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COVID-19 and LGBT Sexual Health:

Lessons learned, digital futures?

Dr Jaime García-Iglesias

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MANCHESTER 1824 The University of Manchester

UK Research and Innovation

LGBT foundation

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Executive summary

The COVID-19 pandemic and the measures put in place to halt its spread have had a profound and long-lasting impact in our societies. However, despite early reporting of the pandemic as a ‘great equalizer’, research has shown that its detrimental effects have been unevenly distributed among populations. In particular, both the virus and social distancing have had a disproportionate impact on LGBT people, who already suffer from higher rates of poor mental health, are more likely to live alone, and require more formal support services. **That is, while COVID-19 may have had specific impacts, it has also exacerbated pre-existing inequalities.**

This report describes the characteristics of online service users during the COVID-19 pandemic, compares them to service users before the pandemic, and explores their experiences accessing services and activities. The research focuses on the Sexual Health Programme run by LGBT Foundation in Greater Manchester, which includes the distribution of condoms and lube, STI and HIV tests, and outreach activities. More generally, during the COVID-19 pandemic, sexual and reproductive health and genitourinary medicine services saw a drastic reduction in capacity and a changed mode of operation. This raised concerns about how populations at high-risk for HIV may be unable to continue to access services. In addition, the temporary reduction in capacity exacerbated pre-existing challenges when accessing services. However, the disruption to service provision may also provide an opportunity for developing new services and modes of delivery.

This free-text survey was open between 28 August and 14 September, obtaining 84 responses. The average age of respondents was 34 years old. The majority of respondents lived in Greater Manchester (76%), followed by UK outside of Greater Manchester (22%) and 1% of overseas respondents. 71% of respondents identified as men (including trans men), 14% as women (including trans women), 7% as non-binary and 7% as 'in another way'. 19% of respondents indicated that their current gender identity was not the same as that which was assigned to them at birth. Half of the respondents identified their sexual orientation as gay (50%), 13% as bi, 10% in another way, 8% as lesbian, and 3% as heterosexual. Respondents were eminently from white backgrounds (combined 82%).

Being LGBT during COVID-19

While a number of respondents answered that their being LGBT had not played a part in their experience of the first lockdown, for many it had been a significant factor. Isolation appeared as a key theme for many respondents, which was compounded for some with being forced to live in spaces and environments that may not be supportive or safe as LGBT people. It was interesting to see some respondents discuss how their emotional responses to COVID-19 were linked to their experiences and memories of HIV and AIDS. Several respondents were also worried about whether they would face barriers when accessing healthcare because of their LGBT identities.

Pandemic sex

A significant number of respondents (37%) explained that they had stopped having sex altogether during the first lockdown, either as a precautionary measure or because lockdown restrictions prevented them from meeting their preferred partners. Others replied that they continued having sex with their long-term monogamous partners (3%), that they had turned to temporary monogamy (5%), or that they had reduced the number of partners they were meeting (11%). It is worth noting how these arrangements and decisions were not fixed but rather flexible and contextual, and depended on respondents' perceptions of risk, public health messages, and regulations.

PEP and PrEP

During the summer 2020 lockdown, PEP could still be obtained from A&E and GUM services. However, 79% of respondents were not aware of this. In addition, it is concerning that some respondents expressed fears that they would face obstacles and discrimination if they had sought PEP from A&E. These potential obstacles, they argued, could have prevented them from trying to access it altogether.

During the summer 2020 lockdown, PrEP provision was uneven across the country and heavily depended on the capacity of each service. 39% of users took PrEP before the lockdown, 22% daily and 17% event-based. All those who took it event-based stopped. Among those who took it daily before the lockdown, more than half (56%) stopped it altogether, 38% continued daily, and 6% moved to taking it occasionally. The majority argued that they stopped taking PrEP because they were no longer having sex. Of the

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respondents that continued taking PrEP during the lockdown (n=7), 100% had to resort to purchasing online to fill-in gaps between NHS prescriptions. These respondents highlighted a lack of support and difficulty in accessing PrEP from NHS sources. It is worth highlighting that some respondents chose to stop or continue PrEP based on misinformation (such as the mistaken belief that PrEP would prevent COVID-19): this reinforces the need for proactive information campaigns about PrEP and partnerships with online pharmacies to deliver accurate and timely information.

Testing during the lockdown

During the first lockdown, 88% of respondents did not seek testing for HIV or other STIs, 9% did so by mail, and 3% did it face-to-face. In general, experiences of mail tests were positive. It is relevant to note that 51% of respondents said they would like to get tested after lockdown and an additional 28% said they 'might' want to get tested. This points to a potential sharp increase in demand for tests once restrictions are lifted. Without drastic upgrades to testing services this demand may not be met.

Accessing online services

33% of people said they felt comfortable accessing online services. A number of people explained that they had faced barriers around access, particularly around finding information about what services were available, concerns around privacy, or difficulty in negotiating anxiety while accessing services online. At the same time, many respondents also acknowledged that online services may be easier to access for some people. Finally, several people recommended the development of support activities targeted at particular communities, such as: migrants/international people, people who experience racism, healthcare staff, trans people, and sex workers. They also suggested that further work may be required to support people struggling with depression and bereavement. Several respondents identified 'social events' as a key activity through which organisations could help people. **These findings evidence how COVID-19 has exacerbated pre-existing access challenges for certain groups. These are likely to stay after the pandemic is over.**

Moving forward

Regarding future services, 46% of respondents answered that they would continue to engage with services after lockdown. Respondents eminently supported the continuation of online services alongside face-to-face services (78%). However, continuing the level of online services and activities while also providing the usual face-to-face services is likely to require an increase in resources. In general, respondents concluded that a combination of online and offline services guaranteed maximum accessibility while also acknowledging that not all services can be delivered online.

The continuation of online and face-to-face services may be a unique opportunity to address pre-existing and long-term issues around access for LGBT sexual health.

Acknowledgements

This report has been possible thanks to the support from UKRI ESRC through the Collaboration Labs programme at the University of Manchester. Particular thanks to Lauren Duffy, Michael Petch and Emma Meehan at LGBT Foundation and Brian Heaphy at The University of Manchester.

Preface by Dr Michael Brady

HIV and Sexual Health consultant

National Advisor for LGBT Health

Although we've been living with the impact of COVID-19 for nearly a year now, we still have much to learn about how we've lived with and through the pandemic and how we need to develop and deliver services as we start to come through the recovery. It is already clear that existing inequalities in marginalised and disadvantaged groups have been exacerbated by the virus and LGBT+ communities are no different. We should remember that many of the inequalities and experiences that LGBT+ people reported in this survey existed before the pandemic – and that we now need to use every opportunity to increase our efforts to address them.

Whilst lockdown has meant a cessation or a significant reduction in sexual activity for many, the need for sexual health information, testing, treatment, contraception and HIV testing and prevention services such as PrEP continues. Where it has not been possible for those services to be delivered face-to-face, they have had to move online. This is convenient, confidential, acceptable and preferable to many – but not accessible for everyone and we need to better understand how LGBT+ people interact with our services and what services they need.

This report highlights many of the impacts of COVID-19 on LGBT communities relating to both sexual and mental health. It reflects the need to ensure that we maintain as much and as many sexual health and HIV preventions services as possible, that we ensure services are LGBT+ inclusive or delivered by LGBT+ organisations and that we maximise the use of online services for those who want and can use them, whilst maintaining some degree of face-to-face services for those who need them or can't access services online.

It is essential that we continue to learn from the communities we serve, and ensure that LGBT+ individuals can access inclusive sexual health and HIV prevention services that are responsive to their needs; both during the pandemic and as we come out of it.

Context

The COVID-19 pandemic and the measures put in place to halt its spread have had a profound and long-lasting impact in our societies, to the extent that queer philosopher Paul B. Preciado argued that the current situation compelled us to reflect on "under what conditions and in which way would life be worth living?" (Preciado 2020). However, despite early reporting of the pandemic as a 'great equalizer', research has quickly and clearly shown that its detrimental effects have been unevenly distributed among populations (e.g. Timothy 2020) and that existing vulnerable groups "are likely to carry a heavier burden of what will be the devastating downstream economic and social consequences of this pandemic" (Stidham Hall et al. 2020, 1176). That is, the COVID-19 pandemic has exacerbated pre-existing inequalities, deepening them.

This project builds on the data revealed by the ground-breaking report *Hidden Figures: The Impact of the COVID-19 Pandemic on LGBT Communities in the UK* (LGBT Foundation 2020b) to discuss the experiences of online delivery of LGBT-specific sexual health services by LGBT Foundation. Since 1975, LGBT Foundation has supported the needs of LGBT people in Manchester and beyond. Among its services, the Sexual Health Programme provides HIV and STI testing, condom and lube distribution, outreach events, and support services. Normal service delivery was disrupted by the COVID-19 pandemic and the social distancing measures put in place to halt is spread. On 18 March 2020, 2020, face-to-face testing clinics were suspended, and remote working implemented across the organisation. On 30 March 2020, LGBT Foundation launched the first group meetings through the video-calling site Zoom. On 29 April 2020, guidance on 'Sex during the Pandemic' and '10 Ways to Stay Safe' were published. That same day, a series of Instagram Live events were launched under the title 'The Tip' which provide a space online for a guest or organisation to talk about a specific area of sexual health and wellbeing. On 15 June 2020, additional material was launched for Men's Health Week and the Sort HIV digital and print media campaign. Despite this methodological focus on LGBT Foundation, the conclusions and recommendations of this report are applicable beyond this organisation to the broader spectrum of service delivery nationwide.

This project aims to describe the characteristics of online service users during the COVID-19 pandemic, compare them to service users before the pandemic, and explore their experiences accessing the services and activities. In so doing, this project does not only provide an evaluation of a challenging period of service delivery but also develops an evidence-based framework for future decisions around online services. These are important questions not only because LGBT people experience a range of health inequalitues in the UK, but also because their continuous access to sexual and reproductive health has been deemed by the WHO as essential during the pandemic (World Health Organisation 2020).

Being LGBT in the UK

While there is a lack of comprehensive data about the experiences and characteristics of people who identify as LGBT in the UK, research has provided several snapshots of this population. It is worth noting that the LGBT population is diverse and complex, and different groups have unique characteristics (see LGBT Foundation 2020a).

As recently as October 2019, just two months before the first cases of what would later be called COVID-19 appeared in Wuhan, China, the Women and Equalities Committee at the UK Parliament released a report on "Health and Social Care and LGBT Communities" that stated that "LGBT people are often less healthy than the wider population [but] they also tend to receive lower levels of care than non-LGBT people" (House of Commons 2019, 3). This argument follows a trend of previous research. For example, in 2018, the National LGBT Survey identified that LGBT people were "less satisfied with their life […] than the general population" (Government Equalities Office 2018, 10).

Perhaps the most comprehensive report is *Hidden Figures: LGBT Health Inequalities in the UK* (LGBT Foundation 2020a). This report concludes that: "due to the range of significant health inequalities experienced by LGBT people throughout their life course, they are more likely to need to access healthcare services. However, health inequalities are often further exacerbated by the barriers that people face when accessing services to treat or support them" (57). These inequalities manifest in significantly higher rates of drug and alcohol use, drastically higher rates of STIs and HIV diagnoses among men who have sex with men, higher rates of homelessness, etc. The report also indicates that LGBT people face significant barriers when accessing mainstream health services, including derogatory comments, judgment and discrimination.

A particular area of concern is mental health. A recent report evidences that LGBT people are at "higher risk of experiencing common mental health problems than the general population" (Bachmann and Gooch 2018a, 6) and that, worryingly, more than half of LGBT people in the study said they had experienced depression in the previous year (5). These challenges exist in addition to a lack of informal support: research has shown that less than half of LGBT people are open about their sexual orientation or gender identity to everyone in their family, 30% of bi men and 8% bi women cannot be open about their sexual orientation with any of their friends, and 11% of LGBT people have faced domestic abuse by their partner in the last year (Bachmann and Gooch 2018b).

The situation does not seem to improve in later life: a 2011 report already identified that lesbian gay and bi (LGB) people were more likely to be single, live alone, have no children, and have no regular contact with biological family than their heterosexual peers. The report argued that, in the absence of informal support networks in later life, LGB people would resort to formal support, being "nearly twice as likely as their heterosexual peers to expect to rely on external services, including GPs, health and social care services and paid help" (Stonewall 2011, 3). These 'formal' support services are likely to be inaccessible routinely during the COVID-19 pandemic.

Given these issues, the COVID-19 pandemic and social distancing measures put in place in the UK have had a disproportionate impact on LGBT people. This is supported by the findings from the report developed by LGBT Foundation to assess the impact of COVID-19

on LGBT people (LGBT Foundation 2020b). The report found that, during the pandemic, poor mental health was a concern for 37% of respondents, and that 42% of respondents would like to access support about it. Similarly, 30% of people said they were living alone (40% in people over 50) and 64% said they would prefer to receive support from an LGBT specific organisation. This supports existing research which shows that LGBT people disproportionally suffer poor mental health, are more likely to lack informal support, and are seeking formal support arrangements from LGBT specific services.

The same report argued that "at the time when our ability to access healthcare, and the way we access healthcare has substantially changed, those who faced barriers prior to the crisis may be particularly affected" (LGBT Foundation 2020b, 24). In fact, it highlighted that online service delivery may exclude a "significant number of people who don't have access to the internet" thus limiting their chances of accessing support at a time of acute need (14). In fact, early research from the US suggests that, for people living with HIV, ongoing support during the pandemic may be "vital to address mental health needs and substance abuse and avoid medication interruptions" (Beima-Sofie et al. 2020).

These findings are further developed by the interim results of a survey about the COVID-19 pandemic of men who have sex with men in the UK: the survey evidenced that one third of respondents were living alone, two thirds were single, and 60% of those with a main sexual partner had been unable to meet them. Interestingly, among the 24% of respondents who had had casual sex during lockdown, many reported that "loneliness and a need for intimate physical contact were important reasons for having sex" (Peabody 2020).

Sexual health services during COVID-19

This project focuses on the Sexual Health Programme run by LGBT Foundation, which includes the distribution of condoms and lube, STI and HIV tests, outreach activities, etc. This programme works in close partnership with services provided by the NHS. During the COVID-19 pandemic in the UK, sexual and reproductive health and genitourinary medicine services saw a drastic reduction in capacity and a changed mode of operation. A survey

among professionals conducted by the British Association for Sexual Health and HIV (BASHH) concluded that 80% of respondents reported their services to have less than 20% of their usual capacity in terms of face-to-face contact for STIs, contraception and HIV. In the majority of cases, assessment had shifted from face-to-face to telephone consultations, with a very low use of video consultations. Similarly, 'walk-in' and 'drop-in' services were mostly discontinued (BASHH 2020a).

In a joint statement, BASHH and BHIVA (2020) highlighted that "whilst many services have rapidly expanded their digital offering, data collected from our members shows that current provision varies hugely across the country, creating a postcode lottery and inequitable access and outcomes as a result". Similarly, concerns have been raised about how populations at high-risk for HIV may be unable to access services due to the new requirements (e.g. connection to the internet, phone service). It is interesting to note, however, that there is evidence that "the population most disconnected were young people who were twofold more likely to have gone missing from care access compared to pre-COVID-19" (BASHH 2020b, 4). Anecdotal evidence among clinicians suggests this may be related to the discontinuation of 'walk-in' services.

The uneven reduction in service provision exists in stark contrast to the advice by the World Health Organisation (2020), which suggests that, in the context of the unavoidable disruptions caused by COVID-19, priorities "should include ensuring access to contraception, abortion to the full extent allowed by law, and prevention and treatment services for sexually transmitted infections (STIs), including HIV and human papillomavirus (HPV)" (29). In particular, they argue that services supporting HIV prevention, testing and treatment "are essential to maintain an effective HIV response during the COVID-19 pandemic" (39). This is important as research has shown that, worldwide, people "may continue condomless sex, thus continuing the spread of STIs" even during a period of lockdown (Nagendra et al. 2020, 434).

More positively, the disruption to service provision may also provide "an opportunity for rapid regulatory change and programme innovation." For example, Marie Stopes International rapidly implemented the use of telemedicine to provide medical abortions at home thanks to legal changes in several countries. (Church et al. 2020, 2). The possibility for the epidemic to trigger innovative approaches to service provision has also been evidenced by a survey of members of the BASHH, 93.6% of whom agreed that post-COVID-19 recovery plans should "take a whole system approach and re-organise rather than restore."

It is within this ambivalent context that this project sits: on the one hand, the goal is to evaluate to what extent and how online service provision met the needs of service users across different populations and, on the other hand, to provide guidelines as to what services may continue after the pandemic is over and how. In so doing, this project follows the principles developed by BASHH (2020b) for the recovery of service provision that argue that any recovery plans should:

> *1-"Be person centred, place based and take a whole system approach to maximise the sexual health and well-being of the population*
>
> *2- Address health inequalities and prioritise restoration of services to the most vulnerable and to those with the most complex needs" (1)*

COVID-19 and LGBT sexual health

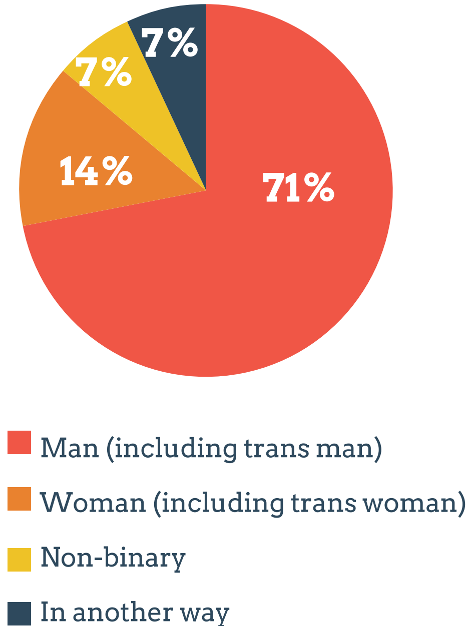
The survey for this report was open between 28 August and 14 September, obtaining 84 responses. On average, multiple-choice questions were answered by 91% of respondents and free-text questions were completed by 66% of respondents. The survey contained four parts: a first part focused on gathering respondents' demographic data, the second looked at their use and feedback of LGBT Foundation services before and during the first lockdown, third there were a number of questions about PEP and PrEP, and then a final section asking for respondents' views on how services and activities should move forward.

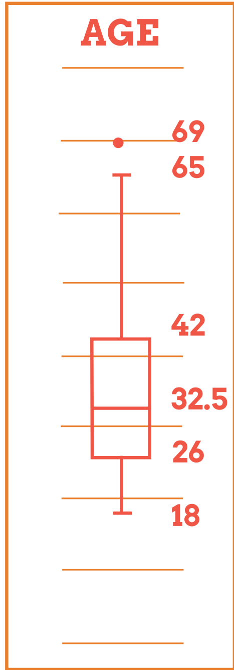
Demographic information

The average age of respondents was 34 years old, with mean 32.5. 50% of respondents were between 26 and 42 years old. The youngest respondent was 18 and the oldest 69 years old. The majority of respondents lived in Greater Manchester (76%), followed by UK outside of Greater Manchester (22%) and 1% of overseas respondents.

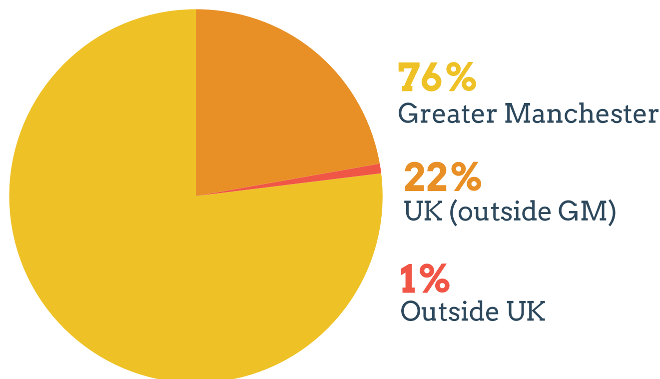
71% of respondents identified as men (including trans men), 14% as women (including trans women), 7% as non-binary and 7% as 'in another way'. 19% of respondents indicated that their current gender identity was not the same as that which was assigned to them at birth. Half of the respondents identified their sexual orientation as gay (50%), 13% as bi, 10% in another way, 8% as lesbian, and 3% as heterosexual.

See figures on the next page.

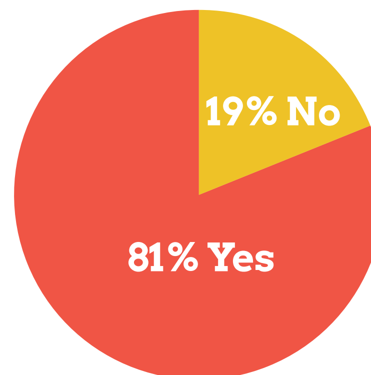




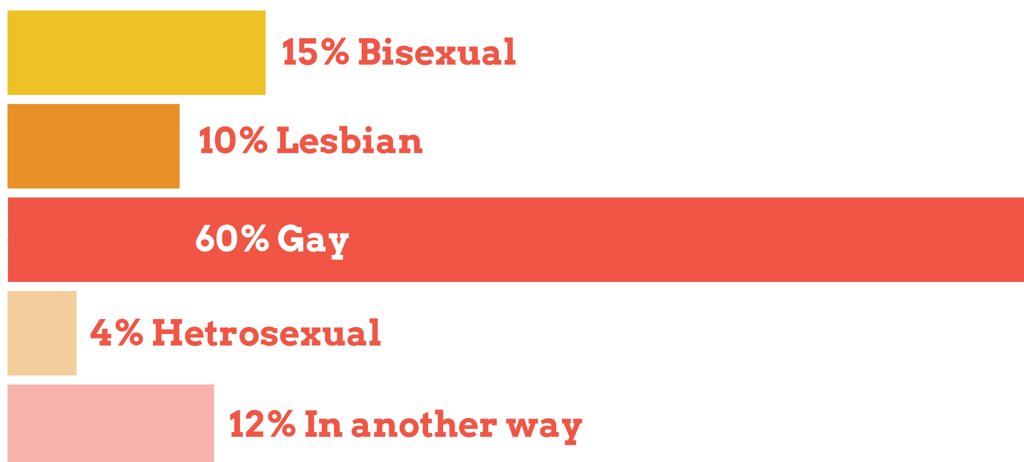
Where do you live?



Is your gender identity the same as it was assigned at birth?

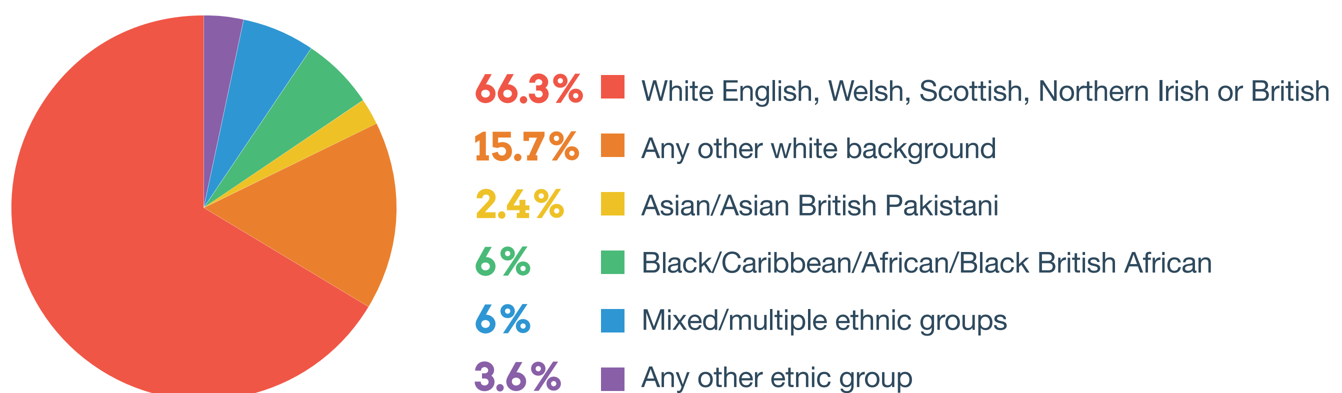


Which of the following best describes how you think of yourself.



Respondents were eminently from white backgrounds (combined 82%).

What is your ethnicity



The survey was distributed through Twitter (both through LGBT Foundation accounts and re-tweeted by other accounts) and Instagram.

Being LGBT during lockdown

Previous research by LGBT Foundation has already discussed the role that being LGBT has played in people's experiences of COVID-19 and the first lockdown measures imposed in its wake. The Hidden Figures report was based on a survey with 555 responses which was open between 4 April and 11 May 2020. The report found that:

42% of respondents would like to access support for their mental health.

30% were living alone. Among those aged 50+, the figure rose to 40%.

8% did not feel safe where they were staying.

18% were concerned that their situation was going to lead to substance or alcoholmisuse or trigger a relapse.

64% would rather receive support from an LGBT-specific organisation.

16% had been unable to access healthcare for non-COVID-19 related issues.

34% of people had had a medical appointment cancelled.

23% had been unable to access medication or were worried that they might not be able to access medication.

An important finding of the Hidden Figures survey is that certain groups are disproportionately affected by COVID-19 and the related lockdown. For example, whereas 40% of all respondents said they would like to access support for mental health during the first lockdown, this figure rose to 66% of BAME LGBT people, 48% of disabled LGBT people, 57% of trans people and 60% of non-binary people. It should be noted, however, that the Hidden Figures survey also was overrepresented by white people (82%), cisgender people (77%), gay people (42%), and men (44%).

Some findings about being LGBT during lockdown

The current survey was open between 28 August and 14 September, and thus provides a longer-term view on people's perception of how being LGBT influenced their experiences of the COVID-19 lockdown. The survey specifically asked: "What role do you feel being LGBT played in your experience of lockdown?". While a large number of respondents answered that it had not played a part in their experience, others did explain that being LGBT had been significant. A respondent replied:

> "A huge part - basically paused my transition."

Themes already identified in the Hidden Figures report (as well as earlier non-COVID-19-related data) continued to play a significant part in the findings. Thus, **isolation** appeared as a key theme for many respondents:

> "Difficult. Single and reduced contact with friends and family made it hard. Add to that no sex made it even harder"

> "I have not had contact with my family for many years, so losing the friends and social relations has been hard"

Isolation was compounded by respondents being forced to live in spaces and **environments that may not be supportive or safe:**

> "It was difficult going back home from uni to not have any friends to hang out with and not having my support network and my parents not wanting to talk about my being gay"

> "I moved back in with my parents for a few months and I definitely feel I couldn't express my queerness as much as normal"

> "Not massively negative experience, but not pleasant. Whilst living back with the family, I felt I couldn't be my true self, which in turn impacted heavily on my mental health (but not to the stage of needing support)"

It was interesting to see some respondents discussed how their emotional responses to COVID-19 were linked to their **experiences and memories of HIV and AIDS:**

> "I think it had to do with all the memories of friends dying from AIDS and the sense of death all around"

> "A LOT! The whole time I just kept thinking about AIDS and HIV and about so many of my friends who live alone and have been feeling so lonely during this time"

Perhaps just like during the years of the AIDS crisis, respondents were concerned about **healthcare.** In particular, respondents were worried about whether they would **face barriers when accessing healthcare** because of their LGBT identities:

> "I thought I had covid and had to get a test and the nurse asked lots of questions about trans and my friend had to be in hospital for a few weeks in a male ward when they wanted a private room because they were not comfortable but didn't put them in one"

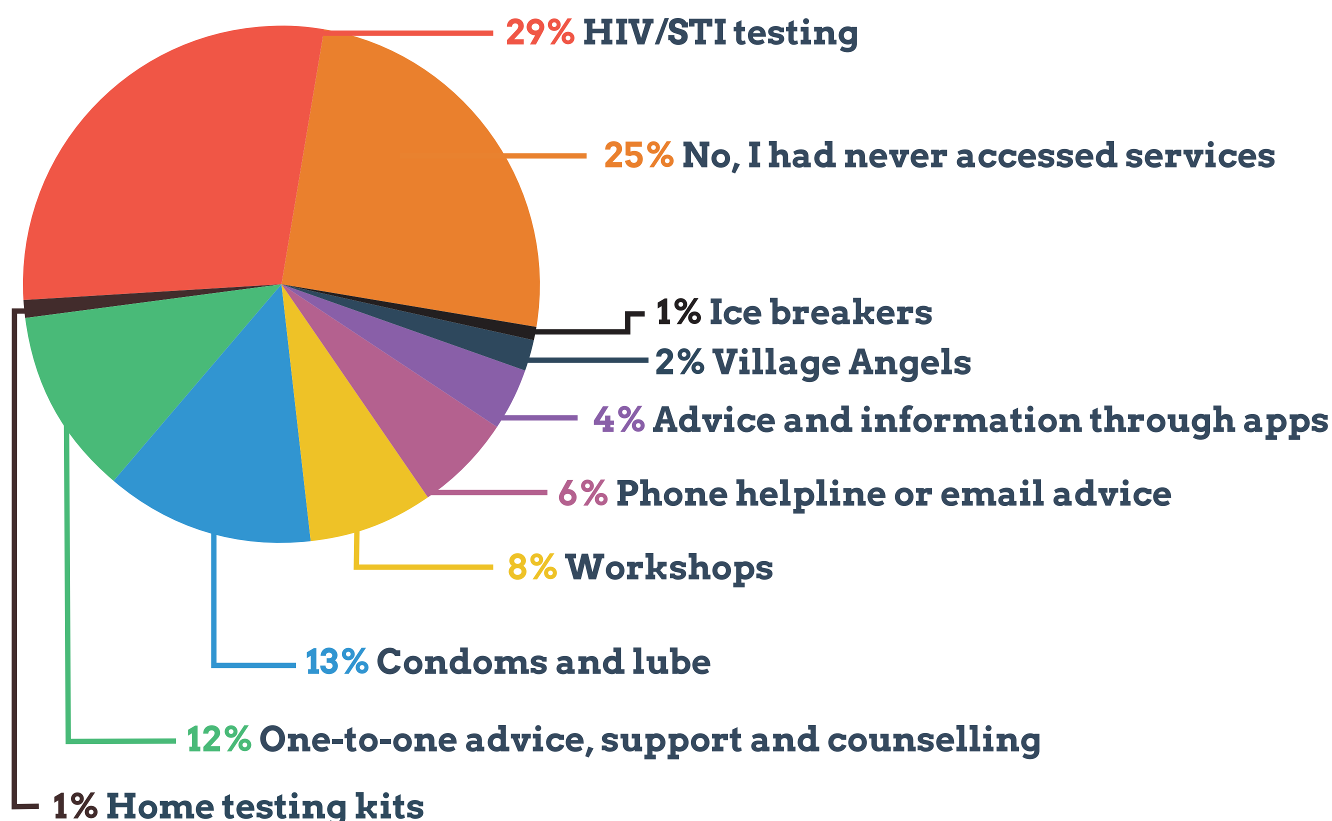
> "I struggled a lot with anxiety and whether going into hospital would mean being in a homophobic place during the covid"

Given the data, the role of LGBT Foundation and similar organisations is key to provide engagement and socialising opportunities for people, help them find safe and supportive spaces, and advocate for standards of care.

Experiences of LGBT Foundation before the first lockdown

One quarter of respondents had not accessed services or activities provided by LGBT Foundation before March 2020. **The most commonly accessed service by respondents before the first lockdown was HIV or STI testing**, followed by counselling, therapy or support, and condoms and lube. However, it is likely that many more have accessed condoms and lube through the distribution scheme but are not aware of it being part of LGBT Foundation. Similarly, some other 'services' or 'activities' may have been accessed that have not been associated with LGBT Foundation.

Before March 2020, which if any of the following services, testing and activities had you accessed at LGBT Foundation?



When asked about their experiences accessing these services, **responses were eminently positive (65%)** but there were a number of issues that resonated across responses (including positive ones). Mostly, respondents perceived services to be **helpful in providing information or helping them find support** and meet other people.

It was many years ago when I clambered up the steps to the LGBT Foundation Office's on Princess Street. I had just found out that I was HIV+ and my life, my whole world fell apart. I was a mess and I thought everything was over. I had no hope. There was no light or brightness inside of me. Just darkness and despair. Having just recently moved to Manchester and alone in the city with no close family, I aimlessly wandered the streets crying and having dark thoughts.

Eventually I phoned a wonderful friend, who met me and then immediately brought me to the LGBT Foundation offices. Someone at the LGBT Foundation came and spoke to us and helped me by calming me after the initial shock. Looking back at that quiet conversation that the LGBT Foundation person had with me, where they gently reassured me that life would be ok, that life would get better.

They were brilliant, and they were right! Now I am married and have a wonderful life! Hope! That is what the people who work at the LGBT Foundation give to others. ""Hope""! It is a wonderful gift to give. And it of course also provides education, support, guidance, friendship.... Thank you to all those who currently work at, or who have previously worked or volunteered at the LGBT Foundation.

You give hope. You save lives. And never forget that!"

> “Good, the staff were always really friendly and the volunteers were too. Everything was very respectful and I felt comfortable and safe.”

> “You guys have been fantastic in answering all my questions and being there when I needed help!”

Negative feedback was focused on issues around organisation and information: respondents complained that there was little information about what services or activities were running when, that wait-times for testing were long, and that processes were tedious (e.g. too many questions, paperwork, or the need to sign a visitor log). Some further respondents identified obstacles around access (e.g. difficult to access for people with anxiety, for those with limited mobility, etc.). One respondent complained that staff were not sufficiently ethnically diverse.

Thus, it can be concluded that respondents who had previous experience of services had an overwhelmingly positive response but faced barriers in terms of access and organisation. It is worth noting that this was a free-text answer and the majority of respondents simply replied ‘good’ or ‘fine’. It is likely that the complaints around organisation or access are more widespread, but respondents did not go into detail or deem them significant enough.

Recommendations:

- **Enhance activities and services that support people’s social lives, particularly among those groups that are most likely to be socially isolated. This is particularly relevant in times of mandatory ‘social distancing’.**
- **Provide clear information about what services are on offer, when they will be accessible, and how they operate. This will help potential service users finding information and alleviate anxiety around what services will be like. This information should be prioritised on social media and the website.**
- **Streamline processes for accessing services, limiting paperwork and ensuring privacy and confidentiality.**

Experiences of the first COVID-19 lockdown

On 23 March 2020, the UK Government announced a series of restrictions to combat the spread of COVID-19, including stay-at-home orders, limiting freedom of movement, and the closure of businesses. While, at the time of writing this report, some restrictions have been lifted (and/or reimposed), certain groups have been advised to shelter-in-place (e.g. people with compromised immune systems).

One of the key goals of the survey was exploring whether sexual health services and activities delivered online would meet the needs of service users and/or whether they would be accessible. To start considering this, the survey asked whether respondents had been able to access the internet during lockdown and whether they had been comfortable accessing LGBT-specific sites. **All of the respondents answered that they had access to the internet during lockdown, and 93.6% of them said they had felt comfortable accessing LGBT-specific sites.** Among those who did not feel comfortable, the main reason was not being comfortable accessing LGBT-sites **around family members:**

> "Not really. My parents don't know I'm gay and it was difficult to have nobody to talk to about it."

> "Initially I was with my parents, where I did not feel comfortable accessing some LGBT specific services. However, I am now on my own and comfortable to access them."

There are two important considerations. First, the survey was conducted online and thus it is likely that respondents who do not normally have access to the internet and/or LGBT-specific sites could not provide their views. Alternative research approaches should be taken to consider their needs. Second, **48.1% of respondents identified that one of the ways in which they accessed the internet during lockdown was through their mobile device or tablet.** It would be worth considering whether services, platforms, and information are designed in a way that is accessible from these devices.

Sexual health during the first lockdown

The survey also asked about people's experiences of sexual health during the first lockdown. This was an open, free-text question that encouraged people to discuss both their physical health and their emotional state, condom use, types of relationships, etc. It was phrased:

> "What was your sex and health like during the lockdown?: This is an intentionally open question: we'd like to hear about your broad experiences of sexual health. For example, did you continue having sex? did you use condoms or PrEP? did the sex that you had change in any way? whom did you have sex with? Or anything you may want to tell us!"

Responses to this question were varied. A significant number of respondents **(37%) explained that they had stopped having sex altogether during the first lockdown,** either as a precautionary measure or because lockdown restrictions prevented them from meeting their preferred partners:

> "Don't normally have much sex (anal) and stopped meeting people for it during it"

> "Completely abstinent—except for frequent masturbation— but not by choice(!)"

> "I had no sex as my partner lives abroad and we haven't been able to see each other since January 2020 due to ongoing travel restrictions."

A number of respondents explained that they **continued having sex with their long-term monogamous partners (3%)**, some that they had turned to **temporary monogamy (5%)**, and others that they had **reduced the number of partners** they were meeting (11%):

> "Only had sex with my partner whom I have been with for eight years and we are monogamous"

> "My partner and I stopped going to bi sex parties or meeting other people via apps. We have only had sex with each other during lockdown"

> "I continued having sex but only initially with my long-term partner. I have recently had more anonymous sex but this has only been with 2 or 3 people. As lockdown eases, I am more comfortable with having sex with more partners but am still nervous about the possibility of catching Covid"

> "I continued having sex with my partner, however the number of additional partners we had (as we are in a sexually open relationship) was significantly reduced. We continued to see regular partners but did not seek new partners until lockdown was lifted a little. We would usually go to clubs/meet with other couples"

It is worth noting how some of these respondents explained that these arrangements and decisions were not fixed but rather **flexible and contextual**, and depended on their perceptions of risk, public health messages, and regulations.

While 74 respondents answered this question, not many explained the emotional effects of their decisions around having or not having sex. In fact, **only 40% discussed their emotions around sexual health and lockdown.** 14% of respondents qualified their sexual health as 'good' or 'normal' while **26% discussed the negative effects the first lockdown** had on their broad sexual and mental health. We will now discuss these in more detail.

A significant number of respondents explained that the very context of lockdown (e.g. reduced mobility or leisure opportunities) and the perceived threat of COVID-19 was a detrimental factor in their mental health, **bringing up anxieties around safety and risk.**

> "I did not have sex during the lockdown but I have never felt so anxious about viruses. I was born in the late 90s but I imagine this is how people felt like in during the AIDS crisis, a constant, unrelenting fear?"

Other respondents identified a more **general concern about ‘anxiety’** as a problem during lockdown:

> “No sex but lots of anxiety”

> “I only had sex with my partner aside from one other person towards the end of lockdown. Sex didn’t happen much after a while due to my partner’s anxiety and it caused a lot of arguments”

A prominent theme emerging from the responses is the **lack of support and social networks** that could have alleviated the issues around anxiety, stress and poor mental health during lockdown.

> “Physically good, didn’t have sex but I struggle with my mental health as I didn’t have any support people to talk to or hang out at home”

> “Not so good, chems by myself”

> “Felt isolated in the first few months as couldn’t see my partner due to lockdown regulations. We don’t live together and feel discriminated against as a couple because we don’t cohabit.”

As evidenced in these responses, support and social networks could take the form of **informal arrangements** (through friends, relatives, or others) **or formal support mechanisms** (e.g. GP, clinics, charities). It is worth noting that only three respondents mentioned the role that **internet mediated communications** played on their mental health:

> "Okay? I didn't have sex but still like used Grindr and had video chats?"

> "Not great mentally, lots of hours on Grindr that wasn't great"

> "Single gay guy under lockdown with elderly parent. So, no opportunity at all for any sexual activity. Few fun chats online but ultimately frustrating. Would love to cruise or go to sauna but cannot as Covid risk too high"

In these three cases, we can see that respondents showed diverse perceptions of their online engagements, ranging from the neutral to the negative (frustrating and poor for mental health). Research is being currently conducted about the role of internet-mediated communications in people's experience of and resilience to the COVID-19 lockdown.

While a small part of the sample, it is worth mentioning that two respondents (3%) self-identified as **sex workers** and explained that they continued meeting clients:

> "Kept having sex but only with regular clients (sw)"

> "I'm a sex worker so I had to keep meeting clients to pay rent and all. still used prep and condoms with most clients"

Given the particularly precarious situation for sex workers in the current context, it would be interesting to develop working synergies with sex-worker specific organisations that can provide specific support, advocacy, and resources.

Recommendations:

-Evaluate the adequacy and adapt communication and resources to be accessed by smartphone, both on social media and the website. This is particularly important given the prevalent use of smartphones as an access device. This can be done through adopting smartphone-friendly website templates, using scrolling-friendly resources, limiting large-size files and downloads, and adopting best practices in creating social media content.

- Clarify what services an organisation provides, including sexual health and mental health services, proactively encouraging people to seek help. This can take the form of nation-wide campaigns, local approaches, or one-to-one interactions. In turn, this may require organisations to:

- Upgrade and rethink service provision to meet increased demand for 'sexual health' broadly conceived, including linking with mental health services.

PEP access

PEP is a strong combination of HIV medicines which can help people stop getting HIV after potentially being exposed to it. It consists of a 28-day course of medication and needs to be started within 72 hours of unprotected sex. It will be more effective the quicker it is started, with some guidelines recommending that it be commenced within 24 or 48 hours. During the first lockdown, PEP could still be obtained from A&E services and from GUM services.

79% of respondents were not aware that they could still obtain PEP from A&E during lockdown, and 16% did know this.

Only one respondent answered that he had tried accessing PEP and his experience was negative:

> "Very bad. Got told off and had to wait for like six hours in Ae. Poor, had sex with a few people because I just couldn't deal with the panic of being home all the time and not knowing when I would be out again and depression. I normally take prep but ran out just a few days into the lockdown so I had to go for PEP because they wouldn't send me a refill of prep in time."

This is a particularly troubling statement given that it identifies a significant gap in PEP provision and care.

In addition, it is concerning that other respondents (who did not seek PEP) **expressed fears that they would face obstacles if they had chosen to do so. These obstacles, they argued, could have prevented them from trying to access it altogether:**

> "I wouldn't have accessed PEP because of how docs would have treated me I'd rather ride it out than be shamed even more"

A further user who identified as a healthcare provider explained that some of those in need of PEP might be scared from having to access it at A&E and that there was a lack of time:

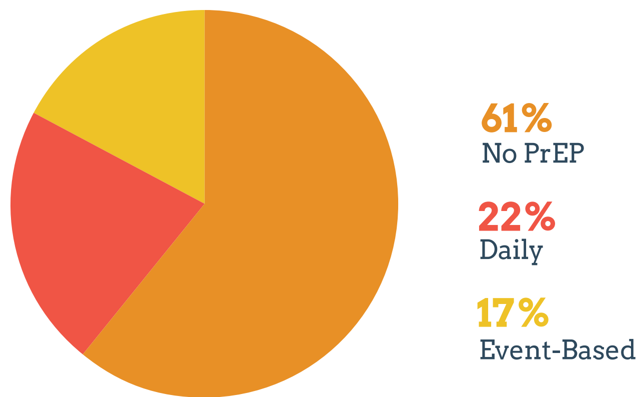
> "Didn't need to access it myself but saw a couple people who needed it, I think most people were scared of coming to A&E and we also didn't have much time (as usual)"

PrEP access

PrEP (pre-exposure prophylaxis) is an HIV prevention strategy that uses anti-retroviral drugs to protect HIV-negative people from HIV infection (Peabody and Nutland 2018). PrEP is taken by HIV-negative people at risk of HIV to prevent infection. For anal sex, PrEP may be taken daily or only before and after particular sexual encounters ('event-based' or 'on-demand'). For more information on dosages, refer to *lgbt.foundation/prep*. In the UK, PrEP may be accessed free of cost from the NHS as part of the IMPACT trial (based at some sexual health clinics) or may be purchased online.

During the first lockdown, PrEP provision was uneven across the country and heavily depended on the capacity of each service. No single consistent approach was established.

PrEP use before lockdown



How PrEP use changed during lockdown

As expected, of the survey respondents, no new users started PrEP during the first lockdown. **39% percent of users took PrEP before the first lockdown, 22% daily and 17% event-based.**

All those who took it event-based stopped it. **Among those who took it daily before the first lockdown, more than half (56%) stopped it altogether, 38% continued daily, and 6% moved to taking it occasionally.** This is consistent with the information about stopping sex in previous sections.

The majority of respondents who explained their decision to stop argued that they stopped taking PrEP because they were **no longer having sex** (or having sex with partners other than their main partner). However, three respondents gave **more worrying explanations:**

> "Couldn't get a refill because the clinic wouldn't answer the phone"

> "I didn't have enough and couldn't get a refill"

> "I didn't want to take it in case it made covid worse"

These responses evidence a l**ack of proper follow-up and support from clinics** providing PrEP (all these men were sourcing PrEP through the IMPACT trial). The role of **misinformation** is of particular relevance in the case of PrEP and COVID-19 given that PrEP uses a type of medication called 'anti-retrovirals' (used in the treatment of HIV infection) which were discussed in the media as a possible treatment for COVID-19. One further respondent argued that he didn't feel comfortable taking PrEP in his new situation:

> "Didn't have sex and didn't want my parents finding the pills"

Among the respondents who decided to continue taking PrEP, a few did provide further information. Some decided to continue taking it because they continued having sex:

> "Had to buy my own supply because clinic couldn't send them to me on time. It's too expensive if you're not rich"

> "Only took it when having sex with two mates I know (who were also shielding)"

> "Still had sex and don't like condoms"

A further respondent explained that he:

> "I do not have much sex, and didn't have any during lockdown, but didn't want to get side effects from stopping"

This goes to confirm the presence of **misinformation,** since stopping PrEP does not lead to any side effects. In this case, the user was sourcing it online (which does not require talking to a healthcare professional) which **reinforces the need for proactive information campaigns and partnerships with online pharmacies. The lack of consistent, clear and accurate information has long been an issue marring PrEP provision in this country, and the COVID-19 lockdown has only exacerbated this.**

One of the key aspects coming from reading people's experiences of accessing PrEP during the first lockdown is a **lack of support and difficulty in accessing PrEP from NHS sources**. Many users explained that, while they normally obtained PrEP through

the IMPACT trial, they had to resort to buying it online due to the difficulty of getting a prescription. Asked about their experiences of sourcing PrEP during the first lockdown, they answered:

> "Difficult! clinic couldn't send it to me first, then didn't have a pick up time, and only after I had run out of it and needed PEP did they send it"

> "Very difficult: the clinic were not helpful at all to people with anxiety or who struggle with dealing with offices"

> "I had to buy 1 bottle online to cover me between gaps in the prescription of the clinic"

This emphasises the **need for clarity in provision.** In fact, before the first lockdown 47% of respondents accessed PrEP through IMPACT while 50% did it online and 4% used both. Of the respondents that continued taking PrEP during the first lockdown (n=7), **100% had to resort to online purchases to fill-in gaps between prescriptions.** This enhances existing inequalities. **This is likely an issue with communication of services rather than continuity of services, as most IMPACT trial sites were still offering PrEP via telemedicine.** However, it should be noted that access to PrEP has been a longstanding issue (in fact, as long standing as PrEP use itself) and will likely remain an issue well after COVID-19 is managed in the UK.

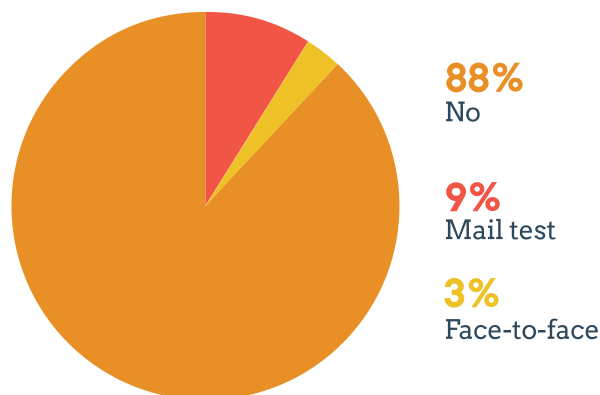
Recommendation:

- **Provide training for A&E staff in prescribing PEP, supporting sexual health and LGBT patients.**
- **Deliver clear messaging around PEP and PrEP availability and help people navigate provision of medication both from NHS and online pharmacies.**
- **Develop clear messages around PrEP and COVID-19, the nature and function of anti-retrovirals, and the safe ways of stopping PrEP. It is important that this includes online pharmacies so that people sourcing PrEP without accessing healthcare services also receive accurate information.**
- **Maintain coherent, consistent, and accessible PrEP provision services even during periods of 'lockdown', with particular emphasis in ensuring access for people most at risk. This has long been an issue with PrEP in the UK.**

Testing for HIV/STIs

As many as 29% of respondents had accessed HIV/STI testing before March 2020. During the first lockdown, **88% of respondents did not seek testing, 9% did so by mail, and 3% did so face-to-face.** None of these were provided by LGBT Foundation, who were unable to offer remote testing options until later in the pandemic.

During the lockdown, did you seek testing for HIV or other STIs?



In general, **experiences of mail tests were positive:**

> "Good, efficient and quick"

With respondents highlighting **negative issues around access and service quality** in the case of mail tests:

> "Had to pay for my own test from superdrug"

> "It took me 6 days of waking up early to get the online test kits as if you were a little bit late they were unavailable"

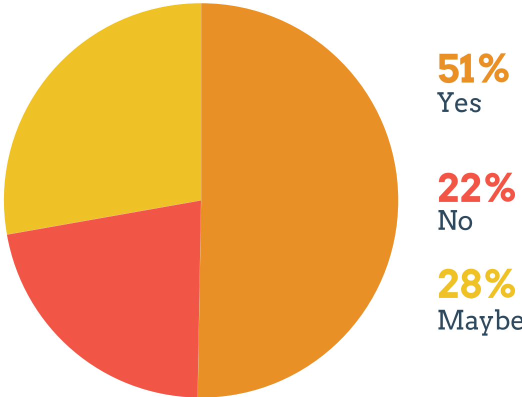
> "It was more difficult that a clinic and took longer to get the results. the results for my clap test didn't come back in one of the tests"

Face-to-face testing also garnered mixed reviews, with a respondent citing it was 'excellent' while another complained that it was:

> "Poor. AE felt very rushed and rude, nurse told me I was taking up the space from someone who actually needed it"

It is interesting to note, however, that **51% of respondents said they would like to get tested after lockdown, 28% said they might want to get tested and only 22% said they wouldn't like to get tested** (the latter all clarified this was because they didn't feel they needed a test).

After the lockdown, would you like to get tested?



This points to a potential **sharp increase in demands for tests once restrictions are lifted**. In addition, a national campaign has also been developed titled 'Break the Chain'. This campaign relies on the assumption that people will abstain from having sex during lockdown. Given that it may take up to three months (depending on the test) for HIV infection to show up in tests, people tested after lockdown could get an accurate result. Anyone who receives a positive result can then access the treatment they need to stay healthy and prevent HIV from being passed on. However, **without drastic upgrades to testing services these objectives seem unfeasible.**

Recommendations:

- **Advocate for quality HIV and STI testing across all providers: sexual health clinics, charities, GP clinics and walk-in services.**
- **Increase and streamline testing capacity and services after lockdown with clear, proactive campaigns that target first-time testers and those who routinely test within the 'window period'.**

LGBT Foundation sexual health services during the first lockdown

LGBT Foundation operations and services were severely disrupted during the COVID-19 lockdown. Starting on 18 March, testing clinics were suspended and remote working implemented across the organisation. On 30 March, the first video group meetings and workshops were held, followed on 29 April with the publishing of 'Sex During a Pandemic' guidance and '10 ways to stay safe'. That same day, a series of workshops and talks on Instagram titled 'The Tip' were launched. These continue as of September 2020. Thus, all the services this survey considers took place online. It is worth clarifying that the following responses are specific to LGBT Foundation services but they nonetheless provide significant insight into needs and service provision which may be applicable to other organisations.

60.3% of respondents answered that they were aware that LGBT Foundation continued to offer virtual support by phone, mail or social media during the lockdown. Asked about how respondents felt about approaching LGBT Foundation during the first lockdown, responses were ambivalent. **33% of people said they felt comfortable accessing the services** (or would feel comfortable if they were to access them):

> "Super easy to dm them on twitter or so"
>
> "Better than having to travel there"
>
> "I felt I could approach the foundation for support"

26% of people explained that they hadn't had the need to access the service:

> "Didn't feel the need to."
>
> "Needs based approach. As I had no specific need during this period I did not engage in any of the foundation services/activities"

A number of people did explain that they had **faced barriers around access.** Most commonly these barriers centred around lack of clear information about what services were available or how to access them. A number of users complained that they had had a **hard time finding informatio**n. Some respondents explained that they **would have accessed services that LGBT Foundation did not offer at the time:**

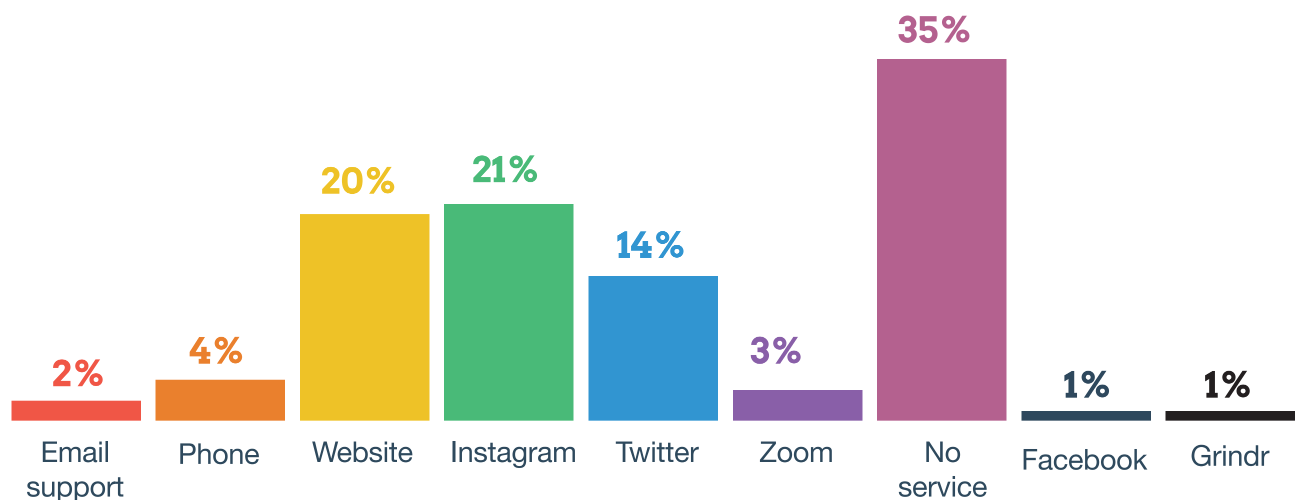
> "I lost two dear friends to covid in the early stages. Since there wasn't a funeral or anything, I felt quite alone in dealing with my grief and would have liked some support"
>
> "Didn't feel they were doing much to help trans or non-binary"

Other users identified concerns around **privacy or accessibility**, as well as difficulty in **negotiating anxiety** while accessing services. It is worth noting that a **key factor** in people's decision to engage or not engage seemed to be their **previous experiences of services.** Thus, a number of respondents highlighted how they felt their previous experiences encouraged or discouraged them from engaging online during the first lockdown:

"I was already a fan of the LGBT foundation before"

"The fact that you're LGBT specific, this really helped me to feel more comfortable with discussions about sex because I'm trans, bi and poly"

65% of respondents had engaged with LGBT Foundation services during the first lockdown. The most common services were activities, resources, or conversations with staff members through Instagram (21%), website (20%), Twitter (14%), followed by phone support (4%), Zoom (3%), email (2%) and Facebook (1%) and Grindr (1%).



It is important to highlight that, eminently, the majority of users who engaged with these had **positive feedback.**

"It was easier than going to the building in the Village"

"Normally don't have time to attend the events you put on but having it online was much better to do in any break from work"

"I talked with a foundation member on Grindr and they were super helpful and nice in answering questions. I'll definitely go get tested after"

"Really good. I'm moving to Manchester for uni this year and, as a queer student, it feels great to know there's a support network of great people in place"

This supports the belief that **online services and activities may be easier to access** for some people and act as a way of engaging new service users who may, later, attend face-to-face services.

Some of the respondents who had engaged continued to emphasise the **barriers and obstacles in accessing services**, particularly around information about what services

where available when. In general, several respondents suggested that they would have wanted **more practical information about COVID-19:**

> "They were good but didn't give too much information on like the actual things happening like covid and all or how to have sex safely"

> "Very good information but not really particular to covid and lockdown. would have liked some info on how to keep having sex safely during"

Some users suggested that **online services were not as satisfactory as face-to-face** services. They had particular concerns around privacy and personal attention:

> "Fine but for platforms such as zoom and all, I wonder where the information will be stored and whether privacy will be breached?"

> "They were okay but not as good as having appointments in the building with the team"

> "They're okay i guess, a bit repetitive and boring, not very personally"

Feedback was eminently positive, a testament to the arduous effort of team members who both designed and implemented online services in a challenging context:

> "Good and funny information and videos, wish my country had similar things (Mexico)"

> "Great. Really hit home and loved the content"

> "the LGBT website is easy to access and very useful with lots of relevant and straight to the point information. It feels very inclusive and informative"

Respondents also suggested further areas of concern and services that could be picked up by LGBT Foundation and other providers. Besides calls for clarity in services available and more practical information about COVID-19, respondents suggested the development of support activities targeted at particular communities:

> "Something more specifically for migrants/international people, for whom biological family etc are not present in the UK. There was a lot of British nationalism in the UK response and rhetoric around the pandemic, and as Australian, and my partner Brazilian, we sort of felt like they weren't "talking to us" ("they" being the government, media etc) - as well as already feeling like the response/government were only really talking to cis-heteronormative families..."

> "Maybe some more support for people from minority backgrounds?"

> "like a welcome pack for new students?"

Particularly, **three groups seem to be of interest: healthcare staff, trans people, and sex workers.**

> "I'm a A&E doctor and I would have liked some support for LGBT front-like workers that covered wellbeing, resilience etc."

"Advocacy to get trans and non-binary actual healthcare and dignity hospitals and doctors"

"They were okay but I had hoped for more advocacy on behalf of trans and non-binary people who were pushed out of services and had a hard time getting healthcare"

"Sex worker support"

A major concern of respondents was the need to **support people struggling with depression and bereavement** more generally:

"Support for depression or people struggling"

"Bereavement for gay men"

Several respondents identified **'social events' as key service** through which organisations could help people, which is in line with the **significance of social isolation** identified in previous questions:

"Personal support, maybe social happy hours on Skype"

"Calls over the phone, check-ups with friends, events on the village"

"More social events to talk to other people. I've been shielding since March, and the foundation always helped me meet others through socials, but i feel pretty isolated during the lockdown"

And, interestingly, financial help was also raised by some respondents:

"Help with buying masks and gel and food for people who were struggling"

While the majority of these responses are specific to LGBT Foundation, they nonetheless present insights into needs, barriers and experiences of services that are important for other organisations to consider. The recommendations that follow are also designed to be applicable to the broader spectrum of organisations.

Recommendations:

- **Provide clear information about what services are on offer, when they will be accessible, and how they operate. This will help potential service users in finding information and alleviate anxiety around what services will be like. This information should be prioritised on social media and website.**
- **For services and activities not offered by an organisation, provide clear information and streamlined links to organisations that do provide them and encourage service users to access them. This can act as a sort of 'resource book' online.**
- **Foresee, as much as possible, people's needs by consulting with existing volunteers and community partners. This will also serve to maintain active communication with volunteers, identifying those in vulnerable positions, and providing support.**
- **Collaborate with other organisations in developing joint services for particular groups that benefit from each organisation's knowledge and expertise. For example, provision of support for LGBT healthcare workers in partnership with unions.**

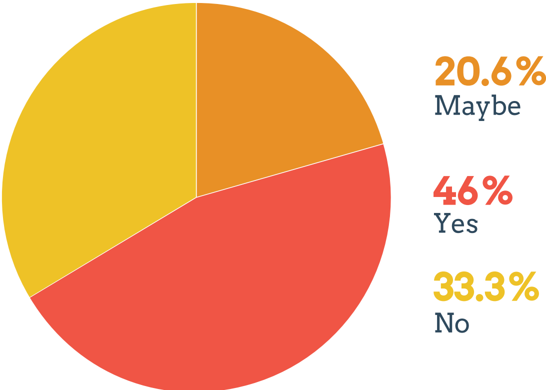
It is interesting that only one respondent highlighted **chemsex support.** Given the prevalence of chemsex practices and the concern about substance use revealed in the Hidden Figures survey, **chemsex is likely to be a significant area of work** even if it has only been highlighted as such by one respondent:

"I feel more support for chems, people don't just stop taking them if anything I took more during it because I was stressed about the whole covid thing"

Future services

46% of respondents answered that they would continue to engage with services after the first lockdown, 33.3% maybe, and 20.6% that they wouldn't.

Will you continue to engage with LGBT Foundation after lockdown?



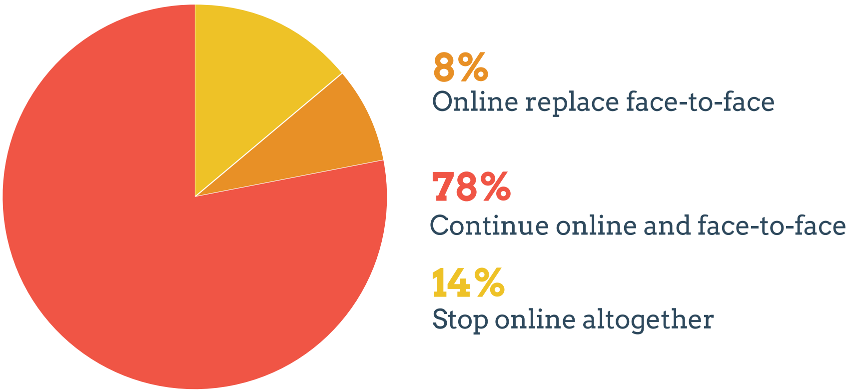
20.6%
Maybe

46%
Yes

33.3%
No

Asked about whether they felt online services should continue at the same rate, should be stopped or should replace face-to-face services, the respondents eminently supported the **continuation of online services alongside face-to-face services** (78%):

How do you feel about us continuing to offer online services after the lockdown?



This finding is important: **continuing the level of online services and activities while also providing the usual face-to-face services is likely to require an increase in resources.**

Those who felt online services should be stopped and replaced by face-to-face services pointed to important issues that have been raised in previous sections around **access, equality and intimacy:**

> "For old people like myself, internet things are difficult to use and can be a barrier to deal with all that"

> "Too nervous to speak online. in person is less scary"

> "Online isn't safe for everyone and neither is being online for support. You can't test online and even if you're guided through it part of going to a clinic is for the support. People in low incomes, in homophobic or transphobic environments, elderly people struggle to access online services and be safe and making services online only is unfair to vulnerable members of our community"

Certainly, these are important concerns and any future service provision online must account for people who will be excluded. The majority of people, however, wanted online services to continue at the current level alongside the usual face-to-face services. These respondents justified their answers by suggesting that a **combination of online and offline guaranteed maximum accessibility:**

> "Accessibility."

> "Some people do not have access to the technology required to access online services. Whilst I do and could choose whether to access online or face to face services, I know other people aren't always as lucky."

> "Easier for people in the closet and people with disabilities"

> "Better access for people who can't travel"

They also argued that a combination of services could best meet people's desires around **personal attention, privacy and help them fit activities within busy schedules:**

> "Good to offer people the choice, some may prefer the face to face personal approach, others may prefer the convenience and/or privacy that online services provide."

> "Online things are easier for people to use when they're busy/don't live in Manchester"

> "I can't travel to Manchester for it so I need the online things"

However, it is worth noting that in the current regulatory landscape not all activities and services can be provided online. Similarly, some users suggest **some services would not be adequate for online delivery**, thus supporting the hybrid online and face-to-face model:

> "As I understand it, the only way to get PrEP is by an in-person appointment. I don't know what PEP is."

Recommendations:

- Evaluate what services and activities may be delivered online, which ones may only work face-to-face and which ones can work in a hybrid model. This will require feedback from users, regulatory approval, financial feasibility and commissioning input.
- Provide clear information about what services are continuing and in what way, and proactively encourage users to continue using services after lockdown.

Asked more generally about **what avenues sexual health services should move forward,** some people suggested:

> "You need to provide support groups for people who got sick with covid, those who lost people to it, or lost their jobs."

> "Bring back in person clinics with PPE provided to all clinic staff"

> "I think services should be informed by the needs of service users who should be asked on a regular basis for their feedback. It is important for organisations to be flexible and responsive in the way they deliver services to meet the requirements of as many people as possible"

These concerns are in line with previous findings and highlight how respondents are particularly concerned with **clarity of information, organisation, and testing.** Before moving to conclusions, it is worth acknowledging that many respondents provided **positive feedback of LGBT Foundation** and, when asked how they felt LGBT Foundation should move forward, replied:

> "Excellent as it is"

> "keep being amazing guys more emphasis on older trans people online"

> "keep the good work online, it's helping lots of people who couldn't have known you otherwise"

Limitations

This survey has several limitations. The first is the relatively small sample size, with 84 responses albeit a high rate of completion. In addition, the sample is heavily biased towards white, cisgender, gay men living in Greater Manchester. This is a result of the channels through which the survey was distributed (mostly Twitter and Instagram) as well as long-standing difficulties to access certain groups. The fact that this was an internet-based survey is also likely to significantly influence the results, particularly around respondents' access to the internet and their confidence in using online services and activities. Finally, this survey remained open for a short time-frame due to restrictions around the project. These limitations, which are in line with those of previous work such as the *Hidden Figures* report, should be considered alongside the results, and further research should look into the experiences of particular communities not represented in this sample.

Conclusions: after COVID-19

The experiences of the respondents to this survey generate an important landscape to understand how sexual health services were delivered online, how users experienced them, and whether they are here to stay. The context in which these online activities and services were developed and implemented was not always planned or clear, but nonetheless the overwhelming positive feedback from respondents is a **testament to the hard work of staff and organisations.** We may be approaching a time free of COVID-19 but we should also take this opportunity to explore new service provision routes so that we not only go back to 'normal' but to an 'improved new normal'.

Perhaps the most salient themes among respondents' experiences of lockdown are the feelings of **isolation, loneliness and anxiety.** These do not only come from the impossibility of meeting preferred partners, but also by the sudden dissolution of informal (and formal) support networks and social events (not least of which, for example, has been the cancellation of many Pride events this year). As explained in the introduction, LGBT communities are already disproportionately affected by poor mental health, and the current climate of crisis and lack of support exacerbates these issues. **LGBT specific sexual health services do not only test for HIV and other STIs, they also provide a critical lifeline to identify vulnerable individuals, support them, and help them attain their full potential.** The first lockdown has troubled this lifeline but also showed us new avenues to meet needs through online platforms. As we move forward to a post-COVID-19 world, we should remember the key role that these organisations and services play in people's lives.

Respondents have recounted positive experiences in using online services, emphasising that they were **more convenient and easier to access**. However, they also highlighted that there are **unique barriers to online platforms:** they may prove difficult to access for people who are not accustomed to the internet and building rapport and trust with service users may be more difficult than in face-to-face encounters. Similarly, respondents also highlighted that there was a **general lack of concise and clear information** about services available. This seems to be a generalised issue, as respondents also evidenced that messaging around PrEP and PEP access and use had not been clear. In addition, this is by no means a COVID-19 specific issue, but the exacerbation of pre-existing dynamics of poor access to information.

Access to PEP and PrEP is one of the most interesting findings of the project: it is remarkable that **100% of respondents who continued using PrEP during the first lockdown turned to sourcing it privately** through online pharmacies and faced barriers when trying to obtain it from the NHS. This is a testament to the need for consistent, clear, equitable and accessible provision nationwide—a historical complaint. Similarly, respondents showed a lack of knowledge about PEP availability and fears about facing stigma when accessing it. Again, **these are by no means unique to COVID-19 situations**

but rather serious and historical complaints by LGBT people. COVID-19 may be the catalyst of change in this respect.

The COVID-19 pandemic is not yet over. In fact, it may never be over: the effects it has had on people's mental health, employment, relationships, and politics will be long-lasting and disproportionally affect the most vulnerable groups. However, as we move forward, there are two main suggestions from this survey that could guide our decisions. The first is the need to **increase our testing and service capacity.** The majority of respondents would like to access testing after the first lockdown, and some organisations, such as 56 Dean Street, have already seen the potential of this to 'break the chain' of transmission. Similarly, it is likely that LGBT-specific sexual health services will have to deal with a **rise in service users requiring mental health support.** Without **significantly more funding** to both diversify and amplify existing programmes, these needs will go unmet. This is particularly urgent after decades of funding cuts that have decimated services.

Similarly, respondents have also evidenced a **desire to maintain a hybrid model,** where some services remain online, others are available offline, and some may be available in both formats. Further research is needed to ascertain what services are likely to most benefit from this model, what communities are likely to be impacted by these changes, and in what ways. However, what is already clear is that maintaining an active online and offline presence will require **resources beyond those currently available, as well as collaborations between organisations to build synergies** that provide accessible, clear, and streamlined services to people.

Finally, it is worth remembering that all of these issues, from isolation to poor access to PrEP, are long-standing issues in LGBT healthcare and wellbeing. They pre-date 2020 and the pandemic has done nothing but exacerbate them and bring them to light. **Eventually, COVID-19 will go away, but the inequalities and problems evidenced in this report will remain.** The lockdown and the subsequent changes provide a unique window of opportunity to evolve our service provision to reach those who we have failed to engage with, to innovate in our delivery, and to assess the many weaknesses and many strengths of our healthcare.

Summary of recommendations

The following recommendations are not specific to COVID-19 and its lockdown. They are suggestions to improving services that address the problems that predate COVID-19, were exacerbated by the lockdown, and will continue affecting our services after the pandemic is over.

- Enhance activities and services that **support people's social lives,** particularly among those groups that are most likely to be socially isolated. This is particularly relevant in times of 'social distancing'.
- **Streamline processes** for accessing services, limiting paperwork and ensuring privacy and confidentiality.
- Evaluate the adequacy and **adapt communication and resources to be accessed by smartphone**, both on social media and the website. This is particularly important given the prevalent use of smartphones as an access device. This can be done through adopting smartphone-friendly website templates, using scrolling-friendly resources, limiting large-size files and downloads, and adopting best practices in creating social media content.
- **Clarify what services an organisation provides,** including sexual health and mental health services, proactively encouraging people to seek help. This can take the form of nation-wide campaigns, local approaches, or one-to-one interactions. In turn, this may require organisations to:
- **Upgrade and rethink service provision** to meet increased demand for 'sexual health' broadly conceived, including linking with mental health services.
- **Provide training for A&E staff in prescribing PEP,** supporting sexual health and LGBT patients.
- **Deliver clear messaging around PEP and PrEP** availability and help people navigate provision of medication both from NHS and online pharmacies.
- **Clear messaging around PrEP. Particularly now, around PrEP and COVID-19,** the nature and function of anti-retrovirals, and the safe processes of stopping PrEP use. It is important that this includes online pharmacies so that people sourcing PrEP without accessing healthcare services also receive accurate information.
- **Equitable, consistent, and accessible PrEP provision** services even during periods of 'lockdown', with particular emphasis in ensuring access for people most at risk. This has long been an issue with PrEP in the UK.
- **Advocate for quality HIV and STI testing across all providers:** sexual health clinics, charities, GP clinics and walk-in services.

- **Increase and streamline testing capacity** and services after lockdown with clear, proactive campaigns that target first-time testers and testers who normally fall within the 'window period'.
- **Provide clear information about what services are on offer,** when they will be accessible, and how they operate. This will help potential service users finding information and alleviate anxiety around what services will be like. This information should be prioritised on social media and website.
- For services and activities not offered by an organisation, provide clear information and streamlined links to organisations that do provide them and encourage service users to access them. This can act as a sort of **'resource book'** online.
- Foresee, as much as possible, people's needs by **consulting with existing volunteers and sessional workers.** This will also serve to maintain active communication with volunteers, identifying those in vulnerable positions, and providing support.
- **Collaborate with other organisations in developing joint** services for particular groups that benefit from each organisation's knowledge and expertise. For example, provision of support for LGBT healthcare workers in partnership with unions.
- **Evaluate what services and activities may be delivered online,** which ones may only work face-to-face and which ones can work in a hybrid model. This will require feedback from users, regulatory approval, financial feasibility and commissioning input.
- **Provide clear information about what services are continuing** and in what way, and proactively encourage users to continue using services after lockdown.

About the author

Dr Jaime García-Iglesias is a Research Fellow at the University of Hertfordshire. He holds a PhD in Sociology from the University of Manchester and has published extensively about HIV prevention, online service delivery, and qualitative methods. He has led a number of research projects at both local and national level looking at sexual health services, evaluation, and prevention.

Email: garciaiglesiasjaime@gmail.com

Linked in: linkedin.com/in/garciaiglesiasjaime/

Twitter: @JGarciaIglesias

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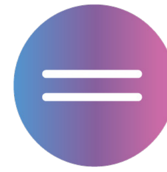

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Email: info@lgbt.foundation
Web: www.lgbt. foundation

LGBT Foundation,
PO Box 5577,
Manchester,
M61 0TT