



# ChemSex and hepatitis C:

a guide for healthcare providers



This guide is endorsed by:

THE  
HEPATITIS



TRUST



**This guide has been initiated and funded by Roche Products Limited.  
Editorial control remains with David Stuart of 56 Dean Street.**

Date of preparation: December 2014

Zinc job code: RXUKCOMM01187e

## Glossary:

AIDS	Acquired immune deficiency syndrome
ARV	Anti-retroviral
BBV	Blood-borne virus
ChemSex	Derived from 'chemical sex', meaning the use of recreational drugs for sex
GBL	Gamma-butyrolactone
GHB	Gamma-hydroxybutyrate
GUM	Genito-urinary medicine
HCV	Hepatitis C
HIV	Human immunodeficiency virus
IVDU	Intravenous drug use/intravenous drug user
MSM	Men who have sex with men

## HGV, HIV and ChemSex key facts:



Morbidity and mortality rates from HCV infection in HIV co-infected patients are increasing<sup>1</sup>

**7%** of HIV infected gay men in London are also infected with HCV<sup>2</sup>



Approximately

**92%**

of HCV/HIV co-infections were in gay men located across London, Manchester & South East England in

**2011<sup>2</sup>**

There are more co-infected gay men than co-infected IV drug users<sup>2</sup>

There is currently no national strategic approach to prevent HCV infections in gay men in the UK<sup>2</sup>

It is estimated that around **25%** of all European HIV patients have concomitant (HCV) co-infection<sup>1</sup>

Co-infection with HIV and HCV complicates each disease<sup>2</sup>

A significant proportion of HIV positive gay men who are successfully treated for HCV are rapidly re-infected with the virus<sup>2</sup> with the two-year re-infection rate at a North London hospital at 40%.<sup>2</sup>

At Chelsea & Westminster Hospital NHS Foundation Trust, which hosts robust ChemSex referral and support services, the reinfection rate is 25%.<sup>3</sup>

## Background

HCV continues to be a highly stigmatised disease associated with much fear, ignorance and misinformation. The high-risk groups continue to be:

- Injecting drug users
- People living with HIV
- MSM

The trends found in the increased prevalence of ChemSex (the use of recreational drugs in a sexual context) by MSM unites all three of these high-risk groups in concentrated clusters, which warrant novel interventions and prevention messages. This poses distinct challenges for healthcare workers who may struggle to contextualise the activities that occur during the course of a ChemSex party.

**This guide, informed by conversations with 500 MSM ChemSex presentations to London's 56 Dean Street GUM/HIV clinic, aims to:**

- Raise awareness amongst clinicians of the HCV risks MSM experience when participating in ChemSex activity
- Improve our confidence and skill in communicating these risks and importance of testing to our patients

## The main factors that have influenced and define ChemSex behaviour have been:



**The increased availability and use of three recreational drugs by MSM in London**, including crystal methamphetamine, mephedrone and GHB/GBL. All drugs are powerful disinhibitors that enhance sex and are associated with: high-risk sexual behaviour, indulgence of sexual fantasies with little regard to consequences, poor ARV adherence for HIV, poor use of condoms, extended episodes of (often traumatic) sexual pursuits (e.g. fisting) typically lasting two to three days, multiple sexual partners, as well as many other non-sexual health/non-BBV-related harms.

As a result of ChemSex behaviour, some London GUM/HIV services have witnessed an increased number of STI/HIV/HCV infections/co-infection amongst MSM, including repetitive HCV infection (some as many as four times). This suggests we can improve our support for these patients regarding the risks they are taking in these environments.



**Increased injecting use of crystal methamphetamine and mephedrone by MSM.** Traditionally, MSM have preferred drugs like ecstasy and cocaine (snorted) to the injecting use of "harder" drugs. This means they are less exposed to the culture of safer injecting messages that have been targeted at (typically street-homeless heterosexual) opiate injectors who frequently visit drug services. Additionally, MSM have been reluctant to access mainstream drug services, preferring to disclose their drug use to/seek support from their favoured sexual health clinics, where safer injecting information and needle exchange has not traditionally been provided. **Hence we have a growing population of MSM injectors who share clumsy injecting practices and knowledge, which are informed mostly by word of mouth and myths that exist within their own drug-using circles.**



**The use of smartphone Apps and online 'hooking-up' sites to seek sexual activity as well as procuring drugs.** While some of this behaviour is occurring in saunas and sex-on-premise venues, the majority is happening in private homes, MSMs having negotiated the sex and drug environment online. This defines this population as particularly hard-to-reach in regards to interventions and messages for facilitating a safe environment for this activity. **While efforts continue to provide safer behaviour messages via media and online channels, these men are less accessible than clubbers or the street-homeless to deliver face-to-face interventions or safer behaviour messages.** For this reason, sexual health clinics have become the new front line in addressing these complex risks and harms, which asks staff in these clinics to adopt awareness and skills beyond their traditional remit.

## Case study: JEFF\*

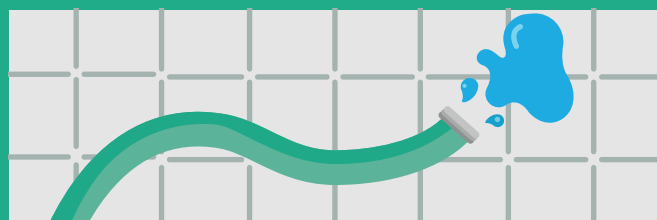
Jeff is a 29 year old gay Londoner, who is HIV positive. He cleared his HCV four years ago, at which time he sought support for his recreational drug use through his local borough opiate/crack cocaine/alcohol service. Though they had some expertise on the drugs, Jeff felt his sexual preferences were not addressed in a way he found helpful. He struggles with intimacy and sober sex and relapses approximately four times a year into ChemSex behaviour, which consists of three to four day benders.



Having had a few drinks out, Jeff returned home alone and began cruising on his smartphone App for sex. He invited himself around to someone's house who was willing to share chems (drugs). Both were HIV positive and agreed to bareback (have condomless sex). Jeff did ask his partner's HCV status, which he has done with some degree of vigilance and fear since his own diagnosis four years ago; though uncomfortable with the question, the partner responded to the best of his knowledge that he was HCV negative.

They both snorted meph (mephedrone) using separate rolled up notes from their wallets and drank some G (GBL). They had clumsy condom-less sex on and off for five hours before they agreed to invite a third person around who was bringing some Viagra and more mephedrone. While they waited, Jeff showered and freshened up. He knew not to use toothbrushes or razors in other people's homes, so made do with a gargle. He'd been chewing his tongue a little and had some ulcerations on the insides of his cheek. He did use some electric clippers to tidy his pubic hair, which he felt was looking unkempt, plus he found it to be erotic. He also douched by removing the showerhead from the hose, as the sex had been quite rough. He was unaware that two guys had been to the house some hours before he arrived who had douched the same way following a fisting session – one of these guys had been HCV positive.

The third guy arrived, and brought with him "Tina" (crystal methamphetamine) and needles, though no Viagra. Jeff, wary of injecting but no longer getting a high from the mephedrone, chose to 'booty bump' the methamphetamine (squirt a mixture of water and dissolved drug up his anus using a 2ml needle-less syringe). He made sure it was an unused syringe, although it's possible the water was taken from the same mug used to mix the drugs injected by the other guys. He hoped the used needles had not been placed in that mug, but events were becoming a bit confusing.



Due to the lack of Viagra, some dildos came into play. There were no condoms around, but Jeff did have the presence of mind to make sure he didn't use any that had been used by anyone else. Again, he was unaware that they had been used by the guys who had been to the house before his arrival.

**By day two**, the drugs had run out and the third guy had departed. Jeff and his host set off on a journey to get more drugs from a drug dealer who lived 20 minutes away. When they arrived, a little worse for wear, they were offered a pipe of crystal methamphetamine to freshen them up. The pipe was a little cracked, however, Jeff thought it was very welcome. Jeff had applied some lip balm to his chapped lips en route, so he believed he was likely protected from the HCV infected blood droplet that lingered on the lip of the pipe that had been shared between many visitors in the prior hours and days.

They both stayed at the drug dealer's house for another 10 hours or so. Jeff succumbed to the temptation of injecting drugs, though everyone there was vigilant about clean needles. There was some traffic throughout the house and sharing of partners, but Jeff was only playing with the guy he arrived with and the drug dealer. While there was some fisting, with gloves, the lube dispenser pump was being shared less than hygienically, so Jeff just hoped for the best. He was very high and having a good time. There was also a moment when he took a little too much GBL and passed out (he thinks) for an indeterminate amount of time – he remembers being very aroused before he passed out and not entirely sure what happened. But his concerned partners injected some diluted methamphetamine up his anus to help bring him around. No-one was able to say whether the syringe used for this had been unused, but it wasn't a welcome topic of conversation at that point.



**Day four**, Jeff woke up at home feeling exhausted and ashamed. He felt there was little point getting tested that week as there was nothing he could do about it anyway and he had "been safe mostly" – he was also eager to avoid the questions he would be asked at his GUM clinic, somewhat ashamed of what he'd done. The following weekend, Jeff relapsed into drug use again and this cycle continued for another five months. He continued his vigilance about not using shared needles and always discussed his HCV status with partners when he could. He was very proud to tell his HIV clinician about these boundaries, though he became re-infected with HCV five months later when he attended his routine HIV appointment. He asked his clinician how he became infected given that he had been strict about clean needles. His clinician, not fully versed in the full range of risks associated with a ChemSex environment, only repeated his advice to always use clean needles and condoms in future. Jeff was convinced his ChemSex days were behind him forever now so the clinician did not refer him to a drug service.



### Key learnings from our conversations with 500 MSM ChemSex presentations

Though much of this high-risk behaviour is alarming, it's important to note that a spectrum of risk does exist. Of the MSM ChemSex presentations to 56 Dean Street, some reported non-injecting use of drugs for sex within their own monogamous relationships, where the risks of HCV transmission were seemingly significantly diminished. Some others favoured one-on-one sex to group sex and some had confident skills in negotiating the risks with their sex partners. While many knew the basics, such as not sharing straws or needles (for snorting or injecting drugs), many found it difficult to adhere to safety measures (such as using condoms for intercourse and with sex toys/gloves for fisting) while in the grip of a prolonged and disinhibiting drug high. Few were aware of the more subtle or less obvious possibilities for HCV transmission in these environments. To further complicate our understanding of HCV transmission in a ChemSex environment, there have been a significant number of HIV-negative, non-injecting drug users who have contracted HCV or become re-infected, despite claims of consistent condom use and sexual health awareness.



### The majority were very well-informed about HIV prevention

There was a degree of confidence about disclosing 'HIV status' and 'undetectability' with regards to viral loads, both online and face-to-face – though a common assumption was that those choosing to participate in condom-less sex at a ChemSex party were already HIV positive. There was significant nonchalance regarding the risks of non-BBV sexually transmitted infections, as they were considered easily treatable.



### All this however, contrasted greatly in HCV – it was rarely disclosed online or face-to-face

When HCV was mentioned, it was more likely to be a stigmatising sentence in an online profile rejecting any potential partners that were HCV positive.

## Language used and incurring trust

One of the challenges that remains is to encourage our patients to (honestly) disclose certain behaviours that put them at risk. There is an inevitable amount of shame and perceived judgment our patients might experience with regards to disclosing ChemSex behaviour to us. It is for these reasons MSM have been reluctant to access mainstream drug services. Within 56 Dean Street GUM/HIV clinics, there has been a discrepancy between what an MSM will disclose to a nurse during a brief GUM consultation regarding ChemSex behaviour and what they disclose to an in-house drugs advisor during a (longer) consultation immediately afterwards.

**Lessons learnt have been that the use of colloquial terms for drugs/drug use and sex practices by healthcare staff have played a large part in encouraging honest disclosure of sex and injecting practices, number of partners or risks taken.**

Obviously, a part of this lies in understanding the complex underlying issues and motivations for ChemSex. It can be challenging for us, as healthcare workers, to witness or empathise with self-harmful behaviour. It's important to know that there are explainable and complex underlying issues that drive ChemSex trends, such as stigma, fear, shame, loneliness, internalised homophobia, gay scene/online norms, the legacy/trauma of a 30 year AIDS epidemic, gay sex having been portrayed as dangerous, disease-fuelled pastime and many other social/sexual issues. These can all be obstacles to pursuing a healthy fulfilling sex and romantic life and may indeed explain some of the harmful behaviour that our patients face. If our patients know that we understand these complex explanations, we can gain their trust more effectively.

## Terms to be familiar with:

Slang, street names, colloquial terms	Definition
Tina/Meth/Ice/Crystal	Crystal methamphetamine, which can be injected, smoked, snorted or booty bumped
Meph/Meow Meow/Drone	Mephedrone, which can be snorted, injected, swallowed or booty bumped
G/Gina	GHB/GBL, taken orally (a liquid)
Slamming/slammed/to slam	Injecting/injected/to inject
Barebacking	Condom-less anal intercourse
Booty-bumping	To squirt diluted drug into the anus
Bender	Episode of drug use
Chems	Recreational drugs

## Questions to ask during consultation

Disseminating HCV prevention messages during a brief consultation can also be a challenge. It can be a confusing and sometimes frightening collection of messages that we hope our patients will be able to retain many days later while (potentially) intoxicated. Again, we can be more effective by toning down our pathology and using language that is familiar and absorbable by our patients, where we are comfortable doing so.

Please find below some questions you may wish to ask during your consultation. A patient version of this page is also available for your dissemination.

Do you sometimes use drugs for sex?

Are you into ChemSex, fisting or slamming (injecting)?

Do you use sex toys/dildos?

Do you use condoms for dildos/toys (and change them between partners)?

Do you use gloves for fisting (and change gloves between partners)?

How many partners might you have during a typical bender?

Do you prefer bareback (condom-less sex)?

Are you comfortable discussing HIV with partners or when hooking-up online?

Are you comfortable discussing HCV with partners or when hooking-up online?

Do you know where to get clean needles from and safer injecting information?

Are you aware that HCV is common amongst gay men who have ChemSex?

Have you ever been tested for HCV?

Would you like to talk with a health advisor about playing as safely as possible?

Offering safer-play advice to MSM who participate in ChemSex remains very difficult given the high number of transmission variables. We can certainly warn our patients that ChemSex play is high-risk and invite them to discuss these risks in a less hurried consultation with a health advisor, who may employ motivational interviewing techniques to help the patient explore the pros and cons of ChemSex.

Certainly, having a familiarity with ChemSex behaviour and terms will make your patients more receptive to your messages, as will having empathy and understanding of the complexities and norms gay men in a big city experience around their sex and romantic lives.

## Transmission risks during ChemSex

ChemSex sometimes involves rougher play for extended periods of time. This is often associated with dehydration that can exacerbate broken skin. Due to the effects of drugs, patients can be less aware of pain or damage caused to their own/others bodies, including:

- Entrance to arse/lining of the anus can be vulnerable
- Sores/cuts/ulcers in mouth/tongue/on lips can be vulnerable
- Bleeding gums can be vulnerable
- Lining of nasal passage can be vulnerable
- Cuts on fingers/fists can be vulnerable
- Cuts/abrasions on penis can be vulnerable

- HCV can be spread by direct blood-to-blood contact
- The blood may not always be visible
- HCV can live outside the body for at least 16 hours and up to 4 days<sup>4</sup>

### Transmission risks via drug paraphernalia

Blood on used needle/in syringe	↔	Broken skin/vein
Blood on used needle/in syringe	↔	Into cup/spoon a clean needle will draw from
Blood in used cup/spoon	↔	Into clean needle/syringe
Blood on/in booty bump syringe	↔	Into abrasions/tears on entrance/lining of anus
Blood on mouth of a meth pipe	↔	Into cracked/broken lips
Blood on a snorting straw	↔	Into damaged lining of nasal passage

### Transmission risks via household paraphernalia

Blood on razor/scissors/toothbrush	↔	Your broken skin/gums
Blood on douching tools/shower hoses	↔	Your damaged entrance/lining of anus

### Transmission risks via sex toys/equipment

Blood on used condoms	↔	Into damaged lining of anus
Blood on re-used condoms	↔	Onto a sex toy > into damaged lining of anus
Blood on glove	↔	Into damaged entrance/lining of anus
Blood on a lube pump handle/lube bucket	↔	Onto damaged penis
Blood on a lube pump handle/lube bucket	↔	Into damaged entrance/lining of anus
Blood on a lube pump handle/lube bucket	↔	Onto a sex toy > into damaged lining of anus

### Transmission risks during sexual contact

Blood in saliva, on tongue/lips	↔	Onto chapped lips, chewed tongue, bleeding gums
Blood in saliva, on tongue/lips	↔	Onto chafed penis, damaged anus
Blood on (fingering/fisting) hand	↔	To damaged entrance/lining of anus
Blood on (fingering/fisting) hand	↔	Onto a chafed penis
Blood on chafed condom-less penis	↔	To damaged entrance/lining of anus
Blood on chafed condom-less penis	↔	Onto chapped lips, chewed tongue, bleeding gums
Blood in urine (rare, but possible when trauma, infection or drug use has occurred)	↔	Any chafed/damaged area during water sports
Blood in semen (rare)	↔	Into chafed/bleeding mouth or anus

## The importance of testing and early treatment

It is possible to treat HCV infection. The increasing rates of HCV detection and therapy were highlighted by the Health Protection Agency (HPA) in its 2011 report as being key to control the epidemic.<sup>2</sup>

It is therefore essential that MSM who are engaging in any of the activities described in this guide, are tested for HCV. We know from experience that they often do not wish to have a HCV test, either as a result of not knowing the facts around the disease or having heard horror stories about treatment. However, it's important to speak to these patients about the importance of being diagnosed promptly – not only for their own health and to consider treatment early, but also for the health of the wider public.

Many MSM who are already seeing their consultant regularly to have blood work taken for other STIs or an existing HIV infection should also be encouraged to be tested for HCV, and if positive, to try treatment in the earlier stages of the disease.

**While about 25% of people infected with HCV clear the virus spontaneously,<sup>5</sup> co-infection with HIV can complicate each disease. Prompt diagnosis of HCV infection has both individual and public health benefits, with early treatment within a year of onset<sup>6</sup> of HCV in HIV positive individuals having a success rate of up to 80%.<sup>2,6</sup>**



### Referral pathways

Few drug services nationally have been fully trained to provide ChemSex support to MSM – although that's not to say they are incapable, as many will be able to adapt their interventions to this patient group.

Health Advisors within [sexual health clinics](#) may be the most direct and effective first referral.

The [Antidote drug and alcohol service](#) at London Friend take ChemSex referrals regardless of a patient's area of residence and offer walk-in services.

[56 Dean Street](#) has targeted ChemSex support with walk-in clinics open to anyone regardless of their area of residence.

## Clean and free injecting equipment

Providing clean needles within your own service is recommended as the most effective way to equip ChemSex patients with a tool to prevent the transmission of BBV's.

Some [sexual health services](#) do provide clean needles to MSM, including [56 Dean Street](#) and [Burrell Street](#).

Most traditional drug services provide clean needles to their service users, though MSM have demonstrated a reluctance to access these services.

Many [pharmacies](#) are part of local needle/syringe exchange schemes, although these also lack the advantage of delivering safer injecting advice to ChemSex patients

A toolkit for adapting ChemSex support within GUM/HIV services (HIV Nursing Journal)  
Stuart D. Sexualised drug use by MSM (ChemSex): a toolkit for GUM/HIV staff. HIV Nursing Journal.2014;14 (Summer 2014):15  
(<http://www.davidstuart.org/chemsex-toolkit>)

A summary of the ChemSex syndemic (HIV Nursing Journal)  
Stuart D. Sexualised drug use by MSM: background, current status and response. HIV Nursing Journal.2013;13.1(Spring 2013)  
(<http://www.davidstuart.org/nursing-journal-1>)

A training video of a ChemSex brief intervention within a GUM setting  
(<https://www.youtube.com/watch?v=q0daouGHXqQ&list=UUgEg04e542sAUnzD4WGKLLA>)



#### References

1. Rockstroh, Jürgen K Managing HIV/hepatitis C co-infection in the era of direct acting antivirals, *BMC Medicine* 2013 11:234
2. National AIDS Trust, *Hepatitis C and HIV Co-infection* 2012
3. Martin T et al. Hepatitis C virus reinfection incidence and treatment outcome among HIV-positive MSM, *AIDS* 2013 27(16):2551-7
4. Center for Disease Control (CDC) Hepatitis C FAQs for the Public available at: <http://www.cdc.gov/hepatitis/c/cfaq.htm> (last accessed December 2014)
5. The Hepatitis C Trust 'Stages of hepatitis C' available at: [http://www.hepctrust.org.uk/Hepatitis\\_C\\_Info/Stages+of+Hepatitis+C/Introduction](http://www.hepctrust.org.uk/Hepatitis_C_Info/Stages+of+Hepatitis+C/Introduction) (last accessed December 2014)
6. 'Acute hepatitis C in HIV-infected individuals – recommendations from the NEAT consensus conference', *AIDS* 2011; 25:399-409





