PROVIDING QUALITY SEXUAL HEALTH CARE TO MEN WHO HAVE SEX WITH MEN (MSM) AND HIJRAS IN INDIA

Clinical Manual

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ABBREVIATIONS

AIDS - Acquired Immunodeficiency Syndrome

CBOs - Community-Based Organizations

HIV - Human Immunodeficiency Virus

IPC - Indian Penal Code

GLBT – Gay, Lesbian, Bisexual, Transgender

HCP - Health Care Providers

HPV - Human Papilloma Virus

HSV - Herpes Simplex Virus

MSM - Men who have Sex with Men

NACO - National AIDS Control Organization [India]

NGOs - NonGovernmental Organizations

SRS – Sex Reassignment Surgery

STDs - Sexually Transmitted Diseases

STIs - Sexually Transmitted Infections*

TPHA – Treponema Pallidum Hemagglutination Assay

VDRL - Venereal Disease Reference Laboratory test

*The World Health Organization recommends that the term 'sexually transmitted disease (STD)' be replaced by the term 'sexually transmitted infection (STI)'. The term sexually transmitted infections has been adopted as it better incorporates asymptomatic infections.

Purpose of this clinical manual

This manual for clinicians can be used as a self-study resource manual to understand the sexual health issues of men who have sex with men (MSM) and Hijras which will enable the clinicians to provide appropriate clinical services to these marginalized populations. It was primarily developed as a resource manual for clinicians who took part in the training programs conducted by Dr. Venkatesan Chakrapani with support from The John D. and Catherine T. MacArthur Foundation.

This clinical manual has to be used along with the handbook for Clinicians & Counselors in Sexual health/STI/HIV (Available online in www.indianGLBThealth.info)

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1. SEXUAL AND STD HISTORY TAKING IN MALES WHO REPORT SAME-SEX BEHAVIOR

(Note: The first half of this section is the article entitled – ***Addressing same-sex/bisexual behavior in HIV/STI risk assessment*** - in the participant resource handbook: Venkatesan Chakrapani, Understanding men who have sex with men (MSM) and Hijras & Providing HIV/STI risk reduction information. Handbook for STI/HIV and Sexual Health Counselors. Sep 2005. www.indianGLBThealth.info)

During STI/HIV risk assessment or in a regular sexual health screening, a significant proportion of doctors and counselors may not take sexual history in detail for a variety of reasons which could be due to:

- Embarrassment
- Feeling that they are not adequately trained in asking sex-related questions
- Fear of the emotions generated by such a discussion
- Awkwardness with sexual language

However, when doctors and counselors do not ask about same-sex/bisexual behavior in their male clients, they are losing crucial opportunities to provide HIV/STI prevention education to these persons from marginalized populations.

Thus, irrespective of whether a person has sex with males, females or both, a detailed sexual history is important for all patients because it provides information that

- Identifies those at risk for sexually transmitted diseases, including HIV;
- Directs risk-reduction counseling; and
- Identifies what anatomic sites are suitable for STD screening.

Subpopulations of men who have sex with men (MSM) in India

'MSM' is a behavioral term and denotes all men who have sex with other men regardless of their sexual identity.

For the sake of simplicity, one can classify 'MSM' according to their socioeconomic and educational status as follows:

MSM from lower socioeconomic class with poor literacy: Kothi-identified homosexual males are a visible and relatively organized group. One can say that Kothi means feminine homosexual males who are mainly receptive partners. **Kothis** call their masculine partners as 'Panthi'. **Panthis** are supposed to be *"real men who only penetrate"*. The term **'Double-decker'** is used by Kothis to refer to someone who penetrate as well as receive.

MSM from the 'middle or upper class': MSM belonging to 'middle or upper class' who are well-educated may have identities like **gay** or **bisexual**.

However, the major subpopulation across any Socioeconomic class is likely to be MSM who do not have any conscious homosexual identity.

(Note: Hijras, though biologically born as males, consider themselves as women. Thus many Hijra activists resist including Hijras under the umbrella term 'men who have sex with men or MSM' since they are "not men". However, if agencies providing services to 'MSM' come across Hijras, they should not be denied services.)

Asking about same-sex/bisexual behavior in males

1. Ask about same-sex behavior/bisexual behavior in all male clients

Counselor should not limit asking their clients about same-sex behavior only if they appear 'feminine'. Men who have sex with men can be masculine or feminine and hence one should not consider gender expression (behaving/appearing in a masculine or feminine manner) to be indicative of behavior.

2. Ask about same-sex behavior even in married men

There should be no assumptions that heterosexually married men cannot be having sex with men. MSM may or may not be heterosexually married. Thus even in married men, one has to ask about same-sex behavior.

3. Ask about same-sex behavior across all age groups

Don't assume that only male youth will be involved in same-sex behavior, MSM belong to all age groups just like heterosexual men.

4. Ask about heterosexual behavior in self-identified homosexual men

Even if a male client openly comes out as that he is having sex with men and/or self-identifies as a homosexual man ('Kothi' or 'gay'), the counselor or doctor needs to ask whether he also has female partners. This is because even self-identified homosexual men often have female partners and eventually may get married heterosexually to fulfill family and societal expectations. Knowing about steady female partners of these men are thus important for referral services and discussing about partner treatment/testing if the client has STI or HIV.

5. Ask about male steady partners of self-identified homosexual men
Among those who admit having had same-sex behavior ask whether they have long term steady partners (Kothi-identified MSM may call these steady partners as 'Panthis'). Again, this has relevance in relation to partner testing/treatment

Eliciting history of same-sex/bisexual behavior in a male client: Some scripts
There are a variety of ways to make the male client feel comfortable about talking about his same-sex/bisexual behavior. For this, developing an appropriate level of trust and rapport during the initial interactions is of importance.

One example:
Counselor/Doctor: When did you last have sex?
Male Client: About a week ago
Counselor/Doc: With whom?
Client: …With a lady in my neighborhood.

Here the interviewer starts with asking when he had sex and with whom. There were no assumptions about the gender of the sexual partners. Even if the male client tells he has had sex with a female it is important to tactfully ask about same-sex behavior in a nonjudgemental manner.

Counselor/Doctor: You said you have had sex with many women. Have you ever had sex with men?
Male Client: (Pauses)….It was about six months ago..

Thus, here the interviewer did not assume that the male client was having sex only with females but asked whether he had sex with any men. If the client feels that the counselor is asking the question in a nonjudgmental manner he is more likely to be honest about whether he has sex with other men.

Now having asked about same-sex/bisexual behavior in your male clients, the next step is to ask about what kind of sexual practices they practice.

Asking about various sexual practices
It is important to know the types of sexual practices and condom use associated with them so that one can assess the risk of STI and HIV associated with various sexual practices and also to provide appropriate HIV risk-reduction counseling.

You can start by saying, "I am going to be more explicit about the kind of sex you have been having over the last three months (can be any relevant time duration) so I understand your risks for STDs and HIV"

"You said you have had sex with women and men. What kind of sexual practices have you had with men (and women)." [You can either list the important penetrative sexual practices or ask individually one by one]

"Do you have vaginal sex, meaning "penis in vagina sex"?
If answer is yes, *"Do you use condoms: never, sometimes, most of the time or always for this kind of sex?"*

"Do you have anal sex with men (and women), meaning "penis in rectum/anus sex" If answer is yes, *"Do you use condoms: never, sometimes, most of the time, or always for this kind of sex?"*

If yes to above:
When having anal sex, do you insert your penis into your partner or does he insert his penis into you? Or both?

"Do you have oral sex with men (and women), meaning "mouth on penis/vagina"?

For condom answers:
If answer is "never", then: *"Why don't you use condoms?"*
If answer is "sometimes", then: *"In what situations, or with whom, do you not use condoms?"*

(The next half of this section is adapted from: *Clinical guidelines for the management of STIs among priority populations.* Australasian College of Sexual Health Physicians.)

Taking a sexual history

a. General points

- Ensure privacy and that the patient is seated comfortably.
- Be non-judgmental and respectful.
- Watch your body language and voice tone.
- Make eye contact and have a relaxed body language.
- Try to understand verbal and non-verbal clues
- Use simple words

- Use open-ended questions
- Don't think that your clients only have sex with opposite sex
- Don't assume about sexual identity or sexual practices of your clients
- Any one could be sexually active at any age.
- Provide the patient with a context for the questions that are to follow (e.g. "I am going to ask you some questions about your sexual activity so that we can decide what tests to do".)

b. Terminology

- Clinicians and patients often struggle with their choice of terminology. It can be difficult to determine whether vernacular or more medical terms will make the patient more comfortable or less.
- Generally use vernacular and colloquial expressions rather than more technical expressions, though use your judgment as this may make some feel more uncomfortable.
- Adapt your language to the level of understanding of the patient.
- Utilize the language used by the patient; though be cautious in understanding what they mean by a particular term especially if they use medical terms.
- It may be helpful to check back with the patient that you have understood what has been said.

c. Asking questions

- The first question is perhaps the most difficult, so start with a general and less threatening question.
- Questions should be open-ended (do not require a yes or no answers), clear and unambiguous.
- Ask 'how', 'what', 'where' type questions to explore behavior.
- Avoid asking 'why' questions as they imply complex understanding of behavior.
- Do not be afraid to be direct.
- Question about sexual partners are important as they may be at risk of STIs because of their partner's sexual activity.
- Ask about knowledge and use of condoms as it provides an opportunity for further information and education.

d. Asking STD history-related questions

Protection from STDs

"What do you do to protect yourself from sexually transmitted diseases and HIV?"

With this open-ended question, you allow different avenues of discussion: condom use, monogamy, patient self-perception of risk, and perception of partner's risk. If you have determined that the patient has had one partner in the past 12 months and that partner has had no other partners, then infrequent or no condom use may not warrant risk-reduction counseling.

Past history of STDs
A history of prior STDs increases a person's risk of repeat infection.
Recent past STDs indicates a higher risk behavior.
"Have you ever had an STD?"
If yes, *"Do you know what the infection was and when was it?"*
"Have any of your partners had an STD?"
If yes, *"Do you know what the infection was and when was it?"*

e. Additional questions to identify HIV and hepatitis risk.
Immunization history for hepatitis A and B can be noted at this point, as well as past HIV testing. Hepatitis A and B immunization is recommended for men who have sex with men (MSM) and those who use illicit drugs.
"Have you or any of your partners ever injected drugs?
"Have you ever gotten hepatitis B vaccine (all 3 doses)?"
"Have you ever gotten hepatitis A vaccine (2 doses)?"

f. Finishing up
By the end of this section of the interview, the patient may have come up with information, or questions that she/he was not ready to discuss earlier.
"Is there anything else about your sexual practices that I need to know about to ensure you good health care?"
At this point, thank the patient for honesty and praise protective behaviors. For a patient identified at higher risk for STDs, be sure to praise the safer sex practices you have identified. After reinforcing positive behavior, it is appropriate to specifically address concerns regarding higher risk practices. Your expression of concern can then lead to your risk-reduction counseling or a counseling referral.

Sexual history checklist

Physical symptoms
• nature of problem
• length of time
• any general sexual concerns

Previous diagnosis of STIs
• previous sexual health issues
• knowledge of increased risk
• vaccination for hepatitis
• symptoms and diagnoses in recent sexual partners
• tested for HIV?

Sexual behavior
• regular/casual sexual partner contact
• last sex contact with other partner/s
• no. of sexual partners (past year)
• gender of sexual partner/s
• type of sexual contact engaged in with each partner
• condom use and consistency of use

Relationship history
• regular partner
• regular partner's sexual activity
• casual partner/s

Drugs and alcohol use
• patterns and frequency of use
• injecting drug use
• harm reduction strategies

Medication
• known drug allergies
• current medications

2. STI-ASSOCIATED SYNDROMES IN MSM AND HIJRAS

(This section is prepared from the various international and national STI management guidelines: WHO, 2003; CDC, 2002;51 (No. RR-6); and National AIDS Control Organization (NACO), Sexually Transmitted Infections – Treatment Guidelines, and Flow Charts on the Syndromic Management of Sexually Transmitted Infections.2004. See the section on key references)

Sexually Transmitted Infections (STIs) in MSM and Hijras are no different from the general population but the types of sexual practices determine the site where STIs occur. To know more about the common clinical pattern of STDs and STI/HIV prevalence among MSM population in India, kindly refer to Appendix-1.

The major STI syndromes and common causative organisms associated with those syndromes are summarized below.

STD-associated syndromes	Possible causative organisms
Urethral discharge	Neisseria gonorrhoea Chlamydia trachomatis (D to K)
Genital ulcers	Treponema pallidum (Syphilis), Hemophilus ducreyi (Chancroid), Klebsiella granulomatis (Granuloma inguinale), Herpes Simplex Virus (HSV-2 &/or 1) (Anogenital herpes)
Inguinal bubo	C. trachomatis (L1, L2. L3) (Lymphogranuloma venereum - LGV), Hemophilus ducreyi (Chancroid)
Scrotal swelling	Neisseria gonorrhoea, Chlamydia trachomatis, surgical conditions
Perianal ulcers	Herpes Simplex Virus (HSV-2 &/or 1) (Anogenital herpes), C. albicans (Perianal candidiasis)
Anal discharge	Neisseria gonorrhoea, Chlamydia trachomatis

Under the simplified and syndrome-based approach developed and promoted by WHO and currently being used in a large number of countries, diagnosis is based on the identification of consistent groups of symptoms and easily recognized signs (syndromes), and the provision of treatment that will deal with the majority of, or the most serious, organisms responsible for producing a syndrome. When a patient comes with complaints, his/her management can be decided according to the clinical management flow chart.

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.

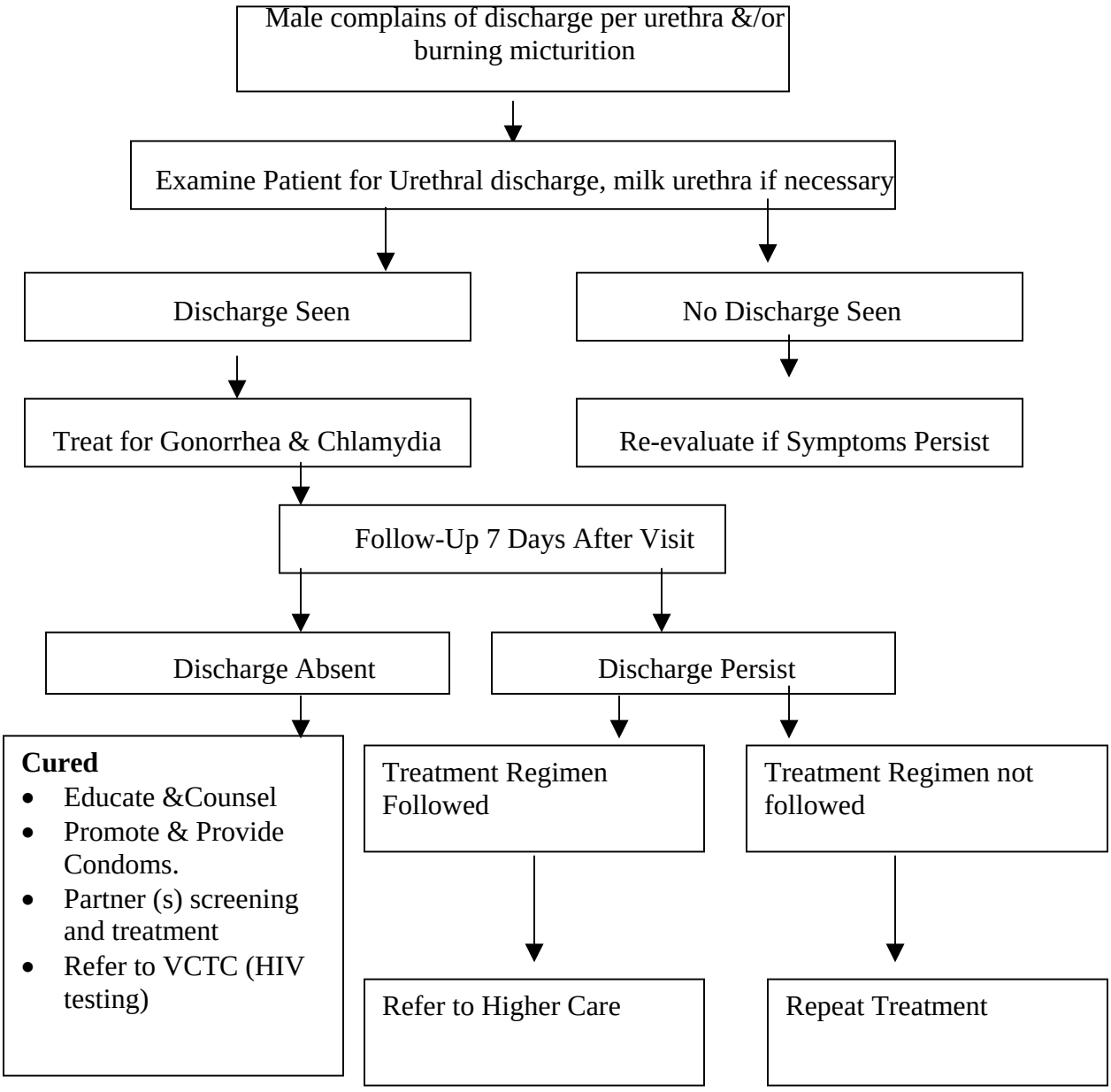
A. URETHRAL DISCHARGE

- 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. (See flowchart-1)

- The major pathogens causing urethral discharge are *Neisseria gonorrhoeae* (*N. gonorrhoeae)* and *Chlamydia trachomatis* (*C. trachomatis*). In the syndromic management, treatment of a patient with urethral discharge should adequately cover these two organisms.

- Persistent or recurrent symptoms of urethritis may result from drug resistance, poor compliance or re-infection. Where symptoms persist or recur after adequate treatment for gonorrhoea and chlamydia in the index patient and partner(s), the patient must be referred.

FLOWCHART-1: URETHRAL DISCHARGE



Recommended syndromic treatment

Therapy for uncomplicated urethral gonococcal and chlamydial infection

Note:
- Azithromycin, 2 g orally as a single dose, can be used to treat both gonococcal and chlamydial infection
- Patients should be advised to return if symptoms persist 7 days after start of therapy.

a. Therapy for uncomplicated urethral gonorrhoea
Recommended regimen
Ceftriaxone, 250 mg by intramuscular injection, as a single dose

Alternative regimens:
Ciprofloxacin, 500 mg orally, as a single dose
OR
Cefixime, 400 mg orally, as a single dose
OR
Spectinomycin, 2 g by intramuscular injection, as a single dose

(Note:
Ciprofloxacin is contraindicated in pregnancy, and is not recommended for use in children and adolescents.)

b. Therapy for uncomplicated urethral chlamydial infection
Recommended regimen
Azithromycin, 1 g orally, in a single dose

Alternative regimens
Doxycycline, 100 mg orally, twice daily for 7 days
OR
Erythromycin, 500 mg orally, 4 times a day for 7 days
OR
Ofloxacin, 300 mg orally, twice a day for 7 days

(Note:
- Doxycyline and other tetracyclines are contraindicated during pregnancy and lactation.
- Erythromycin should not be taken on an empty stomach.)

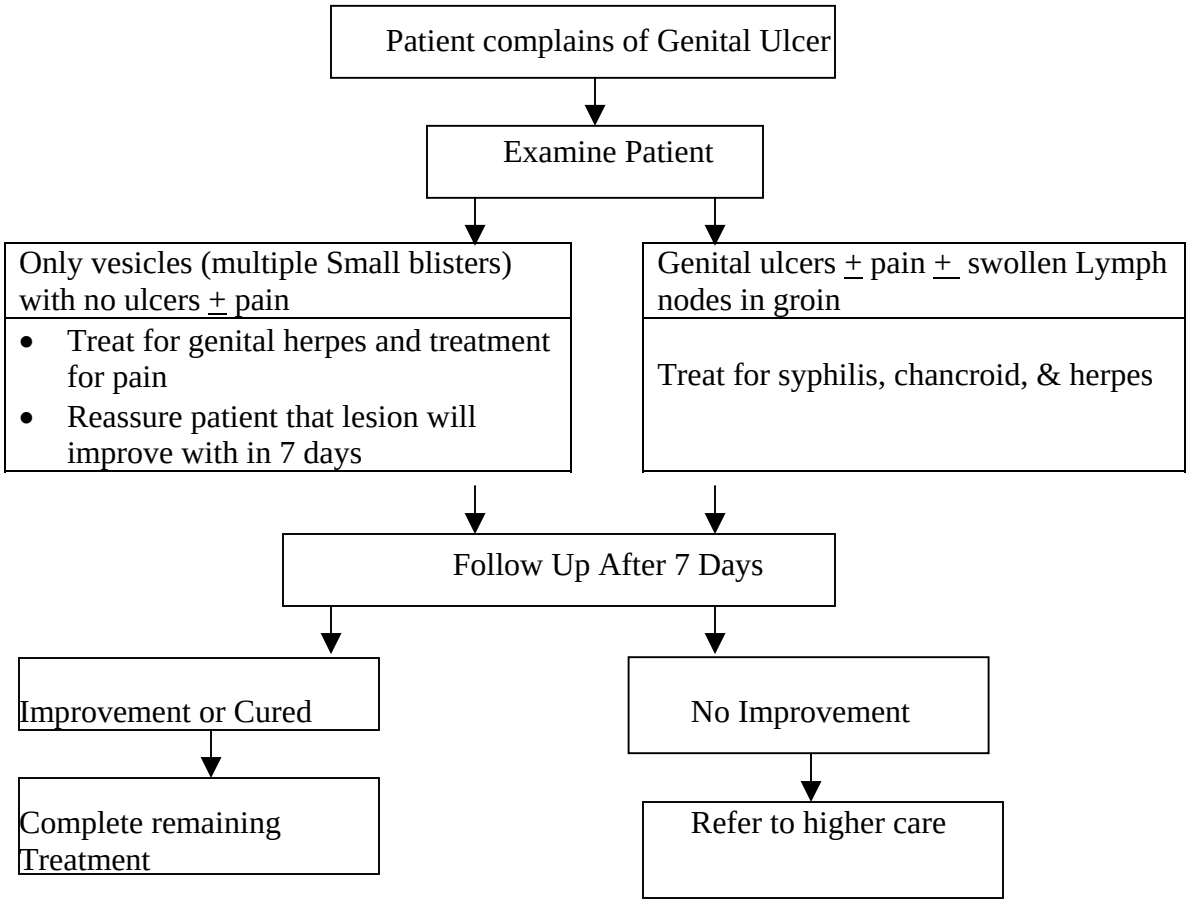
B. GENITAL ULCERS

Patients with genital ulcers should be treated for syphilis (primary chancre), chancroid, and genital herpes. Note that VDRL testing needs to be done as a routine in all patients coming for STD screening or treatment. Even if VDRL is nonreactive as per the syndromic approach, treatment for early syphilis has to be given.

Note:

- Treatment for granuloma inguinale is not included because of its low prevalence. If the ulcers are not responding to the standard treatment, HIV infection or the possibility of the ulcers being granuloma inguinale should be considered.
- If only vesicles suggestive of genital herpes are present then treatment can be given only for genital herpes.

FLOWCHART-2: GENITAL ULCER



Recommended syndromic treatment

Therapy for syphilis + chancroid + herpes

Follow-up

Patients should be followed up clinically until signs and symptoms have resolved.

a. Treatment for early syphilis (Primary chancre or anogenital lesions in secondary syphilis)

Recommended regimen

After testing for sensitivity for penicillin, give:

Benzathine benzylpenicillin, 2.4 million IU by intramuscular injection, at a single session. Because of the volume involved, this dose is usually given as two injections at separate sites (in both buttocks).

Alternative regimen

After testing for sensitivity for penicillin, give:

Procaine benzylpenicillin, 1.2 million IU by intramuscular injection, daily for 10 consecutive days.

Alternative regimen for penicillin-allergic non-pregnant patients

Doxycycline, 100 mg orally, twice daily for 14 days

OR

Tetracycline, 500 mg orally, 4 times daily for 14 days

Alternative regimen for penicillin-allergic pregnant patients

Erythromycin, 500 mg orally, 4 times daily for 14 days

Note: Jarisch-Herxheimer reaction (mild fever, body aches and exacerbation of symptoms within hours of injection) should be treated with paracetamol tablet. Patient should be forewarned of the possibility of this reaction.

b. Treatment for Chancroid

Recommended regimen

Azithromycin, 1 g orally, as a single dose

Alternative regimens:

Ciprofloxacin, 500 mg orally, twice daily for 3 days

OR

Erythromycin base, 500 mg orally, 4 times daily for 7 days

OR

Ceftriaxone, 250 mg by intramuscular injection, as a single dose

c. Treatment for genital herpes

There is no known cure, but the course of symptoms can be modified if oral or systemic therapy with acyclovir is started as soon as possible, preferably within 72 hours following the onset of symptoms. Topical therapy with acyclovir produces only minimal shortening of the duration of symptomatic episodes and is not recommended.

Recommended regimen for first clinical episode

Acyclovir, 400 mg orally, 3 times daily for 7 days

OR

Valaciclovir, 1 g orally, twice daily for 7 days

Recommended regimen for recurrent infection

Acyclovir, 400 mg orally, 3 times daily for 5 days

OR

Acyclovir, 800 mg orally, twice daily for 5 days

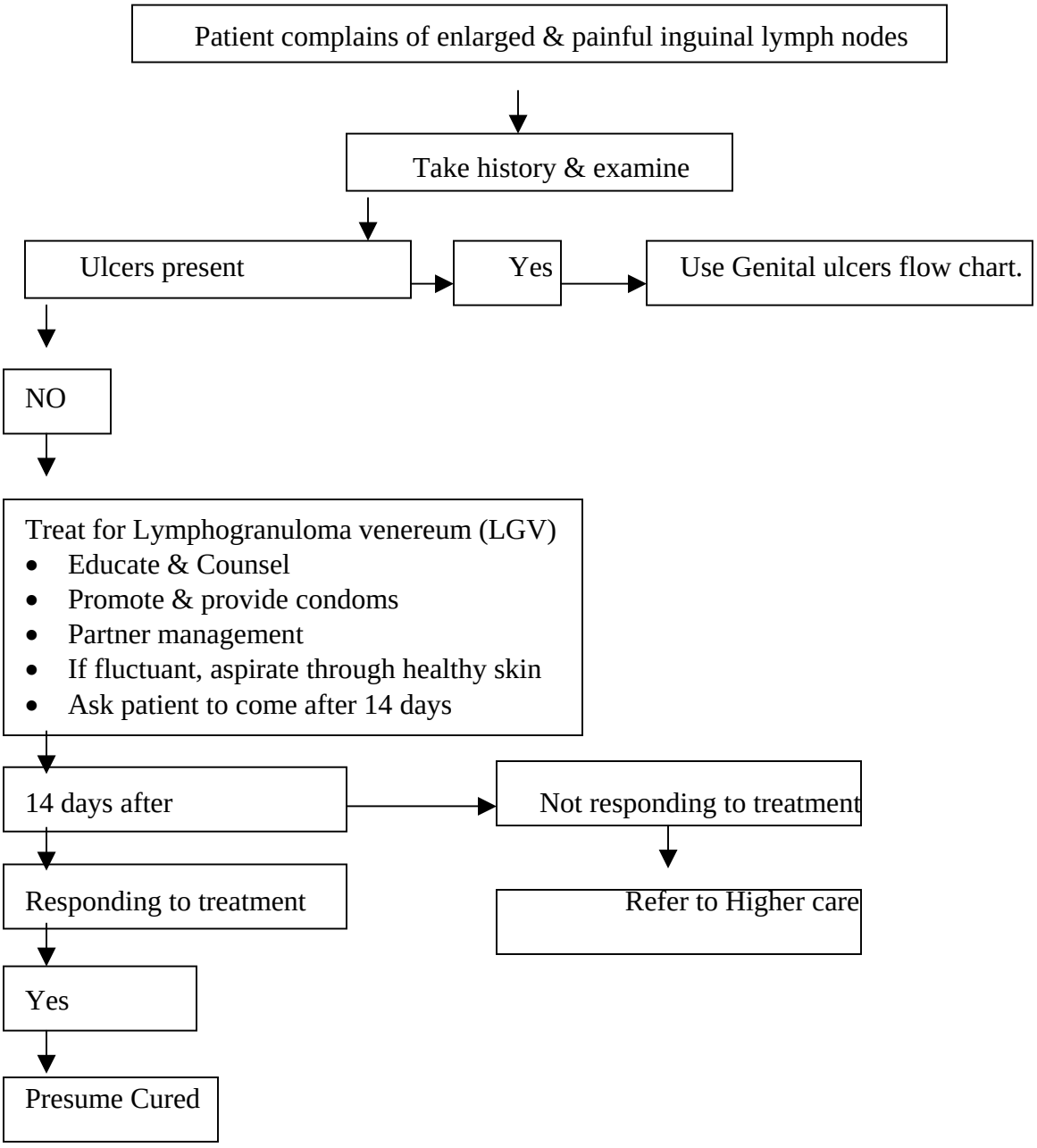
OR

Valaciclovir, 500 mg orally, twice daily for 5 days

C. INGUINAL BUBO

Inguinal and femoral buboes are localized 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.

FLOWCHART-3: INGUINAL BUBO



Recommended syndromic treatment

If only inguinal bubo is present, give treatment for LGV (If associated with genital ulcer, use flowchart for the treatment of genital ulcers)

Recommended regimen
Doxycycline, 100 mg orally, twice daily for 14 days
OR
Erythromycin, 500 mg orally, 4 times daily for 14 days

Alternative regimen
Tetracycline, 500 mg orally, 4 times daily for 14 days

Note
- Tetracyclines are contraindicated in pregnancy.
- Fluctuant lymph nodes should be aspirated through healthy skin. Incision and drainage or excision of nodes may delay healing. Some patients with advanced disease may require treatment for longer than 14 days, and sequelae such as strictures and/or fistulae may require surgery.

D. 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 edema 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.

It is important to consider other non-infectious causes of scrotal swelling, such as trauma, testicular torsion and tumor. 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.

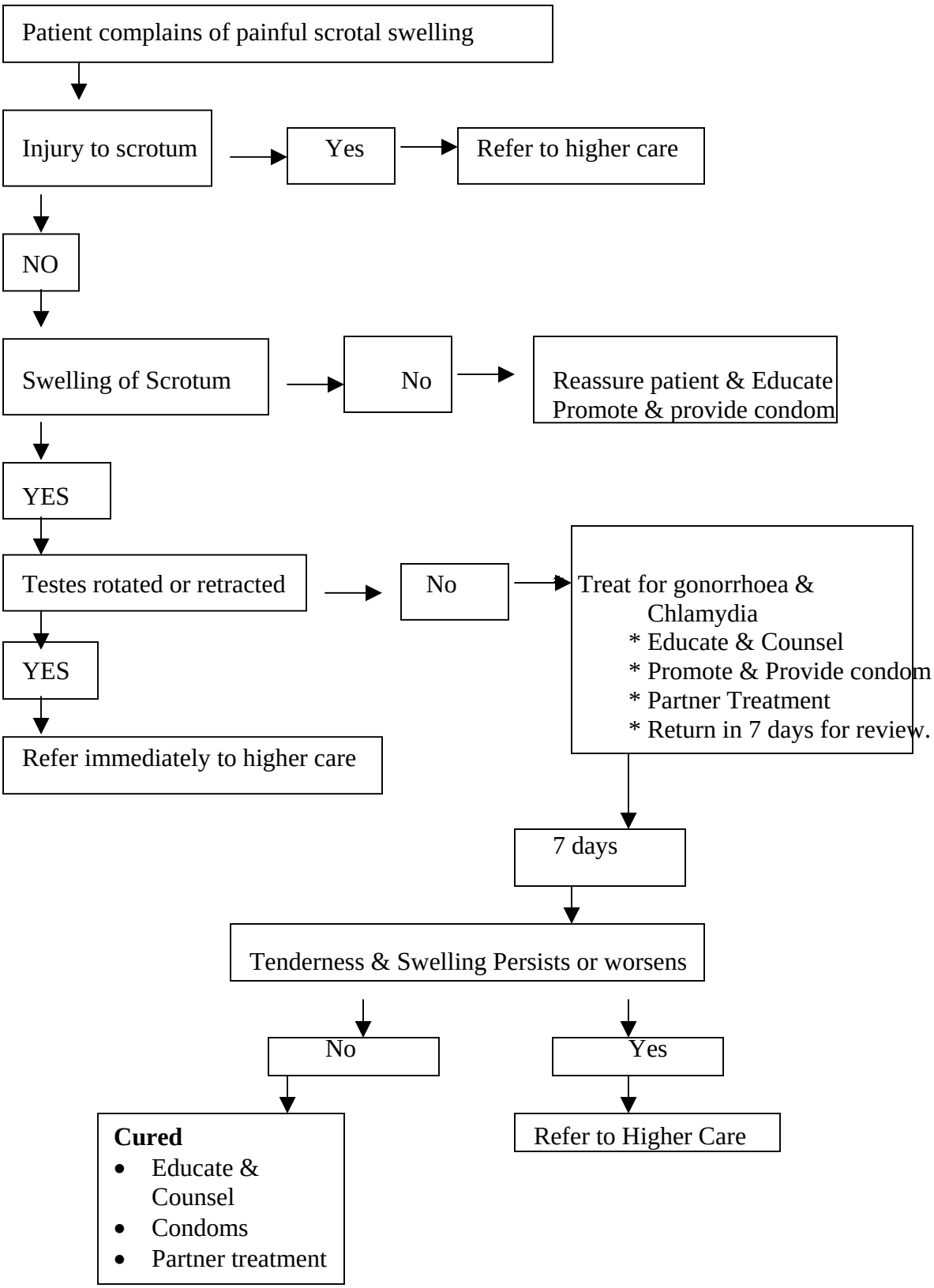
Recommended syndromic treatment

Therapy for uncomplicated gonococcal and chlamydial infection

Same regimens as given for uncomplicated urethral gonococcal and chlamydial infection (see above)

Adjuncts to therapy
Bed rest and scrotal support until local inflammation and fever subside. Analgesics to reduce pain.

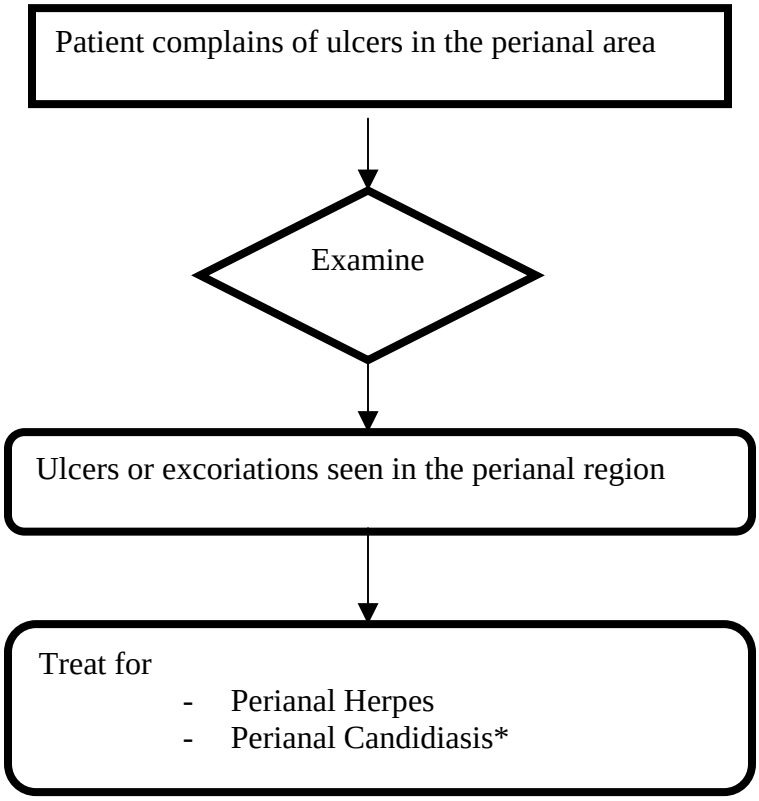
FLOWCHART-4: SCROTAL SWELLING



E. PERIANAL ULCERS

Perianal ulcers in a sexually active patient who may or may not give a history of receptive anal sex could be due to perianal herpes or perianal candidiasis. (Note: Secondary syphilis can manifest as perianal lesions that is associated with reactive VDRL test.)

FLOW CHART-5: ANAL ULCERS



Recommended syndromic treatment:

Therapy for perianal ulcers and perianal candidiasis*
(*If the ulcers are clinically more likely to be herpes then treat for herpes alone while awaiting for VDRL test result.)

Note: Treatment for syphilis is not included since primary syphilis in anal area usually presents in an atypical manner (mimicking anal fissure) and secondary syphilis can be easily recognized because of multiple moist lesions and generalized skin rash.

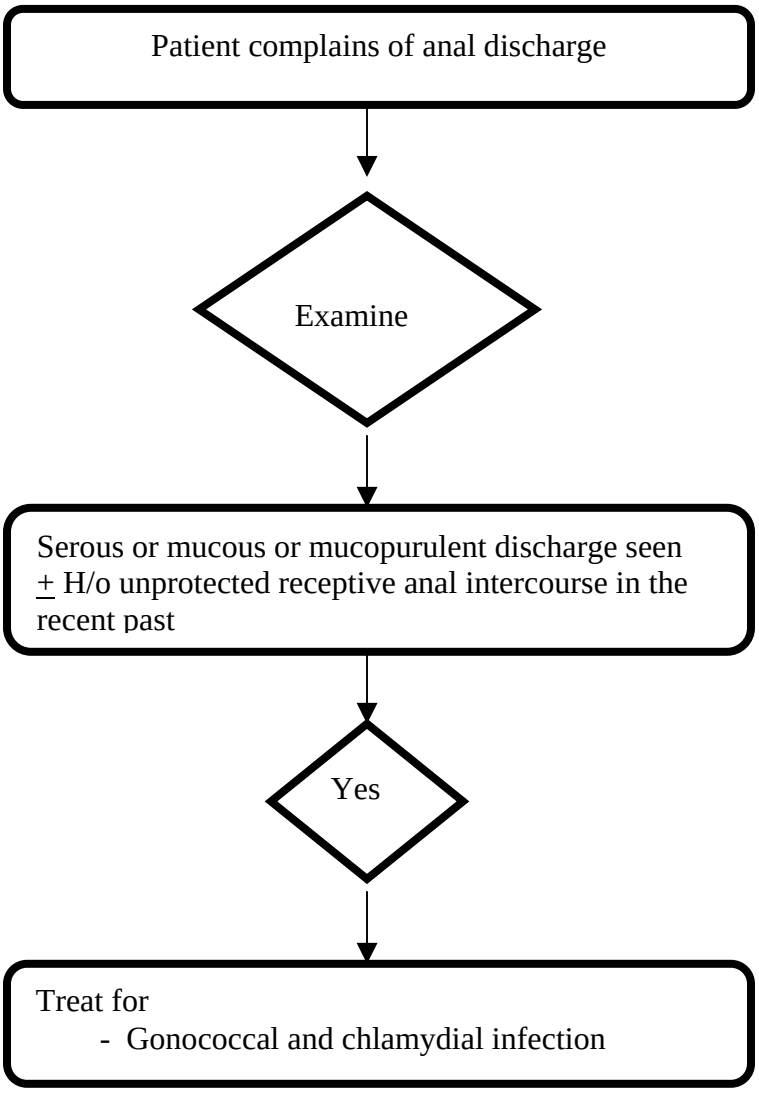
Therapy for perianal ulcers:
Same regimens as given for the treatment of genital herpes (see above).

Therapy for perianal candidiasis:
Fluconazole 150 mg once daily for 7 days with or without local application of gentian violet or miconazole cream (twice daily) until drying/healing occurs.

F. ANAL DISCHARGE

Anal discharge in a sexually active patient who may or may not give a history of receptive anal sex could be due to gonococcal or chlamydial infection.
(Note: Also see the section on 'Clinical Approach to MSM and Hijras presenting with anorectal complaints')

FLOW CHART-6: ANAL DISCHARGE



Recommended syndromic treatment
Therapy for uncomplicated gonococcal and chlamydial infection

Same regimens as given for uncomplicated urethral gonococcal and chlamydial infection (see above)

3. TREATMENT OF SOME SPECIFIC STIs AND GENITAL CONDITIONS

A. GENITAL OR PERIANAL WARTS

The human papilloma virus (HPV) is the causative agent for this common STI. Genital warts are painless and do not lead to serious complications, except where they cause obstruction, especially in pregnant women. The removal of the lesion does not mean that the infection has been cured. No treatment is completely satisfactory. Podophyllin, podophyllotoxin or trichloroacetic acid (TCA) is used to treat external genital and perianal warts.

Provider-administered treatment:

Podophyllin

Podophyllin 10–25% in compound tincture of benzoin, applied carefully to the warts, avoiding normal tissue. External genital and perianal warts should be washed thoroughly 1–4 hours after the application of podophyllin. Podophyllin applied to warts on vaginal or anal epithelial surfaces should be allowed to dry before the speculum or anoscope is removed. Treatment should be repeated at weekly intervals. Where available, podophyllotoxin 0.5%, one of the active constituents of podophyllin resin, is recommended. Its efficacy is equal to that of podophyllin, but it is less toxic and appears to cause less erosion.

Large amounts of podophyllin should not be used because it is toxic and easily absorbed. Its use during pregnancy and lactation is contraindicated

OR

Trichloroacetic acid (TCA)

TCA 80–90%, can be applied carefully to the warts, avoiding normal tissue, followed by powdering of the treated area with talc or sodium bicarbonate (baking soda) to remove unreacted acid. Repeat application at weekly intervals.

B. SCABIES

The causative mite, *Sarcoptes scabiei*, is transmitted by protracted direct bodily contact. Clothing or bed linen that has possibly been contaminated by the patient in the two days prior to the start of treatment should be washed and dried well, or dry-cleaned.

Recommended regimen

Benzyl benzoate 25% lotion, applied to the entire body from the neck down, nightly for 2 nights; patients may bathe before reapplying the drug and should bathe 24 hours after the final application

OR

Lindane 1% lotion or cream, applied thinly to all areas of the body from the neck down and washed off thoroughly after 8 hours

Note: Lindane is not recommended for pregnant or lactating women.

C. MOLLUSCUM CONTAGIOSUM

Molluscum lesions are caused by a type of pox virus and usually appear as papules which are smooth, firm and dome-shaped with characteristic central umblication from which caseous material can be expressed. The removal of the lesion does not mean that the infection has been cured.

Treatment:

- If the patient desires removal of the lesions and only a few lesions are present, then puncture the lesions, express the contents and paint with tincture iodine.
- Refer for cryotherapy if too many lesions are present.

D. CANDIDAL BALANOPOSTHITIS

Balanoposthitis refers to an inflammation involving the glans penis and the foreskin. When caused by *C. albicans* it is characteristically found in men with underlying immunosuppressive disease or uncontrolled diabetes mellitus.

Recommended topical application regimen for balanoposthitis

Clotrimazole 1% cream, twice daily for 7 days

OR

Miconazole 2% cream, twice daily for 7 days

Alternative regimen

Nystatin cream, twice daily for 7 days

E. PUBIC LICE

The louse, *Phthirus pubis*, is the cause of pubic lice. The infestation is usually transmitted by sexual contact. Patients usually seek medical care because of pruritus.

Recommended regimen

Lindane 1% lotion or cream, rubbed gently but thoroughly into the infested area and adjacent hairy areas and washed off after 8 hours; as an alternative, lindane 1% shampoo, applied for 4 minutes and then thoroughly washed off.

OR

Permethrin 1%, applied to the infested and adjacent hairy areas and washed off after 10 minutes; re-treatment is indicated after 7 days if lice are found or eggs are observed at the hair-skin junction. Clothing or bed linen that may have been contaminated by the patient in the two days prior to the start of treatment should be washed and dried well, or dry-cleaned.

Note: Lindane is not recommended for pregnant or lactating women.

Special considerations

Infestation of the eyelashes should be treated by the application of an occlusive ophthalmic ointment to the eyelid margins daily for 10 days to smother lice and nits. The ointment should not be applied to the eyes.

4. STIs AND HIV CO-INFECTION – SPECIFIC CONSIDERATIONS

When to suspect HIV infection in a patient presenting with STI-related symptoms?

- Anogenital lesions are severe or extensive
- Anogenital lesions are atypical and/or chronic
- Minimal or no response to standard therapy in a compliant patient

Impact of HIV on treatment of STI:

- In HIV-infected patients with adequate immunity (early HIV disease) treatment is same as that for HIV-negative patients.
- In HIV-infected patients who are in intermediate or late HIV disease stage, higher dosage of antimicrobials and/or prolonged duration of therapy may be required.
- The response to therapy may not be good and failure of standard regimens may occur.

5. ANORECTAL AND ORAL/PERIORAL STIs IN MSM AND HIJRAS

(This section is adapted from a portion of the article: John Richens. **Main presentations of sexually transmitted infections in men.** *ABC of sexually transmitted infections series. BMJ* 2004;328:1251–3)

1. Anal symptoms

Anorectal STIs

- Sexually transmitted infections can be transmitted by penile-anal contact, oroanal contact, or fingering, resulting in asymptomatic infection, ulceration (for example, herpes and syphilis) warts, or proctitis, the main manifestations of which are pain, tenesmus, bleeding, and discharge.
- Ulceration is investigated in the same way as genital ulceration.
- Discharges require investigation by proctoscopy, during which samples can be taken from the rectum to test for gonorrhoea and chlamydia.
- The management of a sexually acquired rectal discharge parallels that of urethritis. Anorectal infections are a potent cofactor for HIV transmission.
- Anal intercourse can lead to the transmission of a wide variety of other organisms normally transmitted by the feco-oral route. These include hepatitis A virus, *Shigella*, *Salmonella*, and *Giardia*.
- Anal intraepithelial neoplasia and invasive carcinoma may follow infection with certain subtypes of human papillomavirus.

Non-infectious anal conditions

Patients who practice receptive anal sex often present to STI services with anal fissure, hemorrhoids, perianal haematomas, and pruritus ani. It is important to provide training and guidelines for the management and referral of these common conditions in clinics that see clients who practice anal sex.

2. Oral and perioral symptoms

- Oral STIs usually are asymptomatic. *Neisseria gonorrhoeae* and *Chlamydia* infect the pharyngeal mucosa readily but rarely cause acute inflammation.
- Primary syphilis may present on the tongue or lips, and secondary syphilis can produce an oral mucositis.
- Warts may develop in and around the mouth as a result of orogenital sexual activity.
- Oral herpes can be acquired or transmitted sexually (peno-oral or oro-vulval contact).

6. ANOGENITAL EXAMINATION IN MSM AND HIJRAS: TIPS FOR MAKING IT COMFORTABLE

(This section is adapted from: *Clinical guidelines for the management of STIs among priority populations.* Australasian College of Sexual Health Physicians.)

Physical examinations may be embarrassing for some patients and is often a factor in patients delaying presenting to a clinician for diagnosis and treatment.

Over time, and with practice, clinicians develop a range of individual techniques that they find enable patients to become more relaxed and comfortable with a physical examination. The following are some hints that aim to promote good examination practice.

• *Good preparation* will enable the examination to proceed smoothly and efficiently and won't unnecessarily prolong the examination. Ensure equipment is at hand and ready for use and that the lighting is adequate.

• *Explain the examination procedure* to the patient and provide an opportunity for questions to be asked prior to proceeding with the examination. Allay any concerns that the patient may have.

• *Be understanding* of patient sensitivity towards undergoing a physical examination.

• Establish a trusting environment is important to *minimise fear and embarrassment*. Acknowledging the patient's embarrassment may assist them.

• Often patients need to be assured about the *confidential* nature of STI testing and diagnosis.

• *Ensure the patient is comfortable.* Factors that can impact upon patient comfort include an inadequately heated room, lack of privacy, patient uncomfortably positioned and inadequate warming of metal instruments.

• While it is important to avoid unnecessarily prolonging an examination, it is also important to ensure a *thorough examination.* Developing a systemic approach may help prevent omissions.

7. PERFORMING PERRECTAL (PR) EXAMINATION IN MSM & HIJRAS

(**Note:** Below are the steps for performing a comprehensive anorectal examination. Not all these steps are needed for patients coming for STI check-up)

1. Perform a rectal examination only after explaining to the patient what the examination entails and how it will feel.

2. Drape the patient for the rectal examination so as to avoid unnecessary exposure.

3. Position the patient for the rectal examination in one of the standard positions to allow minimum discomfort to the patient while the examination takes place.

4. Inspect the sacrococcygeal and perianal areas for: masses; inflammation; eruption; excoriations.

5. Palpate any abnormal areas seen on inspection for firmness and tenderness.

6. Inspect the anus for lesions (with the patient straining down).

7. Palpate the rectum (using suitable lubricant) for: anal sphincter tone; tenderness; irregularities; masses; presence and character of stool.

8. Identify changes in anal sphincter that are associated with the aging process.

9. Palpate the prostate* and seminal vesicles for: size; shape; consistency; nodules; tenderness.
(*In emasculated Hijras, prostate gland has to be examined, especially in those who are above middle-age)

10. Look at the characteristics of the discharge or fecal material adherent to the examining glove after completing the rectal examination.

11. Test fecal material adherent to the examining glove for occult blood after completing the rectal examination.

12. Record physical examination findings for the anus and rectum.

13. Assist the patient in cleaning up after rectal examination.

8. ANOSCOPIC OR PROCTOSCOPIC EXAMINATION

1. Anoscopic examination is best conducted by placing the patient in the lateral Sims position with the patient retracting the right buttock with his right hand and the examiner using his left hand to retract the left buttock.

2. With the patient remaining in the Sims position, the tip of the anoscope should be well covered with a water soluble lubricant, and the instrument firmly but gently pressed into the anal canal while being slowly rotated.

3. It is usually best to pass the scope its full depth before the obturator is removed, and the examination carried out as it is slowly withdrawn.

4. Look for:

- Discharge (chlamydial or gonococcal infection)
- Ulcers (syphilis or herpes)
- Warts*
- Lumps or growth
- Internal hemorrhoids

(*Avoid proctoscopy if extensive perianal warts are present since doing proctoscopy may introduce human papilloma virus into the anal cavity if already not there)

5. During proctoscopic examination, specimen collection can also be done.

9. CHECKLIST FOR ANOGENITAL EXAMINATION IN MSM AND HIJRAS

*(*Compiled by: *Dr. Venkatesan Chakrapani)*

1. Penis

- Prepuce: present or not? Retractable? After retraction, look for any lesions over the undersurface of the prepuce, glans penis & coronal sulcus
  (Prepuce should be drawn forwards after examination)
- Shaft: Look for lesions (like warts, Ulcers, burrows, rash, etc)
- Discharge: Is it coming from urethra or beneath the prepuce? i.e. Subprepucial discharge. If no discharge seen but patient complains of discharge, milk the urethra.
- External urethral meatus:
  - Location (Hypo/Epispadiasis), look for inflammation, discharge, stricture, etc.
  - Retract the lips of the meatus to look for intrameatal warts or meatal chancre

(Normal structures or normal variations: Fordyce's spots, coronal papillae, pearly penile papules)

2. Scrotal Skin:

- Rugosity maintained? (lost in inflammation, and swelling)
- Any redness, swelling, or ulcer
- Lift scrotum to inspect its posterior surface
  (E.g., Anterior ulceration – Gumma, Posterior Ulceration – TB)
- Look for - Angiokeratoma, Sebaceous cysts

3. Testes:

- Size, shape
- Palpation: Any nodularity/irregularity, tenderness
- Compare with opposite testis

4. Epididymis:

- Size, shape
- Palpate - Globus minor, Globus major & tail

5. Spermatic cord:

- Compare thickness with opposite side (Simultaneously palpate on both sides)
- Is it thickened? tender? Varicocele?

6. Anorectal Examination:

- Position: Left lateral position with knees drawn up (or in Sim's position) or in knee-elbow position
- Look for inflammation, ulceration, fissure, tags, warts
- Laxity of anal sphincter
- Proctoscopic examination: (Avoid if perianal warts are present) look for pus, inflammation, warts, thread worms.
- PerRectal (PR) Examination - if indicated

7. Pubic regions & Groin:

- Groin swelling – Is it hernia or lymphnode enlargement? Description of lymphnodes
- Look for Pediculosis pubis, Tinea cruris, Thrush (candidiasis), Scabetic lesions, etc.
- If emasculated Hijra, look for urethral stenosis

10. CLINICAL APPROACH TO MSM AND HIJRAS PRESENTING WITH ANORECTAL COMPLAINTS

1. Patient complains of ulcers in the anal region:

- Looks like anal fissure – Can be primary syphilis (Perform VDRL test)
- Single ulcer, well demarcated painless – more likely to be primary syphilis
- Multiple moist lesions with generalized skin rash (subtle or obvious) – Can be secondary syphilis (Condylomata lata). Perform VDRL test (Rule out prozone phenomenon)
- Multiple small superficial ulcers or coalescent large perianal ulcer(s) - Can be perianal herpes (ask for history of recurrence)

2. Patient complains of anal discharge with or without pain or bleeding

On inspection - serous or mucopurulent discharge from anus. More likely to be gonococcal and/or chlamydial infection (Proctitis).

3. Patient complains of growth in the anal region:

Can be warts or any non-neoplastic/neoplastic growths.

(Watch for any neoplastic changes in long-standing warts)

4. Patient complains of pain during defecation or bleeding

No obvious external signs hence need to perform digital and anoscopic examination.

Digital examination:

- Look for piles and internal anal fissure
- Look for discharge on the gloves

Anoscopic examination: (especially if digital examination reveals nothing)

- Look for any ulcers (may be STI-associated – example: Herpes)
- Look for any inflammation (may be STI-associated – example: gonococcal and/or chlamydial infection). Correlate with sexual history. Can take specimens from rectum to rule out gonococcal/chlamydial infection.

11. INTERPRETATION OF THE LABORATORY TESTING FOR SYPHILIS (VDRL AND TPHA) AND TREATMENT FOR LATENT SYPHILIS

a. Reactive VDRL and TPHA – with anogenital lesions

If the patient has reactive VDRL and TPHA and has already been treated for early syphilis (since came with genital or anal lesions in the first visit) then follow-up the patient as per the following guidelines.

Follow-up (Early syphilis): Patients should return for examination and repeat quantitative VDRL tests 1, 2, 3, 6, 9, 12 months after treatment. If VDRL titers have not declined fourfold by 3 months for a patient with primary or secondary syphilis, or by 6 months for a patient with early latent syphilis, or if signs or symptoms persist, the patient should be evaluated for re-infection and neurosyphilis and should be retreated. Testing for HIV should be considered 3 months after therapy, if currently HIV seronegative.

b. Reactive VDRL and TPHA – with no symptoms (latent syphilis)

If the patient has reactive VDRL and TPHA and has no symptoms then for all practical purposes assume that that he/she is in late latent stage of syphilis. The treatment and follow-up need to done as given below.

Recommended regimen

After testing for sensitivity for penicillin, give:

Benzathine benzylpenicillin, 2.4 million IU by intramuscular injection, once weekly for 3 consecutive weeks

Alternative regimen

After testing for sensitivity for penicillin, give:

Procaine benzylpenicillin, 1.2 million IU by intramuscular injection, once daily for 20 consecutive days

Alternative regimen for penicillin-allergic non-pregnant patients

Doxycycline, 100 mg orally, twice daily for 30 days

Alternative regimen for penicillin-allergic pregnant patients

Erythromycin, 500 mg orally, 4 times daily for 30 days

Follow-up (Late latent syphilis): Follow-up is the same as for early syphilis.

c. Reactive VDRL and nonreactive TPHA (and no anogenital symptoms)

More likely to be false-positive reaction especially if VDRL titer is less than 1:8 dilutions. If so, no need to give treatment for syphilis.

d. Nonreactive VDRL and reactive TPHA (and no anogenital symptoms)

More likely to be due to previously treated syphilis. Could be due to untreated or partially treated syphilis. If in doubt, refer to a specialist.

12. STI/HIV TESTING RECOMMENDATIONS FOR MSM AND HIJRAS

(Adapted from various professional guidelines: US-CDC guidelines, Australasian College of Sexual Health Physicians and Queensland Management Guidelines for the Detection and Treatment of Sexually Transmissible Diseases and Genital Infections)

While we wait for evidence-based guidelines in India, the following guidelines can be adapted as per the prevalence of symptomatic and asymptomatic STIs among men in various parts of India. Those marked with asterisk (*) are strongly recommended (based on the available clinical data on MSM and Hijras in India).

All males and Hijras who had sex with a man in the previous year should be offered at least once a year:

- HIV serology (if previously negative) *
- Syphilis serology* (TPHA test if necessary)
- Pharyngeal culture for gonorrhoea (if history of peno-oral sex but no symptoms)
- If facilities are available, anal culture for gonorrhea and nucleic-acid amplification tests for chlamydia can be done (especially if history of anal sex but no symptoms)

Clinical indicators for anal tests (irrespective of the consistency of condom use) include:

- Any anal sex with casual partners
- Any unprotected anal sex
- Any anal symptoms (bleeding, itching, discharge, pain)
- HIV-positive
- Past history of gonorrhea
- Contact with any STI

Lab test for:

- Hepatitis A serology - Immunize if negative
- Hepatitis B serology* - Immunize if negative

More frequent STD screening (e.g., at 3- or 6-month intervals) may be indicated for MSM at highest risk (e.g., those who acknowledge having multiple anonymous partners with inconsistent condom use)

(Immunization tips for MSM

HIV negative MSM: Once an immunocompetent patient is immunized against HAV and HBV further Hepatitis A or B serology is unnecessary.

HIV positive MSM: HBV surface antibody levels may be indicated after double dose Hepatitis B vaccination in HIV+ MSM.)

13. ISSUES FACED BY HIV-POSITIVE MSM IN THE INDIAN HEALTH CARE SYSTEM: FOCUS ON DISCRIMINATION BY OMISSION

(Dr. Venkatesan Chakrapani, M.D. www.indianGLBThealth.info)

Issues faced by HIV-infected MSM in the health care system differ according to:

- Presence of specific identities related to sexual behavior/attractions
- Sexual behavior/practices
- Marital status
- Provider sensitivity
- Stage of the disease

Omissions in Pre-test HIV counseling:

Could be in the first-time HIV testing or during 're-confirmation' testing

- Assumption about sexual behavior and practices
- No enquires about same-sex/bisexual behavior or attractions

This means:

- Non-disclosure of same-sex/bisexual behavior or sexual orientation by the patient – due to fear of discrimination or thinks inappropriate to volunteer that information or thinks that has no clinical significance

Can result in:

- Inappropriate counseling on risk reduction and lost opportunity to provide safer sex education tailored to particular sexual practices
- Creation of or increase in guilty feelings in the patient about same-sex/bisexual behavior or attractions

Omissions in Post-test HIV Counseling:

Similar issues as in pre-test HIV counseling.

In addition, if HIV-positive,

- No discussion on notifying HIV status to male partners (irrespective of marriage status)
- No assistance in disclosure of HIV status to male or female partners
- No assistance in negotiating condom use with steady partners (female or male) - until disclosure of HIV status

Omissions in Follow-up visits:

- Assumption about sexual activity (example: assumed to be in abstinence)
- No baseline or periodic screening for STDs: sexual risk behavior screening or clinical or lab screening
- Not educating about certain issues like:
  Risk of HIV transmission to others by oral sex or acquisition of other STDs

Risk of transmission/acquisition of other HIV types or drug-resistant strains
Patients with undetectable plasma viral load can still transmit HIV infection ('HIV optimism')

Omissions in making correct clinical diagnosis or providing necessary clinical advice:

- Not screening for anorectal STDs
- Misdiagnosing anorectal STDs as something else (e.g., warts misdiagnosed as piles)
- Missing sexually transmitted gastrointestinal infections (and providing empirical therapy for routine infections)
- Misdiagnosing Kaposi's sarcoma as something else (though low HHV-8 prevalence in India)
- Not providing vaccination-related advices (e.g., vaccination against HBV) (Note: All sexually active homosexual men are recommended to have HBV vaccination by CDC, USA)

Omissions in providing appropriate Psychological support:

- HIV diagnosis may be devastating in a person with guilty feelings about his same-sex/bisexual behavior and can have serious consequences (example: vengeance, ignoring both HIV diagnosis and same-sex attraction and engaging in destructive behavior, etc.). Need to deal with internalized homophobia in addition to HIV.
- Support system may not be in place (no connections with biological family or wife). Need to recognize and involve the alternative families (e.g., support system by gay friends).
- Clinician to engage male partner in important decisions – on treatment, referrals, end-of-life care, etc.
- Assisting in disclosure of HIV diagnosis and sexual orientation to patient's female spouse (if requested by the patient) and providing supportive counseling to female spouse.
- Address 'Guilty-survivor' syndrome (if partners and friends died of HIV)

Omissions in taking care of the steady male partner of the patient:

Clinician to address:

- Guilty feelings in the HIV-negative partner since he has 'escaped' (a form of 'Guilty-survivor' syndrome). Unprotected sex in an effort to become infected.
- Guilty feelings in the HIV-infected partner that he is responsible for infecting his partner.

Thus there is a crucial and urgent need to address the discrimination by omission in the Indian health care system to provide quality services to MSM.

14. HEALTHCARE FOR HIJRAS: BASIC INFORMATION

Hijras are especially likely to have experienced discrimination and misunderstanding in a healthcare setting. Most health care providers, like most people in general, do not know much about the issues of Hijras.

- Remember that gender identity is distinct from sexual orientation.
- Be aware of uncomfortable feelings that Hijras may feel about their bodies or life histories and the particularly difficult experiences they may have had in the healthcare environment.
- Sometimes Hijras might come in male dress but mention their 'female' name and would like to be treated as a female. It is important to respect their preferred name and also preferred way of calling them (using appropriate pronouns). If you have any doubts, you can ask them how they would like to be called as.
- Recognize that even in Hijras who have undergone emasculation or sex change operation, prostate examination has to be conducted. This may be uncomfortable, and it is critical that you handle it sensitively.
- Educate yourself about basic transgender healthcare issues, including hormone doses and their effects and available surgeries.
- Hijras receiving (or self-administering) hormone therapy should be monitored carefully by knowledgeable providers.
- Enquire about hormonal therapy and sex reassignment surgery: Are you currently on female hormones? Which ones and for how long? Have you had any complications or concerns? Have you used hormones in the past? If not, do you plan to pursue hormone therapy in the future? Have you undergone sex reassignment surgery? If not, do you plan to pursue surgery in the future?

Sensitive issues in relation to physical examination

Most Hijras usually agree to undergo external anogenital examination especially if they have primarily come for STI screening or treatment of problems in their anogenital region. Some would prefer to show their anal area in the lithotomy position (which is the usual position for clinical examination in females).

Some male-to-female transgender persons (Ackwa Hijras) may be in woman's dress but might not have undergone emasculation (removal of male external genitalia). In such situation, they may be reluctant or feel ashamed to show their male external genitalia and thus just show their pubic area after hiding the male genitalia behind the thighs. They

should be explained that even though they might have never inserted any male/female, there are some STDs like genital warts or herpes that can be transmitted by prolonged skin-to-skin contact (while having sex with their partners) and hence the need for physical examination of male external genitalia.

Health issues

In a qualitative study, Hijras mentioned that their main health service needs are in relation to their sexual health especially sex reassignment surgery, urological problems following the emasculation operation, hormonal therapy, and screening and treatment of STDs.

Hormonal therapy

Many Hijras might be taking female hormones without doctor's prescription. Hence it is important to enquire them about whether they are currently taking female hormones or whether they have any intention to take female hormones in the near future. If they express desire to take female hormones for breast development and feminization, they should be given adequate information about female hormones and referred to endocrinologists or medical practitioners who have good experience in administering hormonal therapy.

Sex Reassignment Surgery (SRS)

Many Hijras go to unqualified medical practitioners ('quack doctors') for undergoing emasculation operation. Because emasculation is not done in a proper manner by these quack doctors, many Hijras develop post-emasculation urethral stenosis. It is important to refer them to urologists and/or plastic surgeons for urethral dilatation or urethroplasty.

Those Hijras who are considering to undergo SRS have to be referred to qualified psychiatrists and surgeons. Only a very few public hospitals in India perform sex reassignment surgery. Private practitioners who perform SRS charge heavily and Hijras could not afford.

Note: There are no national guidelines for hormonal therapy or sex reassignment surgery for Hijras in India. However, international guidelines like - the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders - can be adapted in India.

APPENDICES

APPENDIX-1: SEXUAL BEHAVIOR, STD/HIV PREVALENCE AMONG MSM ATTENDING A GOVERNMENT STD CLINIC IN CHENNAI, INDIA

B Srinivasan, V S Dorairaj, V Chakrapani. Sexual behavior, STD and HIV prevalence among men who have sex with men (MSM) attending a government STD clinic in Chennai, India. XV International AIDS Conference 2004, Bangkok, Thailand, July 11-16, 2004.

Background: The study objective was to document the sexual behavior, STD and HIV prevalence among men who have sex with men (MSM) attending the STD outpatient clinic of the Institute of STD, Madras Medical College, Chennai.

Methods: 150 MSM aged >18 years attending this clinic from April 2001 to March 2002 were enrolled. Informed consent was obtained and a structured questionnaire was administered. Clinical examination & serological tests for HIV (ELISA), HBV (HBsAg) & Syphilis (VDRL/TPHA) were done.

Results: Among the 150 MSM, half [50.7%] were 18–25 years & 43.3% were 26-35 years. Majority were from lower socioeconomic status & less educated. About one-third (18.7%) were married heterosexually. Sexual behavior in the last year: 42.7% had sex with both males & females and 41.3% had sex only with males; 40.7% had sex with female sex workers & 22% had sex with transsexual sex workers; 11.3% received money for sex; more than two-third (78%) had anogenital sex with males; and in anogenital sex, 46.7% never used condoms & 32.7% occasionally used. Pattern of STDs: Syphilis - Early Latent Syphilis (ELS) alone - 11.3%, secondary syphilis alone - 3.3%, and primary chancre - 5.3%; genital herpes alone - 6% and chancroid alone - 1.3%; ELS & genital herpes - 1.3%; Non-Gonococcal Urethritis - 6% and Acute Gonococcal Urethritis alone - 3.3%; perianal warts alone - 1.3% and ELS with perianal warts - 0.6%. Other: Balanoposthitis - 6%, candidal intertrigo alone - 3.3 %, Molluscum Contagiosum alone - 2.6%, genital scabies alone - 2.6% and Prostatitis alone - 5.3%. 24% were VDRL reactive & 14.7% were TPHA reactive; 13.3% were HIV+; and 10.7% HBsAg+. 3 were HIV & VDRL reactive, 6 were VDRL reactive & HBsAg+, and 7 were both HIV+ & HBsAg+.

Conclusions: This study shows high prevalence of STD & HIV among MSM attending a government STD clinic. Clinicians should enquire about bisexual behavior in men and screen for co-infections.

APPENDIX-2: DIAGNOSIS OF THE GENDER IDENTITY DISORDERS – ICD-10, WORLD HEALTH ORGANIZATION

(ICD-10 - International Classification of Diseases)

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
2. The transsexual identity has been present persistently for at least two years;
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Dual-role Transvestism (F64.1) has three criteria:
1. The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex;
2. There is no sexual motivation for the cross-dressing;
3. The individual has no desire for a permanent change to the opposite sex.

Gender Identity Disorder of Childhood (64.2) has separate criteria for girls and for boys.
For boys:
1. The individual shows persistent and intense distress about being a boy, and has a desire to be a girl, or, more rarely, insists that he is a girl.
2. Either of the following must be present:
a. Preoccupation with stereotypic female activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of stereotypical male toys, games, and activities;
b. Persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions:
1. That he will grow up to become a woman (not merely in the role);
2. That his penis or testes are disgusting or will disappear;
3. That it would be better not to have a penis or testes.
3. The boy has not yet reached puberty;
4. The disorder must have been present for at least 6 months.

Other Gender Identity Disorders (F64.8) has no specific criteria.

Gender Identity Disorder, Unspecified has no specific criteria.

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