

GROWING TOGETHER FOR HEALTH AND HAPPINESS

Guidance on Providing Sexual and Reproductive Healthcare for Young People Living with HIV

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Abbreviations

ART	antiretroviral therapy
BV	bacterial vaginosis
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
BPAS	British Pregnancy Advisory Service
CDC	Centers for Disease Control and Prevention
CHARS	Children's HIV and AIDS Reporting System
CSA	child sexual abuse
CSE	child sexual exposure
CHIPS	Collaborative HIV Paediatric Study
CSRH	Community Sexual and Reproductive Healthcare
CT	*chlamydia trachomatis*
EBP	event-based PrEP
EC	emergency contraception
FGM	female genital mutilation
GBL	gamma-butyrolactone
GHB	gammahydroxybutyrate
GBMSM	gay, bisexual, and other men who have sex with men
GC	gonococcus
GDPR	General Data Protection Regulation
GMC	General Medical Council
DoxyPEP	doxycycline post-exposure prophylaxis
GUM	Genitourinary Medicine
HARS	HIV AIDS Reporting System
HAV	hepatitis A virus
HBV	hepatitis B virus
HCP	health care professional
HIV	human immunodeficiency virus
HPV	human papillomavirus
HSV	herpes simplex virus
IMB	intermenstrual bleeding
ISOSS	Integrated Screening Outcome Surveillance Service
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual
LUTS	lower urinary tract symptoms
MCA	Mental Capacity Act

MGen	*Mycoplasma Genitalium*
MSM	men who have sex with men
NSHPC	National Surveillance of HIV in Pregnancy and Childhood
PCB	post-coital bleeding
PEP	post-exposure prophylaxis
PHE	Public Health England (now disbanded)
PLWH	people/person living with HIV
PrEP	pre-exposure prophylaxis
RCPCH	Royal College of Paediatrics and Child Health
SARC	sexual assault referral centre
SRH	sexual and reproductive health
STI	sexually transmitted infection
TAF	tenofovir alafenamide
TasP	treatment as prevention
TOP	termination of pregnancy
TV	*Trichomonas Vaginalis*
'U = U'	undetectable equals untransmittable
UKHSA	UK Health Security Agency
VMMC	voluntary medical male circumcision
VVC	vulvovaginal candidiasis
WHO	World Health Organization
WSW	women who have sex with women

1. Scope and purpose of guidance

Key points:

- This guidance is not intended to train all health care professionals (HCPs) as sexual and reproductive health (SRH) experts, but to give guidance around these topics within a legal and ethical framework. It signposts HCPs to the relevant guidelines and indicates when referral to specialist services is required.
- Incredible developments in HIV treatment and care over the last decade have drastically changed the outlook for young people living with HIV, who can now expect a near-normal life expectancy, to enjoy healthy sexual relationships without fear of transmitting HIV and, if they choose, to have HIV-negative children of their own.
- However, young people living with HIV may still have additional complex medical and psychological needs, many of which are not typically seen in other chronic diseases of childhood.
- The transition process from paediatric to adult services should be gradual and patient-centred, with a documented transition plan in place, in line with national guidance.
- Increasing numbers of young people living with HIV that identify as gay, bisexual, or men who have sex with men (GBMSM). The majority of these young people acquired HIV sexually, and there is limited third sector support for them.
- HCPs can play an important role in debunking HIV myths and empowering young people living with HIV to pursue the lives they wish for.

This guidance was originally published in 2011, in response to requests from paediatric health care professionals (HCPs) providing care for young people living with HIV. The aim was to provide specific knowledge and guidance around the sexual and reproductive health (SRH) needs of young people living with HIV, where HIV has been acquired either perinatally or via other routes.

This guidance is not intended to train all HCPs as SRH experts but to give guidance around these topics within a legal and ethical framework. It signposts HCPs to the relevant guidelines and indicates when referral to specialist services is required.

In this guidance we refer to young people as those aged 15 to 24 years old.
This guidance uses the terminology suggested by the 'People First Charter.' This resource was launched in 2021 to promote person-first HIV and SRH language. People living with HIV, or at risk of HIV acquisition, often experience stigma and discrimination and language can perpetuate this [18].

Clinic models

Clinic models have developed and, at the time of writing, pre-pubertal children living with HIV are generally cared for in the paediatric setting. Transition to adult care usually begins when the young person is fully aware of their HIV diagnosis and perceived to be ready.

Two common models of transition care are:

- 'young person clinics' within adult services that are specifically designed to cater to the additional needs of young people living with HIV or
- integrating the transitional services available into paediatric and adult HIV clinics to facilitate the transfer of care [1-4].

The transition process from paediatric to adult services should be gradual and patient-centred, with a documented transition plan in place, in line with national guidance [5].

Outlook for young people living with HIV

Incredible developments in HIV treatment and care over the last decade have drastically changed the outlook for young people living with HIV who can now expect a near-normal life expectancy, to enjoy healthy sexual relationships without fear of transmitting HIV and, if they choose, to have HIV-negative children of their own.

Robust data supports the universally accepted and unambiguous message that 'undetectable equals untransmissible' or 'U=U'. People living with HIV on effective antiretroviral therapy (ART), with an undetectable viral load (<200 c/ml) cannot pass on the virus to others [6,7].

In 2020, pre-exposure prophylaxis (PrEP) became available on the NHS after great efforts from key campaigners [8]. PrEP is a tablet taken to prevent HIV acquisition

with up to 99% efficacy. This has further reduced rates of HIV transmission and given further reassurance to people living with HIV [9].

Vertical transmission (transmitting HIV during pregnancy, birth, or breastfeeding) in the UK is now extremely rare, thanks to the high uptake of antenatal screening and ART, specialist HIV antenatal care, and baby feeding support [10].

However, young people living with HIV may still face additional complex medical and psychological challenges, many of which are not typically seen in other chronic diseases of childhood.

Young people with perinatally-acquired HIV may find themselves negotiating their first romantic and sexual relationships while already living with a 'sexually transmitted infection' (STI). They may struggle with the difficult issues of stigma and secrecy.

Relationships for young people are often transient, within close social groups such as school, university or the workplace. Decisions around sharing their status and maintaining confidentiality are therefore extremely complex [11,12].

Conversations about sexual health

Despite so many breakthroughs, myths and misconceptions about HIV remain, and they can stop people from accessing treatment and from living well with HIV. HCPs can play an important role in debunking these myths, particularly around sex and HIV [13].

A third of UK adolescents are sexually active by the age of 16, and the age of first sex in young people with perinatally acquired HIV is similar [11,14]. Therefore, it's vital that HCPs initiate conversations around SRH needs at the earliest appropriate opportunity, and before a young person starts to have sex.

Alongside conversations beneficial for all young people, those living with HIV require additional discussion specific to HIV. This includes transmission and risk reduction, contraception and planning pregnancy, vaccination, and maintaining sexual wellbeing whilst living with a highly stigmatised chronic medical condition [15,16].

It's also important to note that there are high rates of unplanned pregnancy reported in perinatal cohorts.

Of further note is the increasing numbers of young people living with HIV that identify as GBMSM, the majority of whom have acquired HIV sexually [17]. This group may face sexuality-based stigma and discrimination, and it's vital that support is offered around coming out, mental wellbeing, and recreational drug use, including chemsex.

2. What is sexual and reproductive health?

Key points:

- The World Health Organization (WHO) describes sexual and reproductive health (SRH) as an integral part of overall health, wellbeing, and quality of life.
- All young people have the right to pleasurable and safe sexual experiences, free from coercion, discrimination, and violence.
- HCPs should be familiar with the services available to young people in their area. In this document we refer to these services as GUM/SRH services.

The World Health Organization (WHO) describes sexual and reproductive health (SRH) as an integral part of overall health, wellbeing, and quality of life. It defines SRH as "a state of physical, emotional, mental and social, wellbeing in relation to sexuality, and not merely the absence of disease, dysfunction, or infirmity" [1].

Everyone has the right to pleasurable and safe sexual experiences, free from coercion, discrimination, or violence. For this to be attained and maintained, the sexual and reproductive rights of young people must be respected, protected, and fulfilled.

This requires a personalised approach, where various issues are being navigated, including peer pressure, socio-cultural barriers, experimentation, and increasing autonomy.

Available services

In the UK, the medical specialities of Genitourinary Medicine (GUM) and Community Sexual and Reproductive Healthcare (CSRH) work to support the prevention and management of HIV, sexually transmitted infections (STIs), and unwanted pregnancy. In the UK, these specialities operate from a variety of premises, based at both hospital and community sites.

In this document we refer to these services as 'GUM/SRH' services. HCPs should be familiar with the services available to young people in their area.

The NHS 'find a clinic' tool can be used by both HCPs and patients.

3. Epidemiology

Key points:

- The majority of young people living with HIV in the UK have acquired HIV perinatally or through sexual contact.
- Young people living with HIV have reduced rates of treatment coverage and viral suppression compared to other age groups.
- A significant number of young people living with HIV identify as GBMSM and have specific needs that should be addressed by HCPs.

HIV and young people in the UK

The majority of young people living with HIV in the UK have acquired HIV through vertical transmission (sometimes called perinatal acquisition or mother-to-child transmission), or through sexual contact (horizontal transmission).

- In 2023, 1744 people living with HIV were aged 15 to 24 years.
- In 2024, treatment coverage was lowest in this group at 96%, in comparison to 99% for all other age groups.
- In 2024, only 91% of people aged between 15 to 24 years were virally suppressed, with the proportion suppressed increasing with age [1].

The paediatric population

At the time of their HIV diagnosis, all young people under the age of 18 in the UK are reported to the Integrated Screening Outcomes Surveillance Services (ISOSS) (previously the National Surveillance of HIV in Pregnancy and Childhood (NSHPC)).

Up until 2022, the majority of these young people were followed up through paediatric care using prospective surveillance within the Collaborative HIV Paediatric Study (CHIPS).

CHIPS was established in the year 2000 [2]. In 2022, CHIPS was replaced by the Children's HIV and AIDS Reporting System (CHARS) [3]. CHARS is not age-limited, but it reports on those in paediatric care.

Future linkage to HIV AIDS Reporting System (HARS) [4] data will provide greater insights as their transition into adulthood continues.

4. Key legislation and guidance when working with young people

Key points:

- Al HCPs working with young people must be familiar with key legislation related to their care. This includes the Mental Capacity Act, Gillick competence, Fraser guidance, and the Sexual Offences Act.
- All under-18s are subject to child protection laws, and they require capacity and safeguarding assessments at each visit, with confidentiality upheld unless they are a risk to themselves or others.
- HCPs should be aware of their local pathways for when concerns around a young person's safety are identified.
- HCPs should undergo training in the identification and management of young people who have undergone female genital mutilation (FGM).

Good medical practice states that you must safeguard and protect the health and wellbeing of children and young people. Wellbeing includes treating children and young people as individuals, respecting their views, and considering their physical

and emotional welfare. When treating children and young people, you should consider their parents and others close to them, but your patient must be your first concern [1].

In all UK nations, the age at which a person can legally consent to sexual activity (the age of consent) is 16 years old.

This is the same regardless of the person's gender identity, sexual identity, and whether the sexual activity is with a person of the same or different gender [2].

- All young people under 18 are subject to child protection regulations.
- All young people under 18 should have a safeguarding assessment documented at each attendance.
- Young people aged 16 and 17 are presumed to have capacity to consent to healthcare, unless there is sufficient evidence to the contrary.
- Young people under 16 have capacity to consent to healthcare if deemed Gillick competent [3].
- It is best practice to give young people the opportunity to be seen for care without their parent or carer.

Box 1: Key things to remember when working with people under 18

Alongside being familiar with the General Medical Council (GMC) publication '*0-18 years. Professional standards: More detailed guidance*,' [1], HCPs also require appropriate training around the key legislation related to treating under-18s, including:

- the Mental Capacity Act
- Gillick competence
- Fraser guidance
- the Sexual Offences Act.

All HCPs working directly with young people under 18 are also required to complete Level 3 safeguarding training as per Trust/local arrangements.

Confidentiality

The GMC publication '*0-18 years. Professional standards: More detailed guidance*' [1] outlines the legal framework on child protection, consent, and confidentiality. It clearly states the right of young people to confidentiality when accessing health services.

However, young people should be informed of the limits of confidentiality. They should also usually be informed of any disclosures to multi-agency safeguarding partnerships, e.g. an HCP referring the patient to their local/Trust safeguarding team or Social Services.

The GMC guidance also reaffirms the right of HCPs to provide sexual health services to young people, without disclosure to a parent or carer, as long as the young person is deemed competent and has capacity to consent (see **Box 2: Principles of Gillick Competency** and **Box 3: Fraser Guidelines**).

Sexual health information from the records of young people, including third party information, should not be routinely disclosed to multi-agency support partners (including parents) except for exceptional circumstances when advice has been sought. Such requests will need to be made via Trust/local protocols, e.g. via a Subject Access Request [4].

The Mental Capacity Act

The Mental Capacity Act (MCA) [5] applies to 16- and 17-year-olds and presumes capacity to consent to surgical, medical, and associated procedures unless it is established that the person lacks capacity. The MCA framework requires an assessment of capacity before treatment using 5 key principles:

1. Assume a person has capacity unless proven otherwise.
2. Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them do so.
3. A person should not be treated as incapable of making a decision just because their decision may seem unwise.
4. Always do things or make decisions for people without capacity in their best interests.
5. Before doing something to someone, or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

Gillick competence and the Fraser guidelines

Gillick competence is the central doctrine with which to judge capacity in under-18s. The Fraser guidelines refer specifically to those receiving contraceptive advice [6].

Children under the age of 16 can consent to their own treatment if they are believed to have enough intelligence, competence, and understanding to fully appreciate what is involved in treatment. This is known as being Gillick competent, the principles of which are outlined in **Box 2: Principles of Gillick competency** [7]. Otherwise, someone with parental responsibility can consent for them [8].

The young person must demonstrate their ability to:

- understand the relevant information
- hold that information in their mind for long enough to weigh up and use the information to decide
- effectively communicate their decision.

Box 2: Principles of Gillick competency

The Fraser guidelines [7] specifically outline the criteria that need to be met for an HCP to deliver contraception or sexual health care and treatment to those aged under 16. The principles are outlined in **Box 3: Fraser guidelines**.

HCPs using the Fraser guidelines should be satisfied with the following:

- The young person cannot be persuaded to inform their parents/carers that they are seeking this advice or treatment.
- The young person understands the advice being given.
- The young person is likely to begin or continue sexual activity without contraception.
- The young person may suffer harm to their physical or mental health if they do not receive advice and/or treatment AND
- It is in the patient's best interests to give advice and/or treatment without parental consent.

Box 3: Fraser guidelines

HCPs can explore with young people if they are comfortable discussing their relationships with their parent, carer, or an extended family member.

Common reasons cited by young people for not wanting to discuss sex with parental figures include fear of awkward conversation and fear of negative reactions.

There is evidence to show that extended family members (e.g. older siblings, aunts) may be a valuable teenage resource for sexuality communication, particularly when teenagers feel uncomfortable talking with their parents [9].

The Sexual Offences Act 2003

The Sexual Offences Act 2003 (England) [10] states that sexual activity in young people under 16 years old is illegal. However, HCPs are not required to mandatorily report every sexually active person under 16 if it is deemed a normal and safe consensual relationship and/or sexual activity and there is no cause for concern.

Examples of causes for concern include significant age disparities, a partner in a position of trust, or gang involvement.

To assess this, all under-18s should have a safeguarding assessment at each attendance, focusing on the risk of child sexual exposure (CSE)/child sexual abuse (CSA), which must be fully documented.

An example proforma is the '*Spotting the Signs*' tool produced by the British Association for Sexual Health and HIV (BASHH) and Brook in 2023 [11].

Download Spotting the Signs from www.brook.org.uk

Those under the age of 13, irrespective of the HCPs personal assessment, are not competent to consent to sexual activity. This means that for young people under 13, sexual activity cosxnstitutes statutory rape in all cases [10, 12].

This situation should always give rise to serious concerns and must be escalated urgently via local safeguarding protocol [13].

HCPs working with sexually active young people: The legal position

The Sexual Offences Act 2003 states clearly that sexual health care providers are protecting a child if they are preventing STIs or pregnancy and are therefore not liable to prosecution for providing care.

This applies whether children are under 16 years old or under 13 years old

Further guidance is provided by the BASHH *Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People (2021)* [13].

Female genital mutilation (FGM)

Female genital mutilation (FGM) describes the deliberate cutting of, injury to, or change to the female genitals, without medical reason [14]. FGM is child abuse.

FGM is done for socio-cultural reasons in certain communities due to the incorrect belief that it will benefit the female. FGM most often happens to young people between infancy and the age of 15 (most commonly before puberty starts) without their consent.

FGM is usually performed by people without medical training, often without anaesthetic or aseptic conditions.

There are four main types of FGM which are defined by the WHO as:

- Type 1 (clitoridectomy): removing part or all of the clitoris.
- Type 2 (excision): removing part or all of the clitoris and the inner labia (the lips that surround the vagina), with or without removal of the labia majora (the larger outer lips).
- Type 3 (infibulation): narrowing the vaginal opening by creating a seal, formed by cutting and repositioning the labia.
- Type 4: all other harmful procedures to the female genitals, including pricking, piercing, cutting, scraping, or burning. This also includes genital piercings or tattoos that the young person under 18 says they consented to.

FGM can have significant physical, psychological, and social impacts, particularly on sexual activity and pregnancy. Fatalities can also occur as a result of FGM due to complications from the procedure, such as bleeding and infection.

FGM is illegal in the UK. If someone performs FGM they can be sentenced to imprisonment of up to 14 years. If someone is found guilty of failing to protect a young person from FGM they can be sentenced to imprisonment of up to 7 years.

It's also an offence to help anyone to perform FGM within or outside the UK.

What do I do if a young person has undergone FGM or is at risk of FGM?
If you suspect a young person may have had FGM very recently or that a young person is at serious/imminent risk of FGM (e.g. there are plans for them to be taken out of the country), you should immediately seek urgent safeguarding advice.

- As per the Serious Crimes Act 2015, all known cases of FGM (new or historic) on a child under 18 years of age must be reported to the police via the 101 non-emergency number and a crime reference number obtained. This applies whether the young person believes they gave consent for the procedure or not.
- It is the duty of the professional who initially identifies known or disclosed FGM to report it. It is best practice to report before the end of the next working day and mandatory to report within 48 hours. HCPs who do not comply with this requirement may be subject to local or professional disciplinary proceedings.
- If a patient with FGM is pregnant, their obstetric team should be informed immediately.
- The young person must be counselled that FGM is illegal, has no health benefits, may cause lifelong health problems, and is not a religious requirement. However, young people must be reassured that they have not done anything wrong, and that their physical and psychological wellbeing is the most important thing.
- All young people who have had FGM should have a safeguarding assessment performed [15,16].

Managing complications of FGM

Common problems arising from FGM include issues with:

- menstruation
- urination and recurrent urinary tract infections (UTIs)
- sexual function
- psychological sequelae
- pain and discomfort resulting from FGM.

HCPs should be aware of their local referral pathways for young people living with HIV who have been affected by FGM. In some regions, dedicated FGM Support Clinics offer deinfibulation (a procedure used to open the closed area formed by FGM) which can provide relief from symptoms. They also offer emotional support.

5. HIV Transmission

Key points:

- HIV cannot be transmitted if someone is on effective antiretroviral therapy (ART) and has an undetectable HIV viral load (U=U).
- HCPs should not presume that young people living with HIV are aware of the concept of U=U and this must be discussed with them at an appropriate stage.
- The various methods of preventing HIV transmission must be discussed with all young people on a case-by-case basis. This includes the availability of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for sexual partners where required.

Young people living with HIV must navigate the same social pressures and expectations as young people living without HIV, but with the potential added burden of living with a highly stigmatised chronic medical condition [1].

Despite the many breakthroughs in HIV care, myths and misconceptions about HIV remain, and they can stop people from accessing care and living well with HIV [2].

HCPs can play a vital role in debunking these myths, particularly around HIV and sex, allowing young people living with HIV to enjoy healthy and fulfilling sexual relationships.

Routes of HIV transmission

HIV cannot be transmitted if someone is on effective ART and has an undetectable HIV viral load (see the following section, **U=U**).

For those with a detectable viral load, it can be transmitted through several well-established routes:

- Sexual: Receptive unprotected anal sex with ejaculation has the greatest risk (1 in 65) [4].
- Mother to child (vertical): This can occur during pregnancy, labour, delivery, and/or breastfeeding.
- Sharing injecting equipment.
- Receiving blood and blood products that are not screened for HIV: This is increasingly rare worldwide, but still occurs in some countries.

There are several situations that can further increase the risk of HIV transmission if the person is not on ART. This includes:

- a very high HIV viral load, such as that seen in primary HIV infection and/or seroconversion
- breaches in the mucosal barrier such as genital trauma and concomitant STIs. This is particularly relevant with genital ulcer disease. STIs such as syphilis, herpes simplex virus (HSV), and trichomonas vaginalis (TV) can also damage protective genital epithelial membranes, increasing the ability of the HIV virus to penetrate target cells
- late pregnancy and the postpartum period (studies have shown there is a greater risk of HIV acquisition at this time compared to during the non-pregnant period) [5]
- menstruation (theoretical risk only).

U=U

HIV cannot be transmitted if someone is on effective antiretroviral therapy (ART) and has an undetectable HIV viral load.

This concept is universally known as ‘undetectable equals untransmittable’ or ‘U=U’.

Achieving an undetectable viral load on ART is the key goal in preventing HIV transmission, also known as treatment as prevention (TasP).

The unrefuted evidence for this comes from several studies, including HPTN 052 [6], PARTNER 1 [7], PARTNER 2 [8] and Opposites Attract [9]. These studies have demonstrated zero transmission risk, regardless of partner type or sexual activity.

U=U is endorsed by UK and European Guidelines (BHIVA [16] and EACS [17]), the CDC [18] and International AIDS Society [19].

However, U=U relies on continued adherence and is only effective if the viral load is consistently undetectable. The studies mentioned used a viral load cut off of 200 copies/ml, i.e. viral blips of 200 cp/ml or less will not transmit. Caution must be advised for individuals with recurrent viral blips (sometimes referred to as low level viraemia) and where adherence is a concern. In these situations, the use of condoms, PEP, and PrEP should be discussed on a case-by-case basis.

Explaining this message to young people living with HIV is vital. U=U is an empowering message, associated with favourable health outcomes [10]. Explaining it in practical terms can be helpful, rather than just the message and evidence. For example, explaining scenarios of when PrEP or PEP is advised for partners.

Young people can be signposted toward ‘Frequently Asked Questions about U=U’ from Terrence Higgins Trust

U=U and young people living with HIV

In 2024, only 91% of people aged between 15 to 24 years were virally suppressed, with the proportion who are suppressed increasing with age [3].

HCPs should not presume that young people living with HIV are fully aware of the HIV 'basics', including the concept of U=U. It is vital that this is discussed with all those transitioning to adult care.

Alongside adherence support, those without an undetectable viral load require thorough discussion around preventing HIV transmission to a sexual partner, including:

- condom use
- PrEP for partners
- PEP in the event of a potential transmission, e.g. condom failure or PrEP not taken
- potential sharing of status.

See section **6. Sharing information about HIV status with other people** for further information.

Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) refers to ART taken by an HIV-negative person before sex to prevent HIV acquisition. PrEP is generally recommended to groups of people who are at higher risk of HIV acquisition e.g. GBMSM, partners of people with HIV with a detectable viral load, and transgender women.

However, PrEP is available to any individual who feels they would benefit from it after discussion with a trained HCP.

Partners of young people living with HIV who would like to access PrEP should be signposted to their local GUM/SRH clinic. PrEP is available free of charge at all GUM/SRH clinics nationally. For more information see *British HIV Association (BHIVA)/BASHH guidelines on the use of HIV pre-exposure prophylaxis (PrEP) 2025* [11].

Oral PrEP can be taken in two ways:

- daily PrEP which is taken every day
- 'on demand' or 'event-based dosing (EBD)' which is taken around the time of sexual risk.

It is important that each individual discusses their needs with a trained HCP to determine what PrEP routine will be effective and safe for them.

Oral PrEP for adults is typically tenofovir disoproxil fumarate/emtricitabine, at the time of writing. However, NHS England commissions all under-18s to be offered second line PrEP with tenofovir alafenamide (TAF)/emtricitabine, known as Descovy, due to TAF's more favourable outcomes regarding developing bone mineral density.

Long-acting injectable PrEP (cabotegravir) is also available on a case-by-case basis if PrEP is unsuitable [21].

Post-exposure prophylaxis

Post-exposure prophylaxis (PEP) is a 28-day course of ART taken following a high-risk exposure to HIV infection. PEP is offered on a case-by-case basis, depending on the type of sex or exposure and viral load. The table below is a summary of the PEP prescribing recommendations from the BASHH*UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021* [4].

	Index HIV-positive		**Index unknown HIV status**	
Exposure type	**HIV VL unknown or detectable**	**HIV VL undetectable**	**High prevalence country/risk-group**	**Low prevalence country/group**
Receptive anal sex	Recommend	Not recommended (b)	Recommend	Not recommended
Insertive anal sex	Recommend	Not recommended (b)	Consider (c,d)	Not recommended
Receptive vaginal sex	Recommend	Not recommended (b)	Generally not recommended (c,d)	Not recommended
Insertive vaginal sex	Consider (c)	Not recommended	Generally not recommended (c,d)	Not recommended
Fellatio with ejaculation	Not recommended	Not recommended	Not recommended	Not recommended
Fellatio without ejaculation	Not recommended	Not recommended	Not recommended	Not recommended
Splash of semen into eye	Not recommended	Not recommended	Not recommended	Not recommended
Cunnilingus	Not recommended	Not recommended	Not recommended	Not recommended

Sharing of injecting equipment	Recommended	Not recommended (b)	Generally not recommended (e)	Not recommended
Sharps injury	Recommended	Not recommended (b)	Generally not recommended (c,e,f)	Not recommended
Mucosal splash injury	Recommended	Not recommended (b)	Generally not recommended (c)	Not recommended
Human bite	Generally not recommended (g)	Not recommended	Not recommended	Not recommended
Needlestick from discarded needle in the community	Not recommended		Not recommended	Not recommended

Recommended: the benefits of PEP are likely to outweigh the risks; PEP should be given unless there is a clear reason not to. **Consider:** the risk of HIV transmission is low, the risk/benefit balance of PEP is less clear. The risk should be assessed on a case-by-case basis taking into consideration factors shown in footnotes c and d. **Generally not recommended:** the risk of HIV transmission is very low, the potential toxicity and inconvenience of PEP is likely to outweigh the benefit unless there is a clear specific extenuating factor which increases the risk (see footnotes c, d, e, f). We anticipate PEP should very rarely be given when the risk has been assessed and discussed. **Not recommended:** the risk of HIV transmission is negligible; PEP should not be given

(a) High prevalence countries or risk-groups are those where there is a significant likelihood of the index case individual being HIV-positive. Within the UK at present, this is likely to be GBMSM, people who inject drugs from high-risk countries and individuals who have immigrated to the UK from areas of high HIV prevalence (>1%), particularly sub-Saharan Africa. Country specific HIV prevalence can be found at *UNAIDS.*

(b) The index case has been on ART for at least 6 months with an undetectable plasma HIV viral load at the time of last measurement and within the last 6 months) with good reported adherence. Where there is any uncertainty about HIV VL results or adherence to ART then PEP should be given. The viral load threshold considered 'undetectable' in the PARTNER 1 and 2 and HPTN052 studies was <200 copies/ml.

(c) Factors that influence decision-making in all exposures: More detailed knowledge of local HIV prevalence within index case sub-population (a). The recommendations relate to high-risk groups living in the UK. Where the index case is from a high-risk group and normally resides outside the UK, the risk may be greater and where there is doubt PEP should be given.

(d) Factors that may influence decision-making include in sexual exposures: (1) Breaches in the mucosal barrier such as genital ulcer disease and anal or vaginal trauma following sexual assault or first intercourse. (2) Multiple episodes of exposure within a short period of time e.g. group sex. (3) Sexually transmitted infection in either partner. (4) Individuals at higher risk of acquiring HIV e.g. transgender people

(e) HIV prevalence amongst IDUs varies considerably depending on whether there is a local outbreak and country of origin and is particularly high in IDUs from Eastern Europe and central Asia. Region-specific estimates can be found in the *UNAIDS Gap Report*

(f) Factors that may influence decision-making include in occupational exposures: Deep trauma or bolus of blood injected

(g) PEP should only be considered after a bite if all three criteria are met: a) the biter's saliva was visibly contaminated with blood; b) the biter is known or suspected to have a plasma HIV viral load >3.0 log copies/ml; and c) the bite has resulted in severe and/or deep tissue injuries

PEP should be started as soon as possible, and always within 72 hours of potential exposure.

Partners of young people living with HIV that require PEP should be discussed with the appropriate clinician on call for GUM/SRH services in the local area. They can also be signposted to their local GUM/SRH clinic or accident and emergency department.

For more information see the BASHH*UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021* [4] and the Chiva *Post-exposure prophylaxis (PEP) guidelines for children and adolescents potentially exposed to blood-borne viruses* [20].

Circumcision

There is currently no public health evidence to recommend voluntary medical male circumcision (VMMC) as a strategy for HIV transmission reduction in the UK, either at a population or individual level [14].

However, studies do confirm the benefit of male circumcision in significantly reducing the risk of HIV acquisition [12]. VMMC is associated with around a 60% reduction in the risk for female-to-male transmission of HIV.

The US Centers for Disease Control and Prevention (CDC) supports VMMC for HIV prevention in prioritised African countries [13].

Superinfection

People living with HIV who are not taking effective ART are at risk of HIV superinfection. This is the acquisition of a new, phylogenetically different HIV virus, which might be more virulent and resistant to ART.

Recombination of the two viruses can lead to a rapid increase in HIV viral diversity, and an emergence of antiretroviral resistance, which limits future treatment options and leads to a poorer prognosis overall.

The risk of superinfection is negated in people taking ART [15].

6. Sharing information about HIV status with other people

Key points:

- Some young people living with HIV share their HIV status with their HCPs and/or close family only.
- HCPs should help young people living with HIV weigh up the pros and cons of sharing their status, offer practical tools, and identify support options in case of a negative reaction.
- In England and Wales, there is no legal obligation to share your HIV status with sexual partners, but if HIV transmission occurs through sex there is the potential for legal investigation.
- Conversations about criminalisation are vital, but they should be handled sensitively and not introduced immediately after diagnosis. Clear, supportive education empowers young people living with HIV without increasing fear.

Sharing HIV status is sometimes referred to as HIV 'disclosure.' As per the People First Charter, we encourage HCPs to use the less stigmatising terms 'share' or 'discuss' with their patients.

We advise all people living with HIV are encouraged to share their status with other HCPs in their life, e.g. their GP, dentist, pharmacist, or psychologist. This will mean that all HCPs are better able to provide appropriate care that meets the patient's needs.

A person's HIV status is private personal data which is protected by the UK General Data Protection Regulation (GDPR). It is an individual's decision to share their status or not. There are only a few exceptions to this, and these are specific to a person's employment (e.g. in some healthcare settings).

Many young people living with HIV have told very few people about their HIV status. As young people living with HIV transition to adult HIV services, they should be given support by HCPs around sharing their HIV status with others.

The decision to share HIV status with a sexual partner, friends, or family can be an extremely difficult decision to make. There are both advantages and disadvantages to sharing status, and these should be carefully weighed up on a case-by-case basis.

Advantages of sharing status may include:

- feelings of empowerment and relief
- gaining a support system of people who are aware of the person's status, which can help when dealing with a chronic medical condition and during times of illness
- combatting stigma
- increased trust and intimacy in relationships
- the opportunity to talk about ways in which a partner can manage their own health, e.g. discussing U=U, PrEP, condoms, and regular HIV testing
- sharing aspects of their journey which may have shaped their experiences and contributed to who the person is in a meaningful way.
- being able to request reasonable adjustments from their employer under the Equality Act (e.g. time off to attend appointments) as is their legal right [6].

Unfortunately, there is still a great deal of stigma and negative perceptions around HIV and many people living with HIV have been subject to rejection and hurtful or harmful reactions. The fear of negative reactions affects many young people's decision to share their HIV status [1,2].

Disadvantages of sharing status include:

- rejection/social ostracisation
- abandonment (which may be linked to loss of economic support)
- discrimination
- risk of violence
- secondary/indirect sharing of status (e.g. that of a parent)
- work-based discrimination
- once information about HIV status is shared, it cannot be taken back. Control over the shared information is lost once discussed with another person. Information about HIV status can be used against the person living with HIV or as 'gossip.'
- changing deep-seated beliefs and attitudes can be very challenging and it may not be something a person living with HIV wants to take on.

Sharing HIV status with sexual partners and HIV Criminalisation

> "Please don't bring up the issue of HIV criminalisation straight after someone has been told about their HIV – it can be very scary. It's okay to be 'human' when talking about sharing HIV status. Young people have had experiences where clinicians can be impersonal talking about it. This is unhelpful and can feel insensitive."

Box 4: A young person's view on discussions of HIV criminalisation

Research clearly demonstrates that the criminalisation of reckless - rather than intentional – transmission of HIV does not reduce the number of HIV transmissions.

It feeds stigma, including self-stigma, damages the wellbeing of people living with HIV, affects openness and trust in relationships, and is a barrier to achieving a good quality of life for people living with HIV [3].

However, people living with HIV need an understanding of the law around HIV transmission to be able to protect themselves from liability, alleviate fears, and encourage sexual enjoyment. This information should be discussed sensitively and supportively.

Anxiety around the legal implications of having sex whilst living with HIV are common, and young people living with HIV may express concern that they 'will be arrested for giving someone HIV.'

They can be reassured that the likelihood of this happening is extremely low.

Facts regarding criminalisation

To date, there has been one successful conviction of intentional transmission of HIV and 29 of reckless transmission of HIV (out of 34 prosecutions) in England and Wales.

For transmission of HIV to be deemed reckless under the Offences Against the Person Act (1861), guidance from the Crown Prosecution Service sets out five criteria that all need to be met:

- the accused knew they had HIV AND
- they understood how HIV is transmitted AND
- they engaged in a behaviour that risked transmission of HIV AND
- HIV transmission occurred AND
- the person who acquired HIV didn't know the accused was living with HIV at the time of transmission [4].

The key difference between reckless and intentional transmission is that, under reckless transmission, there is an absence of intent or malicious behaviour. Instead, there is a knowledge of HIV (status, modes of transmission) and a demonstrable lack of mitigating behaviour to prevent transmission occurring (e.g. not wearing a condom or not being on effective ART).

In addition to the above, in Scotland, someone risks being charged for putting another person at risk of HIV transmission even if they don't acquire HIV – this is known as 'reckless endangerment.'

Sharing HIV status with sexual partners

In England and Wales there is no legal obligation for people living with HIV to tell their sexual partner about their HIV status. However, a person may be legally investigated (in England and Wales) if:

- they had sex with someone who did not know about their HIV status
- they knew they were living with HIV
- they understood how HIV was transmitted
- they had sex which risked transmission (i.e. not using a condom, not having an undetectable viral load, or not knowing their partner was taking PrEP)
- HIV was transmitted to the person.

All young people living with HIV should be educated about U=U and the risk of HIV transmission to their sexual partner(s) during sex, as well as what to do if a transmission risk occurs:

When seeking sexual health support, young people living with HIV with a detectable viral load should:

- Be offered free condoms and a condom demonstration if required.

- Be supported and encouraged to share their status and advise their partner to attend their local GUM/SRH centre or Emergency Department to be assessed for PEP if the condom breaks or comes off.
- Be reassured that if a condom breaks it does not mean that they are prosecutable. Wearing a condom shows evidence of taking precaution, and the condom breaking is not their fault.
- Be supported to share their status with a partner if they wish to do so, e.g. their partner could come with them to a clinic appointment if they feel this would be safe and beneficial. It is then the partners responsibility to make their own risk assessment and access prevention tools (e.g. PrEP).
- Be given information about what they will do for immediate support if something goes wrong after sharing status, e.g. a direct contact identified in their centre of care.

Whilst never encountered in a court of law as far as we are aware, it is reasonable to assume that if a patient with a detectable viral load knows that their partner is taking PrEP, this would count as an effective method of preventing HIV transmission and would therefore be a suitable defence in the event of legal investigation.

In the rare instance that an allegation is made against a young person, early discussion with specialist agencies such as National AIDS Trust, Terrence Higgins Trust, Chiva, BASHH, or BHIVA is advised.

7. Young people and STIs

Key points:

- Age of sexual debut (first sexual intercourse) is similar in young people living with HIV compared to the general population.
- STIs affect young people living with HIV and regular offers of screening are vital.
- Young people living with HIV are at an increased risk of the effects of HPV, and it is vital that HPV vaccination is offered to this group.

Around one quarter of young people living in the UK have had sex before their sixteenth birthday [1] and studies show high rates of condomless sex in young people globally [2].

UK data suggests that the age of first sexual intercourse (sexual debut) is similar when comparing young people living with and without HIV. But condom use is higher among those living with HIV [3].

STIs

STIs are frequently asymptomatic, and regular offers of STI screening to those young people living with HIV at risk of STIs are essential to diagnose STIs early, avoid disease complications, and reduce the number of onward transmissions.

Young people experience the highest rates of the most common STIs.

The *Sexually transmitted infections and screening for chlamydia in England: 2024 report* shows that STI diagnoses had increased by 4.7% since 2022, with the impact of STIs remaining greatest in those aged 15-24 years, in GBMSM, and in some ethnic minority groups. There are also economic differences. Chlamydia detection rates are highest among young women living in the most deprived quintile in England [4].

Encouragingly, when compared to rates reported in 2019, the 2023 report shows that first episode genital warts diagnosis were reduced by:

- 49.7% in young women
- 68.4% in young men
- 81.6% in GBMSM aged 15-17 years.

Declines were also seen in all 18–24-year-olds.

These are all groups with direct or indirect protection from the human papillomavirus (HPV) vaccine that gives protection against HPV strains associated with both genital warts and anogenital cancers.

HPV vaccination is offered as part of the national vaccination programme at age 12-13 years and to all young people living with HIV. Studies demonstrate that people living with HIV have a six-fold higher risk of developing cervical cancer compared to their peers without HIV.

The WHO recommend that HPV vaccination strategies target young girls aged 9-14 years, before sexual debut, to ensure the highest level of protection (see section **9: Vaccination**) [5].

8. Taking a sexual history

Key points:

- When a young person living with HIV is fully aware of their HIV diagnosis, they should be encouraged to spend all or part of the consultation alone with the HCP to facilitate open discussion.
- A sexual history should be part of a routine medical history for young people living with HIV and HCPs play a vital role in creating an open forum for discussion around sex.
- HCPs should not assume that the young person is sexually active, nor make assumptions about their gender identity or sexuality.
- All HCPs caring for young people should be up to date with Level 3 safeguarding training and be aware of their local pathways for accessing immediate care after sexual assault and other forms of gender-based violence.

A sexual history should be part of a routine medical history for young people living with HIV, and it is our role as HCPs to create an open forum for discussion around sex.

It can take time to establish a trusting relationship with a young person, and discussions should not be forced. The HCP should carefully explore areas of concern and, if required, arrange for the young person to return and revisit the topic in the future.

Young people living with HIV consulted on this guideline were asked what they wanted from an HCP when talking about sex. Their top three requirements were someone who:

1. Is non-judgemental.
2. Has the correct information.
3. Maintains confidentiality.

When talking to HCPs, they also commented that:

- assumptions were made about them being sexually active
- assumptions were made about their sexual orientation
- the words used were “too long” and “confusing”
- “they did not ask me what I wanted”.

When a young person living with HIV is fully aware of their HIV diagnosis, they should be encouraged to spend all or part of the consultation alone with the HCP (without parents or carers).

Alongside encouraging independence, this provides privacy and an opportunity for questions and education around SRH. The young person should be reassured that discussions are confidential (within the usual limitations) and will not be shared with parents or carers.

If it is outside the remit of the HCP to provide SRH advice, the young person should be signposted to their local GUM/SRH service for ongoing care.

Robust and rapid referral pathways should be established with local GUM/SRH services.

Appendix 1 is an example proforma covering all areas that should be covered during a sexual history.

Key points to remember during a consultation include:

- HCPs should not assume that the young person is sexually active, nor make assumptions about their gender identity nor sexuality.
- It is essential to use appropriate, sensitive language and to regularly check patient understanding.
- Don’t overload the young person with too many questions, facts, or statistics until asked for them.
- Have the resources to be able to signpost the young person towards further reading after the consultation.

Sexual assault

All HCPs caring for young people should be up to date with Level 3 safeguarding training. HCPs should be aware of the local pathways for accessing immediate care after sexual assault and other forms of gender-based violence. This includes:

- where to access immediate clinical care. This may be via accident and emergency, a sexual assault referral centre (SARC), or a local GUM/SRH clinic. PEP, vaccinations, and emergency contraception should not be withheld whilst waiting for forensic examination. Each case will be individual, and we recommend HCPs contact their local GUM/SRH clinic or SARC for clinical advice in this scenario to ensure appropriate, timely care
- being aware of local referral pathways to Trust Safeguarding and other support services, e.g. SARC, social services, police.
- knowing where to refer young people for advice, support and counselling.

Further guidance is available from the *BASHH National Guideline on the Management of STIs in Young People 2021* [2] and the Royal College of Paediatrics and Child Health (RCPCH) [1].



The 'Physical Signs of Sexual Abuse (Purple Book)' is available at: www.childprotection.rcpch.ac.uk

Psychosexual issues

Psychosexual difficulties, including erectile dysfunction and vaginismus, may happen for several reasons, including physical and psychological conditions, and social circumstances.

Young people presenting with psychosexual difficulties should be assessed sensitively and referred to a specialist as appropriate. HCPs should know their local pathway for referring patients that require psychosexual input.

Genital dermatology

Patients with symptoms of a genital dermatosis, such as persistent genital itching (in the absence of STIs), skin changes, or difficulty retracting the foreskin, should be referred to Level 3 GUM/SRH services for assessment by a specialist.

9. Testing for Sexually Transmitted Infections (STIs)

Key points:

- STI screening can be offered within the HIV clinic if resources are available. Otherwise, young people living with HIV should be referred to local GUM/SRH services or signposted to online STI testing services where available and appropriate.
- Many STIs are asymptomatic, making regular screening essential to reduce complications and prevent transmission.
- Symptomatic patients should be referred to Level 3 GUM/SRH services for examination and expanded testing as appropriate.
- STIs may present atypically or more severely in immunocompromised patients.
- All young people living with HIV with a positive STI result should be referred to GUM/SRH services for treatment and partner notification support.

Asymptomatic patients

Many STIs are asymptomatic most of the time. It is therefore essential to offer STI testing to those at risk, whether symptoms are present or not. This is vital to diagnose STIs, to prevent complications from untreated infections, and to reduce onward transmissions with partner notification.

Young people living with HIV without symptoms can be reassured that tests for chlamydia and gonorrhoea can be self-taken (a urine sample for those with a penis or self-taken swab for those with a vagina) and do not require intimate examination. Syphilis and hepatitis screening are done via a finger prick blood test.

We recommend that screening is repeated with every new sexual partner. It's also recommended at three- to six-monthly intervals in GBMSM, and at least annually in heterosexual patients.

If a person tests positive for an STI, we recommend onward referral to GUM/SRH services for assessment and treatment.

People with vaginas:

- Self-taken vulvovaginal swab (chlamydia/gonorrhoea Nucleic Acid Amplification Tests (NAAT)).
- Syphilis serology and, if indicated by sexual history/non-immune, hepatitis B/C serology.

People with a penis:

- First void urine (chlamydia/gonorrhoea NAAT).
- Syphilis serology and, if indicated by sexual history/non-immune, hepatitis B/C serology.

Gay, bisexual, and other men who have sex with men (GBMSM):

- First void urine, rectal and pharyngeal swabs ('triple sites') (chlamydia/gonorrhoea NAAT).
- Syphilis serology and, if indicated by sexual history/non-immune, hepatitis B/C serology.

Box 6: Asymptomatic screening procedures

Symptomatic Patients

When symptoms are present, examination and more invasive tests may be necessary. This might include urethral swabs for those with a penis and speculum examination for those with a vagina.

All patients with symptoms should be referred to Level 3 GUM/SRH services for assessment where they may be offered tests for other STIs such as herpes simplex virus (HSV) and trichomonas vaginalis (TV). They might also be offered testing for non-STIs such as vulvovaginal candidiasis (VVC) and bacterial vaginosis (BV).

STIs in immunocompromised patients may present atypically and be associated with more severe disease, requiring longer courses of treatment.

See **Appendix 2: Table 1** and **Appendix 2: Table 2** for information about the different STIs/conditions. This information has been summarised from the relevant BASHH guidelines for each condition, which can be accessed at the BASHH website [1].

Partner notification for STIs

Partner notification (PN) is the process of trying to ensure that all sexual contacts of a person who tests positive for an STI receive testing and treatment.

This is vital as many infections are asymptomatic but can cause complications later. Patients can notify sexual partners themselves, or GUM/SRH clinics can provide anonymous provider notification should the young person feel uncomfortable with sharing information about a diagnosis.

PN is not required for HSV, or genital warts (HPV). Candida, bacterial vaginosis, and molluscum contagiosum are not STIs and therefore do not require PN.

For more information see *BASHH Statement on Partner Notification for Sexually Transmissible Infections* [2].

10. Vaccinations

Key points:

- Young people living with HIV are eligible for various vaccinations, including hepatitis A and B, human papillomavirus (HPV), mpox, and gonorrhoea.
- Young people living with HIV with a CD4 count of less than 200 should not receive replicating (live) vaccines as these carry a risk of vaccine-induced disease.

Where possible, vaccines should be given by the HIV parent team, or patients can be referred to GUM/SRH services. HCPs should follow Chiva and BHIVA guidance and be aware of the UKHSA Green Book updates to the UK immunisation schedule [1,2,3].

Appendix 3: Table 3 summarises the vaccine requirements for young people living with HIV.

All people living with HIV should be screened for hepatitis A and B at diagnosis. They should also be screened if they haven't been immunised and there is a suspicion of active infection.

Human papillomavirus (HPV) vaccine

Studies demonstrate that people living with HIV have a six-fold higher risk of developing cervical cancer relative to their peers without HIV. The WHO recommend that HPV vaccination strategies target young girls aged 9-14 years, before sexual debut, to ensure the highest level of protection [4].

Data on HPV among people with a penis who acquired HIV perinatally are scarce.

In the UK, HPV vaccination is offered as part of the national vaccination programme at age 12-13 years. However, most under 25s are offered only one dose via the national programme. Young people living with HIV require three doses and so it is important to ensure that the course is completed.

Consideration should also be given to young people living with HIV who have arrived from overseas and may not have received any HPV vaccines at all.

11. Cervical screening

Key points:

- Cervical screening for PLWH should follow NHS and BHIVA guidelines, starting at age 25.
- Cervical cancer is rare under 25, but symptoms such as bleeding after sex or consistently bleeding between periods require assessment.
- People living with HIV have a six-fold higher risk of developing cervical cancer, with higher cervical intraepithelial neoplasia progression and lower regression in immunosuppressed individuals. They are offered annual cervical screening from the age of 25.
- Barriers such as non-disclosure of HIV status to GPs, or gender identity concerns, can hinder access, and alternative screening routes should be offered and supported.

Age of screening

In the absence of specific guidance, the age of cervical screening for young people living with HIV remains in line with the *UKHSA national guideline for cervical screening* and *BHIVA Guidelines for The Routine Investigation and Monitoring of Adult HIV-1-Positive Individuals*.

Reasons for cervical screening, annual frequency of screening, and what happens during the procedure should be discussed with young people living with HIV who are approaching the age of 25. Patients should attend screening whether they are sexually active or not.

Patients with symptoms

Cervical cancer in under 25s is rare. Symptoms of cervical cancer in under 25s include post-coital bleeding (PCB) and persistent intermenstrual bleeding (IMB).

- The critical intervention in the diagnosis of cervical cancer is an urgent speculum examination by a trained practitioner, as recommended by SIGN and NICE guidance, to enable a clear view of the cervix.
- This should be alongside STI screening, bimanual examination (to exclude pelvic inflammatory disease), and a pregnancy test.

This can be offered at GUM/SRH services.

If the cervix looks suspicious, urgent referral is required to colposcopy under the 'two-week wait' pathway to rule out malignancy. The published NHS guidance *Clinical Practice Guidance for the Assessment of Young Women aged 20 -24 with Abnormal Vaginal Bleeding* is available for further information [1].

Accessing screening

Most cervical screening takes place in primary care. However, if a patient is reluctant to share their HIV status with their GP this may create barriers to annual testing.

Without the relevant clinical information, a patient may appear to be outside the usual screening interval, and their samples may be rejected for analysis. These patients should be supported to access services, either through encouragement to share their status with their GP, or through provision of cervical screening by their HIV parent team or GUM/SRH services, where possible.

Transgender patients

Transgender men and non-binary people who have had a total hysterectomy to remove their cervix do not need cervical screening. Those who still have a cervix should have cervical screening to help prevent cervical cancer.

It is well established that transgender people with a cervix face many barriers to equitable care. They also often experience anxiety relating to cervical screening. One study demonstrated that only 53% of transgender people who were eligible to be screened felt that they had enough information about the procedure, and almost half had chosen not to attend based on their gender identity. They reported concerns regarding dysphoria, unprofessional behaviour, and pain [2,3].

Information around how to support transgender and non-binary patients to safely access cervical screening is available from organisations such as the Eve Appeal [4].

12. Reproductive Health

Key points:

- In young people living with HIV, there are significant rates of unplanned pregnancy and studies show low frequency of documentation by HCPs of discussions around contraception with patients.
- The availability of contraception should be discussed with all young people living with HIV of childbearing potential, before they are sexually active. Those considering contraception should be assessed by a professional trained in contraception provision.
- Young people living with HIV requiring emergency contraception should be signposted to appropriate services.
- In the event of an unplanned pregnancy, young people living with HIV should be directed to appropriate services to discuss their options and help them to make an informed decision.
- For people living with HIV on effective treatment, with an undetectable viral load, there is an extremely low risk of vertical transmission of HIV during pregnancy and birth.
- National guidance recommends that women/birthing parents feed their babies with formula milk (or donor milk) exclusively to ensure that the risk of HIV transmission to their infants postpartum is zero. However, those that wish to breastfeed can be supported to do so.

Barriers to discussing contraception

There has been significant progress in reducing teenage pregnancy rates in England over the last two decades, with the conception rate for those aged under 18 years in England and Wales reduced by more than half between 2011 and 2021.

However, young people in England still experience higher teenage birth rates than their peers in other Western European countries.

Inequalities in teenage birth rates persist between and within local authorities, and outcomes for young people and their children are disproportionately poor, contributing to intergenerational inequalities [1,2].

Whilst studies show obstetric and virological outcomes in pregnant young people living with HIV in the UK are favourable, high rates of these pregnancies are unplanned.

Significant rates of repeat conceptions within the year have also been found, and studies show low frequency of documentation by HCPs of discussions around contraception with patients [3].

Multiple HCP-related factors can impact discussion and contraception with young people living with HIV, such as:

- general discomfort amongst paediatric HCPs when addressing issues relating to sex in younger patients
- consultations being focused on the prevention of STIs and HIV transmission rather than contraception
- lack of healthcare provider knowledge
- concerns around drug interactions between contraceptives and ART.

Patient-related barriers are multiple and complex, such as:

- difficulty discussing their SRH needs with an HCP they have known for a long time
- impairments in cognitive ability and requiring information adapted to their learning needs [4].

Contraception

The availability of contraception should be discussed with all young people living with HIV of childbearing potential, before they are sexually active.

Those considering contraception should be seen by a professional trained in contraception provision – they can be referred to local GUM/SRH services if required.

There are numerous contraceptive options available, as summarised in **Appendix 4: Tables 4 & 5.**

Free condoms are available at all GUM/SRH clinics and at other outlets.

Free condom services are listed on the NHS service 'Find a Condom'

Not all methods of contraception are compatible with antiretroviral therapy (ART). Prescribers should refer to the Liverpool HIV Drug Interactions Checker [13] and seek advice if required.

ART that's based around integrase inhibitors has minimal interactions with contraceptives.

Emergency contraception

Emergency contraception (EC) is a treatment that can be used after condomless sex to prevent a pregnancy before it occurs. There are 3 methods available in the UK:

- oral levonorgestrel
- oral ulipristal acetate
- the Cu-IUD (copper coil)

EC is available from various places including GUM/SRH clinics and GP surgeries. Oral methods are also available at pharmacies and can be bought online.

Patients can use the NHS 'Find Emergency Contraception' tool

Oral EC is not suitable for use with some older, less commonly used ART. Prescribers should refer to the Liverpool HIV Drug Interactions Checker [13] and seek advice if required.

EC should be given by an HCP trained in contraception provision to work out which method is most suitable for the patient, to advise on follow-up pregnancy testing, and discuss future contraception.

Unplanned pregnancy

In the event of an unplanned pregnancy, young people living with HIV should be directed to appropriate services to discuss their options and be supported to make an informed decision.

A variety of services are available for information including GUM/SRH clinics, GPs, and dedicated termination of pregnancy (TOP) providers, such as the British Pregnancy Advisory Service (BPAS) (www.bpas.org). HCPs should be familiar with their local pathways.

If a young person chooses to terminate a pregnancy, future contraception should be discussed and plans made to start contraception post-TOP. For more information see the *NICE Guideline on Abortion Care (2019)* [5].

Fertility

Studies have demonstrated an inverse association between HIV and fertility [7,8] in those with childbearing potential, which may increase the demand for fertility treatment.

There is evidence that people living with HIV show a significant impairment of semen parameters compared to the reference values [9]. Data has also shown poorer fertility outcomes in a group of patients with perinatally-acquired HIV [10].

For these reasons, people living with HIV who are trying to conceive should be referred for fertility evaluation if they have not conceived within 6-12 months of trying to conceive. Earlier referral should be made if there is a history of pelvic inflammatory disease.

Conception

Young people living with HIV should have access to support that includes accurate information about safe conception for themselves and their partners, involving their partners where appropriate to do so.

The main objectives are to achieve a successful pregnancy while:

- avoiding viral transmission to the seronegative partner
- avoiding viral transmission to the child.

Serodiscordant couples (where one partner is living with HIV and the other is not) can be counselled that conception through unprotected sexual intercourse is an appropriate and safe option if the partner living with HIV is on suppressive ART with an undetectable viral load

If the HIV-positive partner is not on ART and/or not suppressed, this should be reviewed. ART should be offered or optimised as appropriate, and the risks of onward transmission to the partner not living with HIV discussed.

Pregnancy

For people living with HIV on effective treatment, with an undetectable viral load, there is an extremely low risk of vertical HIV transmission during pregnancy and birth.

Some young people will have acquired HIV via vertical transmission themselves, and it is vital that they are given accurate, up-to-date information about pregnancy outcomes to ease anxieties and allow them to make informed life choices.

The UK has met and exceeded the Joint United Nations Programme on HIV/AIDS target since 2017. A major success has been the low vertical HIV transmission rate which has been estimated as less than 0.4% since 2012. This reflects the high uptake of HIV antenatal testing (99.8%) and the impact of the NHS Infectious Diseases in Pregnancy Screening Programme [6].

All pregnant young people living with HIV should be managed in a Specialist HIV Antenatal and Obstetric service, as well as receiving routine care from their regular HIV physician.

They will be seen more frequently for close viral load monitoring and regular wellbeing assessment. For more information see the *BHIVA Guidelines of the Management of HIV in Pregnancy and the Postpartum Period 2025* [11].

Breast/chest feeding

Suppressive ART significantly reduces, but does not eliminate, the risk of vertical transmission of HIV through breast/chest feeding. 'U=U' applies only to sexual transmission, and we currently lack data to apply this to breast/chest feeding.

Choosing not to breastfeed removes the risk of postpartum HIV transmission to infants. For this reason, BHIVA recommends that babies are fed with formula milk (or donor milk) exclusively to ensure that the risk of HIV transmission to their infants postpartum is zero [11].

However, it is recognised that abstaining from breast/chest feeding can have financial, cultural, and psychological repercussions. Therefore, people who are virologically suppressed on ART with good adherence and who choose to breast/chest feed should be supported to do so.

They should be informed about the very low risk of transmission of HIV through breast/chest feeding in their situation and requirement for extra maternal and infant clinical monitoring.

Breast/chest feeding should be for a maximum of 6 months as HIV transmission risk increases with longer durations of breast/chest feeding, even when the parent is on suppressive ART.

Mixed feeding with formula should not be recommended but can be supported in certain situations, on a case-by-case basis, in consultation with an HCP experienced in HIV. Mixed feeding with solids (supplementing milk with solid food) before the age of six months is never recommended. See the interim *BHIVA position statement on HIV and mixed infant feeding (2020)* for more information [12].

All people living with HIV who choose not to breast/chest feed are eligible for free formula, and it is vital that HCPs are familiar with their local pathways to access this for patients.

13. Key populations

Key points:

- Lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual (LGBTQIA+) people experience worse outcomes than the general population in most areas of healthcare and are disproportionately affected by HIV.
- Young GBMSM are a vulnerable group and tailored sexual health support is required, including discussion around vaccinations, doxyPEP, chemsex, and support around coming out.
- A large proportion of young women who have sex with women (WSW) have had, or are having, sex with men, and remain at risk of all STIs and unplanned pregnancy.
- Young people living with HIV who identify as transgender and non-binary have unique SRH needs and may often lack access to culturally competent, and age appropriate SRH care and education. HCPs should be aware of where to signpost patients requiring specialist services.
- Young people living with HIV may be disproportionately affected by learning difficulties and disabilities. Services providing GUM/SRH care to young people living with HIV should undertake mandatory training as per local protocol and have well established links with their local learning disability teams.

Supporting LGBTQIA+ young people

The LGBTQIA+ acronym stands for lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual. The plus holds space for the diverse spectrum of gender and sexual identities people may identify with.

LGBTQIA+ people experience worse outcomes than the general population in most, if not all, areas of healthcare, including access to GUM/SRH services. Reasons for this include:

- lack of appropriate services
- discrimination within services
- lack of knowledge around the specific risks faced by some LGBTQIA+ people.

There is a significant lack of research, but where evidence exists, it paints a stark picture of LGBTQIA+ people's unmet needs. The aforementioned barriers may result in missed opportunities for STI screening, SRH provision, risk assessment and support around sexual wellbeing. It is vital that services caring for young people living with HIV have a service design that caters to the needs of this community [1].

It remains illegal to be LGBTQIA+ in 64 UN member States, with the death penalty imposed in some countries. This is vital to consider for young people living with HIV who have arrived in the UK from countries where they may have suffered physical or mental abuse because of their sexuality or gender identity, and who may benefit from support around this [3].

It must also be considered for young people living with HIV planning to travel to these countries where their HIV status and carrying ART may restrict entry [4].

aidsmap has information on Travel restrictions for people with HIV

Young gay, bisexual, and other men who have sex with men

LGBTQIA+ people are disproportionately affected by HIV and GBMSM remain the group at highest risk of HIV acquisition in the UK [2].

Young GBMSM can be a vulnerable group and require tailored sexual health support. There can be a lack of appropriate relationships and sex education (RSE) in schools for this group, as well as a lack of supportive peer relationships around negotiating safer sex.

The following areas should be covered with all young people living with HIV that identify as GBMSM:xs

- Vaccination provision for HAV, HBV, HPV, gonorrhoea, and mpox.
- The availability of doxycycline post-exposure prophylaxis (doxyPEP).
- Risk assessment of vulnerability factors, CSE and high-risk sexual behaviours.
- Discussion around certain sexual activities, such as chemsex.
- Support around 'coming out.'

Stonewall has information for young people about coming out

DoxyPEP

Taking a dose of oral doxycycline up to 72 hours after a sexual risk can significantly reduce the risk of syphilis and chlamydia acquisition. This is known as doxyPEP and is now available via the NHS nationally.

DoxyPEP can be offered to all GBMSM and transgender women at an elevated risk of acquiring syphilis. It can be considered for other groups on a case-by-case basis.

Patients should be signposted to their local Level 3 GUM/SRH service to discuss. For more information see the *BASHH UK National Guideline for the Use of Doxycycline Post-Exposure Prophylaxis (DoxyPEP) for the Prevention of Syphilis* [5].

Alcohol, recreational drugs, and chemsex

A key component of a sexual history is asking about recreational drugs and alcohol, because their use is a major factor in sexual risk taking. HCPs should:

- be able to identify problematic substance misuse
- be aware of commonly used drugs and the potential complications of their short- and long-term use
- know where to signpost/refer patients requiring support.

One in five 16–24-year-olds have used a recreational drug in the last year, and their use is reported by three quarters of GBMSM.

Chemsex is the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit, or facilitate the sexual experience. Common chemsex drugs include:

- methamphetamine (crystal meth)
- gammahydroxybutyrate (GHB)
- gamma-butyrolactone (GBL)
- mephedrone.

Multiple drugs may be used during a single session, which may extend over multiple days, and involve higher risk sex with multiple partners. There is also evidence of increasing levels of injecting (known as slamming) and sharing equipment. A significant proportion of GBMSM using chemsex drugs are living with HIV [6].

A small number of questions can be asked to identify substance use, and whether it is likely to be problematic and/or impact on sexual health (see **Box 7**: **Questions to help identify substance use**).

To assess problematic alcohol use, screening tools such as FAST [7] are quick and simple to do and some services choose to offer Alcohol Brief Interventions [31].

- Have you used drugs in the past 12 months?
- Which ones?
- Did you inject them? If so, did you ever share equipment?
- Are you, or anyone close to you, worried about your drug use, or think it may be having a bad effect on you or your health?

Box 7: Questions to help identify substance use

Ketamine

Ketamine is a class B drug. It's cheap and accessible, and its use among 16–24-year-olds has more than doubled since 2013.

Increasing numbers of young people are suffering with the complications of ketamine use, such as ketamine uropathy or 'ket bladder'. This is a debilitating and potentially irreversible combination of lower urinary tract symptoms (LUTS).

Patients reporting LUTS should be directly asked about ketamine use so that patients are assessed and supported appropriately. See the *British Association of Urological Surgeons Consensus statements on the management of ketamine uropathy for more information* [8].

Young women who have sex with women

Young women who have sex with women (WSW) can be a vulnerable group. There are misconceptions that they have a lower risk of STIs and engage in fewer risk behaviours compared to other groups.

WSW includes women who identify as lesbian, bisexual, and pansexual, as well as those who identify with other sexualities. A large proportion of WSW have had, or are having, sex with men.

Studies show that, compared to their heterosexual peers:

- young WSW have higher pregnancy rates
- young WSW have higher rates of coerced sex, injecting drug use, and multiple lifetime sexual partners
- WSW are more likely to report having sex with GBMSM
- WSW are more likely to report having sex with injecting drug users.

Sensitive discussions with WSW should include discussion around:

- contraception (with a trained HCP)
- STI risks associated with skin-to-skin contact, exchange of bodily fluids, and exposed sites, the use of barrier methods, and support in negotiating safer sex with both male and female partners, if relevant
- the need to complete the HPV vaccination programme
- the need to attend the cervical screening programme from the age of 25 years (regardless of sexual history) [9].

Transgender and non-binary people

Gender identities exist on a continuum.

- The term transgender describes those whose gender identity does not match their assigned biological sex at birth. The term transgender is often shortened to trans.
    - A transgender woman is someone who was assigned the sex of male but identifies as a woman.
    - A transgender man is someone who was assigned the sex of female but identifies as a man.
- The term non-binary describes those whose gender identity is not defined within a binary classification of gender, i.e. not male or female.

Of the 212 trans people accessing HIV care in 2022, 22.2% were aged 15-34 [2].

Young people living with HIV who identify as transgender or non-binary have unique SRH needs and may lack access to culturally competent, and age appropriate SRH care and education.

There is a growing body of evidence around transgender and non-binary young people's sexual activity, pregnancy, and STI rates, but gaps remain.

BASHH have provided sexual health service standards for trans and non-binary people and the key considerations with regards to sexual health care for this group include:

- Establishing the patient's pronouns.
- Under the Gender Recognition Act (2004), the knowledge that a patient is transgender is considered to be protected information.
- Sharing of this information with another HCP should only occur for medical purposes, and if the person sharing the information reasonably believes that the subject has either given consent or cannot consent. It is good practice to seek and document explicit consent from the patient.
- Pregnancy risk should be assessed in everyone with a womb and ovaries having sex with a risk of pregnancy that does not wish to conceive. This includes anyone assigned female at birth who has not undergone a hysterectomy or bilateral oophorectomy.
- Transgender men taking testosterone remain at risk of pregnancy.
- Contraception should be discussed with all people with childbearing potential. Guidance on contraception options for transgender and non-binary patients can be found in the *FSRH CEU Statement: Contraceptive Choices and Sexual Health for Transgender and Non-Binary People* [11] and the *BASHH Recommendations for Integrated Sexual Health Services for Trans, Including Non-Binary, People* [10].

Learning difficulties and learning disabilities

A learning disability (LD) is a reduced intellectual ability leading to difficulty with everyday activities such as household tasks, socialising, or managing money. It affects someone for their whole life.

A learning difficulty usually presents in childhood and can cause a person to experience problems in a traditional classroom setting, such as dyslexia or dyspraxia. It does not affect general intellect.

Learning disabilities in young people living with HIV

The developing brain is particularly vulnerable to the effects of early biological and/or psychosocial adversity.

The neurocognitive impact of living with HIV on the developing brain, particularly for those presenting with severe disease, such as infantile HIV encephalopathy, can be significant, resulting in poorer school performance and difficulties in executive functioning.

This can further impact on the ability of some young people living with HIV to negotiate their healthcare [12]. There are also other contributory factors.

- Parents or carers may not highlight concerns they have about their child's development with school or other services due to fears about their child's, or their own, HIV status being shared.
- Parents or carers living with HIV may have their own mental health, cognitive, or functioning difficulties, which impacts the recognition, reporting, or support of impairments.
- Children living with HIV in the UK are overrepresented by minority ethnic populations. Approximately half are born outside of the UK. Many don't have English as a first language, and the majority are likely to have experienced stressful life events growing up, such as family bereavement, and migration to a different country [13].
- Children with HIV may have additional neurodevelopmental risk factors, such as co-infections, premature birth, and perinatal drug and alcohol exposure [14].
- Environmental factors, such as lower socioeconomic status and changes in primary caregiver, further add to the risk of poorer cognitive and educational outcomes [15].
- Social stigma, including devaluing and stereotyping of individuals living with HIV, can be related to lower social support, increased risk of mental health symptoms, and poor physical health [16].

Learning disabilities and sex

Just like everybody else, people with LD have sexual rights, which need to be affirmed, defended, and respected. These rights were written into UK law by the Human Rights Act 1998 [17]. The United Nations Convention on the Rights of Persons with Disabilities [18] explicitly sets out the rights of disabled people to plan a family and the Mental Capacity Act 2005 supports the rights of people with LD to engage in consensual sex [19].

The nationally representative *Next Steps* study suggests that young people with mild to moderate LD were as likely to have had sex by the age of 19 as their peers without LD [20]. However, this group often face barriers and limited sexual freedoms due to a variety of factors, including:

- concerns from families, carers, and HCPs around the ability to consent and vulnerability to exploitation
- concerns from families, carers, and HCPs around STIs and pregnancy [21]
- societal stigma
- infantilising attitudes towards people with disabilities [22-24].

There is little information available estimating the prevalence of sexual health issues amongst young people with LD, but studies demonstrate that they are more likely to practice condomless sex compared to other young people. Those of childbearing potential are also more likely to have been pregnant or be a mother [25].

Young people with a disability are over three times more likely to be abused or neglected than those without a disability [26,27]. They may not understand that they are being abused, be unable to ask for help, or rely on their abuser to provide their care. They may also be specifically targeted by abusers due to their vulnerabilities.

Signs that a young person with a disability is being abused or neglected may also be misinterpreted as part of their impairment.

Accessing GUM/SRH services

Services providing GUM/SRH care to young people living with HIV with LD should undertake mandatory training as per local protocol and have clear pathways with their local LD teams [28].

All services should implement reasonable adjustments. Under the Equality Act 2010, all disabled people have the right to reasonable adjustments that ensure they have equal access to good quality healthcare.

Reasonable adjustments can be simple changes made:

- by an individual HCP, such as speaking clearly and slowly
- by a service, such as offering a quiet place to wait or flexible appointment times [29].

Visit www.mencap.org.uk for more information

Lack of accessible sex education information means that many people with a LD are not taught about sexual health, contraception, LGBTQIA+ relationships, masturbation, and the legal and emotional aspects of sex.

HCPs play an important role in providing the best standard of care to people with LD. Areas of focus should include STIs, cervical screening, and contraception.

STIs

Easy-to-read patient information leaflets should be available to all patients around sexual health testing and management.

Examples can be seen at Let's talk about sex: Easy read leaflets.

Cervical screening

Rates of cervical screening are low for those with LD compared to the general population. Young people living with HIV who have a learning disability should be supported to engage in annual cervical screening [30]. Support may include adjustments to the room and/or equipment and offering longer appointments.

Contraception

Studies show that people with LD feel that they do not have the opportunity to make their own family planning decisions. The use of long-acting reversible contraceptives in this group is high, and those involved in research report that decisions are imposed on them.

Some individuals are assessed as unable to make their own decision about contraception, and the involvement of others is required to make a 'best interests' decision on their behalf. For those involved in this sensitive task it is crucial that decision-making is undertaken in ways that uphold the autonomy, wishes, and preferences of the individuals themselves [31].

14. Sex and the media

Key points:

- The mainstream media and other technologies have been shown to have significant impact on young people's sexual behaviours and attitudes towards sex.
- Concerns include exposure to sexual content, sexting, online grooming, and online peer pressure.
- Young people should be aware that it is illegal to send naked images or videos of, or to, people under 18. If a person is over 18, it is illegal for them to receive sexually explicit photos of someone who is under 18. This is even if they are in a sexual relationship with the other person.
- Parents and HCPs should have open conversations with young people about online safety and responsible digital behaviour, and signpost them to further information they can look at in their own time.

The digital era has radically changed the way we communicate and share information. The use of social media (such as Instagram and TikTok), digital communication channels (such as Snapchat and WhatsApp), the mainstream media, and other technologies among young people has been shown to have significant impact on their sexual behaviours and attitudes towards sex.

Exposure to sexual content

Young people have easy access to sexually explicit content, ranging from post-watershed productions to online pornography. This can impact expectations around relationships and sex and normalise risky behaviours [1].

www.choicesupport.org.uk has easy-to-read information on porn

Sexting

Sexting is the sharing of sexually explicit messages, images, and videos through digital communication channels. Images and videos sent are usually of the sender. These are commonly referred to as 'nudes.

Young people should be aware that it is illegal to send naked images or videos of, or to, people under 18. It is also illegal for a person over 18 to receive sexually explicit photos of someone who is under 18, even if they are in a sexual relationship with

them. Once images are shared online, control over them is lost, and this can risk image-based abuse and/or cyberbullying [2].

☎	**You can call the Revenge Porn Helpline on 0345 6000 459**

Online grooming
Young people may seek validation from online communities and experience peer pressure to conform [3]. Perpetrators can form trusting relationships with young people through online channels such as social media or video games. They can also use more sophisticated methods, such as using the dark web, to groom young people for sexual exploitation.

Young people who have experienced online sexual exploitation should be helped to access support services.

Media and young people living with HIV
A key concern for young people living with HIV using social media is their privacy and confidentiality.

Social media use among people living with HIV, including GBMSM, ethnic minority groups, and young people is increasing, and studies demonstrate that these groups use social media to form social ties, access health information and emotional support, and build a sense of community with peers.

The increased social support provided by social media has been shown to improve treatment adherence and assist with coping with HIV-related stigma [4].

How to support all young people in the digital age
Parents and HCPs should have open conversations with young people about online safety, responsible digital behaviour, and signpost them to information they can look at in their own time

🔎	**Visit Taking control of your online safety on the Childline website**

Encourage young people to use strong privacy settings on social media platforms.

Parents/carers should be advised to monitor young people's online activity, especially for younger children. This can be done whilst still respecting privacy boundaries.

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Appendices

Appendix 1: Sexual Health History Taking Guideline

All young people:

- Confidentiality statement for under 18s.
- Ascertain gender identity and preferred pronouns.
- Ascertain if the young person is sexually active or planning to be. If a young person is not yet sexually active, this is an excellent opportunity for education and establishing rapport.
- Ask what the young person would like to know about sex.
- Ask if there are any specific questions around sex and HIV, e.g. sharing status, having children.

- Performing oral sex on a penis: fellatio, "blow job."
- Performing oral sex on the vulva: cunnilingus, "giving head."
- Vaginal sex: frontal sex, insertive sex.
- Insertive anal sex (patient's penis penetrates the partner's anus): "Top," "Giving."
- Receptive anal sex (patient's anus is penetrated): "Bottom," "Receiving."
- "Versatile" is when the patient has both insertive and receptive anal sex.

Box 8: Commonly used alternative terms

If the young person is sexually active:

Do they have any symptoms?

- e.g. Change in vaginal discharge, intermenstrual or post coital bleeding, abdominal pain or dyspareunia in women/patients assigned female at birth.
- e.g. Urethral discharge/dysuria and testicular pain in males/patients assigned male at birth.

Symptomatic patients should be discussed with/referred to a local GUM/SRH services for examination and testing.

When did they last have sex?
STIs observe window periods and may not show up if a test is performed within it. E.g. chlamydia and gonorrhoea both have a window period of two weeks.

What was the gender of their partner(s)?
e.g. to a cis male: "Was that partner a boy or a girl/male or female/did they have a penis or a vagina?" This will guide where swabs need to be taken from and what tests should be done.

How long have they been having sex with that partner(s)?
Again, this can guide the HCP re: window periods and the need for future testing.

What sort of sex did they have? i.e. oral, vaginal/frontal, anal (see commonly used terms (Box 8).
This will guide where swabs need to be taken from.

Did they wear a condom? If so, did they wear it throughout sex, did it break or come off?
(Not expected for oral sex).

Check Hepatitis A and B immunity
All young people living with HIV should be vaccinated against hepatitis A and B

Check they have been vaccinated against HPV
All young people living with HIV should be vaccinated against HPV.

Is their partner aware of their HIV status?
See section 6 for guidance around sharing HIV status with a partner.

Have they discussed condoms/PrEP/PEPSE with their partner if appropriate?

Reproductive Health

All young people:

Are they or their partners using contraception?
If so, which method and are they happy with it?

Individuals of childbearing potential:

- First day of last menstrual period (LMP) and usual cycle length, character of periods, i.e. light or heavy, are they painful (which may influence choice of contraception).
- Have they ever been pregnant? What was the outcome? (TOP/miscarriage/delivery).

Individuals with a cervix approaching their 25th birthday
Require annual cervical screening via their GP or HIV service.

If the YP is aged 17 and under:

- Assess CSE risk. Most sexual health clinics have a departmental CSE proforma based on the BASHH/Brook document 'Spotting the Signs.'

All patients, irrespective of age, should have a vulnerability assessment.

- This includes:
    - Do they feel safe at home?
    - Have they been pressured into sex/had non-consensual sex?
    - Have they ever received money for sex or paid for sex?
    - Have they undergone female genital mutilation (FGM?)
- Ask about smoking, alcohol consumption and recreational drug use. Alcohol and recreational drug use may influence sexual activity, and this can be an opportunity to signpost patients to support services. Intravenous drug use and sharing 'straws' to snort drugs confer a risk of Hepatitis B and Hepatitis C and these should be tested for if there is an identified risk.

Appendix 2: Non-sexually transmitted and sexually transmitted infections (STIs)

Table 1: Non-sexually transmitted infections

Infection/ Condition	Things to know	Symptoms/Signs	Complications	What to do?
Physiological vaginal discharge	This is a normal, hormonally driven change in discharge throughout the menstrual cycle. It may be more noticeable during pregnancy and the use of hormonal contraceptives. It contains lactobacilli that help to maintain healthy vaginal pH.	Usually a clear/white, odourless discharge that is cyclical in amount and consistency.	N/A.	Patients can keep a 'discharge diary' to recognise cyclical variation and become familiar with their menstrual cycle. **If a patient has concerns about their vaginal discharge they should be signposted/referred to Level 3 GUM services for assessment.**
Vulvovaginal Candidiasis (VVC)	VVC is caused by yeasts that belong to the genus *Candida.*	<u>In those with a vagina:</u> Vulval itch. Non-offensive vaginal discharge.	VVC occurs more frequently and with greater persistence in PLWH.	Patients with signs/symptoms of VVC should be signposted/referred to

	Candida are present in low numbers on healthy skin in moist areas: but their overgrowth can cause infection to develop.	Soreness or burning. Superficial dyspareunia. <u>In those with a penis:</u> Rash. Soreness. Itch.		Level 3 GUM services for assessment.
Bacterial vaginosis (BV)	BV is the commonest cause of abnormal discharge in those of childbearing age. Lactobacilli are the dominant bacteria in the healthy vagina. In BV, the pH of vaginal fluid increases, allowing anaerobic bacteria to grow to high levels. **Risk factors for pH change include:** vaginal douching, receptive cunnilingus, new sex partner, smoking, presence of an STI.	<u>In those with a vagina:</u> Offensive, fishy-smelling vaginal discharge.		Patients with signs/symptoms of BV should be signposted/referred to Level 3 GUM services for assessment.

Table 2: Sexually Transmitted Infections (STIs)

Infection	Things to know	Symptoms/Signs	Complications	What to do?
Chlamydia (CT)	*Chlamydia Trachomatis* is the most commonly reported, curable bacterial STI in the UK. The highest prevalence rates are in 15–24-year-olds and it is easily transmitted. It's most often identified in the genital tract (penis/vagina), rectum and pharynx. Conjunctival infections can rarely occur. **Window Period: 2 weeks.**	**Mostly asymptomatic.** <u>In those with a penis:</u> Urethral discharge. Dysuria. Testicular pain/swelling. <u>In those with a vagina:</u> Change in vaginal discharge. Post-coital (PCB) and intermenstrual bleeding (IMB). Dysuria. Lower abdominal pain. Deep dyspareunia. <u>Can also cause:</u> Anorectal discharge/bleeding/pain.	Untreated CT can ascend the genital tract, leading to pelvic inflammatory disease (PID) (see below) and Epidydimo-orchitis (E-O) (see below). Lymphogranuloma Venereum (LGV) is an aggressive serovar of CT that can cause altered bowel habit, anorectal pain/ discharge/ bleeding and lymphadenopathy. Sexually acquired reactive arthritis (SARA).	Offer all asymptomatic patients at risk a combined CT/Gonorrhoea NAAT. All patients that test positive for CT should be immediately signposted/referred to Level 3 GUM services for assessment, treatment, partner notification and arrangement of test of cure.

		Pharyngeal infections are largely asymptomatic.		
Gonorrhoea (GC)	*Neisseria gonorrhoea* is a bacterial STI, transmitted via direct inoculation of infected secretions from one mucous membrane to another, i.e. urethra, endocervix, rectum and pharynx. **Window Period: 2 weeks.**	**Can be asymptomatic**. <u>In those with a penis:</u> Urethral discharge. Dysuria. Testicular pain/swelling. <u>In those with a vagina:</u> Change in vaginal discharge. Dysuria. Lower abdominal pain. IMB (rarely). <u>Can also cause:</u> Anorectal discharge/bleeding/pain. Pharyngeal infections are largely asymptomatic.	Transluminal spread of GC from the urethra or endocervix may occur and cause PID, E-O or prostatitis. Haematogenous dissemination may occur to cause skin lesions, arthralgia, arthritis and tenosynovitis (disseminated gonococcal infection).	Offer all asymptomatic patients at risk a combined CT/GC NAAT. All patients that test positive for GC should be immediately signposted/referred to Level 3 GUM services for assessment, treatment, partner notification and arrangement of test of cure.

Tricho-monas vaginalis (TV)	TV is a flagellated protozoan. In cis-men, infection is usually urethral. In cis women, it's found in the vagina, urethra and paraurethral glands. TV is not a known issue for those with a neovagina following gender reassignment surgery. TV may enhance HIV transmission and there may be an increased risk of TV infection in those that are HIV positive.	**Up to 50% are asymptomatic.** <u>In those with a penis:</u> Urethral discharge Dysuria and urinary frequency. <u>In those with a vagina:</u> Altered, often offensive discharge. Genital itch and vulval ulceration. Dysuria. Lower abdominal pain.	TV infection may be associated with preterm delivery and low birth weight and TV infection at delivery may predispose to maternal postpartum sepsis.	Patients with symptoms/signs of TV should be immediately signposted/referred to Level 3 GUM services for assessment.
Mycoplasma Genitalium (MGen)	MGen is a bacterial STI and untreated infection can persist for years.	**Mostly asymptomatic.** <u>In those with a penis:</u> Urethral discomfort/Urethritis.	Untreated MGen can ascend the genital tract, leading to PID.	Patients with symptoms/signs of MGen should be immediately

	However, evidence suggests that the majority of people infected with MGen in the genital tract do not develop disease.	Urethral discharge. Dysuria. <u>In those with a vagina:</u> Change in vaginal discharge. Dysuria. PCB and IMB. Lower abdominal pain. Deep dyspareunia.	Persistent/recurrent urethritis.	signposted/referred to Level 3 services.
Anogenital Herpes Simplex Virus (HSV)	HSV-1 is the usual cause of orolabial herpes and now the most common cause of genital herpes in the UK. HSV-2 is more likely to cause recurrent anogenital symptoms. Incubation of infection from acquisition to first clinical signs and symptoms varies, ranging from days to years.	<u>Local symptoms of a HSV outbreak include:</u> Painful ulceration. Dysuria. Penile/Vaginal discharge. Systemic flu-like illness in primary infection (primarily fever and myalgia).	Autonomic neuropathy leading to urinary retention. Autoinoculation to fingers and adjacent skin e.g. on thighs. Proctitis. Aseptic meningitis.	Patients with symptoms/signs of anogenital HSV, should be immediately signposted/referred to Level 3 services. **Pregnancy: there is a risk of perinatal HSV transmission, which can be life-threatening to the neonate.** Any patient with active HSV or a history of HSV who

	For PLWH, HSV may present with more frequent, severe recurrences and require longer/second-line treatment courses. The most important risk factor for HSV reactivation being the degree of HIV-associated immunosuppression. HSV infections may facilitate onward HIV transmission to sexual partners and HSV infection is associated with an increased risk of HIV acquisition.			is pregnant, or whose partner is pregnant, should be discussed immediately with local GUM/SRH specialists.
Syphilis	Caused by infection with the spirochete bacterium *Treponema*	Often asymptomatic. Syphilis is a multi-stage, multi-system disease,		Regular syphilis serological screening for PLWH is routinely

	pallidum, subspecies pallidum. Transmitted by direct contact with an infectious lesion. Clinical features of syphilis are generally no different in people living with HIV from those in individuals not living with HIV.	with a wide spectrum of presentations.		recommended and after any new risk. Patients with symptoms/signs or serology suggestive of syphilis infection should be signposted/referred to Level 3 GUM/SRH services.
Non-Gonococcal Urethritis (NGU)	Urethritis, or inflammation of the urethra, is a multifactorial condition which is often sexually acquired. The commonest implicated organisms are CT and MGen.	<u>In those with a penis:</u> Urethral irritation. Urethral discharge. Dysuria. Penile irritation.	E-O. SARA (<1%).	Patients with symptoms/signs of NGU should be signposted/referred to Level 3 GUM services for assessment.

Anogenital Warts	Anogenital warts are caused by the *human papillomavirus* (HPV) of which over 100 genotypes have been identified. Around 90% of anogenital warts are caused by HPV types 6 or 11. **All PLWH under the age of 25 should be offered a course of three HPV vaccines.** Warts may be more extensive and persistent in PLWH and HPV clearance is impaired in those with a low CD4 count/uncontrolled HIV.	Warts are benign epithelial lesions, most often multiple. Lesions may be seen anywhere on the anogenital skin and mucosa including the vulva, vagina, cervix, urethral meatus and anal canal.	Extragenital sites affected by genital HPV subtypes include the lips, oral mucosa, oropharynx, larynx, conjunctivae, and nasal cavity.	Patients with symptoms/signs of genital warts should be signposted/referred to Level 3 GUM services for assessment. Biopsy may be needed where there is diagnostic uncertainty.
Molloscum Contag-iosum (MC)	This is a benign epidermal eruption of the skin, caused by	Smooth-surfaced, firm, dome-shaped papules with central umbilication.	Severe molluscum infection can manifest in the context of immunocompromise,	Patients with signs of MC should be signposted/referred to Level 3 GUM services

	molluscum contagiosum, a large DNA virus. It may be spread by physical and sexual contact, fomites or autoinoculation. Giant mollusca can occur with immunocompromise.		notably late-stage HIV infection.	for assessment and consideration of treatment.
Scabies	Scabies is caused by the mite *Sarcoptes scabiei var hominis*. Transmission occurs through close skin contact.	Intense generalised pruritus that is usually worse at night. Skin lesions, including: Erythematous papules, often excoriated, seen in a characteristic distribution over the interdigital web spaces, sides of fingers, under fingernails, flexor aspects of wrists, extensor aspects of elbows, anterior and	Persistent nodular lesions (post-treatment) which are thought to result from a hypersensitivity reaction to the mite. 'Crusted' or 'Norwegian" scabies is characterized by erythematous scaly crusted lesions, associated with fissuring and can affect any part of the body or head. It is	Patients with signs/symptoms of Scabies should be signposted/referred to Level 3 GUM services for assessment.

		posterior axillary folds, around the nipples, penis and scrotum, umbilicus, upper medial aspect of thighs, buttocks and sides/backs of feet. Burrows, which are linear intra-epidermal tunnels produced by the moving mite, appearing as short threadlike elevations of 2-10 mm in length. Nodular lesions, especially on the penis and scrotum, buttocks, groin, and the axillary regions. These are intensely pruritic.	more common in those with a low CD4 count.	
Pubic lice	Sometimes known as 'crabs,' public lice infestation is with the	Adult lice infest coarse hairs of the pubic area, body hair and, rarely,		Patients with signs/symptoms of Pubic Lice should be

	crab louse *Phthirus pubis*. The louse is transmitted by close body contact.	eyebrows and eyelashes. Eggs (nits) are laid which adhere to the hairs. The main symptom is itch due to hypersensitivity to feeding lice. Blue macules (maculae caeruleae) may be visible at feeding sites.		signposted/referred to Level 3 GUM services for assessment.
Pelvic Inflamm-atory Disease (PID)	PID occurs when untreated genital infection ascends the genital tract to cause cervicitis/endometritis/salpingitis and oophoritis. CT and GC account for a quarter of UK cases. PLHIV may have more severe symptoms but	Lower abdominal pain, typically bilateral. Deep dyspareunia. Change in vaginal/cervical discharge. PCB, and IMB. Menorrhagia/dysmenorrhoea. Systemic signs of sepsis in moderate-severe disease, e.g. pyrexia,	There is a low threshold for treatment to prevent sequelae including: Ectopic pregnancy. Chronic pelvic pain. Subfertility.	In any patient with suspected PID, you must IMMEDIATELY exclude pregnancy and a surgical abdomen. Patients with signs/symptoms of PID should be immediately signposted/referred to Level 3 GUM services for assessment or

	respond well to standard treatment.	tachycardia, hypotension.		inpatient services in moderate-severe presentations.
Epididymo-Orchitis (E-O)	Acute E-O is a clinical syndrome consisting of pain, swelling and inflammation of the epididymis +/ testis. There are a number of causes, the commonest being bacterial infection (STIs, gram negative enteric organisms) and viral infection (e.g. mumps).	Acute onset unilateral scrotal pain, swelling and erythema. Urethritis and urethral discharge. Dysuria, frequency and urgency. Systemic signs of sepsis in moderate-severe disease.	Reactive hydrocoele. Abscess formation. Infarction of the testicle (rare). Subfertility.	In any patient in whom you suspect E-O, you must IMMEDIATELY exclude testicular torsion. Patients with signs/symptoms of E-O should be immediately signposted/referred to Level 3 GUM services for assessment or inpatient services in moderate-severe presentations.
Mpox (formerly known as monkeypox)	mpox virus can be transmitted via close physical contact with Mpox blisters or scabs, e.g. via touch, kissing or	Flu-like symptoms can precede a rash that can affect any part of the body: raised spots evolve into fluid-filled	Dehydration. Secondary bacterial skin infections. Conjunctivitis, keratitis. Pneumonia.	Anyone suspected of mpox should self-isolate whilst the HCP urgently refers to Level 3

	touching bedclothes/towels or via respiratory droplets.	blisters/sores that can be confused with Chickenpox. Anal pain and rectal bleeding.	Encephalitis.	GUM/SRH or inpatient services as appropriate.
Hepatitis A virus (HAV)	HAV is a faeco-orally transmitted RNA virus that can be passed on sexually, e.g. oro-anal contact (e.g. 'rimming') and digital-rectal contact. All PLWH should be screened to assess if they are immune to HAV and if not, offered a vaccine.	Often asymptomatic. <u>In the acute phase:</u> Flu-like illness. Jaundice. Abdominal pain (RUQ). Pale stools and dark urine.	<u>Rarely:</u> Severe hepatitis. Acute liver failure. Chronic infection. In pregnancy, there is an increased rate of miscarriage and premature labour.	If a patient presents with symptoms suggestive of acute viral hepatitis, discuss with the relevant team for inpatient assessment. **Acute HAV is a notifiable disease.**
Hepatitis B Virus (HBV)	HBV is a blood-borne DNA virus that can be sexually transmitted. All PLWH should be screened to assess if	<u>In the acute phase:</u> Flu-like illness. Jaundice. Abdominal pain (RUQ).	<u>Rarely:</u> Acute liver failure. In pregnancy, there is an increased rate of miscarriage and	If a patient presents with symptoms suggestive of acute viral hepatitis, discuss with

	they are immune to HBV and if not, offered a vaccine. The rate of chronic HBV infection is higher in PLWH who are immunocompromised. Profound immunosuppression can also reactivate HBV infection.	Pale stools and dark urine.	premature labour and a risk of vertical transmission. Chronic infection may lead to chronic liver disease and an increased risk of hepatocellular carcinoma (HCC).	the relevant team for inpatient assessment. Patients diagnosed with chronic HBV should be referred to a team experienced in managing HIV/Hepatitis co-infection for assessment and ongoing management.
Hepatitis C Virus (HCV)	HCV is a blood borne RNA virus that can be sexually transmitted. It's more common in GBMSM, with associated factors including the presence of other STIs, traumatic anal sex, fisting, sharing sex toys, communal lubricant, group sex and	The majority of patients are asymptomatic. Acute HCV is rare but may present with: 'Flu-like illness. Jaundice. Abdominal pain (RUQ). Pale stools and dark urine.	Rarely: Acute liver failure. Some patients may clear HCV spontaneously. It may lead to chronic liver disease and an increased risk of HCC. In pregnancy, there is an increased rate of miscarriage and	If a patient presents with symptoms suggestive of acute viral hepatitis, discuss with the relevant team for inpatient assessment. Patients who are found to have chronic HCV should be referred to a team experienced in managing HIV/Hepatitis

	recreational drug use (including snorted drugs). No vaccine is available against HCV and so regular testing based upon risk is vital. In severe immunosuppression, HCV Ab may be negative but PCR positive: HCPs should consider HCV PCR with abnormal liver function tests and significant risk.		premature labour, proportional to the severity of the illness.	co-infection for assessment and ongoing management. HCV is now curable with the use of Direct-Acting Antivirals (DAAs).

References:

- British Association for Sexual Health and HIV (BASHH) website. Guidelines. https://www.bashh.org/resources/guidelines/. Accessed 25/2/25

Appendix 3: Vaccine requirements for young people living with HIV

Table 3: Vaccine requirements for young people living with HIV

Infection	Vaccine	Replicating?	Indication	Things to know
Hepatitis A (HAV)	Inactive	No	All non-immune.	Seroconversion rates and antibody titres may be lower in PLWH, relating to CD4 count at the time of immunisation. Response to vaccination should be checked routinely and further immunisation considered where applicable with specialist advice. Neither the hepatitis A/B ('Twinrix') nor hepatitis A/typhoid combined vaccine are recommended due to possible reduced immunogenicity.
Hepatitis B (HBV)	Subunit	No	All non-immune.	Response rates may be lower depending upon the degree of immunosuppression. Response to vaccination should be checked routinely and further immunisation considered where applicable with specialist advice.

				The hepatitis A/B ('Twinrix') combined vaccine is not preferred due to reduced immunogenicity.
Human Papillomavirus (HPV)	Virus like particles	No	All GBMSM and women living with HIV up to the age of 40. All other PLWH up to the age of 26.	All young people aged 12-13 years are offered the HPV vaccine in school as part of the UK National Vaccination Programme with Gardasil 9. It confers protection against anogenital cancers and genital warts and is safe and highly immunogenic in PLWH.
MPox	Replication-defective virus MVA-BN	No	At risk patients, e.g. GBMSM.	The safety and immunogenicity of MVA-BN in PLWH with CD4 cell counts above 100 cells/mm has been demonstrated, but the immune response to the vaccine could be reduced in severely immunosuppressed individuals.
Gonococcus (GC)	Multicomponent protein vaccine (MenB)	No	At risk patients, e.g. GBMSM.	It should be offered to all GBMSM and on a case-by-case basis to other patients at high-risk of GC acquisition.

References

- Public Health England. Immunisation against Infectious Disease. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book Updated 2024. Accessed 14/3/25.
- Vaccination of children living with HIV (UK schedule, 2022). Chiva 2022. https://www.chiva.org.uk/wp-content/uploads/2023/05/Vaccination-of-Children-living-with-HIV-Final-2023.pdf. Accessed 14/3/25.
- British HIV Association guidelines on the use of vaccines in HIV-positive adults 2015. BHIVA 2015.

Appendix 4: Contraception

Non-user dependent contraception or long-acting reversible contraception (LARC)

LARC methods are extremely effective at preventing pregnancy, as they do not need to be remembered daily and do not interrupt sex. They can provide protection for long periods of time. They can however require a procedure to fit which can be uncomfortable and carries risks as below.

LARC methods DO NOT protect against STI transmission, including transmission of HIV.

The following table gives a brief overview of the different LARC methods. For further information for professionals, the FSRH guidelines are accessible from the FSRH and information for patients is available from Contraception Choices.

Table 4: LARC methods

Method of contraception	Things to know	Failure rate	Pros and Cons
Copper Intrauterine Device (Cu-IUD) or 'copper coil'	A small, T-shaped device containing copper that is toxic to eggs and sperm, preventing fertilisation and implantation. Lasts up to 10 years.	Typically, fewer than 1 in 100 will get pregnant in one year.	Pros: ● Non hormonal. ● Can be used as emergency contraception. Cons: ● Can cause/worsen heavy menstrual bleeding (HMB)/dysmenorrhoea/length of periods. ● Requires a procedure to fit, with risks.

Levonorgestrel Intrauterine System (LNG-IUS) or "hormonal coil"	A small, T-shaped device containing levonorgestrel. Progestogenic effects on cervical mucus prevent the passage of sperm and alter the endometrium to prevent implantation. It may also inhibit ovulation. Lasts up to 8 years.	Typically, fewer than 1 in 100 will get pregnant in one year.	Pros: ● Periods are likely to be lighter, less painful or may stop. Cons: ● May cause hormonal side-effects, e.g. mood changes, skin problems, breast tenderness. ● Requires a procedure to fit, with risks.
Subdermal implant (SDI) or "implant"	A single-rod implant that releases etonogestrel (ENG). It acts by suppressing ovulation, with additional effects on the endometrium and cervical mucus. Lasts up to 3 years.	Typically, fewer than 1 in 100 will get pregnant in one year.	Pros: ● Periods are likely to be lighter, less painful or may stop. Cons: ● Requires a procedure to fit, with risks. ● Irregular bleeding occurs in 1 in 5 users. ● May cause hormonal side-effects, e.g. mood changes, skin problems, breast tenderness.
Progestogen-only injection or "depo"	Injection of medroxyprogesterone that is administered every 13 weeks. It acts by suppressing ovulation, with additional effects on the endometrium and cervical mucus.	Typically, fewer than 1 in 100 will get pregnant in one year.	Pros: ● Periods are likely to be lighter, less painful or may stop. May reduce pain from endometriosis. ● May offer protection against ovarian and endometrial cancers.

			<u>Cons:</u> ● Associated with weight gain, particularly if aged under 18 and if BMI greater than 30. ● Fertility can take up to one year to return after discontinuation. ● May cause hormonal side-effects, e.g. mood changes, skin problems.

User-dependent contraception

User-dependent methods of contraception tend to be less effective than 'LARC' as they rely on the user remembering to take them and may interrupt sex. However, they do not require a procedure to fit and can afford the user autonomy in starting/stopping the method. Some also protect against STIs.

The following table gives a brief overview of the different user-dependent methods. For further information for professionals, the FSRH guidelines are accessible from the FSRH and information for patients is available from Contraception Choices.

Table 5: User dependent methods

Method of contraception	Things to know	Failure Rate	Pros and Cons
Condoms	External (male) and internal (female) condoms are available. Internal condoms are lubricated sheaths inserted into the vagina before sex. They provide a physical barrier to sperm reaching the cervix.	Condom use is highly user dependent. With 'perfect' use, less than 2 in 100 people using external condoms will get pregnant in a year and less than 5 in 100 for those using internal condoms. With typical use however, it's estimated that 15 in 100 people will get pregnant in a year.	Pros: ● Protects against STI transmission, including HIV. ● Non-hormonal. Cons: ● Condoms can interrupt sex and may reduce pleasure. ● They can break or slip off/slip out.

			• It can be difficult to negotiate using condoms.
<u>Combined hormonal contraceptive methods (CHCs)</u> **Combined oral contraceptive pill (COCP)** **Transdermal patch (CTP)** **Vaginal ring (CVR)**	These methods contain an oestrogen and a progestogen delivered orally as the COCP, transdermally as the CTP or the CVR. The primary mechanism of action is prevention of ovulation. Changes to cervical mucus, endometrium and tubal motility that result from progestogen exposure may also contribute to the contraceptive effect.	CHC is highly user dependent. If used perfectly, the risk of CHC contraceptive failure is low (fewer than 1 in 100 will get pregnant in one year) but with typical use it's estimated that around 9 in 100 may get pregnant in a year.	<u>Pros:</u> • May improve acne. • May treat symptoms of endometriosis, PCOS and menopause. • May protect against womb, ovarian and bowel cancer. <u>Cons:</u> • May cause problematic intermenstrual bleeding (IMB). • May cause hormonal side-effects, e.g. nausea, sore breasts, mood changes or change in libido. • Increased risk of blood clots in the legs or lungs (5-12 in 10,000 users). • The CTP is only available in lighter skin tones.

Progesterone only pill (POP) – 'mini pill'	This oral POP contains a form of oral progesterone only. The primary mechanism of action is prevention of ovulation. There are additional contraceptive effects on the viscosity of cervical mucus, on the endometrium, and activity of cilia in the fallopian tube.	POP use is highly user dependent. If used perfectly, the risk of CHC contraceptive failure is low (fewer than 1 in 100 will get pregnant in one year) but with typical use it's estimated that around 9 in 100 may get pregnant in a year.	<u>Pros:</u> ● Periods may be lighter, less painful or may stop. ● Often suitable for people who can't take oestrogen. <u>Cons:</u> ● May cause problematic IMB. ● May cause hormonal side-effects, e.g. nausea, sore breasts, mood changes or change in libido.
Diaphragm ('Caya')	**For PLWH, the use of a diaphragm is currently a UK Medical Eligibility Criteria (UKMEC) Category 3 and NOT RECOMMENDED.**		

References

- The College of Sexual and Reproductive Health Care (CoSRH). Standards and Guidelines. https://www.fsrh.org/Public/Public/Standards-and-Guidelines.aspx?hkey=86c80484-36fe-4d6d-96c6-05cdc8e7b8da. Accessed 14/3/25.
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