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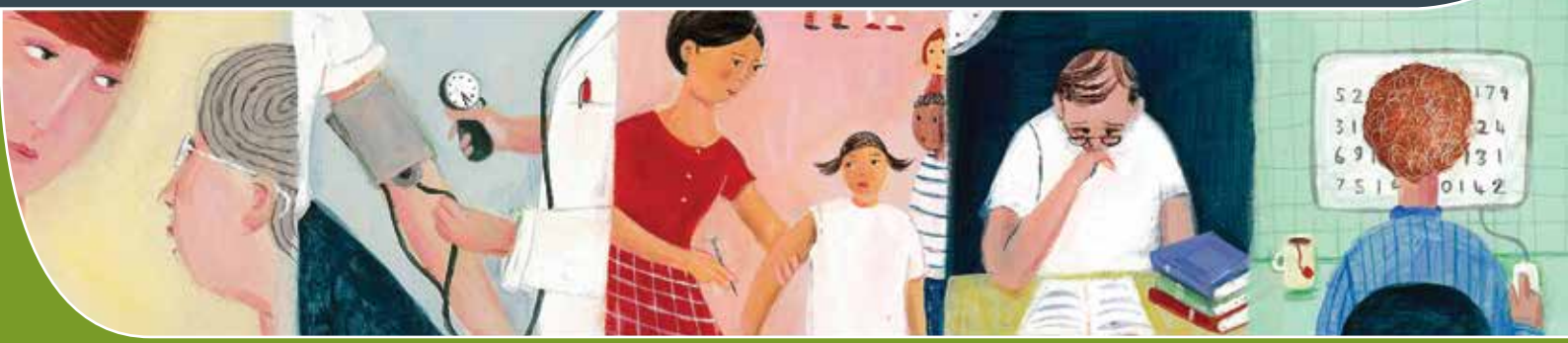

Unit 496 July 2013

Sexuality and sexual health

RACGP

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Independent learning program for GPs

Sexuality and sexual health

Unit 496 July 2013

The five domains of general practice
Communication skills and the patient–doctor relationship
Applied professional knowledge and skills
Population health and the context of general practice
Professional and ethical role
Organisational and legal dimensions

RACGP

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This unit of *check* on sexuality and sexual health covers one of the more challenging and sensitive aspects of general practice. Often patients are reluctant to speak about their sexuality and may not be forthcoming about this topic. Asking patients about their sexuality in a non-threatening and comfortable way is not always easy, but GPs need to be respectful and non-judgemental of their patients' identities.

This issue of *check* looks at clinical scenarios in relation to various aspects of sexuality, and offers advice about ways to explore problems and issues of sexuality in different situations.

We would like to thank the author, contributors and reviewer for providing a wealth of information about sexuality and sexual health for this unit of *check*.

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The learning objectives of this unit are to:

- demonstrate a way of eliciting information about a person's sexuality in a non-threatening and non-judgemental way
- write a list questions that can be used for all patients when taking a sexual history
- develop a checklist of tests recommended for men having sex with men
- list the exceptions to confidentiality that need to be discussed with patients
- evaluate contraception methods for different life stages
- identify ways to make your practice more inclusive of gender diversity.

We hope this edition of *check* will be helpful when consulting about sexuality with your patients.

Kind regards

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ABBREVIATIONS AND ACRONYMS – SEXUALITY

FGM/C	female genital mutilation/cutting	HIV	human immunodeficiency virus	SDA	strand displacement amplification
FSH	follicle stimulating hormone	IUD	intrauterine device	STI	sexually transmitted infection
FtM	female to male	IV	intravenous	TMA	transcriptional mediated amplification
GLBTI	gay, lesbian, bisexual, transgender and intersex	LNG-IUD	levonorgestrel-releasing IUD		
HEADSS	Home and environment, Education and employment, Activities, Drugs, Sexuality, Suicide/depression assessment	MSM	men who have sex with men		
		MtF	male to female		
		NAAT	nucleic acid amplification test		
		PCR	polymerase chain reaction		

CASE 1

HALIMA NEEDS A TEST FOR CHLAMYDIA

Halima, aged 24 years, is an international student from Egypt, studying for a Masters degree at a local university. Halima hasn't attended your practice before. Halima seems a little embarrassed, and says that she needs a chlamydia test because she had treatment for chlamydia infection a few months ago and was advised to be tested again in 3 months. You ask her which clinic she attended for the chlamydia treatment and she tells you that it was a large clinic in the city where she had a termination of pregnancy.

QUESTION 1

Halima has presented for her sexual health. What are important attitudes and preliminary discussions for taking a sensitive sexual and reproductive history in general practice?

QUESTION 2

In taking a sexual history, what useful questions can you ask about risk factors for sexually transmitted infections (STIs) (including HIV and syphilis)?

QUESTION 3

What questions can you ask about symptoms of STIs?

QUESTION 4

What questions can you ask a female patient about reproductive history?

FURTHER INFORMATION

Halima doesn't currently have a regular sexual partner and last had vaginal sex using a condom with a casual male partner 6 weeks ago. Her last period was 3 weeks ago and was normal in timing, bleeding pattern and associated symptoms. She has had two other male partners in the last 12 months and used withdrawal when she had vaginal intercourse. She had an unplanned pregnancy, which resulted in a termination of pregnancy, 3 months ago. Her chlamydia infection was picked up on screening and she was asymptomatic. Halima also had a Pap test, which was normal. Halima didn't start any ongoing method of contraception at the time of the termination of pregnancy as she didn't have a regular sexual partner. Halima seems surprised that you are willing to talk about her sexual health with her as she didn't realise that GPs could help with this.

QUESTION 5

Halima has presented for a sexual health consultation. In general practice, do you need to take a comprehensive sexual history prior to offering STI screening or contraceptive advice?

FURTHER INFORMATION

Halima comes from country where female genital mutilation/ cutting (FGM/C) may be practised.

QUESTION 6

How can you sensitively ask a woman about FGM/C?

CASE 1 ANSWERS

ANSWER 1

It is most important that your attitude is non-judgemental.

Before asking any questions, it is important that you explain:

- about confidentiality/privacy (and exceptions – if she is at risk of harm, suicide or harming someone else)[2]
- why you are asking the questions that you will be asking (e.g. to assess risk, to help work out what tests are needed)
- that some questions may be quite personal.

Ask permission to take the history and reassure the person that they do not have to answer a question if they prefer not to.

It is important not to assume anything about sexual history, attraction, identity or behaviour. A patient's gender, age or cultural background (or even marital status) doesn't enable you to know their sexual behaviour and potential sexual health issues.[3]

Normalise your questioning (e.g. 'I ask all my patients about these things') so that your patient knows that they are not being judged and so that you are confident and practised.

ANSWER 2

Questions about risk factors for STIs include the following.

- Are you sexually active?
- When did you last have sex?
- When did you last have sex with someone else (change of partner)?
- Are your partners male, female or both? (Men who have sex

with men have higher rates of most STIs, including human immunodeficiency virus (HIV) and syphilis.)

- Are any of your partners from overseas (high prevalence countries)? Have you had sex overseas?
- Are any of your partners men who have sex with men, intravenous (IV) drug users, HIV positive or have an STI?
- Have you had an STI?
- What type of sex did/do you have – oral, vaginal, anal? Receptive or insertive (give or receive, top or bottom)?
- Was the sex consensual?
- Do you use condoms? What percentage of the time? For what type of sex? Do you use the condom for all of the intercourse, or just for ejaculation? Have you had any condoms break? Are you able to negotiate condom use with your partner/s?

Other risk assessment questions include asking about tattoos, blood transfusions, drug and alcohol use, and number of sexual partners in the past 3 months and the last 12 months.

ANSWER 3

Questions that need to be asked about symptoms of STIs include asking about:

- discharge (urethral, vaginal) or stained underwear
- itch
- pain (including superficial or deep dyspareunia)
- lumps or bumps
- sores, ulcers or fissures
- the site of symptoms – anal, vaginal, urethral, oral
- urinary symptoms
- throat symptoms
- anal symptoms – bleeding, discharge, pain
- systemic symptoms such as fever, rash, joint inflammation
- in females: menstrual history, including last normal menstrual period, postcoital bleeding and intermenstrual bleeding.

ANSWER 4

Questions about a reproductive history include the following.

- How many pregnancies have you had (including miscarriage and termination of pregnancy)?
- Do you need contraception?
- Are you planning a pregnancy? How would you feel if you found out you were pregnant?
- What contraception are you using/have you used in the past?
- Do you use withdrawal as a method of contraceptive?[4,5]
- Have you taken emergency contraception? Are you aware that it is available over the counter at pharmacies?
- Are your Pap tests up to date?

ANSWER 5

No, not always.

Opportunistic chlamydia screening should be offered to all sexually active patients under 30 years of age[6] and can be offered without taking a detailed history.[7] For example, you might say 'We recommend testing for all sexually active people under 30 for chlamydia, and the test is done with a simple urine test. Would you like to do that test today?'

Likewise, opportunistically asking women if they need contraception if they are presenting for other health complaints may be very useful, particularly for patients from overseas who may not be aware that GPs are able to provide this service and do it routinely. Patients may not be aware of the range of contraceptives available (particularly the long-acting reversible methods), and may not have an understanding that in Australia it is considered good practice to be prepared with contraception and condoms to prevent unintended pregnancy and infections.[8]

ANSWER 6

When asking a patient about FGM/C, use value-neutral non-judgemental questions such as, 'Do you have a traditional cutting?' or 'Have you been circumcised?'.

FEEDBACK

FGM/C may occur in many countries of Africa as well as parts of the Middle East and Asia (including Indonesia, India, Malaysia, Israel and Iraq). FGM/C is not a religious practice. It is not legal to be performed in Australia, but there are many women living in Australia who have had this performed. FGM/C can vary from ritual pricking of the clitoris to infibulation, which involves removal of clitoral and labial tissue and fusing of the labia so that only a small hole is left for urine and menstrual blood.[1]

CASE 2

ADELE HAS LOW LIBIDO

Adele, aged 49 years, consults you complaining that her sex drive is very low. She has no desire to have sex with her husband of 5 years, Stephan, and this is placing a strain on their relationship. Adele has been your patient for many years. She has good health and takes no medications. You know that Adele has two sons from her first marriage, aged 18 and 26. Adele separated from her first husband 17 years ago.

QUESTION 1

What history would you like to obtain from Adele to assess her low libido?

QUESTION 2

What are common factors in low libido in women?

QUESTION 3

Is it unusual for a woman in a relationship such as Adele's to experience low sex drive?

FURTHER INFORMATION

Adele has had two relationships. She married her first husband, Mark, at the age of 22, after an unplanned pregnancy early in their relationship. She felt a high sex drive early in this relationship but their sexual activity lessened during their relationship with busy work and parenting roles. They divorced soon after the birth of their second child, when Mark met a new partner and left Adele. Adele's life was then extremely busy, taking sole care of her two children, and she rarely thought about sex. Adele fell in love with Stephan 6 years ago and after a whirlwind romance they married. Adele felt strong sexual desire with Stephan for the first 2 years and enjoyed sex, although she found Stephan to have high expectations of her sexual performance. Initially this was exciting, but gradually Adele has found that Stephan is constantly pressuring her to have sex and he makes snide comments to his friends about a lack of sex, which Adele finds humiliating. Stephan is very physically demonstrative but is often quite critical of Adele and her children. Adele now finds herself avoiding physical closeness with Stephan as she knows that he will expect sex. Adele and Stephan use condoms for contraception. Adele has regular periods. She works full time and manages the home, as Stephan has traditional ideas about gender roles in housework. Adele's mother is widowed and has mild dementia. Adele's sons live at home with the youngest in his final year of school.

QUESTION 4

What factors in Adele and Stephan's relationship and lifestyle may be affecting her libido?

QUESTION 5

What are the principles of management for Adele?

FURTHER INFORMATION

You refer Adele to a relationship counsellor. She returns to see you 6 weeks later in great distress. She tells you that she is enjoying sex again and her relationship has improved following help from the counsellor. However, she is at the clinic today having experienced a condom breakage and she is very afraid of unplanned pregnancy. She acknowledges that fear of pregnancy concerns her and interferes with her enjoyment of sex. She would like to consider more effective contraceptive options.

QUESTION 6

What are Adele's options for emergency contraception?

QUESTION 7

At age 49, what options do Adele and Stephan have for ongoing contraception?

CASE 2 ANSWERS

ANSWER 1

For Adele, a woman with low libido in a relationship, the history will need to include questions about the following.

- What is going on sexually? Do she and Stephan have sex and how often?
- How do she and Stephan negotiate sex?
- What is her sexual enjoyment – does she enjoy sexual pleasure or orgasm alone or with Stephan? Does she experience superficial or deep dyspareunia? Does she have any other pain associated with sex, which may not be genital or pelvic?
- What is the quality and dynamics of the relationship – is there goodwill in the relationship? What are the patterns of communication and interaction in general and with regards to sex?

Take a thorough history about:

- the perception of libido – both Adele's and Stephan's perception of the low libido, including who is actually concerned about the low libido, what is the perception of blame for this and what impact it is having on the relationship
- Adele's physical health – general health, fatigue, medications, hormonal status (pregnancy, breastfeeding, menopause), alcohol and drug use, sexual and reproductive health
- Adele's mental health – stress or poor self-esteem
- the social history of both partners – women often juggle many roles and responsibilities.

ANSWER 2

Common factors in low libido in women are the following.

- Relationship duration – female desire will naturally decline as they move on from the early romantic phase of the relationship, often declining much more than a man's desire.
- Women are generally less sexually motivated than men (although they may still enjoy sex).
- The media portray an unrealistic picture of women with high libido and athletic sexual performance, and often the perception that sex is only for the thin and young.
- A woman's libido will be easily affected by factors such as stress and fatigue.

ANSWER 3

It is common for women to have low motivation for sex (over 50% in an Australian survey[9]) and to not feel a strong desire to initiate sex once a relationship is established. Although women may experience less lust than in the initial stage of the relationship, they may find pleasure in sex with their partner if the relationship and the sex are good.

ANSWER 4

Relationship and sexual factors that may be affecting Adele's libido are:

- unrealistic expectations about female libido and associated blame
- unhelpful pattern of behaviour with desire discrepancy – Adele withdraws, Stephan pursues
- performance anxiety
- critical or negative communication
- physical discomfort because of female lack of desire and physical readiness for sex with lack of lubrication and possibly condom use
- previous unplanned pregnancy, anxiety about pregnancy, failure of previous marriage when sex became less frequent.

Lifestyle and social factors that may be affecting Adele's libido are:

- fatigue
- multiple roles and distractions
- stress and pressure
- cultural expectations (e.g. a female may be expected to take the role of carer for ageing relatives)
- inequitable share of housework.

All of these important factors are contributing to Adele's low libido and it is not surprising that she isn't much interested in sex!

ANSWER 5

The principles of management for Adele are as follows:

- Ask – be willing to ask about sexual problems.
- Listen – take a thorough history of the problem and possible causes and impact.
- Assess – what is the problem, is it a relationship and/or sexual problem, is there pathology? Use a biopsychosocial approach:
  - assess medication, drug and alcohol use
  - assess for general health as any chronic medical condition that results in pain, fatigue or depressed mood that may affect libido (so optimising management may assist)
  - assess hormonal status as changes such as during menopause (or breastfeeding) may have an impact.
- Advise – normalise and explain common problems; provide specific suggestions such as recommended reading (see *Resources*).
  - Adele and Stephan could work on reducing the factors that inhibit Adele's desire for sex (such as being too tired or being fearful of unplanned pregnancy), and increasing factors that boost desire (such as communication, non-sexual affection or compliments).[10] They may find it helpful to schedule in sex as it may not happen spontaneously.
  - Suggest trying a lubricant if hormonal changes are an issue.
  - Self-help exercises can be used to increase focus on touching and pleasurable sensations such as Sensate-focus exercises.[10] This type of exercise may be suggested and explained by the GP or by a sexual and relationship counsellor.
- Refer – if needed (e.g. relationship counselling, sexual counselling).
- Motivate and follow-up.

ANSWER 6

Adele's two main options for emergency contraception are:[11]

- oral levonorgestrel 1.5 mg, which can be taken up to 4 days after sex (and can be used without harm up to 5 days, but with much lower efficacy), is available over the counter.
- copper intrauterine device (IUD) insertion up to 5 days after sex.

ANSWER 7

At age 49 years, Adele's fertility is diminishing rapidly; the average age of menopause in Australia is 51 years.[12] International[13] and Australian[11] guidelines recommend that combined hormonal contraception (the combined oral contraceptive or combined hormonal vaginal ring) and the injectable contraceptive are not used from the age of 50 years, due to unacceptable risks of cardiovascular complications.

Options for women aged 50 years and over, with higher typical use efficacy than male condoms, are:

- progesterone-only pill
- contraceptive implant
- IUD (hormonal or copper)
- male or female sterilisation.

Other methods, such as the female condom, diaphragm, natural family planning or the withdrawal method, have similar or lower typical use efficacy than the male condom, which Adele and Stephan are currently using.

- Male condoms are 98% effective and female condoms are 95% effective at preventing pregnancy but only when used consistently and correctly.
- In typical use, male condoms are only 82% effective and female condoms are only 79% effective at preventing pregnancy.[14]

Explain to Adele the efficacy of available contraceptive options as well as her relatively low fertility. The risk of unplanned pregnancy with lower efficacy contraceptives needs to be balanced with any potential risks of higher efficacy contraceptives (such as procedural risk with IUD insertion or sterilisation).

FEEDBACK

While the chance of pregnancy over 50 years of age is exceptionally low, there is evidenced-based guidance[15] for assisting women in deciding when to cease hormonal contraception at menopause. Key points include the following.

- **For women using non-hormonal contraception, contraception can be ceased after 12 months of amenorrhoea in women over the age of 50 years and after 2 years of amenorrhoea in women below the age of 50 years.**
- **Follicle stimulating hormone (FSH) levels cannot be used as an indicator of ovarian failure in women using combined hormonal contraceptive methods (which suppress FSH levels), but can provide guidance for women aged over 50 years using the progestogen-only pill, implant or levonorgestrel-releasing IUD (LNG-IUD) who are amenorrhoeic. Women with FSH levels ≥30 IU/L on two occasions 6 weeks apart need only continue the method for another 12 months.**
- **Contraception is not required beyond the age of 55 years.**

CASE 3

VICTOR'S MUM IS WORRIED

Victor's mother, Lin, is a regular patient. At a recent visit Lin mentioned that she was concerned about her son Victor, aged 17 years. Victor is starting to receive poor marks at school and she was upset on coming home recently to find Victor at home on a school day. She says she intends to organise an appointment for Victor to see you. You know that Victor's family are ethnic Chinese from Malaysia who moved to Australia when Victor was aged 4 years. The family have a strong Christian faith. When you see that Victor has an appointment with you, you review his file and see that he is usually well. When you call Victor from the waiting room his mother comes in with him.

QUESTION 1

What should be your approach to this consultation with Victor and his mother, Lin, presenting together?

FURTHER INFORMATION

After briefly listening to Lin's concerns you then see Victor on his own. Victor seems guarded with his mother in the room, but once she has left and you explain confidentiality and the exceptions to confidentiality, Victor seems happy to talk to you. You explain that you would like to know a bit more about what is happening in his life and start a HEADSS (a psychosocial interview for adolescents – Home and environment, Education and employment, Activities, Drugs, Sexuality, Suicide/depression) assessment.[16] Victor lives at home with his parents and his younger sister, Julie. He says he is feeling pressure from his parents to achieve high grades and he has mixed feelings about attending church each week as he doesn't feel connected to the Christian religion. Victor acknowledges that his school marks have declined, and says he can't wait to finish school. On further questioning he tells you that he has had a falling out with his best friend and is being picked on by classmates. Victor used to play basketball but has recently stopped to avoid spending time with his peers. Victor doesn't take drugs and although he went to parties where he drank alcohol in the holidays, he does not drink alcohol regularly, nor does he binge drink. He does not smoke.

QUESTION 2

How do you ask Victor about sex without making assumptions about his sexuality or sexual behaviour?

FURTHER INFORMATION

Victor tells you that he isn't currently sexually active. When you ask him about sexual attraction, he tells you that he is attracted only to guys and has known about this attraction from the age of 10. He mentions that he feels OK about telling you this as he is used to seeing posters and pamphlets about gay health in your waiting room. Victor tells you that he is quite worried about having an STI, as he and a male family friend, John, of the same age, experimented with some gay pornography online and masturbated each other. He hasn't had contact with John since and Victor's messages on Facebook have been ignored. You ask Victor if he has told anyone about his sexual attraction. Victor becomes quite distressed and manages to tell you that he came out to his best friend at school, who then told other classmates, who are now bullying him. Victor is being called 'fag', feels physically threatened at school and fears travelling home after school. Victor has started leaving school early to avoid confrontation and is feeling depressed and alone. Victor has feelings of hopelessness for his future as he cannot see his homosexuality being accepted by friends or family. He feels overwhelmingly different and doesn't know anyone else who feels like he does. On specific questioning Victor has had fleeting suicidal ideation but no current plans or thoughts.

QUESTION 3

What information can you give Victor about his concern about STIs?

QUESTION 4

What STI screening would you advise for a sexually active man who is having sex with men?

QUESTION 5

What other health issues are more prevalent in same-sex attracted patients?

QUESTION 6

What are positive factors that will help mental health and improve resilience for Victor?

QUESTION 7

What consulting skills can you use to support Victor, who has same-sex attraction and is experiencing significant distress?

CASE 3 ANSWERS

ANSWER 1

Greet Victor and address questions to him directly. Explain at the beginning of the consultation that it is your usual practice to see a young person on their own, with the option of bringing the parent back at the end of the consultation. When you see Victor alone, explain that your discussion is private, and outline the exceptions (i.e. if a person is at risk of significant self-harm or harm by others, at risk of suicide, or at risk of physically harming someone else).[17] Add that you would explain to him if you felt that you needed to break confidentiality, and why. After your consultation with Victor, come to an agreement about what information, if any, you can share with his mother.

ANSWER 2

When asking about sexual history or sexuality, it is important not to make assumptions.

In asking Victor about sexual partner/s, it may help to normalise the process by using a third person approach such as, 'Many people your age are beginning to experiment with sex[17] is that something that you have started?' If he has, you can ask if his partners are male, female or both, such as, 'Is that with a guy, a girl or both?' If not, ask him about sexual attraction in the same way.

You may need to ask Victor some specific questions about sexual activity. Explaining why you are asking is key, so explain that this helps you to know if there is risk of infection, or helps with testing or advice. Ask about sexual practices – oral, vaginal and anal sex. With oral and anal sex, ask if he was 'giving' or 'receiving' (often called 'top' and 'bottom' with anal sex). Ask specifically if condoms were used for some or all of the sexual activity.

FEEDBACK

Making an assumption about heterosexuality will reduce the likelihood of disclosure of same sex attraction (or bisexuality).[3] So, rather than asking young males if they have a girlfriend, and young females if they have a boyfriend, find a neutral term such as 'partner' and ask about gender/s of partners. Also keep in mind that many people who have same-sex attraction or who have sex with people of the same gender may not identify with the labels homosexual, gay or lesbian. In Australia approximately 2% of adults identify as lesbian, gay or bisexual, whereas up to 15% report same-sex attraction.[18]

ANSWER 3

Mutual masturbation is very low risk for STI and Victor can be reassured.

Victor may have very little knowledge about STI risk with different sexual behaviours. Provide him with information about common STIs and how they are transmitted, with supporting written information.

Discuss condoms, how to use them correctly and where they can be bought. At subsequent consultations check for understanding and explain that some STIs may be asymptomatic and that some sexual activities have significantly higher risk.[19]

Estimation of transmission of HIV from an HIV-positive source is shown in *Table 1*.[19,20,21]

The estimated prevalence of HIV in gay males in Australia is 13%.[21]

Table 1. Estimation of transmission of HIV from an HIV-positive source

Receptive anal intercourse	1/120 – 1/30
Receptive vaginal intercourse	1/1000
Insertive anal intercourse	1/1000
Insertive vaginal intercourse	1/1000
Receptive oral intercourse with ejaculation	not measurable

ANSWER 4

Guidelines have been developed for STI testing for men who have sex with men (see *Table 2*).[22]

Table 2. Sexually transmitted infection testing guidelines for men who have sex with men

At least once a year: all men who have had any type of sex with another man in the previous year should be offered:

- pharyngeal swab for gonorrhoea NAAT (e.g. PCR, SDA, TMA) or culture
- anal swab for gonorrhoea NAAT or culture and chlamydia NAAT
- first void urine for chlamydia NAAT
- serology for HIV, syphilis, hepatitis A, hepatitis B, hepatitis C (if HIV positive or injecting drug use).

More frequent testing: 3–6 monthly testing is recommended for men who:

- have episodes of unprotected anal sex
- have had more than 10 partners in the past 6 months
- participate in group sex or use recreational drugs during sex.

HIV positive MSM: 3-monthly syphilis testing as part of routine HIV monitoring.

Repeat testing: People diagnosed with chlamydia or gonorrhoea should be retested in 3 months.

MSM = men who have sex with men; NAAT = nucleic acid amplification test; PCR = polymerase chain reaction; SDA = strand displacement amplification; TMA = transcriptional mediated amplification

*First void urine = initial part of the urine stream. Not first urine of the day and not midstream urine

Reproduced with permission of the STIs in Gay Men's Action (STIGMA) group.[22] Sexually transmitted infection testing guidelines for men who have sex with men 2010, STIGMA, Sydney. http://stigma.net.au/resources/STIGMA_MSM_Testing_Guidelines_2010.pdf

ANSWER 5

Due to homophobia, gay, lesbian and bisexual people have higher rates of mental illness and social issues, including:[23]

- depression
- anxiety
- substance abuse
- self-harm
- suicide
- violence
- abuse
- family rejection
- homelessness
- disconnection
- discrimination
- stigma
- seeking or accessing healthcare.

ANSWER 6

Positive factors for health are social supports, institutional support (e.g. school, work, healthcare), community connectedness, self-acceptance and being in a relationship.[23]

ANSWER 7

Consulting skills needed to support Victor include the following.

- Be respectful.
- Be self-aware of your own identity and assumptions (e.g. assumptions of heterosexuality).
- Emphasise and protect confidentiality.
- Normalise sexual variations such as homosexuality or bisexuality.
- Don't 'out' your patient if they don't (i.e. don't use term 'gay' if they don't use it).
- Be sensitive about not forcing disclosure.
- Understand that 'coming out' is a process and may follow the pattern of coming out to self, others, family, and then community. This is a very variable process. Also be aware that not all same-sex attracted people will identify as gay, lesbian or bisexual.
- Discuss with Victor if he is ready to disclose to family and/or school.
- If he is ready to disclose to family or school, explore possible positive and negative consequences and offer support.
- Support and follow up (including mental health, particularly suicide risk, and physical health).
- Refer to or suggest sensitive referral networks.
- Make your practice inclusive and welcoming by:
  - having signs (such as the rainbow symbol) or posters or visible policies that show an inclusive approach
  - providing registration forms that have options such as 'partnered' as an option, or 'preferred contact' instead of 'next-of-kin'
  - educating staff about same-sex attracted patients and confidentiality.[23]

FEEDBACK

Coming out usually coincides with first realisation of same-sex attraction in young people who are in open, accepting environments; however, in contexts where the environment is conservative, restrictive and homophobic, coming out will often be delayed after first realisation until the environmental context is more conducive (such as moving from a homophobic secondary school into the adult learning environment of university).[23]

CASE 4

MADDY REQUESTS CONTRACEPTION

Maddy, aged 16 years, has made an appointment to see you to request 'the rod'. She tells you that her friend has one and thinks it is awesome, and that she wants to use something that is safer than condoms. Her friend comes to your clinic. This is Maddy's first presentation to you as her family usually sees another local doctor. Maddy has come in on her own. She is a Year 9 student at the local high school. She is a non-smoker and tells you that she does not like drinking alcohol. On first presentation she looks well and healthy. Her periods are regular, between every 28–31 days and typically last 5 days. Menarche was at 13 years of age. She has no dysmenorrhea or symptoms suggestive of premenstrual tension.

QUESTION 1

Is Maddy able to consent to treatment with a hormonal contraceptive implant? What do you need to document in your notes? Do you need to discuss this with Maddy's parents?

QUESTION 2

What if this request was made by a young person aged 14 or 15 years? Does underage sex need to be reported? Does this fall under mandatory reporting?

FURTHER INFORMATION

Maddy has been sexually active with her boyfriend, Jack, aged 17 years, for a few months. She hasn't had any other sexual partners. She thinks Jack has had one other girlfriend. Maddy and Jack have had oral and vaginal sex. She tells you that they have always used condoms for vaginal sex with no slippages or breaks, and that they have not used condoms for oral sex.

QUESTION 3

Maddy is requesting the progestogen contraceptive implant. What are the important points to cover when counselling for this type of contraception? What are the benefits, side effects and contraindications?

QUESTION 4

What other contraceptive options are suitable for Maddy?

QUESTION 5

Maddy has come to see you on a school curriculum day and would find it difficult to return to your practice on a school day. Maddy is day 9 of a 28–31 day cycle. What options for timing of insertion can you discuss with Maddy?

QUESTION 6

Your advice to Maddy is to continue to use condoms to reduce the risk of STIs. What STI testing, if any, is appropriate for Maddy today? What sample/s would you use for testing?

FURTHER INFORMATION

You don't have time to offer implant insertion today, but you notice that your colleague who has recently trained in implant insertion has an available appointment in an hour, so you discuss this with your colleague and Maddy and they agree that you can provide Maddy with a prescription now so that she can attend for a Quick Start[11] insertion later in the day with your colleague.

QUESTION 7

What follow-up is needed?

CASE 4 ANSWERS

ANSWER 1

The ability for a minor under the age of 18 years to consent to treatment needs to be assessed against the laws of the relevant jurisdiction.

In South Australia, the *Consent to Medical Treatment* and *Palliative Care Act 1995* permits a child under the age of 16 years to consent to a medical treatment if this is corroborated in writing by at least one other medical practitioner who has personally examined the child before the treatment was commenced.[24]

In New South Wales, the *Minors (Property and Contracts) Act 1970* allows minors aged 14 years or over to consent to their medical treatment. However this Act also permits parents of children under 16 to grant consent, and does not deal with the potential conflict that may ensue.

Remaining jurisdictions are guided by the common law, and medical practitioners must determine whether the minor has the capacity to consider the treatment options and consequences. This is commonly referred to as the 'Gillick competent' child, or the 'mature minor'.[24] The level of intelligence and understanding required to validly consent is a question of fact. In assessing competency consider age, maturity, intelligence, education level, social circumstances (e.g. a HEADSS assessment[16]), as well as the complexity and nature of the treatment and associated risks.

In practice, a patient aged 16 requesting reversible contraception is likely to be a 'mature minor' and you should document their understanding of potential risks and benefits. Document that the young person is having (or would be having) sex and that it is in the best interest of the young person to have contraception.

In the case of a mature minor you do not need to obtain permission from a parent, but it is recommended that you discuss and document any pros or cons for the young person telling their parent. It is important that you discuss confidentiality and its exceptions[17] with Maddy.

ANSWER 2

A child who is 14 or 15 requesting contraception must generally be assessed as above in *Answer 1*.

The legal age of sexual consent in Australia is generally 16 or 17 years of age dependent on jurisdiction. Underage sex is dealt with by the relevant criminal codes, and in itself is not a reportable offence unless harm or abuse is suspected to be occurring. This would be similar to the situation of a patient disclosing use of illegal drugs. According to the Australian Institute of Family Studies, sex between peers who are close in age – with no power imbalance or violence – is not a legal issue. Therefore medico-legal assessment is generally around ability to consent to treatment as a 'mature minor' and the potential risk of harm.

Mandatory reporting obligations differ in each state and territory[25] and require a reasonable suspicion that a child has been, is being, or is likely to be harmed. An assessment of risk and protective factors, such as the HEADSS psychosocial assessment for adolescents, may be useful. If unsure, consult with a peer, medical defence organisation or discuss with the child protection agency in your state or territory.

ANSWER 3

It is important to discuss bleeding patterns when women begin using this form of contraception. All women will experience a change in their usual pattern and generally bleeding will become less regular. About 1 in 5 women experience amenorrhoea and 1 in 5 women experience prolonged, frequent or heavy bleeding.

Other adverse events listed in the product information as occuring in about 5% of women are headache, weight gain, acne, breast pain, emotional lability and abdominal pain. While mood changes, weight gain, headaches and loss of libido are reported, direct evidence is limited and there may not be a causal association with these. Acne may develop, worsen or improve. Local scarring may occur but is usually minor.[11]

The benefits of a long-acting progesterone implant include the highly effective contraceptive effect it has for a period of 3 years. This method is rapidly reversible and means that the woman does not have to remember daily oral contraception. Another benefit is that many women with dysmenorrhoea will experience an improvement in their symptoms.[11]

Contraindications listed in the product information to the use of a progesterone implant include pregnancy, breast cancer and other sex steroid sensitive malignancies, liver tumours (benign or malignant), severe liver disease, active thromboembolism and undiagnosed vaginal bleeding. The only absolute contraindication is breast cancer that has been active in the last 5 years.[11]

ANSWER 4

Other forms of contraception include combined hormonal contraceptives (the pill and the ring) and the progestogen contraceptive injection. An IUD could be considered if these methods were not suitable as nulliparity is not a contraindication to use.[11] Condoms are important in addition to these methods for STI risk reduction.

ANSWER 5

The options for timing include the traditional starting method and the Quick Start method. In the traditional starting method insertion is done on day 1–5 of the menstrual cycle, which gives immediate cover. If the woman is day 6 or later of her cycle, waiting for her next period to start contraception may increase risk of unintended pregrancy as a result of the delay.

The Quick Start regime can be used for most women and is particularly useful for women who need contraception that cycle, where it is difficult for a woman to return to initiate (e.g. receive implant insertion by a doctor) or if she has long or unpredictable cycles. Quick Start involves starting the hormonal method of contraception outside the recommended time even if the woman is beyond day 5 of the cycle. Using Quick Start balances the risk of conceiving while waiting to start the contraceptive method with the risk that an early pregnancy may not have been excluded. So, to reduce the implications of an unrecognised early pregnancy, the doctor needs to arrange a system for pregnancy testing in 4 weeks.

This recall and documentation is particularly important for methods such as the implant that can cause irregular bleeding and amenorrhoea, meaning a woman may be confused about symptoms of early pregnancy. The implant is rapidly reversible and inadvertent use early in pregnancy is thought to not affect the health of an ongoing pregnancy. If Quick Start is used, the method is not effective for the first 7 days. [11]

In summary, using Quick Start involves the following:

- starting beyond day 5 of the cycle, understanding the possibility that early pregnancy cannot be excluded
- using another method of contraception for the first 7 days
- carefully documenting instructions and putting in place a recall system for pregnancy testing in 4 weeks. In some patients it may be appropriate to check or remind them to do a pregnancy test at home rather than attend the clinic.

ANSWER 6

All young people under the age of 30 who are sexually active should be offered chlamydia testing.[6]

This can be done with first pass urine, vaginal (including self-collected), or cervical swab for PCR/NAAT testing. There is no role for blood testing for chlamydia. It is important to ask Maddy if she has been vaccinated for hepatitis B and human papilloma virus.[26]

A useful summary is provided in the STI testing tool on page 16.

ANSWER 7

Offer follow-up in:

- 4 weeks for pregnancy testing, irrespective of bleeding (could be done via phone call to check on home pregnancy testing)
- 3 months for implant check-up – this is good timing to discuss bleeding patterns and other adverse events.[11] At this time also follow up on safe sex messages and any need for further STI testing (e.g. change of partner).[27]

Maddy should start having Pap tests from age 18–20 years, and should be offered annual chlamydia screening.[6]

STI Testing Tool

Who? is the patient?	Why? would you do an STI test?	Which? STI	How? WHAT specimen do you need?	How? WHAT test do you order?
A sexually active young person under 29 years	This population is at higher risk for Chlamydia	Chlamydia	First pass urine **OR** Self-collected vaginal swab **OR** Endocervical swab	NAAT
		HBV	**Consider vaccination for HBV & HPV**	
A sexually active Aboriginal young person under 29 years	This population is at higher risk for Chlamydia * Can also be conducted as part of the Aboriginal health check - Medicare item 715	Chlamydia Gonorrhoea	First pass urine **OR** Self-collected vaginal swab **OR** Endocervical swab	NAAT
		HBV	Blood **Consider vaccination for HBV & HPV**	HBcAb
An (asymptomatic) person of any age requesting "a STI checkup"	The patient has requested it, so may be at risk. Ideally, take a sexual history to ascertain: a) if they fall into one of the groups below b) help you decide on sites for specimen collection	Chlamydia	First pass urine **OR** Self-collected vaginal swab **OR** Endocervical swab	NAAT
		HIV Syphilis HBV	Blood **Consider vaccination for HBV**	HIV Ab Syphilis EIA HBcAb
A man who has sex with men (MSM)	This population group is at higher risk for Chlamydia, Gonorrhoea, Syphilis, HIV, HAV, HBV	Chlamydia	First pass urine & anal swab	NAAT
		Gonorrhoea	Throat swab Anal swab	Gonorrhoea culture NAAT
		HIV Syphilis HAV HBV	Blood **Vaccinate for HAV & HBV**	HIV Ab Syphilis EIA HAV Ab (total) HBcAb
A sex worker	This population group is at higher risk for Chlamydia, Gonorrhoea, Syphilis, HIV, HBV See above for MSM sex workers	Chlamydia Gonorrhoea	First pass urine **OR** Self-collected vaginal swab **OR** Endocervical swab	NAAT
		HIV Syphilis HBV	Blood **Vaccinate for HBV**	HIV Ab Syphilis EIA HBcAb
A person who injects drugs	This population group is at higher risk for Chlamydia, Gonorrhoea, Syphilis, HIV, HBV and HCV* * HCV is not an STI but is included due to risks associated with injecting drugs	Chlamydia Gonorrhoea	First pass urine **OR** Self-collected vaginal swab **OR** Endocervical swab	NAAT
		HIV Syphilis HBV HCV	Blood **Vaccinate for HBV**	HIV Ab Syphilis EIA HBcAb HCVAb

Produced March 2012

HAV = Hepatitis A
HBV = Hepatitis B
HCV = Hepatitis C

HPV = Human Papilloma Virus

NAAT= Nucleic Acid Amplification Test (eg: PCR)

Information on vaccination www.immunise.health.gov.au
Information on HIV Pre & post-test discussion www.ashm.org.au/uploads/HIV_viral_hep_Chapter_9.pdf

Figure 1. STI Testing Tool. Reprduced with permission from RACGP et al. STI testing tool, 2012. Availalbe from www.stipu.nsw.gov.au/page/General_Practice_Resources/STI_Clinical_Management_2 (accessed 26 March 2013).

CASE 5

AL FEELS LIKE A BOY

Al, aged 19 years, is waiting to see you in the treatment room. You are working a weekend shift at your practice. The receptionist phones you when you have just finished seeing a patient, and says, 'I've just put a teenager in the treatment room with a knife wound'. You rush in to see an overweight young person with short hair, wearing a loose shirt and tracksuit pants, sitting on the treatment bed holding a cloth to their chest. You introduce yourself and your patient tells you in a husky voice that their name is 'Al'. You check the wound and see that it is a long very superficial incised wound across the upper chest, which has stopped bleeding. There are a few scars in the same area, which alerts you to the possibility of self-harm. Al has breasts that look female, but Al looks like a male. Wound management is straightforward, but you realise that there is more to this presentation, so you ask Al to come with you to your consulting room.

QUESTION 1

You are feeling confused as you are uncertain of Al's gender. How can you manage this situation sensitively?

FURTHER INFORMATION

Al tells you that he is a guy. He says he was called Alison as a child, but now only uses the name Al. He wants to be known as a male and has a history of self-harm and feels disgusted by his breasts. Al is unemployed and living with his older sister.

QUESTION 2

What do the terms transgender, transsexual and transvestite mean? Which may apply to Al? Is there a possible medical diagnosis?

QUESTION 3

Are transgender people usually also homosexual?

FURTHER INFORMATION

Al tells you that he has felt like a boy for as long as he can remember. He always preferred to dress in boys' clothes and play with boys' toys. At puberty he thought that he might be a lesbian, but later realised that his true gender was male. He hates his body and wants to get rid of his breasts and his 'monthlys'. He can't cope with studying because of his experiences of being bullied. He has lost his job and he feels rejected by his parents. His older sister is supportive of him and lets him crash on her couch as he has nowhere else to stay. Al seems pleased to have told you about this and agrees to return to see you for another appointment.

QUESTION 4

What initial steps can be taken to help Al with his distress and sense of gender incongruence?

QUESTION 5

What are other treatment options for AI in the future?

QUESTION 6

What is the role of the GP in ongoing care for transgender patients?

CASE 5 ANSWERS

ANSWER 1

If you are unable to identify the patient's gender, then this may be an indication that the patient is gender questioning or transgender. Rather than assume or guess a person's gender, it is best to ask.[28] For example, you could ask, 'AI: a guy or a girl?' or 'AI, can I clarify your gender, male or female?' Questioning in a clear and non-judgemental way will facilitate but not force disclosure of gender questioning or transgender identity. You may need to explain the relevance of asking these questions, and also to be respectful of silence if the person does not want to disclose this information. This might also be an opportunity for AI to tell you that many people confuse his/her gender.

ANSWER 2

Transgender refers to people who identify as the gender opposite to their assigned birth gender some, or all of the time. Transgender can be male to female (MtF or transfemale), or female to male (FtM or transmale). Generally use the pronoun 'she' for transfemale and 'he' for transmale. Transgender (or 'trans') is the term that applies to AI.

Transsexual refers to people who are making or have made the transition to their identified gender with hormone or surgical treatment. Transvestite refers to a man who is usually heterosexual and wears female clothes, at times for sexual pleasure.

AI may have a medical diagnosis of transsexualism,[29] which is a gender identity disorder in DSM-IV. This diagnosis involves a strong persistent cross-gender identity with associated significant distress and impairment of functioning. This diagnosis can assist patients who are seeking treatment such as hormonal therapy and gender reassignment surgery.

ANSWER 3

Gender identity doesn't determine sexual orientation. Generally trans people will identify their sexuality based on their core sense of gender self. So a transmale who is attracted to females is heterosexual.

ANSWER 4

AI's distress may be helped by initial steps to help him to 'pass' as a male. AI has already chosen a male form of his name, which helps him to pass as a male. Taking a male name and using the correct pronoun is also useful and AI needs to be supported in this. Passing may include dressing as a male, breast minimisation bras or breast binding. The use of the oral contraceptive pill in a continuous manner can reduce or relieve bleeding.

AI needs assessment for depression. He may also need referral to local services for employment or training and possibly housing assistance. AI can also be referred to a specific trans support service.[27]

ANSWER 5

If AI has persistent gender dysphoria (and as AI is over 18 years of age), he may be referred to a gender dysphoria clinic, although these are few in number and have long waiting times.[30] Psychiatric assessment is part of this process. Treatment options include speech pathology, hormone therapy (testosterone for transmen and oestrogen and anti-androgens for transwomen) and surgery. Surgery for transmen can include chest reconstruction, hysterectomy, oophorectomy and clitoral lengthening. Phalloplasty is rare and limited in success. There are conditions on timing of these treatments and Medicare funding is not available for all treatments. Some treatments are not reversible. Not all transgender patients have a strong wish for hormones and surgery.

ANSWER 6

The GP has important roles in caring for transgender patients.

- Have a non-judgemental attitude and be respectful of diversity.
- Remember that issues of gender and sexual orientation can change.[3]
- Provide support and a safe place and be prepared to take time.
- Be knowledgeable about gender diversity including common health issues for transgender patients such as depression, self-harm and suicidality.
- Monitor hormonal side effects and provide screening (e.g. Pap test).
- Support family members.
- Work to make your service respectful of diversity.
- Provide links or referrals to support groups, counselling or organisations. For some patients these may be some distance away, and websites may be particularly useful.

CASE 6

MELANIE IS HAVING TROUBLE BECOMING PREGNANT

Melanie, aged 30 years, has been attending your practice for many years. She sees several different doctors; this is the first time that you have seen her. In Melanie's record you see that she has a diagnosis of intellectual disability. She is taking an oral contraceptive pill containing 30 mcg ethinyl oestradiol and 150 mcg of levonorgestrel. Melanie tells you that she has made an appointment today because she is having trouble falling pregnant.

Melanie lives alone, with support from a case worker and support workers to help with housework and cooking. Melanie works doing packing in a factory in a supported environment. Melanie has a boyfriend, Jarred, also aged 30, who works in the same supported environment workplace. From the clinical record you can see that Melanie attends your practice regularly with her mother to obtain prescriptions for the pill.

QUESTION 1

How can you make sure that your communication with Melanie, who has an intellectual disability, is effective in this consultation?

QUESTION 2

Melanie wants to become pregnant but is on the pill. How can you check for understanding of the contraceptive action of the pill? How can you check for understanding about sex and family planning?

FURTHER INFORMATION

Melanie had thought that she was taking the pill to help her stay healthy. She didn't understand the word 'contraception', but did know that there were ways to stop a woman becoming pregnant and she understood about condoms. Melanie knows that a woman could become pregnant by having sexual intercourse. Melanie usually attends with her mother for prescriptions. Melanie tells you that her parents aren't very happy that she has a boyfriend.

QUESTION 3

Is it important for Melanie to give informed consent when being prescribed the pill?

QUESTION 4

Do Melanie's family have the right to insist that she uses contraception? What legal assistance may be obtained?

QUESTION 5

Do people with an intellectual disability have the right to make their own decision with regard to sexuality?

CASE 6 ANSWERS

ANSWER 1

It is important when communicating with Melanie to:

- keep sentences short – one idea at a time
- look for a shared understanding when using medical terminology and then use this term consistently
- use simple language and avoid jargon or abstract words
- check for understanding – ask Melanie to explain the information back to you
- avoid questions with a yes/no answer as these can be ineffective
- use literal pictures or models to explain[31] (e.g. simple black and white diagrams without labels)
- provide age-appropriate information in a developmentally appropriate way (for Melanie, this means providing information appropriate for a 30-year-old woman, but using communication strategies to make this developmentally appropriate)
- if examination or investigation is required, show the instruments that you will use and walk Melanie through every step, providing realistic expectations (e.g. discomfort, embarrassment)
- schedule longer or multiple appointments as needed.

For general issues related to sexual questioning of a person with a disability, see *Table 3*.

Table 3. Discussing sexual issues with a person with intellectual disability

See the person alone for at least part of the consultation if at all possible. If the person is unable to communicate without support, address questions directly to the person and observe their response to the question and to their support person's reply. Assume that the person understands more than they can express.
Ask the person's permission to discuss sexual issues. The person may need reassurance that it is acceptable to be sexually active and to talk about it.
Use plain language but accurate terms for body parts. If the person uses their own terms, clarifying meaning and matching the person's language may be useful.
Ask open ended questions as far as possible. However, be aware that the person's language skills may not allow detailed answers.
Visual material such as pictures or models can be very helpful, especially for a person with limited verbal skills
Reproduced with permission from Aust Fam Physician.[30] www.racgp.org.au/download/documents/AFP/2011/April/201104eastgate.pdf

ANSWER 2

Using a picture of a pregnant woman may assist this discussion. Suitable questions may include:

- What happened to this woman?
- How did the baby get inside her?
- What can a woman do if she doesn't want to get pregnant when she has sex?
- What can a woman do if she wants to have a healthy baby?

ANSWER 3

Commonwealth legislation supports and expects health professionals to provide sexual healthcare to people with an intellectual disability (*Disability Discrimination Act 1992*). There is the presumption of capacity to consent, unless this can be shown to be impaired. Melanie needs to have accurate information about her options and the potential consequences, and be able to make a decision using this information to consent to the pill.[32] Therefore she needs to understand the contraceptive effects of the pill to give her informed consent to this medication.

ANSWER 4

Melanie's family do not have the right to insist that she uses contraception.[31] In addition, Melanie has the right to confidentiality.

If a doctor wants to check if a patient has a medical guardian, the office of the public advocate/guardian[33] can be contacted to ascertain the details of the Guardianship order, or for further advice or support regarding the patient's capacity to consent and the possible involvement of a substitute decision maker.[34]

ANSWER 5

People with a disability have the right to sexual and reproductive health. They are able to have consensual sex and have the right to take risks (or choose unwisely). Health information and services may need to be presented in a different way to meet the needs of a person with a disability. Accurate and appropriate sexuality education is essential in improving the sexual and reproductive health outcomes of people with disabilities.

Women, or couples, with disability usually need support in family planning and parenting (as do many other groups in our community such as very young parents, or parents with other medical or mental health issues). This is a complex situation that may need exploration of issues, such as discussion of realistic plans for parenting.[31]

In Australia, all states and territories have legal restrictions around sterilisation for a person with an intellectual disability, and approval needs to go through the guardianship authority for adults[33] and the Family Court of Australia for children.

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RESOURCES FOR DOCTORS

SEXUALITY AND GENDER DIVERSITY

- *Standards of care for the health of transsexual, transgender, and gender-nonconforming people* Version 7 can be found in International Journal of Transgenderism 2011; 13:165–232, at www.wpath.org/documents/IJT%20SOC,%20V7.pdf
- A report on the health and wellbeing of transgender people in Australia and New Zealand can be found in Couch M, Pitts MK, Mulcare H, Croy S, Mitchell A, Patel S. *TranzNation: a report on the health and wellbeing of transgender people in Australia and New Zealand*. Melbourne: Australian Research Centre in Sex, Health and Society, 2007. Available from www.glhv.org.au/files/Tranznation_Report.pdf [accessed 28/03/2013].
- The Australian and New Zealand Professional Association for Transgender Health (ANZPATH) website includes service providers and links: www.anzpath.org/ANZPATH_Inc/Service_Providers.html
- A guide to gay, lesbian, bisexual, transgender and (GLBTI) intersex inclusive practice for health and human services can be found at Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing. *Well proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services*. Victoria: Department of Health, 2009. http://docs.health.vic.gov.au/docs/doc/75618B0EE0847E0FCA257927000E6EED/$FILE/Well%20Proud%20Guidelines%20updated%202011.pdf
- An informal tool to help you assess GLBTI people's access and quality of care at your service can be found at www.qahc.org.au/files/shared/docs/GLVH_HealthServicesAudit.pdf
- A guide to sensitive care for lesbian, gay and bisexual people attending general practice can be found at http://www.glhv.org.au/fact-sheet/guide-sensitive-care-lgb-people-attending-general-practice

CONTRACEPTION AND STIs

- Family Planning New South Wales, Family Planning Queensland, Family Planning Victoria. *Contraception: an Australian clinical practice handbook.* 3rd edn. Australia: Family Planning New South Wales, Queensland, Victoria, 2012, provides current, evidence-based, best practice recommendations for contraceptive delivery in Australia.
- The Sexual Health & Family Planning Australia website www.shfpa.org.au/home has links to state and territory organisations.
- National management guidelines for sexually transmissible infections are available from http://mshc.org.au/healthpro/Guidelines/NationalManagementGuidelinesForSTIs/tabid/278/Default.aspx
- The STI testing tool is available from www.stipu.nsw.gov.au/page/General_Practice_Resources/STI_Clinical_Management_2/
- STI testing guidelines for men who have sex with men are available from http://stigma.net.au/resources/STIGMA_MSM_Testing_Guidelines_2010.pdf
- An illustrated sheet showing the efficacy of contraceptive methods can be found at www.shfpa.org.au/images/stories/reports/170912_updated%20contaceptive%20ccard.pdf
- State and territory organisation websites for patient information can be found at www.shfpa.org.au/home

FEMALE GENITAL MUTILATION/CUTTING

- The FGM/C Service Coordination Guide and Care Plan Flow chart is available on Family Planning Victoria's website www.fpv.org.au/advocacy-projects-research/projects/female-genital-mutilation-cutting/

DISABILITY

- State and territory-based disability services can be found by searching for the individual state or territory name and 'disability services'. See the centre for Disability Health Victoria at www.cddh.monash.org
- AGAC member organisations by state and territory can be found at Australian Guardianship and Administration Council, www.agac.org.au/links, accessed 28 March 2013.
- *Australian medico-legal handbook* is an excellent resource (Kerridge I and Parker M, 2008, Church Livingstone Elsevier).

RESOURCES FOR PATIENTS

DISABILITY

- HealthyStart www.healthystart.net.au/ is a Commonwealth initiative which provides resources for mothers with learning disabilities and the professionals who support them.
- Family Planning Queensland www.fpq.com.au/publications/fsBrochures/Br_Contraception_Disability.php has produced a brochure *Contraception – Disability* for those with a disability.
- A book based on interviews with new mothers with a range of disabilities is: Judith Rogers, *The disabled woman's guide to pregnancy and birth*, New York: Demos Medical Publishing, 2005.

SEXUALITY AND GENDER DIVERSITY

- The National LGBTI Health Alliance (lesbian, gay, bisexual, transgender, intersex and other sexuality) website www.lgbthealth.org.au/. Includes a national member list and the resource *Respecting people at intersex trans and gender diverse experience*.
- Dude magazine http://dudemagazine.wordpress.com/ is a collection of various perspectives related to female to male transgender issues.
- The Gay and Lesbian Community Services www.glcs.org.au has a telephone counselling service: 9420 7201, 1800 184 527.
- Each state and territory has an AIDS council. The Australian Federation of AIDS Organisations www.afao.org.au/living-with-hiv/?a=5083 lists all state and territory councils.
- The National LGBTI Health Alliance www.lgbthealth.org.au is the peak health body for organisations that provide health-related programs, services and research targeting lesbian, gay, bisexual, transgender, intersex and other sexuality, sex- and gender-diverse people.

LOW LIBIDO

- Vivienne Cass, *The elusive orgasm: a woman's guide to why she can't and how she can orgasm*. Boston MA: Da Capo Press, 2007.
- King R. *Where did my libido go*? North Sydney: Ebury Press, 2010.
- General information on libido can be found at www.healthforwomen.org.au/images/stories/Education/Documents/info/libido.pdf and www.jeanhailes.org.au/resources/fact-sheets/fact-sheet-by-topic/604-libido

Sexuality and sexual health

In order to qualify for 6 Category 2 points for the QI&CPD activity associated with this unit:

- read and complete the unit of *check* in hard copy or online at the *gplearning* website at www.gplearning.com.au, and
- log onto the *gplearning* website at www.gplearning.com.au and answer the following 10 multiple choice questions (MCQs) online, and
- complete the online evaluation.

If you are not an RACGP member, please contact the *gplearning* helpdesk on 1800 284 789 to register in the first instance. You will be provided with a username and password that will enable you access to the test.

The expected time to complete this activity is 3 hours.

Do not send answers to the MCQs into the *check* office. This activity can only be completed online at www.gplearning.com.au

If you have any queries or technical issues accessing the test online, please contact the *gplearning* helpdesk on 1800 284 789.

FOR A FULL LIST OF ABBREVIATIONS AND ACRONYMS USED IN THESE QUESTIONS PLEASE GO TO PAGE 3.
FOR EACH QUESTION BELOW SELECT ONE OPTION ONLY.

QUESTION 1

Jenny, aged 51 years, has just started a new relationship. Her periods have been irregular for 6 months. She wants to know what contraception she should use. Of the following, what is the most likely first choice for Jenny?

A. Combined hormonal vaginal ring
B. Combined oral contraceptive
C. Progesterone-only pill
D. Injectable contraception
E. None needed.

QUESTION 2

Crys, aged 49 years, uses condoms for contraception. Her regular periods stopped 3 years ago; however, she continued to have irregular bleeding for 12 months. When could Crys stop using condoms?

A. After finding FSH levels >30 IU/L on two occasions 6 weeks apart.
B. She can stop now as she has been amenorrhoeic for more than 12 months.
C. She can stop now as she has been amenorrhoeic for more than 2 years.
D. She needs to continue using a condom for 12 months.
E. She needs to continue using a condom until the age of 55 years.

QUESTION 3

Brooke, aged 52 years, has been on the progesterone-only pill for several years. Her periods stopped 2 years ago. When should she stop using the progesterone-only pill?

A. After finding FSH levels of 30 IU/L or above on two occasions 6 weeks apart.
B. 12 months after finding FSH levels of >30 IU/L or above on two occasions 6 weeks apart.
C. After finding FSH levels of 50 IU/L or above.
D. After 12 months of amenorrhoea.
E. When she reaches the age of 55 years.

QUESTION 4

Enrica, aged 22 years, has an intellectual disability following a car accident as a young child. She lives with her mother and father and comes to the clinic with her mother, Maria. Enrica has met a man and wants to discuss contraception with you. Maria has indicated to you prior to this consultation that she wishes Enrica to have a sterilisation procedure as Maria considers Enrica will never be in the position to look after a child. Which of the following statements is true for this situation?

A. Enrica has an intellectual disability and should have a sterilisation procedure.
B. Enrica has an intellectual disability so her mother should make the decision about sterilisation.
C. Enrica has an intellectual disability so her parents jointly should make the decision about sterilisation.
D. Enrica has an intellectual disability so the situation should be automatically referred to the guardianship authority.
E. Enrica is over 18 years of age and therefore is presumed to have the capacity to make the choice about sterilisation for herself, unless the doctor deems that she lacks this decision-making capacity.

QUESTION 5

Which of the following is true about FGM/C?

A. It is commonplace in many countries.
B. It is a religious practice.
C. It is legal in Australia.
D. It involves fusing of the labia.
E. It involves removal of the clitoris.

QUESTION 6

Anton, aged 35 years, sees you for a regular check of his blood pressure. His family has attended the clinic for many years. He has a wife and a son aged 3 years. During the consultation he mentions that the relationship with his wife is not happy and he is in a relationship with a man. He wonders if he should have any tests. He has no symptoms of an STI. On further questioning he tells you he is not using condoms. What STI tests should you order?

A. Pharyngeal swab for gonorrhoea

B. Anal swab for gonorrhoea and chlamydia

C. Urine test for chlamydia

D. Serology for HIV, syphilis, hepatitis

E. All of the above.

QUESTION 7

How often should Anton (see Question 6) be advised to have these tests?

A. Every 2 years

B. Every 12 months

C. Every 3–6 months

D. Every 1–2 months

E. Every 2 weeks.

QUESTION 8

Taylor, aged 26 years, is a school teacher who has just met someone. She is at the start of a new relationship. She would like to know more about her contraceptive options. What are the advantages of using a progestogen implant method of contraception?

A. It provides immediate contraceptive cover.

B. It provides long-term protective cover for 3 years and is easily reversible.

C. It protects against STIs.

D. It can be used in clients with breast cancer.

E. It doesn't require follow-up.

QUESTION 9

Leila, aged 27 years, is a designer who comes to see you in a distressed state. She came home early from work 2 days ago and found her long-term boyfriend Jeremy dressed in her clothes. She was embarrassed and didn't know how to handle the situation. He reassured her and told her that a previous girlfriend didn't mind but she has come to discuss the situation with you. She is worried about the implications for her relationship.

What is the most likely definition/explanation for this type of behavior?

A. Jeremy is transgender.

B. Jeremy is transsexual (MtF).

C. Jeremy is transvestite.

D. Jeremy has gender identity disorder.

E. Jeremy is homosexual.

QUESTION 10

Grace, aged 19 years, is a university student who comes to see you requesting a Pap test. She has been sexually active since the age of 17 with the same partner. What sort of STI testing should be offered to all patients under the age of 30 who are sexually active?

A. Syphilis

B. Chlamydia

C. HIV

D. Gonorrhea

E. There is no need to offer any testing.