





## ORIGINAL ARTICLE

# Experiences with health care services and HIV testing after sexual assault in cisgender gay, bisexual and other men who have sex with men and transgender people

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## Abstract

**Objectives:** This qualitative sub-study aimed to explore how cisgender gay, bisexual, and other men who have sex with men (cis-GBMSM) and transgender people who reported non-consensual sex (NCS) accessed health care services, what barriers they faced, and how this experience influenced subsequent HIV testing.

**Methods:** SELPHI is an online randomized controlled trial evaluating both acceptability and efficiency of HIV-self testing among cis-GBMSM and transgender people. Semi-structured interviews were conducted, audio-recorded, transcribed, and analysed through a framework analysis, as a qualitative sub-study. We identified narratives of NCS from interviews and investigated experiences of cis-GBMSM and transgender people accessing health care services following sexual assault.

**Results:** Of 95 participants, 15 (16%) spontaneously reported NCS. Participants reported a broad range of NCS, including partner's coercive behaviours, non-consensual removal of condoms, and rapes. All feared HIV transmission, leading them to test for HIV, underlining a marked lack of awareness of post-exposure prophylaxis (PEP). Most had negative experiences in communicating with reception staff in sexual health clinics following these incidents. A lack of confidentiality and empathy was described in these situations of psychological distress. Clinic visits were primarily focused on testing for HIV and sexually transmitted infection, and generally no specific psychological support was offered. Getting a negative HIV result was a key step in regaining control for people who experienced NCS.

**Conclusions:** Sexual health care providers should take care to more fully address the issue of NCS with cis-GBMSM and transgender people when it arises. Recognizing and managing the emotional impact of NCS on affected patients would prevent negative experiences and increase confidence in care.

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**KEYWORDS**

HIV test, men who have sex with men, non-consensual sex, sexual health, United Kingdom

**INTRODUCTION**

Non-consensual sex (NCS) is an increasingly recognized concern for sexual and gender minorities, including cisgender and transgender gay, bisexual, and other men who have sex with men (cis-GBMSM), and transgender women [1, 2]. Approximately 30%–50% of cis-GBMSM report having experienced sexual assault in their lifetime [3, 4]. Transgender people are disproportionately affected, experiencing almost four times more sexual violence than cisgender men [5, 6]. NCS covers a broad spectrum of situations that include partner's coercive behaviours, non-consensual condom removal, and rape [7, 8]. The stories of cis-GBMSM and transgender people who have experienced NCS highlight difficulties in identifying whether certain sexual contacts are inappropriate [9].

No research in this population has investigated how people who experience NCS manage HIV risk. Access to health services after NCS is a crucial step in testing for HIV and sexually transmitted infection (STI), access to HIV post-exposure prophylaxis (PEP), provision of psychological support, and assistance with legal procedures. No studies have examined PEP after NCS in cis-GBMSM and/or transgender people, except for assessing tolerance and completion rates without including patients' narratives.

Our aim was to explore the experiences of cis-GBMSM and transgender people accessing health care services following sexual assault, what barriers they faced, and how this influenced subsequent HIV testing. To reach our aim, we analysed interview data from participants without HIV in the SELPHI randomized controlled trial (RCT) who spontaneously reported NCS [10]. SELPHI investigated the acceptability, feasibility, and impact of HIV self-testing among cis-GBMSM and transgender people. Qualitative data were generated through interviews with SELPHI participants, although these were not originally intended to explore NCS. The frequent spontaneous mention of NCS by respondents prompted us to conduct this additional work and to develop recommendations to improve care for cis-GBMSM and transgender people.

**METHODS**

The SELPHI protocol is published elsewhere [10], as are comprehensive descriptions of trial pathways and interventions [11–16]. Nested qualitative research was

conducted, consisting of 95 interviews with SELPHI participants. A total of 46 interviews were conducted with a general sample of cis-GBMSM, 29 with Asian, Black and Latin American cis-GBMSM, and 20 with transgender people (i.e., 12 transgender men and eight transgender women). Ten interviews took place in May 2017 during the RCT pilot phase, and 85 were conducted during and following the main trial between January 2018 and July 2020. Interviews with participants across England and Wales were conducted remotely ( $n = 73$ ) or face-to-face ( $n = 22$ ) depending on location and COVID-19 restrictions. SELPHI participants who consented to in-depth interviews were approached by the members of the study team (TCW, TW). Interviews were conducted by TCW, TW, PS, and EJM. Participants provided written or verbal recorded consent and were compensated £30. Ethical approval was granted by University College London (ref: 24477/001).

Semi-structured interviews followed a topic guide covering: HIV testing history, HIV testing patterns, experiences of sexual health services, mental health, engagement with HIV self-tests, and experiences of the gay scene. This analysis focuses on respondents who spontaneously reported NCS, primarily to questions in the first section related to the types of risks that might prompt HIV testing. We identified NCS using the definition inspired by Drückler et al., which includes “all sexual experiences beyond one's limits or unpleasant sexual experiences”, although in our sample, participants reported experiences of coercive sex more pronounced than an unpleasant experience [8].

Interviews were audio-recorded and transcribed verbatim. Data analysis followed a framework approach [17, 18]. RP and TCW familiarized themselves with the transcripts and developed an analytical framework. RP, TCW, and AR then met to discuss and refine this framework. The framework was piloted on the first transcripts by RP and then further refined. The transcripts were then coded by RP and discussed with TCW and AR.

**RESULTS**

Of 95 interviews conducted with SELPHI participants, NCS was reported in 15 interviews. Table 1 presents participant characteristics. NCS was described as rapes ( $n = 6$ ), including one case of intimate partner violence, non-consensual condomless sex with non-negotiated

TABLE 1 Participant demographic characteristics.

Demographic characteristic	Number of respondents
Age (years)	
20–35	9
36–50	4
51–65	2
Ethnicity	
White	7
Asian	3
Black	3
Mixed	1
Undisclosed	1
Gender	
Cisgender men	11
Transgender women	2
Transgender men	2
Sexual orientation	
Homosexual	12
Bisexual	1
Undisclosed	2

condom removals ( $n = 5$ ), sexual assaults following blackouts during parties due to spiked drinks ( $n = 3$ ), and coercive behaviours by a regular partner ( $n = 1$ ). Of the 15 participants, nine had accessed a sexual health clinic after NCS, one had consulted his general practitioner, one had used an HIV self-test at home, two had not been tested for HIV or accessed support in the weeks following NCS (data were missing for two participants). No respondents were taking HIV pre-exposure prophylaxis (PrEP) at the time of the reported NCS.

### NCS and perception of HIV transmission risk

Five of the 15 respondents had not tested for HIV before the NCS, whereas 10 had established HIV testing routines. In both groups, NCS (or potential NCS in the case of drug-induced blackout) was perceived to be the highest risk for HIV transmission of all other sexual experiences. For respondents who had not previously tested, NCS served as a warning about HIV-related issues and gave rise to their entry into regular HIV testing and precautionary behaviour:

“Up to that point, I never even gave HIV a thought really. I knew it was around, but I

was one of these people that thought, it will never happen to me. So, I think that it was traumatic, but it was a big wake-up call for me as well.”

*(36–50-year-old white gay cis-man)*

For respondents who already tested regularly, NCS disrupted their HIV risk management. For these individuals, the main focus of their anxiety around HIV transmission was due to non-consensual condom removal and the unknown HIV status of the aggressor. One participant who had an HIV testing routine with generally low testing-related anxiety in normal circumstances reported dramatically heightened emotions surrounding her HIV test following NCS:

“That changed things a lot. That was a horrible feeling. I think I was just convinced that ... I was just convinced that something was going to go wrong.”

*(36–50-year-old trans-woman, undisclosed ethnicity and sexual orientation)*

However, in some cases, the fear of contracting HIV was not at the forefront after NCS and did not lead to being tested for HIV. This was the case for respondents who reported NCS with a regular partner. In contrast, sometimes it was other factors beyond the assault itself (e.g., not being able to reconnect with the assailant, being blocked on social media and dating apps by the partner, or being told that the assaulting partner had an STI) that underlined the importance of HIV and STI testing:

“So, obviously, red flags started ... And I just started thinking, Oh, my God, if I ... So, yeah. I kept leaving it and I thought, Do you know what? This is my health at the end of the day. If someone sees me going in or whatever, it's tough. And then I've just gone. I mean I've gone, and I did, but that was only why. Otherwise, I probably wouldn't have, to be honest.

- So, how long did it take you to go and get tested that time?
- After sleeping with him?
- Yeah.
- A good ... I know, I feel daft, but a few weeks” *(20–35-year-old white gay trans-woman)*

A long delay between experiencing NCS and the first medical visit and the first HIV test argued for a poor

appropriation of the prevention tools, as illustrated by this extract.

Six of the 15 respondents had taken PEP. Four had actively sought it as a matter of urgency after NCS:

“The first thing in my mind was to get PEP, I would say. And I just wanted to go through the motions of it more than anything else, so that was the first instinct I would say that I had, from, like you said, the plan that I had built up with my knowledge of HIV. And I think I just went into autopilot [· · ·]”

*(20–35-year-old Black gay cis-man)*

PEP was offered to and accepted by two additional respondents whose potential exposure to HIV was within 72 hours of the PEP timeframe. One respondent declined to take PEP after being reassured by the regular partner who had just raped him about their HIV status, and another was too busy to get to the clinic in sufficient time. Seven respondents did not mention PEP, suggesting a lack of awareness of this prevention tool, although we are unable to confirm this.

### **Clinic experiences could amplify the trauma of sexual assault**

Almost all respondents expressed a desire to access sexual health services after NCS, to seek HIV/STI testing, and for broader support, underlining the centrality of these services as a primary source of care for cis-GBMSM and transgender people.

Access to the sexual health clinic was often perceived as challenging because of geographical distance or difficulty getting an appointment, and this was amplified by the COVID-19 pandemic:

“I was standing in front of these health professionals in a sexual health clinic [· · ·] under stress because I’d just gone through this domestic abuse situation where I was physically beaten up. At the time, covered in bruises and whatever. And they were just brushing me aside and saying, basically, Fuck off! We are protecting ourselves. Go away. This was COVID time.”

*(51–65-year-old white gay cis-man)*

For people attending a clinic after NCS, the first contact with the reception staff was nearly universally a poor experience. The lack of discretion (i.e., reception open to waiting area, questions asked aloud, etc.) was problematic.

Many respondents were afraid of seeing someone they knew. In addition, transgender people frequently experienced additional clinical barriers related to their gender identity, such as incongruence between their gender and their medical records. Many participants felt that their anticipation of potentially negative experiences at the clinic made accessing care more difficult under already challenging circumstances.

“I feel that the offer is there, but the actual execution of it has been quite poor in most general cases. I feel like there is still quite a barrier in terms of accessing services as a gay Black person, or gay minority, and you kind of feel it when you do go into the reception, or you’re dealing with people and you’re having to give details with the level of information that they want with relation to the instances, or the sexual partners, and the frequency of it. And it does feel like you can be quite judged, and so it does kind of deter me from going.”

*(20–35-year-old Black gay cis-man)*

All participants felt that their exceptional and traumatic experiences should have warranted special attention.

“When you are walking into these places, there is the worry that you could see somebody that you know. I think just the manner in which the reception staff could behave. I think it is quite a difficult scenario for most people to go there [following sexual assault], and while I know they have been trained to be very open and caring, sometimes that does get lost. And I think a lot of the time they are dealing with people that are quite out of their normal comfort zones, so that should be taken more into account, or more training needs to be provided.”

*(20–35-year-old Black gay cis-man)*

The consultation time with the doctor, nurse, or health advisor was frequently appropriate and calming. Many of these providers were able to provide a safe space to talk after NCS. However, for some respondents, accessing care after a traumatic situation in a setting characterized by time pressure and a lack of resources led to feeling let down by clinical staff, who were perceived as unable or unwilling to provide the support they required.

“Obviously just having been assaulted, there were a lot of things running through my

mind, and I feel like I did show signs that I had been assaulted. It was just easier for them to kind of just get rid of me than to really take the time to actually provide the support that I felt that I really needed.”

*(20–35-year-old Black gay cis-man)*

Experiences of NCS caused a great deal of stress and, in some cases, psychological distress. Most respondents agreed that the medical care (e.g., HIV and STI testing) provided was appropriate. However, specific support taking into account the impact on mental health was generally not offered, nor was legal advice.

“I was offered everything that I needed in terms of swabs and blood tests and basic information. But other than that, it was ... he was kind. I wouldn't say he was dismissive or absent or rude. But it was just that. Kind of basic.”

*(20–35-year-old Asian gay cis-man)*

Indeed, there was some ambivalence about psychological support. Several respondents said that they needed it but were not able to receive it at the time of the clinic visit. For others, this visit could be very emotional, even oppressive, and they often wished to shorten it. Some respondents considered that they were only there for medical issues, and they seemed to be fine with this dichotomy.

“I was very pragmatic, I am sensible in that situation. The emotional part of it was a different thing, but they didn't really need to know about the emotional part of it, at my testing, they're just there for a clinical reason.”

*(36–50-year-old white gay cis-man)*

All agreed that the medical staff should (at least) provide some contacts for further support and some self-initiated psychological support after the visit to the clinic.

Several respondents discussed the best way to get tested for HIV following NCS. Most felt that the optimal response was to attend clinics to ensure all their needs were met by professionals, especially when lucidity may be impaired by emotional distress. However, the use of HIV self-tests was preferred by respondents who found it too difficult or traumatic to recount their experiences of NCS to others. We were unable to confirm whether participants were aware of the delay before obtaining a positive test using self-tests in the event of HIV transmission.

## Impact of HIV testing following NCS

NCS left respondents feeling vulnerable and unable to protect themselves; HIV testing was universally felt to be an important response, vital to restoring order. Not having control during NCS amplified the importance of regaining control, which could include maintaining physical health, taking PEP, or testing negative for HIV and STIs.

“Especially after an assault scenario, it [testing HIV negative] then makes you feel you're in control, and makes you feel you're in control. That's so important. So important. You're in charge of your health, that anything that might have happened to you, touch wood, or could prove difficult for your future health, has been resolved. Either way it's been resolved. That puts you in the driving seat. You know that kind of thing, so it's good.”

*(51–65-year-old Asian gay cis-man)*

Getting a negative HIV test result was felt to be a “reset” and useful for moving on.

“She was like: if you have anything else like we could give you numbers and stuff. But I didn't really want to go to anyone to talk about. Because I was just thankful that nothing [HIV sero-conversion] happened.”

*(20–35-year-old white gay cis-man)*

For respondents who had not previously tested, or tested irregularly, accessing HIV testing after NCS made them aware of the need to always know their HIV status. All engaged in a routine of testing, usually every 3–6 months.

“After my first HIV test, I sort of made it mandatory to myself to have a test every six months because at that time it was suggested to have an HIV test every six months, especially if you are sexually active. So, I made a point to have a test every six months after my first test.”

*(20–35-year-old Black gay cis-man)*

In an effort to maintain control, some maintained this routine even when they were in a monogamous relationship. Finally, two respondents reported that they chose to use HIV self-testing to avoid returning to the clinic because of their negative experiences at the time of the NCS.

## DISCUSSION

This study explored experiences of accessing health care services and HIV testing among 15 cis-GBMSM and transgender people who reported NCS in interviews conducted during the SELPHI RCT. The narratives of NCS occurred spontaneously in 15 of 95 (16%) interviews. This underlines the importance of this research area, especially as the incidence of NCS was probably underestimated in our interviews as questions about assaults were not directly asked and because NCS is sometimes not recognized by cis-GBMSM and transgender people themselves [19].

Indeed, dominant discourses of masculinity and homosexuality promote the idea that cis-GBMSM have voracious sexual appetites and are always consenting, which can make the status of the victim invisible [7, 20]. Coercive dynamics have been shown to shape sexual relationships [7, 19, 21, 22]. Many cis-GBMSM report that they feel “forced” to have sex, not because of direct pressure, but rather because of the “prescriptive cultural norms” of the gay community [22]. This is further complicated when NCS occurs in the context of drug or alcohol use. Within the LGBTQ+ community, transgender people are most affected by NCS of all types, with severe mental health impacts, for reasons similar to those documented for cis-GBMSM, and because of gender-based violence [23–25].

Our interviews showed that, in the context of NCS, including some experiences of non-negotiated condomless sex, HIV transmission was always a concern. However, narratives suggested low awareness of PEP, which is strongly recommended after forced sex with a partner of unknown HIV status and should be started as soon as possible. This is in line with many reports showing the lack of knowledge of PEP among cis-GBMSM and transgender people [26–28]. Despite incomplete appropriation of prevention tools, HIV testing remained at the heart of participants’ concerns, highlighting the importance of improving the quality of sexual health services. However, many reported poor experiences in health care clinics after NCS, highlighting the need for improved responses to sexual violence. The lack of discretion and empathy of the reception staff led to increased emotional difficulty, compounded by a lack of psychological support offered. This issue has been previously described by cis-GBMSM who needed PEP [29].

Our analysis has some limitations. The interview guide was not designed to explore issues related to NCS, which led to discrepancies between the depth of discussion between participants and interviewers. It is likely that not all occurrences of NCS were reported, as the question was not systematically asked. All respondents chose to participate in a trial that collected a significant amount of personal data, and all consented to be

interviewed. This sample therefore potentially does not include those most concerned about disclosure of sensitive information about themselves, a group assumed to have different experiences of engagement with health care professionals, especially following NCS. Finally, none of the respondents were taking HIV PrEP at the time of reported NCS. PrEP is now a key tool for HIV prevention, but it has also profoundly altered the burden of HIV on the sexuality of cis-GBMSM and transgender people [30]. We speculate that the experience of HIV testing after NCS among PrEP users may be different.

In conclusion, our results should encourage sexual health care providers to systematically address the issue of NCS with the cis-GBMSM and transgender people they see for HIV and STI testing. Reception staff, doctors, and nurses should be aware of the potential psychological distress caused by this situation in order to avoid bad experiences with lasting negative impacts in sexual health clinics. Sensitivity training could be useful. More broadly, information on mitigating NCS, as well as immediate access to PEP after NCS, needs to be reinforced among cis-GBMSM and transgender people.

### AUTHOR CONTRIBUTIONS

Qualitative sub-study design: RP, AJR, TCW. Data collection: TCW, TW, PS, EJN. Data curation: IYHC, RP. Analysis: RP, AJR, TCW. Drafting: RP. Conceptual input: RP, AJR, TCW. All authors have approved the final manuscript.

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### CONFLICT OF INTEREST STATEMENT

All authors declare no conflicts of interest.


### ETHICS STATEMENT


Participants provided written or verbal recorded consent. Ethical approval was granted by University College London (ref: 24477/001).

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