

Swinging: If you don't ask you won't find – but you need to.

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Sexual health services in the UK are under increasing financial pressure[1] so the need to ensure that those at greatest risk of STIs and HIV receive appropriate care is greater than ever. While some men who have sex with men (MSM) have long been recognised as one such population group[2] with well-established systems to identify them, others such as swingers are not as the paper by Dukers-Muijrs *et al* highlights[3]. Their data from sexual health clinics in the Netherlands show how patients who, *when asked*, identified as swingers and/or who reported partner-swapping, having sex with other couples together with their partner, or visiting sex clubs with for couples, also reported other behaviours known to be important for STI/HIV transmission including larger numbers of partners, condomless sex, paid and same-sex partners[3]. I emphasise 'when asked' as these questions were not routinely asked in one of the study clinics, meaning that many swingers will have missed out on receiving the care they needed, with implications for their own, their partners', and public health.

So, how many swingers are there? Reliable estimates are difficult to come by, in part because swingers are a hidden population and also because swinging can be defined in various ways, as reflected by the clinics in Dukers-Muijrs *et al* study asking several questions to determine a patient's 'swinger status'[3]. Indeed, some studies include singles in their definition as well as partners in a committed relationship, all of whom report engaging in sexual activities with others as a recreational or social activity[4]. Britain's most recent National Survey of Sexual Attitudes and Lifestyles (Natsal) asked: "*In the last year, have you and a partner, as a couple, engaged in sex with other couples?*"[5], which resulted in a population prevalence estimate of swinging of 0.64% (95% confidence interval: 0.52%-0.80%), which seems low in contrast to claims made by the tabloid press[6] and swinging websites[3]. This may be due to participants' reluctance to disclose this behaviour (even though Natsal-3 asked about swinging in a computer-assisted self-interview alongside a number of other highly-sensitive questions[5]), which would tally with the observation in Dukers-Muijrs *et al*'s study of an under-reporting of swinging in patients' online registration – despite their study's more-liberal setting of the Netherlands.

The secrecy surrounding swinging and the club-like nature of the swinging community means that developing and delivering effective interventions to reduce STI transmission in this hidden population are likely to be challenging. Working with its gate-keepers (e.g. website hosts and providers, convention organisers) will be key to reach those who choose the lifestyle[7] as privacy is at the heart

of swinging etiquette[8,9]. Despite agreeing boundaries at the outset seemingly the norm, qualitative research suggests that rules regarding condom use in swinging encounters are less frequently established and/or adhered to[8]. Perhaps unsurprising, several studies have reported that only a small minority of swingers use condoms regularly or consistently[10,11]. When discussed, the decision of whether or not to use condoms is said to reflect whether the couples have had previous encounters together, their knowledge of the extent to which the other couple engage in swinging, and "*the cleanliness of the other couple*" [8, p.795]. While it was rare for the swingers interviewed for Kimberly and Hans' study to have regular or repeat encounters with other swingers[8], reflecting how variety was their *raison d'être* for swinging, the other reasons reported for condomless sex, especially the assumption of being able to detect 'clean' partners, are areas that health promotion messaging can - and should - address. A large challenge in promoting condom use is the emphasis on sexual pleasure in swinging encounters[12] as for many people, swingers and non-swingers alike, condoms are perceived as diminishing sexual pleasure. Health promotion opportunities also exist for partner notification, which Dukers-Muijers *et al* argue is a key component of an appropriate care package for swingers[3]. Swinging seldom involves completely anonymous sex such that getting partners tested and treated is, in theory, possible. As swinging encounters typically - and deliberately - lack an emotional bond then this may make partner notification more acceptable and feasible in practice, especially if promoted as a way of protecting the lifestyle.

Aside from health promotion, what do the findings of Dukers-Muijers *et al*'s work mean for clinical practice? Patients must be routinely-asked direct questions about swinging, thus beyond simply the number and timing of their partners. While doing so may result in only a small proportion of a clinic's population identifying as swingers, these patients are epidemiologically important. Their high-risk behaviour and their position and connectivity in the sexual network mean they play a disproportionate role in STI transmission. The appropriate care of one patient identifying as a swinger is therefore likely to yield far greater public health gain, justifying the additional investment of time and resource. As far as what constitutes 'appropriate care', swingers should be tested according to the sexual practices they report, which again requires that they are *asked* about these behaviours rather than making assumptions based on their heterosexual identity. For example, the Dutch study reported a high prevalence of oral and anal sex among swingers, requiring swabs to be taken from extra-genital sites[3].

Dukers-Muijers *et al* found that the swingers in their sample frequently tested, which, as they recognise, can be a good thing especially when other risk behaviours are reported[3]. However, the

resource implications mean that it is even more important that an episode of care involves appropriate care for swingers and *their partners* through partner notification to break the cycle of (re-)infection and to reduce their time between clinic visits. As a clinic-based study, it was not possible for Dukers-Muijers *et al* to comment on swingers who did not seek care. Although the number of participants in Natsal-3 reporting swinging in the year prior to interview was small (n=133) precluding detailed analyses, the majority of the swingers in Natsal-3 (n=91, 68%) did not report attending a sexual health clinic during this time, yet 13 reported having had STI(s) diagnosed in the past year. This corresponds to around 10% of swingers, which compares to 6% among MSM[13], both of which are considerably higher than the 1% observed for the general population[14]. It is imperative therefore that sexual health services routinely ask about swinging in order to identify and appropriately care for this high-risk population.

[1046/1200 words]

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