

Clinical Guidelines

...for Sexual

Health Care of

Men

who Have

Sex

w i t h

Men



IUSTI Asia Pacific Branch

The Asia Pacific Branch of IUSTI is pleased to introduce a set of clinical guidelines for sexual health care of Men who have Sex with Men. This guideline consists of three types of materials as follows:

- 1. The Clinical Guidelines for Sexual Health Care of Men who Have Sex with Men (MSM)**
- 2. 12 Patient information leaflets (Also made as annex of item 1 above)**
 - o Male Anogenital Anatomy
 - o Gender Reassignment or Genital Surgery
 - o Anogenital Ulcer
 - o Genital Warts
 - o What Infections Am I At Risk Of When Having Sex?
 - o Hormone Therapy for Male To Female Transgender
 - o How To Put On A Condom
 - o Proctitis
 - o What Can Happen To Me If I Am Raped?
 - o Scrotal Swelling
 - o What Does An STI & HIV Check Up Involve?
 - o Urethral Discharge
- 3. Flip Charts for Clinical Management of Sexual Health Care of Men Who Have Sex with Men (Also made as an annex of item 1 above)**

The guidelines mentioned above were developed to assist the following health professionals in Asia and the Pacific in providing health care services for MSM:

- Clinicians and HIV counselors who work in hospital outpatient departments, sexually transmitted infection (STI) clinics, non-government organizations, or private clinics.
- HIV counselors and other health care workers, especially doctors, nurses and counselors who care for MSM.
- Pharmacists, general hospital staff and traditional healers.

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Disclaimer

These guidelines are, often sexually explicit. This is necessary for educational purposes. The guidelines are intended for health professionals only and are not to be distributed publicly or to minors.

Note

The naming of individual surgeons specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the author and Technical Advisory Group in preference to surgeons, or similar products that are not named.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
IUSTI	International Union against Sexually Transmitted Infections
MSM	Men who Have Sex with Men
NGO	Non–Governmental Organization
STI	Sexually Transmitted Infection
WHO	World Health Organization

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Introduction

These guidelines have been developed to assist clinicians, counselors and other health care workers, especially doctors, nurses and counselors who care for men who have sex with men (MSM) and for transgender people in Asia. As used in this document, the term “MSM” includes all biological males who have any type of sexual contact with other biological males. The transgender people with whom the guidelines are concerned are those who are born male but live or wish to live in a feminized social role. The guidelines do not address the specific needs of those who are born female and wish to live in a male social role.

The guidelines are principally intended for clinicians and counselors who work in hospital outpatient departments, sexually transmitted infection (STI) clinics, non-government organizations and private clinics. Drug sellers, general hospital staff and natural healers may also find the guidelines useful. ***However, the guidelines are not intended to replace proper training in sexual health care.***

It is understood that few clinicians in such settings in Asia have any substantial knowledge of either the theoretical background or ‘real life’ context of the lives of MSM or transgenders. Accordingly, these guidelines offer substantial information that is otherwise very difficult for clinicians to access in their professional lives providing sexual health care to MSM and transgenders. In particular, information about sexuality, gender identity, gender reassignment surgery and related issues are given more attention in this volume than they would usually receive in other guidelines that are more narrowly focused on managing sexually transmitted infections (STIs) in other populations. It is acknowledged that, in most resource-poor settings, few individuals would be able to afford expensive options such as gender reassignment surgery.

However, clinicians in such settings are often expected to have knowledge and to give well-informed advice on such topics. In other settings, notably Thailand, gender reassignment surgery or other feminizing plastic surgery is common. Thus, the content on these topics is expected to fulfill a range of needs for clinicians supporting MSM and transgenders in Asia and the Pacific.

These guidelines provide generic information only and are not country-specific. It is anticipated that various stakeholders at national level might adapt the guidelines for local use with particular attention to local guidelines for STI management. The use of these guidelines in programs targeted at MSM and transgender people will augment efforts for the prevention and care of HIV (human immunodeficiency virus) infection and other STIs.

Aim

The aim of these guidelines is to:

- improve the sexual health of MSM and transgender people in Asia and the Pacific by assisting with information and training.
- provide practical guidelines in the provision of sexual health care to MSM and transgender people.
- Suggest appropriate standards of care for MSM and transgender people.

The need for these guidelines arose from observations of inadequate quality of sexual health care for MSM and transgender people in various settings in Asia - especially in the areas of:

- sexual history taking, examination, diagnosis and general clinical management,
- managing anorectal conditions including those caused by STIs,
- transgender hormone therapy and gender reassignment surgery,
- psychosocial issues of concern to MSM and transgender people, and
- STI and HIV prevention, education and counseling.

Also, while there are generic guidelines for the syndromic management of STIs in most countries in Asia, the existing guidelines typically neither make specific mention of the management of anorectal STIs nor specifically address psychosexual issues for MSM and transgender people.

Sexual Health: A working definition

Sexual and reproductive health is one of the most important and sensitive areas of human experience. Many attempts have been made to define what we mean by sexual health. One of the most durable definitions was written some 30 years ago for a World Health Organization (WHO) document on the training of health workers in sexuality issues.

Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love. Fundamental to this concept are the right to sexual information and the right to pleasure.¹

WHO also included the following elements in the definition from an earlier report:

A capacity to enjoy and control sexual and reproductive behavior in accordance with a social and personal ethic; Freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationships; and Freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions.²

Many implications for sexual and reproductive health services flow from such a definition. Some of these relate to the challenges of integrating STI services into long-established and institutionalized services for family planning and maternal and child health. These efforts have been given substantial political support as a result of global conferences such as the International Conference on Population and Development held in Cairo in 1994 and others since then. Inevitably, such efforts are rarely inclusive of the special needs of MSM and transgenders.

However, there are even broader implications that relate to other social issues such as:

- Community attitudes to sexual issues (including sexuality, fertility, sex work and pre-and extramarital sexual activity)
- Roles of religious and moral leaders in community discourse on sexual matters
- Roles of health workers in community discourse on sexual matters
- Appropriate settings and ages for education of children on sexual and reproductive health issues
- Need for sexually explicit messages and materials in sexual health education of various audiences
- Measures to address stigma and discrimination based on sexuality, STI and HIV status and unplanned pregnancy
- Need to educate health and education professionals in sexuality issues beyond the biomedical aspects of STIs, contraception, obstetrics and gynecology

References

1. WHO Technical Report Series Nr. 572, *Education and treatment in human sexuality: the training of health professionals*. Geneva, 1975.
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Reorienting the Clinical Environment

1

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Reorienting the Clinical Environment

This chapter provides guidelines for the development of a health care environment that is welcoming and friendly for MSM and transgender people. It is a basic principle of health promotion to make health services accessible and acceptable to the community they serve.¹

Many MSM and transgender people experience ridicule, humiliation, violence and imprisonment as a result of disclosing their sexual behavior to health care providers. Research has shown that fear of discrimination and stigma cause many MSM and transgender people to postpone or decline seeking medical care. Others, once in care, withhold personal information that may be critical to their care. It is therefore no surprise that a clinical environment can be very threatening to MSM and transgender people when presenting with anogenital symptoms or being asked questions related to sexual behavior. Undisclosed behavior, especially anal sex and symptoms lead to poor clinical care by the clinician and poor health outcomes for the patient.²

Some health care providers believe they have no MSM or transgender clients or staff in their facilities; many are unsure about what their role should be in identifying and addressing MSM and transgender issues and few have policies to guide staff or clients.

Using external cues, clients will have formed views about the friendliness of a service before they arrive or speak to a member of staff. For example, the location of the service (is it easy to get to?), the opening hours (are they convenient for the staff or the clients?), service signage (is it discreet, or confronting by revealing the intentions of those who enter?), the availability of community newspapers (do they reflect the values of the readers?) and clinic decoration (does it reflect community issues or tastes?) all provide correct or incorrect impressions of the service. New clients may already have spoken to other clients of the service about how friendly the staff are or what happens to you when you attend. The client will also be sensitive to language and manners that suggest discrimination against them when they approach reception staff or complete registration forms. While waiting, the client may hear staff speaking to new clients at the reception area or on the telephone and note how much personal or identifying information is discussed publicly. Are there client brochures available—about the service and how it operates—about sexual health problems—and are they written in an easily understood manner? All of this happens before the new client has even seen the doctor!

One basic approach to service development maximizes the success of any reorientation initiatives. Actively seek the views of the MSM and transgender communities. An active engagement with the MSM and transgender communities during service development will demonstrate that your service seeks and values the views of the communities and that there is a commitment to their health care. By contributing their knowledge to the clinic operations, MSM and transgender community members also develop a sense of ownership of the success of the service and therefore share the rewards and help to seek solutions to any failures.

MSM and transgender community input can help with decisions about the scope of services, location, times and signage for the clinic, what decorations are in the clinic (and even creating the decorations), pilot testing the client sexual health literature and registration forms and participating in the recruitment of new staff.

During service delivery, many specific issues arise that are beyond the scope of these guidelines; these issues will require local solutions. Most challenges to service delivery can be overcome by a process of adequate consultation and negotiation between affected parties. Solutions in one service cannot always be duplicated exactly in another clinic but can provide ideas and directions. An example of a specific service challenge is when male-to-female transgender clients in a general STI clinic wish to use the women's toilet or sit in the women's waiting room in a clinic where there are separate rooms

for men and women.

It may be a female sex worker clinic session during which transgender sex workers also attend, or an MSM clinic session for which there is only a male toilet. Some clinics and clients have no problem with this arrangement; in others, both the female and male clients complain about it. Consultation with the affected parties usually reveals the true problem (is it a specific individual or a larger issue?), a solution and/or a compromise that will work for most clients most of the time. Solutions include having separate men's, women's and other (or "unisex", meaning any sex) toilets and having separate clinic times. Notices should inform clients and the affected communities about the agreement reached during consultation and staff should be prepared to revisit the decision at any time. Staff will also need to be prepared for the times when the arrangement does not work, to prevent escalation of conflict and disruption of the service.

General guidelines for MSM and transgender health care services*

There are six key areas that require attention when orienting services to MSM and transgender clients:²

1. Clinic staff
2. Client rights
3. Client reception
4. Service planning and delivery
5. Confidentiality
6. Community relations

Within each key area there are two or more applicable standards. **These offer minimum standards for the conduct of a clinic.** It would be unrealistic to expect that all of these policies could be adopted and implemented immediately. Therefore, a step-by-step approach should be explored with the full inclusion of staff and clients alike. Examples are provided of quality indicators within each area to assist with fulfilling the standard.

Key area 1: clinic staff

Standard 1. Employment of qualified MSM and transgender staff at the clinic where possible

The strongest indicator of a non-discriminatory, welcoming workplace for MSM and transgender clients is the employment of MSM and transgender staff. Even when it is not obvious to clients that these staff belong to these communities, the staff possess unique knowledge and skills that will not only benefit the clients but also assist with training other staff in behavioral and cultural issues. MSM and transgender staff should be visible to clients and not employed only on hidden tasks. Their visibility is one of the key assets of the service.

Indicator: Active recruitment and employment of qualified MSM and transgender staff.

Indicator: Written recruitment policies in favor of diversity and opposing discrimination and harassment in relation to MSM and transgender staff.

* Adapted with permission from the Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients. Gay, Lesbian, Bisexual, and Transgender Health Access Project, Boston.



Standard 2. A workplace free of discrimination and harassment for MSM and transgender staff

Once employed in the service, MSM and transgender staff must have the same workplace and employment conditions as other staff. This may be viewed as “special treatment” by heterosexual and non-transgender staff who are familiar with the usual discrimination, harassment and abuse of MSM and transgender people in their community. However, equal terms and conditions of employment must be vigorously enforced for MSM and transgender staff. Without the safety of this equality, the service will simply reinforce the destructive aspects of MSM and transgender people’s lives rather than serve as an environment in which staff can work effectively for their communities. If a service is unsafe for MSM and transgender people to work in, it will be seen by their communities as a clinic that is also unsafe to attend as a client and it will be counterproductive to the promotion of MSM and transgender health. When a service is reorienting towards the MSM and transgender community, non-MSM and transgender staff need to be included in workplace changes to ensure they can voice their views and acquire the necessary skills and attitudes. Further, it should not be assumed that MSM understand transgender issues or vice versa.

Indicator: Written notice to all employees that discrimination against or harassment of other employees in relation to MSM and transgender issues is not allowed and that disciplinary action may include dismissal.

Indicator: Annual review of all policies with staff input and training.

Indicator: Posting of staff non-discrimination and harassment policies prominently in clinic.

Indicator: Development and implementation of policies to ensure effective procedures for dealing with staff complaints of discrimination or harassment related to MSM and transgender issues.

Indicator: All staff provided with training in MSM and transgender cultural and behavioral issues at the start of their employment and regularly thereafter.

Key area 2: client rights

Standard 3. Policies for non-discriminatory service delivery

High-quality sexual health care cannot be delivered to MSM and transgender people in a discriminatory clinical environment. A high-quality service has comprehensive policies prohibiting discrimination in the delivery of services to MSM and transgender clients. Staff need to learn and use culturally appropriate language when dealing with MSM and transgender clients. Written forms and policies will also need to use such language. Information brochures about the policies should be provided to clients when they attend and posters clearly outlining the anti-discrimination policies of the service should be prominently displayed. The policies will need to be discussed regularly during clinic promotion to the MSM and transgender communities. Examples of unacceptable discriminatory practices by clinics and doctors include requiring male-to-female transgender clients to wear male clothes in the waiting room, staff leaving early from or arriving late to an MSM clinic; rushing examinations; and not asking MSM or transgender people about sex with women.

Indicator: Written policies stating that the service does not discriminate against MSM and transgender people in the provision of services.

Indicator: Conspicuous posting of anti-discrimination policies in appropriate language, including in clinic brochures and other informational and promotional materials.

Indicator: Mechanisms to ensure that anti-discrimination policies and procedures are appropriately conveyed to all clients, including those with learning and language difficulties.

Indicator: All staff are required to agree to these policies under the terms of their employment.

Standard 4. Complaints procedures for anti-discrimination policies

Once anti-discrimination policies are written and implemented it is important to know whether they are effective. The effectiveness of policy implementation can be assessed in several ways, such as observing interactions between staff and clients in the clinic, seeking the views of clients or having a clear process by which clients can complain about the service. Criticism or complaints are often viewed negatively because they are often delivered with strong emotion and are about something that has gone wrong. But it need not be this way. Criticism is an opportunity for the service to reflect on a staff–client interaction in detail and to review the expectations of the service and community. Community members must feel that they can provide feedback (or criticism) and staff must respect this right. On the other hand, managers must ensure that staff members are not victimized in the process but are supported so that they can learn from a complaint.

Services should have comprehensive and easily accessible procedures in place for clients to file and resolve complaints alleging violations of anti-discrimination policies.

Indicator: Written complaint procedures.

Indicator: One or more staff members responsible for ensuring that the clinic complies with the policy.

Indicator: Conspicuous posting of complaint procedures, inclusion of procedures in clinic brochures and in informational and promotional materials given to clients.

Key area 3: client reception

Standard 5. MSM and transgender sensitive clinic reception procedures and staff

The first person to greet a client in most clinics is a receptionist or administration clerk who will need to adopt an open, welcoming and non-judgmental manner. Commonly, the clerk's main task during reception is to gather identifying information to create a unique client record (usually with a unique record number) to be used by staff at the clinic. This information usually includes personal and family names, date of birth, sex and contact details and is gathered by asking the client to complete a form or brief questionnaire. Clients should not be asked to show official identification papers. This reassures them that there is no link between the clinic and official (usually government) agencies. Clients with low literacy skills need assistance.

Clients must be reassured that their personal information is confidential (see below under Key area 5: confidentiality) and given a brief explanation why this information is gathered and how it is protected. Clients should be encouraged to provide true details because false details may jeopardize their care by creating confusion between clinic records. However, when clients are hesitant, they should be offered the option of providing a minimum of three pieces of identifying information such as a first name, a birth date and sex, for example "Mohamed, 10/12/1970, male." If the information appears to be false, the client should be told to remember the information because it will be used to confirm the medical record and number for any subsequent visits.

Providing an "other" option for sex in addition to male and female shows a sensitivity to transgender clients who do not wish to identify as either male or female. Reception staff also need to be familiar with culturally appropriate language, behavior and manners of MSM and transgender people. Registration forms should allow optional self-identification of gender identity and marital or partnership status. Clients should have an opportunity for further written or verbal explanation about the registration procedure

The role of the reception clerk is pivotal to the smooth operation of the clinic, so a strong investment in cultural training and technical skill is essential. In summary, the key elements of good client

reception are:

- Open and friendly manner
- Creating a unique client record and number
- Explaining why identifying information is needed
- Reassuring the client about confidentiality
- Gathering a minimum of three items of identifying information
- Investing in skill development for reception staff

Indicator: All reception staff are trained to use appropriate language for MSM and transgender clients.

Indicator: Development and implementation of appropriate registration forms.

Key area 4: service planning and delivery

Standard 6. *Culturally competent in MSM and transgender issues services*

An effective reorientation of a clinic to meet the needs of the MSM and transgender community can occur only if all staff members have a basic familiarity with MSM and transgender cultures and manners. This should include an understanding of the issues affecting their lives including discrimination, harassment, poverty, victimization, rejection by families, and unemployment. External members of management boards should also undertake such training. Some staff will have greater skill than others in managing MSM and transgender issues and an early referral to these staff will ensure the best health care outcome for the client.

Indicator: Development and implementation of training for all staff on basic MSM and transgender issues including diversity, harassment and anti-discrimination.

Indicator: Creation and implementation of mechanisms for identification of staff with special expertise in and sensitivity to MSM and transgender issues.

Indicator: Development of a comprehensive resource list for appropriate referrals for special MSM and transgender health concerns.

Indicator: Outreach to and development of relationships with other agencies and providers with expertise in MSM and transgender health issues.

Indicator: Evidence of cooperation with other services to whom MSM and transgender clients may be referred for specialized care.

Key area 5: confidentiality

Standard 7. *Confidentiality as a cornerstone of sexual health care*

Confidentiality is a cornerstone of high-quality sexual health clinical care. Clinics need clear confidentiality policies that are vigorously enforced and publicized. Staff orientation and regular training need to cover confidentiality of client data, including information about sexual behavior and transgender issues. MSM and transgender clients should be informed about data collection that includes references to sexual behavior and/or gender identity, including the circumstances in which such information may be disclosed, whether it may be disclosed as aggregate or individual information, whether personal identifiers may be disclosed, and how and by whom such information may be used.

A simple approach that covers most of these issues is to have a clinic policy that prevents release of any identifying information about a client without the written consent of the client. De-identified, aggregate data is commonly used for service planning and evaluation and should not pose a serious threat to a

person's confidentiality. However, if there are very few people with a specific condition or behavior from a defined location, care will be needed as a community and individual members of the community may then be identifiable within aggregate data.

There are many ways to maintain confidentiality within the clinic. For example, when discussing cases or calling a patient from the waiting area, some clinics use only the client's first name (although when the patient's name is common, their identity will need to be confirmed once in a private space, say by asking them for their family name), while others use only the client's registration number when referring to patients. Care will also be needed when discussing a patient's sexual health care with colleagues to ensure that names, diagnoses, behaviors or gender issues are not linked, if the discussion can be overheard by others.

Indicator: Written confidentiality policies explicitly include sexual behavior and gender identity as highly sensitive information, treated as such.

Indicator: Sexual behavior and gender identity designations are optional on forms and records.

Indicator: Comprehensive training for staff on data collection and reporting issues, especially confidentiality.

Indicator: Written notice to patients explaining when their information may or must be disclosed to others and when this may include information about sexual behavior and gender identity.

Standard 8. Privacy

Another important aspect of patient confidentiality is privacy. Many clinics have space restrictions and struggle to provide a quiet, private and comfortable space for sexual health consultations. A flimsy curtain on a doorway is a poor sound barrier and is open for people to walk through without warning, even if this is accidental. A consultation cannot be confidential if it is not private. Patients are asked to disclose intimate personal details about their lives and then to undress, exposing the most personal part of their body to a person they do not know. A screen between the interview desk and the examination couch allows patients some privacy while they undress. For a comfortable and effective consultation, the basic requirements are a room in which the consultation cannot be heard or seen by others (preferably with a door and, when the door is closed, a sign alerting outsiders that a consultation is in progress), and where there will not be any interruptions (except in emergencies). Knocking on doors should be standard clinic practice to alert room occupants that someone wishes to enter. The occupants can then provide their permission if it is convenient. Also, the patient must provide their consent to other people being in the room, including chaperones.

Indicator: Separate, private, patient consultation room. The room should have a door and a "consultation in progress" sign, and be arranged so that others outside cannot hear the consultation.

Indicator: A patient privacy screen between the interview desk and the examination couch.

Indicator: Policy and practice that staff knock on the consulting room door before entering a room. Permission to enter must be granted by the occupants.

Standard 9. MSM and transgender youth and children issues

In some countries and states, the sexual health care of MSM and transgender youth who are children or minors (as defined by local laws) may be complicated by a clinic's legal obligations to report child sexual abuse to government agencies. The clinic should be familiar with country and state laws on whether minors can give consent for care and treatment. Staff should be trained and clients of the service who are minors informed of various mandated reporting laws and their implications.

Indicator: Staff training on the legal rights (if any) of children and youth.



- Indicator:** Development and implementation of procedures for care of children and young people that is sensitive to gender identity and sexual behavior.
- Indicator:** Written and oral notice to minors of legal requirements and of their rights regarding confidentiality and treatment without parental consent.
- Indicator:** Reception staff trained to be sensitive to issues of MSM and transgender youth.

Key area 6: community relations

Standard 10. *MSM and transgender community input to board of directors*

Just as employing MSM and transgender staff helps to reorient a clinic, opportunities for representation from MSM and transgender communities on the clinic board of directors and other institutional bodies should be encouraged. This representation demonstrates transparency in the procedures required to operate clinics and will, for example, allow for early input from community members to policy changes affecting them and ensure support for the implementation of the policies.

Indicator: The process for electing and appointing members of boards of directors and other institutional bodies includes MSM and transgender candidates.

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2. Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients. Boston, MA: Gay, Lesbian, Bisexual, and Transgender Health Access Project, 2001. At www.glbthealth.org. Accessed January 14, 2004.

Human Sexuality

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Human Sexuality

Sexuality is an important aspect of being human. It is experienced and expressed in many ways and influenced by many factors. The World Health Organization defines “sexuality” as:

“... a central aspect of being human throughout life [which] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.”¹

However, while not all of these dimensions of sexuality need be expressed or experienced, our sexuality is expressed and experienced in what we are, feel, think and do. With such a complex definition, it is essential to keep an open mind when dealing with any aspect of sexuality. The sexual world of each person is unique.

Sexual behavior

Sexual activity is a basic and universal behavior. However, humans are not “driven” by an inner force to have sex. Such a concept assumes living organisms are inert and must be driven to activity. Humans are alive and manifest sexual behavior along with other kinds of activities. For example, speaking, laughing, walking and reading all occur without a respective drive.²

The biological factors leading to human sexual arousal and orgasm are common to men and women, but how we think, feel and behave concerning erotic responses are socially learned.³ While there is great variation in the sexual behavior of humans, there appear to be two major outcomes of erotic beliefs and customs: physical pleasure and psychological intimacy. These outcomes are both very powerful and they reinforce each other. The joy of sexual arousal and orgasm, and the feelings of physical and psychological intimacy provided by sexual contact, are incomparable experiences. People seek this joy in ways unique to their sex, gender identity and roles, sexual orientation, erotic experiences and reproductive desires.

Sex and gender

Almost all babies are born with genitals that are easily identifiable as either male or female. This is caused by the baby’s male or female chromosomes. Girl babies have ovaries and a uterus; later they menstruate and can become pregnant and give birth. Boy babies have a penis and testicles. These differences are those of **biological sex**. There are other biological sex differences, but most of them are only slight. For example, on average men are a little taller than women, and a little hairier. However, the differences between men and women on average are much smaller than the differences between tall men and short men. Many women are taller than some men.

Every culture treats boys and girls differently, and expects different behavior of men and women. Thus the difference we observe between men and women is only partly due to their biological sex; much of it is due to cultural expectations and learned experience. Cultural practices often seek to exaggerate the difference between men and women. For example, men may be encouraged to wear beards and women to shave any visible body hair, so that all men appear more hairy than all women. This

constellation of factors associated with each sex is called **gender**. Women are generally expected to behave in a feminine way, and men in a masculine way.

Understandings of gender are so deeply embedded in culture and language that it is very hard to distinguish between what is biological and what is cultural—indeed it is almost impossible, because even scientists studying the biology of sex use words and concepts that are formed by the gender understandings of their culture. So it is not surprising that psychologists, sociologists and biological scientists argue vigorously about concepts of sex and gender.

A person's gender as expressed in sexual identity and behavior can be thought of as arising from four related but separate attributes.

1. Genetic sex is the result of the influence of chromosomal inheritance. The X and Y chromosomes (in the case of men) program the various hormonal and biological characteristics and functions of the body. Occasionally, genetic anomalies (such as XYY or XO instead of XY) result in congenital intersex conditions, sterility or other disorders.
2. Physical sex is the primary and secondary sexual characteristics that develop under the influence of the sex hormones from conception to adulthood. Primary sexual characteristics include the possession of a penis or vagina. Secondary sexual characteristics are related structures such as broader shoulders in men and breast development in women. All fetuses are potentially male or female and develop according to the levels of hormones present at critical times. These influences continue throughout childhood, puberty and adulthood. Physical differences include some differences in the organization and structure of the brain. Occasionally, conditions such as androgen insensitivity syndrome cause a genetic male to have genitals that look fully or partly female.
3. Many variations across both men and women in body structure, brain development and personal experiences affect how we love and be sexual, for example aggression, libido or sexual interest, or preference for same-sex sexual partners. These "sex or love patterns" are commonly labeled as feminine or masculine according to what is prescribed as appropriate gender behavior within particular cultures and societies.
4. Gender identity is the composite result of genetic and physical sex and individual characteristics as interpreted by society and the individual. It refers to how people feel themselves to be—their sense of themselves as male or female. Even though gender identity is not fully determined by genetic or physical sex, it is very hard to change. For example, some men "feel" female even though their physical appearance is that of a normal male.

MSM and transgender people in Asia and the Pacific

Male homosexual behavior

Male-to-male sexual behavior in all its diversity is common in Asia and the Pacific; although it has not been systematically studied.⁴ Some Asian countries officially deny the existence of male-to-male sexual behavior;⁵ other countries criminalize sodomy (variably defined) with punishment by incarceration for up to 10 years,⁶ yet, in others, there is no mention of same-sex behavior in law and social tolerance is variable.

Estimates of the number and proportion of men who have had male-to-male sexual behavior vary. In India, from 12 to 38 million have had same-sex contact in their lifetime.⁴ A national behavior survey found 3% of Thai men had sex with a male in their lifetime,⁷ but a survey of military conscripts found that 6% of had done so in the last 12 months.⁸ Among young men in the Philippines, 6% had had male-to-

male sex in their lifetime.⁹ A much smaller percentage of the men in these studies reported exclusively male-to-male sexual behavior.

In large Asian cities, sexual relations between men are becoming partially Westernized and the term “gay” is used, especially among the middle classes.¹⁰ However, terms used in Westernized countries to describe sexuality and sexual orientation such as “homosexual”, “bisexual” and “gay” fail to reflect the meaning or the diversity of Asian male-to-male sexual behaviors. These terms may have meaning among those with English language skills in the middle and upper classes but not among those from the lower or working classes. Some men identify as “gay” when they are young but once they are over 30, marriage as a family commitment becomes a primary focus of their identity. Some men may be known as “gay” in some social networks, for example in the park where they meet men for sex, and as a “husband” at home and in business.¹¹

Male same-sex behavior is described in some Asian countries and cultures in terms of sexual “roles” rather than sexual “orientation”. The roles often reflect cultural attributes of gender: masculinity (active/insertive for anal sex), femininity (passive/receptive for anal sex) and virility (sexually penetrating women or men, having children). Men may use such local terms to describe the roles of other men, rather than of themselves. That is, MSM themselves do not usually adopt an identity based on their sexual role or behavior. Behavioral terms are fluid and subject to rapid change in meaning. Some current examples of terms for sexual roles, behaviors and gender in some Asian countries are listed in Table 1.1. None of the behaviors listed should be considered fixed and comparison across cultures and nations should be made with caution.

Among the men who may participate in male-to-male sexual behavior and may adopt situational roles are: men living away from their wives, young unmarried males, truck drivers, tea shop boys, restaurant boys, taxi drivers, rickshaw drivers, business men, hotel boys, students living in hostels and military personnel.

Transgender identity

In some countries, such as India, Bangladesh and Indonesia, a transgender or “other” gender identity (see Table 1.1) has historical socio-religious sanction in specific contexts. Groups of these men dress as women, feminize their behaviors, and live from earnings through performing rituals at marriage and birth occasions (in India and Bangladesh), through the rightful demanding of food and payment (*badai khata*) and through prostitution in urban settings. Many of these males are ritually fully castrated as a religious sacrifice (penis and testicles removed—an illegal act in these countries), and they will describe themselves as neither male nor female but as “other.” Those *hijras* or *waria* who are not castrated usually do not have sex with each other, nor do they usually penetrate other men. However, there is wide variation in sexual behavior and health care workers should not assume specific behaviors.

In Thailand, a young effeminate man in a rural area may be tacitly accepted if he conforms to a *kathoey* role. People believe that this is punishment for sexual indiscretions in a previous life.⁴ But if this man were to move to an urban area, he might behave as “gay”—or indeed as heterosexual—rather than being constrained to accept a *kathoey* role. Transgender issues are explored in more detail in Chapters 8-11.

Across most of Asia and the Pacific, MSM and transgender people remain significantly marginalized and stigmatized. Even where male-to-male sex is not illegal, these countries provide no protection under anti-discrimination or human rights laws. This lack of legal protection leaves MSM and transgender people open to abuse, victimization and neglect.

A question often asked by MSM and transgenders

“Why am I sexually attracted to men?”

Human sexuality is complex and expressed in many ways. Many things influence our sexual feelings—the genes we inherit, the hormones our body produces and how it responds to them. Our brains and bodies also respond to social, cultural, ethical, legal and spiritual signals that influence how we feel and act upon these feelings. Humans have sex with each other in different ways, just as we eat and walk in different ways.

While sex between men and women is more common and enjoys approval by most societies, sex between men is just different from the more common sex between men and women. Also, being sexually attracted to men does not necessarily mean that you are not a man, although some men feel this way.

There is no single reason why you are sexually attracted to men.

Table 1.1. Terms for sexual roles and identities, and associated male-to-male sexual behaviors and gender, by country.

Country	Sex role or identity term	Male-to-male sexual role and behavior	Gender
Bangladesh ^{12–15}	<i>kothi, dangra</i>	Visible feminized role. Being anally penetrated/receptive	male
	<i>panthi, giriya, do-paratha, double-decker, “gay”</i>	Terms used by <i>kothis</i> of their partners	
	<i>panthi, giriya</i>	Invisible because acts as “ordinary man” or “real man”. Usually insertive anal sex	male
	<i>do-paratha, double-decker, “gay”</i>	Both insertive and receptive anal sex	male
	<i>jiggery dost</i>	Close male friend with whom man sometimes has sex. Manual stimulation; may have anal intercourse	male
	<i>hijra</i>	Commonly receptive, but may also have insertive anal sex	transgender, eunuch, other
Cambodia ¹⁶	<i>kathoey</i>	Feminized behavior, frequently sells sex. Receptive anal sex	transgender

Country	Sex role or identity term	Male-to-male sexual role and behavior	Gender
China ¹⁶	<i>bian xing ren</i> ("change sex person")	Various sexual behaviors. Male–male sexual behavior influenced by widespread belief that male–female sex leads to loss of man's "yang" ("fire" or "male") force, but that male–male sex does not.	variable
India ¹¹	<i>kothi, danga</i>	Visible feminized role. Being anally receptive*	male
	<i>panthi, giriya, do-paratha, double-decker, "gay"</i>	Term used by <i>kothis</i> for their non-effeminate partners	
	<i>panthi</i>	Invisible because acts as "ordinary man" or "real man". Usually insertive* anal sex	male
	<i>giriya</i>	Steady partner of <i>kothi</i> ; husband or "real man"	male
	<i>do-paratha, double-decker, "gay"</i>	Both insertive and receptive anal sex	male
	<i>jiggery dost</i>	Close male friend with whom man sometimes has sex. Masturbation or manual stimulation of partner; may have oral or anal intercourse	male
	gay (self-identified)	Manual stimulation, fellatio, anal sex*	male
<i>hijra</i>	Commonly receptive, but may also have insertive anal sex	transgender, eunuch, other	
Indonesia ¹⁶	<i>laki laki, laki asli</i>	Effeminate man. Commonly receptive anal sex	male
	<i>waria, banci</i> (Batavian), <i>calabai</i> (Buginese), <i>kedie</i> (Javanese, Balinese), <i>kawekawe</i> (Makassarese, Buginese), <i>wan du</i> (Javanese), <i>Bissu</i> (Celebes)	Feminized behavior, cross dressers (subtle cultural differences between each of these roles). Commonly anally receptive, but highly variable	transgender, other
	gay	May be self-identified. Diverse sexual behavior	male

* In anal intercourse or oral sex (fellatio) the man who inserts his penis into the partner's anus or mouth is the **insertive** partner (sometimes called penetrative or "active"). The man whose anus is penetrated, or who uses his mouth, is the **receptive** partner (sometimes called "passive"). The term "anal sex" is used here to refer to anal intercourse, though other anal practices are common such as touching the anus or inserting one or more fingers. Some men do not insert the penis but rub it between the thighs or buttocks.

Country	Sex role or identity term	Male-to-male sexual role and behavior	Gender
Myanmar ¹⁶	<i>acaault</i> (pronounced /achow)	Feminized behavior, frequently sells sex. Receptive anal sex	transgender, third gender
Nepal	<i>meti</i>	Feminized identity. Receptive anal sex	transgender
	<i>ta</i>	Partners of <i>meti</i> ; have sex with men and women	male
	<i>dohori</i>	Masculine-looking MSM, label provided by <i>meti</i>	male
Philippines ¹⁶	<i>bayot</i> , <i>bantut</i> , <i>bakla</i> ("a gay: a woman trapped in a man's body"), <i>ladyboy</i>	Variety of cross-dressing behavior. Receptive anal sex	transgender, third gender
	<i>silahis</i>	Usually married (to a woman) and also has sex with men; also, non-effeminate MSM	male
Thailand ^{4,16}	<i>kathoey</i>	Feminized behavior. Receptive anal sex	transgender
	<i>pet tee sam</i> ("third sex"), <i>phuying praphet song</i> ("second kind of woman"), <i>sao praphet song</i> ("second kind of girl"), <i>nang fajam leng</i> ("transformed goddess"), <i>ork-sao</i> ("outwardly a woman"), <i>tut</i> (as in "Tootsie"), <i>ladyboy</i> , <i>ladyman</i>	As above	transgender
	man	Acts as "real man". Sex with women, insertive anal sex	male
	<i>gay-queen</i> , <i>king</i> or <i>kwing</i>	Description of other or maybe self-identified. Respectively receptive or insertive anal sex or both	male
Vietnam	<i>Bong kin</i> (<i>bóng kin</i>)	Outwardly masculine, diverse sexual behavior	male
	<i>Bong lo*</i> (<i>bóng lô</i>), <i>ladyboy</i>	Effeminate, dress as women, receptive oral and anal sex	transgender

A question often asked by MSM and transgenders.

“Can you cure me of my sexual attraction to men?”

For many years and in many ways, people have tried to “cure” men of their sexual attraction to men. Medical science previously viewed same-sex attraction as abnormal, and attempted to cure it, for example with brain surgery, hormone therapy or aversion (“shock”) therapy.^{19, 20} These treatments either permanently damaged the men or made them very unhappy. The treatments rarely had any effect on their sexual attraction to men, and failed to make them attracted to women. A same-sex attraction is no longer considered a psychiatric disorder and the only “treatment” (if any) needed is support to the man while he accepts his attraction to other men as normal for him. Support might come from friends, family or a trusted health care worker who understands the issues at this sometimes frightening and confusing time.

The process of acceptance of his homosexual orientation by the man, his friends and family is called “coming out” in Western countries. “Coming out” usually involves adopting a gay identity and may not apply in many Asian or Pacific countries or situations.

Some men who are sexually attracted to both men and women find it possible to sustain a relationship with a woman.

Male-to-male sexual behavior

Sex between men is like sex between men and women—it is learned, not instinctive, and is of great variety and meaning. Sex is a way of expressing feelings and connecting with others. It can provide warm feelings of intimacy, tenderness, love and trust or be strongly passionate. Every encounter need not be fulfilling but it should always be consensual. Non-consensual sex is illegal in most countries. Even where non-consensual sex is not illegal, it is an abuse of human rights.

The labels applied to MSM according to their sex or gender roles (see Table 1.1) ignore the subtleties of behavior and may lead to false assumptions about what men do when they have sex. Such labels were probably created for convenience in conversation about others, rather than for the detailed inquiry required when gathering a sexual history. Sex role labels are therefore best avoided in the clinical encounter.

How do MSM have sex?

Many people either cannot imagine two men having sex together or imagine that MSM only have anal sex. People also often assume that a man will only take one position in sex, either insertive or receptive (see note to Table 1.1). Anal sex is enjoyed by many MSM but is only one part of their vast sexual repertoire. Options for erotic play and genital stimulation are only limited by the men’s imaginations and every man has preferences that can change with time.

Sexual behavior between men can be divided into several categories to aid discussion. However, sexual behavior is not bound by categories and usually involves more than one specific behavior during a sexual encounter. Few of the behaviors described here are unique to MSM.

1. Kissing

Kissing has many cultural connotations and social purposes. Kissing between men is often discouraged completely or allowed only if it is on the cheek. Mouth-to-mouth and wet kissing are rarely acceptable public behaviors and therefore fall into the domain of private sexual behavior. The lips and mouth are as sensitive as the genitals or anus and are therefore erogenous zones. The tongue is sensitive to temperature, taste and texture.

Varieties of kissing include:

- Lips to lips
- Tongue into lips or mouth, with movement in, out or sideways
- Sucking or chewing of lips and/or tongue
- Tongue licking in and around ears
- Wet kissing of ears, neck, chest.

Hot, cold, sweet, sour and variously textured foods may also be shared while kissing.

2. Oral sex

Oral sex, or fellatio, is probably the commonest sexual behavior between men. It can be practiced anywhere with clothes on or off and in any position and while undertaking other activities. Oral sex is colloquially referred to as a "blow job". One man inserts his penis into the mouth of another man, who sucks it while moving backwards and forwards. The receptive partner (i.e. the one sucking) can "gag" if the penis hits the back of his throat. The size of the inserter's penis and the ability of the receiver's mouth to control his gagging sensation will determine the successful enjoyment of oral sex for both partners.

Licking lips and tongue around the shaft of the penis, sucking or nibbling of the testicles and tickling the penis head with the tongue are all included under the term of "oral sex". Oral sex is therefore any sexual behavior involving the mouth of one man stimulating the genitals of another.

3. Anal sexual behavior

The anus, and particularly anal sexual behavior, is shrouded in myth and mystery so that it is seen as dirty, scary, unhealthy, shameful and disgusting.¹⁰ Consequently, many people do not want to discuss these issues, let alone have anal sex. Many MSM and transgender people enjoy anal sexual behavior, but this neither defines their identities nor their sexual attractions. People often associate anal sexual behavior with homosexuality, so that some MSM and transgender can feel inadequate if they don't enjoy anal practices: "I can't really be gay if I don't have anal sex." Similarly, some heterosexual men who enjoy anal stimulation worry that this means they have homosexual inclinations; it does not. There is a great variety of forms of anal erotic stimulation. Anal sex can be emotionally important and satisfying where there are high levels of trust and comfort with a partner.

The perianal skin, anal canal and rectum are richly supplied with the same sensitive and tactile nerves that supply the genitals. Anal stimulation can therefore be pleasurable for many men. Stimulation of the perianal skin with fingers, tongue, objects or a penis (sometimes called "anal masturbation") can be as enjoyable as penis-anus penetration. Further inside, the rectal nerves respond only to pressure, not to surface touch, so having a penis in the rectum does not provide specifically rectal pleasure for most men. In addition to stimulating the anus and perianal skin, massaging of the prostate gland by the penis or other object during anal penetration provides additional pleasure. This allows both partners having anal sex to be pleased and to reach orgasm.

Penile-anal penetration: While the mechanics of anal penetration are simple, doing it without discomfort, pain or damage requires some practice. Condoms and water-based lubricant should

be used for anal sex.

The anus and rectum do not naturally lubricate during sexual arousal, so lubrication needs to be added. Generous amounts of lubricant need to be smeared over the penis and around the anus and in the anal canal prior to penetration. The use of water-based lubricant is essential because it reduces trauma during sex and is compatible with latex condoms. Oil-based lubricant like massage oil, skin moisturizer, cooking oil, butter or sun lotion must be avoided as they damage latex condoms, making them more likely to break during sex. Hereby, possibly exposing each partner to the risk of sexually transmitted infections including HIV.

Male condoms: are sheaths of latex shaped to cover the penis. Sheaths of various materials have been used for centuries both for contraception and to prevent the transmission of STIs including HIV. The latex condom is impervious to STI and HIV, so transmission will not occur during intercourse unless the condom breaks or slips off. (See Appendix A: How to use a male condom.) Plastic condoms are available in some countries and are useful if people are allergic to latex.

A female condom: (Femidom[®], Reality[®]) is a polyurethane bag that can be inserted into the anus before anal sex.¹⁷ An outer ring which forms the rim of the bag ensures that the condom does not slide inside the anus during sex. A separate inner ring, which can be removed, helps with insertion. When the inner ring is removed, the condom can be used like a male condom and placed over the penis before anal insertion. Lubrication is essential for female condoms, both inside and outside the condom, and they can be used with oil-based lubricants. However, the use of water-based lubricant is recommended when combinations of male and female condoms are used in order to prevent confusion or mishap.

Female condoms have been explored as an alternative to male condoms for MSM in many countries and some MSM organizations have actively promoted incorporating them into the sexual lives of MSM for use in anal sex.* There has been little research on the use of female condoms by MSM and some researchers have observed problems of rectal bleeding among users.^{21, 22} These factors and the relatively high cost for MSM may well preclude its use in Asian countries – but some further discussion is warranted (See Appendix B: Patient handout: Female condoms and men who have sex with men).

For successful anal intercourse, the receptive partner must be able to relax both the internal and external anal sphincters to comfortably allow the insertion of another man's penis. A well-lubricated condom-covered penis can be inserted into the anal canal to the rectum provided the inserting partner allows for



* For example, the Salisbury Gay Men's Health Project in the United Kingdom has promoted the female condom for gay men. See: www.gmhpc.demon.co.uk/about/newsletter/issue4/femidoms.html

the gradual relaxation of these powerful sphincters. Rushing the insertion can produce sphincter spasm, pain and tearing—not a pleasurable experience and one that can cause anal ill health (see Chapter 6). Sphincter spasm and poor lubrication can also lead to condom breakages.

To maximize the comfort of the receptive partner and to avoid soiling during sex, the receptive partner should empty the bowels about half an hour before having sex.

People who wish to have anal sex should be encouraged to practice inserting their own fingers into their anus before attempting receptive anal sex. This will help them learn about the sensations around and in their anus and allow them to learn relaxation of the anal sphincters when something is inserted from outside. They might then graduate to allowing others to insert their fingers with lubrication before allowing penile penetration. Other techniques to gain confidence for comfortable anal sex include using different positions to gain control of the inserting penis by the receptive partner, such as lowering the anus onto the penis or backing onto the penis, bearing down (increasing abdominal pressure) and breathing techniques during insertion.

Anal intercourse is also referred to as buggery or sodomy. People who disapprove of anal sex frequently use these terms in a derogatory way.

Anal play: Fingers and sex toys, like vibrators and dildos, may also be used to provide erotic stimulation of the anus. These might be used to rub around the anus and perineum or inserted into the anus to provide stimulation in the same way as a penis. To prevent the transmission of infection, these objects (including fingers) should not be shared. That is, condoms should be used to cover inserted objects and then discarded after use, while hands and toys should be washed with soap and water before being used again with another person (see Chapter 6).¹⁸

Oral–anal sex: is the use of a man’s mouth and tongue to stimulate the anus of another man. Sometimes referred to as “rimming” or “anilingus,” licking the anus can be used as foreplay to allow relaxation of the anal sphincters before penile penetration of the anus.

Variations include licking around the anus and in the anal crease, gently biting the perianal and buttock region, tickling the anus with the tongue with a film of saliva and gently inserting the tongue through a relaxing anal sphincter. Oral–anal sex between men can occur in many positions: while standing or in the shower, or one man squatting over the other man’s face. Or two men can simultaneously provide oral–anal sex to each other in “69” position. Washing the perianal skin with soap and water is recommended before having oral–anal sex.

Plastic or latex sheets-called dams or **dental dams** are recommended for placing against the man’s anus that is being licked. This barrier prevents the transmission of STIs including enteric pathogens. The use of lubricant on the anus allows the dam to slide around while it stays in place against the other man’s mouth.

4. Manual stimulation and other practices

The penis can be erotically stimulated either by the man himself (self-masturbation) or by someone else mutual masturbation. The penis can be massaged by gripping and rubbing it with a hand or by rubbing it against someone else’s skin or between their thighs (“thigh sex”), buttocks (“bum sex”), or arms, or against other objects. Transgender-to-male sex may include “chest or breast sex” when the penis is rubbed between breasts.

5. Esoteric sex play

Various forms of erotic sexual behavior are rare but worth noting because they may have specific transmission risks for STIs including HIV. These practices should only occur between mutually consenting adult males and commonly involve the acting out of erotic fantasies. None of these practices is unique to MSM or transgender people. Examples of esoteric sexual practices include:

- Pleasurable use of enemas (introduction of fluid into the rectum)
- Insertion of the hand or forearm into the rectum ("brachioproctic eroticism" or "fisting")
- Having arms, legs or mouth bound while being sexually pleased ("bondage")
- Infliction of pain by slapping, whipping, biting or burning the skin ("sodomasochism" or "S&M").

This may involve skin breakage or laceration. In "bondage and discipline (B&D)" it is practiced on a partner who has been tied up. People who enjoy these sexual games are usually not "sadistic" or "masochistic" in the psychiatric sense of the terms.

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Sexually Transmitted Infections in Asia

3



Sexually Transmitted Infections in Asia

According to the WHO, more than 150 million new cases of curable STIs (gonorrhoea, syphilis, chlamydia and trichomoniasis) are estimated to occur each year in South and Southeast Asia—the highest incidence of curable STIs of any region in the world. In a combined population of 955 million people aged 15 to 49, the number of curable STIs cases at any time is estimated at 48 million, giving an prevalence of approximately 50 per 1000 population.¹

Epidemiological surveys show that the prevalence and incidence of STIs vary widely within countries and between countries in the same region, between urban and rural populations, and even between similar population groups. These differences reflect a variety of social, cultural and economic factors and also differences in access to appropriate services and effective treatment. In general, the prevalence of STIs tends to be higher in urban residents, in unmarried individuals and in young adults. The highest rates of STIs are generally found in urban men and women in their most sexually active years between the ages of 15 and 35. On average, women become infected at a younger age than men.

However, there have been very few studies of STIs in MSM or transgender populations in Asia. HIV prevalence among transgenders attending an NGO clinic in Mumbai was estimated to be approximately four times higher than among MSM (68% and 17% respectively) in 2001². A three-year study commenced in 1999 at a hospital clinic in Mumbai also showed that transgenders were approximately two to four times as likely to be infected with HIV when compared to each other male group attending the clinic. HIV prevalence among transgenders was 41% as compared to 19.65%, 10.58% and 10.84% among homosexuals, bisexuals and heterosexuals respectively.³ Some key studies are summarized in Tables 3.1 to 3.5.

Table 3.1 Prevalence of STIs, India (Mumbai) STI clinic sample, 2002⁴

STI	Test method	Prevalence (%)	
		Homosexually active men (n = 150)	Transgenders (n = 28)
Syphilis	TPHA	17	57
Hepatitis B	HBsAg+	10	21
Genital herpes (HSV2)	HSV-2 antibody	40	71
HIV	HIV antibody	20	68
Chlamydia	Urine PCR	11	0

Note: TPHA = *Treponema pallidum* hemagglutination assay
 HBsAg+ = hepatitis B surface antigen
 PCR = polymerase chain reaction

Table 3.2 Prevalence of STIs, Thailand (Chiang Mai) brothel sample, 1989–1993⁵

STI	Test method	Prevalence (%)
		Male sex workers (n = 1172)
Syphilis	VDRL	8
HIV	HIV antibody	17

Note: VDRL = Venereal Disease Research Laboratory

Table 3.3 Prevalence of STIs, Cambodia (Phnom Penh) community sample, 2000⁶

STI	Test method	Prevalence (%)
		MSM (n = 206)
Syphilis	RPR	6
Gonorrhea	Urethral culture and/or urine PCR	5
Gonorrhea	Rectal culture and/or PCR	0.3
Chlamydia	Urine PCR	7.2
Chlamydia	Rectal PCR	1
HIV	Serology	14

Note: RPR = rapid plasma reagin
PCR = polymerase chain reaction

Table 3.4 Prevalence of STIs, Vietnam (Ho Chi Minh City) STI clinic population, 2000⁷

STI	Test method	Prevalence (%)
		MSM (n = 208)
Syphilis	WR + TPHA	7
Hepatitis B	HBsAg	27
HIV	HIV antibody	6

Note: WR = Wassermann reaction
TPHA = *Treponema pallidum* hemagglutination assay
HBsAg = hepatitis B surface antigen

Table 3.5 Prevalence of STIs, Japan (Tokyo), stored serum from male bathhouse attenders, 1985–1989⁸

STI	Test method	Prevalence (%)
		MSM (n = 34)
HSV-2	Serology	24

Chronic hepatitis B virus infection is endemic throughout the Asia and Pacific region, with whole-country prevalence ranges between 2–4% in Japan and 15–20% in Taiwan.^{9, 10}

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Sexual Health History Taking

4

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Sexual Health History Taking

Before you examine patients and manage their sexual health problems, it is essential, to obtain a sexual history. Many clinicians and HIV counselors worry about their ability to do this, or are embarrassed to take a sexual history from patients, especially if they have been taught that male-to-male sex is a perversion or where religious sensitivities require that the doctor as a high-status person uphold the moral principles of his religion. Patients can also struggle to raise sexual health issues with their doctor because they feel embarrassed or ashamed. Age, gender, race, sexuality and cultural differences between patient and doctor are additional barriers to discussion,¹ although in some settings cultural differences between doctor and patient may make honest discussions easier because a fear of moral censure is removed.

Why take a sexual history?

An accurate sexual history ensures that you are not making assumptions about the patient. It also allows for an exploration of a variety of factors that may affect sexual health. Taking a sexual history provides the patient with an opportunity to discuss issues that may not have otherwise been raised and it can allow for the further identification of risky behavior.

Together with the appearance of HIV, advances in the fields of psychology, anthropology and sociology have focused new attention on the social factors that influence health-factors that were previously given little attention in standard medical history taking. For example, questions on recreational drug use and sexuality have become important additions to history taking for any health care worker who is to gain an understanding of the cultural influences on a patient's health.

Every clinician will develop his or her own individual style for putting patients at ease, although the most important factor will be a non-judgmental approach using both verbal and non-verbal communication skills.

General principles

Taking a standard medical history from a patient usually involves an exploration of the reason for presentation and a sexual history is no different. However, there are some principles unique to sexual history taking.²

Non-technical language

The medical language used to describe genital anatomy and sexual behavior is complicated and not commonly used in the general community. For example, "genitals", "penis" and "urethra" may not be words used by the patient for these parts of the body. Similarly, non-technical language used by the patient will need clarification to ensure that you are both discussing the same thing. For example, the word "sex" can refer to gender but also commonly to sexual behavior, as in, "Are you having sex?" And if patients answer "yes" to this question, what are they actually doing? If they say "anal sex", what exactly does this involve?

The best approach is for you to adapt to the patient's level of understanding and language use. As well as understanding the local terms used for parts of the body and sexual behavior you need to be comfortable with using the terms yourself.

Specific questioning about symptoms

The presenting genital symptom may not be the only problem. Explore for additional symptoms to ensure that you do not miss anything. Directly ask the patient about:

- urethral, neovaginal (i.e. the vagina in a male-to-female transgender after gender reassignment surgery) or rectal discharge and its amount and character
- abnormal neovaginal or rectal bleeding
- genital rashes, lumps and sores
- itching and/or discomfort in the perineum, perianal and pubic region
- lower abdominal pain and painful sex
- difficulties with micturition or defecation.

Remember that many STIs have no symptoms.

Drug allergies and recent oral or topical medications

If antibiotic therapy is needed, ask about previous allergic or specific reactions to medication. Also ask about the use of oral and topical antibiotic, antiviral, antifungal or homeopathic and ayurvedic medication (whether prescribed or not), as it is likely to modify or suppress signs or symptoms of sexual health problems.

Past sexually transmissible infections

Asking about past STIs is an easy and relatively painless way to lead into the sexual history. Previous infections can reveal important markers of behavioral risk, and patients may not think to mention this unless prompted. Also ask about previous blood transfusions and their dates, intravenous or injectable hospital treatments and previous diagnoses of blood-borne infections such as hepatitis B or C.

Partner history

Finding out how, with whom and how often patients have sex reveals more information about them than is revealed by their symptoms. Keep in mind the possibility of sex without consent, which is usually unprotected, and receipt of payment (in money or kind) for sex, whether this is seen as “sex work” or not.

Time

Thorough discussion of sexual behavior can be time consuming. Inexperienced clinicians are usually capable of taking sexual histories but may avoid the topic because they are afraid of free discussions that may venture into areas where they feel uncomfortable or lack confidence, or which require long discussion. With experience, the clinician is able to balance the history taking with open-ended and closed questions that help guide and contain discussion to an acceptable time period. You can always stop and defer the discussion at any time if the consultation is too lengthy. Remember discussion can also continue while the patient is being examined—this may be a helpful distraction for them. Consultations with history and examination of five minutes’ duration for a new patient are not acceptable. An experienced clinician can carry out a consultation with history, examination, diagnosis and brief counseling in 15 to 20 minutes.

Specific principles²

Talking about sex with a clinician is often very difficult for a patient. To encourage honest and free discussion, the clinician needs to convey the message to the patient that it is safe to talk about sex during the consultation. The following points are tips for creating this impression and allowing for a comprehensive sexual history.

- Provide an explanation for why you are asking personal questions, for example, “So that I can work out the right tests or treatment for you, I need to know some more detail about your sex life.”
- Start with the easy questions first and then move to more sensitive ones. Inquiring about genital symptoms first will reassure the patient you are focused on the reason for attending. Then ask when they last had sex. This is a relatively innocuous question and opens up further discussion such as “Was it a regular or casual partner?”
- Avoid asking “why” questions because the answer may require a complex understanding of behavior and most people will struggle to respond. Instead ask “how”, “what”, “where” and “who” questions that will open up dialogue rather than close it. For example, “Why did you have anal sex?” may elicit the answer “Because I wanted to” and close the topic. If the question is framed as “How or when did you have sex?”; “With whom did you have sex?”; or “What happened during the sex?”, the answer will provide specific information. This will lead on to other topics and a more complete picture of the patient. Similarly, “Why didn’t you use a condom?” is better framed as “What problems do you have when using condoms?”
- Ask about specific sexual practices when the patient discloses sexual activity. Never assume that the sex is only genital-to-genital. This is the best time to ask about condom use or other barrier methods—when, how often and any difficulties. If you know the specific sexual practices you can give specific and appropriate prevention messages, interpret examination findings, and decide on the correct laboratory tests (where available).
- Do not presume a patient’s sexual behavior on the basis of his or her appearance or the sex of the most recent sexual partner. Ask “Do you have sex with men, women or both?”
- Avoid expressions or direct questions that label the patient. For example, MSM may not identify with a cultural or role label describing their behavior, so asking a question such as “Are you a panthi?” is unlikely to get you the information you require. A better approach is to ask “Do you have sex with men, women or both?” Then, if the patient answers “Men”, ask “Have you ever had sex with a woman?” and vice versa.
- A patient’s sexual health risk may be the result of the sexual behavior of a regular partner rather than of his or her own sexual behavior. This may be difficult to articulate, so gentle questioning is required, for example, “Risk for STIs can come from regular partners. Are you concerned about this? In what way?”
- Always ask about condom use. This may be raised by asking patients “What do you do to protect yourself from STIs?” This helps explore their knowledge about, use of and attitudes to condoms. Male and female condoms should both be discussed. Preventive education is powerful when initiated by a clinician.
- If the discussion halts because of discomfort or other difficulties, stop the line of questioning and talk about something else. You can always come back to the sexual history later, for example during the physical examination. Persisting with a line of questioning is counter-productive and will create defensiveness or possibly hostility in the patient.
- Transgender issues will require gentle inquiry to uncover areas of concern. The impact of gender identity problems on sexual behavior is profound and cultural factors can be further confounding. (See Chapter 10 for further details.)

The impression to convey to patients is that it is safe to talk about sexual behavior and sexuality because it is a normal part of any professional consultation and important for their care.

In communities where cultural rules about discussing sexual matters are particularly strong, sexual history taking may have to be delegated to someone of the same sex or ethnic background as the patient. Whatever method is used to obtain a sexual history, the patient must feel assured that details given to health care providers are held in strict confidence (see Chapter 2).

With practice, you will easily integrate sexual history taking into your clinical skills. It is encouraging when patients spontaneously tell you that no clinician has ever been as thorough before.

Taking a sexual history: summary¹

General points

- Ensure privacy and that the patient is seated comfortably.
- Be non-judgmental and respectful.
- Avoid making assumptions about people, their sexual identity and sexual practice.
- Make eye contact, unless this is culturally insensitive.
- Ensure the patient remains dressed.
- Assume nothing.
- Explain what you are doing before you start.

Terminology

- Generally, use vernacular or colloquial expressions rather than more technical expressions. Be careful, as patients may be less comfortable with the topic than you are, and they may regard some colloquial terms as obscene.
- Adapt your language to the level of understanding of the patient.
- Use the terms used by the patient, but be cautious as often patients struggle to express issues in medical terms and may get the meaning wrong.

Asking questions

- Start with a general and less threatening question, such as "Tell me about your most recent sexual activity."
- Ask open-ended questions, that is, questions that do not require a yes or no answer.
- Avoid asking "why" questions. Instead ask "how", "what", "where" and "who" questions that open up dialogue rather than close it.
- Ask clear and unambiguous questions.
- Do not be afraid to be direct in order to get clear information.
- Ask about sexual partners, as patients may be at risk of STIs because of their partners' sexual activity.
- Ask about knowledge and use of condoms, as it provides an opportunity for further information and education.

Sexual history checklist¹

Physical symptoms

- nature of problem
- duration
- any general sexual concerns

Previous diagnosis of STIs

- previous sexual health issues
- knowledge of increased risk
- vaccination for hepatitis (B or A if appropriate)
- symptoms and diagnoses in recent sexual partners

Sexual behavior

- contact with regular and/or casual sexual partners
- last sex contact with other partner(s)
- number of sexual partners (in specific time periods, e.g. three months)
- gender of sexual partner(s)
- type of sexual behavior practiced
- sex work
- condom use and consistency of use
- erectile dysfunction
- international sexual contact

Relationship history

- regular partner
- regular partner's sexual activity
- casual partner(s)

Drug and alcohol use

- patterns and frequency of use
- injecting drug use
- harm minimization strategies

Medication and allergies

- medications currently being taken

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Sexual Health Examination

5

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Sexual Health Examination

Many STIs have signs and symptoms on other (non-genital) parts of the body, and many genital signs are not signs of STIs, so it is important to undertake a general physical examination before proceeding to the anogenital region. This also allows the patient to adapt to being examined as you move from more “public” parts of the body to more private parts.

Once the sexual history is complete, tell the patient you would like to examine him or her, and explain why this is necessary. There are many myths about how STI patients are examined, what instruments are used and what treatments are given to people with STIs, so it is best to describe each step in the examination and/or procedure to the patient before you proceed. Allow the patient to view any equipment such as anosscopes, proctoscopes or swabs before you use them, so that the patient will understand what is happening during the examination.

If you follow a routine practice for examination, you will be less likely to miss signs of sexual health problems. Even if the patient indicates a specific lesion, follow this routine before inspecting the lesion.

Examination essentials

A sexual health examination can be very threatening for a patient, especially a patient who has never been examined before. To save time and keep the patient comfortable, a well-lit private room containing a soft-topped examination table is essential. Provide a pillow for the patient’s head and a sheet to cover parts of the body exposed after undressing that do not need to be viewed during the examination. The sheet is also handy to cover the patient if you need to leave the room, so that the patient is not left lying naked on the bed. Use a bright examination lamp with a mobile head to illuminate specific parts of the patient’s body for inspection and definition of any lesions.

Sexual health examination essentials

- Well-lit private space
- Bright examination lamp with a mobile head
- Soft-topped examination table
- Pillow for the patient’s head
- Drawsheet or “modesty” sheet

General examination routine (before genital examination)

- Ask the patient to sit on the side of the examination bed facing you.
- Wash your hands with soap and water.
- Inspect the patient's hands, forearms and inside the elbow. Note any rashes, nail changes or "needle track" marks.
- If the patient is generally unwell, take their pulse and blood pressure.
- Feel the front and back of the neck for lymph node enlargement.
- Inspect the mouth and throat with the aid of a wooden tongue depressor and examination light. Note lymph node enlargement, mucosal ulceration, dental morphology, pharyngeal inflammation, plaques or lesions.
- If the patient is generally unwell, undertake a chest examination by auscultation of breath sounds and heart sounds.

Anogenital examination

To preserve some modesty and save time, the patient need only remove enough clothing to expose the body from navel to knees. Examination of a penis through an open trouser zipper while the patient stands by your desk is inadequate and potentially dangerous for you and the patient.

Explain each part of the examination as you proceed and say what you are looking for, for example, "I am looking for rashes or lumps that might indicate problems." Reassure the patient when the examination is unremarkable, for example, "The skin (or penis or anus) looks healthy today." Encourage patients to disclose any discomfort or to ask any questions about their body or the examination as you proceed. These simple techniques relax patients by providing them with a sense of control over an invasive procedure while simultaneously educating them about their bodies.

Patients who are reluctant to be examined

Some patients feel they have reached their limit of exposure after giving a sexual history. Asking them then to remove their clothes seems too much. This is likely to happen with patients who have never had sexual health discussions with a clinician before and with those who have never had a medical examination.

Patient information leaflets about what happens at the clinic will help to ensure an examination comes as no surprise to most patients.

Obtaining patient consent is essential for examination. Some patients will still decline examination of some or all of their anogenital area, even after a clear explanation of the benefits. If the patient refuses examination of the area where there are symptoms, a diagnosis cannot be accurately made and the patient's health care is compromised. Explain this gently to the patient. Explore the reasons for resisting examination. Would the patient prefer a same-sex clinician? A chaperone or a friend in the room? Are there other cultural barriers?

If there are no symptoms in the area you wish to examine, it is important to respect the patient's wishes, provided you have explained that there may be abnormalities that will help with the diagnosis of other conditions. The patient may allow examination at a subsequent visit once he or she trusts the clinic and clinician. Your respect for this patient is likely to encourage the attendance of other similar patients who otherwise would not have attended.

Anogenital examination

- Ask the patient to lie supine on the examination bed
- Draw the examination curtain around the bed.
- Ask the patient to remove clothing to expose from navel to knees.
- Set up any examination instruments such as anosscopes, proctoscopes, testing and sampling equipment while the patient undresses.
- Do not observe patients while they undress.
- Ask the patient if he or she is ready to be examined.
- Switch on the examination light to illuminate the anogenital area.

Front

- Put on (disposable) latex gloves.
- Inspect the exposed skin from umbilicus to knees for altered pigmentation, rashes, scars and lumps.
- Inspect any hair for signs of ectoparasite infestations.
- Palpate for inguinal lymph node enlargement and tenderness.
- Inspect the inguinal folds for rashes or lumps.
- Palpate the contents of scrotum for lumps and tenderness. This is achieved by gently cradling each testicle in one hand while feeling for the epididymis with the fingers of the same hand. With the other hand, gently roll the vas deferens to detect any lumps. Repeat the scrotal examination with the patient standing - this can be easier and also allows for better detection of conditions such as hernias and varicoceles.
- Inspect the skin along the length of the penis from base to the tip. Note any lumps, rashes or ulcers.
- Retract the foreskin to inspect for lumps, rashes, ulcers and discharge.
- Inspect the urethral meatus by parting the tip bilaterally. Note any discharge, ulcers or lumps.

Back

- Ask the patient to turn onto the left side (left lateral position) and to bend both knees and flex the hips to 45°.
- Ask the patient to place their right hand on their right buttock and to draw it upwards. This gives full exposure of the perianal area and allows you to have both hands free for inspection and examination. (You may wish to kneel down or sit on a chair now to save you from bending your back.)
- Inspect the buttocks, perineum and perianal area. Note any lumps, ulcers, rashes, scars or discharge.
- Perform anoscopy or proctoscopy where appropriate (see below).
- Wash hands with soap and water.
- Ask the patient to get dressed.

Note: For examination of male-to-female transgendered people see Chapter 10.

Using an anoscope

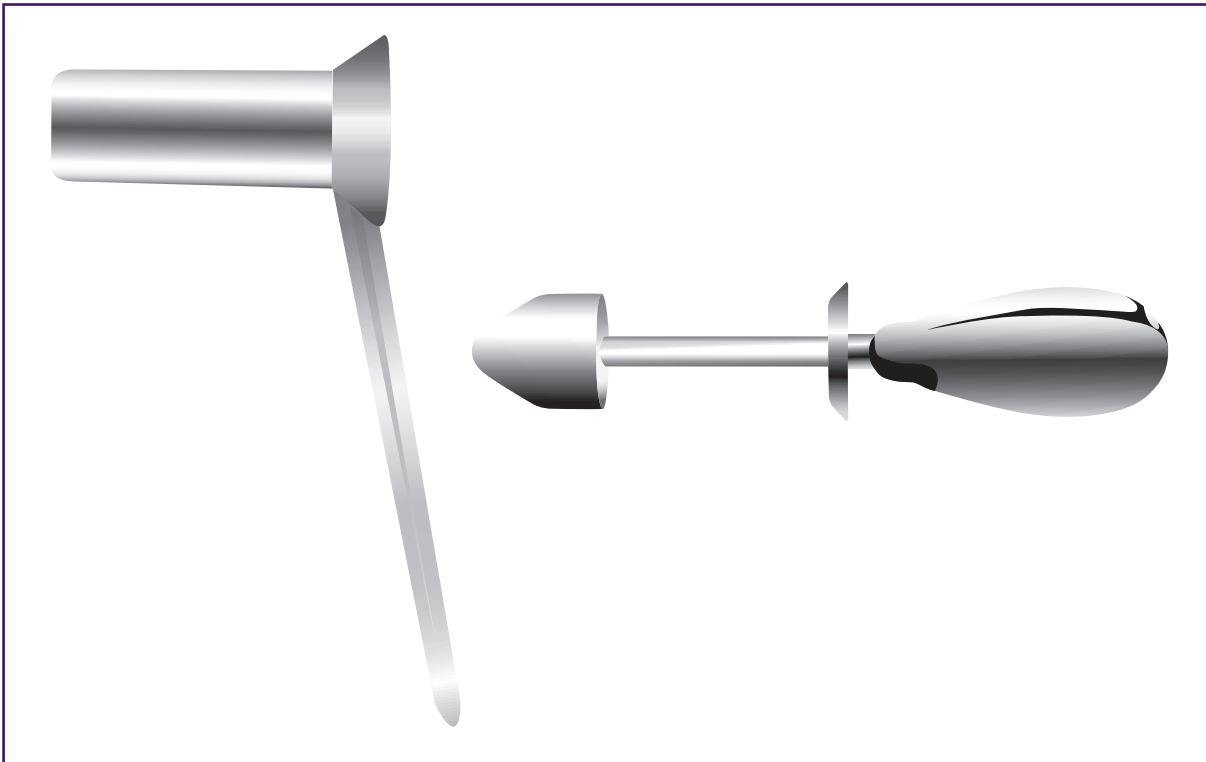
Anoscopic examination is recommended whenever there are any anorectal signs or symptoms. This allows for further inspection of the mucosa and, where facilities are available, collection of laboratory test samples.

An anoscope is a rigid, hollow, tubular instrument about 10 cm long and 2 to 3 cm wide, with a central removable introducer. Short, plastic, disposable anoscopes are recommended, to prevent cross-contamination. Metal anoscopes that can be sterilised or disinfected between patients can also be used but must be warmed with water before insertion. Show the patient the anoscope before you insert it.

Anoscope examination summary

With the patient in the left lateral position:

- Smear lubricating jelly onto the anal verge and length of anoscope.
- Explain what you are about to do.
- If indicated, with a lubricated and gloved right index finger, perform examination per rectum of prostate and lower rectum. Since the finger is smaller than the anoscope, the digital exam is less uncomfortable and helps to relax and lubricate the rectum for anoscopy. The examiner should change gloves between the digital rectal exam and anoscopy. Some clinicians will double-glove the right hand and discard the outer glove after the digital exam and before anoscopy. Some physical findings can be noted on the digital examination that would not be picked up on anoscopy, such as the presence of masses or lumps beneath the rectal mucosa, being able to localize painful areas, and palpating the prostate gland.
- Rest anoscope at anal verge until the sphincter relaxes, then insert slowly while applying gentle constant pressure. Allow anoscope to follow line of least resistance rather than pushing. Generally aim towards the navel. Elevation and relaxation of the buttocks aids insertion, as does asking the patient to “bear down” as if opening the bowels.
- Remove the introducer once the anoscope has reached its limit.
- With the aid of the patient examination light, observe
 - colour and texture of rectal mucosa
 - presence of discharge
 - presence of ulceration
 - bleeding
 - lesions.
- Where laboratory services are available, collect swabs from rectal mucosa for:
 - gram stain smear
 - gonococcal test
 - chlamydial test
- Slowly remove anoscope, checking for haemorrhoids and/or other lesions on withdrawal.
- Remove and dispose of gloves.
- Wash hands with soap and water.
- Ask the patient to get dressed.

Figure 5.1 An image of an anoscope**Table 5.1** Outline of good sexual health examination practice¹

Essential elements	Hint
1. Allay the patient's fears	Explain what will be done and encourage disclosure of any discomfort
2. Privacy	Provide a curtain across the window or around the examination bed and close the door
3. Examination bed	Examine the patient supine
4. Good lighting	Small lesions are best seen with a patient examination light
5. Good preparation	Have equipment (e.g. slides, swabs and spatulas, disposable plastic or sterilisable specula and proctoscopes) nearby
6. General examination	Note nutritional status. Examine the skin, mouth, lymph nodes, chest, cardiovascular system, abdomen and central nervous system
7. Anogenital examination	Patient descriptions of signs can be unreliable; perform anoscopy where indicated
8. Infection control	Wash hands with soap and water before and after examination

Reference

1. Queensland Health. *Queensland Management Guidelines for the Treatment of Sexually Transmissible Diseases and Genital Infections*. Brisbane. Queensland Health. 2002.

Genital Health

6

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Genital Health

Penile health issues

The penis functions both as the outlet of the urinary tract and as a sexual and reproductive organ. Both semen and urine pass through the penile urethra. The erectile function of the penis is produced by the engorgement of venous plexuses within the corpus cavernosum and the corpus spongiosum. The penis can become erect in response to erotic stimuli as well as direct physical stimulation.

Erectile function can be adversely affected by psychological issues such as anxiety and by physical conditions affecting the nerve and blood supply to the penis (e.g., diabetes and arteriosclerosis). Some medications can also be associated with erectile dysfunction. Recent developments (e.g., Viagra® – sildenafil citrate) have transformed the medical management of erectile dysfunction. The detailed management of erectile dysfunction is beyond the scope of these guidelines.

STIs affecting the penis include gonococcal and chlamydial infections of the urethra. These typically manifest as urethral discharge or dysuria. Recent improvements to diagnostic technology (e.g., polymerase chain reaction–PCR testing) have demonstrated that many more urethral infections are asymptomatic than previously appreciated. Other infections that can affect the skin of the penis include genital ulcer diseases (e.g., syphilis, chancroid and herpes) and human papilloma virus (HPV), which can cause ano-genital warts and occasionally anogenital cancer.

The presence of the foreskin in uncircumcized men creates an environment in which pathogenic organisms including those sexually acquired can thrive. Poor hygiene increases the risk that infections can occur beneath the foreskin. Basic daily cleaning with gentle use of soap and clean water will easily keep the skin under the foreskin clean and healthy.

Scrotal health issues

Below the penis is the scrotum. This is the soft bag of skin that contains the pair of testes (testicles). The testes are the organs that produce the sperm contained in semen. The testes also produce the sex hormone testosterone. Normally, the testes are smooth, egg-shaped organs and relative mobile in the scrotum. During sexual arousal or when exposed to cold, the cremaster muscle surrounding the spermatic cord and testes contracts and pull the testes close to the body.

Although rare, testicular cancer occurs mostly in young men (aged 15–35 years) and is generally curable if diagnosed early. Encouraging men to examine their testicles for unusual swelling or lumps on a regular basis is a good way to detect early abnormalities that might suggest a tumor.

Prostate health issues

The prostate is a small, walnut-sized gland at the base of the bladder. The urethra passes through it after exiting the bladder. The prostate also produces a significant proportion of the fluid in semen. The prostate receives fluid and sperm from the seminal vesicle and is connected to the urethra by the ejaculatory ducts. Stimulation of the prostate during anal sexual activity is pleasurable for many men.

In later life, the prostate can become enlarged and limit the flow of urine from the bladder. This can be corrected through surgery. Prostatic cancer is a disease of older men and can be detected through routine skilled rectal examination by a clinician. This is recommended for all men over the age of 50 years.

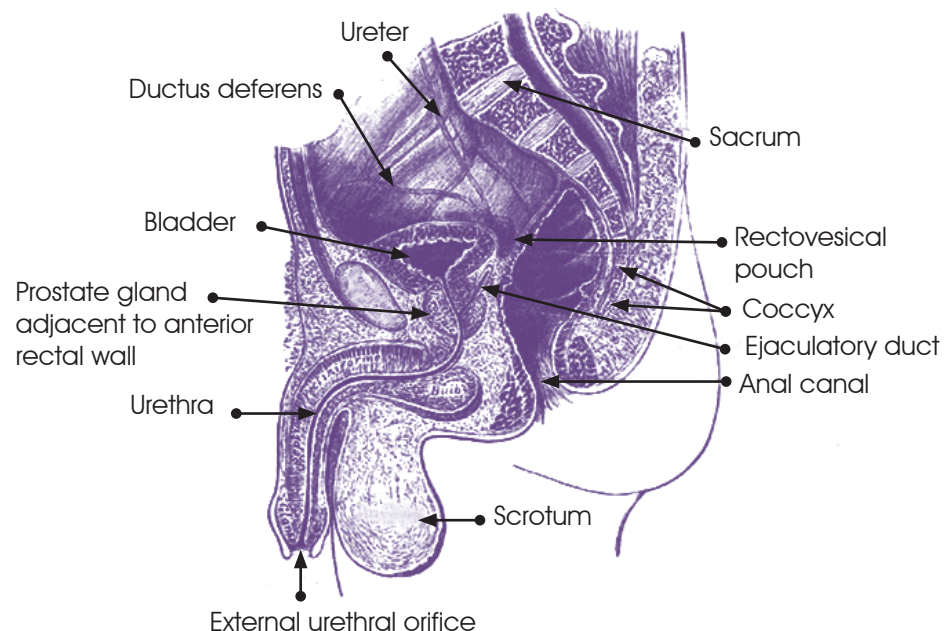
Anal health issues

The anus functions as an aperture for the elimination of waste, as a sexual organ and sometimes as a delivery point for treatment (such as suppositories or enemas). Damage to the internal or external skin and tissue of the anus can affect health, cause pain and impair function.¹ If the perianal skin, anus, anal canal and rectum are involved in sexual activity, care is necessary.

Anal problems can manifest as lumps, ulcers, rashes, discharge, bleeding or difficulties with defecation. STIs affecting the anus or rectum usually have no symptoms or poorly defined symptoms that can mimic other common conditions. Common conditions of the anorectal region and perianal skin are hemorrhoids, anal fissures and conditions causing itching such as dermatitis, fungal and parasitic infections, skin disorders, allergic reactions and poor anal hygiene.

Anogenital anatomy^{2, 3}

Figure 6.1 Male pelvic anatomy²



Glossary

Anus: the opening at the end of the digestive tract.

Bladder: a triangular shaped, hollow organ located in the lower abdomen. It is suspended in the pelvis with ligaments attached to other organs and the pelvic bones. The walls of the bladder relax and expand to store urine and contract and flatten to empty urine through the urethra.

Epididymis: a long tube located on the posterior side of each testicle. Sperm produced in the testicle move to the epididymis through efferent ducts before moving on to the vas deferens for storage. Immature sperm undergo maturation as they move from the head to tail sections of the epididymis.

Penis: the penis is made up of two parts, the shaft and the glans. The shaft has three cavernous erectile bodies: paired corpora cavernosa (which become rigid during erection) and the corpus spongiosum (containing the urethra). The glans is the tip or head of the penis and is part of the corpus spongiosum. All boys are born with a foreskin covering the head of the penis. Circumcision is the removal of the foreskin for cultural, religious or medical reasons.

Prostate gland: a gland in men that encircles the neck of the bladder and urethra and is suspended within the pelvic floor muscles. It is partly muscular and partly glandular, with ducts opening into the urethra. It has three zones, the periurethral, central and peripheral zones. The prostate gland secretes a nutrient fluid that forms 30% of the volume of seminal fluid, which carries sperm.

Rectum: the lower end of the large intestine, leading to the anus.

Scrotum: the bag of skin that holds and helps protect its contents, the testicles. The scrotum has two compartments, each holding one testicle.

Semen: the thick, yellowish-white fluid secretion discharged at ejaculation. As well as reproductive organ secretions, it contains spermatozoa (sperm) and plasma to nourish them.

Seminal vesicles: the paired saccular glands that lie behind the bladder and attach to the vas deferens where it joins the urethra. This shared tube is called an ejaculatory duct. The seminal vesicles release an alkaline, fructose-rich fluid that forms 60% of the volume of semen.

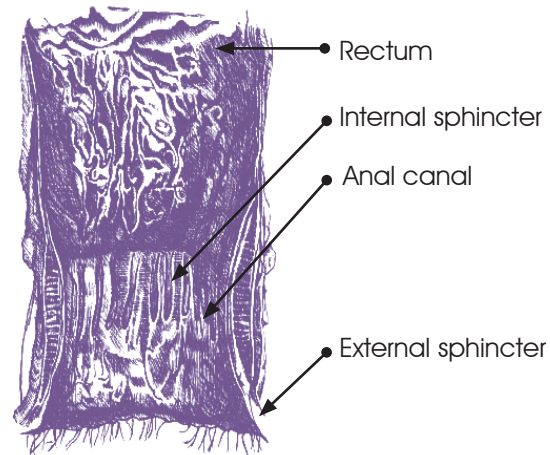
Testes or testicles: two organs contained within the scrotum. The testes produce sperm and secrete the sex hormone testosterone. Hundreds of coiled seminiferous tubules in each testicle produce the sperm, while the cells between the coils produce testosterone. The immature sperm move to the epididymis.

Urethra: the tube that carries urine from the bladder to the outside of the body. It passes through the prostate gland, pelvic floor muscles and penis.

Vas deferens: a tubal extension of the epididymis that carries the sperm out of the scrotal sac. It stores the sperm and carries it to the urethra at the prostate gland.

Anorectal anatomy

The anorectal region has three sections, the anus, the anal canal and the rectum. The anus is the orifice visible externally as the opening of the anal canal. Just inside the anal canal are an external sphincter and an internal sphincter. A sphincter is a circular muscle that can constrict and expand. Anal sphincters constrict to retain feces and expand to allow feces and flatus (colloquially "farts") to pass. The anal canal is about 5 cm long. The anus is closed while at rest and open during defecation and sexual penetration. It leads to the rectum, the cavity that runs vertically from the end of the colon to the anal canal. The rectum is approximately 10 cm long and 3.5 cm wide. It stores feces prior to defecation. The lining of the rectum is relatively insensitive to pain, but the nerves from the anus and nearby external skin are very sensitive to pain. The nerve supply here is the same as to the genitals. The lining of the anus is like that of the surrounding skin-stratified squamous epithelium.

Figure 6.2 Anorectal anatomy**Longitudinal muscle fibres of rectum****Anal health care¹**

Maintaining anal health is important for men who practice any type of anal sexual behavior (see Chapter 1). Applying some simple preventive health care for the anus and perianal skin helps to prevent many common problems. While generally quite tough, the perianal skin can be easily traumatized by fecal soiling, persistent moisture, abrasion from toilet tissue, excessive washing, unlubricated (or forced) anal penetration and application of treatments. Treatments such as over-the-counter steroid, antibiotic or hemorrhoid preparations may reduce the symptoms of anal conditions but may also alter or mask their true clinical signs. It is important to encourage patients to seek clinical advice before applying treatments to the perianal area.

Perianal cleansing

Washing the anal region before and after anal sex reduces the amount of bacteria that could be spread, but may also remove some of the body's natural protection against infection. The use of water only or without soap or detergent can reduce the loss of this natural protection.

Lubrication

The anus does not produce its own lubrication. Lubricant needs to be applied during any anal penetrative sex to prevent mucosal tearing. Lubricant use, cleanliness and condoms reduce the chance of tearing and minimize the risk of transmitting disease during anal sex. Lubricant should be water-based, not oil-based, as oil-based lubricants increase the risk of breakage of latex condoms. Lubricants and condoms containing nonoxynol-9 spermicide should be avoided. Recent data suggest that nonoxynol-9 may increase the risk of HIV transmission by damaging the lining of the rectum.⁴

Condoms and other barriers

Condoms help prevent the spread of STIs when worn prior to and during any anal contact. Oral–anal contact is safest when using a dental dam, a flat sheet of latex that acts as a barrier between the mouth or fingers and the anus. Female condoms may suit some MSM and transgender people. (See Chapter 1.)

Douching

Overuse of enemas (fluids flushed into the cavity of the rectum) can destroy the normal healthy balance of bacteria in the lower intestine. Routine use of enemas is not recommended. Some men douche with warm water before receptive anal sex to clean the rectum and anus.

Common (non-infectious) anorectal problems^{5, 6}

Anal fissure

An anal fissure (anal ulcer) is a tear or ulcer in the lining of the anus.

Anal fissures are usually caused by an injury from a hard or large bowel movement, anal sex without lubrication or inflammation of anal tissues. Anal ulcers can also be produced by some STIs such as syphilis, genital herpes, chancroid and lymphogranuloma venereum. Fissures cause the sphincter to go into spasm, which may restrict blood flow and prevent healing.

Symptoms and diagnosis: Fissures cause pain and bleeding during or shortly after a bowel movement and during receptive anal sex. The pain lasts for several minutes to several hours and then subsides until the next bowel movement or receptive anal sex. The perianal area may itch as the fissure heals. The best way to diagnose an anal fissure is to inspect the anus for a single, painful triangular ulcer at the anal margin. Syphilis and genital herpes are important STIs to consider in the diagnosis. A chronic anal fissure is similar to an acute fissure but frequently has a skin tag ("sentinel pile") at one end of the ulcer.

Treatment: A stool softener such as psyllium may reduce the injury caused by hard bowel movements, and it lubricates and soothes the lower rectum. Lubricant suppositories can also be helpful. Sitting in a warm salt water bath for 10 or 15 minutes after each bowel movement eases discomfort and helps increase blood flow, which promotes healing. Nitroglycerin ointment helps to heal anal fissures. The patient should avoid receptive anal sex until the fissure heals. When these simple measures fail, surgery generally is needed to remove the scar tissue.

Hemorrhoids

Hemorrhoids are swollen tissues that contain veins and are located in the wall of the rectum and anus.

Hemorrhoids may become inflamed, develop a blood clot (thrombus), bleed or become enlarged and protrude. Hemorrhoids that remain in the anus are called "internal hemorrhoids"; those that protrude outside the anus are called "external hemorrhoids" or "perianal hematomas."

Hemorrhoids may develop from repeated straining during bowel movements. Constipation may make straining worse. Liver disease increases the blood pressure in the portal vein, sometimes leading to the formation of hemorrhoids. Hemorrhoids are less likely in people who practice frequent receptive anal sex as they have usually learned good anal sphincter control.

Symptoms and diagnosis: Hemorrhoids can bleed, typically after a bowel movement, producing blood-streaked stools or toilet paper. The blood may turn water in the toilet bowl red. However, the amount of blood is usually small, and hemorrhoids rarely lead to severe blood loss or anemia.

Hemorrhoids that protrude from the anus may need to be pushed back gently with a finger, or they may go back by themselves. A hemorrhoid may swell and become painful if its surface is rubbed raw or if a blood clot forms in it. Less commonly, hemorrhoids may discharge mucus and create a feeling that the rectum is not completely emptied. Itching in the anal region is not a symptom of hemorrhoids, but it may develop because the painful area is difficult to keep clean.

Swollen, painful hemorrhoids are diagnosed by inspecting the anus and rectum. Anoscopy and sigmoidoscopy help to determine whether the person has any other condition further inside.

Treatment: Hemorrhoids do not usually require treatment unless they cause symptoms. Taking stool softeners or psyllium may relieve constipation and the straining that accompanies it. Bleeding hemorrhoids can be treated with an injection of a substance that causes the veins to become obliterated with scar tissue (called “injection sclerotherapy”).

Large internal hemorrhoids and those that do not respond to injection sclerotherapy are tied off with rubber bands. The procedure, called “rubber band ligation,” causes the hemorrhoid to wither and drop off. The treatment is applied, to one hemorrhoid at a time, at intervals of two weeks or longer. Three to six treatments may be needed. Hemorrhoids may also be destroyed using a laser (laser destruction), an infrared light (infrared photocoagulation), or an electric current (electrocoagulation). Surgery may be used if other treatments fail.

When a hemorrhoid with a blood clot causes pain, it is best treated with warm salt water baths, local anesthetic ointments, or witch hazel compresses. Pain and swelling usually diminish after a short while, and clots disappear over four to six weeks. Alternatively, a doctor may cut the vein and remove the clot in an attempt to relieve the pain rapidly.

Anorectal abscess

An anorectal abscess is a collection of pus caused by bacteria invading a gland around the anus and rectum.

Abscesses just under the skin can be swollen, red, tender, and very painful. An abscess can often be seen in the skin around the anus. Using gloved fingers, a tender swelling in the rectum can be felt, even when no external swelling can be seen. Abscesses higher in the rectum may cause no rectal symptoms but may produce fever and pain in the lower abdomen. Anoscopy may be needed (see Chapter 5).

Treatment: Antibiotics have limited value except in people who have a fever, diabetes or an infection in their rectum or elsewhere in the body. Usually, treatment consists of injecting a local anesthetic, cutting into the abscess, and draining the pus. Occasionally, a person is hospitalized and given general anesthesia before a doctor cuts and drains an abscess. After all the pus has been drained, an abnormal channel to the skin (anorectal fistula) may develop.

Anorectal fistula

An anorectal fistula is an abnormal channel from the anus or rectum, usually to the skin near the anus but occasionally to another organ.

Most fistulas begin in a deep gland in the wall of the anus or rectum. Sometimes fistulas result from drainage of an anorectal abscess, but often the cause cannot be identified. Fistulas are more common among people who have Crohn’s disease or tuberculosis. They also occur in those with diverticulitis, cancer or an anal or rectal injury. A fistula in an infant is usually a birth defect; such fistulas are more common in boys than girls.

Symptoms and diagnosis: A fistula may be painful, or it may discharge pus. One or more openings of a fistula can usually be seen or the fistula can be felt beneath the surface. A probe may be inserted to determine its depth and direction. Looking through an anoscope inserted into the rectum and exploring with the probe may help to locate the internal opening. Inspection with a sigmoidoscope helps to determine whether the problem is being caused by cancer, Crohn’s disease or another disorder.

Treatment: The only effective treatment is surgery (fistulotomy), during which the sphincter may be partially cut. If too much of the sphincter is cut, the person may have difficulty controlling bowel movements.

If the person has diarrhea, active ulcerative colitis or active Crohn's disease, all of which may delay wound healing, the operation is usually not performed.

Anal itching

The common causes of itchy skin around the anus are listed in the box.

Common causes of anal itching

- Skin disorders such as psoriasis and atopic dermatitis
- Allergic reactions such as contact dermatitis caused by anesthetic preparations applied to the skin, various ointments, or chemicals used in soap
- Micro-organisms such as fungi and bacteria
- Infestation by parasites such as pinworms and, less commonly, scabies or lice
- Antibiotics, especially tetracycline
- Diseases such as diabetes or liver disease, anal disorders (for example skin tags, cryptitis, draining fistulas) and cancers (for example Bowen's disease)
- Poor hygiene that leaves irritating feces or excessive rubbing and use of soap
- Warmth and excessive sweating because of pantyhose, tight non-cotton underwear, obesity or hot weather
- In people with large external hemorrhoids, the difficulty of keeping the area clean

Treatment: After bowel movements, the anal area should be cleaned gently with plain warm water. Frequent dusting with baby powder or cornstarch may combat moisture. Corticosteroid creams, antifungal creams such as miconazole, or soothing suppositories may be used. Foods that can cause anal itching should be avoided for a while to see whether the condition improves. Clothing should be loose and bed linen light. If the condition does not improve and a doctor suspects cancer, a skin specimen may be obtained for examination.

Pilonidal disease

Pilonidal disease is an infection caused by a hair that injures the skin at the top of the cleft between the buttocks. A pilonidal abscess is a collection of pus at the infection site; a pilonidal sinus is a chronic draining wound at the site.

Pilonidal disease usually occurs in young, hairy white men. To distinguish it from other infections, inspect the area for pits-tiny holes in or next to the infected area. A pilonidal sinus can cause pain and swelling.

Generally, a pilonidal abscess must be cut and drained, while a pilonidal sinus must be removed surgically.

Foreign objects

Swallowed objects (such as toothpicks, chicken or fish bones), gallstones or a hard lump of feces may become lodged at the junction between the anus and rectum. Objects that have been inserted intentionally such as enema tips, thermometers and objects used for sexual stimulation may become lodged in the rectum. These larger objects usually become lodged in the mid-rectum.

Sudden, severe pain during bowel movements suggests that a foreign object, usually at the junction between the anus and rectum, is penetrating the lining of the rectum or anus. Other symptoms depend on the size and shape of the object, how long it has been there, and whether it has caused an infection or perforation. Patients in this situation are highly embarrassed and should be treated with respect and not as a fascinating clinical event.

Locate the object by probing with gloved fingers during a rectal examination. An abdominal examination, sigmoidoscopy and x-rays may be needed to make sure that the wall of the large intestine has not been perforated.

Treatment: Small objects can be dealt with in the clinic. A local anesthetic is usually injected under the skin and lining of the anus to numb the area. If the doctor can feel the object, the anus can then be spread wider with a rectal retractor and the object can be grasped and removed. Natural movements of the wall of the large intestine (peristalsis) generally bring the foreign object down, making removal possible.

Occasionally, if the doctor cannot feel the object or cannot remove it through the rectum, exploratory surgery is needed. The patient is given regional or general anesthesia, so that the object can be gently moved toward the anus or the large intestine can be cut open to remove the object. After the object is removed, the doctor performs a sigmoidoscopy to determine whether the rectum has been perforated or otherwise injured.

Anal neoplasm

MSM have a higher risk of anal cancer than other men. The major risk factor is the very common infection human papillomavirus (HPV). Anal cancer may have no symptoms until it produces bleeding and changes in bowel motions or more systemic symptoms such as weight loss. Anal inspection or anoscope examination may reveal a bleeding, raised ulcer. The management of anorectal tumors is beyond the scope of these guidelines.

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Management of Sexually Transmitted Infections

7

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Management of Sexually Transmitted Infections

Many MSM and transgenders are at great risk of STIs including HIV. This is partly because of high rates of partner change and low rates of condoms use. This situation is inevitably worse where there has been little intervention aimed at increasing condom use or improving both health seeking behavior and the quality of clinical services for STIs.

The high prevalence of STIs means that it is very likely that patients attending a clinic will already be infected with one or more STI. High incidence (i.e. new infections) also means that patients who return to a clinic might well have acquired new - and possibly different infections.

Additionally, many infections remain asymptomatic. For example, the primary chancre of syphilis is typically painless. While a painless penile ulcer is very likely to be noticed quickly by most patients, a painless peri-anal ulcer is much less likely to be noticed. Gonococcal and chlamydial infections of the rectum are commonly asymptomatic. Most syphilis in the community is latent (i.e. asymptomatic) and remains undetected unless serological tests are performed.

Ideally, syphilis patients should be treated with penicillin at the clinic as long as the clinic is equipped to handle the rare event of an anaphylactic reaction.

Injected penicillin is, by far, the optimal treatment for active syphilis—which, if not treated promptly, can lead to serious and potentially life-threatening sequelae.

The practice of skin testing for penicillin allergy is said to be routine in many countries in Asia. This practice should be reviewed if possible although it is recognized that such a review is well beyond the scope of most agencies dealing with STIs.

Many of the infections experienced by MSM and transgenders will be symptomatic. Generally, these will be well managed by following the syndromic approach to STI case management—the usual approach employed in national guidelines in Asia.

However, an effective strategy for controlling STIs among MSM and transgenders requires that both asymptomatic and symptomatic infections be addressed.

Syndromic management of symptomatic infections

Syndromic STI management provides high quality STI care by treating people with one or more STIs with the most effective drugs at their first point of contact with the health service.

The emphasis is on rapid treatment and increasing people's access to sexual and reproductive health care. The syndromic approach is well suited to primary health care services in resource-poor settings because it does not rely upon expensive or inaccessible laboratory tests for diagnosis.

Health workers are trained to diagnose (by taking a history confirmed by examination) and treat on the basis of the identification of a syndrome. An STI syndrome is the grouping of symptoms (given by the patient) and clinical signs shown in the examination by the health worker.

Once the syndrome has been diagnosed, treatment is provided for the majority of organisms known to be responsible for that particular syndrome. The health worker is guided by a flowchart (or algorithm)

to the most effective treatment for a given set of signs and symptoms. A set of algorithms relevant to MSM and transgenders is contained in Appendix C.

Additionally, health workers are trained in other STI management strategies including contact tracing (partners notification) to ensure that their sexual partners are assessed and treated, provision of male and female condoms, counselling and patient education to assist them in taking the full course of treatment.

The syndromic approach continues to provide developing countries with a cost-effective and appropriate means of managing the most common STI syndromes of public health importance. These include:

1. Male urethral discharge;
2. Genital ulcer disease (male and female);
3. Vaginal discharge;
4. Inguinal bubo;
5. Scrotal swelling; and
6. Ophthalmia neonatorum (neonatal conjunctivitis).

For the management of the most common clinical syndromes caused by STIs among MSM and transgenders in Asia, we recommend following the WHO guidelines reproduced in Appendix C. References to pregnancy are of course not relevant to the clinical care of MSM or transgender people.¹

To maximize compliance with treatment, single-dose treatments are preferable wherever possible. However, local patterns of pathogen resistance will dictate which are the most appropriate and effective treatments. The use of injections should be avoided where possible to reduce patient discomfort and the risk of needlestick injury.

A summary of the drugs used in the treatment of uncomplicated STIs is shown in Table 1 at the end of this chapter.

Pharyngeal infections

The prevalence of pharyngeal gonococcal and chlamydial infections among MSM and transgenders in Asia is not known. In the absence of etiological tests for gonorrhoea and chlamydia, it is very difficult to diagnose these infections reliably. Additionally, clinicians should be aware that pharyngeal gonorrhoea can be more difficult to clear than urethral infections.

Other oro-pharyngeal STIs (e.g., herpes and warts) can often be detected by macroscopic examination and managed according to national guidelines.

It is recommended that wherever a patient is suffering from significant pharyngitis and a history of unprotected oral sex makes pharyngeal gonococcal or chlamydial infection a likely risk, patients should be treated presumptively as follows:

Treatment for presumptive pharyngeal gonococcal or chlamydial infection

Ceftriaxone 125 mg intramuscularly as a single dose

PLUS

Azithromycin 1 gram orally as a single dose

Doxycycline 100 mg twice daily for 7 days can be used as an alternative to azithromycin.

Management of asymptomatic STIs

In the absence of quality data on STI prevalence among MSM and transgenders in Asia, the following recommendations are made for a clinical strategy for asymptomatic STIs:

1. All MSM and transgenders should attend for an STI 'check-up' every three months. The check-up would include a sexual history, examination (including external ano-genital and, if indicated, proctoscopic examination as well as VCT for serological testing for HIV and syphilis). All patients practicing receptive anal sex would be offered proctoscopy.
2. Symptomatic STI clients should be managed syndromically according to national guidelines or the protocol below for ano-rectal conditions according to their presenting complaint.
3. Subsequent development of symptoms should also be managed by the syndromic approach.
4. An additional approach for the detection of ano-rectal infections in asymptomatic clients is shown below in Figure 1. A similar flowchart for managing anorectal symptoms is contained in Figure 2.

In the absence of etiological tests for gonorrhoea and chlamydia, it is not possible to diagnose asymptomatic pharyngeal infections with these organisms reliably.

Anorectal sexually transmitted infections

STIs may be spread through anal sex when blood, semen or other body fluid is shared, although hepatitis B and HIV are two serious STIs whose symptoms do not appear on the anus. STIs that affect the anorectal area include:

- Gonorrhoea
- Chlamydia
- Warts (human papillomavirus infection)
- Syphilis
- Herpes (herpes simplex virus infection)
- Giardiasis, shigellosis and infections with other enteric pathogens such as amoebae.

It is possible to acquire an STI without anal penetration. Oral-to-anal contact, whether from kissing or from oral contact with fingers that have been touching the anus or genitals, can spread pathogens and cause infection. The sharing of unprotected or unclean sex toys may also transmit certain diseases. Using condoms is an excellent way to prevent STI transmission although they might be less effective against some STIs (e.g., those transmitted more by skin-to-skin contact such as HPV) than others.

Proctitis²

Proctitis is an inflammation of the rectal wall.

Proctitis is the most common reaction to an anorectal sexually transmitted infection (such as gonorrhoea, syphilis, chlamydia or herpes). Anyone whose immune system is impaired is also at increased risk of developing proctitis, particularly from infections caused by the herpes simplex virus or cytomegalovirus, or from reactivation of an earlier infection. Proctitis may be caused by *Salmonella* spp., *Shigella* spp. or *Entamoeba histolytica* as a part of gastroenteritis, which may be manifest as a diarrheal disease with systemic symptoms of fever, anorexia and abdominal cramps. Antibiotics that destroy normal intestinal bacteria and allow other bacteria to grow in their place may also cause proctitis. Another cause of proctitis is radiation therapy directed at or near the rectum. Herpes proctitis may be mistaken for the rectal manifestation of ulcerative colitis or Crohn's disease.

Symptoms and diagnosis: Proctitis typically causes painless bleeding or the passage of mucus (sometimes mistaken for diarrhea) from the rectum. There may also be ineffectual straining to defecate (“tenesmus”), sometimes mistakenly described as “constipation” by patients. The anus and rectum may be intensely painful, with external and internal ulceration, when the cause is gonorrhea, herpes or cytomegalovirus infection.

To make the diagnosis, anoscopy or proctoscopy will reveal rectal pus, bleeding or ulceration. Samples of pus and the ulcers may be sent to a laboratory for diagnostic tests of bacteria, virus and fungi.

Treatment: The best treatment for proctitis caused by a specific bacterial infection is antibiotics. Most bacterial diarrheal diseases resolve spontaneously with oral rehydration and anti-diarrheal medication such as loperamide. The treatment of ulcerative colitis, Crohn’s disease and radiation colitis is beyond the scope of these guidelines.

Management of anorectal symptoms

In January 2003, the technical advisory group for these guidelines developed the following algorithms to assist with the care of anorectal symptoms in MSM and transgender people. The algorithms are based on the limited epidemiological data about MSM or transgender people in Asia. They recognize that gastroenteritis, gonorrhea and chlamydia are common infections (often asymptomatic) and that the prevalence of other STIs in MSM and transgender people is poorly defined. The effectiveness of these algorithms has not been evaluated. When further epidemiological information is available these algorithms will need to be revised and reassessed.

Figure 1. Management of anorectal STIs in asymptomatic patients

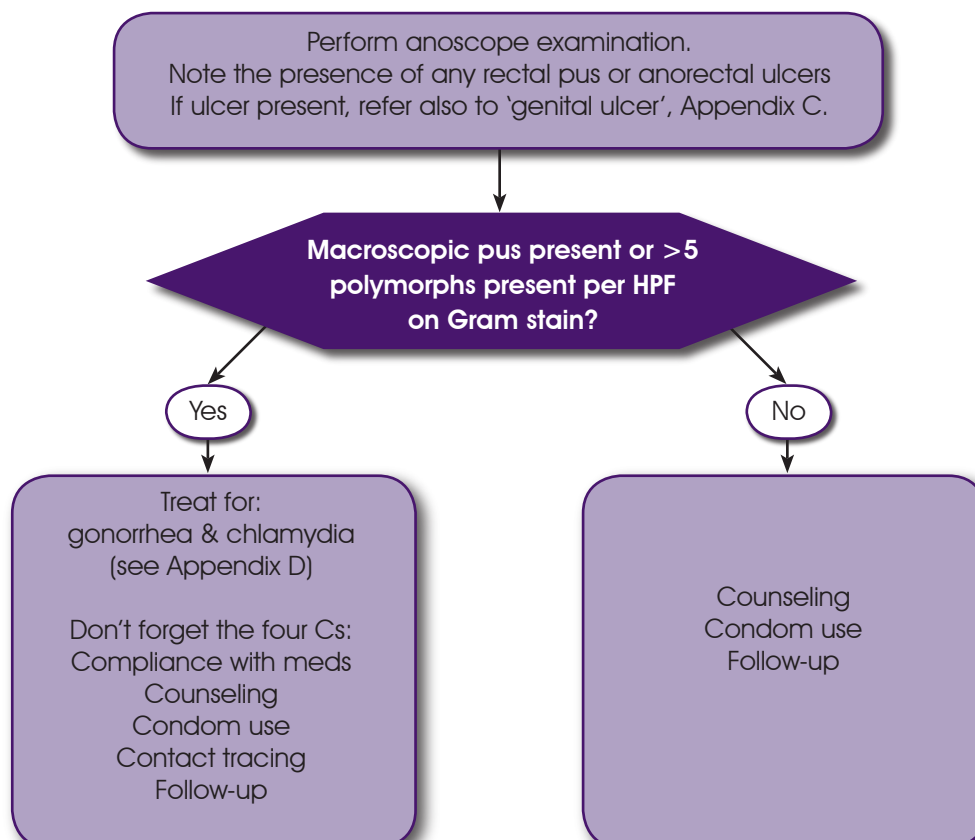
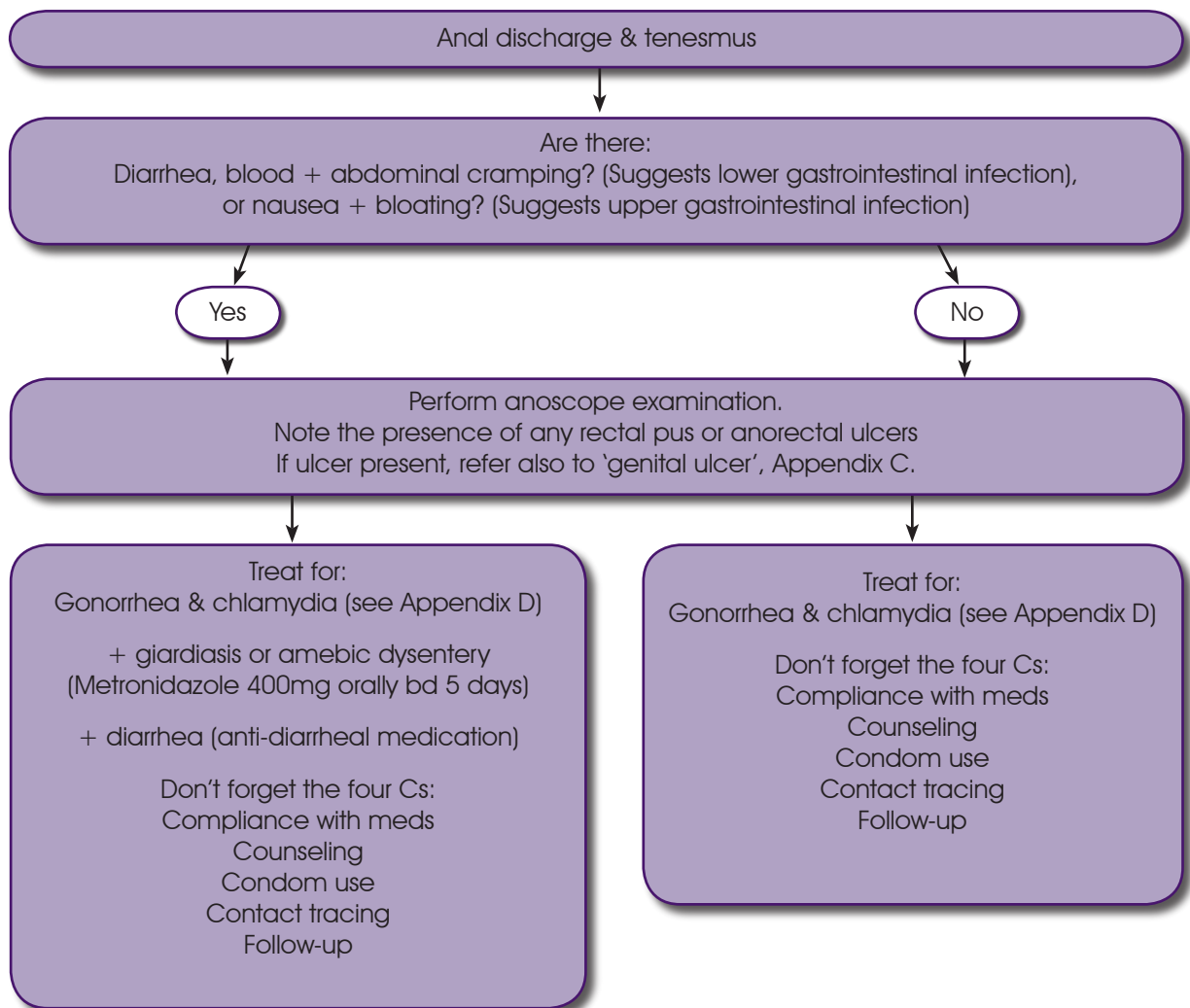


Figure 2. Management of anorectal STIs in symptomatic patients

Clinic equipment

Privacy and confidentiality are essential when conducting a sexual health consultation. This includes both physical and auditory privacy meaning that patients should not be seen or heard by other people during the clinical interaction. Clinics should be equipped with a good light for ano-genital examination and possess several proctoscopes and a sterilizer. Iatrogenic infection risks due to needle-stick injuries should be minimized through the use of a needle and syringe destroyer or other mechanism to ensure the safe disposal of used sharps.

Laboratory support

Some basic laboratory support should be provided wherever possible. The following tests can be provided by an on-site laboratory technician or performed by the clinician in some situations:

- Gram stain of urethral and rectal specimens;
- Syphilis serology (quantified RPR or VDRL on-site if possible and TPHA off-site for confirmation); and
- HIV serology (rapid tests in settings with high HIV prevalence).

The laboratory staff should participate in a quality assurance system for STI testing (e.g., Gram stains, syphilis and HIV serology) whereby positive specimens and a proportion of negative specimens are referred for retesting by a reference laboratory.

Contact tracing (partner notification)

Contact tracing (partner notification) continues to be a problematic area. Many MSM have female partners and many are married. Clinicians are often reluctant to pursue the tracing of partners, particularly in the case of spouses and regular female partners of clients found to be infected with STIs. This is, of course, not without some justification since clumsy or insensitive handling of contact tracing could severely threaten the credibility of the clinical service and sometimes fuel domestic violence.

Counseling

Where possible, clinical services should also be supported by staff specifically devoted to providing support for psychological and nutritional issues. If not, clinicians will need to be able to provide a range of psycho-social support or appropriate referral if necessary. All patients will need counseling on how to reduce their risk of acquiring STIs and to reduce the risk of transmitting infections to their partners. Risk reduction counseling will be necessary whether patients are diagnosed with an STI or not.

Table 1. Summary: treatment of uncomplicated STIs¹

Infection	Treatment
Chancroid	Ciprofloxacin 500 mg orally every 12 hours for 3 days OR Erythromycin 500 mg orally every 6 hours for 7 days OR Azithromycin 1 g orally as a single dose OR Ceftriaxone 250 mg intramuscularly as a single dose (alternative regimen)
Chlamydia	Azithromycin 1 g as a single dose OR Doxycycline 100 mg twice a day for 7 days OR Amoxicillin 500 mg orally 3 times a day for 7 days (alternative regimen) OR Erythromycin 500 mg orally every 6 hours for 7 days
Donovanosis	Azithromycin 1 g as a single dose then 500 mg orally daily until lesions have healed OR Doxycycline 100 mg orally twice a day until lesions have healed
Epididymo-orchitis	Treatment for BOTH gonorrhoea AND chlamydia
Genital herpes	First episode: acyclovir 200 mg orally 5 times a day for 7 days OR famciclovir 250 mg 3 times a day for 7 days OR valaciclovir 1 gram orally twice a day for 7 days Recurrent genital herpes episodic therapy: acyclovir 200 mg orally 5 times daily for 5 days OR famciclovir 125 mg twice a day for 5 days OR valaciclovir 500 mg orally twice a day for 5 days

Infection	Treatment
Genital warts	Self-administered: Podophyllotoxin 0.5% tincture topically twice a day for 3 days in weekly cycles for up to 4 weeks, Provider-administered: Podophyllin 10-25% in compound tincture of benzoin weekly (washed off 1-4 hours after initial application) OR Cryotherapy or other ablative therapy (e.g., diathermy, surgery or trichlor-acetic acid 80-90%)
Gonorrhea	Cefixime 400 mg orally as a single dose OR Ceftriaxone 250 mg in 2 ml 1% lignocaine (plain) intramuscularly as a single dose OR Ciprofloxacin 500 mg orally as a single dose Note quinolone resistance (e.g., ciprofloxacin) is very common in Asia OR Spectinomycin 2 g intramuscularly as a single dose
Lymphogranuloma venereum	Doxycycline 100 mg twice a day for 14 days OR Erythromycin 500 mg 4 times a day for 14 days
Pubic lice	Lindane 1% lotion or cream applied to infested areas and washed off after 8 hours OR Permethrin 1% cream as above
Scabies	Lindane 1% lotion or cream applied to the body below the neck and washed off after 8 hours OR Benzyl benzoate 25% lotion from the neck down nightly for 2 nights OR Permethrin 5% cream as above
Syphilis - early	Benzathine benzylpenicillin 2.4 million IU intramuscularly as a single dose - may be split into two injections at different sites to reduce the volume of each injection
Syphilis - late latent	Benzathine penicillin 2.4 million IU intramuscularly once weekly for 3 weeks may be split into two injections at different sites on each occasion to reduce the volume of each injection
Trichomoniasis (male urethral)	Metronidazole 400-500 mg orally twice a day for 7 days OR Tinidazole 500 mg orally twice a day for 5 days

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2. *The Merck Manual of Medical Information*. Home edition; Section 9, Chapter 103. At www.merck.com/mrkshared/mmanual_home/sec9/103.jsp. Accessed May 2003.

Transgender Identity and Health

8

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Transgender Identity and Health

Terminology used to describe people who are outside male or female gender categories can be very confusing. People who work in the area of gender—especially in the fields of psychology, social work, medicine and psychiatry—commonly create classifications to assist with professional and community discussion and with understanding and management of gender issues. The term “transgender” is an example of this. Classifications have changed with the development of new theories and practices. People are more comfortable knowing how to categorize people and their behaviors. However, any person or behavior that is outside the current view of “normal” risks being described as “disordered” and therefore in need of treatment.

Across different cultures in Asia and the Pacific, there are examples of gender-atypical behavior that appear early in life that do not significantly challenge society. In some cultures, people seem to be able to deal well with the idea of a person who does not behave according to the rules of either femininity or masculinity. For example, a little boy who likes to wear girls’ clothes or plays with girls is not taken to the doctor for treatment of his abnormality, as might happen in Western society. Instead, he is accepted as somewhat girlish and, when he grows up, he might take on a “third” or “other” gender role. This gender identity is supported or accepted, and a historical, cultural or mythical role provides the person with an acceptable, although restricted, place in society. (See Chapter 1 for examples.)

The term “transgender” is also used to include biological males who describe themselves as “other”—neither male nor female. The situation for the transgender person is seen as a difference rather than a medical or treatable disorder.¹ However, the Western psychiatric classification of “gender identity disorder” in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)² is drawn on internationally although its application to Asian and Pacific cultures and countries has not been fully tested.

Furthermore, the limited access to psychiatric services but free access to pharmaceuticals in the region means that for people who wish to change gender from male to female, transition to the preferred gender may be restricted only by the cost of over-the-counter hormones. Some transgender people in Western countries also find the requirement for diagnosis, approval and permission from a mental health professional restrictive and see it as an attempt to control their lives.

However, the diagnostic classification approach, as it applies in Asia and the Pacific, has been adopted here in order to provide practical guidance about transgender health care, not to impose a cultural, psychological or social theory. Chapters 11 and 12 outline the two main areas affecting transgender health, hormonal treatments and gender reassignment surgery.

Terminology

Transgender: For many in the medical and general community, the term “transgender” replaces both the term “transsexual” and the concept of “gender identity disorder.” The term transgender is not a diagnosis (in terms of DSM-IV-TR) but refers collectively to individuals who challenge strict gender norms by behaving as effeminate men or masculine women, by adopting “third gender” roles, by embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex.³ The term can also be used to include those who were born with intersex conditions.

Transsexual: An older term, “transsexual” has been replaced in the West by the term “person with a gender identity disorder.” A person with a gender identity disorder is biologically one gender but identifies as a member of the other gender (see Chapter 1) and wishes to remove their primary and secondary sexual characteristics and live as a member of the opposite sex.

Transvestite: DSM-IV-TR describes transvestism as “transvestic fetishism.” Transvestism involves “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing in a heterosexual male. The fantasies, urges, or behaviors cause clinically significant distress or impairment in social, occupational or other areas of functioning.”² Generally, the term “transvestite” is used more loosely to describe a heterosexual man who cross-dresses for sexual gratification but does not wish to be a woman.

Adequate assessment

The Harry Benjamin International Gender Dysphoria Association is a professional group dedicated to the understanding and treatment of people with a transgender identity. This group has produced standards of care which are intended to provide treatment consistency in the “psychiatric, psychological, medical, and surgical management of gender identity disorders” and are meant to “provide flexible direction in the treatment of gender identity disorders.”⁴

Summary of DSM-IV diagnostic criteria for a gender identity disorder in adults and adolescents

1. A strong and persistent cross-gender identification manifested by a desire to be the other sex, desire to live or be treated as the other sex, or the conviction that one has typical feelings and reactions of the other sex.
2. Persistent discomfort with one’s gender manifested by preoccupation with getting rid of primary and secondary sex characteristics (requesting hormones, surgery or other procedures to simulate the other sex).
3. That the disturbance is not concurrent with a physical intersex condition.
4. That the disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Excerpted from American Psychiatric Association, *Diagnostic and statistical manual of mental diseases*, 4th edition, text revision, Washington, DC: APA, 2000.

The general goal of care for people with a transgender identity, whether it includes psychotherapy, endocrine treatment or surgery, is to make them comfortable in the long term with their own view of their gender so that they are happy and have a fulfilling life.³

While the Harry Benjamin Association guidelines are generally well accepted in the medical community, they are seen as controversial by some in the transgender community who believe that the guidelines unnecessarily restrict access to hormones and surgery. People who support the guidelines argue that proper diagnostic assessment, psychotherapy and “real-life experience” ensure that individuals are provided with careful hormonal and/or surgical intervention.

During a real-life experience, the transgender person lives in the self-identified gender and comes to appreciate the profound personal and social changes involved. This experience can be difficult for individuals who do not yet look convincing in the desired gender, without hormones, electrolysis and cosmetic surgery. Moving to the preferred gender in a workplace is the most challenging part of the change, and some transgender people choose to live their preferred gender everywhere except the workplace. The standards of care acknowledge these difficulties by allowing psychotherapy as an alternative to the real-life experience.⁴ Clearly, the real-life experience is more applicable to most Asian and Pacific’s contexts, especially given the general lack of psychiatry or psychological services in much of the region for the foreseeable future.

Epidemiology

Prevalence

No true prevalence studies of transgender identity have been undertaken. The task is hampered by changing definitions of transgenderism, significant cultural differences in social roles between and within countries, and the difficulty of doing such studies. Because of the very low prevalence of transgender identity, a huge study would be needed in order to get an accurate estimate. Furthermore, people do not confess to a stigmatized identity in household surveys. Estimates from the Netherlands suggest that 1 in 11,900 males may be male-to-female transsexuals, but this is probably an underestimate for three reasons:

1. Psychiatric disorders such as bipolar disorder or conduct disorder may mask gender problems.
2. Some male transvestites, female impersonators and male homosexuals may have a form of transgender identity which they have resolved in another way.
3. The degree of some people's transgender identity may be too mild to be detected clinically.

Somchai's story

When I was five, I felt as though my body looked different from how I felt it should be. I dressed in my sister's clothes because I felt more comfortable in them. My parents were very angry and beat me because I kept changing the boys' clothes my mother dressed me in. When I reached school age, it got even more difficult because the teachers wanted to put me into a boys' class but I wanted to be with the girls. In the boys' class, the other boys teased me and beat me, just like my parents. At the age of 11, I ran away from home to the city because no one seemed to understand me. In the city, I found other people like me who comforted me and accepted that I was the way I was. These "transgender" people sold sex for money and I started to do this too after they taught me how to do it ...

Natural history

A clear understanding of the natural history for transgender identity is lacking, although it appears that most boys with gender identity disorders outgrow their wish to change sex and gender without therapy. After an adult has been assessed as having a transgender identity, the therapy usually includes three parts, sometimes labeled "triadic therapy":

1. a real-life experience in the desired role
2. hormones of the desired gender
3. surgery to change the genitalia and other sex characteristics.

However, there are more recent observations that challenge this three-part approach. Some people who have been well assessed may change their mind with or without psychotherapy and accommodate their gender identities without medical intervention. Studies provide differing estimates of the number of people who have not benefited from triadic therapy. Also, the dropout rate from some clinics is high.

Many people with transgender identity will desire all three elements of therapy. Some take hormones first before embarking on real-life experience in the desired gender, but all have surgery as the final stage. However, it is now clear that not all transgender people need or want all three elements of therapy, so there is a variety of therapeutic approaches.

Cultural differences in gender identity

The behavioral expression of transgender identity is influenced by cultural differences between and within countries. Access to treatment, cost of treatment, the therapies offered, the professionals who deliver care, and the social attitudes towards transgender people differ widely. While transgender behaviors generally invoke a reaction of moral censure rather than compassion, there are striking examples of roles in certain cultures that are not stigmatized and may even be held to be sacred. These are not necessarily associated with sex with men. Furthermore, some cultures have multiple gender roles, while others tolerate cross-gender behavior in young people for a defined period of time with an expectation that the transgender person will later behave in a more gender-typical way.

Psychotherapy

Gaining access to a mental health professional in Asia for the initial assessment of transgender identity is difficult. Psycho-social support is most commonly sought through networks of friends, NGOs and, sometimes, traditional healers and others. It is even harder to arrange on-going psychotherapy. Psychotherapy is not a prerequisite to hormone therapy or surgery. Where therapy is needed and available, the therapist might discuss issues such as the likelihood that no educational, psychotherapeutic, medical or surgical therapy can permanently eradicate all traces of the person's original sex assignment and previous gender experience. The therapist can also support the person through all phases of gender transition.

The processes of psychotherapy have been described as

A series of interactive communications between a therapist who is knowledgeable about how people suffer emotionally and how this may be alleviated, and a patient who is experiencing distress. Typically, psychotherapy consists of regularly held 50-minute sessions. The psychotherapy sessions initiate a developmental process. They enable the patient's history to be appreciated, current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not intended to cure the transgender identity. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work, and gender identity expression. Gender distress often intensifies relationship, work, and educational dilemmas.⁴

In most Asian and Pacific settings, only two levels of mental health care are available to transgender patients:

1. Basic level. Basic psychological support from a transgender-friendly doctor, counselor, friends or transgender organization. This primary health care will probably be what the person can access at no cost.
2. Higher level. At this level, perhaps a multidisciplinary transgender clinic in a large city, there will be a high level of mental health skill. It is likely to be expensive and time-consuming.

Options for gender adaptation⁴

Some activities and experiences may help people to find more personal comfort as they work towards their new gender role; some suggestions are listed next page.

Activities

- Cross-dressing: unobtrusively with underclothes; in a “unisex” or neutral manner; or in a feminine fashion
- Changing the body through hair removal; minor plastic cosmetic surgical procedures
- Increasing grooming, clothing and vocal skills
- Learning about transgender issues from transgender groups and networks
- Involvement in activities of the desired gender
- Cross-gender living in short episodes.

Processes⁴

- Accepting one’s homosexual or bisexual fantasies and behaviors as distinct from the desire to change one’s gender identity and gender role
- Accepting the need to keep a job, look after children, stay committed to a relationship, or avoid distressing a member of the family. This may be a more major concern than one’s wish to live as the desired gender.
- Integrating awareness of male and female genders into daily life
- Identifying “triggers” that increase one’s transgender desires and attending to them, for example becoming more self-protective and self-assertive and developing skills both at work and in interpersonal relationships.

How should you talk to a transgender person?

What pronouns should you use?

Generally, anyone who is dressed as a woman should be addressed as “she” and anyone dressed as a man should be addressed as “he.”

This sounds simple, and it usually is. If someone you have always known as a man suddenly presents as “she,” or if someone who wears women’s clothes still identifies as a man, it can get complicated. If you are telling a story about a cross-dresser who presented as male at the time the story’s events took place, but presents as female now, the best approach is to use the pronoun “he” or “she” appropriate to the time you are talking about.

Avoid the use of gender-neutral language because you will just sound silly. Gender is important to transgender people, otherwise they would not be going to the trouble of changing it. So do not try to avoid gender.

Fortunately, most transgender people have a sense of humor and are happy to tell you how they wish to be addressed. Just ask! Respect works both ways.

Adapted from www.transgendermichigan.org/a/questions.htm, accessed July 4, 2003.

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Hormone Care for Male-to-Female Transgenders

9



Hormone Care for Male-to-Female Transgenders

For transgender people who have been assessed as suitable for medical treatment to assist their change to live as women, hormones play an important role in treatment. Hormones aid the process of gender change both anatomically and psychologically. Hormones are often medically necessary for living successfully in the new gender. They improve the quality of life and reduce the mental health problems that affect people who do not have treatment. When physicians administer estrogens, progesterone and testosterone-blocking agents to biologic males, patients feel and appear more like women.¹

Unfortunately, transgenders in Asia frequently use hormones in an uncontrolled manner with no medical supervision or based only on advice from friends or quacks. Further, this situation is compounded by the fact that few clinicians are able to provide competent advice when it is sought.

This combination of chaotic access to hormones and inadequate clinical support is a sure recipe for significant harmful health outcomes from hormone treatments. The suggestions in this section are perhaps idealistic but they give some indication of a professional standard to which your own clinical practice can be compared.

Hormone treatment can be given to people who do not want surgery and/or have not yet attempted to live as women. However, they must be appropriately diagnosed as having a transgender identity and meet the eligibility criteria.

Eligibility and readiness criteria for hormonal therapy in transgender adults¹

Eligibility criteria

1. The patient is at least 18 years old.
2. The patient knows what hormones can and cannot do medically, and their social risks and benefits.
3. Either (a) the patient has lived as a woman for at least three months before receiving hormones and there is documented evidence of this or (b) the patient has had psychotherapy for a period specified by the mental health professional (usually three months).

Sometimes, if there is a danger that a patient will take hormones without medical supervision by buying them on the black market or on the Internet, it may be acceptable to provide hormones to a patient who has not fulfilled criterion 3.

Readiness criteria

1. The patient has further confirmed her female gender identity through living as a woman or through psychotherapy.
2. The patient has made progress in mastering problems, so that her mental health has continued to be stable or has improved. This means she has satisfactorily overcome problems such as inappropriate social behavior, substance abuse, psychosis and depression.
3. The patient is likely to take the hormones in a responsible way.

Assessment visit²

When a patient sees you to be evaluated for hormone therapy, the first consultation should be long enough to allow time for you to take a full history, do a physical examination and have a full discussion. The discussion should cover the risks and benefits of hormones and also the expectations you and the patient have of the doctor-patient relationship.

History

Start the first visit by asking about the patient's gender experience that has led to the request for hormone treatment. As well as allowing you to understand the patient's life, this enables you to confirm the mental health professional's diagnosis and recommendation for treatment. In taking a complete medical history you should inquire about hypertension, ischemic heart disease, thrombophlebitis or thromboembolic disease, cerebrovascular disease, hepatic dysfunction, renal insufficiency, migraine headaches or seizures that do not respond to treatment, poorly controlled diabetes, obesity, hyperlipidemia and psychiatric illnesses.

It is essential to ask about use of tobacco, alcohol and other pharmaceutical and illicit substances. The patient may have already started using hormones without medical supervision. Ask about experience of premature cardiac death, thromboembolic disease, breast cancer and hyperlipidemia in members of the patient's close family. Also ask about the patient's social circumstances. What kind of support system does the patient have? Do family and friends know about the planned gender transition? Are they likely to support or oppose it?

It is important to communicate in an open and non-judgmental way about the person's sexual history, including gender of past partners, number of partners, sexual practices and sexual identity. This helps you to establish the risk of HIV and other STIs and makes it easier to be open in future discussions. Do not expect all patients to be able to give simple answers to questions about whom they find sexually attractive. Sexual orientation often evolves as an individual changes gender. As one patient said, "I had to get this gender thing figured out before I could figure out who I was attracted to."

Examination

A physical examination helps you to detect medical conditions that were not mentioned when you took the medical history. It is essential to examine the genitals in all transgender patients. In patients older than 40, you should also do a digital rectal examination and palpate the prostate. Initial laboratory testing (where available) should include complete blood count, electrolytes, blood urea nitrogen, creatinine, glucose, liver function tests, thyroid stimulating hormone (optional), complete urinalysis, lipid panel, baseline prolactin and a free testosterone level. Many of these tests will be unavailable or too expensive for patients in most countries of Asia and the Pacific.

Discussion of hormone risks and effects

A discussion of the risks and benefits of hormone therapy is an essential part of the first visit (see boxes). You should discuss the expected physical changes from hormones and the fact that the changes are often irreversible if therapy is discontinued. Patients often expect immediate, rapid and complete changes when they start hormone therapy. In fact the changes are limited and appear gradually over six to 24 months. It is important that patients understand that there are things that hormones cannot change, for example bone structure including hands, feet, hips and height. Give the patient written information describing the expectations of hormone therapy and standards of care for patients. It is helpful to give patients a schedule of planned follow-up visits and laboratory work (where available), so that they can financially prepare for future visits. A consent form (see Appendix E) is a way of formalizing your relationship with the patient by setting out expectations and commitment by both the doctor and patient.

Contraindications

Estrogens should not be used in men with any of the following conditions:

1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease.
2. Known or suspected estrogen-dependent neoplasia.
3. Undiagnosed abnormal genital bleeding.
4. Active thrombophlebitis or thromboembolic disorders.
5. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast malignancy).

Male-to-female transgender hormone treatment²⁻⁴

Hormone therapy for a male-to-female transgender person involves stimulating feminization of secondary sex characteristics with estrogen and reducing androgen (male hormone) effects with spironolactone. Progesterone can also be used to augment breast development, but its use is controversial among doctors caring for transgender patients. Each of these treatments is discussed below.

There are many (semi-) synthetic sex steroid hormones that can be used, but there are few published data comparing the efficacy of different hormones. Optimal doses have not been completely established. The choice of hormone therapy will therefore usually depend on availability (local regulations, pharmaceutical marketing), local traditions, side effects, preferred route of administration, cost and, perhaps most importantly, what your patient and her transgender peer group believe.

Estrogen

Estrogen dosing regimens for gender transition vary widely. Estrogen should be prescribed at the lowest possible effective doses to avoid the serious complications of high-dose estrogen therapy (see below). In terms of estrogenic effect, there is no superior estrogen—your choice will depend on cost, availability and the patient's preference. Currently recommended starting doses of estrogen range from 0.625 to 2.5 mg of conjugated estrogen (Premarin[®]), but higher doses of 5 mg of conjugated estrogen or equivalent per day may be needed. Some clinicians believe synthesized preparations are less likely to induce mood swings or depression than Premarin (which is made from the urine of pregnant horses). For example, estradiol (Estrace[®], 1-2 mg per day), esterified estrogens (Estratab[®], 0.625-5.0 mg per day), and ethinyl estradiol (Estinyl[®], Lynoral[®], 0.05-0.5 mg per day) are widely available and cheap. Patients often take ethinyl estradiol in the form of combined oral contraceptive pills containing estrogen and progesterone that they obtain from female friends or without prescription from pharmacies. The use of combined hormone preparations is not recommended, as the estrogen dose is too low (less than 25% of the recommended dose). It is also difficult to adjust effects to the individual patient, negative side effects are more likely to occur and the usefulness of progesterone is questionable.

There is no published evidence that injectable estrogen (Primogyn Depot[®]) preparations are better than oral preparations in the long term, except that they avoid first-pass metabolism in the liver. Estrogen patches (Climera[®], Estraderm[®]) also avoid hepatic first-pass metabolism and are thought to reduce the risk of thromboembolism, so patients over 40 years old should consider them. They are usually more expensive and have a potential additional side effect of contact dermatitis.

Expected effects of estrogen

Expected effects of estrogen therapy include breast development (painful breast nodules can appear at six to eight weeks), redistribution of body fat to a female pattern, softening of the skin, atrophy of the testicles by about 25%, loss of spontaneous erections, although sexual arousal erections generally persist, and slowing of scalp hair loss, although there is sometimes incomplete regrowth in bald patches.

Estrogen does not cause voice changes or reduce the size of a prominent male “Adam’s apple.” There is no change in penis length, although if the penis is almost completely flaccid (limp) it may appear smaller. Estrogen seems to increase bone mineral density in some male-to-female transgender patients. Some patients report an emotional peace or sense of well-being after starting estrogen and say they feel “more emotionally sensitive.” Estrogen induces breast development, but this can take up to two years. The box lists the effects of estrogen on biologic males. Most patients desire these changes but not all achieve them.

Effects of estrogen on biologic males

- Breast growth
- Some redistribution of body fat to resemble a female body shape
- Loss of upper body strength
- Softening of the skin
- Decrease in body hair and slowing or stopping of loss of scalp hair
- Decreased fertility and testicular size
- Less frequent, less firm erections
- Sense of well-being and of emotional sensitivity

Most of these changes are reversible, although breast enlargement will not completely disappear if treatment is stopped.

Possible serious side effects of estrogen

Uncommon but serious health risks of estrogen therapy include stroke, pulmonary embolism, myocardial infarction and breast cancer. Prescribing the lowest possible dose of estrogen minimizes these risks.

Hyperprolactinemia is a relatively common and dose-dependent side effect of estrogen therapy. Galactorrhea occurs in about 10% of patients on estrogen, whereas hyperprolactinemia is significantly more common. High prolactin levels may be a risk factor for prolactinoma. Where services are available, prolactin levels should be measured. A patient with a high prolactin level may be taking higher estrogen doses than prescribed.

Where laboratory tests are available, significant liver function abnormalities should be investigated. Infections such as hepatitis or other medications are common causes. It may be necessary to discontinue estrogen until the liver function becomes normal again, and then consider a transdermal delivery system. Significant liver abnormalities that do not improve after the patient stops taking estrogen should be investigated further with hepatic ultrasound because hepatic cell adenomas, focal nodular hyperplasia and hepatic cysts have been reported in male-to-female transgender patients.

Antiandrogens

Spironolactone (Aldactone®) is an antiandrogen that prevents the conversion of testosterone to dihydrotestosterone. It acts on the liver enzyme cytochrome P450 to reduce testosterone production and it reduces the effects of testosterone and dihydrotestosterone at the cellular level. If spironolactone is given in doses of 200 to 400 mg per day, the estrogen dose can be reduced to levels comparable to those that occur naturally in women while still producing the desired effects of breast development, feminization of skin, and female fat distribution. Spironolactone can also reduce erections and male hair pattern.

Spironolactone may be initiated at 200 mg per day in single or divided doses. At this dose, it is usually an effective antiandrogen, but it may be increased to 400 mg per day. Spironolactone can usually be discontinued after sex reassignment surgery. For some male-to-female transgender people, the beard androgen receptors are very sensitive to testosterone, so that adrenal testosterone production causes continued facial hair growth. Spironolactone can certainly be continued without difficulty in these people.

Possible serious side effects of spironolactone

Spironolactone has few serious side effects. Patients with low blood pressure can be started on lower doses or counseled to raise the dose with caution to avoid hypotension. Excessive urination usually diminishes after a few weeks of therapy. For those with good renal function who do not take potassium supplements or eat a diet extremely high in potassium, hyperkalemia does not pose a problem. Serum potassium levels may be checked periodically where testing services are available.

Cyproterone acetate (Androcur®) is a powerful antiandrogen and progesterone used in Europe for transgender patients. Its use is limited by its tendency to interfere with corticosteroid production, its high cost, and the side effect of hepatitis, which develops at the doses required for antiandrogen effects. Cyproterone acetate and ethinyl estradiol are available in a combined contraceptive pill (Diane®), which is prescribed for contraception in women who also require specific antiandrogen effects. However, to achieve therapeutic doses of estradiol using this combined medication would lead to possible side effects from the cyproterone.

There are several other antiandrogens used for more serious purposes, such as cancer treatment, whose potential risks of use in transgender patients may outweigh the benefits. Finasteride (Proscar®, Propecia®) is an antiandrogen that opposes the formation of dihydrotestosterone, but not of testosterone itself. Liver dysfunction is a possible side effect and it is more expensive than spironolactone. Flutamine (Eulexin®, Flutamin®, Fugerel®) is a potent antiandrogen, but its short half-life and cost usually limit its use. Leuprolide acetate (Leupron®) can provide chemical castration as it is a naturally occurring analogue of gonadotrophin-releasing hormone, but its very high cost and serious side effect profile limit its usefulness. Side effects include cardiovascular changes (electrocardiograph abnormalities, murmurs, ischemia, hypertension), fluid retention and musculoskeletal pain.

Progesterone

Progesterone is the third and optional component of the male-to-female hormone treatments. Specialists disagree about its use in transgender care. Medroxyprogesterone (Provera®, Depo-Provera®, Ralovera®) is a weak antiandrogen, and testosterone suppression may be achieved with lower doses of estrogen when used together with an antiandrogen. Medroxyprogesterone is less androgenic than norethindrone and norgestrel. Progesterone is commonly added to the regimen for breast development, although this may be of marginal benefit in some patients.

Unlike estrogen, progesterone does not increase the risk of thromboembolism, prolactinoma or myocardial infarction. Although doses of 20 to 40 mg per day are needed to suppress luteinizing hormone, medroxyprogesterone acetate may become androgenic at these doses, so it is prudent to start on 10 mg a day and then increase the dose if needed.

Micronized progesterone (Prometrium®) causes less anxiety and irritability than medroxyprogesterone. It is also less androgenic when higher progesterone doses are needed, but is more costly.

See the box for a list of some combined potential negative effects of estrogen and progesterone therapy in biologic males.

Potential negative side effects of estrogen and progesterone in biologic males

- increased propensity to blood clotting (venous thrombosis with a risk of fatal pulmonary embolism)
- development of benign pituitary prolactinomas
- infertility
- weight gain
- mood instability, including depression
- liver disease
- gallstone disease
- tiredness
- hypertension
- diabetes mellitus
- breast cancer

Other potential benefits of hormones

Hormonal treatment, when medically tolerated, should occur before any surgery on the genitals. If the patient is satisfied with the hormone's effects, her identity as a woman is consolidated and this confirms the decision to proceed to gender transition. If the patient is dissatisfied with the effects of the hormones, this may indicate ambivalence about proceeding to irreversible surgical interventions. In biologic males, hormones alone often generate adequate breast development, precluding the need for breast enhancement. Some patients who receive hormonal treatment do not later desire genital or other surgical interventions.

Other side effects of transgender hormone therapy

In addition to the side effects discussed above, mortality six times greater than the general population has been observed in transgender populations. Suicide and unknown causes are the most frequent reasons for death, which suggests the importance of mental health care for transgender people.

Follow-up care and monitoring

Regular contact with the patient allows you (the prescribing doctor) time for monitoring the patient's expectations and her social, emotional and physical progress. It also allows you to take preventive action against any side effects. Follow-up should occur at three, six and 12 months after initiation of hormones, or more often, and twice a year thereafter. After sex reassignment surgery and full movement into the female role on stable hormone doses, yearly follow-up is enough. During each visit, ask about body changes, breast development and mood. The social impact of the transition and the patient's perspective on body changes should also be discussed. It is common for patients to be frustrated about the length of time required to make the transition, and for them to be disappointed with their breast size and feel shame about their inability to "pass" as female. Most breast development occurs in the first

one or two years of hormonal therapy, but four to six years may be required for full maturation. Specific techniques for measuring breast development may be needed.

Where services are available, laboratory follow-up should include testing of liver function and potassium levels at three and six months and yearly thereafter. Prolactin levels may be measured after six months of therapy, then yearly for three years. Lipid profiles should be followed regularly, especially for patients with high or borderline values. Measuring serum testosterone levels is expensive, but establishing that they are within the normal female range helps you to document that hypothalamic–pituitary suppression is adequate. Such measurements can be especially helpful when you are making a decision about whether to increase estrogen doses.

Although there are many possible risks and side effects of hormonal therapy, most transgender patients make the transition without any serious side effects.

Table 9.1 Sample hormone regimens for male-to-female transgender patients²

Medication*	Starting dose	Subsequent dose	When to change doses
Estrogens			
Conjugated estrogens (Premarin®)	1.25 mg orally per day 0.625 mg orally per day (smoker)	2.5 mg orally per day Do not increase in smokers	To obtain best clinical results, or if testosterone is not suppressed. After sexual reassignment surgery, dose may be decreased without losing secondary sexual characteristics
OR Estradiol (Estrace®)	1 mg orally per day	2 mg orally per day	
OR Transdermal estradiol (Climara®, Estraderm®)	0.1 mg patch per week	Two 0.1 mg patches per week	
Antiandrogens			
Spironolactone (Aldactone®)	200 mg orally per day	May discontinue	After sexual reassignment surgery
Progesterone			
Medroxyprogesterone** (Provera®)	10 mg orally per day	May increase to 20–40 mg (usually not needed)	If testosterone is not suppressed and patient or doctor does not want to increase estrogen.
OR Micronized progesterone** (Prometrium®)	100 mg orally twice a day	May discontinue after breast development complete	Micronized progesterone is more costly, but is less likely to cause anxiety than medroxyprogesterone

* There is no professional consensus on the safest and most effective dosing regimens for gender transition. This table gives reasonable starting and maintenance doses that are supported in the (admittedly less than optimal) medical literature, and reflect the author's opinion and practice. The table is not meant to include all possible hormone regimens, only several of the most commonly used medications.

** There is no professional consensus on the role of progesterone in male-to-female transition.

Table 9.2 Some typical hormone regimens for male-to-female transgender patients⁵

Medication	Dose range
Estrogens	
Estradiol (Estrace [®] , Estrofem [®])	6-8 mg orally or sublingually daily in divided doses
OR Conjugated estrogens (Premarin [®])	5 mg orally daily in divided doses
OR Estradiol (Climara [®] , Estraderm [®])	Two 0.1 mg patches, changed weekly
OR Estradiol valerate (Progynon [®] , Estrofem [®])	20 mg intramuscularly every two weeks
OR Ethinyl estradiol (Estinyl [®] , Lynoral [®])	100 ug (0.1 mg) orally daily
Antiandrogens	
Spironolactone (Aldactone [®])	100-300 mg orally daily in divided doses
Progestogens (usually optional)	
Micronized progesterone (Prometrium [®])	100 mg orally twice a day
OR Medroxyprogesterone (Provera [®])	5-10 mg orally every day

One possible regimen is to start with a moderate estrogen dose (e.g. estradiol, 2 mg twice a day). One month later, advance to a higher dose (e.g. estradiol 6-8 mg a day in divided doses). One month later, add spironolactone 100 mg twice or three times a day. Later add more estrogen or a progestogen as needed to achieve desired feminization, to eliminate spontaneous erections (an index of free testosterone) and to achieve serum testosterone levels in the female range and serum estradiol levels approximately a third to a half of the female mid-cycle peak.

Consider transdermal estradiol for patients over age 40 and for those who have risk factors such as smoking, a personal or family history of deep venous thrombosis or other cardiovascular disease. After orchidectomy, estrogen can be reduced to quarter or half of the preoperative dosage, and antiandrogens can be discontinued.

Table 9.3 Some typical costs of hormone regimens for male-to-female transgender patients using doses from Table 11.2

Medication	Dose range	Bangladesh US\$ per month*	Thailand US\$ per month*
Estrogens			
Estradiol (Estrace®, Estrofem®, Estriol®, Proginova®)	6–8 mg orally daily	\$21	\$15–\$63
Conjugated estrogens (Premarin®)	5 mg orally daily	\$7–\$18	\$23–\$43
Estradiol valerate (Progynon®, Estrofem®)	20 mg intramuscularly every two weeks	Not available	Not available
Antiandrogens			
Spironolactone (Aldactone®)	100-300 mg orally every day	\$5–\$8	\$19
Progestogens (usually optional)			
Medroxyprogesterone (Provera®)	5-10 mg orally every day	\$10	\$7

* Costs calculated as US\$1 = 40 Thai Baht or 58 Bangladeshi Taka.

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1. Harry Benjamin, International Gender Dysphoria Association. *Standards of care for gender identity disorders*. Sixth version. Minneapolis, MN: HBGDA, 2001. At www.hbigda.org/soc.html. Accessed July 2003.
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**Male-to-Female
Gender Reassignment Surgery**

10



Male-to-Female Gender Reassignment Surgery

Gender reassignment surgery (sometimes also called sex reassignment surgery), along with hormone therapy and real-life experience, is a treatment that has proven to be effective and appropriate for transgender people. Sex reassignment is not “experimental,” “investigational,” “elective,” “cosmetic” or optional in any sense when prescribed or recommended by qualified practitioners.¹

Ethics¹

Many people object on ethical grounds to surgery for transgender people. It is commonly thought that the only valid reason for surgery is the removal of pathological tissue or the correction of disturbed function and that these conditions do not exist in transgender people. However, other widely practiced types of surgery such as sterilization do not continue to present such ethical dilemmas. To fully appreciate how surgery can alleviate the psychological discomfort of transgender patients, professionals need to listen to, learn from and discuss their patients’ life histories and share their dilemmas. Professionals dealing with transgender patients must feel comfortable about altering anatomically normal structures.

It is unethical to deny gender reassignment surgery or hormone therapy to patients solely because they have infections such as HIV, hepatitis B or hepatitis C. While some high-dose hormone therapies may exacerbate pre-existing hepatitis, careful monitoring of patients helps to prevent serious problems. There are internationally accepted precautions for preventing the transmission of these viruses during surgery.

The surgeon and the transgender care team

Ideally, the surgeon should belong to an interdisciplinary team of professionals who specialize in transgender patient care. Such teams do not exist everywhere, however, so the surgeon needs at least to be assured that the mental health professional and physician prescribing hormones are reputable professionals with specialized experience with transgender people. The documentation letters from referring doctors should demonstrate an understanding of the standards of care in terms of eligibility and readiness criteria for hormone therapy and successful real-life experience (see box for details). Surgeons should speak with at least one of the referring doctors to discuss each patient, to verify the authenticity of the referral letters and to establish a working relationship.

The surgeon is not merely a technician hired to perform a procedure but is part of the team of clinicians participating in a long-term treatment process. The patient often holds the surgeon in high regard, a fact which in ideal circumstances enables long-term follow-up care by the surgeon. The surgeon has a responsibility to the patient and must understand the diagnosis that has led to the recommendation for genital surgery. Surgeons need to speak at length with their patients to ensure that the surgery will be beneficial.

Before performing any surgical procedures, the surgeon should monitor all medical conditions appropriately, where laboratory services are available, and investigate the effects of the hormonal treatment upon the liver and other organ systems. This can be done alone or in conjunction with medical colleagues. Since pre-existing conditions may complicate genital reconstructive surgery, surgeons must also be competent in urological diagnosis. The medical record should contain written informed consent for the particular surgery to be performed. (See Appendix F for an example of a consent form.)

Minimum eligibility criteria for gender reassignment surgery¹

The patient

1. has reached the legal age of consent to medical treatment in that country.
2. has had continuous hormonal therapy for at least 12 months (unless there are medical contraindications).
3. has had successful continuous full-time real-life experience for at least 12 months. (Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion.)
4. has participated regularly and responsibly in psychotherapy (where available and indicated) throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy *per se* is not an absolute eligibility criterion for surgery.
5. has demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications and postsurgical rehabilitation requirements of various surgical approaches.
6. is aware of alternative surgeons, if available. The patient may wish to seek a second surgical opinion before proceeding.

Readiness criteria¹

1. Demonstrable progress in consolidating gender identity.
2. Demonstrable progress in dealing with work, family and interpersonal issues, resulting in a significantly better state of mental health. This implies satisfactory control of problems such as substance abuse, psychosis, depression and personality disorders.

Most reputable gender reassignment surgeons in Asia generally adhere to these criteria, although sometimes with variations in the periods of time required for hormone therapy and/or real-life experience. Some surgeons waive criteria, for example when a patient has had a long period of time in real-life experience without the use of hormones and has been assessed as psychologically healthy and ready for surgery.^{2,3}

When can surgery be done?

Genital surgery for transgender people should be undertaken only after comprehensive evaluation by a qualified mental health professional. After a comprehensive evaluation, documented in writing, and the person has met the eligibility and readiness criteria, surgery can be done. The mental health professional, the surgeon and the patient share responsibility for the surgery, which is irreversible.

Requirements for the genital reconstruction surgeon¹

Ideally, surgeons should:

- be urologists, gynecologists, plastic surgeons or general surgeons certified by a nationally known and reputable association.
- have specialized skills in genital reconstructive techniques and have had documented supervised training with a more experienced surgeon.
- be willing to have their therapeutic skills reviewed by their peers.

- undertake continuing professional education where new techniques are presented.
- be knowledgeable about more than one of the surgical techniques for genital reconstruction so that they, in consultation with patients, are able to choose the ideal technique for individual patients.
- if they are skilled in only one technique, inform their patients of this and refer those who do not want this procedure or are unsuitable for it to another surgeon.

Genital surgery

The aim of genital surgery is to reshape the genitals from a male to female shape and to allow the new genitals to function like female genitals. All reproductive organs are removed.⁴

The expected outcome of genital surgery is to:

1. approximate the external appearance of female genitals.
2. create a skin-lined vaginal canal.
3. provide normal urinary function.
4. permit sexual sensations.

Genital surgical procedures typically includes all of:

- orchidectomy—removal of testicles.
- penectomy—removal of penis.
- vaginoplasty—construction of a new vagina.
- clitoroplasty—construction of a new clitoris.
- labioplasty—construction of new labia.

Vaginoplasty surgery

Vaginoplasty surgical techniques to create a neovagina vary according to the length of the penis. The four main vaginoplasty techniques are:

- penile skin inversion (performed when the penis is long)
- penile skin inversion with scrotal skin graft (medium length penis)
- pedicle rectosigmoid (colon) transplant (short penis)
- free skin graft to line the neovagina (skin taken from non-genital parts of the body).

The “penile skin inversion” vaginoplasty is the most widely used technique for creating a neovagina. This method is characterized by removing the skin from the shaft of the penis and using the freed skin as the lining of a newly created vaginal cavity 12 to 14 cm deep. Hair does not grow within the neovagina. The illustrations show the steps involved in the surgery.

Labioplasty creates neolabia (labia minora and labia majora) from scrotal skin. A neoclitoris is constructed from penile tissue, usually from the glans. The neoclitoris should therefore retain sexual sensations and erectile function. A neourethra is fashioned from the urethra, with some surrounding erectile tissue removed to prevent excessive engorgement and distortion of the neovagina during sexual arousal.

Genital surgery usually lasts two to three hours and requires five to seven days hospital rest. All of the above procedures are performed during a single operation.

What is to be expected after genital surgery?

Male-to-female transgender people who under take genital surgery have varied outcomes both anatomically and sexually. The surgical wounds heal within four to six weeks.

Irrespective of which vaginoplasty procedure is undertaken, the frequent insertion of gradually larger diameter dilators is an essential part of postoperative care. In order to maintain the length and elasticity of the vagina dilators 28 to 38 mm diameter and 12 to 14 cm long are inserted several times a day for 30 to 40 minutes for several months after surgery. Initially this is painful. Without regular dilation during the immediate postoperative period, the neovagina would heal in an inelastic and contracted way. Vaginal dilation is a part of life-long neovaginal health care, especially during periods when there is no sexual activity that includes vaginal intercourse. Dilation once or twice weekly will be required during these times.

Gentle vaginal intercourse with a respectful partner should be possible six weeks after the operation, although full sexual sensations and orgasm may not come until later. Water-based lubricant and condoms should be used to reduce discomfort and the risk of possible infections. The genital area requires a lot of readjustment to the newly created structures including the nerves. Not only do the local nerves need to regrow, but also the brain has to readjust to the location of the nerves and how they are responding in relation to each other. The individual must explore these new sensations and will need reassurance that there is no set time for all sexual sensations to reappear. There may be powerful sexual sensations in the pelvic area just after the operation because the prostate and bulbourethral tissues are still present. It may be both an exciting and a frightening time for the patient.

Potential surgical complications⁵

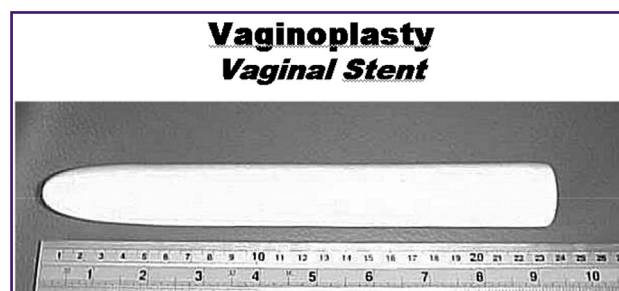
Minor and short-term complications include swelling, infections or bleeding of the wound, urinary retention due to neourethral swelling, sloughing and loss of some of the grafted skin (usually for no more than two to three weeks). There may also be areas of numbness or tingling as a result of nerve injury and disruption. These may manifest as sharp pains like shocks in the wounds as they heal. Most of these minor complications can easily be managed and are under control before the woman leaves the hospital.

Major complications are rare when surgery is performed by reputable surgeons. There may be major local infection or bleeding, or damage to the bladder, prostate or major nerves during the dissection to form the vagina. These complications can be difficult to control and correct, may require an extended hospital stay, and can lead to permanent damage.

Rectovaginal fistula is one of the most feared complications of genital surgery. A fistula can occur if the rectal wall is damaged during dissection of the vaginal cavity or from death of rectovaginal tissue due to the pressure of vaginal packing during the period immediately after the operation. The fistula allows feces to bypass the anal stricture into the vagina. The feces prevents proper healing of the fistula and presents a danger of infection. The damage can be corrected only by a colostomy with a bag to divert the feces while the fistula heals. During this period, proper dilation of the neovagina may not be possible, which may lead to closure of the neovagina. Further genital surgery using skin grafts will then be needed. This complication is reported to occur in three of 1000 operations, but is likely to be significantly underreported.

Shortening and/or narrowing of the neovagina may occur, usually when a patient does not dilate it regularly with her vaginal dilators or has

Figure 12.1 Vaginal stent or dilator



prolonged periods without coitus. However, it is easily overcome by dilating the vagina more often.

Other feminization surgery for the male-to-female transgender person

In order to assist with feminization, some male-to-female transgender people undertake other types of surgery: breast surgery, thyroid reduction chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift or blepharoplasty. Letters of recommendation from mental health professionals are not required for these operations.

There are concerns about the safety and effectiveness of voice modification surgery. More research is required before this procedure can be recommended. Patients who elect to have this surgery are advised to have it after any other surgical procedures requiring general anesthesia with intubation.

Breast surgery

Breast augmentation and removal are common operations, easily obtainable by the general public. Reasons for these operations range from cosmetic indications to cancer. Although some biologic women have very small breasts, breast development is important to many transgenders. Breast operations should be considered with the same care as initial hormonal therapy. Both produce irreversible changes to the body.

For male-to-female transgender patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.

Hair removal

If hair growth is excessive by feminine standards and does not respond to antiandrogen therapy, hair removal may help the transgender person with her transition to her new role. There are many techniques, some more successful than others, at a range of prices. Genital hair removal should not be undertaken immediately before genital surgery, as local skin infections and in-growing hair can complicate the operation. Also, if the surgeon can see where hair grows before the operation, it is easier to see which parts need to be denuded for fashioning the new genitals.

A common question for transgender

“Are you pre-op or post-op?”

Transgender people are often asked this question and usually give a short answer just to get it over with.

But what is this question really asking? It is about the shape of someone’s genitals. If someone you had just met were to ask you: “How long is your penis?” or “How deep is your vagina?”, how would you react? You would want to hit him or have him arrested, wouldn’t you? Unless he was your doctor, or you had been dating him, he would have no business asking the question.

Besides, it is not a simple either-or question. For male-to-female transgenders, the “operation” is actually three operations: orchidectomy, vaginoplasty and labioplasty. These operations are sometimes combined, but not always. So a person could be “mid-op.” Also hormone therapy causes “shrinkage” to the point that the question may be more or less meaningless.

Some transgenders will bring up the subject themselves. When getting the “operation” is the central focus of their life, it is hard to avoid it. When they start telling you far more about their genitals than you want to know, just humor them, and it will pass.

Adapted from www.transgendermichigan.org/a/questions.htm, accessed July 2003.

The cost of male-to-female gender reassignment surgery

Typically male-to-female gender reassignment surgery using the penile inversion technique costs US\$5,000 to US\$8,000 in Thailand and about US\$10,000 in Australia.

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Neovaginal Health

11



Neovaginal Health

The health care of a newly created neovagina (i.e. the new post-surgical vagina) in a male-to-female transgender person is aimed at ensuring the neovagina continues to appear and function in a way that was intended. Clearly, the origins of the tissues used to create a new vagina will limit how it appears and functions, but there are some specific ways to maintain optimal neovaginal health.

For immediate postoperative care, see Chapter 12.

Because most neovaginas are made from penile skin and have associated glandular tissue, they can be affected by the same local conditions that affect the anus (see Chapter 6, Anal health). For example, gonorrhea can infect the urethra, genital warts or herpes can affect the neolabia, and the neolabia can tear during sex. The specific problems affecting neovaginas have not been systematically documented and so only the conditions likely to be unique to neovaginas will be highlighted here. Of course, unprotected sex involving the neovagina can also expose the transgender or her partners to other systemic STIs including HIV infection. Trauma, especially where post-surgical healing has left scar tissue in or around the neovagina, is also likely to increase the potential risk of infection with STIs, especially HIV.

Neovaginal problems may manifest as lumps, ulcers, rashes, discharge, bleeding or dyspareunia.

Neovaginal cleansing

Cleansing the skin of the neolabia with mild soap and water should be done as a normal part of whole-body bathing. Douching inside the neovagina with soap and water is not recommended, although rinsing with plain water is unlikely to be harmful.

Lubrication

Most neovaginas do not self-lubricate, so lubricant needs to be applied liberally during penetrative sex to improve comfort and prevent tearing. Lubrication, cleanliness and condoms reduce the chance of tearing and minimize the risk of transmitting disease during sex. Lubricant should be water-based, not oil-based, as oil-based lubricants can increase the likelihood of breakage of latex condoms. Lubricants and condoms that contain nonoxynol-9 spermicide should be avoided. Recent data suggests that nonoxynol-9 may actually increase the risk for transmission of HIV.¹

Some people report self-lubrication of their neovagina, which probably comes either via the urethra from the remaining Cowper's and prostate glands or from the neovagina itself. People who have had the "colonic inversion" vaginoplasty will self-lubricate and may have the opposite problem of excess lubrication. They may need to wear panty liners to absorb the excess moisture, which can otherwise irritate the skin. Frequent salt bathing can be helpful.

Condoms

Using condoms is an excellent way to prevent STI transmission although they might be less effective against some STIs (e.g., those transmitted more by skin-to-skin contact such as HPV) than others. Getting the male partner to wear a condom or inserting a female condom into the neovagina before any genital contact will provide the most protection.

Reference

1. Phillips DM, Taylor CL, Zacharopoulos VR, Maguire RA. *Nonoxynol-9 causes rapid exfoliation of sheets of rectal epithelium*. *Contraception* 2000; 62: 149-54.

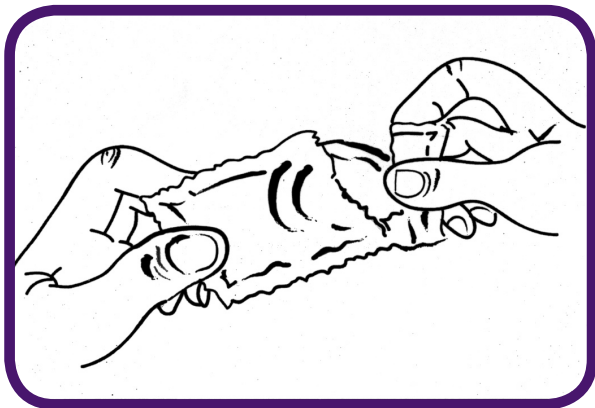
Appendix

A

How to use a male condom

Appendix A

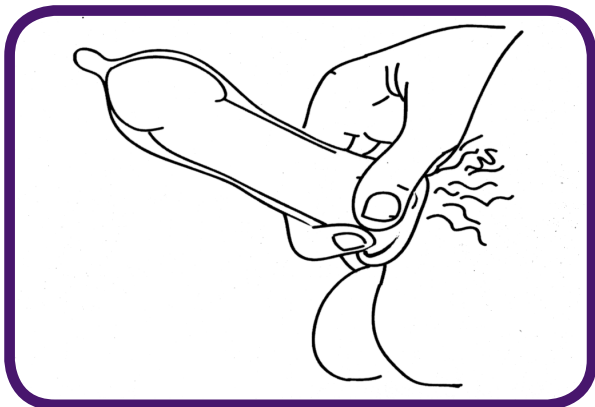
How to Use a Male Condom.



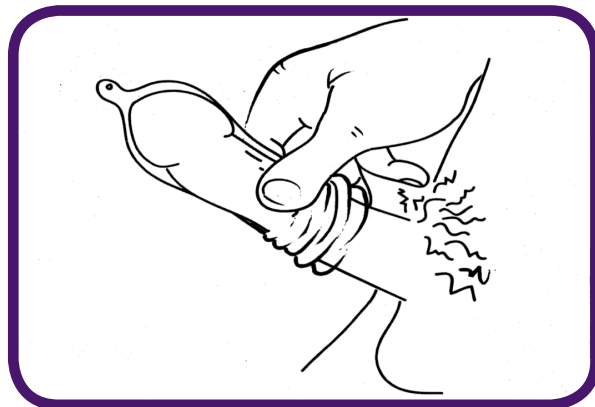
1.
 - Choose a brand that fits comfortably.
 - Do not use teeth to open packet.
 - Be careful not to tear condom with nails.
 - Check 'use by' date (expiry date).



2.
 - Holding the tip, unroll the condom on to erect penis.
 - Pull back on foreskin before applying condom (if uncircumcised).



3.
 - Unroll condom fully to base of penis.
 - Always use water-based lubricant.
 - Do not use oil or Vaseline® (petroleum jelly).
 - During sex, check condom is still in place.



4.
 - When finished, withdraw while penis is still erect.
 - Hold on to base of condom to make sure it comes out and to prevent contents from spilling.
 - Use condom only once.
 - Dispose of condom safely.

Appendix

B

Patient Handout: Female condoms and men who have sex with men

Appendix B

Patient Handout: Female condoms and men who have sex with men

Female condoms (brand names Femidom® and Reality®) have not yet been tested thoroughly for use in anal sex, so men using the female condom for male-to-male sex do so at their own risk.

The female condom is a polyurethane bag with an inner and outer ring that can be inserted into the rectum before anal sex. The outer ring ensures that the bag does not slide inside the anus while the inner ring helps with inserting it. The outer ring is fixed and the inner ring can be removed.

Why use female condoms?

Some men who have sex with other men (MSM) have problems with male condoms. These problems can stop you having anal sex or lead you to do it without a condom. Condoms provide the best protection against HIV and other sexually transmissible infections.

You may have had difficulty in getting conventional male condoms on because they are too tight or will not go over the head of your penis, or because they are too loose. The shape of your penis may prevent the condom from staying on, or you or your partner may go soft (lose your erection) when trying to get the condom on. Some MSM find that male condoms reduce sensitivity, that putting them on interrupts spontaneity, or that they split during sex.

Female condoms may be right for you if you have experienced any of these difficulties.

How to use female condoms

There are two ways to use a female condom for anal sex. Both work well and your preference will depend on your experience.

1. With the inner ring

Female condoms have a loose ring inside to allow them to be inserted into your anus. You may want to do this before having sex or you can do it during sex with your partner's help. It will take some practice to insert the condom smoothly and you will need to add extra lubricant, even though it comes with some lubricant on it. Put lubricant on the inside and outside.

Female condom



Male condom



Before inserting, pinch the inner ring in half from the outside to flatten it, then slide the ring into your anus. Once the ring is inside, slide your finger inside to push the ring in further. Apply more lubricant to your partner's penis just before he sticks it inside. When he inserts his penis, be sure that it goes inside the bag and not alongside it.

2. Without the inner ring

The female condom can be used as a baggy condom without the inner ring. Slide it over your partner's penis just before intercourse and remember to use extra lubricant inside. Extra lubricant helps his penis slide in and out and prevents the bag clinging to his penis.

Advantages

- If you use a female condom, your partner does not have to pull out immediately after ejaculation as he should with the conventional condom. He can go soft inside you and the bag can be removed when it suits you. To remove a female condom, twist the outer ring to keep the semen from dribbling out and then gently pull.
- The sensitivity may return to the penetrating partner's penis.
- Female condoms are made from polyurethane; this means they are not damaged by oil-based lubricants. If you like to massage before sex, female condoms are likely to be a safer alternative, as massage oils will not harm them. Remember that some lubricants can cause irritation to your sensitive anus, so check you are not allergic to a lubricant before you use it. However, to avoid confusion with lubricant used with male condoms, it is better to stick to your standard water-based lube if you use both male and female condoms.

Remember that the female condom only provides a barrier between two people. If there are more than two people having intercourse, the penetrating partners will not be protected from each other.

Where can I get female condoms?

Female condoms can be purchased from pharmacies or obtained free from some NGOs.

Are female condoms reusable?

No, they should only be used once, then thrown into a rubbish bin.

Appendix

C

Treatment of STI-associated Syndromes (WHO recommendations, 2003)

Appendix C

Treatment of STI-associated Syndromes (WHO recommendations, 2003).

Note:

These recommendations are quoted directly (with some minor editing to remove text relating to women) from the most recent WHO STI Guidelines (2003). They are provided for guidance only. It is recommended that local national guidelines for managing these syndromes also be consulted to inform your clinical practice.

Additionally, please note that material for major syndromes affecting women (vaginal discharge and lower abdominal pain) have not been included here. Similarly, references to pregnancy have been removed.

The recommendations for the treatment of specific infections can be found in Table 1 in Chapter 7.

This section discusses the management of the most common clinical syndromes caused by sexually transmitted agents. Flowcharts for the management of each syndrome are provided.

For all these conditions, the sexual partner(s) of patients should also be examined for STIs and promptly treated for the same condition(s) as the index patient.

Successful management of STIs requires members of staff to be respectful of patients and not to be judgemental. Clinical examination must take place in appropriate surroundings where privacy can be ensured and confidentiality guaranteed. When dealing with adolescents, the health care provider should be reassuring, experienced and conversant with the changes in anatomy and physiology associated with the different maturation stages, e.g. nocturnal emissions in boys. In some situations, health care workers require training to overcome their own sensitivities and to be able to address the issues associated with sexuality and STIs in an open and constructive manner.

1. Urethral discharge

Male patients complaining of urethral discharge and/or dysuria should be examined for evidence of discharge. If none is seen, the urethra should be gently massaged from the ventral part of the penis towards the meatus.

If microscopy is available, examination of the urethral smear may show an increased number of polymorphonuclear leukocytes and a Gram stain may demonstrate the presence of gonococci. In the male, the presence of more than 5 polymorphonuclear leukocytes per high power field (x 1000) is indicative of urethritis.

The major pathogens causing urethral discharge are *Neisseria gonorrhoeae* (*N. gonorrhoeae*) and *Chlamydia trachomatis* (*C. trachomatis*). In syndromic management, treatment of a patient with urethral discharge should adequately cover these two organisms. Where reliable laboratory facilities are available, a distinction can be made between the two organisms and specific treatment instituted.



Recommended syndromic treatment

- Therapy for uncomplicated gonorrhoea (for details see Table 1 in Chapter 7)

PLUS

- Therapy for chlamydia (for details see Table 1 in Chapter 7)

Note: Patients should be advised to return if symptoms persist 7 days after start of therapy.

AT A GLANCE

Urethral discharge

For details, see Table 1 in Chapter 7

Treatment options for Gonorrhoea

- Ciprofloxacin (resistance is very common in Asia)
- Ceftriaxone
- Cefixime
- Spectinomycin

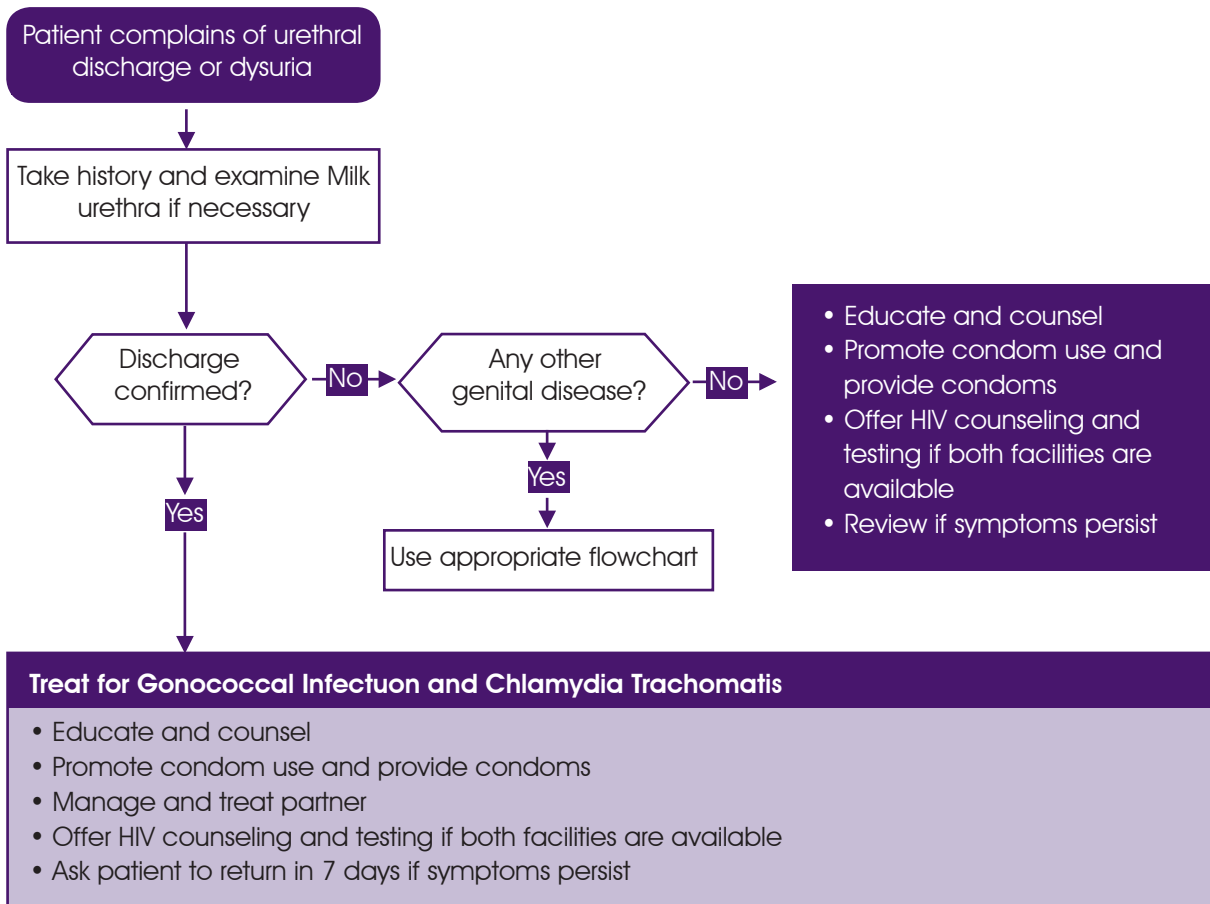
Treatment options for Chlamydia

- Doxycycline
- Azithromycin

Alternatives

- Amoxicillin
- Erythromycin (if Tetracycline contraindicated)
- Ofloxacin
- Tetracycline

Figure 1. Urethral Discharge

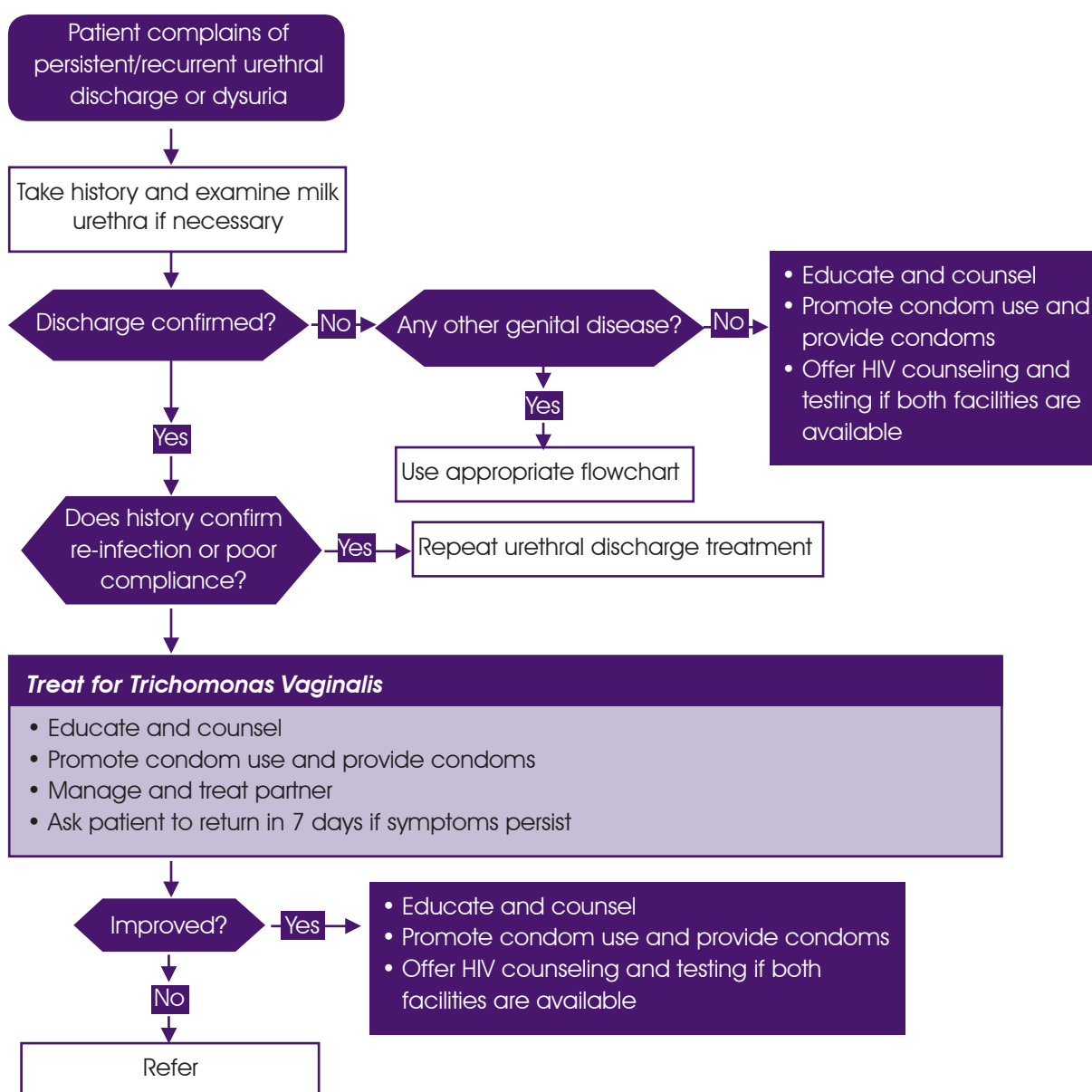


2. Persistent or recurrent urethral discharge

Persistent or recurrent symptoms of urethritis may result from drug resistance, poor compliance or reinfection. In some cases there may be infection with *Trichomonas vaginalis* (*T. vaginalis*).

New evidence suggests a high prevalence of *T. vaginalis* in men with urethral discharge in some geographical areas. Where symptoms persist or recur after adequate treatment for gonorrhoea and chlamydia in the index patient and partner(s), the patient should be treated for *T. vaginalis* if the local epidemiological pattern so indicates. If the symptoms still persist at follow-up the patient must be referred. For details, see Table 1 in Chapter 7.

Figure 2. Persistent/recurrent urethral discharge in men



Please note: This flowchart assumes effective therapy for Gonorrhoea and Chlamydia to have been received and taken by the patient prior to this consultation.



3. Genital ulcers

The relative prevalence of causative organisms for Genital Ulcer Disease (GUD) varies considerably in different parts of the world and may change dramatically over time. Clinical differential diagnosis of genital ulcers is inaccurate, particularly in settings where several etiologies are common. Clinical manifestations and patterns of GUD may be further altered in the presence of HIV infection.

After examination to confirm the presence of genital ulceration, treatment appropriate to local etiologies and antimicrobial sensitivity patterns should be given. In areas where both syphilis and chancroid are prevalent, for example, patients with genital ulcers should be treated for both conditions at the time of their initial presentation, to ensure adequate therapy in case of loss to follow-up. In areas where either granuloma inguinale or lymphogranuloma venereum (LGV) is prevalent, treatment for either or both conditions should be included for the same reason.

Recent reports from parts of Africa, Asia and Latin America indicate that GUD is more frequently a result of Herpes Simplex Type 2 (HSV2) infections. This has implications for the efficacy of the syndromic management of GUD if specific antiviral treatment of HSV2 is not considered. In areas of high HIV prevalence, the clinical presentation of these HSV2 ulcers is different from the classical descriptions.

The GUD flowchart presented in this section proposes specific HSV2 treatment, where indicated.

Laboratory-assisted differential diagnosis is also rarely helpful at the initial visit, as mixed infections are common. In areas of high syphilis prevalence, a reactive serological test may only be a reflection of a previous infection and give a misleading picture of the patient's present condition, and a negative test does not necessarily exclude an ulcer of primary syphilis as seroreactivity may take 2–3 weeks to show.

Genital ulcers and HIV infection

There have been a number of anecdotal reports in the literature suggesting that the natural history of syphilis may be altered as a result of concomitant HIV infection. Some reports have indicated atypical presentations of both primary and secondary syphilis lesions. Some have noted an increase in treatment failure rates among patients with early syphilis who are treated with single-doses of penicillin.

In chancroid, atypical lesions have been reported in HIV-infected individuals. The lesions tend to be more extensive, or multiple lesions may form that are sometimes accompanied by systemic manifestations such as fever and chills. Reports of rapidly aggressive lesions have been noted by some clinicians. This emphasizes the need for early treatment, especially in HIV-infected individuals.

There is evidence to suggest that HIV infection may increase rates of treatment failure in chancroid, especially when single-dose therapies are given. More research is needed to confirm these observations.

In immunosuppressed individuals, herpes simplex lesions may present as persistent multiple ulcers that require medical attention, as opposed to the self-limiting vesicles and ulcers which occur in immunocompetent individuals. Thus, antiviral treatment is particularly important in such instances, to be given therapeutically or prophylactically to offer comfort to the patient. Adequate education needs to be given to the patient as well, to explain the nature and purpose of treatment and in order to avoid false expectations of cure.

Recommended syndromic treatment

- therapy for syphilis (for details see Table 1 in Chapter 7)

PLUS EITHER

- therapy for chancroid where it is prevalent (for details see Table 1 in Chapter 7)

OR

- therapy for granuloma inguinale where it is prevalent (for details see Table 1 in Chapter 7)

OR

- therapy for LGV where it is prevalent (for details see Table 1 in Chapter 7)

OR

- therapy for HSV2 infection where indicated (for details, see Table 1 in Chapter 7)

AT A GLANCE

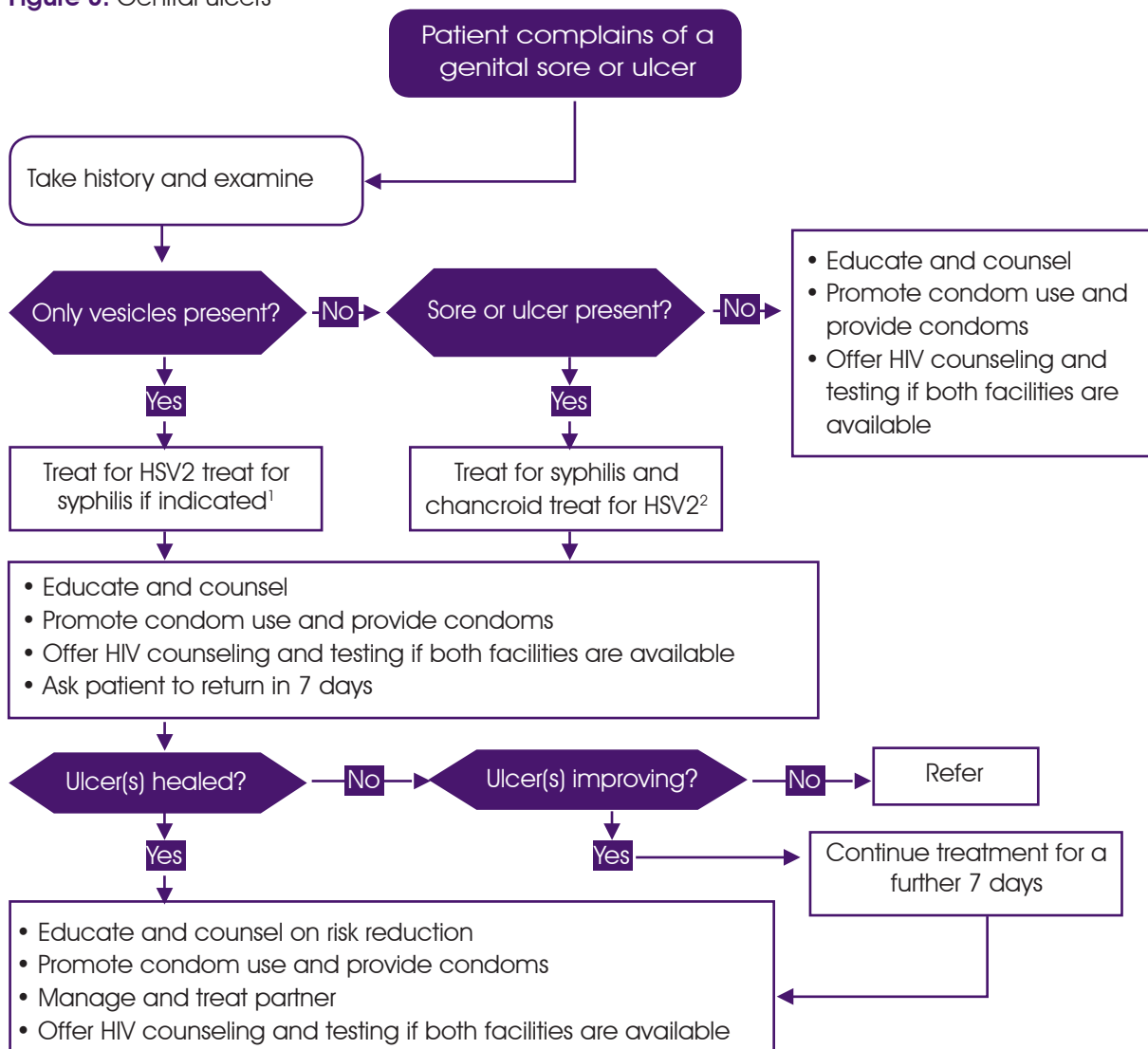
Genital ulcer disease <i>For details, see sections Table 1 in Chapter 7</i>				
Drug options for syphilis	Drug options for chancroid	Drug options for granuloma inguinale	Drug options for LGV	Drug options for genital herpes
Benzathine benzylpenicillin	Ciprofloxacin Erythromycin Azithromycin	Azithromycin Doxycycline	Doxycycline Erythromycin	Acyclovir Valaciclovir Famciclovir
Alternatives	Alternatives	Alternatives	Alternatives	
Procaine benzylpenicillin	Ceftriaxone	Erythromycin Tetracycline Trimethoprim sulfamethoxazole	Tetracycline	
Penicillin allergy				
Doxycycline Tetracycline				

Note

- The decision to treat for chancroid, granuloma inguinale or LGV depends on the local epidemiology of the infections.
- Specific treatment for herpes genitalis is recommended as it offers clinical benefits to most symptomatic patients. Health education and counselling regarding the recurrent nature of genital herpes lesions, the natural history, sexual transmission, probable perinatal transmission of the infection and available methods to reduce transmission, are an integral part of genital herpes management (see Table 1 in Chapter 7).

Genital ulcer disease management	Herpes simplex management
<ul style="list-style-type: none"> ▪ Treat for syphilis, and, depending upon local epidemiology, either chancroid, granuloma inguinale or lymphogranuloma venereum ▪ Aspirate any fluctuant glands (surgical incision should be avoided) ▪ Educate and counsel on risk reduction ▪ Offer syphilis serologic testing and HIV serologic testing where appropriate facilities and counselling are available ▪ Review if lesion not fully healed in 7 days ▪ Promote condom use and provide condoms 	<ul style="list-style-type: none"> ▪ Advise on basic care of the lesion (keep clean and dry) ▪ Provide or prescribe specific antiviral herpes treatment according to local policy ▪ Educate and counsel on compliance, risk reduction and natural history of HSV2 infection ▪ Offer syphilis and HIV serologic testing where appropriate facilities and counselling are available ▪ Promote condom use and provide condoms ▪ Advise to return in 7 days if lesion is not fully healed, and sooner if there is clinical deterioration; if so, treat for other causes of GUD as per guidelines

Figure 3. Genital ulcers



1. Indications for syphilis treatment:
 - RPR positive; and
 - Patient has not been treated for syphilis recently.
2. Treat for HSV2 where prevalence is 30% or higher, or adapt to local conditions.

4. Inguinal bubo

Inguinal and femoral buboes are localised enlargements of the lymph nodes in the groin area, which are painful and may be fluctuant. They are frequently associated with LGV and chancroid. In many cases of chancroid an associated genital ulcer is visible. Non-sexually transmitted local and systemic infections (e.g. infections of the lower limb or tuberculous lymphadenopathy) can also cause swelling of inguinal lymph nodes.

Recommended syndromic treatment

- ciprofloxacin, 500 mg orally, twice daily for 3 days

AND

- doxycycline, 100 mg orally, twice daily for 14 days

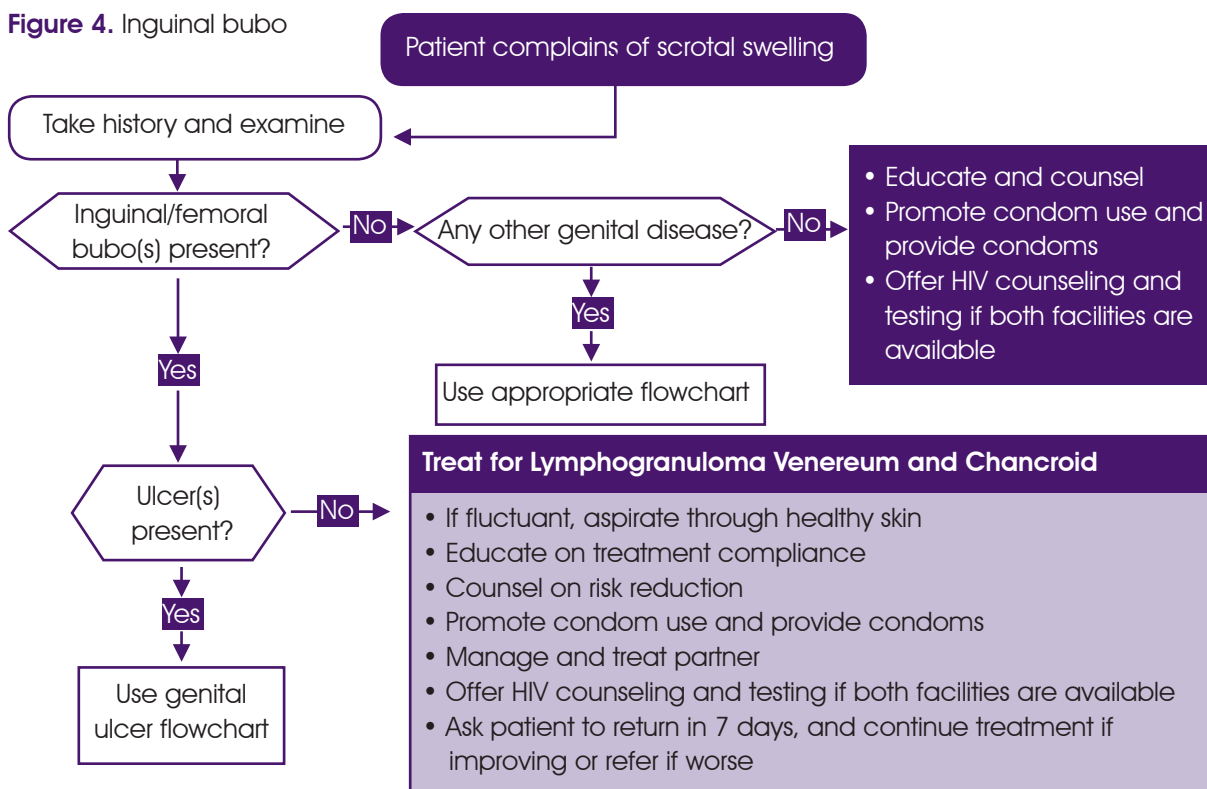
OR

- erythromycin, 500 mg orally, four times daily for 14 days

Note

- Some cases may require longer treatment than the 14 days recommended above.
- Fluctuant lymph nodes should be aspirated through healthy skin. Incision and drainage or excision of nodes may delay healing and should not be attempted.
- Where there is doubt and/or treatment failure, referral for diagnostic biopsy is advisable.

Figure 4. Inguinal bubo





5. Scrotal swelling

Inflammation of the epididymis (epididymitis) usually manifests itself by acute onset of unilateral testicular pain and swelling, often with tenderness of the epididymis and vas deferens, and occasionally with erythema and oedema of the overlying skin. In men under 35 years this is more frequently caused by sexually transmitted organisms than in those over 35 years. When the epididymitis is accompanied by urethral discharge, it should be presumed to be of sexually transmitted origin, commonly gonococcal and/or chlamydial in nature. The adjacent testis is often also inflamed (orchitis), giving rise to epididymo-orchitis.

In older men, where there may have been no risk of a sexually transmitted infection, other general infections may be responsible, for example, *Escherichia coli*, *Klebsiella spp.* or *Pseudomonas aeruginosa*. A tuberculous orchitis, generally accompanied by an epididymitis, is always secondary to lesions elsewhere, especially in the lungs or bones. In brucellosis, usually caused by *Brucella melitensis* or *Brucella abortus*, an orchitis is usually clinically more evident than an epididymitis.

In pre-pubertal children the usual etiology is coliform, pseudomonas infection or mumps virus. Mumps epididymo-orchitis is usually noted within a week of parotid enlargement.

It is important to consider other non-infectious causes of scrotal swelling, such as trauma, testicular torsion and tumour. Testicular torsion, which should be suspected when onset of scrotal pain is sudden, is a surgical emergency that needs urgent referral.

If not effectively treated, STI-related epididymitis may lead to infertility.

Recommended syndromic treatment

- therapy for uncomplicated gonorrhoea (for details, see Table 1 in Chapter 7)

PLUS

- therapy for chlamydia (for details, see Table 1 in Chapter 7)

AT A GLANCE

Scrotal swelling

For details, see Table 1 in Chapter 7

Drug options for Gonorrhoea

Ciprofloxacin (resistance is common in Asia)
Ceftriaxone
Spectinomycin
Cefixime

Drug options for Chlamydia

Doxycycline
Azithromycin

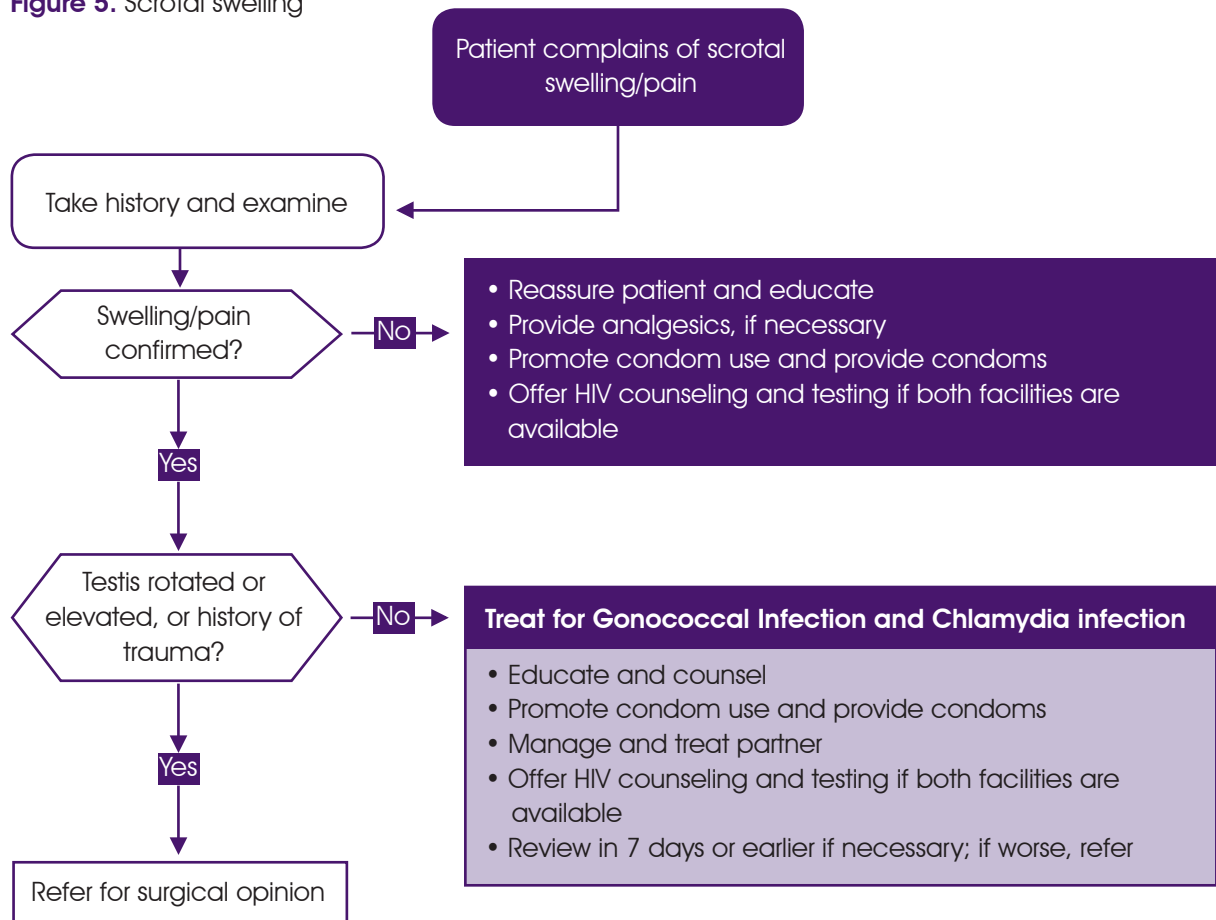
Alternatives

Amoxicillin
Ofloxacin
Erythromycin (if Tetracycline is contraindicated)
Tetracycline

Adjuncts to therapy

Bed rest and scrotal support until local inflammation and fever subside.

Figure 5. Scrotal swelling



Reference

1. World Health Organization. *Guidelines for the management of sexually transmitted infections*. Geneva: WHO, 2003:6-20.

Appendix

D

Treatment of Specific STIs

Appendix D

Treatment of Specific STIs.

Table 1. Summary: treatment of uncomplicated STIs¹

Infection	Treatment
Chancroid	Ciprofloxacin 500 mg orally every 12 hours for 3 days OR Erythromycin 500 mg orally every 6 hours for 7 days OR Azithromycin 1 g orally as a single dose OR Ceftriaxone 250 mg intramuscularly as a single dose (alternative regimen)
Chlamydia	Azithromycin 1 g as a single dose OR Doxycycline 100 mg twice a day for 7 days OR Amoxicillin 500 mg orally 3 times a day for 7 days (alternative regimen) OR Erythromycin 500 mg orally every 6 hours for 7 days
Donovanosis	Azithromycin 1 g as a single dose then 500 mg orally daily until lesions have healed OR Doxycycline 100 mg orally twice a day until lesions have healed
Epididymo-orchitis	Treatment for BOTH gonorrhea AND chlamydia
Genital herpes	<i>First episode:</i> acyclovir 200 mg orally 5 times a day for 7 days OR famciclovir 250 mg 3 times a day for 7 days OR valaciclovir 1 gram orally twice a day for 7 days <i>Recurrent genital herpes episodic therapy:</i> acyclovir 200 mg orally 5 times daily for 5 days OR famciclovir 125 mg twice a day for 5 days OR valaciclovir 500 mg orally twice a day for 5 days
Genital warts	Self-administered: Podophyllotoxin 0.5% tincture topically twice a day for 3 days in weekly cycles for up to 4 weeks.

	<p><i>Provider-administered:</i> Podophyllin 10-25% in compound tincture of benzoin weekly (washed off 1-4 hours after initial application)</p> <p>OR</p> <p>Cryotherapy or other ablative therapy (e.g., diathermy, surgery or trichlor-acetic acid 80-90%)</p>
Gonorrhoea	<p>Cefixime 400 mg orally as a single dose</p> <p>OR</p> <p>Ceftriaxone 250 mg in 2 ml 1% lignocaine (plain) intramuscularly as a single dose</p> <p>OR</p> <p>Ciprofloxacin 500 mg orally as a single dose Note quinolone resistance (e.g., ciprofloxacin) is very common in Asia</p> <p>OR</p> <p>Spectinomycin 2 g intramuscularly as a single dose</p>
Lymphogranuloma venereum	<p>Doxycycline 100 mg twice a day for 14 days</p> <p>OR</p> <p>Erythromycin 500 mg 4 times a day for 14 days</p>
Pubic lice	<p>Lindane 1% lotion or cream applied to infested areas and washed off after 8 hours</p> <p>OR</p> <p>Permethrin 1% cream as above</p>
Scabies	<p>Lindane 1% lotion or cream applied to the body below the neck and washed off after 8 hours</p> <p>OR</p> <p>Benzyl benzoate 25% lotion from the neck down nightly for 2 nights</p> <p>OR</p> <p>Permethrin 5% cream as above</p>
Syphilis - early	<p>Benzathine benzylpenicillin 2.4 million IU intramuscularly as a single dose - may be split into two injections at different sites to reduce the volume of each injection</p>
Syphilis - late latent	<p>Benzathine penicillin 2.4 million IU intramuscularly once weekly for 3 weeks - may be split into two injections at different sites on each occasion to reduce the volume of each injection</p>
Trichomoniasis (male urethral)	<p>Metronidazole 400-500 mg orally twice a day for 7 days</p> <p>OR</p> <p>Tinidazole 500 mg orally twice a day for 5 days</p>

Reference

1. World Health Organization. *Guidelines for the management of sexually transmitted infections*. Geneva: WHO, 2003.

Appendix

E

Patient Handout: Guidelines for male-to-female hormone therapy

Appendix E

Patient Handout: Guidelines for male-to-female hormone therapy

The process of changing one's gender is a serious, important, and potentially dangerous project. The normal process of going through puberty is a gradual one, and to transform a male body to a female one also takes time. There are several things you can do to achieve optimum results both physically and psychologically in a safe manner.

In our program, we have some general principles that we address with you numerous times. They may be different from things you may hear from friends, on the Internet, or from other doctors. However, in reviewing the medical literature, communicating with other gender centers, and following patients for years, we have found them to be sound principles that result in safer transitions with excellent results.

Principles

1. Gender change is a gradual change both physically and psychologically. Your body and mind need time to adjust in a healthy manner. It takes approximately 5 years to complete the process.
2. Living in your chosen role is the single most important thing that you can do in this process. For a variety of reasons, some transsexual individuals are not able or willing to live in their chosen role. Your physician may still prescribe hormones in these cases, assuming you continue psychotherapy. Your doctor will have ongoing discussions with you about your thoughts on this process.
3. Hormones are potent medications with potentially serious side effects. They must be used carefully and with regular monitoring.
4. We will work with you to optimize your health in all areas, not just specific to gender. We will have frank discussions about how cigarettes, alcohol, illicit drugs, and obesity may have an impact on your health and gender transition. We ask that you agree to and follow these guidelines as you go through your treatment. Because living in the role is an important step, we prefer that you have a defined plan to make this change. In most cases, it is preferable that you complete this transition within 2 years. If you do not complete this step, we may need to re-evaluate the appropriateness of hormone therapy. We will continue to check in about your plan, and may request permission to talk to your therapist.
5. Our goal is to give you the best clinical results in the safest manner possible. Larger hormone doses may be associated with more side effects than smaller ones, some of which are dangerous.
6. It is important that you take the hormones and medications as prescribed by your physician. Violation of this may mean termination from hormone therapy.
7. Cigarette smoking and estrogen are a dangerous mix. If you choose to smoke, your physician may choose not to prescribe hormones or do so with lower doses.
8. Dysfunctional use of alcohol and other drugs must be dealt with before any other therapy is initiated.
9. We strongly recommend a continued relationship with a therapist who is experienced with transgender issues. In many cases, hormonal therapy is contingent on a continued relationship with a therapist. If you need assistance finding a therapist, we can help.



10. You are responsible for your medical bills. We cannot falsify records to suggest another diagnosis. In general, the cost for initial consultation, physical exam, and laboratory testing is very expensive. Follow-up visits at 3 and 6 months and at 1 year tend to be less costly, with fewer laboratory studies.
11. Our transgender program has, as the highest priority, the medical safety of persons receiving hormone therapy.

Reference

Oriel KA. *Medical care of transsexual patients. J Gay Lesbian Med Assoc* 2000; 4: 185-94.

Appendix

F

Consent Form for Administration of Female Hormones to Biologic males

Appendix F

Consent Form for Administration of Female Hormones to Biologic males

The use of female hormones (estrogen) in males has profound and often irreversible effects. These effects include, but are not limited to: enlargement and increased sensitivity of the breasts, weight change, decreased muscle mass, shrinkage of the genitals, infertility, decreased libido (sex drive) and changes in mood and personality.

The use of female hormones can cause the following conditions: fluid retention, nausea, jaundice (yellowing of the skin), headache, dizziness, depression, changes in vision, and decreased glucose tolerance.

Estrogen use in biologic males has been associated with increased risk of: liver abnormalities (including non-cancerous and cancerous tumors); elevated blood pressure; gallbladder disease; milk production from the breasts; non-cancerous growths of the pituitary gland (a part of the brain); blood clots in the veins; blood clots in the lungs; stroke; heart attack; and breast tumors.

Complications occurring from the use of female hormones can, very rarely, cause death.

Additional effects, risks and adverse reactions not known at this time may also exist.

The effects associated with the use of female hormones may or may not be reversible by discontinuing their use.

I have read this document and have been given the opportunity to discuss the effects, risks and possible adverse reactions of the use of female hormones with Dr_____. Having discussed these matters, I voluntarily give my informed consent to use female hormones (estrogen and possibly progesterone) along with the antitestosterone drug spironolactone/cyproterone for the purpose of transition to the female gender.

I agree to undergo regular physical examinations and laboratory testing as required by my treating physician.

I agree not to change hormone dosages without consultation with my physician. I realize that doing so may result in my discontinuation in the gender change program.

Signature

Date

Print name as signed

Source: Adapted from Oriol KA. Medical care of transsexual patients. *J Gay Lesbian Med Assoc* 2000; 4: 185-94.

Appendix

G

Surgeon List

Appendix G

Surgeon List

THAILAND

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<http://www.bangmodhos.com/eng/sex.html>

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Kamol PANSRITUM
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info@yanhee.net
http://www.sexchangecenter.com/website_en/index_en.asp

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Preecha TIEWTRANON
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<http://www.pai.co.th>

Chettawut TULAYAPHANICH
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<http://www.chet-plasticsurgery.com>

Saran WANNACHAMRAS
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<http://www.doctorsaran.com>

Suporn WATANYUSAKUL
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<http://www.supornclinic.com>

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the_docbangkok@yahoo.com
<http://www.ramhospital.com/GenderDisorderClinic.htm>

Appendix

H

Resource List

Appendix H

Resource List

STI Reference Books

1. Control of sexually transmitted diseases: a handbook for the design and management of programs. Dallabetta G, Laga M, Lampthey P (editors). AIDS Control and Prevention Project (AIDSCAP), Family Health International, 2101 Wilson Boulevard, Suite 700, Arlington, Virginia 22201, USA.
Tel: +1-703-516 9779
Fax: +1-703-516 9781
E-mail: publications@fhi.org
Web-site: www.fhi.org
2. Sexually Transmitted Disease (3rd edition). Holmes KK et al (Eds). McGraw-Hill, New York, 1999. ISBN: 0-07-029688-X. USD\$154.95.
Consider the cheaper Sexually Transmitted Diseases: Companion Handbook (2nd edition). Adimora A, Hamilton H, Holmes KK, Sparling PF. ISBN: 0-07-112534-5. McGraw-Hill, 1994.
McGraw-Hill Publications, Princeton-Hightstown Road, New Jersey 08520, USA.
Web-site: www.mcgraw-hill.com
3. Adler M, Foster S, Grosskurth H, Richens J, Slavin H. Sexual Health and Health Care: Sexually Transmitted Infections — Guidelines for Prevention and Treatment. Health and Population Occasional Paper. Department for International Development. London: DFID, 1996.
4. Handsfield HH. Color Atlas & Synopsis of Sexually Transmitted Diseases (2nd ed), 2001. ISBN: 0-07-026033-8. McGraw-Hill Publications, Princeton-Hightstown Road, New Jersey 08520, USA.
Web-site: www.mcgraw-hill.com
5. McMillan A, Young H, Ogilvie MM, Scott GR. Clinical Practice in Sexually Transmitted Infections. Saunders 2002. ISBN: 0-7020-2538-0.
Web-site: www.elsevierhealth.com
6. Sexually transmitted diseases: diagnosis in colour (2nd ed). Wisdom A, Hawkins DA. ISBN: 0-7234-2496-9. Mosby-Wolfe Medical Publications, c/- Harcourt Brace & Company Ltd, 24-28 Oval Road, London NW1 7DX UNITED KINGDOM and Mosby International, 5th Floor, Lynton House, 7-12 Tavistock Square, London WC1H 9LB, UNITED KINGDOM.
Tel: +44-181-300 3322, +44-171-388 7676
Fax: +44-181-309 0807, +44-171-391 6555
Web-site: www.mosby.com
7. The psychology of sexual health. Miller D, Green J. 2002. ISBN: 0-632-04979-0. Blackwell Science, 54 University Street, Carlton VIC 3053 AUSTRALIA.
Tel: +61-3-9347 0300
Fax: +61-3-9347 5001
Web-site: www.blackwell-science.com

8. Sexual health concerns: interviewing & history taking for health practitioners (2nd ed). Ross MW, Channon-Little LD, Rosser BRS. MacLennan and Petty, 2000. ISBN: 0-86433-136-3. MacLennan and Petty, Unit 4/809 Botany Road, Rosebery, Sydney, NSW 2018, AUSTRALIA.

STI Guidelines

1. WHO Guidelines on the Management of Sexually Transmitted Infections, 2003. WHO Publications, Distribution and Sales, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland.
Tel: +41-22-791 2111 / 2476 / 2477
Fax: +41-22-791 4834 (Dir) / 4857
E-mail: hiv-aids@who.int, publications@who.ch
Web-site: www.who.int/HIV_AIDS/
www.who.int/Reproductive_health
2. Guidelines for Treatment of Sexually Transmitted Diseases. Centers for Disease Control and Prevention. 2002. MMWR 2002;51(No. RR-6). MMWR , Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333, USA.
Tel: +1-888-232-3228
+1-202-512-1800
Web-site: www.cdc.gov/mmwr

Useful Low-cost STI Texts

1. Adler MW. ABC of Sexually Transmitted Diseases (4th ed). British Medical Journal, London, 1999. Length 75 pages. Availability £15.00 plus post & packing. ISBN: 0-7279-1368-9.
BMJ Publishing Group, BMA House, Tavistock Square, London WC1H 9JR, UNITED KINGDOM.
Tel: +44-171-383 6270
Fax: +44-171-383 6402
E-mail: bmjsubs@dial.pipex.com
Web-site: www.bmjpg.com
2. The diagnosis and management of sexually transmitted diseases in Southern Africa. 3rd edition, 2000. ISBN: 0-620-25045-3. Guidelines and slide set (full price R752.40). Guidelines only R30.00. STD Society of Southern Africa, c/- National Centre for STDs, South African Institute of Medical Research, PO Box 1038, Johannesburg 2000.
Tel: +27-11-489 9490
Fax: +27-11-489 9492
E-mail: nrcstd@lia.co.za
Web-site: www.lia.net/HomePages/nrcstd.htm

Videos

1. a. Examination of Vaginal Wet Preps [15 mins].*
- b. The Physical Examination of the Female Patient for Sexually Transmitted Diseases [30 mins].*
- c. The Physical Examination of the Male Patient for Sexually Transmitted Diseases [25 mins].**

* Produced by the Seattle STD/HIV Prevention Training Center.

** Produced by the Birmingham STD/HIV Prevention Training Center [all funded by CDC]. The Physical Examination videos are available for \$25 each plus \$6.75 shipping and handling for the first two tapes, \$1 for each additional [USA only].

Total cost \$126.75 (\$90 + \$5 + \$25 + \$6.75). Payment is required with your order.

Contact: Kingfisher Media.

Tel: +1-206-935-0185

See: <http://depts.washington.edu/seaptc>

Clinical Guidelines for Sexual Health Care of Men Who Have Sex with Men
