

BASHH



BASHH RECOMMENDATIONS FOR INTEGRATED SEXUAL HEALTH SERVICES FOR TRANS, INCLUDING NON-BINARY, PEOPLE

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1 - GLOSSARY

CISGENDER/CIS

A cis person's gender identity is generally congruent with the sex they were assigned at birth.

GENDERQUEER (SEE ALSO NON-BINARY)

A person who does not subscribe to conventional gender distinctions.

GENDER IDENTITY

An individual's innate sense of their own gender, which may or may not be congruent with the sex they were assigned at birth.

MEDICAL TRANSITION

A medical process that may include the use of hormone therapy, and/or a number of surgeries. Not all trans people will pursue a medical transition, while others may pursue hormone therapy without surgery or surgery without hormones. Surgeries can include breast augmentation, double-mastectomy, orchidectomy (removal of testicles), vaginoplasty (creation of vagina often from scrotal and penile tissue), metoidioplasty (release of clitoris and use of local tissue to create a penis), scrotoplasty (testicular implants), phalloplasty (creation of penis from donor site, often abdominal or forearm flap).

NON-BINARY

This is a term for individuals whose gender identity does not align with either of the binary categories of 'man', 'woman' or 'male', 'female'. Non-binary identities may be static, or fluid. Some non-binary people may include some aspects of male and female into their identities, others may reject them entirely. For some, 'non-binary' is an identity in itself, for others it is a way of describing or categorising their gender (or lack of) or distinguishing between binary and non-binary genders.

TRANS

An umbrella term to describe people whose gender identity differs from the sex they were assigned at birth. There is a spectrum of trans identities, including but not limited to: trans woman, trans man, transgender, genderqueer, non-binary, agender.

As a working group we would like to highlight that throughout this document, when reference is made to trans people, our intention is that this is a fully inclusive term to include all people whose gender identity differs from that expected to follow from their birth assigned sex, and therefore includes all trans people, including those with both binary and non-binary identities. Terminology is both sensitive and constantly evolving and we therefore advise local service user engagement to ensure that the terminology used in individual services is acceptable to the people who use them.

2 - SUMMARY OF RECOMMENDATIONS

- Trans individuals may face multiple barriers when accessing integrated sexual health services. The following recommendations aim to promote an inclusive environment where appropriate sexual health care can be delivered for trans people.

Recommendations for services:

- Registration forms should not be segregated by gender. Forms should ask a two-part question, 'Which of the following options best describes how you think of yourself?' followed by 'Is your gender identity the same as the sex you were assigned at birth?' (with tick-box options for responses) allowing all service users to fill out whichever parts they feel comfortable with.
- Waiting rooms should not be segregated by gender. Ideally, individual examination rooms should have interchangeable couches and should be marked with descriptive rather than gendered signs.
- Toilets for patients and staff should not be segregated by gender and should have no gendered markings on the doors. They should be simply labelled by which facilities are available. Sanitary bins should be provided in all toilets.
- Waiting room literature, posters, online links and health-promotion messaging should be inclusive and affirmative of all trans identities.
- Any paper forms or notes used for taking sexual/medical histories and recording examination findings should not be visibly segregated by gender (e.g. pink and blue files). The same should apply for home sampling kits. For electronic medical records, proformas should be flexible so that it is possible to select appropriate schematic genital diagrams and code for contraceptive information regardless of the gender marker on the record.
- All staff, including clinical, reception and administrative staff, should have appropriate equality and diversity training which includes accurate and appropriate information about gender diversity. Ideally this training would be trans led. This should be supported by formal equality and diversity policies and a transparent complaints procedure.
- Clinicians and services should recognise that it may be unlawful to disclose a person's birth-assigned sex without their consent or to misgender them. Be sensitive about including gender-related information when referring patients to other services or back to a GP, seek explicit consent and discuss information sharing with the individual before doing so.
- Explicitly seeking feedback from trans individuals may be valuable in assessing whether your service is inclusive and welcoming. Reach out to local trans groups and be prepared to act on comments, suggestions and complaints.
- Consider providing specialised outreach services and/or holistic services for trans individuals who may be unaware of their sexual health needs or reluctant to attend sexual health clinics. This might include promotion of services at sex-on-premises venues, peer-led support groups, drop-in information sessions, housing advice, or specific support around transition, body image, and PrEP.

Recommendations for clinicians:

- Ask every patient how they identify their gender and which pronouns they use as part of routine enquiry. Always use their chosen name, pronoun and/or title.
- Ask "what gender are your partners?" as part of routine enquiry with all patients rather than "do you have male or female partners?"
- Misgendering someone (e.g. using 'she' instead of 'he') can be highly distressing to trans people. If this happens, apologise immediately and acknowledge your mistake and then move on with the consultation.
- Not all trans people will have had, or want to have, gender-affirming treatments such as hormonal medication or genital surgery. Ask about a patient's preferred language when it comes to their body and genitals and mirror their language in the consultation. Avoid assumptions about their anatomy and how they have sex - using models

or diagrams may be more helpful than ‘anatomically correct’ terminology. Explain that you are asking so that you can understand what specific sexual health tests they may need.

- Screen according to an individual’s sexual practices and risks. Urine NAAT testing for chlamydia and gonorrhoea is appropriate for all trans people, with additional swabs from the throat, rectum and vagina as appropriate. Screening for HIV, syphilis, and hepatitis should be offered in line with national guidelines. Self-taken swabs are encouraged for asymptomatic patients.
- Remember that trans individuals experience higher rates of violence, domestic abuse, sexual abuse, and harassment than cisgender individuals. They may also be more likely to be involved with commercial sex work, and to misuse drugs and alcohol. Sensitive questioning about this should be part of routine enquiry with all patients.
- Understand that trans people, and particularly trans women, face unique barriers to HIV care. Individuals may not receive identifiable HIV prevention messages, may test late, and may be concerned about potential interactions between HIV medications and hormone treatments. Pre-existing socio-economic inequalities, mental health concerns, and substance/alcohol misuse may also affect adherence to PEP, PrEP and HIV treatment regimens. Provide encouragement and support around testing, and provide information on PrEP based on risk behaviours.
- The FSRH has specific guidance on contraception for trans people. In general, combined hormonal methods are not suitable for trans men and non-binary people who take testosterone, but progestogen-only methods, the IUS/IUD, and emergency contraception can all be used.
- Cervical screening is recommended for everyone with a cervix, but may be psychologically or physically challenging for trans men and non-binary people. Consider and offer opportunistic cervical smears if appropriate to trans men and non-binary people, which may need additional labelling to avoid rejection by local laboratories. Encourage participation with breast, bowel, and AAA screening programmes, remembering individuals may be missed from automatic recalls following a change of gender marker on GP records.
- Work within your competence. If specific advice or knowledge is necessary (for example, managing genital post-operative complications), seek advice from your local surgeons and specialist gender services.
- The BASHH GSM website aims to be an up-to-date resource, for when additional advice is needed.

3 – INTRODUCTION

This document was produced following a meeting of the Gender and Sexual Minority Special Interest Group (GSM SIG) of the British Association for Sexual Health and HIV (BASHH). The GSM SIG aims to represent sexual health service provision for men who have sex with men, trans people, and women who have sex with women. A working group was convened. The group met in January 2018 to discuss the provision of integrated sexual health services inclusive of the needs of trans people with the aim of producing a series of recommendations.

4 - SCOPE OF RECOMMENDATIONS

Empirical evidence in this specific area is lacking and so the current recommendations additionally draw from expert consensus, local evidence, existing models of good practice, and personal experience. The aim is not to provide guidance on the creation of new specialist services, but rather to outline principles for inclusion of trans including non-binary people within all sexual health services.

5 - GENERAL PRINCIPLES FOR INCLUSIVE SERVICES

Trans people have historically had little visibility within most sexual health services. They may face personal, social, economic, institutional and structural barriers to accessing appropriate and affirmative care. It is possible that they may previously have had negative experiences in healthcare settings and may worry that healthcare professionals will not understand their specific identity, needs and concerns. ^(1, 2, 3)

An inclusive and welcoming sexual health service is one that actively tries to reduce barriers to trans people. Examples of such barriers may include the constant explanation of identity, or worries about how they will be treated either because of their gender identity or their gender history or both. It tries to avoid reinforcing essentialising ideas about gender (for example, that someone with a uterus is always female) or binary thinking (for example, that everyone will fit into the traditional categories of either ‘male’ or ‘female’).

Working in partnership with trans individuals, community groups and national organisations is important. It may be useful to actively seek and respond to feedback on various aspects of your service from trans users, including registration forms, clinical proformas, and the physical layout of your clinical and non-clinical areas. Such an approach to service design, where the groups who will ultimately utilise the service become stakeholders rather than the passive recipients of care, both recognises the value of relationships with trans peer/community groups and promotes partnership working.

Both International and UK data suggests some trans people may have higher rates of HIV acquisition,^(4,5) transactional sex, and risky sex than the cisgender population.⁽⁶⁾ Prevalence rates for bacterial STIs have also been shown to be higher.^(6,7) At the same time, trans people may be unaware of their increased sexual health needs due to a lack of targeted health promotion messaging. Therefore, welcoming and holistic sexual health services are needed to help optimise care for trans individuals. Data has shown 55% of people accessing care at one UK Gender Identity Clinic to have never had an STI screen and only 20% to have had a screen within the preceding year.⁽⁸⁾ In 2017, Public Health England presented data from HARS demonstrating that 199 trans people had accessed HIV care in 2016 and that trans patients were twice as likely as other adults to be diagnosed at a late stage of infection.⁽⁵⁾ Barriers to trans people attending sexual health services include perceived lack of knowledge amongst testing providers, perceived gap between trans-inclusive policies and implementation in practice in addition to general difficulties accessing services as experienced by the cis population.⁽⁹⁾

6 - SERVICE DESIGN: BUILDING, FACILITIES, CLINIC ROOMS, AND ADDITIONAL SERVICES

Simple changes to the physical layout and signage of your service can create a more welcoming and inclusive environment for trans people. Patient waiting rooms should not be divided by gender, all waiting rooms should be gender-neutral. Toilets and bathrooms, for both patients and staff, should be gender neutral and not labelled with any sort of gendered markings (e.g. 'ladies', 'gentlemen' or male/female icons) but simply with which facilities are available (e.g. 'toilet cubicle and urinals', 'toilet cubicles, no urinals'). Ensure the provision of sanitary waste bins in all toilet facilities.

Ideally, beds and couches in clinical rooms that are used for examinations should be interchangeable, with the ability to add or remove leg rests. If possible, avoid dividing examination rooms into 'female' (couches with leg rests) and 'male' (couches without). If this is unavoidable, label the room as an examination room and ensure a log of the examination rooms is kept centrally and is visible to all staff working in the clinic (e.g. examination room 1 – couch with leg rests, examination room 2 – flat couch, no leg rests).

Consider the provision of specific drop-in help and support services or groups for trans people, which may include a community space for people to socialise. These may be run in partnership with local community organisations and should ideally be led by trans people. Online sessions for support and signposting, either 1:1 or groups, may widen access for people who have concerns about attending physical services. Outreach clinics and services may also be of utility for trans people who are unaware of the existence of services or how to access them. These may include, but should not be considered to be limited to, visiting red-light areas or sex-on-premises venues.

7 - SERVICE DESIGN: INTAKE FORMS AND REGISTRATION

Non-inclusive registration forms (paper or electronic) and registration processes create barriers to effective service provision and reinforce personal, societal and institutional vulnerabilities for trans people. Registration forms should not be explicitly gendered (e.g. by using pink and blue paper, or by having different 'male' and 'female' forms) but the same unified form or document should be used for everyone attending the service. Remember that gender may evolve or be fluid, so it may be that new registration forms are required at each visit. We suggest that all such forms include the following two-part question: '

Q1 Gender identity - Which of the following options best describes how you think of yourself?

Female (including trans woman)

Male (including trans man)

Non-binary

In another way*

Not stated (*PERSON asked but declined to provide a response*)

Not known (*not recorded*)

* Coded as "Other" in the NHS data dictionary

Q2 Is your gender identity the same as the sex you were assigned at birth?

Yes

No

Not stated (*PERSON asked but declined to provide a response*)

Not known (*not recorded*)

Asking all clinic attendees this two-part question allows trans people to be identified, may help to address perceived barriers and stigma, and also increases awareness of gender diversity among cisgender people.

Registration forms are commonly used for triaging and to highlight specific reasons for attendance, but also serve a function to advertise the range of services available, so it may be helpful to include options for 'trans specific services', 'psychological support', 'survivor of a hate crime' and so on, if these are offered within your clinic.

8 - SERVICE DESIGN: HEALTH PROMOTION MESSAGING AND LITERATURE

Health promotion messaging within sexual health clinics may involve the use of posters, flyers, patient information leaflets, magazines, videos or static images on electronic displays, banners or links on a website, and social media accounts run by the service. Trans people are generally under-represented or not represented at all in health promotion messaging and it is important to address this. Positive and affirmative images of trans people on posters and readily available, relevant trans-specific literature helps promote a welcoming environment. Consider adding a link on your website to your local trans community or support group if one exists, and signpost to further online resources around trans health. See the BASHH GSM website pages for an up to date resource of available clinic literature.

9 - SERVICE DESIGN: PROFORMAS, NOTES AND HISTORY SHEETS

Clinical proformas or history sheets, whether paper or electronic, should strive to be inclusive. Do not use explicitly gendered paper proformas (e.g. pink and blue forms or filing covers) or home sampling kits. Some EPR (electronic patient record) systems allow flags to be set for people who identify as trans, which can guide clinicians in history-taking and understanding which tests are appropriate. However, it is important to remember that many trans people may not explicitly identify as such and may indicate their gender as 'male' or 'female' on intake forms. Moving forwards, it is recommended that EPR systems should be able to record gender identity and sex assigned at birth (as above), have the ability to select appropriate schematic anatomical/genital diagrams and code for contraception regardless of a person's gender marker.

10 - SERVICE DESIGN: DATA COLLECTION AND MONITORING

In general, it is important to explain to patients why data is being collected about their gender, trans status and sexual orientation. It can be helpful to let patients know that this is to be done to inform which tests and investigations will be needed for sexual health screening, and also to better understand the clinic population for service planning purposes.

Local audits should be encouraged in all aspects of trans sexual healthcare given the current paucity of data. However, if a clinic is only seeing a very small number of trans patients, this may have implications for anonymity in terms of data collection and monitoring. When presenting data about groups of service users, aggregating or masking groups if there are fewer than 5 people in that category should be considered best practice.

11 - SERVICE DESIGN: STAFF TRAINING

It is the responsibility of each service to ensure that all staff, including reception staff, clinical staff and administrative teams, have appropriate training on gender diversity at induction. Check whether your local Equality and Diversity training is fit for this purpose, and consider delivering additional focused training. Training on the Equality Act 2010, Gender Recognition Act 2004, data protection, and on the Human Rights Act 1998 is advisable. Ideally this training should be led by trans people. There are several national trans advocacy groups who may be able to provide training and there are also e-learning modules available. A list of helpful contacts will be maintained on the BASHH GSM group website pages.

Training should be updated regularly, as a minimum in line with local requirements for equality and diversity training. Clinical staff will additionally need sufficient training to be able to appropriately and sensitively take a sexual history,

understand sexual risk, and examine and counsel trans including non-binary people. It is the responsibility of the service to ensure that all staff are using a patient's correct name and pronouns, and to proactively respond to instances of misgendering (be they accidental or deliberate).

12 - CLINICAL ASPECTS: HISTORY TAKING

Begin the clinical consultation by confirming that you are using the patient's correct name and ask them which pronouns they use. We support asking all patients, 'how do you identify your gender?' or 'what is your gender?' as part of routine enquiry, which helps to raise awareness of trans identities amongst cisgender people. Avoid closed questions such as 'are you male or female?'. Explain why personal questions are being asked as part of the sexual history, especially if it is a patient's first visit to a sexual health service.

Establish with a patient what terms they use (and avoid) to refer to their genitals, and what terms they would like you to use during the consultation. Respect these choices in your own use of language as far as possible without causing clinical confusion. If there is a need to document using terms that someone has identified as potentially distressing, the reasons for this should be explained. Avoid making assumptions about genital anatomy or terminological preference based on gender presentation. Be aware that not all trans patients will have had, or hope to have, genital surgery. Also, discussion around genital anatomy and sex may, for some trans people, provoke feelings of dysphoria.

For all patients, it is helpful to ask, 'what gender are your partners?' rather than 'do you have male or female partners?'. During the sexual history, establish how the patient has sex to inform your understanding of appropriate sampling sites and sexual risk. Using models or diagrams to help patients explain may be more helpful than using 'anatomically correct' terminology. Usual discussions around HIV transmission, sexually transmitted infection (STI) risk reduction, and safer sex should take place if any specific risks are identified. Offer sexual health screening tests based on risk, explaining to the patient different tests and the importance of sampling the most appropriate anatomical sites.

Points to remember:

- Some trans users of services may not be 'out' (open about being trans or non-binary) so be careful of confidentiality and do not 'out' the person
- If you make a mistake such as using the wrong pronoun, apologise and move on
- Intentionally misgendering someone is prohibited by the Equality Act 2010
- Continue to respect a patient's gender and pronouns if you need to discuss an individual case with clinical colleagues without the patient present
- If taking hormonal medications, some people may express emotional changes such as anger and low mood, so it is important to be aware of this and be compassionate
- Understand that you may need more time when consulting with trans people

13 - CLINICAL ASPECTS: ASSESSING RISK

It is important to consider that rates of transactional sex, drug and alcohol use⁽¹⁰⁾, and risky sex are often higher in trans populations than in cisgender populations. Rates as high as 65% of trans women⁽⁶⁾ and 29% of trans men⁽¹¹⁾ having received condomless anal sex in the previous 3 months have been documented. Routine enquiry about commercial sex work, drug and alcohol use (including intravenous drug use) should be part of every consultation.

Trans people may also be at higher risk of assault, abuse, hate crime and violence including inter-partner violence. Routine enquiry about childhood sexual abuse and domestic violence, and subsequent risk assessment, should be carried out in line with usual clinic policy. Data from the 2012 Transgender Mental Health and Emotional Wellbeing Study which questioned around 500 trans adults highlighted 88% of those questioned also admitted to previous or current depression and 84% admitted to having had previous suicidal ideation.⁽¹²⁾

As always it is important to consider how and where onward referral should be made in cases of disclosure.

14 - CLINICAL ASPECTS: EXAMINATION

If patients are asymptomatic, self-taken samples are appropriate. If examination is needed (and especially if someone has not previously been examined in a sexual health clinic) be careful to explain what the examination will involve before beginning. Again, be sensitive to the patient's preferred use of language to refer to their anatomy and use these terms during the examination.

If a patient has had genital surgery, be aware that post-surgical complications do occur and can mimic presentations of STIs. It is important to be aware that for both trans people who have a vagina that they were born with, and for trans people who have had genital surgery to construct a vagina, examination can be more uncomfortable and restricted than for cisgender women. Testosterone therapy may cause vaginal atrophy, irritation and dryness. Consider using a smaller speculum or a proctoscope if vaginal examination and sampling is needed, and offering for the patient to insert their own speculum or proctoscope if this may be more comfortable for them.

15 - CLINICAL ASPECTS: INVESTIGATIONS

All trans people attending services should be offered HIV and syphilis testing in line with national guidance. Testing for other blood-borne viruses such as Hepatitis B and C should be carried out according to risk. UK data is not available, but overseas data suggests very similar prevalence rates of Hepatitis B and C in cis and trans people with a higher prevalence among HIV positive people of all gender identities.⁽¹³⁾

In general, urine NAAT testing for chlamydia and gonorrhoea is appropriate for all trans people. Throat and rectal swabs should be guided by sexual history taking. Vaginal swabs are advised for any trans person who has a vagina.

If your service runs an asymptomatic screening service, without clinician input, ensure that these are trans inclusive (for example, a trans woman who has not had genital surgery and who has sex with cis men should not be offered a vaginal test, but instead needs to be offered throat, urine and rectal sampling). This will need to be considered when developing paperwork for such services.

When seeing people presenting with symptoms it is important to also consider the following;

- Has any genital surgery taken place, if so: what, when and where?
- What is the person's current anatomy?
- Are they taking hormones?
- What types of sex do they have?

Genital symptoms in trans people should initially be approached in a routine way however, some symptoms in people who have had surgery may warrant a surgical review. The average time for complications to occur following penile inversion vaginoplasty is 4 months, 29% of people will have some form of complication with 9% requiring further surgery.⁽¹⁴⁾ Examples of complications may include urethral meatal stenosis, wound healing issues (including the development of excess granulation tissue), vaginal strictures and stenosis and loss of vaginal depth.⁽¹⁵⁾ Despite presentations to sexual health services not being infrequent,⁽¹⁶⁾ there remains little guidance for sexual health clinicians in terms of managing post-operative complications for trans people after genital surgery. Remember to work within your competence; it may be appropriate to seek advice from your local urology or gynaecology surgeons first and consider together whether to seek the advice of specialist gender surgeons.

Some surgical vaginoplasty procedures use bowel to create the vagina. In this scenario if vaginal symptoms are present the patient should be managed as though proctitis is a possibility. Diversion colitis can occur so if infection has been fully excluded discuss with colorectal colleagues.⁽¹⁷⁾ Following colovaginoplasty, complications are common with up to 79% requiring further surgery and 54% presenting with vaginal stenosis.⁽¹⁸⁾

Regular dilation is required by trans women to maintain vaginal depth post-vaginoplasty. Post-operatively patients are given a dilation schedule, if there are problems with dyspareunia – it may be that an increased dilation frequency or larger dilators are required. Douching is required especially post dilation to maintain hygiene and avoid vaginal discharge. Both douching and vaginal dilation are required in the longterm.

Unexplained vaginal bleeding in trans people with a uterus should be investigated appropriately as for cis women, particularly if it occurs in patients who have previously had testosterone-induced amenorrhoea. There is no evidence of an increased risk of ovarian cancer for such patients taking testosterone treatments. The risk of endometrial hyperplasia or endometrial cancer is generally thought to be low, as testosterone tends to cause endometrial atrophy, however current guidelines on this are conflicting and historically there has been a concern about aromatisation of excess testosterone to oestrogen which, in the absence of progestogen, is considered unopposed and may predispose to endometrial hyperplasia. The RCOG are currently working to produce a 'Green Top Guideline' which will hopefully address this issue. In the interim

we recommend using clinical judgement, liaison with local gynaecology services and consideration of ultrasound to assess endometrial thickness if this is indicated and acceptable to the patient. Vaginal bleeding may also be the result of changes to the vaginal epithelium as a result of some hormonal interventions, which in turn changes the microflora and can result in a vaginal wall more prone to trauma.

16 – CLINICAL ASPECTS: VACCINATION

Hepatitis A and/or B vaccination may be appropriate for certain patients based on sexual risk in line with national guidance.

One study has indicated that trans women who have had genital surgery and are sexually active have high rates of high-risk HPV in the vagina.⁽¹⁹⁾ Adult HPV vaccination is not currently universally available in the UK. Vaccination for MSM aged 45 years and under is however available through specialist sexual health or HIV services. Formal guidance recommends that the eligibility of trans people through this vaccination programme should be a case-by-case clinical decision based on a risk assessment that includes the person's sexual behaviour and the sexual behaviour of their partners. Trans women are eligible if their risk of acquiring HPV is equivalent to the risk of MSM eligible for the HPV vaccine. Trans men are eligible for vaccination if they have sex with other men unless they have previously completed a course of HPV vaccination as part of the school Year 8 HPV vaccine programme, in which case no further doses need be given. We recommend an individual risk assessment is made for those with non-binary identities based on the advice for other trans people.

17 - CLINICAL ASPECTS: HIV, PEP AND PREP

Trans people have higher rates of HIV than the cisgender population. Trans women are especially at risk, with HIV rates 49 times that of cisgender controls.⁽⁴⁾ They have low rates of HIV testing and are more likely to be diagnosed late, with low CD4 counts. For trans women, these findings may be explained by the links between social stressors and HIV risk - with socio-economic inequalities, mental health concerns, drug and alcohol use, commercial sex work, assault and abuse contributing to transmission.

Barriers to testing and treatment for HIV may include stigma (enacted or internalised),⁽²⁰⁾ decreased access to healthcare or previous negative experiences within healthcare, and worries that clinicians will not have trans-specific knowledge or competence. Trans women especially may choose not to test for HIV or engage with HIV services because they may prioritise transition and gender-related care over HIV care; in view of the other social stresses that they face they may 'prefer not to know' their HIV status and historically there was discrimination faced by trans people seeking gender affirming surgery if they were living with HIV. Trans people who are taking hormonal medications may also have specific concerns about the interactions between these and anti-retroviral medications, and so may be reluctant to take Post-Exposure Prophylaxis (PEP), Pre-Exposure Prophylaxis (PrEP), and HIV treatment. Up to date information on interactions can be found at <https://www.hiv-druginteractions.org>

Improved social support reduces HIV acquisition rates, improves testing rates, and promotes engagement with care for people living with HIV, so signposting individuals to appropriate sources of local support may be invaluable. Creating safer spaces within your service where intergroup contact between HIV positive and negative individuals is facilitated may also decrease feelings of isolation and stigma.

There is a general lack of HIV testing/HIV risk reduction health promotion messaging aimed specifically at trans people, which may mean they have lower levels of knowledge around HIV, PEP and PrEP and may not perceive themselves as being at risk or their behaviour as risky. In general, PEP for HIV following a sexual exposure should be offered to trans people where their risk would fall within the current national guidance. Discuss PrEP with all sexually active trans people.

Currently, NHS funded PrEP is only available in England for both cis and trans people via the IMPACT trial, run by Public Health England to provide PrEP to 10,000 people. Many people however choose to buy PrEP privately online and can be signposted to appropriate websites and offered monitoring, in line with usual clinic practice.

Remember if performing monitoring blood tests for PEP and PrEP that laboratory reference ranges may be gender-specific. This may be particularly relevant when considering eGFR. (Trans women may have a falsely low eGFR and trans men have a falsely high eGFR if their gender markers on their NHS records have been changed). There is currently no data available about the efficacy of PrEP for trans including non-binary people on testosterone having vaginal sex.

18 - CLINICAL ASPECTS: CONTRACEPTION

Specific guidance on contraception for trans and non-binary people has been published by the Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit and is available here: <https://www.fsrh.org/documents/fsrh-ceu-statement-contraceptive-choices-and-sexual-health-for/>.

In general, contraception is recommended for trans men and non-binary (birth assigned female) people who have not had hysterectomy or bilateral oophorectomy and where there is a risk of pregnancy. Testosterone treatment or gonadotrophin releasing hormone (GnRH) analogues cannot be considered to provide adequate contraceptive protection, and testosterone may be teratogenic if pregnancy were to occur. Copper intrauterine devices (Cu-IUD) are safe and do not interfere with hormonal treatment, but may be difficult to insert. Progestogen-only contraceptive methods are not thought to interact with hormonal treatment and are generally acceptable. The use of combined hormonal contraceptives is not recommended for trans men and (birth assigned female) non-binary people undergoing hormone treatment because the oestrogen component will counteract the effects of testosterone. Cu-IUD, ulipristal acetate 30mg, and levonorgestrel 1.5mg can all be used as emergency contraception and are unaffected by testosterone.

For trans men and non-binary people with a uterus, monthly menstruation may be a significant source of dysphoria. The use of testosterone can take several months to induce amenorrhoea. For this group and those not on testosterone consider using depot medroxyprogesterone acetate or an IUS.

For trans women and non-binary (birth assigned male) people who have not had orchidectomy or vasectomy, contraception is needed if they are having vaginal sex with a partner where there is a pregnancy risk and they do not want to conceive. Oestradiol hormonal treatments, GnRH analogues, finasteride or cyproterone acetate do not reduce or block sperm production sufficiently to be considered effective contraceptives. Condoms or other barrier methods should be recommended to all patients to prevent risk of STIs.

19 - CLINICAL ASPECTS: INCLUSION IN SCREENING PROGRAMMES

Cervical screening for all people with a cervix should be carried out in line with national guidance. It is important to note that if someone changes their gender marker on their general practice (GP) records (for example, from 'female' to 'male'), they may not be automatically included in cervical screening recall lists, and so may miss screening invitations. Some trans men and assigned female non-binary people may find undergoing a cervical smear physically or psychologically challenging (due to vaginal atrophy or gender dysphoria) and so they should be made aware that opportunistic cervical smears can be performed in sexual health clinics at the same time as vaginal examination for sexual health testing.

Note that testosterone therapy makes inadequate cervical smear samples more likely.⁽²¹⁾ In this scenario consider using topical oestrogen nightly for a couple of weeks prior to repeating in those with previous inadequate cervical cytology.

Laboratories may reject samples for patients whose gender marker is 'male' on their medical records unless the sample is adequately labelled. It is *essential* to seek a patient's consent for including information about their gender status and testosterone therapy on the sample request form, the reason for doing so should be clearly explained to the patient, and such information should be marked as 'confidential'.

Note that the prostate gland is not removed during gender reassignment surgery. It is located anterior to the vagina and will not be palpable per rectum. Prostate Specific Antigen (PSA) testing is unreliable in trans women and can be falsely low so should not be relied upon to determine risk of prostate cancer.

Remind patients about, and discuss participation in, other national screening programmes such as breast cancer, bowel cancer, and abdominal aortic aneurysm screening. Further information on this can be found on the following websites.

<http://www.screeningforlife.wales.nhs.uk/sitesplus/documents/1129/Trans%20screening%20v2%20English%20250516.pdf>
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/623309/Transgender_cross_programme_screening_leaflet.pdf

20 - CLINICAL ASPECTS: INTERFACE WITH OTHER SERVICES

Occasionally, trans people may present to sexual health clinics with problems that require referral to other services such as colposcopy, termination of pregnancy, urology or gynaecology. In addition, there may be instances where you wish to refer a patient back to their GP for ongoing care. In all of these instances, it is important to consider the appropriateness of such a referral and seek a patient's *explicit consent* to include information about their gender status in the referral if this is clinically

necessary. Further information on this can be found in Section 21. Enquire about a patient's relationship with their GP (if they have one), remembering that a patient may not be 'out' to their GP. With services that are traditionally explicitly gendered (e.g. colposcopy, gynaecology) it may be helpful to explain this to a patient so that they know what to expect when attending an appointment and liaise with the department on the patient's behalf, in advance.

Many healthcare databases still record gender as binary male and female. Where laboratory IT systems do this, problems can arise and samples may be needlessly discarded by laboratories unless services meet with them to ensure a gender neutral specimen request system. Examples could include vaginal chlamydia NAAT samples being discarded in cases where the gender is indicated as male or ultrasound requests declined for testicular assessment in trans women. It is recommended to approach local laboratory and other services to address these areas in advance to prevent incidences that could deter a trans person from accessing care in the future.

21 - LEGAL CONSIDERATIONS FOR SERVICE PROVISION

Less favourable treatment of a person because of their gender identity is likely to be unlawful under anti-discrimination law. The Equality Act 2010 is the law that prohibits discrimination, harassment, and victimisation in the workplace and in wider society. It is designed to ensure that people with certain 'protected characteristics' are not put at a disadvantage or subjected to unwanted conduct because of that characteristic. 'Gender reassignment' is one of the nine protected characteristics under the Act. It covers anyone who is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning their sex by changing physiological or other aspects of sex. Furthermore, public bodies (such as local authorities and NHS trusts) have an active duty to eliminate discrimination, harassment, and victimisation of anyone who is protected under the Act and foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The full terms of the Equality Act 2010 can be viewed at: <http://www.legislation.gov.uk/ukpga/2010/15/contents>.

For sexual health services, it is important to note the broad definition of 'gender reassignment' in the Act - implying that a person does *not* need to have formally changed their name or gender marker, be under medical supervision, or have had any hormonal or surgical treatments to be considered as having the protected characteristic. Harassment in this context is generally taken to mean unwanted conduct related to a protected characteristic that has the purpose or effect of violating someone's dignity or creating an intimidating, hostile, degrading, humiliating, or offensive environment for them. Harassment could include accidentally or intentionally misgendering a patient. Unintentional harassment could still be unlawful, and this needs to be considered in Equality and Diversity training and policies. We suggest that services publicly display posters about equality and inclusion, reminding both patients and staff of their rights and duties. It is important also that a service has an easily accessible and transparent complaints procedure.

At present, the Gender Recognition Act 2004 (GRA), which outlines the process in the UK by which someone can obtain legal recognition of their affirmed gender, is undergoing a parliamentary review. The GRA allows trans people, provided they meet the requirements outlined in the Act, to obtain a Gender Recognition Certificate (GRC). As well as granting legal recognition of a person's affirmed gender, a GRC enables them to receive a birth certificate with the correct gender marker on it. A person does not need a GRC to be protected under the Equality Act 2010. In most circumstances, it is not lawful to ask a person if they have applied for or have a GRC. Disclosing 'protected information' (e.g. that a person holds or has applied for a GRC) is a criminal offence if the information was acquired in an official capacity. There are some exceptions to this, including where a disclosure is made to a health professional, the disclosure is made for medical purposes, and the person making the disclosure reasonably believes that the subject has given consent to the disclosure or cannot give consent.

Confidentiality is of particular importance for trans patients and information about trans status should not be shared between services unless this is strictly clinically necessary. In these instances, it is good practice to seek expressed consent from the patient and an explanation of why the information is being shared should be provided. Respect individual privacy and preferences: a patient has a right to refuse the sharing of their information. Striving to use a patient's preferred name, title and pronoun at all times should be emphasised.

All patients entering a healthcare service should be aware how their personal health information will be used and potentially disclosed. This includes information sharing within the department to provide safe clinical care. One way of ensuring this may be to provide a written statement to all service users when they are registering/booking-in and recording written agreement for all patients. This statement should outline the limits of confidentiality and the information that clinical details/test results may be seen by members of both clinical and administrative teams. If a patient does not agree to information-sharing within the department this should be discussed with a senior member of staff to explore reasons and if needed signposting to an alternative service could be arranged in order to provide safe care. This should be considered as standard practice for all patients, but may have particular importance for some trans people. When referring patients to other services it is important to explain what information may be disclosed. Information provided should be relevant to the referral. Written consent is recommended.

22 - SUGGESTIONS FOR FUTURE DEVELOPMENTS

Future developments in terms of inclusive sexual health services may involve the recruitment of local or regional champions (or teams of champions) for trans sexual health who can act as sources of support and advice, and lead on implementing change within their areas. Such a person or group of people do not need necessarily to be clinicians, and may include patient representatives or trans/non-binary advocates.

Holistic services incorporating sexual health, psychological support, social care advice, and community/peer support for trans people may help to serve their needs. The voices of trans and non-binary people living with HIV should be involved in the creation of HIV services. Inter-service working with improved communication between primary care, specialist gender clinics, sexual health, and social care providers is likely to be beneficial in the future.

23 – USEFUL ON-LINE RESOURCES

The BASHH GSM SIG website aims to maintain an up-to-date source of useful information to complement this recommendations document. This will include links to training and guidance as well as contact details for local clinical champions.

It can be accessed here: <https://www.bashh.org/bashh-groups/special-interest-groups/gender-sexual-minorities-gsm/>

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