access - statement 4 should be highlighted as key to improving access for patients ' Statement 4 People contacting a sexual health service about a sexually transmitted infection are offered an appointment that is within 2 working days.' https://www.nice.org.uk/guidance/qs178/chapter/Quality-statements Our experts note that it is essential that people who feel they have an STI, particular those with urgent symptoms, can access services in a timely manner. Recent mystery shopping studies undertaken on behalf of BASHH have demonstrated poor and year on year worsening access to services across the UK.	Thank you. It is envisaged that the recommendations on accessing sexual health services (1.1.1, 1.1.2, 1.1.3) will help people to access services in a timely manner by providing a wide range of services and settings and addressing barriers to access. The rationale and impact section also now refers to the BASHH standard on the management of STIs, which specifies that people should be offered an appointment within 2 days of contacting the service, which should further support timely access. The NICE quality standard is based on the guideline, so the current quality standard will be reviewed and may need updating once the guideline is published.

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Royal College of Physicians (RCP)	Guideline	010	012 - 029	**Section 1.3** **Partner notification** Our experts note that this section needs something about ensuring appropriate look back for each STI whether symptomatic or asymptomatic, ideally in line with BASHH recommendations for individual infections (https://www.bashh.org/guidelines) should include some reference to trans people	Thank you. Recommendation 1.3.5 references the BASHH statement on partner notification for STIs which includes detailed information on look back intervals by STI type.
Royal College of Physicians (RCP)	Guideline	012	001 - 021	**Section 1.4** **HPV and hepatitis A and B vaccination in gay, bisexual and other men who have sex with men** Our experts note that this section should include some reference to trans people	Thank you. The guideline committee were asked to look specifically at increasing the uptake of HPV vaccine in GBMSM. Broader issues about HPV vaccination or access for other eligible groups are outside the scope of this guideline. Please see the scope document on the NICE website. However, the committee agreed to add a 'be aware' recommendation (1.4.1) to highlight that there are other groups eligible for these vaccinations.
Sexpression:UK	Guideline	024	010 -012	We are concerned that the committee suggests that people self-identifying to services should automatically be regarded as high risk. The suggestion made in the guideline is facilitating shame in accessing sexual health services, where it should be promoting empowerment and engagement with sexual health, specifically for young people or those who have never accessed services before. This suggestion ignores factors that would constitute an individual being more high risk and instead uses it as a blanket term for all of those accessing services. Recognising the need for and importance of regularly accessing services is a behaviour that we need to encourage. We have	Thank you. This sentence has been edited to be clearer about our meaning.

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				concerns that labelling everyone that presents to sexual health services as high risk for contracting STIs may create a barrier to attendance. The public may perceive this statement to mean they should only attend services if they are high risk.	
SH:24	Guideline	004	004	Rec 1.1.1 We endorse this recommendation and agree that services should be targeted to those with the greatest sexual health needs. Much of this data should be found in local JSNA's.	Thank you for the endorsement.
SH:24	Guideline	004	007	Rec 1.1.2 We agree, and would recommend a Human Centred Design approach to ensure that services are developed and designed to reflect the users requirements.	Thank you. The committee did not consider evidence on which method of engagement was most effective and therefore did not recommend a specific approach.
SH:24	Guideline	005	002	Rec 1.1.3 We agree, and would add that including an online component in any network of sexual health services improves access and increases flexibility of services. The nature of online services means that users have access to up-to-date information on services as well as information on prevention and diagnosis, treatment.	Thank you. 'Including online services' has been added to recommendation 1.1.3 (now 1.1.1).
SH:24	Guideline	005	010	Rec 1.1.4 We endorse user consultation in development of accessible services.	Thank you for your endorsement.
SH:24	Guideline	005	010	Rec 1.1.5 We agree with the actions listed, and would like to add 'provision of online services' in order to reduce barriers for groups with greater sexual health needs	Thank you. Reference to online services has been added to 1.1.1 and 1.1.2 so it is not necessary to add it to 1.1.5 (now 1.1.3).
SH:24	Guideline	006	002	Rec 1.1.6 We recommend a Human Centred Design (HCD) approach to developing services and interventions to reduce STI transmission.	Thank you. No evidence was found on Human Centred Design approaches therefore the committee were not able to recommend this specific approach.

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SH:24	Guideline	007	020	Rec 1.1.10 We agree, and would add that access to online to services can be facilitative for other community services in reducing STI's. For example, drug and alcohol services can make use of easy referral pathways into online sexual health services for their users	Thank you. 'Including online services' has been added to recommendation 1.1.1, which talks about forming networks of services providing sexual health care. This should enable easy referral between services both within the network and with other local services.
SH:24	Guideline	008	010	Rec 1.1.13 SH:24 works on principle of promotion of self-care and providing people with the information, tools and remote clinical support when required to understand their risks and take necessary actions.	Thank you for this information, which is a good example of what is recommended in 1.1.14.
SH:24	Guideline	009	004	Rec 1.2.1 We agree, and believe that online services are key part of a continuum of care from promotion of self-care through to tertiary services	Thank you for your endorsement.
SH:24	Guideline	009	009	Rec 1.2.3 The nature of digital services means they are often better placed to give up-to-date service information, in a timely way	Thank you.
SH:24	Guideline	009	011	Rec 1.2.4 We agree, and would add the BASHH guidance on the design of self-sampling packs to this recommendation: https://www.bashhguidelines.org/media/1280/bashhguidanceself-samplingaug2021.pdf	Thank you. Reference to this resource has been added to the rationale and impact section.
SH:24	Guideline	009	016	Rec 1.2.5 In SH:24's experience, access a self-sampling kit through an online service does not seem to have put up significant barriers. SH:24 do offer a range of alternative options (kits are available to pick up in GP practices and pharmacies and we operate a click and collect service in some clinics) however return rates for these 'offline' options tend to be low.	Thank you. The committee noted that the digital divide could potentially widen health inequalities because not everyone who might want to order a remote self-sampling kit would necessarily have access to online ordering services, so they considered it important to ensure a range of 'offline' options were also available.

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SH:24	Guideline	009	019	Rec 1.2.6 In online services, data on return rates of kits is available very quickly (e.g. with 2 days of a kit being returned), enabling timely and continuous monitoring of kit return rates amongst local populations.	Thank you for this useful information.
SH:24	Guideline	010	009	Rec 1.2.9 We agree. In our experience services almost certainly get better responses, particularly from young people, if recall messages use low-level tailoring such as the first name of the service user.	Thank you. The evidence and experiences of committee members agreed that low-level personalisation can be effective.
SH:24	Guideline	010	013	Rec 1.3.1 Agree, we offer a digital PN tool with signposting to services for all partners of service users who we have prescribed treatment for.	Thank you for your endorsement of this recommendation.
SH:24	Guideline	011	012	Rec 1.3.4 Agree, we would recommend the use of an online PN tool which allows users to notify partners anonymously.	Thank you. The committee discussed the potential of online PN but did not consider it necessary to explicitly mention online PN in the recommendations, although they agreed to add reference to online PN in the rationale and impact section. The importance of options for anonymously notifying partners is outlined in recommendation 1.3.2.
SH:24	Guideline	021	005 - 009	Research recommendations for remote self-sampling: We agree these are important research questions and we would be happy to support in any further development of these research objectives.	Thank you for your support.
SH:24	Guideline	022	001 - 003	Research recommendation for delivering effective sexual health services: We agree this is an important research question and we would be happy to support in any further development of this.	Thank you for your support.
UCL Centre for Population Research in	Guideline	005 - 006	007 - 009	on p.5; 2 on p.6 Whilst it is good practice and beneficial to consult groups with greater sexual health needs (and p.6, line 2: "Co-	Thank you. The committee discussed this and acknowledged that it may be more difficult to engage with some groups. Although they recognised the

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Sexual Health and HIV				produce services and interventions with the groups that they are for"), some groups are less visible and/or less willing to contribute to such consultations, so how will their voices heard and be taken account?	challenge of public and service-user involvement, they emphasised its importance and agreed it should be done. A sentence has been added to the rationale and impact section to acknowledge this.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	009	016 - 018	Again, shouldn't online options be mentioned here: "Widen access to self-sampling kits. For example, by having a system for 16 people to order a kit by phone, or providing self-sampling kits through 17 'pop-up' or outreach services."	Thank you. 'Online' has been added to recommendation 1.2.5.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	010	002 - 005	This aligns with my third comment re. not simply catering for the needs of those most visible/vocal at the expense of overlooking under-served groups and individuals (as per line 5).	Thank you for your endorsement of this recommendation
UCL Centre for Population Research in Sexual Health and HIV	Guideline	011		We wish the Committee's attention to the work of the NIHR-funded LUSTRUM programme of research (https://www.lustrum.org.uk/), which included an evidence-based process to develop new PN outcomes and inform standards of care. These include six new PN outcome measures at five stages of the cascade, including stratification by sex partnership type (as recognised in lines 7-8). A summary of this work is published in *Eurosurveillance* (https://doi.org/10.2807/1560-7917.ES.2022.27.3.2001895)	Thank you. The published study was not included the partner notification review as it was published after the review was completed. The committee were aware of the LUSTRUM programme and acknowledged the importance of PN outcome measures and sex partnership types. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date and to ensure these outcomes are taken into account next time this guideline is updated.
UCL Centre for Population Research in	Guideline	011	020 -021	The BASHH statement cited (https://www.bashh.org/documents/4445.pdf) is dated 2012 but is due to be updated this year (2022) taking on board findings from the LUSTRUM study, summarised in	Thank you. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure

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Sexual Health and HIV				*Eurosurveillance* (https://doi.org/10.2807/1560-7917.ES.2022.27.3.2001895)	that they are up to date and will monitor the publication of this update.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	011	023 -024	The recommendation tallies with qualitative research undertaken with MSM in England that found support for the development of new interventions that use dating apps and social media for sexual health promotion, including with respect to STI risk reduction and STI testing – see: https://doi.org/10.1186/s12889-019-7558-7	Thank you for this reference that supports the use of dating apps and social media in sexual health care, although it does not reference partner notification.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	022	001 - 003	We wish to draw the Committee's attention to qualitative and quantitative research undertaken with gay, bisexual and other MSM recruited from the community (rather than sexual health clinics) as part of the NIHR-funded Health Protection Research Unit in Blood-borne and Sexually Transmitted Infections. This research showed that understanding MSM's awareness of, and attitudes towards, STIs is essential in developing health promotion interventions to reduce STI transmission, and although some MSM are well informed, there is a widespread lack of knowledge about the prevalence, modes of transmission, health implications and treatment regimens of particular STIs [https://doi.org/10.1071/SH18025]. A significant proportion of MSM engaging in STI risk behaviours do not test as per the recommendations, such that again, there is a need to improve STI knowledge, and from this research, especially among HIV-negative/unknown-status men [DOI: 10.1111/hiv.12753.] Since the	Thank you. We will pass this comment on to the NICE surveillance team who will monitor for the publication that is in preparation. The evidence and the committee discussion agree with your view that awareness and knowledge are key factors in health promotion with people with greater sexual health or access needs and wrote recommendation 1.1.8 to reflect this.

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				introduction of COVID-19 restrictions, and the shift in the provision of sexual healthcare, there seems to have been an exacerbation of health inequalities in terms of those MSM more prone to experiencing adverse sexual health outcomes being more likely to have an unmet need for STI and HIV testing. This evidence was presented at the British Association of Sexual Health and HIV Annual conference in October 2021 (presentation V11) and the corresponding paper is currently under review with BMJ *Sexually Transmitted Infections.* In terms of the impact of COVID-19 restrictions on the delivery of effective sexual health services, we also draw the Committee's attention to the findings of the Natsal-COVID study (https://www.natsal.ac.uk/natsal-covid-study), and in particular the recently-published paper that investigated the impact of COVID-19 on sexual health service use and unmet need in the British population as a whole [doi: 10.1016/S2468-2667(21)00253-X]. This paper from the first wave of the study concluded that many people accessed still accessed sexual health care during the 4 months following the initial lockdown but young people and those reporting sexual risk behaviours reported difficulties in accessing services such that services might need to address a backlog of need. Findings from wave 2 of Natsal-COVID that reports sexual and healthcare seeking behaviour in the full year following the initial lockdown are due to be made available as a pre-print shortly ahead of peer-reviewed publication.	

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UCL Centre for Population Research in Sexual Health and HIV	Guideline	023	011 -016	This recommendation seems contradictory: "…made group-specific recommendations problematic […] Nevertheless, they agreed that interventions should be tailored to the needs of specific groups,…"?	Thank you. This section has been edited to ensure it makes sense.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	023 - 024	032 -003	Completely agree that identifying groups should be evidence-based but we need to recognise that there are some groups, for example heterosexually-identifying MSM , some ethnic groups, where the evidence may be limited or not as robust, but that does not necessarily mean these groups do not need prioritising. Doing so – i.e. not just 'going for the low hanging fruit' – may therefore have resource implications to understand the prevalence and needs of these under-served groups, especially at a local level.	Thank you. The committee were of a similar view, and further agreed that even though it may be challenging to engage with some groups, local providers should have plans to actively engage with underserved groups. The rationale and impact section has been updated to reflect this.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	024	015 - 018	"Additional appointment time would be needed for conversations about risk reduction, …" as recognised elsewhere, not just conversations about STI risk reduction rather sexual wellbeing more broadly and potentially other needs, eg alcohol / drug dependency. Indeed for some groups may find a focus on risk reduction off-putting, such that there may be a need to flip the focus to a more sex-positive approach in order to appeal to those who are not accessing sexual health services but who have need(s) to do so.	Thank you. Sexual wellbeing has been added to this sentence.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	025	006 - 009	It is commendable to propose that "data from various sources […] should be used to commission and provide services to meet local need" but that commissioners need to understand how to source and use the available data, recognising that while data for a local area are sometimes limited, regional and national data (e.g.	Thank you. The committee expect local commissioning bodies to have these skills, and could be supported by local public health and health intelligence staff.

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				national surveys like Natsal) as well as non-sexual health-focused data (e.g. census data) can also be informative in understanding a local population and its sexual health needs, although this can involve data manipulation and therefore skills in how to do so.	
UCL Centre for Population Research in Sexual Health and HIV	Guideline	026 - 027	027 - 003	Line 27 recognises "…regional variations in [sexual health] provision…" so lines 29-31 seem contradictory "…to support people in accessing the service that is right for them…" Many areas of the country do not have a range of sexual health services for people to choose what "is right for them". Furthermore, the recommendation (line 3, p.27) to offer a choice of sexual health provision "as part of broader support services, for example in drug and alcohol services, or within HIV care services" seems even unrealistic for those not living in/close to urban centres. For both recommendations, the potential role of online services to provide this choice and the option of integrated care is not mentioned, which seems an oversight especially given the shift to online sexual health services seen during COVID restrictions.	Thank you. A sentence has been added to the section to highlight the importance of online services.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	028	014 -016	(and p.21) (4-9 on p.21) As the Committee is no doubt aware, the NIHR-funded projects ASSIST (https://www.ucl.ac.uk/global-health/research/z-research/assist) and Sequence Digital (https://www.sequencedigital.org.uk/) are investigating the potential for the digital divide exacerbating health inequalities.	Thank you. This has been added to the equality impact assessment as a potential risk.
UCL Centre for Population Research in	Guideline	031	027 -028	We are concerned that there seems to be a lack of recognition of the limited resource for "making people **aware** of the different partner notification methods", aside from actually offering **support** for patient-led	Thank you. The reference to making people aware of the different partner notification methods was not in relation to general awareness raising approaches but was specifically about discussing the different methods with

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Sexual Health and HIV				referral and giving real choice of PN methods (e.g. provider referral) - and not just in non-specialist sexual health services (e.g. general practice) but increasingly in specialist sexual health services too.	the person attending for partner notification and ensuring they understand the range of methods and options available to them. This would be part of the support offered to individuals so additional resource for general awareness raising activities would not be required.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	032	023 -024	We agree that "…provider referral may be the most appropriate method when the person expresses a desire to remain anonymous" but are concerned as to the extent that services can provide this PN method in practice.	Thank you. The committee recognised that not all services would be able to undertake provider referral so made a recommendation about referral to specialist sexual health services when further support with PN is required. They recognised that those specialist services would have staff with expertise in contact tracing and counselling, as outlined in recommendation 1.3.5, so would be able to provide this PN method.
UCL Centre for Population Research in Sexual Health and HIV	Guideline	033	001 - 003	We note that "these recommendations are already within the scope of practice **of services that undertake partner notification**…" recognising that (i) not all services are able to undertake PN despite p.31 lines 21-23 acknowledging that PN is "one of the most important ways of preventing reinfection and reducing the transmission of STIs"; and (ii) while these recommendations maybe "already within the **scope** of practice of services that undertake partner notification" that does not necessarily tally with these services being able to do so in practice due to budget constraints.	Thank you. The committee agreed and made a recommendation to reflect this (1.3.4).
UCL Centre for Population Research in Sexual Health and HIV	Guideline	033	003 - 005	As well as the resource impact for those services needing "to improve their practices in this area", it needs to be recognised that some PN activity is more resource intensive for services than others. In addition to provider referral requiring greater budget than patient referral generally, it needs to be recognised that sexual partners	Thank you, the committee reached a similar conclusion and also made a recommendation about using geospatial networking apps for tracking partners (1.3.6).

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				of index patients that are more casual in nature are likely to more likely to require provider referral, but that the public health gain of reaching casual partners and getting them tested/treated is far greater than achieving this with more regular/steady/cohabiting partners. This is because casual partners are more likely to have other partners/experience greater partner change rates and so have a greater potential for onward transmission of STIs. Therefore PN that targets casual partners, rather than regular or live-in partners, prevents more secondary transmissions per partnership; it is also more resource intensive, but the public health benefit is greater – see doi: 10.2105/AJPH.2011.300211	
UCL Centre for Population Research in Sexual Health and HIV	Evidence Review A	General	General	It is unclear why studies involving digital interventions are excluded. This seems short-sighted given the increasing role of digital in the delivery of healthcare.	Thank you. Digital interventions were excluded because this is covered in the Behaviour change: digital and mobile health interventions guideline, which has a specific section on sexual health
UK Health Security Agency (UKHSA)	Guideline	General	General	Sec 1.1 Suggest adding that commissioners and providers of sexual healthcare should promote/advertise their services to make it easier for people to navigate to the most appropriate service to meet their needs. This will support self-referral and meet their needs.	Thank you for your suggestion. The committee discussed this and agreed that many sexual health services already do this in a range of ways (e.g. posters advertising services, outreach services, offering a range of service options such as online, remote, clinic-based and in non-clinical settings). They also agreed that this was covered in 1.1.1 by recommending networks of services that can help people navigate to the most appropriate service to meet their needs.
UK Health Security Agency (UKHSA)	Guideline	General	General	Sec 1.1 Consider merit to also talking about access to sexual health services for the general population as well as groups with the greatest sexual needs.	Thank you. The recommendations in section 1.1 were based on evidence for higher risk groups only so it was

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					not possible to make specific recommendations for the general population here. However, the committee agreed to amend the wording of 'who is it for' from "people with an STI or who are at high risk of having one" to "sexually active people," to make it clear that the guideline is not just for those with greater sexual health needs.
UK Health Security Agency (UKHSA)	Guideline	General	General	Sec 1.2 Consider reference to the role of clinic-based services in terms of a) screening people with no symptoms and b) testing people with symptoms.	Thank you. The wording of 1.2.2 has been changed to emphasise that remote self-sampling for people without symptoms is an option, but that clinic-based services could also be an option.
UK Health Security Agency (UKHSA)	Guideline	General	General	Consider the rationale for including PrEP in this document and excluding other HIV prevention interventions such as PEP as HIV treatment as prevention.	Thank you. The decision to include PrEP and not PEP and TasP was made during the scoping phase of this guideline, and consulted on in August/Sept 2019. The decision to include PrEP was made in support of the then ongoing PrEP trial in the UK.
UK Health Security Agency (UKHSA)	Guideline	General	General	Consider the rationale for including sections on vaccination and PrEP but not including a section on condoms.	Thank you. NICE has a guideline on condoms (NG68). The decision about what to include in this guideline was made during the scoping phase and consulted on in August/Sept 2019.
UK Health Security Agency (UKHSA)	Guideline	General	General	Unlike the 2007 version as these recommendations are not directed to specific actors it is not clear who should be taking on each of the actions and there is a concern that they lose focus as a result.	Thank you. In the broad context of healthcare delivery it is often not useful to specify an actor because many different professionals may be providing the same service in different ways, in different settings and in different areas. The sexual health care sector in particular is in flux, and often many different actors provide different services across a range of settings, including third sector and voluntary organisations, so it is not always possible to specify who should take on each action.

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UK Health Security Agency (UKHSA)	Guideline	006	008	Rec 1.1.7 Given the importance of condoms in relation to protection from STIs (and unintended conceptions) it is good to see reference to condoms. Could the document consider more reference to condoms to give equivalent prominence to other protective measures for instance vaccination and PrEP?	Thank you. NICE has a guideline on condoms (NG68) so condoms were not given equivalent prominence in the scope. The decision about what to include in this guideline was made during the scoping phase and consulted on in August/Sept 2019. The guideline contains a link to the NICE guideline on sexually transmitted infections: condom distribution schemes in recommendations 1.1.8 and 1.5.3.
UK Health Security Agency (UKHSA)	Guideline	006	019	Rec 1.1.7 Consider referencing PrEP and vaccination here as additional examples of risk reduction intervention. Help create thread to the sections on PrEP and vaccination.	Thank you. The recommended components outlined in 1.1.8 were based on evidence that focused on interventions to reduce or prevent the acquisition and transmission of STIs and excluded PrEP or vaccinations. These interventions have separate sections in the guideline so the committee did not consider it necessary to also reference them in 1.1.8.
UK Health Security Agency (UKHSA)	Guideline	007	021	Rec 1.1.10 Can interventions be described or referenced – condoms, PrEP and PEP, vaccination etc. – as well as the settings.	Thank you. The recommendation focuses on the potential to deliver sexual health interventions across a range of services and relates specifically to the interventions described in recommendations 1.1.7 to 1.1.10 rather than other interventions such as condoms, PrEP, PEP and vaccinations.
UK Health Security Agency (UKHSA)	Guideline	008	018	Rec 1.1.14: The UK Health Security Agency (formerly Public Health England), provides guidance and resources for practitioners to undertake evaluations of sexual health services. If appropriate, it would be helpful to readers to signpost to these resources: https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-services-evaluation-resources	Thank you for highlighting this resource. It has been added to the rationale and impact section as a possible resource to help with service evaluation.

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UK Health Security Agency (UKHSA)	Guideline	009	019	Rec 1.2.6: This recommendation simply makes reference to 'groups who are not making use of self-sampling', whereas the real concern is that self-sampling widens existing inequalities, and those who most need to access STI testing are least likely to use self-sampling. (For example see: Sonubi T et al The relationship between socioeconomic deprivation and chlamydia screening in England - an analysis of national surveillance data, 2015-2019. In: Poster presented at: BASHH Annual Conference 2020, Virtual.) We would therefore suggest that this recommendation needs to talk more specifically about the need to monitor the impact on groups in greatest need /impact on inequalities.	Thank you. The wording of recommendation 1.2.6 has been amended to "Monitor provision and return rates of kits to identify any groups that have low rates of accessing or returning them. Take action to try to address the reasons for the low rates."
UK Health Security Agency (UKHSA)	Guideline	009	019	The supporting evidence (Evidence reviews D) acknowledge that the cost effectiveness of STI testing provided via self-sampling is very sensitive to return rate. This is not drawn out sufficiently in the recommendations. This recommendation (1.2.6) mentions return rates, but in relation to accessibility, with no reference to cost effectiveness. We would suggest that there needs to be a clear recommendation related to return rates and cost effectiveness.	Thank you for your comment, and we agree that one of the key parameters that drives the cost-effectiveness of self-sampling is return rates. The committee were keen to stress that issues with lower return rates should not be used as a reason not to have self-sampling available as an option, but instead areas should look to identify reasons for these low return rates and take action to improve them. The wording of this recommendation has been amended to make this clearer – in particular it now references both monitoring of overall kit return rates, as well as looking at differences in request or return rates between different populations.
UK Health Security Agency (UKHSA)	Guideline	012	016	Rec 1.4.3 - providing vaccinations during routine health appointments – this can only occur in settings where there is infrastructure to store and staff trained to administer vaccines – what did the panel consider as the range of possible venues?	Thank you. The committee agreed that there was a range of settings where appropriately trained staff could store and administer these vaccines and they did not want to limit the settings with an exhaustive list.

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UK Health Security Agency (UKHSA)	Guideline	012	021	Rec 1.4.4 – To "confirm that the person has received the reminder" is a very specific recommendation and potentially difficult to do; and is also only necessary for those that do not respond to the earlier reminder.	Thank you. This sentence has now been removed from recommendation 1.4.5
UK Health Security Agency (UKHSA)	Guideline	013	017	Rec 1.5.3 Consider adding reference to condoms. Suggest 'ensure that all sexually active people understand that condoms are for protection from sexually transmitted infections including HIV as well as unintended conceptions'.	Thank you. This recommendation has been edited to include reference to barrier methods.
UK Health Security Agency (UKHSA)	Guideline	014	001	Rec 1.5.5 Consider reference to combination prevention rather than PrEP alone. Suggest 'use peer support to normalise the use of combination prevention including the use of condoms and PrEP'.	Thank you. The committee discussed this but agreed that it was adequately covered elsewhere. They thought that adding it to this recommendation would dilute the message about PrEP.
UK Health Security Agency (UKHSA)	Evidence review D	007	021	1.1.9.1 The outcomes that matter most – it is clearly stated here that the 'committee agreed that the re-testing rate was also very important since people who continue to be at very high risk need to test regularly'. There is also evidence that those who previously test positive are more likely to test positive subsequently. Despite this, the guideline includes no recommendation on re-testing either of those who have previously tested positive, or for those who remain at high risk. We would suggest a recommendation (or number of recommendations) should be included in relation to this in the guidelines.	Thank you. The committee discussed this and added commentary about the importance of re-testing to the rationale and impact section of the guideline. They agreed that many of the recommendations they had made about strategies to increase STI testing uptake would also apply to increasing the frequency of testing in very high risk groups.
UK Health Security Agency (UKHSA)	Evidence review	057	001 - 005	Re: "The modelling found that, assuming self-sampling interventions were as effective in real world settings as in the identified RCTs, offering this as an intervention would be highly cost-effective, with the additional costs generated by the higher volume of tests requested generating considerable additional QALYs, as well as	Thank you for your comments. A number of sensitivity and threshold analyses were conducted as part of the modelling, and the committee discussed both these and the limitations of the model in detail. These sensitivity

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				some downstream savings from prevented complications and secondary infections." 1.1 Were the assumptions used subject to either sensitivity analyses or mentioned as possible limitations in the discussions? Re: "Long-term complications for each STI were included in the model and assumed to be averted if the STI is diagnosed, and therefore, treated. The cost and health impact of testing was estimated by calculating the number of complications averted from excess cases being detected through remote self-sampling, which would have otherwise remained untreated." - The costs averted are probably overestimated if based on the assumption that all complications would be prevented, as asymptomatic testing would likely diagnose some infections past the point of irreversible progression to complications. Plus, any noncompliance with treatment (shown as assumed to be 100% in fig 1.7). - Was the assumption that all remote self-sampling diagnoses would have remained undiagnosed? If so, this would be another probable cause of over-estimation of benefit.	analyses are all presented in the write-up of the model (appendix I in evidence review C). On your points around the estimation of averted complications, it was assumed that all excess STIs detected with home testing are treated and not associated with the development of downstream costs. A limitation of this is that there is overestimation of the clinical benefits of home testing. However, it is difficult to accurately calculate how many of the STIs, though treated, are past the point of full clinical recovery, with the added complexity that this would differ between the STIs considered. If this were to be modelled, additional assumptions will be required which will add further uncertainty to the model and would likely not be based on robust evidence. This includes assumptions around the extent to which each STI must progress before it results in downstream clinical consequences as well as assumptions regarding what proportion of sexual partners would still be at risk of infection from a positive partner for the excess cases that are identified and treated. Data to inform the latter component in particular is difficult to source. The committee noted the result of this may be to slightly overestimate potential downstream benefits, but also noted a number of areas where the model was likely to underestimate benefits. For example, cost data used to inform the model are likely to be greater than the actual costs, due to either being based on London prices (which may be higher) or costs sourced from previous

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				1.2 Is the assumption that all partners (of an infected person) with condom less sex are infected? This would overestimate the benefits due to infections prevented by remote testing. **Summary response** Consider whether the cost effectiveness of remote testing has been overestimated? Strongly recommend an expert peer review of the model is considered before basing recommendations based on its findings. In the absence of a peer review, at the very least, we would recommend that it is clearly stated that great caution should be advised against reliance on these modelling figures as the basis for recommendations.	years, where this may be lower now (due to greater uptake of home self-sampling, and consequent reduction in costs due to economies of scale). Lower costs for self-sampling kits would of course increase the cost-effectiveness of the intervention from that estimated in the model. The model does not assume all partners of an infected person with condom less sex are infected, but instead uses probabilities of infection for different STIs (65% for chlamydia based on partner notification data, and a conservative estimate of 20% for gonorrhoea and syphilis due to the lack of equally robust data for those STIs). The model assumptions and results have all been validated with the guideline committee, as well as subject to public consultation. We agree that reliance on these modelling results alone would be inappropriate for making recommendations, and the committee considered the full totality of the evidence available (RCTs, qualitative and economic) as well as their own knowledge and experience when making their recommendations.
ViiV Healthcare UK LTD	Guideline	038	026 - 030	***The text states*** **'**The committee were also interested in the potential adherence benefits of offering long-acting PrEP, and noted that some people may prefer it to taking tablets. However, they thought there was insufficient evidence to recommend it and that research was needed to establish whether it is as effective as PrEP tablets'	Thank you. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. They will monitor these for publication.

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ViiV Healthcare UK LTD	Evidence Review G	489		**L.3.1** ***The text states*** **'**The committee were also interested in the potential adherence benefits of offering long-acting PrEP, and noted that some people may prefer it to taking tablets. However, they thought there was insufficient evidence to recommend it and that research was needed to establish whether it is as effective as PrEP tablets' **This text was identified as confidential and has been removed**	Thank you. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. They will monitor these for publication.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*