NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Reducing sexually transmitted infections

Draft for consultation, December 2021

This guideline covers interventions to prevent sexually transmitted infections (STIs). It aims to reduce the transmission of chlamydia and other STIs, including HIV, and includes ways to help increase the uptake of vaccines and STI testing.

This guideline will replace NICE guideline PH3 (published February 2007).

Who is it for?

- Commissioners of sexual health services, including local authorities, Integrated Care Systems (ICS) and NHS England
- Providers of sexual health services, including GPs who offer level 1 or level 2 sexual health services
- Healthcare professionals and others involved in delivering or signposting to sexual health services
- Voluntary organisations and advocacy groups that provide or have an interest in STI prevention
- People with an STI or who are at high risk of having one, or who use sexual health services, their families and carers

What does it include?

- the recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice.

- the guideline context.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

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Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

These recommendations should be read in conjunction with relevant NICE guidelines on sexual health and contraception..

1.1 Preventing people getting and transmitting STIs

Meeting the needs of groups with greater sexual health needs

1.1.1 Target interventions at groups with greater sexual health needs. Identify local needs and priorities using data from the Joint Strategic Needs Assessment (JSNA) and other data sources.

1.1.2 Engage with groups with greater sexual health needs to understand how best to meet their sexual health and wellbeing needs. Take into account factors such as existing barriers to access (for example, for people with learning difficulties, or because of their gender or sexuality), language and other socioeconomic factors, including deprivation.

For a short explanation of why the committee made these recommendations see the rationale and impact section on meeting the needs of groups with greater sexual health needs.

Full details of the evidence and the committee's discussion are in evidence reviews A: evidence review for interventions to reduce the acquisition and transmission of STIs in high risk groups; and B: qualitative evidence synthesis for

the acceptability of interventions for reducing or preventing the acquisition and transmission of STIs.

Accessing sexual health services

1.1.3 Form a network of services providing sexual healthcare for an area to ensure that everyone who needs it is signposted to, and can access, the care they need. Ensure that local pathways are in place to link people into the best possible care for them, including those that are traditionally underserved.

1.1.4 Determine the most appropriate settings, in consultation with the groups with greater sexual health needs, in which to deliver services and interventions to increase access and uptake.

1.1.5 Reduce barriers to services for groups with greater sexual health needs populations by:

- emphasising confidentiality, empathy and a non-judgmental approach
- offering access to a translator or interpreter instead of waiting for the person to ask, to ensure they are fully able to communicate and understand
- making sure staff are familiar with people's entitlements to services and that they do not refuse access to someone who is entitled to the service, for example, open access to sexual healthcare regardless of the location of the service or their area of residence
- supporting people to attend appointments and engage with treatment and wider support
- taking part in outreach activities to bring the services you provide as a health and care professional to the community.

Take into account guidance on making services more welcoming and inclusive, such as the Department of Health's 'You're Welcome' quality criteria or Public Health England's Inclusion health: applying All Our Health.

For a short explanation of why the committee made these recommendations see the rationale and impact section on accessing sexual health services.

Full details of the evidence and the committee's discussion are in evidence reviews A: evidence review for interventions to reduce the acquisition and transmission of STIs in high risk groups; and B: qualitative evidence synthesis for the acceptability of interventions for reducing or preventing the acquisition and transmission of STIs.

Co-producing interventions to reduce STI transmission

1.1.6 Co-produce services and interventions with the groups that they are for, in line with NICE's guideline on community engagement. Ensure that interventions are culturally competent (including being delivered in a suitable language for people whose main language is not English). This includes recognising that people may be engaged in activities that their culture or peers would not approve of.

1.1.7 When co-producing interventions for the groups identified from the JSNA and other data sources (see recommendation 1.1.1) to reduce the risk of people acquiring or transmitting STIs, include some or all of the following components:

- Information and education about STIs
- information about the rates of STIs to explain why some groups are at higher risk
- sex-positive approaches to consistent and correct use of barrier methods, including providing condoms in different sizes and textures (see NICE's guideline on sexually transmitted infections: condom distribution schemes)
- risk assessment and risk-reduction activities, for example developing personalised risk-reduction plans, identifying triggers and setting goals
- Information Motivation Behavioural skills (IMB) model approaches and motivational interviewing techniques to guide conversations about risk

reduction or safer-sex practices and address informational, motivational and skills-based barriers to change

- activities to increase sexual self-efficacy (for example talking about sexual consent, condom negotiation and negotiating sexual preferences) and broader self-efficacy (for example, self-esteem), exploring the links between emotion and sexual behaviour, and coping skills - for example, using cognitive behavioural approaches
- a plan for follow-up - for example, repeated contact to review progress or make new plans.

1.1.8 Take into account the recommendations in the NICE guidelines on behaviour change when designing or co-producing interventions to reduce STIs.

1.1.9 Tailor interventions to the needs of the groups identified and take into account safety concerns, stigma and discrimination. Be aware that membership of a particular group does not imply that a person is necessarily at high risk of getting an STI. Address this with cultural competency (that is, take into account factors such as language, cultural norms and expectations about sexual behaviour).

For a short explanation of why the committee made these recommendations see the rationale and impact section on co-producing interventions to reduce STI transmission.

Full details of the evidence and the committee's discussion are in evidence reviews A: evidence review for interventions to reduce the acquisition and transmission of STIs in high risk groups; and B: qualitative evidence synthesis for the acceptability of interventions for reducing or preventing the acquisition and transmission of STIs.

Delivering and evaluating interventions to reduce STI transmission

1.1.10 Deliver interventions to reduce STIs across a range of services, including within broader support interventions and community services (for

example, in drug and alcohol services, HIV care and mental health services).

1.1.11 Think about whether one-to-one or group delivery is the most appropriate for the community the intervention is aimed at, and the content and aims of the intervention. Take into account people's preferences and any resource impact.

1.1.12 If possible, ensure that people have the opportunity to have interventions that are delivered by peers or other trusted people they can relate to, who share a cultural or group background with the target group.

1.1.13 When delivering interventions:

- Avoid making assumptions about people or judging them. This could include using gender neutral language and recognising different kinds of relationships and sexual behaviours.
- Be sex and identity positive (for example, by using gender-affirming language and being respectful of the sex they have). Focus on self-worth and empowering people to have autonomy over their bodies and their sexual decision making.

1.1.14 Commissioners and providers should regularly evaluate interventions, including the methods used to co-produce them, to determine their effectiveness and acceptability and identify gaps to make service improvements across the pathway.

For a short explanation of why the committee made these recommendations see the rationale and impact section on delivering and evaluating interventions to reduce STI transmission.

Full details of the evidence and the committee's discussion are in evidence reviews A: evidence review for interventions to reduce the acquisition and transmission of STIs in high risk groups; and B: qualitative evidence synthesis for

the acceptability of interventions for reducing or preventing the acquisition and transmission of STIs.

1.2 Improving uptake and increasing the frequency of STI testing

Self-sampling

1.2.1 Offer a range of STI testing options based on local need, including remote self-sampling, in-person attendance at specialist clinics or in primary care, and outreach services.

1.2.2 Offer people without symptoms remote self-sampling STI services as an alternative to clinic attendance.

1.2.3 Ensure that local service websites give up-to-date information on which testing options are available in their area.

1.2.4 Ensure that testing kits meet the NHS Accessible Information Standard and are inclusive (for example, addressing the needs of trans and gender diverse people, being available in different languages or being available in different formats such as videos targeted at people with learning difficulties).

1.2.5 Widen access to self-sampling kits. For example, by having a system for people to order a kit by phone, or providing self-sampling kits through 'pop-up' or outreach services.

1.2.6 Monitor the return rates of kits to check they are accessible to local populations and to highlight groups who are not making use of self-sampling.

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on self-sampling to improve the uptake and increase the frequency of STI testing.

Full details of the evidence and the committee's discussion are in evidence reviews C: evidence reviews for effectiveness, acceptability and cost effectiveness of strategies to improve uptake of STI testing; and D: evidence reviews for effective and cost-effective interventions to increase frequent STI testing in very high-risk groups.

Tailoring interventions

1.2.7 Tailor interventions and information to the target users of the service. Ensure that the tailoring does not exclude other groups. (See also recommendation 1.1.9.)

1.2.8 Recognise people's individual needs. Be aware that membership of a particular group does not imply that a person is necessarily at high risk of an STI. Address this with cultural sensitivity and competency within the context of sex-positive approaches.

1.2.9 Consider personalising automated recall messages using low-level tailoring, for example adding the name of the person and clinician to the message.

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on tailoring interventions to improve the uptake and increase the frequency of STI testing.

Full details of the evidence and the committee's discussion are in evidence reviews C: evidence reviews for effectiveness, acceptability and cost effectiveness of strategies to improve uptake of STI testing; and D: evidence reviews for effective and cost-effective interventions to increase frequent STI testing in very high-risk groups.

1.3 Partner notification

1.3.1 Regardless of where testing takes place, encourage people diagnosed with an STI to engage in partner notification and signpost them to services that do this.

1.3.2 Advise people diagnosed with an STI about the importance and benefits of partner notification, the possibility of sex partners being infected even if asymptomatic, and the risk of reinfection. Discuss the different methods of partner notification with them.

1.3.3 Help people decide how to notify their sex partners. Discuss ways of having these difficult conversations and suggest ways to deliver this information. Discuss the best method of partner notification in light of the person's relationship status and other circumstances. Alternative methods of disclosure may need to be used in different contexts (for example, those who may be at risk of domestic violence, or if the person expresses a need for anonymity).

1.3.4 If a person feels unable to tell their sex partners about the STI or is showing signs of difficulty dealing with their diagnosis, refer them to specialist sexual health services that can offer them more support with partner notification.

1.3.5 Ensure that there is a clear referral pathway to specialist sexual health services that can help with partner notification so that people can be referred seamlessly and without the need for self-referral.

1.3.6 Partner notification on behalf of a person with an STI should be carried out by professionals with expertise in contact tracing and counselling in line with the BASHH statement on partner notification for sexually transmitted infections.

1.3.7 Consider how geospatial networking apps may be used for partner notification, for example by:

- suggesting that people who use geospatial networking apps to find sex partners use the apps to notify partners about contacting a sexual health service for STI testing
- using app profiles to inform contacts of their need to be tested when notifying partners on behalf of a person with an STI.

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on partner notification.

Full details of the evidence and the committee's discussion are in evidence review E: evidence reviews for partner notification methods to prevent or reduce STIs.

1.4 HPV and hepatitis A and B vaccination in gay, bisexual and other men who have sex with men

1.4.1 Consult local gay, bisexual and other men who have sex with men to identify their needs and the barriers to vaccine uptake and course completion.

1.4.2 Opportunistically discuss HPV, hepatitis A and hepatitis B vaccination with gay, bisexual and other men who have sex with men who are eligible for the vaccines (see NHS information on HPV vaccine eligibility, hepatitis A vaccine eligibility and hepatitis B vaccine eligibility). Give them information on HPV, hepatitis A and hepatitis B vaccination, including:

- the diseases and their potential severity
- the risks and benefits of vaccination, including individual benefits and, if relevant, population benefits (protecting other people in their community)
- the importance of having all doses of a vaccination course.

1.4.3 Consider providing HPV and hepatitis vaccination during other routine health appointments for gay, bisexual and other men who have sex with men.

1.4.4 Identify gay, bisexual and other men who have sex with men who do not return for follow-up vaccinations (second and third doses), and send a reminder. Confirm that the person has received the reminder.

For a short explanation of why the committee made these recommendations see the rationale and impact section on HPV and hepatitis A and B vaccination in gay, bisexual and other men who have sex with men.

Full details of the evidence and the committee's discussion are in evidence review F: evidence reviews for increasing uptake of hepatitis A, hepatitis B and human papillomavirus (HPV) vaccinations in gay, bisexual and other men who have sex with men.

1.5 Pre-exposure prophylaxis for HIV

These recommendations should be read in conjunction with NICE's guideline on HIV testing: increasing uptake among people who may have undiagnosed HIV.

Encouraging take up of pre-exposure prophylaxis for HIV

1.5.1 Raise awareness of pre-exposure prophylaxis (PrEP) among local groups with greater sexual health needs:

- Use methods designed to target specific populations (for example, social media and relevant local organisations or groups).
- Follow the advice in NICE's guideline on community engagement.
- Pay particular attention to groups in which PrEP is less well-known or uptake is lower, such as trans people, cisgender women, young people (aged 16 to 24), people with a Black African or Caribbean family background and people from a lower socioeconomic status background.

1.5.2 Give relevant local community groups support and information resources to help them raise awareness of PrEP and increase trust in services.

1.5.3 Ensure that people in groups with greater sexual health needs understand that PrEP is for HIV prevention only and that it does not protect against other STIs.

1.5.4 Co-produce materials that target specific information gaps and causes of stigma within the target population.

1.5.5 Use peer support to normalise PrEP use, reduce all forms of stigma (originating from the person themselves, professionals and the wider society) and increase trust in services.

1.5.6 Tell trans people undergoing medical transition that there are no clinically significant interactions expected between PrEP and the common hormones used in this process, and that using PrEP will not affect their transition.

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on encouraging take up of pre-exposure prophylaxis for HIV.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV.

Service design for PrEP services

1.5.7 Ensure that services offering PrEP are welcoming and accessible (see recommendation 1.1.5) for all the different population groups who are eligible, for example by co-designing services with the key population groups. Ensure that tailoring services to specific communities does not exclude or alienate other groups.

1.5.8 Raise awareness among healthcare professionals (particularly those in primary care, community settings and gender identity clinics) about which groups of people are eligible for PrEP. This could be done through continuing education or through commissioning (for example, through local networks see recommendation 1.1.3).

1.5.9 Provide protected time for healthcare professionals who have day-to-day contact with people eligible for PrEP to have training on relevant issues.

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on service design for PrEP services.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV.

Access to PrEP services

1.5.10 Services that do not provide PrEP should connect people who are interested in PrEP and eligible for it to a service that can prescribe it.

1.5.11 Ensure there are clear referral pathways between services that do not provide PrEP and those that do.

1.5.12 Make provision for people who want to be referred to services outside their local area or community.

See also recommendation 1.1.3.

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on access to PrEP services.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV.

Prescribing PrEP

Recommendations 1.5.13 to 1.5.19 support recommendations in the BHIVA/BASHH guidelines on the use of PrEP for HIV and should be implemented with reference to them.

1.5.13 Support people who are taking PrEP, for example in decisions around the use of condoms and dental dams and attending follow-up appointments.

Continue to offer them all other relevant sexual health services, such as information, behavioural support and condom provision.

1.5.14 Offer PrEP to people at high risk of HIV, using the criteria in the BHIVA/BASHH guidelines.

1.5.15 Support people who are taking PrEP to get regular HIV testing and STI screening (every 3 months).

1.5.16 Give people taking PrEP tailored information and education on effectiveness, adherence, side effects and monitoring risks (see NICE's guideline on shared decision making).

1.5.17 Follow up people taking PrEP in line with the good practice points in the BHIVA/BASHH guidelines.

1.5.18 Monitor the kidney function of people taking PrEP, and any other adverse health events.

1.5.19 Help people taking PrEP to maximise adherence to treatment. Follow the general principles in NICE's guideline on medicine's adherence and address factors specific to the use of PrEP, including those listed in section 6.3 of the BHIVA/BASHH guidelines (Settings and context to administer PrEP).

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on prescribing PrEP.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions see the NICE glossary and the Think Local Act Personal Care and Support Jargon Buster.

Groups with greater sexual health needs

These groups have higher rates of sex partner change or less contact with the healthcare system than average. People are most at risk of STIs if they are involved in higher rates of risky sex (for example, they may have condomless sex with multiple partners or frequently change partners). There may be more people practising these behaviours in some groups than others, but this does not mean that everyone in the group is necessarily at high risk. For example, gay, bisexual and other men who have sex with men are a high risk group for STIs and HIV, but this does not mean that every person in that group is at high risk.

Pre-exposure prophylaxis (PrEP)

The use of antiretroviral medicines in people who are HIV negative to reduce their risk of HIV infection.

Remote self-sampling

The person collects a sample themselves outside the clinic environment (for example, a swab or a urine sample) and sends it to a lab for analysis. This is different to self-testing, for which the person conducts the test and reads and interprets the result themselves.

Sex-positive approaches

Being non-judgmental, openly communicating and reducing embarrassment around sex and sexuality. Recognising the diversity of sexual experiences that exists and that sex can be an important and pleasurable part of a person's life.

Sexual self-efficacy

A person's sense of control over their sexual life and sexual health, and their ability as an individual to have safe, consensual and satisfying sex.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Availability of PrEP

What is the effectiveness and cost effectiveness of providing PrEP outside sexual health services, and does this reach eligible population groups different from those who do access sexual health services?

For a short explanation of why the committee made this recommendation see the rationale section on access to PrEP services.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV.

2 Value of incentives

What incentives are effective and cost effective in increasing STI testing and diagnosis, and what, if any, are the adverse and unintended consequences?

For a short explanation of why the committee made this recommendation see the rationale section on self-sampling to improve the uptake and increase the frequency of STI testing.

Full details of the evidence and the committee's discussion are in evidence reviews C: evidence reviews for effectiveness, acceptability and cost effectiveness of strategies to improve uptake of STI testing; and D: evidence reviews for effective and cost-effective interventions to increase frequent STI testing in very high-risk groups.

3 Delivering effective sexual health services as part of other services

How can sexual health services best be delivered together with other services (for example, drug and alcohol services)?

For a short explanation of why the committee made this recommendation see the rationale section on delivering and evaluating interventions to reduce STI transmission.

Full details of the evidence and the committee's discussion are in evidence reviews A: evidence review for interventions to reduce the acquisition and transmission of STIs in high risk groups; and B: qualitative evidence synthesis for the acceptability of interventions for reducing or preventing the acquisition and transmission of STIs.

4 Tailoring outreach services

How can outreach be tailored to specific groups to increase their access to sexual health services and their uptake of STI testing?

For a short explanation of why the committee made this recommendation see the rationale section on meeting the needs of groups with greater sexual health needs.

Full details of the evidence and the committee's discussion are in evidence reviews A: evidence review for interventions to reduce the acquisition and transmission of STIs in high risk groups; and B: qualitative evidence synthesis for the acceptability of interventions for reducing or preventing the acquisition and transmission of STIs.

5 Reducing stigma

What are the most effective methods of reducing the stigma associated with accessing sexual health services?

For a short explanation of why the committee made these recommendations see the rationale and impact section on co-producing interventions to reduce STI transmission.

Full details of the evidence and the committee's discussion are in evidence reviews A: evidence review for interventions to reduce the acquisition and transmission of STIs in high risk groups; and B: qualitative evidence synthesis for

the acceptability of interventions for reducing or preventing the acquisition and transmission of STIs.

Other recommendations for research

Vaccination course completion

What are the barriers to completing the full course of hepatitis A and B or HPV vaccinations and how do people think they might be encouraged to complete it?

For a short explanation of why the committee made this recommendation see the rationale section on HPV and hepatitis A and B vaccination in gay, bisexual and other men who have sex with men.

Full details of the evidence and the committee's discussion are in evidence review F: evidence reviews for increasing uptake of hepatitis A, hepatitis B and human papillomavirus (HPV) vaccinations in gay, bisexual and other men who have sex with men.

Adverse effects of long-term PrEP use

What are the long-term adverse events (including the impact on bone density) of taking PrEP for an extended period after starting at a young age?

For a short explanation of why the committee made this recommendation see the rationale section on prescribing PrEP.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV

Mode of PrEP delivery

What is the effectiveness, cost effectiveness, accessibility and adherence to forms of PrEP other than oral delivery, particularly long-acting PrEP (such as injections), including in women?

For a short explanation of why the committee made this recommendation see the rationale section on prescribing PrEP.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV

Eligibility for PrEP

What is the cost effectiveness of providing PrEP to people who do not report recent condomless sex?

For a short explanation of why the committee made this recommendation see the rationale section on encouraging take up of pre-exposure prophylaxis for HIV.

Full details of the evidence and the committee's discussion are in evidence review G: evidence reviews for the effectiveness, cost effectiveness, acceptability and unintended consequences of pre-exposure prophylaxis (PrEP) for HIV

Remote self-sampling

Have people's attitudes to remote self-sampling and regular testing for STIs changed as a result of self-sampling for COVID-19?

What are the effectiveness and adverse outcomes of self-sampling for people with symptoms, if remote triage (for example, phone triage) indicates that this is appropriate?

For a short explanation of why the committee made this recommendation see the rationale section on self-sampling to improve the uptake and increase the frequency of STI testing.

Full details of the evidence and the committee's discussion are in evidence reviews C: evidence reviews for effectiveness, acceptability and cost effectiveness of strategies to improve uptake of STI testing; and D: evidence reviews for

effective and cost-effective interventions to increase frequent STI testing in very high-risk groups.

Delivering effective sexual health services

What are the experiences of LGBT+ people in accessing STI testing services, including online?

For a short explanation of why the committee made this recommendation see the rationale section on tailoring interventions to improve the uptake and increase the frequency of STI testing.

Full details of the evidence and the committee's discussion are in evidence reviews C: evidence reviews for effectiveness, acceptability and cost effectiveness of strategies to improve uptake of STI testing; and D: evidence reviews for effective and cost-effective interventions to increase frequent STI testing in very high-risk groups.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice or services.

Meeting the needs of groups with greater sexual health needs

Recommendations 1.1.1 to 1.1.2

Why the committee made the recommendations

The committee discussed how the wider determinants of health can influence sexual health and wellbeing. These include stigma, discrimination faced by those who are part of a minority group, housing instability, poverty, substance use, mental health and intimate partner violence. They agreed that it is important to consider the social, cultural, emotional and economic aspects of a person's life when seeking to address their sexual risk behaviour. The committee also recognised that STI incidence is just one aspect of sexual health, and that taking a broad perspective that encompasses wider aspects of sexual wellbeing is important.

The committee agreed that interventions and services should be targeted at people with greater sexual health needs because that represents the most effective and cost-effective strategy. They discussed the complexity of reaching individual people with greater sexual health needs rather than targeting everyone in high-risk groups because not all people in high-risk groups need sexual health support or interventions. However, by targeting high-risk groups, individuals needing help would benefit. The committee recognised that local areas vary in their cultural and demographic profiles and agreed that data from various sources (including the Joint Strategic Needs Assessment) should be used to commission and provide services to meet local need.

The committee discussed the evidence specific to each of the high-risk groups identified but agreed that the degree of intersectionality and the likely variation in experiences and identities within these groups made group-specific recommendations problematic. Nevertheless, they agreed that interventions should be tailored to the needs of specific groups, such as gay, bisexual and other men who have sex with men, or trans people. The committee agreed that there was little evidence about how to tailor outreach services to best meet the needs of specific groups to improve their access to sexual health services and uptake of STI testing, although expert testimony provided some promising examples. They made a research recommendation about this (see research recommendation 4). The committee also considered the evidence for culturally relevant interventions and agreed that interventions should be culturally competent.

The committee discussed the expert testimony about the inclusion health agenda and their own expertise and experience of reducing barriers to services for people from underserved groups (those who existing services are not accessible to). They noted that a key part of service accessibility was about avoiding assumptions about things like gender or sexuality, or being judgmental about people's relationships or sexual practices.

How the recommendations might affect services

Targeting interventions at groups in which greater sexual health needs have been identified locally will make the use of resources more efficient by ensuring that they are used where they are most needed. Identifying groups will make use of existing

data, for example from the JSNA or from STI diagnosis data, and will not have a large resource impact. Engaging with groups with greater needs is already good practice in sexual health and should not have an impact on resources.

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Accessing sexual health services

Recommendations 1.1.3 to 1.1.5

Why the committee made the recommendations

The committee considered who should be offered interventions and when, noting that often the people who most need support with their sexual health and wellbeing are those least likely to access services. They also noted that people who do access services can be regarded as high risk because they are self-identifying as being at risk by presenting to services.

How the recommendations might affect practice or services

Existing clinic appointments could be used to identify people with greater sexual health needs and signpost them to appropriate services. However, additional appointment time would be needed for conversations about risk reduction, particularly if brief motivational interviewing, CBT or condom-focused interventions are used.

Changing settings in which services are delivered could have a cost impact because services may need to be moved or started up, but reducing barriers to access those services need not be resource intensive. The committee noted that fairly simple changes can make a large difference to people's ability to access services.

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Co-producing interventions to reduce STI transmission

Recommendations 1.1.6 to 1.1.9

Why the committee made the recommendations

Committee members suggested that the most effective way to ensure that interventions and services meet the needs of specific groups, communities or

cultures is to plan, design and implement them in consultation with the people who will be using them (co-production). This was supported by the broader evidence. It helps to ensure that they are culturally sensitive and appropriate to the group they are for. They noted that further research was needed to understand and reduce the stigma associated with accessing sexual health services (see research recommendation 5).The committee recognised that local areas vary in their cultural and demographic profiles and agreed that data from various sources (including the Joint Strategic Needs Assessment) should be used to commission and provide services to meet local need.

The committee considered evidence for a range of interventions designed to reduce sexual risk and prevent STIs. The evidence was mixed, with some studies showing no effect on sexual health outcomes and other studies showing a positive impact on condom use, STI incidence and sexual health knowledge. No single intervention type emerged as consistently or substantially effective. Motivation-based approaches, CBT and cognitive approaches, condom-focused approaches and culturally relevant interventions all performed comparatively well compared with no intervention. Based on this evidence and their experience, the committee agreed that interventions should aim to adopt a multi-model approach by incorporating components from some or all of these approaches, and that people designing interventions should look at NICE's guidelines on behaviour change. The committee also agreed that all interventions should be sex and identity positive – that is, they should recognise the broad range of people's sex lives and their identities without being judgmental.

The committee noted the evidence for condom-focused approaches and agreed that condom use is a fundamental method of preventing STIs. Therefore, supporting people to use condoms correctly and consistently is important. They agreed that condom-positive approaches would be most effective, with a focus on pleasure, the wide variety of condoms available, the importance of fit and feel, barriers to use and strategies for negotiating use. They also noted the importance of both internal and external condoms and of dental dams. They agreed that demonstrations of condom use were also valuable, particularly if people were given the opportunity to practice.

The committee agreed that motivation-based approaches such as motivational interviewing were useful for risk-reduction interventions but recognised that the

evidence for their effectiveness was mixed. They heard expert testimony from organisations delivering motivation-based interventions, which helped them to better understand how well these approaches work, who they may be most suited to and the best way to deliver them.

The committee agreed that, given the challenging life contexts in which many people with greater sexual health needs of STIs live, it is important to offer people support to develop their understanding of the link between emotions and sexual wellbeing, stress management and coping skills, and that these should be incorporated into sexual-risk-reduction interventions. They discussed that cognitive behavioural approaches were particularly useful for addressing psychological aspects of sexual wellbeing and the evidence to some extent supported this.

How the recommendations might affect services

The committee agreed that co-produced interventions were far more likely to be effective and therefore cost effective because they would be better suited to the people they were serving. They agreed that although co-production does have a resource impact compared with usual planning and commissioning, it need not be significant.

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Delivering and evaluating interventions to reduce STI transmission

Recommendations 1.1.10 to 1.1.14

Why the committee made the recommendations

The setting of interventions is important. The committee discussed current sexual health provision across primary care, sexual health services and third sector organisations and agreed that people should be able to attend the service most suited to them. They recognised the value of collaborative working and the importance of supporting people to access services that already deliver suitable interventions. However, they also acknowledged regional variations in provision and that many tailored interventions for high-risk minority groups do not exist outside London. The committee agreed that the onus should be on services to support people in accessing the service that is right for them rather than just leaving it up to

the person. They also agreed that one of the ways that people could be encouraged to use sexual health services was to provide them as part of broader support services, for example in drug and alcohol services, or within HIV care services. They agreed it was important to take into account that people's sexual health is only one aspect of their overall wellbeing. The committee also discussed the importance of Making Every Contact Count and agreed to link sexual health interventions to broader support services, for example drug and alcohol services, HIV care and mental health services. The committee were unaware of research about the most effective ways to deliver sexual health services together with other services and made a research recommendation about this (see research recommendation 3).

The committee agreed that co-producing interventions would help people to decide if interventions were best delivered in 1-to-1 or group settings (this might also relate to considerations about safety and stigma).

The committee considered the evidence for peer delivery and, in combination with their experience, agreed that interventions were best delivered by peers if possible. The committee clarified their understanding of peers as people with a shared identity with the target group or another person who they could relate to, and that the ability to empathise and understand the person's needs and life context was crucial. Committee members with experience of commissioning and delivering peer-led interventions emphasised the value and effectiveness of this approach.

The committee agreed that because the interventions were not based on strong evidence that it was important to evaluate them regularly and use the results of the evaluation to improve services and pathways.

How the recommendations might affect services

Increased awareness of personal risk may lead to more people accessing STI testing services, which may affect service capacity and allocation of resources in clinics that deliver STI testing. However, the committee expect sexual health services in general to be providing cost-effective interventions and care, so even if more people using them increases costs, that is likely to be a cost-effective use of resources.

Evaluating interventions should already be inbuilt into all intervention delivery and therefore will not have a resource impact.

Return to recommendations

Self-sampling to improve the uptake and increase the frequency of STI testing

Recommendations 1.2.1 to 1.2.6

Why the committee made the recommendations

The committee were satisfied that the evidence supports the use of STI testing outside clinical services using self-sampling kits for people who are asymptomatic. They agreed that it encourages people who have previously never engaged with sexual health services to come forward for testing, so widening access to these kits would be a good thing. The committee agreed that local service websites needed to be kept up to date about available options so that people knew what was available in their area and how to access it. However, they 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.

There is regional variation in whether remote tests are offered and how many are available. In locations that do offer remote testing, not everyone who is eligible can have a test. The demand for these tests is often greater than the supply and kits are not always returned, so there is some wastage, with the intervention become less cost-effective the lower the return rate. As a result, the committee was aware that some areas were capping the number of kits available, creating a tension between widening access and limiting the number of kits. The committee therefore agreed that services should monitor kit return rates in different populations to ensure they were meeting the populations' needs. They also noted that there can be unintended consequences as a result of not having direct contact with a clinician. For example, it removes an opportunity to diagnose and treat an STI and to start partner notification, and therefore should only be used as an option for testing, but not the only option.

In committee members' experiences, self-sampling is suitable for chlamydia and gonorrhoea but not always for other STIs. Tests that need a blood sample, such as

syphilis, are more challenging to complete so are more likely to be returned in an unsuitable state for analysis. Antibodies from previous infections can also result in initially reactive results that need confirmation through a test at a clinic. They concluded that remote self-sampling should be part of a suite of testing options and be aimed primarily at people without symptoms. They were aware that during the COVID-19 pandemic, some areas had used remote self-sampling after telephone triage for people who had symptoms. The evidence was unclear about this so the committee made a research recommendation to assess the effectiveness and adverse outcomes of self-sampling for people with symptoms (see the research recommendations on remote self-sampling). In particular, committee members highlighted the self-efficacy needed to access, complete and return tests and to understand the implications of the results. They discussed how some people might have difficulty accessing the right tests for their anatomy, or understanding the instructions. As a result they agreed on the importance of ensuring that kits meet accessibility and inclusivity standards. Overall, they agreed that it was better to attend a clinic if symptoms were present, but acknowledged that in extenuating circumstances (for example, during the COVID-19 pandemic) using self-sampling kits even for some symptomatic people was better than not testing them at all. They were interested to know whether people's attitudes to home-based self-sampling and regular testing for STIs changed as a result of self-sampling for COVID-19 most people have undertaken and made a research recommendation about this (see the research recommendations on remote self-sampling).

The committee discussed the lack of evidence for the value of incentives in encouraging uptake of STI testing, but agreed there needed to be further research on this and made a research recommendation (see research recommendation 2). They also discussed the lack of evidence for improving the uptake of testing in people from very high risk groups such as sex workers and men who engage in sex under the influence of stimulant drugs (such as methamphetamine or mephedrone), typically with multiple partners (so-called chemsex). Although there was a lack of evidence, the committee agreed that the recommendations they had made would be applicable to these groups.

How the recommendations might affect services

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.) It would be important to monitor things like return rates for kits and positive test result rates to determine whether broader testing was identifying more people with STIs. They were also satisfied that the evidence supporting a strategy of offering remote self-sampling was cost effective compared with clinic only testing, but that this was very sensitive to the return rate of the self-sampling kits

Return to recommendations

Tailoring interventions to improve the uptake and increase the frequency of STI testing

Recommendations 1.2.7 to 1.2.9

Why the committee made the recommendations

The committee agreed that it was important to target information to the groups identified in the recommendations on preventing transmission (for example, a website could be tailored towards particular communities that are at higher risk), and that the same considerations about co-producing information materials with the target groups and communities meant that information about testing would be more likely to make an impact. But they were also aware that this should not exclude other groups.

The committee reiterated that people providing services need to look at those using services holistically rather than assuming they are at risk because they are members of a group with a high incidence of STIs.

The evidence showed that individually tailored interventions were effective, whereas motivational interventions without tailoring were not. The committee thought that this was consistent with previous discussions about cultural competence in targeting interventions to specific groups. They decided that detailed and specific tailoring may

be too resource intensive in practice, so favoured low-level personalisation such as adding names and demographic-specific information to communications.

The committee were interested in the experiences of LGBT+ people in accessing STI testing services, including online services, and made a research recommendation about this (see the research recommendation on delivering effective sexual health services). They believed this could improve services for LGBT+ people in the future.

The committee discussed the lack of evidence for improving the uptake of testing in people from very high risk groups such as sex workers and men who engage in sex under the influence of stimulant drugs (such as methamphetamine or mephedrone), typically with multiple partners (so-called chemsex). Although there was a lack of evidence, the committee agreed that the recommendations they had made would be applicable to these groups.

How the recommendations might affect services

The committee agreed that low-level tailoring of interventions would mostly involve modifying things that are already being done and need not have a substantial resource impact.

Return to recommendations

Partner notification

Recommendations 1.3.1 to 1.3.7

Why the committee made the recommendations

The committee acknowledged that any type of partner notification is beneficial. It is one of the most important ways of preventing reinfection and reducing the transmission of STIs. It also ensures that partners have the opportunity to be tested and, if necessary, treated. They noted the importance of discussing these benefits with people newly diagnosed with an STI, including both the personal benefits and benefits to their sexual partners.

The committee noted the importance of making people aware of the different partner notification methods, and providing information about the methods available to them may support their decision making. The quantitative and qualitative evidence

supported the committee's view that patient-led referral to sexual health services may be particularly beneficial for both index patients and their partners. They also recognised the benefits of other methods of partner notification, such as provider referral, in certain contexts (for example, if the person feels unable to make the referral themselves).

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 safety and patient choice, and acknowledged that there may be situations in which partner notification is not appropriate. The committee also noted that their clinical responsibility was to the index patient and not their sex partners, although the needs and preferences of partners being notified remain important.

The committee considered other potential harms of partner notification, including unintended disclosure of relationship, sexuality or STI status. They recognised the importance of anonymity and confidentiality for all partner notification methods but did not consider it necessary to make specific recommendations about patient confidentiality because this is standard practice for all healthcare professionals. However, the committee agreed that when telling people about the partner notification methods available, it is important to highlight the option to maintain anonymity. They noted that provider referral may be the most appropriate method when the person expresses a desire to remain anonymous.

The committee discussed anonymous sex arranged using geospatial networking apps and websites and how this made partner notification difficult. They noted that there was a potential to use these apps for partner tracing and notification if the person did not know their partner's name or contact details. They agreed that this could be done by the person themselves, and were aware that some services set up profiles on these apps for the purposes of anonymous partner notification.

How the recommendations might affect practice

These recommendations are already within the scope of practice of services that undertake partner notification, so there should be no additional cost. Some services may need to improve their practices in this area, which may have a modest resource impact (for example, increasing the length of appointments).

Return to recommendations

HPV and hepatitis A and B vaccination in gay, bisexual and other men who have sex with men

Recommendations 1.4.1 to 1.4.4

Why the committee made the recommendations

The committee were aware that a NICE guideline on improving vaccine uptake in the general population was being developed and agreed that it would be important to consider the recommendations in that guideline when thinking about HPV and hepatitis vaccinations. The committee saw very little evidence about the effectiveness of interventions to increase the initial uptake of HPV and hepatitis vaccinations, and less evidence on whether interventions improved course completion. As a result they felt unable to recommend specific interventions to increase vaccine uptake (see the research recommendation on vaccination course completion).

The committee saw qualitative evidence about the perceived barriers to vaccination among gay, bisexual and other men who have sex with men and agreed that this supported their expertise and experience. On this basis, they agreed on the need to encourage all healthcare professionals to opportunistically discuss vaccination and explain the importance of completing the full course of vaccinations. They also discussed that many gay, bisexual and other men who have sex with men still find it difficult to discuss their sexual health needs with healthcare professionals, so it was important for organisations to consider ways to make services more accessible. They agreed that the You're Welcome criteria, although specifically aimed at young people, modelled good practice that could also be used for other groups (see also recommendation 1.1.5). They noted that in their view and experience, many men did

not return for their follow-up vaccines. They agreed that it was important to highlight this, and the need to follow those men up, by making a recommendation.

Although they did not see any evidence to support it, the committee agreed that in their experience, uptake might be increased by providing these vaccines during other routine health appointments for gay, bisexual and other men who have sex with men.

How the recommendations might affect practice

The committee agreed that these recommendations would not have a large impact on resource use. Sexual health services should already be providing information about vaccination to gay, bisexual and other men who have sex with men who are eligible for vaccination, and many primary care providers already offer these vaccines. Providing vaccinations alongside existing services should be a more efficient method of delivery, where this is possible.

The committee also noted that because these vaccines had already been assessed as being cost effective by the Joint Committee on Vaccination and Immunisation, an increase in the number of people being vaccinated should also be cost effective.

Return to recommendations

Encouraging take up of pre-exposure prophylaxis for HIV

Recommendations 1.5.1 to 1.5.6

Why the committee made the recommendations

The committee agreed that increasing uptake of pre-exposure prophylaxis for HIV (PrEP) among eligible populations was the highest priority. The evidence showed differing experiences and beliefs about PrEP for different populations, so they wanted to target populations that had negative experiences or are less engaged. With this in mind they agreed that local groups with greater sexual health needs were an appropriate target for awareness raising, in line with NICE's guideline on community engagement. They agreed that particular attention needed to be paid to groups in which uptake of PrEP is lower, such as cisgender women with a Black African family background. They cautioned that it was also very important to make sure that people knew that PrEP was for HIV prevention specifically and that it did

not protect against other STIs. The committee noted the eligibility criteria for PrEP currently restricted it to people who reported recent condomless sex. They were therefore interested in whether providing PrEP to people who do not report recent condomless sex would also be cost effective (see the research recommendation on eligibility for PrEP).

The evidence showed that people are more likely to trust those from their own community or group when it came to information about PrEP. So the committee agreed that engaging with peers was a good way to normalise PrEP use and reduce both stigma and mistrust in services. They noted qualitative findings (from research predating more widespread use of PrEP) that stereotyped people who use PrEP as promiscuous or reckless. They also agreed that co-producing materials with those communities and groups could help to challenge stigma.

The committee noted that trans people in qualitative studies frequently expressed concerns about potential interactions between PrEP and gender-affirming hormones and the possibility of PrEP interfering with their transition. The committee reported information from the University of Liverpool HIV drug interaction checker, which they agreed was robust based on communication with the University of Liverpool about the methodology underpinning the checker. This showed that there were no interactions expected, and thought that education was needed to raise awareness of the safety of PrEP for those undergoing medical transition. The committee agreed it was important to use this information to reassure potential PrEP users because participants with these concerns expressed that they would prioritise their transition above HIV prevention and may avoid PrEP because of this uncertainty.

How the recommendations might affect practice and services

Additional resources will be needed to train healthcare professionals on the needs of populations eligible for PrEP. If the total time allotted for training does not increase, this training will come at the expense of other training options.

Existing appointments can be used to identify people eligible for PrEP and signpost them to appropriate services, but this might add to the time needed for each appointment to cover the additional conversations about PrEP.

Return to recommendations

Service design for PrEP services

Recommendations 1.5.7 to 1.5.9

Why the committee made the recommendations

The committee were concerned that access to services is a barrier to PrEP uptake. The evidence suggested that this is because PrEP is only provided at sexual health clinics (in line with current NHS England commissioning policy) and that some groups are less likely to seek healthcare in this setting. Conversely, some committee members thought that PrEP should only be prescribed by healthcare professionals with knowledge of it and training in sexual health, which would generally mean only in a sexual health clinic.

The committee agreed that it is important that healthcare professionals in primary care, community settings and gender identity clinics are aware of who is eligible for PrEP, regardless of whether the setting provides it. This means that they will be better able to refer eligible people to services where PrEP can be provided. They agreed that healthcare professionals needed training about this. They acknowledged that some populations face particular barriers to accessing PrEP services in sexual health clinics.

The qualitative evidence indicated that some groups, particularly LGBT+ people, thought that healthcare professionals did not understand their sexual practices and individual risk factors. This led to them feeling uncomfortable discussing sexual health and being worried about feeling judged, therefore making it harder for them to start conversations about PrEP

How the recommendations might affect practice and services

Additional resources will be needed to train healthcare professionals on the needs of populations eligible for PrEP. If the total time allotted for training does not increase, this training will come at the expense of other training options.

Increased uptake of PrEP is likely to have an impact on service capacity and allocation of resources in clinics that deliver PrEP and provide monitoring and testing

for PrEP users. Clinics may need additional funding or expansion of services to meet increased demand. However, PrEP itself is a highly cost-effective intervention and therefore this should be a cost-effective use of resources.

Return to recommendations

Access to PrEP services

Recommendations 1.5.10 to 1.5.12

Why the committee made the recommendations

In addition to making existing services more accessible, the committee were interested in the possibility of offering PrEP in other settings. However, they agreed that more evidence was needed on the effectiveness of doing this before they could recommend specific actions (see research recommendation 1). They thought that, for now, increasing awareness of eligibility and enabling wider services to refer people to PrEP clinics was more important than prescribing PrEP in other settings. They agreed that there needs to be clear pathways for healthcare professionals who cannot or do not provide PrEP to support people in accessing services that prescribe it, and that the responsibility for this should lie with the healthcare professional. The committee agreed that this meant it was important for people to be able to access services outside of their local area or community.

How the recommendations might affect practice and services

Additional resources will be needed to train healthcare professionals on the needs of populations eligible for PrEP. If the total time allotted for training does not increase, this training will come at the expense of other training options.

Existing appointments can be used to identify people eligible for PrEP and signpost them to appropriate services, but this might add to the time needed for each appointment to cover the additional conversations about PrEP.

Return to recommendations

Prescribing PrEP

Recommendations 1.5.13 to 1.5.19

Why the committee made the recommendations

The committee recognised the evidence for the effectiveness of PrEP and thought that it was important for all groups outlined in the BASHH/BHIVA guidelines to be able to access it according to the risk criteria in these guidelines.

The committee agreed that the available economic evidence showed PrEP to be cost effective in a population of gay, bisexual and other men who have sex with men at high risk of HIV (matching the criteria in the BASHH/BHIVA guidance). They also agreed that the findings should be generalisable to other populations at equivalent risk of HIV, as both the potential benefits and costs in those populations should be similar. The evidence also suggested that PrEP would remain cost effective in these populations regardless of potential unintended consequences (such as changes in condom use). Therefore, they were confident that these potential consequences did not need to result in any restrictions made to people eligible for PrEP.

The committee recognised from the evidence that the effectiveness of PrEP directly corresponded to adherence, so it is vital that people taking it are made aware of this and given support to take it as prescribed (see NICE's guideline on medicines adherence). They recognised that some people might experience barriers to adherence, so promoting knowledge and understanding about PrEP would be important for these people. The committee agreed that anyone taking PrEP needed knowledge of the risks involved (HIV, antiretroviral drug resistance) in not adhering to the treatment.

The committee recognised the importance of adherence to PrEP, the risk of adverse events and the potential relationship between these. So they felt that clinical follow-up of anyone taking PrEP was important and that the BASHH/BHIVA good practice points could be followed.

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 (see the research recommendation on mode of PrEP delivery).

The evidence also suggested some adverse effects associated with PrEP use (such as kidney or gastrointestinal symptoms). The committee recognised that people needed to be made aware of these so they could make an informed choice and manage their symptoms (see NICE's guideline on shared decision making). They noted that the evidence for increased risk of kidney problems corresponded to their own knowledge of how PrEP works pharmacologically. They therefore agreed that monitoring the renal health of those taking PrEP was important. Although the committee were aware of evidence showing that bone-mineral density will rebound after stopping PrEP, there was a lack of data on this for young people who have not yet reached their peak bone density (see the research recommendation on the adverse effects of long-term PrEP use).

The committee discussed the risk of antiretroviral therapy resistance in prescribing PrEP to people who were HIV positive and strongly supported current guidelines about the importance of regular HIV testing and the requirement for a negative HIV test before prescribing.

The committee noted that ongoing research seemed to be showing an association between people taking PrEP and an increase in STI rates, but they emphasised that it was not clear whether there was any causal link. They discussed several other plausible reasons for the association and agreed that it will be important to see how the evidence develops. They agreed on the value of providing condoms and behavioural support to this high-risk population, and that they should have regular screening for other STIs.

How the recommendations might affect practice and services

Increased uptake of PrEP is likely to have an impact on service capacity and allocation of resources in clinics that deliver PrEP and provide monitoring and testing for PrEP users. Clinics may need additional funding or expansion of services to meet increased demand. However, PrEP itself is a highly cost-effective intervention and therefore this should be a cost-effective use of resources.

Return to recommendations

Context

Sexually transmitted infections (STIs) can affect personal wellbeing, mental health and relationships. They can also lead to serious health problems including pelvic inflammatory disease, ectopic pregnancy and infertility. The rates of STIs are highest in young people aged 15 to 24; people from a Black family background; and gay, bisexual and other men who have sex with men.

In 2020, there were 3,482,700 consultations at sexual health services and 317,901 diagnoses of new STIs in England. This was a decrease of 10% and 32%, respectively, compared with 2019, but this largely reflects the rapid reconfiguration of sexual health service delivery in response to the COVID-19 pandemic. But the number of internet consultations doubled from 511,979 to 1,062,157 over the same period. Sexual health services carried out 1,649,429 sexual health screens (tests for chlamydia, gonorrhoea, syphilis or HIV) in 2020, a 25% decrease compared with 2019.

New HIV diagnoses have declined over the past decade, with a substantial decrease during 2019 (4,139 cases, a 10% fall from 4,580 in 2018). This recent reduction has been mostly driven by fewer HIV diagnoses among gay and bisexual men, which have decreased by 47% since 2014. There is also an ongoing HPV vaccination programme for gay, bisexual and other men who have sex with men. The vaccine is recommended for all men up to and including the age of 45 who have sex with men.

Social and sexual networking apps have made it easier to buy recreational drugs. People who use drugs during sex are more likely to report unsafe sexual behaviours than those who do not.

Mycoplasma genitalium is being increasingly recognised as a public health concern because of its relatively high prevalence (1 to 2% of the general population) and high levels of antimicrobial resistance, along with already recognised drug-resistant gonorrhoea.

Sexually transmitted infections are a major public health concern which may seriously impact the health and wellbeing of affected individuals, as well as being costly to healthcare services. They also fall disproportionately on certain populations

and can cause serious long-term consequences (for example sterility, cancer or death). Although the COVID-19 pandemic has reduced diagnosis rates of STIs, this has coincided with a decrease in sexual health screening caused by the disruption to service provision. The overall trends continue to rise. Together with new evidence identified, this highlights the need for an updated guideline on this topic.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on sexual health.

For details of the guideline committee see the committee member list.

Update information

This guideline is an update of NICE guideline PH3 (published February 2007) and will replace it.