HIV/Sexual Health Clinical Education Session

http://courses.ashm.org.au/HIV/hiv-sexual-health-clinical-education-session/

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Australian and New Zealand Journal of Public Health

Journal Club 7th March 2018

Loretta Healey
RPA Sexual Health

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The journal

- Impact fact 1.69
- Open access journal. Cost to publish $500 if member of Public Health Association- $1500 if not.
- Most cited journal articles 2017:
  - 'A quantitative analysis of the quality and content of the health advice in popular Australian magazines'
  - 'Experts' views regarding Australian school-leavers' knowledge of nutrition and food systems'
  - 'The social determinants and starting and sustaining quit attempts in a national sample of Aboriginal and Torres Strait Islander smokers'
  - 'Awareness and correlates of short-term and long-term consequences of alcohol use among Australian drinkers'

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Anne Pennay et al "Improving alcohol and mental health treatment for lesbian, bisexual and queer women: Identity matters" 2017 online

- Qualitative study of 25 of same sex attracted women
- Meta-analysis: risk of lifetime mood disorders, anxiety disorders and substance use 1.5 times higher in LBQ
- Higher rates alcohol and mental health problems among LBQ women→ seeking and receiving treatment
- Evidence of higher rates of dissatisfaction with GP
- Semi-structured interviews on sexual identity, alcohol use, mental health and treatment seeking
- Healthcare experiences- neg-49 pos-15

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Pennay (cont)

- The need for more inclusive language
- The need to acknowledge sexual identity as an important component of identity while not assuming it is the cause of all mental health and alcohol problems
- The need for improved training in LBQ issues and LBQ specialist services.
- Opposing views found on relevance of sexuality
- Only pattern found was LBQ 'identity salience' was an important indicator of people's experiences and views

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Michael Doyle et al 'Hepatitis C virus prevalence and associated risk factors among Indigenous Australians who inject drugs' 2017 online

- Recruitment from Needle and syringe program Survey- annual bio-behavioural surveillance project 2006-2015
- 17413 respondents, 2215 (13%) indigenous-DBS used

when compared to non-indigenous Indigenous respondents are more likely to be exposed to Hep C (53% vs 60% p<0.001)

Independent factors

- History of imprisonment
- Opioid injection
- Recruitment in a metro location
- Engagement in opioid substitution therapy
- Length of time since first injection

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Doyle (cont)

- Indigenous respondents commenced injection at a significantly younger age than non-indigenous respondents
- Younger Indigenous people as likely to be exposed to Hep C as older (in contrast to non-Indigenous)
- Women comprised a significantly greater proportion on Indigenous compared to non-Indigenous respondents (42% vs 31%)- younger PWID (52% vs 35%)
- Among young indigenous higher number of women (52% vs 48%)- worldwide men outnumber women 4 to 1
- women more likely to share and inject after male partner
- High rates of incarceration
- Culturally sensitive interventions needed

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Megan S.C Lim et al 'Young Australians' use of pornography and associations with sexual risk behaviours" Vol 41 No 4 pp 438-443

- Prevalence and factors assoc with viewing frequency and age at 1st viewing
- Cross sectional online survey 15-29 yr old through social media N=941,
- Ever viewing: 87%, median age at 1st viewing 13 years M, 16 F
- ↑ frequency viewing assoc with male gender, younger age, higher education, non-heterosexual, younger age at 1st sex and recent mental health problems
- ↓ age at 1st viewing assoc with male gender, younger current age, higher education, non-heterosexual, younger age at 1st sex and recent mental health problems
- Should be addressed in education

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Michael B MacIsaac et al: 'The association between exposure to interpersonal violence and suicide among women; a systematic review. 2017 Vol 41 No 1.

- Meta-analysis of 38 studies
- Hx of violence identifies in 3.5% to 62.5% of female suicides
- Being a victim or perpetrator appears to be associated with risk of suicide
- Role of mental illness to this association is unclear
- Several papers questioned any association
- Is there an opportunity to target suicide prevention strategies to victims or perpetrators of violence?

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Tinashe Dune et al: 'The built environment and sexual and reproductive health' Commentary 2017, Vol 41, No 5 pp 458-459

- Environmental influences on well-being
- Paucity of statistics on sexual and reproductive health issues experienced by people in disadvantaged areas
- Wilson's 'broken windows' theory neighbourhood disorder → greater tolerance for behaviours that are socially unacceptable.
- Cohen- higher rates of gonno in neighbourhoods with higher levels of disorder. Increased prevalence for STIs was not socioeconomic but statistically attributable to cosmetic and structural damage to built environment.
- Connection between studies of built environment and sexual and reproductive health

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Hayley J Denison et al 'Barriers to sexually transmitted infection testing in New Zealand; a qualitative study' Vol 41 No 4 pp 432-437

- 24 university students interviewed: 16 F, 7 M, 1 'genderqueer'
- Eligibility: presented for STI test in past 18 months

Barriers

- Personal: self conscious; fear; underestimating risk
- Structural: cost; clinician attitude
- Social: concern re being stigmatised

- Authors recommend holistic approach to encourage testing including addressing personal beliefs, working with HCWs to address structural barriers and developing initiatives to change social views

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Glen Driver et al "HIV testing within the African Community using home-based self collection of oral samples: 2017 Vol 41 No 4 p 446

Letter:

- African communities have HIV prevalence 0.7 compared to population prevalence of 0.14 with later diagnoses
- Use of trained bilingual community health workers
- Use of Orasure non-invasive technology
- 100 tests. None positive- 92 negative, 8 invalid
- high level of satisfaction with process
- Refusal rates between 5% and 50%
- 22 could not be contacted for results

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Kamalini Lokuge et al 'Indigenous health program evaluation design and methods in Australia: a systematic review' 2017 Vol 41 No 5

- Aim to quantify methodological and other characteristics of indigenous health program evaluations published in peer reviewed literature.
- Systematic review
- 118 papers describing 109 interventions
- Most common design was before/after comparison. 82% included a quantitative.
- 57% reported on service delivery component/process outcomes vs health outcomes
- Strategies required to increase high quality accessible evaluation in Indigenous health

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Laura Tarzia et al 'Sexual violence associated with poor mental health in women attending Australian general practices', 2017 Vol 41 No 5 pp 518-523

- SV defined as any sexual act carried out against a person's will and may not necessarily involve direct physical contact.
- Studies demonstrate strong assoc between SV & PTSD, depression, anxiety
- Most studies focus on rape and sexual assault
- People may disclose to GPs.
- This study focusses on SV as an adult and depression and anxiety

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Methods

- Short anonymous survey on IPad- 'unwanted sexual contact'
- 54 private GP practices- confidential
- Stata v13- used to estimate sample size
- Use of validated self reporting scales
- Risks managed
- Experience of SV coded as a binary variable
- Linear regression used for level of anxiety
- Logistic regression used for depression
- Adjusted for age and hx of CSA

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Results

- 230 of 313 (73%) eligible women participated;
- 104 (45.2%) SV; > 40% experienced more than 1 item of SV.
- 62 (26.9%) people reported some form of CSA;
- Women who experienced SV had higher anxiety in last 2/52;
- More likely to feel down, depressed or hopeless in last 2 weeks- association disappeared after adjusting for CSA

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Table 1 Demographic characteristics of the sample.

Characteristic	Overall (n=230)	SV (n=104)	No SV (n=102)
	Mean (SD)	Mean (SD)	Mean (SD)
Age in years	51.1 (16.4)	48.5 (14.8)	51.5 (16.7)
	n (%)	n (%)	n (%)
Born in Australia	170 (73.9)	86 (82.7)	70 (70.7)
Married/De facto	142 (60.8)	64 (61.5)	69 (67.6)
Heterosexual	206 (89.5)	98 (94.2)	95 (93.1)
Lives alone	36 (15.7)	16 (15.4)	14 (13.7)
Tertiary educated	122 (53.0)	66 (63.4)	52 (50.9)
Currently studying	22 (9.5)	12 (11.5)	9 (8.8)
Currently in paid employment (inc. self-employed)	109 (47.3)	52(50.0)	52 (50.9)

Note. SV = participant has experienced some form of sexual violence. No SV = participant has not experienced any form of sexual violence.
Denominators may vary due to missing data.

Results

- Exposed their body parts to you, flashed you, or masturbated in front of you- 26.8%
- Harassed you while in a public place in a way that made you feel unsafe- 21%
- Fondled or grabbed your sexual body parts- 20%
- Wearing you down by repeatedly asking for sex or showing they were unhappy -14.7%
- Kissed you in a sexual way- 8.6%
- Refused to use a condom- 6.9%
- Use of physical force or threats of physical harm to make you have vaginal sex- 6.8%

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Conclusions

- Higher % due to broad spectrum of behaviours included
- Link between health issues and SV
- May need bigger sample size to determine if independent association between SV and depressive symptoms without CSA
- This study suggests even ‘lesser’ instances of SA may be associated with women’s current mental wellbeing
- GPs should consider all forms of SV as potential factors in people presenting with anxiety and depression symptoms

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My thoughts

- Important issue to raise awareness of past trauma in medical consultations.
- Recruitment done well though authors disappointed with low sample size
- Use of valid depression & anxiety scales
- Should SV be coded as a binary variable- a 3 way comparison?
- Are lower level experiences associated with anxiety?

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The Clinical Management of Gender Dysphoria in Adults

Dr Emanuel G Vlahakis MBBS FRACGP FAChSHM

Specialist Physician in Sexual Health Medicine

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Gender Dysphoria in Adults and Adolescents-DSM V Definition

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced gender and primary and/or secondary sex characteristics (or anticipated secondary sex charac.)
- A strong desire to be rid of one's primary and or secondary sex charac. Because of a marked incongruence with one's experienced gender
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong to desire to be of the other gender (or some alternative gender to one's assigned gender)
- A strong desire to be treated as the other gender (or alternative gender)
- A strong conviction that one has the typical feelings/reactions of the other gender

The condition is associated with clinical significant distress or impairment-social, occupational

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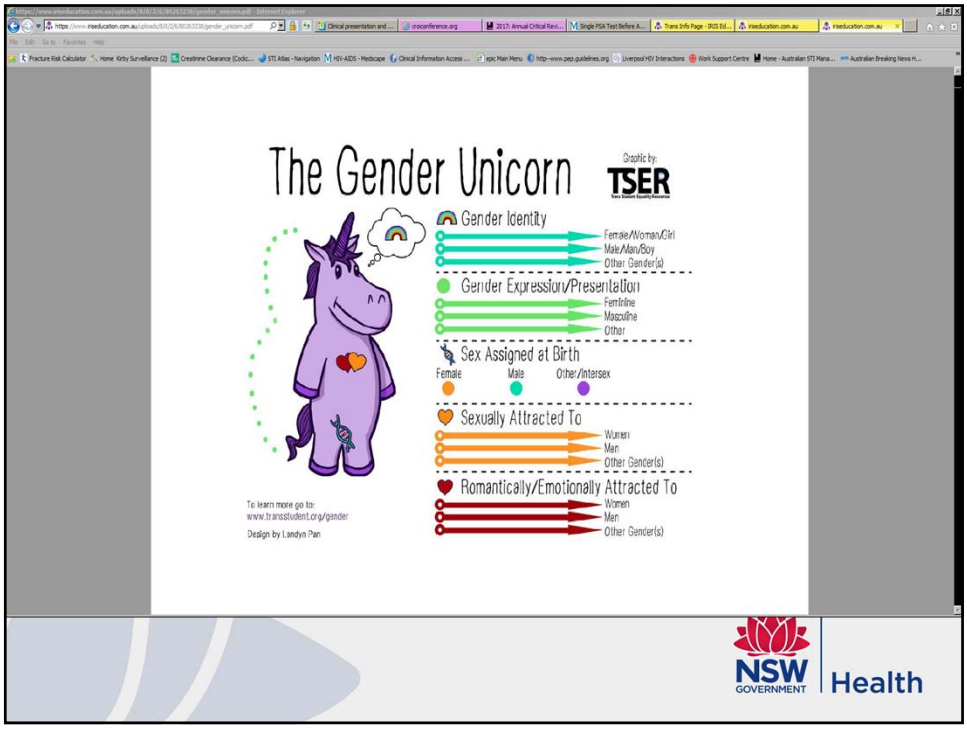

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Prevalence of Gender Dysphoria in Adults

Range of prevalence figures reported include -

1:11 000-1:45 000 for natal males and 1: 30 400-1:200 000 for natal females (De Cuypere et al 2007)

Self reported gender non conformity in Dutch sample population (N=8064 aged 15-70 years) was 0.6% for natal men and 0.2% for natal women (Kuyper L 2014)

New Zealand Adolescent Health Survey (Youth12) in random sample high school students (n=8500) showed 1.2% self report as transgender (Clarke et al 2014)

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Standards of Care for the Health of Transexual, Transgender, and Gender-Nonconforming People-WPATH Guidelines version 7

- Published in the *International Journal of Transgenderism*, 13:165-232, 2011
- www.wpath.org
- Referred to as SOC from now on
- Adopted as the standard of care by ANZPATH
- www.anzpath.org
- Also reference Endocrine Society Clinical Practice Guidelines *JClinEndocrinolMetab 94:3132-3154*

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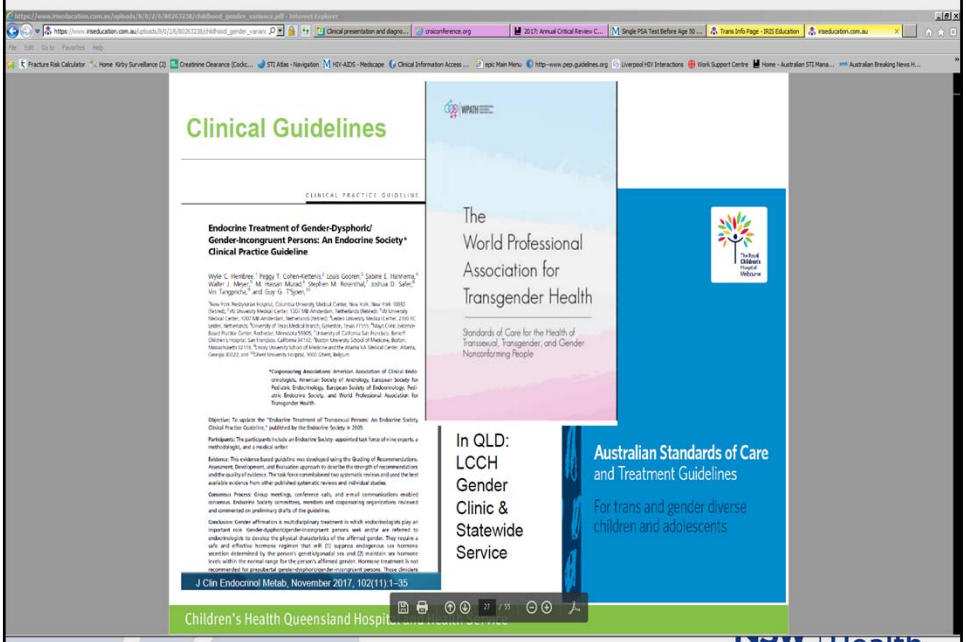

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Initial Assessment

Successful transition involves:

- Psychological transition
- Physical transition
- Social transition
- Legal transition

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Medical Assessment

- Full medical history-gender dysphoria, clotting disorders, liver disease, CVD, previous psychiatric issues, drug and alcohol use, sexual attraction, vaccination history (Hep A/B, HPV), employment, support structure

- Targeted physical examination-cardiovasc, BMI, appropriate secondary sexual characteristics (note genital examination often deferred)

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Medical Assessment

- Baseline labs- FBC, MBA, testosterone/oestrodiol/LH/FSH/SHBG, fasting sugar and lipids and as appropriate STI/HIV testing, HPV/Cx smear
- Discuss fertility, semen/egg storage
- Outline the process and reinforce the need for working with a mental health professional

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Medical Treatments for Gender Dysphoria in Adults

According to SOC the criteria for hormonal therapy are:

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision
- Age of majority in a given country (18 years in Australia)
- If significant medical or mental concerns are present they must be reasonably well controlled

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Medical Treatments for Gender Dysphoria in Adults

SOC p186

"feminizing/masculinizing hormone therapy is a ***medically necessary intervention*** for many transexual, transgender and gender non-conforming individuals with gender dysphoria"

(Newfield et al 2006; Pfafflin and Junge 1998)

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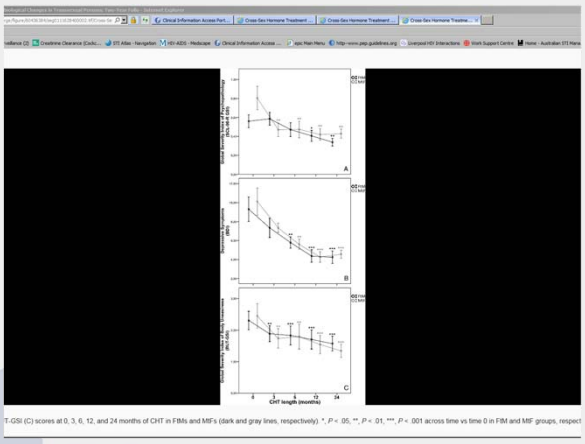

T-GSI (C) scores at 0, 3, 6, 12, and 24 months of CHT in FtMs and MtFs (dark and gray lines, respectively). *, P < .05, **, P < .01, ***, P < .001 across time vs time 0 in FtM and MtF groups, respect

Psychopathology post HRT

Fisher et al, JCEM Nov 2016

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Medical Treatments for Gender Dysphoria in Adults-Feminizing therapy

Feminizing therapy involves 2 components;

1. Blocking endogenous androgens-androgen blockers such as cyproterone (25-50mg daily) or spironolactone (100mg twice a day)
2. Replacing with feminizing hormones-oestradiol (Progynova 4-6mg daily, Sandrena Gel 1-2mg daily, Estradot patches 100-200mcg/24hrs twice weekly, oestradiol implants 100 q6-12 months), conjugated oestrogens (Premarin 1.25-2.5mg daily)
3. No evidence that progesterone affects final breast size (Wierckx et al 2014)

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Feminizing effects in MTF transexuals

Effect	Onset[1]	Maximum[1]
Redistribution of body fat	3–6 months	2–3 yr
Decrease in muscle mass and strength	3–6 months	1–2 yr
Softening of skin/decreased oiliness	3–6 months	Unknown
Decreased libido	1–3 months	3–6 months
Decreased spontaneous erections	1–3 months	3–6 months
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 months	2–3 yr
Decreased testicular volume	3–6 months	2–3 yr
Decreased sperm production	Unknown	>3 yr
Decreased terminal hair growth	6–12 months	>3 yr[2]
Scalp hair	No regrowth	[3]
Voice changes	None	[4]

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Monitoring of feminizing therapy in MTF transexuals*

- For first 12 months quarterly FBC,UEC,LFT,lipids,BSL,prolactin, weight BP then every 6-12 months
- Monthly testosterone and oestradiol levels until target levels are achieved (testosterone <1mg/L and oestradiol 300-700pmol/L) then every 6-12 months
- Annual STI/HIV testing (or more frequent if high risk)
- Routine age appropriate cancer screening (breast,colon,prostate)
- Consider baseline BMD if high FRAX score otherwise at 60 yrs

- Adapted from Hembree et al 2017

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Risks associated with feminizing therapy in MTF transexuals

Likely increased risk:

Thromboembolic disease, weight gain, hypertrigs, gallstones, elevated LFTs, hyperprolactinaemia

Possibly increased risk:

Macroprolactinoma, CVD, migraines, hypertension, permanent infertility

No increased risk or inconclusive

Breast cancer, Type 2 diabetes, osteoporosis

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Medical Treatments for Gender Dysphoria in Adults-Masculinizing therapy

Masculinizing therapy involves the administration of testosterone either

- Parenteral administration-testosterone enanthate (Primoteston) 100-250mg IMI q2-4 weeks or testosterone undecanoate (Reandron) 1000mg IMI q8-14 weeks

- Transdermal administration-Testogel 1-2 sachets daily

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Masculinizing effects in FTM transexuals

Effect	Onset (months)[1]	Maximum (yr)
Skin oiliness/acne	1–6	1–2
Facial/body hair growth	6–12	4–5
Scalp hair loss	6–12	[2]
Increased muscle mass/strength	6–12	2–5
Fat redistribution	1–6	2–5
Cessation of menses	2–6	[3]
Clitoral enlargement	3–6	1–2
Vaginal atrophy	3–6	1–2
Deepening of voice	6–12	1–2

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Monitoring of masculinizing therapy in FTM individuals

- For first 12 months quarterly FBC,UEC,LFT,lipids,BSL,weight,BP then every 6-12 months
- Monitor oestrogen/testosterone/LH/FSH levels every 2 months until testosterone is within the normal male range-timing is important!
- HPV testing if cervix present
- Mammograms as appropriate until mastecomy occurs (pre-mastectomy mammogram important)
- BMD if risk factors / high FRAX score or after 60 yrs

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Risks associated with masculinizing therapy in FTM individuals

Likely increase risk:

Weight gain, acne, baldness, erythrocytosis (hematocrit >50%), sleep apnoea

Possibly increased risk:

Abnormal LFTs, hyperlipidaemia, CVD, HT, Type 2 diabetes, destabilisation of psychiatric conditions, permanent infertility

No increased risk or inconclusive:

loss of BMD, cancer-breast, uterine, ovarian, cervical

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Surgical treatments for Gender Dysphoria in Adults-MtF individuals

- Breast augmentation
- Genital surgery-orchidectomy, full SRS (penectomy, vaginoplasty, clitoroplasty and vulvoplasty)
- Other-facial feminization surgery (FFS), thyroid cartilage reduction, liposuction or lipofilling

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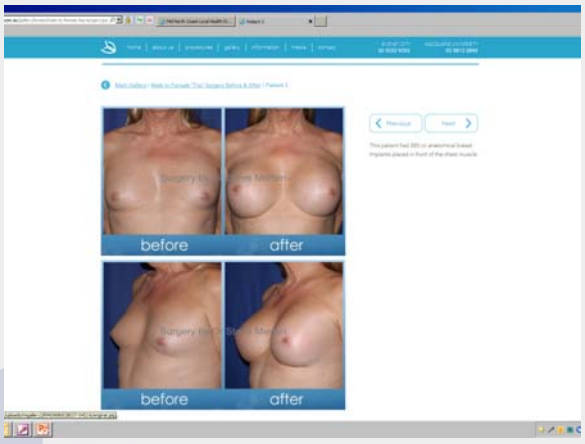

Breast Augmentation

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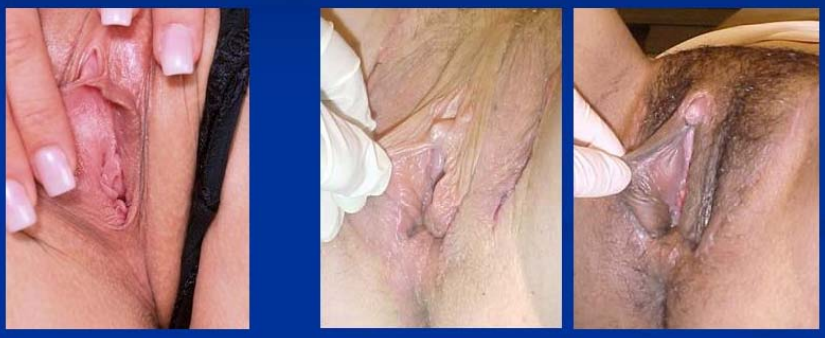
Cosmetic results with Chonburi flap

Create the shape of clitoris, hood, and frenulum that continuity with labia minora



Genital female Suporn's technique of SRS

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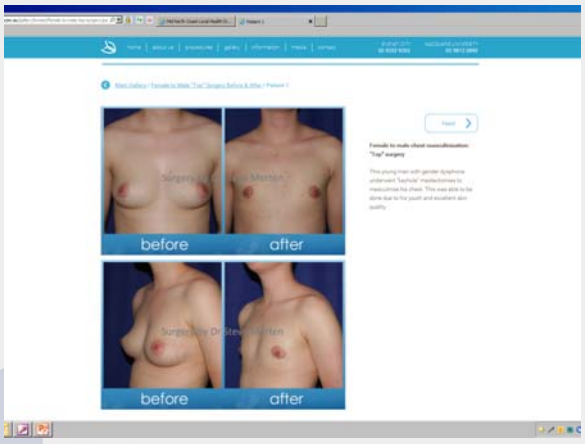

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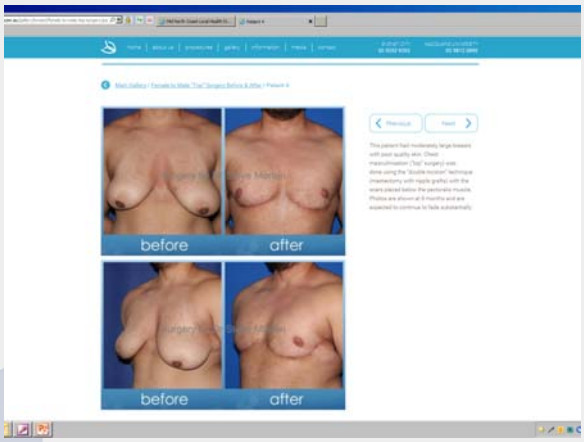

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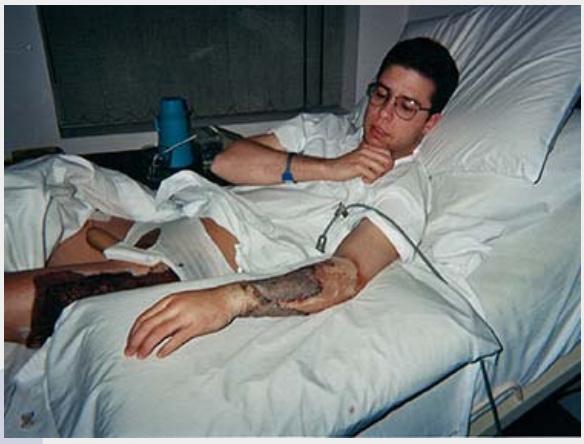

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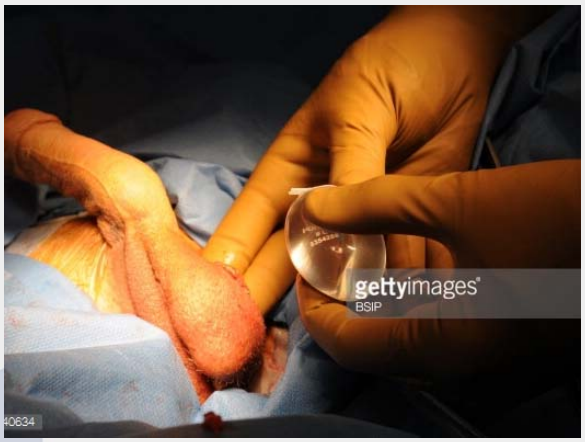
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What does medicare cover?

- Psychological support-available via Mental Health Care Plan (10 visits per calendar year with eligible MHP)
- Medical practitioners –get rebate, few services bulk billed, often large gap fees, limited availability of appropriately skilled practitioners (very appropriate for PFSHS!)
- HRT for MTF/FTM are PBS subsidised; for FTM will need appropriate authority script
- No surgery for MTF is subsidised ; for FTM mastectomy and hysterectomy attract modest rebate

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Legal transition

Main aspects of legal transition involve change to;

- Name
- Passport
- Birth certificate

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If you build it they will come

Establishing a Medical Service for Gender Dysphoria in a Regional Sexual Health Service

Dr Emanuel G Vlahakis MBBS FAChSHM
Helen Young BSW

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Aboriginal artwork produced by Gumbaynggir artist Brentyn Lugnan.

If you build it they will come

1. Sexual health clinics are widely distributed across the country and offer a free and accesible service
2. Transgender clients are considered a ‘key population’ for STI screening and treatment within the sexual health services
3. If care is expanded to offer wholistic transgender medical services within these clinics the result would be acessible, affordable care

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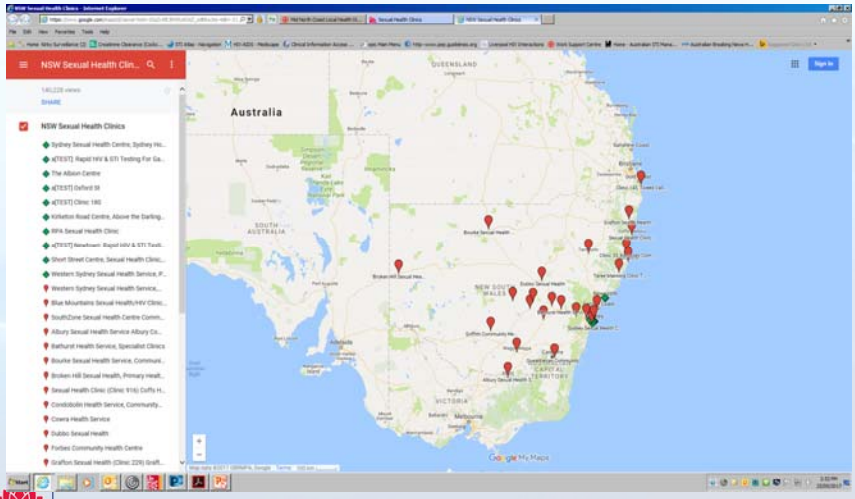
1. Sexual health clinics are widely distributed and accesible



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2.Transgender clients are considered a 'key population' for STI screening and treatment within the sexual health services

De-identified health data were extracted from 41 sexual health clinics participating in a national health surveillance network ('ACCESS') over a seven-year period 2010-2016 the ACCESS network captured:

- 600 trans men
- 544 trans women, and
- 554 trans patients without specified gender identity.
- 5.2% were known to be HIV positive
- 8.0% of patients were diagnosed with a bacterial STI [1]

1. D Callander, Kirby Institute NSW , personal communication

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If you build it they will come

The Mid North Coast Experience

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Mid North Coast Local Health District (MNCLHD)

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If you build it they will come

- Prior to April 2015 the Sexual Health service relied on FIFO medical staff-no services for transgender clients beyond STI screening and HIV care
- April 2015 employment of a 0.5 FTE Sexual Health Physician with an interest and experience in the medical care of Gender Dysphoria (GD)
- November 2015 a 2 day GD training workshop was arranged by local psychotherapist and was attended by 36 participants comprising medical doctors, psychologists, social workers, school teachers and counsellors

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If you build it they will come

- Since June 2015 we have received 36 referrals
- New referrals continue to come at a rate of 1-2 per month
- Referral sources have been Headspace, ACON, local GPs and self referral/word of mouth

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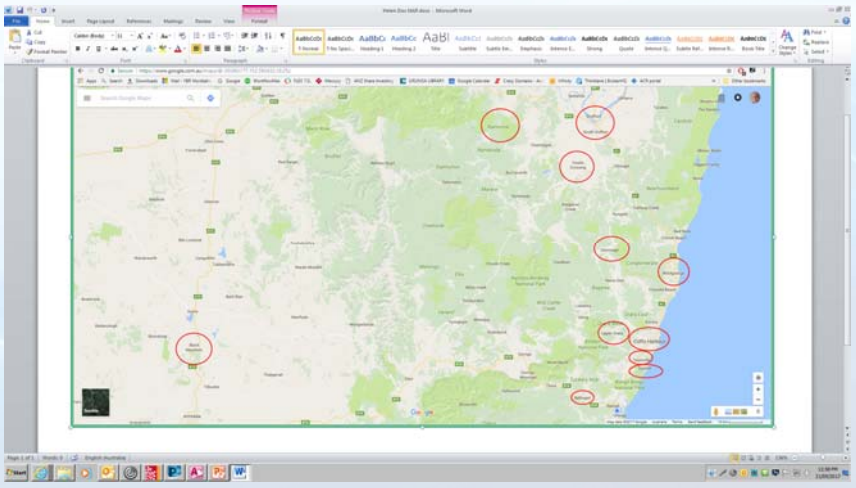
If you build it they will come



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Demographics

	Trans male (n=9)	Trans female (n=20)	Gender Diverse (n=1)
Treatment initiated	5	6	n/a
Treatment continuation	2	10	n/a
Initial assessment	2	4	1 (AFAB)
Mean age (range)	24 (16-39)	41 (16-85)	19
Ongoing MHP	3/9	10/18	1/1

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Demographics-referrals

Referral source	Number = 30
Headspace	6
Mental Health Professional	8
GP	9
Other specialist	3
Self/word of mouth	4

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Demographics-sexual health

Sexuality	Transmen	Transwomen	Gender Diverse
Heterosexual	2	6	
Homosexual	2	8	
Bisexual		1	
Virgin	4	4	
Unknown	1	1	1

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Demographics-employment

Employment Status	N (%)
Students	12 (40)
Employed	7 (23.3)
Retired	3 (10)
DSP	7 (23.3)
Unknown	1 (3.3)

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Demographics-sexual health

- Only one client is HIV positive
- Only one client treated for STI

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If you build it they will come

Great enthusiam and appreciation for the service from community and health professionals

"When I started my journey there was very little knowledge in the area concerning treatment for transgender people and my experiences was very poor …. It has been a real boon for everyone here and I am very glad he is in Coffs Harbour' Karen

"Thanks to having access to expertise at the Sexual Health Clinic at the Coffs Harbour Health Campus, I am now able to function on what is a normal level for myself, and am able to enjoy my life on a daily basis." P, transguy

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Regional issues

Same issues as faced in other areas-only augmented

- Lack of awareness in community
- Lack of skilled clinicians especially mental health
- No appropriate child/youth referral pathway (we're working on it!)
- Lack of social support services
- Lower socio-economic area so money for medication, transport to clinic

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If you build it they will come

1. Sexual health clinics are widely distributed across the country and offer a free and accesible service
2. Transgender clients are considered a 'key population' for STI screening and treatment within the sexual health services
3. If care is expanded to offer wholistic transgender medical services within these clinics the result would be acessible, affordable care

NSW GOVERNMENT Health