approach to sexual health that encompassed multiple, complementary strategies for managing sexual health. Participants characterised this conceptual model as the ‘ideal’, acknowledging that in reality and within each domain this vision is not always realised. For example, participants described stigmatising reactions to partner notification and condom use (or non-use). Physicians, on the other hand, reflected on the real-life limitations of providing individualised patient care, particularly the strain frequent testing and treatment places on resource-limited health settings. Finally, many participants felt that some strategies (notably HIV pre-exposure prophylaxis) were disproportionately valued by individuals and health organisations, undermining a holistic approach by focusing on one dominant strategy.

Conclusion The conceptual model defined by this research provides a framework for future efforts to promote sexual health while acknowledging enduring challenges to normalised, individualised and holistic approaches. Gay and bisexual men and sexual health physicians value a multifaceted and choice-driven approach to sexual health, reinforcing the need for a menu of prevention options that reflect the realities of STI transmission balanced against the resources required to deliver sexual health care.

Disclosure No significant relationships.

Background Bacterial sexually transmitted infections (STIs) are preventable, treatable, and have been increasing among men who have sex with men due to limited STIs/HIV screening and high-risk sexual behaviors, including partner concurrency and condomless anal sex. Within stable relationships, sexual behavior patterns may change over time. This analysis was conducted to estimate if relationship length is associated with the resources required to deliver sexual health care.

Disclosure No significant relationships.