Reframing Gender Affirming Care: Focusing on “Unboxing” Sexual Health

Braeden Bash, MPAS, PA-C
Aliens for Health + Wellbeing
[they, them, theirs]

Disclosures

• I have no financial disclosures

Learning Objectives

1. Differentiating and navigating the gender and sexual minority spectrum
2. Reframing our history and physical models to acquiring the information needed, with a focus on sexual health, for preventative measures or age appropriate health screenings
3. Identifying trauma-informed care models to develop rapport with patients who identify as transgender, gender non-conforming/gender expansive, non-binary, agender, etc.
4. Furthering gender affirming care pertaining to sexual health: STI screening, age-appropriate cancer screenings, HPV vaccination, HIV prevention/PrEP, safer sex practices, harm reduction efforts with individuals engaging in sex work"
Terminology

- **Sex:** biological differences, chromosomes, endogenous hormones, etc.
- **Gender:** social, cultural, and behavioral constructs/distinctions/intersections
- **Gender expression:** presentation of self through behaviors, mannerisms, speech patterns, clothing, hairstyles, use of makeup, other artforms of self
- **Gender identity:** an internal sense of self in regard to their gender
- **Sexual orientation/identity:** identity related to physical, sexual, and emotional attractions to others
- **Sexual practices:** individualized sexual practices that may or may not align with someone's sexual orientation

Sexual identity is not Gender identity

- Separate identities
- How people identify can change over time
- Terminology can change over time
- Vocabulary and language can fail us in describing our human experience
- "Who we want to go to bed with vs who we want to go to bed as"

Sexual identity/orientation can vary

- Sexual orientation of gender diverse individuals
  - 19%: Queer
  - 16%: Gay/Lesbian
  - 15%: Heterosexual/Straight
  - 14%: Bisexual
  - 10%: Asexual
  - 6%: Sexual orientation not listed

---

Parts of life can be a gray area

- Sexual identity/orientation can vary
  - Sexual orientation of gender diverse individuals
  - Different terms can be used
  - What is important for you is the way you identify and the way you feel comfortable being with others.
Terminology Continued

- Transgender: gender identity that is incongruent with sex assigned at birth
- Terminology/Verbiage can vary person to person
  - Transgender woman/transfeminine individual/a woman of trans experience/Transgender female AMAB
    - AMAB: Assigned male at birth
    - Outdated/adhering to binary: MTF/MtF
  - Transgender man/transmasculine individual/a man of trans experience/Transgender man AFAB
    - AFAB: Assigned female at birth
    - Outdated/adhering to binary: FTM/FtM


Prevalence of Individuals of Trans Experience

- Many studies suggest a difference in prevalence of individual who identify within the spectrum of T/GNC/NB
  - Reports suggest 0.3-0.6 % of the adult US population identify as transgender1,2
  - Similar to the prevalence of DM Type 1 in the US5
  - Data of those who self-report as T/GNC/NB show an incidence of 871 per 100,000 people4
- Nearly 90% of Americans say they personally know someone who is LGB
  - However, approximately 20% of Americans say they personally know someone who is transgender

5: GLAAD Transgender Medical Program: https://www.glaad.org/transgender

GLAAD Transgender Medical Program: https://www.glaad.org/transgender
LGBT Survey of US adults 2017, Pew Research Center;
Prevalence of Individuals of Trans Experience

- 2015 US Transgender Survey
  - 40% reported all of their current health care providers knew that they were T/GNC/NB
  - 13% reported “most knew”
  - 17% reported “some knew”
  - 31% reported that none of their health care providers knew whether they were T/GNC/NB


Barriers to Care: Mistrust vs Distrust

Table 1: Fears and concerns about accessing health care

Table 2: Health care professionals refused to touch me or used excessive precautions

Table 3: Health care professionals used harsh or abusive language

Table 4: Health care professionals were physically rough or abusive

Understanding Stigma

- Interpersonal stigma
  - Discrimination via LGBT community members/peers/health care settings/etc.
- Structural/Systemic stigma
  - Limited to lacking LGBTQ/GAC education in healthcare provider programs, research/data that perpetuates stereotypes/invalidates identity (TW in MSM data)
- Intrapersonal stigma
  - Internalized distress/policing of self/self-hatred perpetuated via societal constraints and societal influence

Questioning motives of others/engaging with healthcare providers driven due to safety measures, survival mode, and incentivizing

- As a result, behavioral health, sexual health AND physical health needs are not being addressed; therefore, worse long-term health outcomes

Sexual/Gender Minority Stress Model

- Internal/external stressors of individuals of minority communities that implicate physical and mental health outcomes
  - Meyer et al. describes this intersectional system in 2003
  - These systems have been updated/revised over the years
  - Testa et al. added resilience factors and connectivity to community/peers in 2015

- Simplified to “Expecting Rejection,” via Rood et al. in 2016
  - (1) where to expect rejection;
  - (2) thoughts and feelings associated with expectations of rejection and self;
  - (3) coping strategies used to manage the expectation of rejection; and
  - (4) the intersection of race and ethnicity with rejection expectations

These stressors can perpetuate health disparities within T/GNC/NB communities

References:
STIs are INCREASING yearly

- Prevalence of STIs and exposure to STIs are on the rise
  - Increased detection\textsuperscript{2}
    - Individuals engaging in care, increased access to healthcare
  - Increased transmission/exposure\textsuperscript{2}
    - Smart technology, geosocial networking/dating/sex apps
    - Increased awareness and use of PrEP/HRV TaSP and U=U
    - Extragenital testing\textsuperscript{2}

Limited STI data

- No national surveillance data and TW often incorporated into MSM studies
- US systematic review: STI lifetime prevalence 21.1%; greater in TM than TW\textsuperscript{1}
- STI data does show some increased risk:
  - Increased UVR seropositivity in TW compared to cis-MSM populations\textsuperscript{2}
  - Increased GC/CT prevalence GC/CT compared to cis-MSM populations\textsuperscript{3}
    - Overall GC prevalence ranged from 2.1% to 10.5% in transgender women; and 1% to 10.5% in transgender men.
    - CT prevalence ranged from 2.7% to 24.7% in transgender women; and from 1.2% to 11.1% in transgender men.
  - Increased rates of HPV, HBV/HCV, and HSV compared to cis-MSM populations\textsuperscript{3}
    - Seroprevalence of HSV-2 in TM/NG population ranged from 7.5% to 86.7%, which is higher than the seroprevalence of the general population (reported to be 12.1% in 2015–2016).
    - Data re: HIV exposure in neovaginal tissue is unknown
  - HIV exposure risk may be correlated with donor site tissue


\textsuperscript{3} Gupta. Intention to treat concept: A review. STD 2011

Testing could be better...

- CDC and USPTF recommendations for universal HIV screening for all adults AND at least annual screening in high-risk sexually active adults that may have had a new sexual partner within the last 60 days, exposure to blood products, injectable paraphernalia use, other vulnerable populations
  - HIV screening is low within T/GNC/B populations
  - Per CDC, only 35.6% of transgender women and 31.6% of transgender men have ever had an HIV test in their lifetime

AND testing could still be better...

- Are we utilizing extragenital testing for every patient? T/GNC/NB patients?
  - One study of publicly funded STI services in clinics across 6 US cities:
    - Most transgender women (86.0% and 80.9%, respectively) and more than a quarter of transgender men (28.6% and 28.6%, respectively) with an extragenital chlamydial or gonococcal infection had a negative urogenital test at the same visit
  - If we are only screening urogenital regions, we are missing quite a lot of STIs

HIV prevalence within transgender populations

- One systematic review found HIV prevalence to be up to 49.6% in transgender women, which is consistent with the reportedly high HIV burden in this population.
  - Transgender women were disproportionately better studied than transgender men, who were found to have up to 8.3% prevalence of HIV
    - HIV rates are disproportionately higher in transgender women compared to other high-risk groups like MSM and sexual partners of PLWHIV.
    - This is hypothesized to be related to behaviors such as commercial sex work, unprotected receptive anal intercourse, multiple sex partners, unsafe needle injection practices associated with gender-affirming therapy and body modification procedures like community acquired/administered silicone injections
  - HIV prevalence among African American transgender women is 56.3%
HIV perceived risk vs HIV exposure risk

- Infrequent condom use is also described among transgender men.
  - In one study that included 62 transgender men, 71% reported not using a condom during their last sexual encounter.1
  - Similarly, in a study of 23 transgender men in Boston, 26% reported consensual or anonymous anal and vaginal sex.
  - While cisgender MSM engage in condomless sex up to 57% of the time, sexual risk behaviors in transgender men still likely impact the STI milieu affecting this population and further study is needed.1
- Multiple HIV risk factors have been associated with transgender men, including lack of access to intramuscular needles for testosterone injections, unprotected sex, vaginal/fron-hole tissue atrophy and belief within the community that they are not at risk of infection.3

Why take a sexual history?

- Sexual activity/function, sexual desire, and sexual drive is lifelong and can evolve over lifespan.
- Correlated with morbidity and mortality.1
- Sexual activity can be associated with physical and emotional intimacy with partners, and can be part of social bonding.1
  - Also can be associated with gender euphoria, longevity, and well-being.
- There is a high prevalence of sexual dysfunction*.11
- Is everyone having sex? Connecting over sexual activity?
  - Asexual spectrum identities have a prevalence of 1% of the general population.2
  - A 2017 study found that more than one in five people engaged in consensual non-monogamy at some point in their lives.3
  - While in a 2014 survey, 4%-5% of Americans reported currently being polyamorous.3

Where does a sexual history belong?

- Sexual history sandwiched between substance use assessment and PMHx/past Surgx Hx?
- Are we utilizing sexual histories on all of our patients?
- Do you feel comfortable discussing sexual function/sexual histories with your patients?
- How do you respond to awkwardness or pauses during sexual history questions?
  - "You cannot eliminate bias by pretending you not to have any."
Establishing connection and rapport

- Normalize discussing sexual habits, behaviors, and practices
- Utilize active listening skills and mirroring
- Names, pronouns, names of body parts, etc.
- Use individualized, patient centered approach
- Acknowledge prior health care setting experiences and lead with respect and advocacy
- Approach trauma experiences slowly and at a time where support can be offered
- Your tone and rapport matter as much as the questions we ask!

Talking about Sex

- Do not assume… anything
- Do not assume body parts with gender identities of either patient
- Do not assume names of body parts, they can vary person to person
- Do not assume names of body parts, they can vary person to person
- Do not assume names of body parts, they can vary person to person
- Do not assume names of body parts, they can vary person to person
- Do not assume names of body parts, they can vary person to person
- Cengage to patients about the importance of discussing sexual health
- Normalise or "less desired" responses
  - "We both were in the room before you came in. Did we use the condom at every sex act?"
- Introductory language
  - Start with your own questions and mirror patient language if possible

Word choice is important!

<table>
<thead>
<tr>
<th>Use this</th>
<th>Instead of this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genitals</td>
<td>Vulva, vagina, penis, testicles</td>
</tr>
<tr>
<td>External area, external pelvic area, outside</td>
<td>Vulva</td>
</tr>
<tr>
<td>Genital opening, front pelvic opening</td>
<td>Vaginal opening</td>
</tr>
<tr>
<td>Frontal canal, internal canal, inside</td>
<td>Vagina</td>
</tr>
<tr>
<td>Internal organs, organs you retain</td>
<td>Uterus, ovaries, cervix</td>
</tr>
<tr>
<td>Chest</td>
<td>Breasts</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Period, menstruation</td>
</tr>
</tbody>
</table>
Be careful about boxing questions ...

- Avoid questions/verbiage that can be close ended and assuming heteronormativity
- Use nonjudgmental, descriptive language
- Even intake forms/sexual history forms can be lacking in representation and write-in options

<table>
<thead>
<tr>
<th>Do you have sex with?</th>
<th>Men?</th>
<th>Women?</th>
<th>Both?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you have sex with?</th>
<th>Anal?</th>
<th>Vaginal?</th>
<th>Oral?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Condom use with sexual activity?</th>
<th>Always?</th>
<th>Sometimes?</th>
<th>Never?</th>
</tr>
</thead>
</table>

Be sure to avoid these ...

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>DOWNSIDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you sexually active?</td>
<td>No timeframe, vague</td>
</tr>
<tr>
<td>Do you have a girlfriend, husband, etc?</td>
<td>Assumes heterosexuality</td>
</tr>
<tr>
<td>Do you have sex with men, women, or both?</td>
<td>What about trans and/or non-binary people?</td>
</tr>
<tr>
<td>Do you use protection?</td>
<td>Protection is more than condoms – PEP, OCPs, etc.</td>
</tr>
<tr>
<td>You haven’t had sex for a while?</td>
<td>Conveys a judgement and leads to a “correct” answer</td>
</tr>
<tr>
<td>Have you had insertive/receptive anal intercourse?</td>
<td>Patients may not understand these terms</td>
</tr>
</tbody>
</table>

Try direct, plain language

- Are you engaging in sexual activity?
- How do your sexual partners identify?
- Have you had any new sexual partners in the past 60 days?
- Has any one of your recent partners told you about a possible STI exposure?
- Which body parts do you use when you engage in sex?
- How do you protect yourself against STIs during sex?
- Do you ever experience discomfort with sexual activity?
- Have you ever experienced any violence prior to, during, or after sexual activity with a partner? Do you feel safe in the presence of your partner?
Sexual partners can vary over time


Sexual behaviors can vary over time

Clinical Interviewing: Needs expansion

• CDC recommendations: 5 “P’s”
  1. Partners
  2. Practices
  3. Past STI History
  4. Protection against STIs
  5. Pregnancy Plans

• Sexual Health 8 “P’s”
  1. Preferences
  2. Partners
  3. Practices
  4. Past STI History
  5. Protection against STIs
  6. Pregnancy/Contraception
  7. Pleasure
  8. Partner Violence
No one and no relationship is “cookie-cutter”

- Monogamy, Polyamorous, Open relationships
  with/without outside partners, BDSM, kink, etc.
- Sexual activity: oral sex, anal sex, vaginal sex, etc. — many menu options!
- STI protection: use with outside partners, fluid bonding with main partner(s)
- Gender presentation and disclosure to others
- PrEP use: daily use, episodic/vacation use for outside or long-distance partner
- Survival sex and those who engage in sex work
- Transitioning in an established romantic/sexual relationship
- The decision to engage in sexual activity
- Trauma: past/present traumatic events related to sexual activity/relationships
Examination: driven based on need

- Keep in mind: any exam has the potential to be traumatizing.
- Prior to examine:
  - Discuss patient’s prior experiences with examination of body parts
  - Discuss age appropriate health screenings prior to exam
  - Address areas of concern at the pace of the patient
  - Ask how the exam can be made more comfortable
  - Vocalize that the patient is in control and establish open communication
  - Voice actions as you go, step by step, drape as appropriate
  - Stay calm and provide reassurance!
- Numerous exam modifications can be utilized

Examination: breaking gendered depictions

- Just as we should use gender inclusive verbiage, we should use gender inclusive images to document
- Many people may not identify with gendered body forms to discuss areas of concern
- Gender neutral body maps do exist!

Examination: Modifications

<table>
<thead>
<tr>
<th>Exam or Technique</th>
<th>Modification options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaperone</td>
<td>Patient’s choice of support person</td>
</tr>
<tr>
<td>Position for exam</td>
<td>Feet on tablet rather than footrests</td>
</tr>
<tr>
<td>Speculum</td>
<td>Consider small or pediatric speculum</td>
</tr>
<tr>
<td>Speculum/enoscope insertion</td>
<td>Ask patient if they want to bring home or practice</td>
</tr>
<tr>
<td>Cervical sampling</td>
<td>Transvaginal person on T with prior unsatisfactory pop: pre-treat with topical estrogen</td>
</tr>
</tbody>
</table>
**Examination: Modifications**

<table>
<thead>
<tr>
<th>Phrases to Avoid</th>
<th>Modification options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t be scared, everything will be fine.</td>
<td>• What are you most afraid of?</td>
</tr>
<tr>
<td>Stims</td>
<td>• How can we help you through this?</td>
</tr>
<tr>
<td>Avoid unnecessary touching of the patient (e.g., “Scrub down on the table until your bottom touches my hand”).</td>
<td>• Please move your body down until you’re almost hanging off the edge of the table.</td>
</tr>
<tr>
<td>I’m going to insert the speculum.</td>
<td>• I’m going to place the speculum now.</td>
</tr>
<tr>
<td>I’m going to take the sample now. You may feel a “pull” (“puck”).</td>
<td>• You may feel a little discomfort or cramping.</td>
</tr>
<tr>
<td>Hold still. Relax</td>
<td>• If you need to move, wiggle your toes/squeeze your hands.</td>
</tr>
<tr>
<td>• Try to keep your palms resting on the table.</td>
<td></td>
</tr>
</tbody>
</table>

**Competent and confident with sexual histories**

- Create patient-centered, gender inclusive environment
- Utilize open-ended, closed frame questions and motivational interviewing skills
- Establish rapport through shared trust and open communication
- Discuss sexual function and pleasure just as much as sexual dysfunction and risks
- Recognize health disparities
  - Higher rates of trauma, intimate partner violence, STI exposure, gender dysphoria, body dysmorphia, mental illness, substance use/abuse
- Preventative measures and age appropriate health screenings
  - STI screening— including extragenital screening
- Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), if appropriate
- STI Protection: Safer Sex Tools
  - Condoms: try not to use gendered language, instead use internal and external
  - Dental dams and nitrile/latex gloves: use is determined by anatomy
  - PrEP and TasP: PrEP evaluation, TasP for PLWHIV, Undetectable = Untransmittable
  - Regular, routine STI screening: offer all screenings, dependent on behaviors
  - Extragenital screening dependent on anatomy
    - Lower anogenital, extragenital swabs with urinalysis
    - Consider direct NAAT swabs rather than urine NAAT testing
    - Ultra sampling with urinalysis on bladder complex; not appropriate for STI screening
  - Neovaginal tissue may yield adequate sampling for direct NAAT swab testing
  - Self-collection HPV DNA testing: more accurate than provider collection in atrophied tissue of transmasculine/transgender male populations
  - Vaccination: HAV/HBV vaccination, HPV vaccination (up to age 45)
  - Encouraging open communication between sexual partners

---


Sex positive, body positive, affirming guides

Summary
• Use respectful language to elicit pronouns, gender identity, sexual orientation/identity, and sexual behaviors/practices.
• Build rapport and open lines of communications when discussing vulnerable subject topics.
• Be conscious of past and present trauma.
• Do not use biased, closed-ended questions that may be gender exclusive.
• Practice makes perfect: the more you routinely elicit sexual histories, the easier it will seem to ask these questions.
• Do not assume anything. Normalize everything.
• “Wherever you have sex, is where we screen.” Extragenital screening!
• Discuss potential STI exposure, evaluate for PrEP and discuss other STI protection practices.

Questions? Questions? Questions?

Resources

- Clinical Guidelines:
  - World Professional Association for Transgender Health. Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version: http://www.wpath.org/publications_standards.cfm
  - Center of Excellence for Transgender Health, UCSF. Primary Care Protocol for Transgender Patient Care: http://transhealth.ucsf.edu/trans/page-protocol-00-00
  - Transline: Transgender Medical Consultation Service: https://transline.zendesk.com/hc/en-us