Sexual Health

Background/Introduction

Sexual health has a profound impact on physical and psychological well-being, regardless of one's sex, gender, or sexual orientation. However, sex, gender and sexual orientation shape people's opportunities to live out their sexuality and to receive appropriate sexual health care. Specifically, in most societies, cisnormativity and heteronormativity lead to the assumption that all people are cisgender and heterosexual (Bauer, et al., 2009) and that this combination is superior to all other genders and sexual orientations (Nieder et al., 2020; Rider et al., 2019). Heteronormativity negates the complexity of gender, sexual orientation, and sexuality and disregards the diversity and fluid understanding of these concepts. This is all the more important since both the sexual identities and orientations of transgender and gender diverse (TGD) people and their sexual practices are characterized by an enormous diversity (Galupo et al., 2016; T'Sjoen et al., 2020). Therefore, the World Health Organization (WHO, 2010) emphasizes that sexual health depends essentially on whether the sexual rights of all people are respected, including the right to express diverse sexualities and to be treated respectfully, safely, and free from discrimination and violence. Sexual health discourses have focused on agency and body autonomy, which include consent, sexual pleasure, partnerships, and family life (Cornwall & Jolly, 2006).

In light of this, the WHO defines sexual health as "a state of physical, emotional, mental, and social well-being in relation to sexuality and not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled" (WHO, 2006, p. 5).

Focusing on the promotion of sexual health, the World Association for Sexual Health (WAS) asserts the importance of sexual pleasure and considers self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations as major facilitators (Kismödi et al., 2017). To contribute to the sexual health of TGD people, health care professionals (HCPs) need both trans-related expertise and sensitivity (Nieder et al., 2020). With the goal of improving sexual health for TGD people to a comparable, ethically-sound, evidence-based and high-quality level, HCPs must provide their health services with the same care (i.e., with trans-related expertise) and respect (i.e., with trans-related sensitivity) they provide for cisgender people (Holmberg et al., 2018).

Performances of TGD people, such as gender atypical expressions, can have strong reactions in many people. Thus, when initiating a health-related contact or establishing a therapeutic relationship, being sensitive here means first of all not to let oneself be guided by the fact that the person seeking care is TGD. A nonjudgmental, open, and welcoming manner is most likely ensured when HCPs reflect on their emotional, cognitive, and interactional reactions to the person (Nieder et al., 2020). In addition, trans-related expertise refers to identifying the biographical impact of growing up as transgender or gender diverse on the person being cared for (Rider et al., 2019). To adequately address the specific physical, psychological, and social conditions of TGD people, HCPs must be aware these conditions are generally overlooked for reasons of heteronormativity, lack of knowledge and lack of skills (Rees, et al., 2021). In addition, HCPs must be sensitive to the history of (mis)use of sexual identity and orientation as a gatekeeping function to exclude transgender people from transition-related care (Nieder & Richter-Appelt, 2011; Richards et al., 2014). The following recommendations aim to improve sexual health care for TGD people.

Summary of Recommendations

Statement 1: We recommend health care professionals who provide care to transgender and gender diverse patients acquire the knowledge and skills needed to address sexual health issues (relevant to their care provision).

Statement 2: We recommend health care professionals who provide care to transgender and gender diverse patients offer the possibility of including partner(s) in sexuality-related care, if appropriate.

Statement 3: We recommend health care professionals counsel transgender and gender diverse patients about the potential impact of stigma and trauma on sexual risk behavior, sexual avoidance, and sexual functioning.

Statement 4: We recommend any health care professional who offers care that may impact sexual health provide information, ask about the patient's expectations, and assess their level of understanding of possible changes.

Statement 5: We recommend health care professionals who provide care to transgender and gender diverse patients counsel adolescents and adults regarding prevention of sexually transmitted infections.

Statement 6: We recommend health care professionals who provide care to transgender and gender diverse patients follow local and World Health Organization guidelines for human immunodeficiency virus/sexual transmitted infections (HIV/STIs) screening, prevention, and treatment.

Statement 7: We recommend health care professionals who provide care to transgender and gender diverse patients address concerns about potential interactions between antiretroviral medications and hormones.

All of these statements have been recommended based on the large amount of background literature and a favorable risk-benefit ratio of providing sexual health counseling to patients, partners, and loved ones. We recognize in some areas evidence is limited, sexual health services may not be accessible or desirable, or both situations may exist.

Statement 1:
We recommend health care professionals who provide care to transgender and gender diverse patients acquire the knowledge and skills to address sexual health issues (relevant to their care provision).

It is important HCPs addressing the sexual health of TGD people be familiar with commonly used terminology (see terminology chapter) and invite those seeking care to explain terms with which the provider may not be familiar. In this context, it is also important HCPs (are prepared to) take a sexual history and offer treatment (according to their competencies) in a trans-affirming way (Centers for Disease Control, 2020). To achieve this, it is crucial HCPs providing transition-related medical interventions be sufficiently informed about possible effects on sexual function and pleasure (T'Sjoen et al., 2020). Considering that clinical data indicate that TGD people score significantly lower in sexual pleasure compared to cisgender

individuals, this is even more important (Gieles et al., submitted). If the HCP cannot provide information about the effects of their treatment on sexual function and pleasure, they are at least expected to refer the individual to someone qualified to do so. If the sexuality-related effects of their treatment are not known, HCPs should inform their patients accordingly. As introduced above, the sexuality of TGD people often challenges heteronormative views. Nevertheless, there is a large amount of literature (e.g., Bauer, 2018; Laube et al., 2020; Hamm & Nieder, 2021; Stephenson et al., 2017) highlighting the spectrum character of sexuality that does not fit into expectations of what male and female sexuality entails (neither cis- nor transgender), let alone gender diverse people (e. g., nonbinary, agender, genderqueer). Thus, these aspects should be carefully considered by HCPs as cisnormativity, heteronormativity, and transition-related medical interventions, all have a strong impact on sexual health.

Statement 2:
We recommend health care professionals who provide care to transgender and gender diverse clients offer the possibility of including partner(s) in sexuality-related care, if appropriate.

When appropriate and relevant to clinical concerns, inclusion of a sexual partner, romantic partner(s), or both in sexual health care decision-making can increase TGD patients' sexual well-being and satisfaction outcomes (Kleinplatz, 2012). TGD patients may choose a range of transition-related medical interventions, and these interventions may have mixed results in shifting experiences of anatomical dysphoria (Bauer & Hammond, 2015). When discussing the impact of medical interventions on sexual functioning and pleasure, inclusion of partner(s) can increase knowledge of potential changes and encourage communication between partners (Dierckx et al., 2019). Because the process of transitioning is not a completely solitary endeavor, including a sexual partner, romantic partner, or both in transition-related health care can facilitate the process of 'co-transitioning' (Lindley et al., 2020; Siboni et al., 2021; Theron & Collier, 2013) and can also support sexual growth and adjustment both in the individual as well as in the relationship. Social and psychological barriers to sexual functioning and pleasure, including experiences of gender dysphoria, stigmatization, lack of sexual and relationship role models, and limited skills, can have negative impacts on overall sexual health (Kerckhof et al., 2019). Supportive, gender-affirming sexual communication between partners improves sexual satisfaction outcomes for TGD patients (Stephenson et al., 2017; Wierckx et al., 2011). Inclusion of partners, when appropriate and as desired by patients, offers an opportunity to set realistic expectations, disseminate helpful and accurate information, and facilitate gender-affirming positive communication related to sexual health.

Statement 3:
We recommend health care professionals counsel transgender and gender diverse patients about the potential impact of stigma and trauma on sexual risk behavior, sexual avoidance, and sexual functioning.

The TGD community is disproportionately impacted by stigma, discrimination, and violence (de Vries et al., 2020; EU FRA, 2020; McLachlan, 2019). These experiences are often traumatic in nature (Burnes et al., 2016; Mizock & Lewis, 2008) and can create barriers to sexual health, functioning, and pleasure (Bauer & Hammond, 2015). For example, stigmatizing narratives about trans sexualities can increase dysphoria and sexual shame, increasing potential avoidance of the sexual communication needed for safety and optimizing pleasure (Stephenson et al., 2017). Research demonstrates that stigma, a history of sexual violence, and body image concerns can negatively impact sexual self-esteem and

agency, for example the ability to assert what is pleasurable or to negotiate condom use (Clements-Nolle et al., 2008; Dharma et al., 2019). Additionally, gender dysphoria can be exacerbated by past trauma experiences and ongoing trauma-related symptoms (Giovanardi et al., 2018) as well as that childhood adversities are associated with adult depression and suicidality even after gender affirming treatment (Biedermann et al., 2021). For example, it may be difficult for some TGD individuals to engage sexually using the genitals with which they were born, and they may choose to avoid such stimulation altogether, disrupting arousal, orgasmic processes, or both (Anzani et al., 2021; Bauer & Hammond, 2015; Iantaffi & Bockting, 2011). Some level of disconnect or dissociation may also be present, particularly in the case of acute trauma symptoms (Colizzi et al., 2015). It is important for HCPs to be aware of these potential impacts on sexual health, functioning, and pleasure so they may refer patients, as needed, to trauma-informed sexual counselors, mental health providers, or both, who may be of further assistance.

Statement 4:
We recommend any health care professional who offers care that may impact sexual health provide information, ask about the patient's expectations, and assess their level of understanding of possible changes.

HCPs should inform their TGD patients about treatments among the ones being offered that can affect sexual function and pleasure and, specifically, how these will be impacted (Garcia, 2021; Holmberg et al., 2018). Transition-related care can affect sexual function and pleasure, both in positive and negative ways (Holmberg et al., 2018; Kerckhof et al., 2019; Tirapegui et al., 2020). Sexual desire and arousal, the ability to have an erection and ejaculation, a satisfying orgasm, and general sexual satisfaction may be affected by the use of psychotropic drugs (Montejo et al., 2015). As some TGD people are prescribed similar medication to treat depression (Heylens et al., 2014), anxiety (Millet, Longworth & Arcelus, 2017) or other mental health concerns (Dhejne et al., 2016), their potential side effects on sexual health should be considered. Furthermore, transition-related hormones may have similar effects on sexual function and pleasure, among others that are not yet fully understood (Garcia & Zaliznyak, 2020; Kerckhof et al., 2019; Wierckx et al., 2011). Transition-related hormones may affect mood, sexual desire, and sexual arousal processes, which in turn can affect sexual function and pleasure as well as sexual self-expression (Defreyne et al., 2020; Klein & Gorzalka, 2009).

Many gender affirming surgeries can have significant effects on erogenous sensation, sexual desire and arousal as well as sexual function and pleasure. The impact of these changes for patients may be mixed (Holmberg et al., 2018). Chest surgeries (breast reduction, mastectomy, and breast augmentation) and body contouring surgeries, for example, may offer desired changes in form and appearance thereby reducing psychological distress that can disrupt sexual functioning, but may adversely affect erogenous sensation (Bekeny et al., 2020; Claes et al., 2018; Rochlin et al., 2020). Genital surgeries in particular can potentially affect sexual function and pleasure in adverse ways, although they are likely to be experienced positively as the patient's body becomes more aligned with their gender, potentially opening new avenues for sexual exploration, pleasure, and satisfaction (Hess et al., 2018; Holmberg et al., 2018; Kerckhof et al., 2019).

There are numerous examples of this in the extant literature:

- Surgery may result in a decrease, a total loss, or a possible increase in erogenous stimulation and/or experienced sensation as compared to the patient's presurgery anatomy (Garcia, 2018; Sigurjónsson et al., 2017).

- A particular surgical option may be associated with specific limitations to sexual function that may manifest immediately, in the future, or at both timepoints, and which patients should consider before finalizing their choice when considering different surgical options (Frey et al., 2016; Garcia, 2018; Isaacson et al., 2017).

- Postsurgical complications can adversely affect sexual function by either decreasing the quality of sexual function (e.g., discomfort or pain with sexual activity) or by precluding satisfactory intercourse (Kerckhof et al., 2019; Schardein et al., 2019).

In general, satisfaction with any medical treatment is heavily influenced by the patient's expectations (Padilla et al., 2019). Furthermore, when patients have unrealistic expectations before treatment, they are much more likely to be dissatisfied with the outcome, their care, and with their HCP (Padilla et al., 2019). Therefore, it is important to both provide patients with adequate information about their treatment options and to understand and consider what is important to the patient with regard to outcomes (Garcia, 2021). Finally, it is important that the HCP ensure patients' understand the potential adverse effects of a treatment on their sexual function and pleasure so that a well-informed decision can be made. This is relevant for both meeting the standard of informed consent (i.e., discussion and understanding) and for providing an opportunity to offer further clarification to patients and, if desired, to their partners (Glaser et al., 2020).

Statement 5:
We recommend health care professionals who provide care to transgender and gender diverse patients counsel adolescents and adults regarding prevention of sexually transmitted infections.

TGD persons are disproportionately impacted by human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) relative to cisgender persons (Baral et al., 2013; Becasen, Denard, Mullins, Higa, & Sipe, 2018; Poteat, Scheim, Xavier, Reisner, & Baral, 2016). The United Nations Joint Programme on HIV/AIDS estimates that transgender women are 12 times more likely than other adults to be living with HIV (UNAIDS, 2019). A meta-analysis estimated a pooled global HIV prevalence of 19% among transgender women who have sex with men (Baral et al., 2013). HIV/STI risk is concentrated among TGD subgroups at the confluence of multiple biological, psychological, interpersonal, and structural vulnerabilities. In particular, transfeminine persons who have sex with cisgender men, belong to minoritized racial/ethnic groups, live in poverty, and engage in survival sex work are at elevated HIV/STI risk (Becasen et al., 2018; Poteat et al., 2016; Poteat et al., 2015). Less is known about HIV/STI risk among transgender men or gender diverse persons assigned female at birth. Small studies in high-income countries indicate a laboratory-confirmed HIV prevalence of 0-4% among transmasculine people (Becasen et al., 2018; Reisner & Murchison, 2016). However, research on sexual risk indicates that transmasculine persons who have sex with cisgender men should be a priority for HIV/STI prevention (Golub, Fikslin, Starbuck, & Klein, 2019; Reisner et al., 2019; Scheim, Bauer, & Travers, 2017).

Therefore, TGD persons who are sexually active or considering sexual activity may benefit from sexuality-related communication or counseling for the purpose of HIV/STI prevention. In primary care settings for all patients, the WHO (2015a) strongly recommends that HCPs implement brief sexuality-related communication with adolescents and adults and provides guidelines for such communication. HCPs will need to supplement these guidelines by developing knowledge and skills for discussing sexual health issues with TGD patients, such as the use of gender-affirming language (see Statement 1 in this chapter). Well-prepared HCPs (including but not limited to mental health providers) may also engage in in-depth counseling with their patients to address the underlying drivers of HIV/STI risk (see

Statement 3 in this chapter). In all cases, HCPs should be sensitive to the collective and individual histories of TGD patients (e.g., stereotypes and stigma about trans sexualities and gender dysphoria) and should explain to patients the reasons for sexuality-related enquiries and the voluntary nature of such enquiries, all the while avoiding assumptions about HIV/STI risk based solely on a patient's gender identity.

Statement 6:
We recommend health care professionals who provide care to transgender and gender diverse patients follow local and World Health Organization guidelines for human immunodeficiency virus/sexual transmitted infections (HIV/STIs) screening, prevention, and treatment.

Like cisgender patients, TGD adolescents and adults should be offered screening for HIV/STIs in accordance with existing guidelines and based on their individual risk of HIV/STI acquisition, considering anatomy rather than gender identity. Where local or national guidelines are unavailable, WHO (2015b) offers global recommendations. However, gender-affirming genital surgeries and surgical techniques have implications for STI risks and screening needs, as outlined in recent guidelines from the U.S. Centers for Disease Control (Workowski et al., 2021). For instance, transfeminine persons who have had penile inversion vaginoplasty using only penile and scrotal skin to line the vaginal canal are likely at lower risk of urogenital Chlamydia trachomatis and Neisseria gonorrhoeae, but newer surgical techniques that employ buccal or urethral mucosa or peritoneum flaps could in theory, increase susceptibility to bacterial STIs relative to use of penile/scrotal skin alone (Van Gerwen et al., 2021), though evidence of this is limited. Routine STI screening of the neovagina (if exposed) is recommended for all transfeminine persons who have had vaginoplasty (Workowski et al., 2021). For transmasculine persons who have had metoidioplasty with urethral lengthening, but not vaginectomy, testing for bacterial urogenital STIs should include a cervical swab because infections may not be detected in urine (Workowski et al., 2021).

Further, it is important for HCPs to offer testing at multiple anatomical sites as STIs in transgender patients are often extragenital (Hiransuthikul et al., 2019; Pitasi et al., 2019). Consistent with WHO (2020) recommendations, self-collection of samples for STI testing should be offered as an option, particularly if patients are uncomfortable or unwilling to undergo provider-collected sampling due to gender dysphoria, trauma histories, or both. Where relevant, integration of HIV/STI testing with regular serology used to monitor hormone therapy may better facilitate access to care (Reisner, Radix, & Deutsch, 2016; Scheim & Travers, 2017).

Statement 7:
We recommend health care professionals who provide care to transgender and gender diverse patients address concerns about potential interactions between antiretroviral medications and hormones.

For TGD adolescents and adults at substantial risk of HIV infection (generally defined as an ongoing serodiscordant relationship or condomless sex outside of a mutually monogamous relationship with a known HIV-negative partner; WHO, 2017), pre-exposure prophylaxis (PrEP) is an important HIV prevention option (Golub et al., 2019; Sevelius, Deutsch, & Grant, 2016). For treatment among people living with HIV, transgender-specific guidelines are available in some settings (e.g., PAGAA, 2019). For both HIV prevention and treatment, there are antiretroviral dosing and administration considerations specific to TGD persons. For example, only daily dosing of PrEP is currently recommended for TGD patients, as studies demonstrating the effectiveness of event-driven PrEP with tenofovir disoproxil

fumarate/emtricitabine have been limited to cisgender men (WHO, 2019). As long-acting injectable antiretroviral formulations of PrEP and HIV treatment become available, indicated injection sites (i.e., the gluteal muscle) may be unsuitable for patients who have used soft tissue fillers (Rael et al., 2020).

There is little evidence supporting the occurrence of drug-drug interactions between gender-affirming hormones and PrEP medications. A few small studies, primarily relying on self-reported PrEP use, have shown reduced PrEP drug concentrations in transgender women undergoing hormone therapy, although concentrations remained in the protective range (Yager & Anderson, 2020). A subsequent drug-drug interaction study using directly observed PrEP therapy failed to detect an impact of hormone therapy on PrEP drug concentrations in transgender women and found that transgender women and men on hormone therapy achieved high levels of protection against HIV infection (Grant et al., 2020). Most importantly, for many TGD patients, no impact of PrEP on hormone concentrations have been detected. With regard to HIV treatment, specific antiretroviral medications may impact hormone concentrations; however, these can be managed by selecting alternative agents, monitoring and adjusting hormone dosing, or both (Cirrincione, Senneker, Scarsi, & Tseng, 2020) as detailed in guidelines from the US Department of Health and Human Services (PAGAA, 2019). Nevertheless, concerns about drug-drug interactions, and particularly interactions that may limit hormone concentrations, represent a key barrier to the implementation and adherence to antiretroviral therapy for HIV prevention or treatment (Radix, Harris, & Goldstein, 2020; Sevelius, Deutsch, & Grant, 2016). Therefore, it is advisable for HCPs to proactively address such concerns with patients who are candidates for PrEP or HIV treatment. Integration of PrEP or HIV treatment with hormone therapy may further reduce barriers to implementation and adherence (Reisner et al., 2016). Integration may be achieved through colocation or through coordination with an HIV specialist if the primary care provider does not have the necessary expertise.

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