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Sexually transmitted diseases among psychiatric patients in Brazil

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ABSTRACT

Sexually transmitted diseases are still highly prevalent worldwide and represent an important public health problem. Psychiatric patients are at increased risk of sexually transmitted diseases but there are scarce published studies with representative data of this population. We sought to estimate the prevalence and correlates of self-reported sexually transmitted diseases among patients with mental illnesses under care in a national representative sample in Brazil ($n = 2145$). More than one quarter of the sample (25.8%) reported a lifetime history of sexually transmitted disease. Multivariate analyses showed that patients with a lifetime sexually transmitted disease history were older, had history of homelessness, used more alcohol and illicit drugs, suffered violence, perceived themselves to be at greater risk for HIV and had high risk sexual behavioral: practised unprotected sex, started sexual life earlier, had more than ten sexual partners, exchanged money and/or drugs for sex and had a partner that refused to use condom. Our findings indicate a high prevalence of self-reported sexually transmitted diseases among psychiatric patients in Brazil, and emphasize the need for implementing sexually transmitted diseases prevention programs in psychiatric settings, including screening, treatment, and behavioral modification interventions.

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Introduction

Sexually transmitted diseases (STDs) are still highly prevalent worldwide. According to the 2005 World Health Organization (WHO) estimates,[1] 448 million new cases of curable STDs (e.g., syphilis, gonorrhea, chlamydia, and trichomoniasis) occur annually throughout the world, not including HIV and other STDs (like herpes or hepatitis), and, among these, 50 million cases occur in the Americas.[1]

In 2005, the Brazilian Ministry of Heath evaluated the prevalence of STDs on three different populations in six Brazilian capitals: pregnant women, male workers from small industries (both considered to be at an average risk for STDs), and patients from an STD clinic (male and female sample of a group regarded as having a high-risk sexual behavior).[3] The prevalence of at least one STD in each of these three populations was, respectively, 42.0%, 5.2% and 51.0%. The prevalence of STDs was higher among younger age groups (20 years old

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or less), among those with multiple partners, who practised unsafe sex, anal sex, and in those who used injected drugs. In another national survey,[4] 35.6% of truck drivers reported a lifetime history of STD and, relative to those without STD history, they were older, consumed more illicit drugs, had been incarcerated more often, and had more sex with sex workers.

STDs also represent an important public health problem due to their complications such as neonatal syphilis – which may result in stillbirth, neonatal death or malformation[1]; cervical cancer caused by human papilloma virus (HPV)[5]; and pelvic inflammatory disease and infertility due to *Chlamydia*.[5] In addition, STDs, especially genital ulcerative diseases, can facilitate transmission and acquisition of HIV.[6] A study[7] using anonymous HIV testing and counseling program, conducted in Taiwan from 2006 to 2010, showed 10.7% of participants with at least one STD and 3.5% with HIV in that sample. In the same study, the HIV prevalence was 14.7% among patients with previous STDs, while among those without STDs history it was only 3.0%.[7]

Patients with chronic mental illness are at increased risk of STDs and present elevated rates of high risk sexual behavior.[8] A national sample of psychiatric patients in Brazil[9] demonstrated that these patients are sexually active at rates that are similar to those of the overall adult Brazilian population.[10] Furthermore, only 16.0% of these psychiatric patients used condoms in the last six months, in comparison to 20.6% among estimates for the overall Brazilian adults during the last year.[11] In addition, the use of psychoactive drugs was higher among psychiatric patients compared to the general population, 25.1%[9] and 8.9%,[12] respectively. In the same sample of psychiatric patients,[9] unprotected sexual behavior was associated with having sex under the influence of alcohol and having multiple sexual partners.

However, there are few published studies addressing STDs among patients with psychiatric illnesses.[13] A systematic review indicated that most of the published studies on this population are from developed countries and are based on relatively small and non-representative samples.[14] The prevalence of selected STDs among psychiatric patients varied from 0.8% to 29.0% for HIV; from 1.6% to 66.0% for Hepatitis B; from 0.4% to 38.0% for Hepatitis C; and from 1.1% to 7.6% for syphilis.[14] Over one-third (38.0%) of a sample of patients from two American psychiatric hospitals reported a lifetime history of one or more STDs.[15] HIV-related knowledge, greater self-perceived HIV risk, higher intention to use condom and higher rates of unprotected vaginal and anal sex emerged as significant correlates of a prior STD.

The objective of this study was to estimate the prevalence and correlates of lifetime self-reported STDs among patients with mental illnesses under care in a national representative sample in Brazil.

Materials and methods

Study design and participants

The sample for the current analysis was drawn from a larger national multicenter cross-sectional study conducted in 11 public psychiatric hospitals and 15 public mental health outpatient clinics (CAPS) in Brazil in 2006, designed to assess risk behavior and sexually transmitted infections/HIV prevalence in a national representative sample of patients with chronic mental illnesses under care ($n = 2475$) previously described.[16,17] Briefly, participants had be 18 years old or over and be capable of providing written informed consent.

A preliminary assessment was carried out by mental health professionals in order to evaluate the subjects' capacity to participate and sign the consent form – those with delusional symptoms, acute psychosis and a severe degree of mental retardation were not eligible. Ethical approval was obtained from the Federal University of Minas Gerais (UFMG/ETIC 125/03) and the National Ethical Review Board (CONEP 592/2006), and all participants signed written informed consent. For the current analysis, only those participants who reported being sexually active at least once in life were included ($n = 2145$).

Data collection

A semi-structured person-to-person interview was conducted using a previously tested and validated questionnaire.[17] It was administered by experienced and trained mental health care professionals and aimed at obtaining sociodemographic, clinical and behavioral data. The main outcome in this analysis was lifetime self-reported history of STDs and it was assessed with the question: "Have you had any disease transmitted through sexual intercourse or venereal disease?". Additional questions were asked regarding three main syndromic groups (genital/anal ulcerative diseases, warts, and discharge) and specific STD medical diagnoses (e.g. syphilis, herpes, chancroid, chlamydia, gonorrhea, lymphogranuloma venereum, and condyloma).

Good to excellent reliability (intra and inter-rater) was found for all self-reported data used in the present analysis, including being sexually active (kappa = 0.76) and having an STD history (kappa = 0.70).[18]

Explanatory variables included in this analysis were: sociodemographic data (e.g. age, gender, skin color, marital status, schooling, family income, living situation, history of homelessness); clinical characteristics (e.g. type of recruitment center, psychiatric diagnosis, STD history, previous psychiatric hospitalization, previous HIV testing); and, behavioral data (e.g. lifetime tobacco, alcohol, illicit drug and injection drug use, sex under the influence of alcohol/drugs, lifetime unprotected sex, having a partner that refused to use condom, exchanging money/drugs for sex, number of sexual partners, age at first sexual intercourse, lifetime verbal physical or sexual violence, lifetime incarceration, HIV/AIDS knowledge, and self-perception of HIV risk).

Psychiatric diagnoses were obtained from medical charts and were coded according to the International Classification of Diseases-10th Edition (ICD-10). When more than one psychiatric diagnosis was present, these were hierarchically grouped according to clinical severity as follows: (1) schizophrenia (and other psychotic disorders), depression with psychotic symptoms and bipolar disorder; (2) depression, anxiety and others (3) substance use disorder. Living conditions at the time of the interview were defined as stable, when participants reported living in houses, apartments, or hospitals, or unstable, when

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