Basics and Beyond

A Manual for Trainers

Integrating Sexuality, Sexual and Reproductive Health and Rights

Introduction

Anyone who has worked on contraceptive choices, HIV prevention, sexuality education, or even the management of sexually transmitted infections or reproductive tract infections, will agree that these issues are interconnected. But for most part, sexuality, sexual health, reproductive health, and their connections with each other as well as with human rights have been addressed as separate issues and concerns.

Now, however, these connections are being articulated with increasing authority and influence, especially after the International Conference on Population and Development (ICPD) in Cairo in 1994, and the Fourth World Conference on Women (FWCW) in Beijing in 1995. Still, more than ten years later, many practitioners feel inadequately prepared to address and integrate these issues effectively in their work. They may not have the language to talk about them or the information and comfort levels to discuss them confidently.

The Why and How of *Basics and Beyond*

Because sexuality is complex – being deeply personal yet highly socially regulated – it can often be difficult to address. It calls for appropriate, culturally relevant and creative training material to provide a multi-layered knowledge and understanding not just of factual information about bodies and how they operate sexually or of how infections are transmitted or prevented, or how contraceptives work. It also requires developing an understanding of how these play out in a given socio-cultural context and an appreciation of how connecting sexuality to human rights makes for better health and improved well-being.

Basics and Beyond provides training content, tools and methods to demonstrate and strengthen the connections between sexuality, sexual health, reproductive health and human rights. It is based on TARSHI trainings for practitioners on sexuality since 1999 and on trainings on sexuality, sexual health, reproductive health and rights since 2003. Most of the exercises in this manual have been developed and tested at these training programmes. Some exercises have been adapted from other sources that have been duly acknowledged. In a few cases, it has not been possible to trace the original creator of an exercise because the

exercise had been widely used and much modified long before we encountered it. We have received and incorporated feedback on the contents of the manual from various experts in the field and welcome further feedback and suggestions for improvement from users.

Who can use it

Basics and Beyond is a valuable resource on sexuality, sexual health, reproductive health and rights for individual trainers as well as organisations working on these issues. It provides resources to effectively conduct a training course on these issues for participants working in a variety of related fields. Exercises in the manual cover basic concepts along with more complex issues. Detailed message points and instructions for each exercise make *Basics and Beyond* appropriate for both experienced as well as novice facilitators. The exercises combine information on sexuality, sexual health, reproductive health and rights to elicit discussion and build clarity and understanding for participants on a variety of subjects and topics. The exercises also give participants tools and ideas to implement these issues in their day-to-day work.

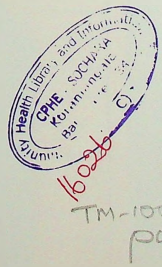
Because *Basics and Beyond* contains a substantial number of handouts, it can also be used as a mini-compendium of basic facts about sexuality, sexual health, reproductive health and rights. It can therefore be used as a resource book by individuals and organisations interested in a basic or more complex understanding of the themes of the manual, by those looking for new ideas on these issues, and those that want to link and integrate these issues more effectively into their advocacy and work.

How to use *Basics and Beyond*

Basics and Beyond contains five modules in addition to a special section for facilitators (*Preparing To Train*). It contains over 75 exercises covering more than 70 hours of training time.

The chapters and exercises in *each module* have been constructed and organised to systematically build on concepts and ideas – earlier chapters in a module lay the foundation for a deeper and more complex discussion in later chapters. Similarly earlier exercises in a chapter establish basic ideas whereas the later exercises introduce more complex concepts.

The manual can be used in a variety of ways depending on the facilitator's goals and the level of understanding, experience and nature of work of the participants. A facilitator can pick and choose exercises from the modules that address issues relevant to the training group's needs and can tailor sessions accordingly. The manual can also be used in its entirety to conduct a comprehensive training programme. A sample



7-day training schedule that combines a variety of the issues covered in the manual can be found in the section *Preparing to Train*. This is only an example of a training schedule to stimulate ideas on how to use the exercises and topics. Each facilitator should evaluate the needs and level of understanding of the group being trained and choose topics and exercises accordingly.

The Structure of *Basics and Beyond*

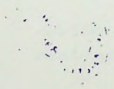
Basics and Beyond begins with a section for the facilitator called *Preparing to Train*. This section is intended to increase the facilitator's understanding and capacity to train on the topics covered in the manual. Using exercises and information handouts, this section provides a foundation for the facilitator to become comfortable and confident about issues of sexuality, sexual health, reproductive health and rights. In addition, *Preparing to Train* includes general training tips and ideas to give the facilitator basic tools and methods to conduct an effective and interesting training. Whether the facilitator using this manual is experienced or not, going through this section will ensure a more effective and comprehensive training.

Preparing to Train is followed by five Modules. Each module has the following components.

Module Introduction: Every Module has an overarching theme and contains chapters that address different aspects of this theme. The introduction includes a list of the exercises for the chapter, and assessment options to evaluate the training session.

Chapters: Each chapter in a Module begins with an overview and rationale for the chapter that prepares and guides the facilitator about the main themes and messages of the included exercises. It also contains additional resources that facilitators can explore and use to learn more about the topics covered in the chapter.

Exercises: Every exercise outlines the objectives for the exercise along with the materials required, duration, advance preparation and handouts needed. It also contains the key messages the facilitator needs to communicate, tips on how to train effectively on the topic, and how to connect the ideas brought up in the exercise with other issues in *Basics and Beyond*.



The Appendices at the end of *Basics and Beyond* contain Internet links to selected relevant human rights documents (Appendix A), and a sample listing of films that can be used to enhance the training process (Appendix B).

Contents

Preparing to Train

Introduction

In creating this manual, we recognise that a range of facilitators and groups with varying levels of knowledge and skills use this resource. With this in mind, we created this *Preparing to Train* section, modelled after a 'training of trainers' approach. *Preparing to Train* recognises that some facilitators may come to the issues of sexuality, sexual and reproductive health, and rights for the first time; some may want to analyse how these issues intersect with one another with a fresh perspective; or need to brush up their information on some aspects of these topics.

Preparing to Train increases the facilitator's understanding and capacity on issues of sexuality, sexual and reproductive health, and rights. It guides facilitators through the primary issues and topics of this manual using exercises and information handouts. When worked through in their entirety, in the order presented, these exercises provide a foundation for understanding basic issues and the ability to impart training on this information.

Tips and tools are also included in *Preparing to Train* to enable the facilitator to conduct an effective and interesting training session. These include icebreakers, different training methods, and tips on how to approach difficult training situations.

ADDITIONAL RESOURCES:

- CREA. 2005. *Adolescent Sexual and Reproductive Health and Rights in India*. New Delhi: CREA.
- De Bruyn, M. 2002. *Gender or Sex? Who Cares? Skills-Building Resource Pack on Gender & Reproductive Health for Adolescents & Youth Workers*. IPAS.
- JHPIEGO. 2003. *Training Works! What You Need to Know About Managing, Designing, Delivering, & Evaluating Group-Based Training*. Baltimore, MD. JHPIEGO.
- Mertus, J., Flowers, N., Dutt, M. 1999. *Local Action Global Change*. UNIFEM and The Center for Women's Global Leadership.
- TARSHI. 1999. *The Red Book – What You Need to Know About Yourself (10-14 Years)*. N. Delhi.
- TARSHI. 1999. *The Blue Book – What You Need to Know About Yourself (15+ Years)*. N. Delhi.
- Youth Coalition. For a list of training resources on young people and sexual and reproductive health and rights, see resources section of http://www.youthcoalition.org

Chapters in Preparing to Train

Chapter 1: Exploring Knowledge and Attitudes

- Preparing for Module 1: Basic Concepts on Sexuality
- Preparing for Module 2: Sexual and Reproductive Health
- Preparing for Module 3: Sexual and Reproductive Rights
- Preparing for Module 4: Beyond Basics
- Preparing for Module 5: Making it Work

Chapter 2: Tips and Tools for the Facilitator

- Planning a Training
- Setting Expectations and Ground Rules for a Training
- Selection of Training Methodologies
- Ideas for Icebreakers and Energisers
- Trouble Shooting Challenging Situations in Training
- Ideas for Training Assessments

Sample Training Schedule

Below is a sample training schedule for seven-day training session using this manual. Please note this is **only a sample** and does not include all the exercises from the manual. It may not be appropriate for all audiences or cover all essential topics required for all participants. Please use this sample as a guide to how the manual can be used for training on sexuality, sexual and reproductive health and rights. A blank sample training schedule can be found following this sample agenda for facilitators to fill and plan their training.

EVENING BEFORE DAY 1: ORIENTATION TO THE TRAINING

TIME	SESSION	RATIONALE
4:00 - 5:00	Introductions	To introduce participants to each other the day before the training begins.
5:00 - 5:30	Expectations from the Training	Set expectations in order for facilitators and participants to know how the training will be shaped and what it will focus on.
5:30 - 5:45	Ground Rules	Establishing the ground rules the day before the actual training will give participants this foundation before beginning any exercise.
5:45 - 6:30	Going through the Agenda, Readings and Expectations of the Participants	To have participants know what to expect and to list their expectations of the training.
6:30	Tea/Refreshments	To have participants socialise in the group.

DAY 1

TIME	SESSION	RATIONALE
9:30 - 9:45	Icebreaker	To energise the group at the beginning of the day.
9:45 - 10:45	Guess the Value	To establish foundation for the entire training by introducing the 5 Core Values that inform Human Rights.
10:45 - 11:00	Tea/Refreshments	
11:05 - 11:50	Understanding Sexuality	To establish basics of sexuality for the duration of the training.
11:50 - 12:00	Quick Energizer/Break	
12:00 - 1:00	Why talk about Sexuality?	To continue discussion of sexuality from previous exercise and help participants understand why it is important to address sexuality.
1:00 - 2:00	Lunch	

2:00 - 2:10	Gender as Social Construct (as an Energizer)	If participants have background of gender, this is only a refresher of the concepts.
2:10 - 3:00	Varieties of Sexual Expression	To increase participants' comfort with ideas of sexuality and behaviour and familiarise them with lesser-known forms of sexual expression.
3:00 -3:45	Good Sex/ Bad Sex	To follow up the previous exercise and help participants examine their attitudes and dis/comfort with certain sexual behaviour and expression.
3:45 - 4:00	Tea/Refreshments	
4:00 - 5:15	Human Rights Tree	An introduction to human rights and their connection to sexuality and reproductive and sexual health.
5:15 - 5:30	Review for next day/ feedback group/ other instructions	Give any assignments and readings to reinforce the day's learning/ to prepare for the next day's sessions

DAY 2

TIME	SESSION	RATIONALE
9:30 - 9:45	Report of previous day	To refresh ideas and see if questions remain from the day before.
9:45 - 10:15	Freedom To/ Freedom From	To begin discussions on reproductive and sexual rights.
10:15 - 11:30	Speed questions on Reproductive Rights with discussion.	Having begun with brief introduction to reproductive rights in previous exercise now can start to relate it to personal lives.
11:30 - 11:45	Tea/Refreshments	
11:45 - 1:00	Case Study on Sexuality, Sexual Health and Sexual Rights	To have more complex discussions on issues of sexual rights and apply theoretical concepts to a real-life situation.
1:00 - 2:00	Lunch	
2:00 - 2:30	Why do we have Sex?	To begin a discussion on the importance of addressing pleasure in the context of one's work and to make participants more comfortable before the next exercise.
2:30 - 3:30	Pleasure Stories	To make participants more comfortable with talking about sexuality and pleasure
3:30 - 4:15	Sex and Gender Identities	Now that sexual rights have been introduced, this exercise establishes that these rights apply to people of all identities.
4:15 - 4:45	Tea/Refreshments	
4:45 - 5:30	Who Has The Power?	To introduce how people can experience less or more power and opportunities in society depending on their circumstances, life choices, identities etc.
5:30 - 5:45	Review for next day/ feedback group/ other instructions	Give any assignments and readings to reinforce the day's learning/ to prepare for the next day's sessions

DAY 3

TIME	SESSION	RATIONALE
9:30 - 10:15	Report of previous day	To refresh ideas and see if there are still questions from day before
10:15 – 11:00	Pre-test Quiz game: Anatomy, physiology, contraception, conception and abortion	If participants already have a background in reproductive health, this will be a review and ensure that all are at the same level of understanding.
10:30 - 11:15	Tea/Refreshments	
11.15 - 12:30	Case studies on Infertility and Options	After discussing the information-based topics, the participants can begin to analyse the social implications from a rights-based approach by discussing surrogacy, adoption and assisted reproductive technologies.
12:30 - 1:30	My Views on Abortion	To help participants clarify their own values and attitudes to abortion and to listen to other viewpoints as well.
1:30 – 2:15	Lunch	
2:15 – 4:00	HIV/AIDS Basics	Some participants may have experience in HIV/AIDS related issues. This exercise can be a review for them and provide information to participants with little knowledge of the topic.
4:15 – 4:15	Tea/Refreshments	
4:15 – 5:30	Film screening (See Appendix B for list of films)	The film can be on any of the topics discussed thus far. Films break the monotony of a training course and are an effective way of getting ideas across/ starting discussions on a topic.
5:30 - 5:45	Review for next day/ feedback group/other instructions	Give assignments and readings to reinforce the day's learning/ to prepare for the next day's sessions

DAY 4

TIME	SESSION	RATIONALE
9:30 - 9:45	Report of previous day	To refresh ideas and see if questions remain from the day before.
9:45 – 10:30	Stigma and Identities	To examine stereotypes related to various identities and how these can stigmatise, discriminate and marginalise and link it to rights in the context of sexuality and reproductive and sexual health.
10:30 - 11:15	Stigma Mapping	After discussing HIV/AIDS and identities the previous day, participants can discuss stigma and discrimination faced by various groups of people.
11:15 - 11:30	Tea/Refreshments	
11:45 - 1:00	Abuse of Power: Sexual Violence and Harassment	To understand the link between abuse of power and rights in the context of sexuality and reproductive and sexual health.
1:00- 2:00	Lunch	

2:00- 3:00	Abuse of Power: Child Sexual Abuse	As an appropriate continuation of the earlier discussion on abuse of power.
3:00-3:15	Tea/Refreshments	
3:15-5:30	Film Viewing and discussion (See Appendix B for list of films)	The film can be preceded by brainstorming about a topic addressed by the film and can be followed by a discussion to make learning effective and fun.
5:30-5:45	Reading/ assignments for the day off/ feedback	Give assignments and readings to reinforce learning/ to prepare for the sessions to follow.

DAY 5 BREAK/ OFF-DAY

DAY 6

TIME	SESSION	RATIONALE
9:30 - 9:45	Report of previous day	To refresh ideas and see if questions remain from the day before.
9:45 - 11:15	Disability and Sexuality Film Clips	Introduction of this topic, which may be new to participants. Film clips will help open up discussions and increase comfort with the issue.
11:15 - 11:30	Tea/Refreshments	
11:30 - 1:00	Representation in the Mass Media	To begin to discuss representation and who and how images and ideas reflect and influence people's ideas about sexuality and gender and link this to stereotyping and discrimination.
1:00 - 1:30	Lunch	
1:30 - 2:45	Negotiating with Other Stakeholders	Continue discussions on representation and link it with freedom of expression and the right to information
2:45 - 3.00	Tea/Refreshments	
3:00 - 4:15	Case Studies on Ethical Dilemmas	Switching gears to bring together many of the training topics with a discussion of ethics in case studies based on real-lifesituations
4:15 - 5:30	Case Studies on Campaigns for Sexuality, Reproductive and Sexual Health and Rights	To continue to apply the ideas and issues of the training to the campaign case studies. Participants will continue to see how these topics play out in their work and real situations.
5:30 - 5:45	Reading/ assignments for the day off/ feedback	Give assignments and readings to reinforce learning/ to prepare for the sessions to follow.

DAY 7

TIME	SESSION	RATIONALE
9:30 - 9:45	Report of previous day	To refresh ideas and see if questions remain from the day before.
9:45 - 11:15	Guiding Principles: Assessment	To evaluate how participants integrate the issues of sexuality, reproductive and sexual health and rights into their work by having them develop guiding principles for working on sexuality.
11:15 - 11:30	Tea	
11:30 - 1:30	Parking Lot issues	To review or discuss issues and questions left unanswered throughout the training. Facilitator may want to conduct an exercise or have a discussion or show a film etc to address an issue that was left out/ requires more clarification.
1:30 - 2:15	Lunch	
2:15 - 3:00	Assessment of Training	To evaluate how much the participants learned and their opinions on the exercises and facilitator style.
3:00 - 4:00	Farewell exercise and Certificate distribution	To wrap up training with key messages - this can be done as a short slide presentation highlighting key ideas participants should be taking back from the training.
4:00pm onwards	Tea/Refreshments	

SAMPLE TRAINING SCHEDULE

Below is a template for a one day training schedule. Depending on the focus of the training and the topics it aims to cover, the facilitator can fill in this blank schedule with exercises from one module/chapter or in combination with exercises from other modules/chapters

9:30 - 9:45	Icebreaker
9:45 - 10:45	Exercise 1
10:45 - 11:00	Tea
11:00 - 12:00	Exercise 2
12:00 - 12:10	Short break/ quick energiser
12:10 - 1:00	Exercise 3
1:00 - 2:00	Lunch
2:00 - 2.15	Energiser/Ice breaker
2:15 - 3:00	Exercise 4
3:00 - 3:45	Exercise 5
3:45 - 4:00	Tea
4:00 - 5:00	Exercise 6
5:00 - 5:30	Review for next day/ feedback group/ assessment of the day's sessions

Chapter 1
Exploring Knowledge and Attitudes

This chapter is appropriate for both a novice facilitator who wants to increase comfort and confidence in addressing sexuality and related issues, and for a seasoned facilitator to review key points and examine more complex topics. Sexuality, sexual and reproductive health, and rights are complex and dynamic issues. New aspects to these topics constantly arise and can be approached differently at different points in one's personal and professional lives, and in different contexts, cultures and times. It is therefore important for a facilitator to re-visit these issues from time to time in order to present them in a relevant and comprehensive way to one's audience. The exercises and handouts mentioned in this chapter can help a facilitator with this task.

This chapter refers to certain exercises that appear in the various modules of *Basic and Beyond* that can prepare a facilitator to clarify their own knowledge and views on topics covered in the manual. It follows the same topical sequence as the rest of the manual. For example, the first exercises and topics referred to in this chapter correspond to Module 1: Basic Concepts on Sexuality. Within each section of exercises, there is first a brief description of the module the facilitator is being prepared for, followed by references to the handouts they must review for the module. The referenced exercises that follow correspond to exercises in the manual that the facilitator should look up and go through themselves. These exercises provide information and concepts covered in the module, introduce or refresh one's understanding of the issues, and anticipate participant questions and concerns.

This section can be completed all at once, or the facilitator may want to cover the modules over a period of time. These exercises can also be used as review/revision prior to a training day for a particular module or chapter.

Preparing for Module 1
Basic Concepts Related To Sexuality

At the start of any training, it is necessary to establish a sound understanding of basic ideas and information. This module gives participants a solid foundation before moving on to more complex issues. The information and ideas included in Module 1 include not just definitions for terms such as sexuality and gender, but also exercises on language and how values and attitudes affect work on issues around sexuality, sexual and reproductive health, and human rights. This basic information is particularly valuable if the topic of sexuality is new to participants. It is also useful for those who have been working on these issues and want to review these topics.

Exercises to Prepare for this Module:

It is recommended that the facilitator go through the following exercises selected from Module 1: Basic Concepts on Sexuality to prepare to conduct the exercises in this module effectively.

- **Introduction to Module 1: Setting the Tone**

  The objective of this exercise is to describe and discuss the five core values that act as a foundation for the discussion of sexuality, sexual and reproductive health, and rights. Understanding the link between values and sexuality allows for an appreciation of the advantages of using a rights-based approach to sexuality and sexual and reproductive health.

- **Module 1, Chapter 1, Exercise 1: Understanding Sex and Sexuality**

  The objective of this exercise is to understand sexuality as more than acts of sex and comfortably discuss this with participants. Issues of sexuality are laden with values, subjective and are not experienced and expressed in the same way by everyone. Being aware of these individual differences is important in order to provide effective services that respect people's choices and the opportunities to lead healthier and safer lives.

- **Module 1, Chapter 1, Exercise 3: Understanding Gender**

  The objective of this exercise is to understand how gender is socially constructed and relates it to sexuality as well. Social construction of gender means that it is determined by our social, cultural and psychological surroundings and environment.

What to Review

A review of the following handouts from the module is recommended in addition to going through the exercises mentioned alongside. For additional information to supplement these handouts and exercises refer to *Additional Resources* at the beginning of each chapter in Module 1.

HANDOUTS:

Handout 1.1
Five Core Values

Handout 1.2
Basic Information on Sex, Sexuality and Gender

Handout 1.3
Understanding Sexuality: Terms and Definitions

Handout 1.4
Basic Information on Sexual Identity and Gender Identity

Handout 1.5
Varieties of Sexual Behaviour and Expression

- **Module 1, Chapter 2, Exercise 1: Sexual and Gender Identities**

  The objective of this exercise is to understand and define different sexual and gender identities and to examine common experiences and issues faced by different identities. Identities are fluid, changing and personal. Every individual has multiple identities which intersect in unique ways. For example, someone may identify as a woman, a mother, a lesbian, a daughter, and a nationalist. Stereotypes focus on only a single identity of an individual and may be used to judge a person unfairly.

- **Module 1, Chapter 2, Exercise 2: Varieties of Sexual Expression**

  The objective of this exercise is to acquire awareness of, and comfort around the diversity and variety of sexual behaviors and expressions and learn the appropriate terms for these practices. Recognising the diversity of behaviours helps affirm the rights of people to engage in consensual sex without fear of judgment or punishment.

- **Module 1, Chapter 3, Exercise 1: Experiences of Sexuality Through Life**

  The objectives of this exercise are to appreciate that sexuality is experienced throughout life and to acquire comfort around talking about sexuality at different stages of life.

- **Module 1, Chapter 4, Exercise 1: Sex for Pleasure?**

  The objective of the exercise is to explore attitudes and ideas surrounding sex and pleasure. Pleasure is an important consideration in the context of sexual health and safer sexual practices. For example, when safer sexual practices are being promoted, the fact that people often have sex because it feels good must be recognised so as to find an effective and 'user-friendly' method of protection that does not reduce pleasure. Talking openly about pleasure and its place in sexual experiences can also reduce shame and guilt, allow for the expression of fears and clarify misconceptions around this issue.

- **Module 1, Chapter 2, Exercise 6: Representation in the Mass Media**

  The objective of the exercise is to recognise how identities are represented in mass media. These representations can lead to stereotypes and discrimination. Being aware that sexuality and sexual and reproductive health related issues are also represented through language, images, documentation, campaigns, advertisements, reports and brochures, and documentaries, can help in designing effective campaigns and communication materials.

Preparing for Module 2 Sexual and Reproductive Health

While sexuality is not restricted to the physical body, it is largely expressed and experienced through the body. Any discussion on sexual and reproductive health requires a basic understanding of body functioning. This information-based module is intended to provide information on human sexual and reproductive anatomy and physiology, conception, contraception, abortion, infertility, sexual problems, sexually transmitted infections and HIV/AIDS. Beyond basic understanding, the chapters explore attitudes and ideas on these issues and also link them to values and rights, for example the rights of people to have/not have children, the rights of HIV positive people to marry, etc.

For the facilitator to be adequately prepared for this module, it is important to review the information-based material for each chapter and to examine and analyse the associated issues. The handouts mentioned alongside provide the basic information for each topic, while the exercises can help move beyond information and explore discussions and debates around the issue.

Exercises to Prepare for this Module:

Two exercises follow: one is selected from Module 2: Sexual and Reproductive Health and the other has been designed for the facilitator to prepare them for issues brought up in this module and to conduct the exercises in the module effectively.

- **Module 2, Chapter 1, Exercise 4: Sexual and Reproductive Physiology**

  The objective of the exercise is to identify the differences and similarities in sexual and reproductive physiology. Recognising sexual functions of different parts of the body and the zones of pleasure is important and should go hand in hand with understanding reproductive functions.

- **Module 2, Exercise for the Facilitator: Opinions and Ideas**

  The exercise below combines questions and exercises from all the chapters in Module 2. The objective is to analyse and engage in issues related to sexual and reproductive health.

What to Review

A review of the following handouts selected from the module is recommended in addition to going through the exercises mentioned alongside. For more information to supplement these handouts and exercises refer to *Additional Resources* at the beginning of each chapter in Module 2.

SELECTED HANDOUTS:

Handout 2.1 Facilitator Copy: True and False Pre-test on Sexual and Reproductive Anatomy and Physiology

Handout 2.3 Facilitator Copy: Diagram of the Human Sexual and Reproductive Anatomy and its Physiology

Handout 2.4 Participant Copy: Diagram of the Human Sexual and Reproductive Anatomy and its Physiology

Handout 2.6 Basic Information on Conception

Handout 2.7 Basic Information on Contraception

Handout 2.8 Basic Information on Abortion

Handout 2.9 Facilitator Copy: Pretest on Conception, Contraception, Abortion

Handout 2.11
Basic Information on Infertility

Handout 2.12
Basic Information on Options for Infertility

Handout 2.13 Facilitator Copy:
Myths and Facts on Infertility and Assisted Reproductive Technologies

Handout 2.16
Basic Information on HIV/AIDS

Handout 2.17
Quiz on Basics of HIV/AIDS

Handout 2.18
Testing, Treatment Care and Support of HIV/AIDS

Handout 2.19
Basic Information on Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs)

Handout 2.20 Facilitator Copy:
STIs and RTIs Pre-test

Handout 2.24
Basic Information on Sexual Problems

Handout 4.25 Facilitator Copy:
Myths and Facts on Sexual Problems

Handout 2.28
A New View of Women's Sexual Problems

Look over the following statements and write responses to them. Do you **agree** or **disagree** with them? Why? If you **are unsure**, list out arguments for both viewpoints and try to analyse them using a rights based perspective (See Module 3 for more on rights)

1. The most important thing a person can do is to have children.
2. People should have children only if they are married.
3. Sex-selective abortion is a woman's reproductive right.
4. If a woman is raped it is okay for her to have an abortion.
5. Abortion should be a woman's choice.
6. Abortion should be legal and free.
7. Mandatory HIV testing is a good policy for couples to be wed.
8. All people entering the country should undergo mandatory testing for HIV.
9. A doctor has the right to tell a partner of someone who has just tested HIV positive of his/her partner's status without the consent of the positive person.
10. All HIV positive women should not be allowed to have children.
11. Infertility in a couple adversely affects the woman more than the man.

What are some debates taking place around these issues in your community at present? Have there been any recent legal actions, media reports or instances related to these issues? You may want to keep track of recent debates in your community to learn more about these. In addition to providing examples for your training, this information will also help you to make the concepts more relevant to your audience from the same community.

Preparing for Module 5 Making it Work

Regardless of whether participants work in reproductive health interventions, sexuality education programmes, or sexual health clinics, integrating the ideas and information in this manual into their work can make it stronger and more effective. It can be a challenge however, to apply the ideas and concepts in this manual to the work and advocacy we do. How have individuals/ organisations successfully accomplished this before? What lessons can we learn from the successes and challenges of other campaigns and programmes? What principles do we need to apply to be effective and respectful of the people we work with?

Module 5: Making it Work, addresses these questions. It brings together topics from the other modules and illustrates how these can be used effectively to improve work in fields of sexuality, sexual and reproductive health, and advocacy. To provide participants with these tools, a facilitator should explore different advocacy methods and how to combine the lessons learned from *Basics and Beyond* into practical applications.

Selected Exercises to Prepare for this Module:

- **Module 5, Chapter 2, Exercise 3: Ethical Dilemmas**

  The objective of the exercise is to identify ethical issues in real-life situations and examine useful approaches to dealing with issues of sexuality, sexual and reproductive health, and rights. Crosscutting principles such as confidentiality, beneficence, respect and non-exploitation run through the ethical concerns of training, funding, service delivery and research. The facilitator can go through some or all the case studies in the exercise to familiarise themselves with the range of ethical issues and how they can be addressed.

- **Module 5, Chapter 3, Exercise 3: Campaigns for Sexuality, Sexual and Reproductive Health and Rights**

  The objective of the exercise is to examine real-life campaigns and movements on sexuality, reproductive and sexual health and rights, analyse the successes and challenges of these campaigns and ascertain how similar ideas and approaches can be used in other advocacy work.

What to Review

A review of the following handouts selected from the module is recommended in addition to going through the exercises mentioned alongside. For additional information to supplement these handouts and exercises refer to *Additional Resources* at the beginning of each chapter in Module 5.

SELECTED HANDOUTS:

Handout 5.1
Guiding Principles for Working on Sexuality

Handout 5.3
Basic Information on Ethical Principles

Handout 5.4
Sample Ethical Guidelines

Handout 5.5
Ethics Case Studies

Chapter 2
Tips and Tools for the Facilitator

The purpose of this chapter is for facilitators to learn about the kind of preparation necessary to conduct and lead an interesting and effective training workshop and to acquire comfort with potentially problematic training situations and assess possible ways of overcoming them.

In the previous chapters, the focus was on learning and preparing to be an effective facilitator in the areas of sexuality, reproductive health, and rights. At the same time, preparation is also essential to be an effective overall facilitator regardless of the subject matter. Being an effective facilitator takes more than just mastery of information; it also requires an understanding and awareness of participants in the training, comfort in difficult situations, enthusiasm, and the proper application of tools and resources that can benefit and improve training sessions for the participants as well as the facilitator.

The following sections in this *Tips and Tools* chapter will provide facilitators the methods, resources, tools, techniques and exercises to improve their overall performance. Whether the facilitator is highly skilled with years of training experience, or a new facilitator just starting out as a trainer, working and reading through the sections that follow will ultimately benefit their professional impact.

The tips and techniques in this chapter are designed to complement the knowledge from the previous chapter *Exploring Knowledge and Attitudes* so that the facilitator may be able to effectively get the information and ideas across to their audiences.

Setting Expectations and Ground Rules for a Training

Establishing expectations and setting ground rules during the introduction and beginning of any training is important to set the tone. Ground rules firmly establish respect and listening as central to learning during the training. Expectations also guide the facilitator to address the specific issues and questions of participants and inform participants about the scope and focus of the training. One way of establishing ground rules is through an interactive exercise in which participants agree upon rules they find appropriate and essential for the training. Since this method is participatory and democratic, it helps participants identify with the rules and therefore adhere to them. As another option, the facilitator can write the ground rules beforehand. These can be displayed in the training room or distributed as a handout to each participant. In this case, the facilitator should read through the ground rules with participants to ensure that they are understood and agreed upon. Some examples of common ground rules are given in the box alongside.

Establishing expectations may be done through individual questionnaires. The *Listing Expectations Questions* below can be copied, handed out to each participant to complete and then evaluated by the facilitator.

Another option for setting expectations is to have each participant write out one or more expectations on a slip of paper and post them on a chart paper in the room.

Listing Expectations Questions:

- What are your expectations from this training workshop? Please list these.
- What specifically do you hope to learn from this training?
- What skills do you want to acquire?
- Do you have any background in sexuality, sexual and reproductive health or human rights? If yes, describe.
- Are you here voluntarily or are you a mandatory participant, sent by your organisation?

COMMON GROUND RULES:

- Respect the ideas, opinions and views of the other group members.
- Listen to other group members.
- Maintain confidentiality: whatever is shared in this space must stay within it.
- There is no pressure to share personal information.
- Punctuality.
- No insults, foul language or cursing; no discriminatory language or behaviour.
- No name calling, placing blame, or making fun of other participants/ resource person/s.
- Any questions can be asked.
- Participate to your fullest capacity, and encourage quieter participants to do the same.
- Feel free to express an opinion that is different from that of other people.
- Mobile phones must be switched off during sessions.

Planning a Training

MATERIALS YOU MIGHT NEED:

- Participant kits - Name tags, pens, note books, files, bags, and reading material
- Flipcharts
- Markers
- Pens, pencils
- Scrap paper, newspapers, chits of paper
- Stationary: Scissors, punching machine, stapler, glue sticks, pins, tape
- Materials for various exercises including handouts, case studies, instructions etc.
- Equipment - film/s, projectors, computer, screen
- Camera in case you want to video-document the training
- Feedback/assessment/evaluation forms for participants.

Planning training sessions require a great deal of time and preparation: in addition to planning the content of the training, a location must be identified; invitations extended to participants; meals and snacks ordered; and travel arrangements and lodging coordinated, to name a few. Once all this is in place, the facilitator must prepare to conduct the training. Below is a checklist of basic issues and items to be kept in mind prior to the first day of training.

Who is your audience?

- How many people will attend the training?
- What are the ages, genders, and religious backgrounds (if relevant) of the participants?
- Are the participants coming from urban or rural areas?
- Do they all speak the same language or have the same language fluency? Is English, or the language you will be conducting the training in, their first language?
- Are the participants coming from organisations or individually? Will some know each other prior to the training?
- Have any participants in the group attended a similar training? Are all participants of the same level of 'seniority'?

If you do not have all of this information before the training you could do an icebreaker exercise at the beginning that will reveal some of the information (please see the Icebreaker Section for suggestions). It would, however, be useful to have some information available in advance. For example, gauging participant comfort levels with language and literacy levels is important in case arrangements need to be made for an interpreter or exercises need to be modified for a non-literate audience.

What is the training facility like?

- Will there be electricity?
- Will there be access to computers, overhead projectors, or video equipment?
- Is it a small room; is there space to move around?
- Will people be sitting on the floor or on chairs? If participants are on the floor throughout, it may be necessary to do additional

energising exercises throughout the training to keep the group engaged besides providing mats and cushions for comfort.

- It is preferable to have participants seated in a circle during the training. Is it possible to do so in this training space?
- How long will it take to get to the training venue from where the participants are staying?

Is your training planned as a residential one? If yes:

- Have you booked the rooms in advance?
- Have you prepared a rooming list if participants are sharing rooms?
- Have you sent out instructions to participants beforehand about how to reach the venue with a map and other directions?
- Are you planning an evening of entertainment for the participants such as a talk/ lecture/cultural show/party etc.? If yes, do you want to invite other colleagues/organizations from the area to the event as well?

Do you have back-up materials in case something unplanned happens?

- If you plan on using overheads do you have flipcharts, markers and notes in case the electricity fails?
- Do you have handouts and copies of power point slides if your computer does not work?
- Can you anticipate any other eventuality that you must be prepared for?

Are you planning a field visit or are you inviting a guest speaker/ resource person to conduct sessions in your training? If yes:

- Do you need to ask for permission or extend an invitation in writing to the organisation to be visited or people to be invited?
- How will participants travel to the host organisation and will you give the speaker or resource person/s a travel allowance?
- Will you give an honorarium to the host organisation or the speaker/resource person?
- Will you need to provide a profile of the participants to the host organisation or speaker/resource person?
- If the planned visit is at a facility such as a HIV/AIDS hospice, an orphanage etc., is a quick 'briefing' of protocol for the visit necessary? For example, briefing participants to avoid asking intrusive/inappropriate questions and making false promises etc.

MISCELLANEOUS

- Are participants required to read anything prior to the training? If yes, will you be sending out the reading material in advance?
- Are participants required to bring anything to the training from their organisations like their brochures/ publications/a short presentation on their work?
- Do you plan to have a post-training follow-up with the participants, such as setting up an email-group for participants and resource persons to share their ideas and work even after the training process? If yes, what do you need to prepare in advance?

Selection of Training Methodologies

People learn in different ways. Therefore using only one method for training will not work for all participants. During any training session, it is best to use a variety of training exercises and techniques to keep the training interesting and address the various modes of learning each participant may find most effective. Below are training methods used in this manual and other methods that are recommended.

Assessments Written and/or participatory assessments presented in this manual are meant to help the facilitator and participants evaluate whether the objectives of the exercises have been met and whether participants have learned what they were intended to. Assessments can be done as a written form (see Sample Assessments later in this chapter for examples), a role-play (to assess attitudinal changes), or through developing a charter of rights/guiding principles/curriculum for sexuality education etc.

Brainstorming These exercises ask participants to list and propose ideas and comments on a specific issue or topic proposed by the facilitator. Brainstorming can foster creative thinking by the group and helps engage quieter participants. Brainstorming allows participants to observe the diversity of ideas and approaches to an issue and recognise the complexities of a given issue.

Case Studies Case studies present participants with scenarios or stories portraying a real-life situation that they can analyse. Each case study in this manual is accompanied with guiding questions to promote discussion and debate among the group and match the key messages to be conveyed to participants by the facilitator. Case study exercises are effective in getting participants to apply an issue or theory to real-life scenarios and learn from each other during the discussion.

Categorisation Categorisation exercises require participants to individually write out answers to a few separate categories of questions. The answers to these are collected and read out to see the range of answers and opinions on an issue. This exercise is good for topics that may initially be uncomfortable for a group to discuss, such as what a person considers 'good sex' or 'bad sex', since it allows for anonymity. It can also indicate areas or questions that participants still need clarification on.

Circle orientation

Seating participants in a circle can be the most effective way to conduct a training session. This allows them to face each other during conversations and have an open dialogue. It can also increase comfort during conversations and is more participatory than the conventional 'class-room' arrangement.

Debates

Participants are divided into groups and told to prepare arguments that support or oppose a given topic. The groups then debate the issue with each other. Debates promote participant understanding of all sides of an argument or issue, and enable them to articulate their ideas clearly.

Energisers

Energisers are quick, fun activities that can help participants regain their energy and prepare for the next exercise, particularly when they have been sitting in one place for a long time, are experiencing post-lunch sluggishness, have completed an emotionally or intellectually demanding exercise, or when the group is tired and/or bored. A facilitator can choose to use these quick exercises whenever required. Please see the Energiser Section in this chapter for examples.

Film and Discussions

Showing documentaries, feature films, or television programmes and having a discussion about it is an interesting and non-threatening way of addressing some issues contained in this manual. It also allows participants to visually engage with an issue making it more 'real' for them. For a list of selected films on related issues please see Appendix B or visit http://www.asiasrc.org/films.php.

Group Discussions

These are structured discussions where participants talk about a topic or questions posed by the facilitator and subsequently hear a variety of opinions and learn from one another. While this is an excellent method to encourage group engagement with an issue, the facilitator must guide the discussion by addressing and commenting on certain points made by the group as well as interjecting appropriate questions to spur the conversation forward. It is important to also keep the group focused on the issue and encourage shy or quiet group members to participate. This method is a great tool to use after a lecturette or an interactive exercise, to debrief from the exercise and expand the discussion.

Icebreakers

Icebreakers are meant to increase the comfort level in the group and allow participants to get to know each other. They can be effective if used before introducing a topic that requires talking about personal issues, and in the beginning of each module or training day to get participants reacquainted with one another.

JAM (Just A Minute) Sessions

JAM sessions are a variation of a popular competitive event in most school and college festivals in India. Participants sit or stand in a circle and are given a topic to speak about in 'Just A Minute'. When one participant finishes the minute, stumbles or repeats the same idea more than once, they lose their turn and the next participant in the circle speaks for a minute on the same or different topic. This continues through all the participants in the circle. At the end, the facilitator and/or participants can select the best speaker.

Lecturette

A lecturette is a shorter version of a lecture and is used when a large amount of information needs to be conveyed to participants in a short period of time. This method emphasises brief and concise presentations to avoid overburdening the facilitator or participants with too much information. The lecturettes in this manual use handouts to guide the facilitator. It is highly recommended that the information provided in the handouts be presented to the participants in its entirety. However the facilitator is free to use a different style of presentation that will still convey all the information from the handouts. Conducting a lecturette puts the emphasis on the facilitator, and the following points should be keep in mind for a lecturette:

- Speak slowly.
- Address all the points and messages on the handout.
- Ask for questions and comments throughout the presentation to involve the participants and make it more interesting and interactive for them.
- Try not to make the presentation impersonal or dominate the discussion. If you do not know the answer to a question asked by participants, write it down on a chart that everyone can see and return to it later once you have the correct answer.
- You may want to use a flipchart to write down the bullet points and important messages in the handouts.
- Information about HIV/AIDS, Assisted Reproductive Technologies etc keep changing with new advances in science for example. Be sure to check if the information in the Handouts are up-to-date and make any changes if required before presenting the lecturette.

Myth or Fact

In these exercises, participants are asked to decide whether a statement is a myth or fact/ true or false, after which the facilitator gives the correct answer (if not given already) with an explanation. As an alternative, the facilitator can discuss only the myths and ask participants why each statement is a myth. This is effective in dispelling myths participants or their communities may have, as well as to introduce important facts. In the end, the facilitator must stress on the facts rather than on myths.

Opinion Continuum

In a variation of the polarisation exercise (see below), participants are asked to respond to a statement on an opinion 'scale' from *strongly agree* to *strongly disagree*. A line is drawn/made using a ribbon/rope from one side of the room that is designated *strongly agree* to the opposite side designated *strongly disagree*. After reading out the statement, participants are asked to stand on the line based to their opinion of the statement. This exercise is effective for creating discussions around contentious issues and also can be a way of energising participants by making them move around the room.

Parking Lot

The Parking Lot is time allotted during a training session, either at the end or periodically throughout, for issues that cannot be adequately discussed during an exercise or that day. This may be due to time constraints or because the topic does not fit into the outline of the exercise and is taking the discussion off-track. It may be beneficial to have chart paper up on the wall labelled 'Parking Lot Issues' where the facilitator can list out the issues that need to be addressed later in the training. This will assure participants that these topics have not been forgotten and will be discussed later. Parking Lot can even be some time set aside in the schedule for additional questions.

Party Games

Adapting various games like Charades and Speed Dating to suit the objectives of your exercise is another lively and interesting way of getting participants to address difficult issues.

Polarisation

This method has participants responding to a series of statements read out by the facilitator, deciding whether they agree or disagree with the statement and moving to the side of the room designated for that response. Polarisation exercises are effective when looking at a contentious or difficult issue to open up discussion between differing viewpoints and opinions. Insisting participants choose a position on the statement can also clarify ideas for them and help them learn to effectively defend their positions.

Pre-tests

Pre-tests can come in many forms - true/false, myth/fact, short answers etc. They are designed to help the facilitator assess the level of understanding and gaps in knowledge of the participants. This can help better structure the training and ensure that such gaps are addressed.

Question/Idea Box

Placing an anonymous question/idea box placed in the training room with paper and pens is an effective way of allowing participants to ask questions or make comments that they would otherwise be uncomfortable about in front of the whole group or facilitator. Participants can write questions or comments and place them in the box. The facilitator can review additions to the box at the beginning and/or the end of each day and can either address the issues then or at an appropriate point in the training.

Quiz

This format is effective to cover information-based issues. Participants are divided into teams and asked questions in a quiz-style exercise. Healthy competition between teams keeps enthusiasm levels high. The team with the highest score is declared the winner. This exercise may also be used as an assessment exercise.

Role-plays

Role-plays are interactive exercises that place participants in small groups and ask them to act out a given situation or scenario. This method allows participants to apply their skills, ideas, and understanding to a real-life situation. It is also stimulates discussion and conversation in the group about the different choices and decisions people can make in any given situation. A role-play can also be adapted into an assessment exercise.

Small group work

This method has the facilitator dividing participants into smaller groups to work on a given task or assignment (for example, discussing case studies, making a charter of rights/list of guiding principles, listing out behaviours/challenges/strategies etc.). This is an effective way to have participants discuss an issue when there is a limited amount of time in the session and can be especially beneficial for those participants who are not comfortable speaking in front of the larger group. Small groups then share their discussion and outcomes with the larger group to maximise learning and exchange of ideas.

Self-reflection

For this exercise, participants need to spend time individually answering questions and thinking about an issue and their views on it. After a personal reflection, participants can be asked to get back together as a large group and discuss their answers and ideas with each other. This exercise can be beneficial for working on topics that participants may be uncomfortable with, or those they may not have encountered before.

Situational Statements

In these exercises, participants are given a variety of statements and must decide and discuss the validity of these statements or what kind of situation these describe. This can be a different way to generate conversation or discussion on a topic and present real-life situations.

Teaching the Class

In these exercises, participants are divided into small groups and given information on a topic and then asked to create a presentation that will 'teach' the larger group this information. In this manual the appropriate and specific information to be conveyed by each group is found in the handouts that correspond to these exercises. Teaching the class engages the group with the material and can be more interesting than having the facilitator lecture on a topic. During these presentations the facilitator must ensure that the groups cover all the points from the handouts and that no inaccurate information is conveyed. Therefore the facilitator needs to be alert and vigilant throughout the group presentations.

Ideas for Icebreakers

OBJECTIVE:

To learn about participants' backgrounds (gender, age, religious affiliation etc.).

WHEN TO USE:

This is best used at the beginning of any training because it gives the facilitator information on the background of the participants and allows people to get to know one another as well as learn about the diversity of the group.

Get to Know One Another Groups

INSTRUCTIONS:

Read out a statement and ask participants to form groups with people who would respond to the statement similarly. For example, if the statement is 'born in the same decade', participants should find other participants and form groups according to the decade they were born in – there may be a group of 1950's, 60's, 70's etc.

Example Statements:

Born in the same decade

Like the same kind of music/ adventure activity

Like the same type of food

Come from the same state/country

The first language you learned

The language you are most comfortable communicating in

OBJECTIVE:

To emphasise the importance of listening during trainings.

WHEN TO USE:

This exercise is best used at the beginning of a training session to emphasise the ground rules. It can also be used if the facilitator notices that participants are not paying attention as the training proceeds.

Listening Exercise

INSTRUCTIONS:

Divide the participants into pairs and have them decide who will be called ***A*** and who ***B*** for this exercise.. Each pair should have ***A*** draw a picture using only three shapes: a circle, a square and a triangle. ***A*** draws without letting their partner ***B*** see the drawing. Once ***A*** completes the drawing, they have to describe the drawing in words to ***B*** who in turn should try to draw what is being described. ***B*** may/may not be allowed to ask for questions and clarifications of ***A*** while trying to replicate the drawing. After they are done, they should compare the drawings. Are they the same? Are they different? Could ***A*** have described the picture differently or with more detail in order to have ***B*** draw a more accurate picture? Did ***B*** not listen well enough to the instructions?

Interview another Participant

INSTRUCTIONS:

Ask participants to walk around and find someone in the room they do not know well and have not spoken with during the training. After everyone has a partner they should interview one another for 2 minutes each. In the interviews they should gather as much information as they can about one another. The questions can be about anything: where they are from, their families, likes and dislikes. After they have both been interviewed bring the group back together and have each participant briefly describe what they learned about the person they interviewed.

OBJECTIVE:

To get participants to talk to people in the group they may not know.

WHEN TO USE:

This icebreaker is best used at the beginning of a training, when the facilitator notices participants are not interacting with one another, or if participants are inactive in the group discussions or exercises.

Names and an Adjective

INSTRUCTIONS:

Ask participants to sit in a circle and have each introduce themselves. They have to do this by using an adjective that describes them. The adjective should also begin with the letter that their name begins with. (For example: 'Hi my name is Neetu and I am Nice' or 'I am Nice Neetu'; 'Hello I am Patient Pawan' etc.).

OBJECTIVE:

To help the facilitator and participants learn names and relax the group.

WHEN TO USE:

At the beginning of a training when people have just begun to introduce themselves.

Two Lies and a Truth

INSTRUCTIONS:

Ask each participant to take a few minutes to think of three statements about themselves: two of these should be false and one should be true. The statements can be as personal as a participant wants but acceptable enough to share with the whole group. Invite participants to share their statements without revealing which are true and which false. After the participant tells all three statements, the rest of the group must decide which of these is true.

OBJECTIVE:

To have participants get to know each other better and increase comfort when sharing personal information. This can also help dispel myths participants may still have about each other.

WHEN TO USE:

This exercise is best used after participants have got to know each other a little and have already gone through some exercises together.

OBJECTIVE:

To have participants to get to know more about each other. To also demonstrate how hard it can be to define oneself when asked.

WHEN TO USE:

This exercise can be used at the beginning of a training, before identity exercises or exercises related to stigma and discrimination.

Your Biography in 30 seconds

INSTRUCTIONS:

Ask participants to stand in a circle. Tell them they have 30 seconds to tell the group their life story. Begin with one participant and go around the circle using a stopwatch to time each life story.

OBJECTIVES:

To have participants to get to know each other better and what is important to each person.

WHEN TO USE:

This exercise can be used at any time.

What to Save

INSTRUCTIONS:

Ask participants to take a few minutes and think about which two items they would save from their homes if there was a fire and all of their family, friends, pets etc were already safe. Ask them to explain their choices.

OBJECTIVES:

To have participants to get to know each other better and what is important to each person.

WHEN TO USE:

This exercise can be used at any time.

Desert Island

INSTRUCTIONS:

Ask participants to share three things they would want to bring with them on a lifeboat, aside from friends and family or pets, if they were stranded or on a desert island.

Ideas for Energisers

Energiser exercises are short, quick ways to boost the energy and morale of the group. It is a great idea to use energisers between modules, after meals, after a difficult or challenging exercise, or right before leaving for the day. They are a lively and effective way to bring people back into the conversations. Party games can be modified for short energisers as well. Below are some energising exercises that can be used during training sessions.

Spell out a word

Ask participants to stand up and invite a volunteer to choose a word (the word can be related to the theme of the training, such as pleasure, gender, rights). Have participants spell out the chosen word using their whole body (for example they may spell the letter 'I' by standing straight with their arms raised over their heads). Do a few rounds of spelling the word, increasing the speed with each round.

Pass a Face

Ask participants to stand in a circle. Begin with one participant making a face (a silly face, a sad face, an angry face). The person next to this participant must imitate that face, passing it around the circle until it returns to the original person who made the face. Has the face changed?

Dance and Freeze

If you can, put on some music. If not, you can clap or sing a song instead. Ask the participants to dance to the music, and freeze in place when the music stops. The last person to freeze is disqualified and must answer a question from the group: what is their favourite movie, favourite food, what they like best about where they live etc. After they answer the question the music starts up again. Continue playing until there is a 'winner'.

Trouble Shooting Challenging Situations in Training

Case Study 1- Dealing with Difficult Group Members

You have just started a five-day training workshop and you are excited. The group you are working with seems great and well balanced: there are equal numbers of men and women of varying ages and backgrounds. The participants for the most part are respectful and kind to each other and after the first day of exercises they are beginning to bond and become more comfortable sharing personal details about their lives with each other. One participant, however, is turning out to be difficult. The participant rarely contributes to discussions, makes rude remarks, criticises other group members and their comments, talks over other participants, or laughs whenever sex is mentioned. You have gone over the list of Ground Rules on the first morning of the training and it is currently posted in the training room for all to see. You keep going over these with the group at the start of each module and even stress the rule of respecting others and not talking over them, in the hope that the difficult participant will understand that they are breaking these rules and change their behaviour. But the participant continues to act out and their behaviour becomes ruder and more inappropriate with each passing exercise. This cannot go on for the rest of the training as it has already begun to distract other participants. Plus you begin to notice that the rest of the group has become more and more uncomfortable speaking after this participant's outbursts, and is angry at the comments made. What should you do in this situation?

Suggestions:

- Ask to speak to the participant privately during or after the session. Start out by asking about the participant's impressions of the training and whether they have any concerns or issues with the training. Address concerns that come up, and then explain to the participant that ground rules have been developed to facilitate the comfort of group members and enable them to be effective in the training, and that by speaking out of turn etc they are not following these rules, absorbing the training and are disrupting the process.
- The next time you observe such behaviour or at the beginning of the next morning, announce that you feel the group is being less participatory than usual. Give examples of how the group was more participatory before and how they have become less participatory, encouraging the former behaviour.

- Do an exercise on the ground rules to solidify them for the group. Ask each person to take one ground rule and explain why it is important. Emphasise that you will not tolerate behaviour that continually breaches the code of conduct agreed upon by the group.
- Conduct another icebreaker, perhaps a trust/team building exercise.
- Remind the group that this is a safe space to share and discuss opinions and ideas and if they feel uncomfortable or threatened they should express this either in front of the group or to the facilitator privately.
- Think of what else you could do in such a situation and discuss with a co-facilitator/ colleagues before you begin training so that you are prepared for such an eventuality.

Case Study 2 - Equipment Breakdown

You are leading a new training this week at a facility you have never been to before, located a couple hours from where you live. You have heard this is a good location with friendly staff and are eager to get there to set up for the session. You get to the training site on the first day and go the meeting rooms to set up your equipment. You have planned to use PowerPoint slides and overheads for almost every exercise because you feel most comfortable using these tools to present and facilitate any discussions. This is especially the case with the current training since you are using definitions/statistics to go over many of the topics and fear that the exercises will be irrelevant without them. After you arrive and set up your equipment at the site the power dies and you are told it will probably be down for a good portion of the day. You are unsure about what you should do. Participants have arrived and are beginning to register themselves before the session begins, but you are unprepared to facilitate without these aids! At the same time you realise that you cannot cancel or reschedule the training. What should you do? Could this have been prevented?

Suggestions:

- Ask the facility staff if there is a flipchart and write out the some of the important points from the overheads and PowerPoint onto the flipchart. Make sure that you carry a print-out of your slides so that you do not have to spend time thinking about the points you wanted to make.
- Conduct the training without any visual aids and when power resumes go over your slides to make sure that there were no areas left out. If there were, go over them at the next session.
- Inform the group of the equipment failure, let them know it was beyond your control and assure them that you will proceed with the training in the best possible way.

- Write out bullet points on a flipchart for the next day in case the power goes again.
- If it is feasible, try to get a backup generator for the next days.
- Be prepared with possible modifications to the exercises in advance.

Case Study 3 - Refocusing the Group

You are working on an exercise on basics of sexuality. The group has been very engaged in the topic, asking many questions and providing insightful and thought-provoking comments. However, at one point in the exercise a question is asked about the definition of oral sex. A variety of comments and questions on the topic come up and the group slowly moves away from the focus of the exercise. While this is an important conversation to have at some point, because of links to safer sex messages for example, the focus of the exercise and chapter is to understand the basics of sexuality, not the varieties of sexual expression. It will also be difficult to move forward in discussions without this basic information. At the same time, the training in intended for the participants and their interests and concerns must be addressed. What should you do?

Suggestions:

- Refocus the group and ask them if they can defer this discussion for a later time. Emphasise that they will return to this discussion by writing the issue on a flipchart where people can see it (as is done for Parking Lot issues).
- Keep in mind that not everyone wants to have this conversation and that it is also a disservice to those wanting to focus on the topic of the exercise to not return to the exercise.
- Stress that a conversation on oral sex will be more meaningful after a discussion on the basics of sexuality first.
- Compliment the group on their engagement in the issues and quickly paraphrase the new discussion that has ensued. Explain that while this current discussion is important, it does not fit into this exercise or session at the moment and can be worked on later. Discuss the option of stopping the session to have the conversation versus tabling it for later and how that will actually affect the agenda or flow of the training.
- Suggest that this topic be discussed after the day's training or at lunchtime.

Case Study 4 - Unmet Expectations

It is the first morning of a six-day training workshop and you ask the participants to write down their expectations from the training. The participants write down many points excitedly. After they have finished, you read through them and assess that most of the expectations and needs seem to be in line with your own aims for the training and learning. The next few days of the training proceed as you have planned. During the lunch break on the fifth day of training, a participant approaches you and tells you that although they are really enjoying the training, one of their primary expectations for the course was to become more comfortable and aware of issues involving older adults and sexuality (they have a large client base in their 50s-70s and this is an area they thinks they should be more comfortable with) and that even after these past 5 days, they are still uncomfortable talking about these issues and the terms associated with it. They add that while one day is left for the training, they are not sure will be able to gain much in that time. They are somewhat disappointed as this was their primary expectation and goal for the training. You thought that the training was going well for the participants so you are a little shocked by these comments, and feel terrible that they are not satisfied! What do you do?

Suggestions:

- You may want to explain to participants that while expectations and goals are important to the training and should be met, sometimes there are areas participants need to work on independently after the training is complete. They can continue to use the lessons and information from the training to increase their understanding and knowledge of an issue they may have difficulty with.
- To avoid such surprises you may want to assess participant satisfaction periodically throughout the training, perhaps by having a suggestion/ idea box and encouraging participants to use it. You can check this every day and respond to the comments and suggestions. If any suggestions are outside the scope of the training, the facilitator should make this clear.
- If you have time, you may also want to suggest meeting the unsatisfied participant at some point in the evening to talk more about their concerns and needs.

Case Study 5 - Silent Participants

The current training workshop that you are leading is a difficult one. The participants are friendly and kind, but barely speak during an exercise. This is particularly when the topic of sexuality is brought up and you find this to be challenging. You have tried to be friendlier during breaks with the group to increase their comfort level; you have done initial icebreakers with them; but they are still not responding. You are not sure whether they are reluctant or simply uninterested in participating and speaking during the exercises. What more could you do?

Suggestions:

- Keep calm.
- Choose a few participants and encourage them to speak on or comment about an issue. Observe their reactions and see whether you could pursue this approach with others.
- Share your concerns with the group and ask them whether you are getting through to them. Find out how they are faring so far in the training. Ask participants why they are quiet, and if they want to address anything apart from the topics being discussed.
- Ask if there are any fears or doubts about the training topics.
- Because the generation of a more active discussion may take time, you may want to reschedule or drop some sessions from the training agenda.
- Use energisers and icebreakers liberally.
- Use the ideas box as a secret ballot and ask participants to write one suggestion for the training each. You do not need to mention the reason for this request.
- Raise highly debatable/contentious questions which are context-specific. This will help generate comments and reactions.
- Do small group work with participants. Sometimes this can help people speak more openly and 'find their voices'.

Ideas for Training Assessments

Using assessment forms or informal assessment groups after exercises can help facilitators evaluate how much participants have learned from the exercises and training and which areas still need attention. Below are three sample assessment forms for a facilitator. **These are only samples** and can be modified to fit the kind of group being trained and the material being covered. Assessment forms are not the only way to evaluate the efficacy of a training and learning. The facilitator can also create a feedback group from among the participants, whose responsibility is to get feedback from participants on the exercises and training. Feedback can include questions such as 'What did you feel about the sessions of the day?', 'What did you like and what could be improved upon?', 'What is a new piece of information you learned today?' This information can be given to the facilitator at the end of each training day to evaluate the training and to give the facilitator time to modify exercises etc for subsequent days.

SAMPLE ASSESSMENT FORM 1: EVALUATION OF A MULTI-DAY TRAINING

Please take a few minutes to complete the following questions

1. Is this the first training you have attended on Sexuality, Sexual and Reproductive Health and Human Rights:
   Yes No Comments:

2. What are two things you will take back to the work you do from this training?
   1.
   2.

3. Were the exercises:

   Interesting?
   Yes No Comments:

   Effective in communicating information?
   Yes No Comments:

4. Was there enough time for:

   The exercises?
   Yes No Comments:

   Discussions?
   Yes No Comments:

5. What exercises did you like the best? Why?

6. Which exercises did you like the least? What do you suggest as an alternative?

8. Please check Yes or No for each topic and give comments:

After this training do you feel you have a better understanding of:

TRAINING TOPIC	YES	NO	COMMENTS
Values and Principles for Working with Sexuality			
Sexuality			
Gender			
Human Rights			
Sexual Identity and Gender Identity			
Reproductive health and rights			
Sexual health and rights			
HIV/AIDS			
Contraception, conception, abortion			
Stigma			
Sexual Harassment and Violence			
Child Sexual Abuse			
Disability			
Pornography			
Ethics			
Advocacy Campaigns			

9. Were there other issues/topics you wanted to discuss not addressed in the training?
Yes No Comments:

10. Do you think the facilitators were:

Effective in their presentation of the information?
Yes No Comments:

Effective at conducting the exercises?
Yes No Comments

SAMPLE ASSESSMENT FORM 2:

ASSESSMENT FOR SPECIFIC EXERCISE(S) (FOR EXAMPLE, EXERCISES 2, 3 AND 4 , MODULE 1, CHAPTER 2)

Please circle Yes or No to the following questions.

BEHAVIOUR	DID YOU KNOW WHAT THIS BEHAVIOUR WAS BEFORE THIS SESSION?		DO YOU FEEL COMFORTABLE DISCUSSING THIS SEXUAL BEHAVIOUR WITH OTHERS?	
Fantasizing	Yes	No	Yes	No
Anal sex	Yes	No	Yes	No
Oral sex	Yes	No	Yes	No
Peno-vaginal sex	Yes	No	Yes	No
Masturbation	Yes	No	Yes	No
Mutual masturbation	Yes	No	Yes	No
Sex talk with a partner	Yes	No	Yes	No
Sex talk with a stranger (on the phone)	Yes	No	Yes	No
Reading erotica	Yes	No	Yes	No
Watching erotic films or pictures	Yes	No	Yes	No
Chatting online about sex	Yes	No	Yes	No
Sex between two men/ two women	Yes	No	Yes	No
Group sex/ threesomes	Yes	No	Yes	No
Sex between a younger man and an older woman	Yes	No	Yes	No
Exchanging money for sex	Yes	No	Yes	No
Watching others have sex with/ without their knowledge and consent	Yes	No	Yes	No
Being tied up/whipped with consent as part of sex	Yes	No	Yes	No

Additional behaviours you learned about in this session or feel more comfortable speaking about:

SAMPLE ASSESSMENT FORM 3:

ASSESSMENT FOR CHAPTER(S) (FOR EXAMPLE, EXERCISES 1 AND 2, MODULE 2, CHAPTER 4)

Please take a few minutes to complete the following questions

Affiliation:

1. Is this the first training you have attended on HIV/AIDS?
   Yes No Comments:

2. Please indicate whether you think the following statements are True or False:

   The routes of transmission for HIV are unprotected sex, infection from mother to child, contaminated blood, and through bites from insects and animals.
   True False Comment:

   The risk of HIV can be significantly reduced with correct and consistent condom use.
   True False Comment:

   A person can test negative for HIV but actually have the virus as in the case of being tested in the window period.
   True False Comment:

   Mandatory testing for HIV can result in stigma and discrimination.
   True False Explain why you think so:

3. What are two new things other than the ideas mentioned in Question 2 you learned from this session?
   1.
   2.

4. Do you think the facilitator was:

   Effective in the presentation of the information?
   Yes No Comments:

   Effective at conducting the exercise?
   Yes No Comments:

5. Do you think the exercises were:

   Interesting?
   Yes No Comments:

   Effectively communicated the information?
   Yes No Comments:

6. Was there enough time for:

   The exercises?
   Yes No Comments:

   The discussions?
   Yes No Comments:

7. Were there other issues you wanted to discuss left unaddressed?
   Yes No Comments:

8. Any further comments or remarks:

SAMPLE ASSESSMENT 4: PEER ASSESSMENT BY PARTICIPANTS

Peer assessments help participants develop confidence and critical thinking and analytical abilities. The following assessment can be used for the suggested modification to Exercise 1, Chapter 1, Module 5.

Guiding Principles: Group Feedback

After listening to the Guiding Principles created by the group, please fill out this assessment form. This is not a 'grade' for the group, but a way to provide feedback and point out strengths and areas for improvement in the principles.

1. Did the Guiding Principles presented include the core values of:

Dignity	Yes	No	Comment:
Respect	Yes	No	Comment:
Equality	Yes	No	Comment:
Diversity	Yes	No	Comment:
Non-judgmental	Yes	No	Comment:

2. Could you use these Guiding Principles in the work you do? Would they be appropriate/applicable? Why or why not?

3. Did the Guiding Principles:

Address sexuality in a positive way?	Yes	No	Comment:
Address gender in a positive way?	Yes	No	Comment:
Address the range of sexual and gender identities	Yes	No	Comment:
Have a rights-based approach?	Yes	No	Comment:

4. How could these guiding principles be improved? Is there anything missing?

Additional comments:

MODULE 1
Basic Concepts on Sexuality

Introduction

At the start of any training it is necessary to begin with basic ideas and information. Module 1 covers basic concepts related to sexuality. The chapters and exercises give participants a solid foundation of knowledge related to issues and ideas addressed in this manual. This information is particularly valuable if the topic of sexuality is new to participants. The module is also useful as review material for participants who have previously worked on these issues.

Module 1 also introduces participants to values and attitudes and their influence on personal and professional behaviour and choices. A section called ***Setting the Tone*** follows this introduction and includes an exercise on the values that underlie rights-based work.

Module 1
Basic Concepts on Sexuality

Assessment for Module1 Basic Concepts on Sexuality

At the end of this module the facilitator can conduct an assessment, which will evaluate any increase in participant knowledge, changes in attitudes, preferences for different exercises, and/or opinions on the facilitator's skills. For this module, an assessment can be done using the following tools:

- Adapting one of the sample assessment forms found in Chapter 2 *Preparing to Train.*
- Using the facilitator preparation exercises for this module found in Chapter 1 *Preparing to Train.*
- Developing a new assessment depending on the type of information the facilitator is looking to discover.

Sample Training Schedule

A blank template of a training schedule as well as a sample seven-day training schedule can be found in *Preparing to Train*. Depending on the focus of the training and the topics it aims to cover, the facilitator can fill in the blank schedule with exercises from this module or in combination with exercises from other modules.

Introduction Exercise
Setting the Tone

Module 1 focuses on basic concepts and ideas that lay a foundation for the topics to follow in later modules and chapters. In keeping with this objective, Module 1 begins differently than the other modules in *Basics and Beyond*. It starts with an introductory exercise called *Setting the Tone*.

The purpose of this exercise is to provide participants with the initial tools and language to discuss the topics and issues covered in this manual. To establish this language and understanding, *Setting the Tone* introduces participants to values that inform work in the fields of sexuality, sexual and reproductive health and rights – specifically the basic values of choice, dignity, diversity, equality and respect. These basic values underlie the concept of human rights and affirm the worth of all people.

What do we mean by values and why is it important to begin any training with a discussion of values? Values are standards, beliefs, attitudes or principles that people consider important and worthwhile to the way they conduct themselves – whether that be related to work they do or the personal lives they lead. The five basic values of choice, dignity, diversity, equality and respect are examples of such standards and principles and discussed in *Setting the Tone*.

A training session using this manual should begin with the following introductory exercise. Whether beginning with basic exercises in Module 1 or addressing more complex issues covered in Module 5, this exercise sets the necessary tone for any session.

Exercise
Setting the Tone

PARTY GAME

Instructions

1. Divide the participants into five groups. Distribute one core value to each group. Give participants 15-20 minutes to create their role-play/scenario/skit illustrating the word they received. The aim of each scenario is to have the other groups guess the word without it being said in the role-play/scenario/skit. For example, if the word is Respect, the scenario could depict a doctor who is respectful of a patient's rights and treats them accordingly.

2. Bring the groups back together and invite one group at a time to act out their scenario. At the end of each scenario ask the other groups to guess the core value being enacted. Write down the words and phrases that are guessed on a flipchart. Go through each group and their word conducting the same exercise. Use a separate flipchart page for each word. No more than 5 minutes should be spent guessing each word.

3. After this, display the list of words from each flipchart and explain that these and other ideas around Choice, Dignity, Diversity, Equality, Respect are the foundation for this training and for discussions and advocacy on sexuality, sexual and reproductive health, and human rights. Ask if the participants have questions or comments on these words and ideas.

   Suggested Questions:

- How did you feel during this exercise? Was the exercise difficult to do or not, and why?
- Can you see how these concepts create a foundation and opportunity to talk about issues such as sexuality and human rights?
- Do these values of choice, dignity, diversity, equality, and respect motivate you in your daily life and work? How do you apply these to your own life and work?
- Are there other words or ideas you think should be added to these core values?

Purpose of the exercise:

To describe and discuss the five core values that act as a foundation to discuss sexuality, sexual and reproductive health, and rights.

TIME

60 minutes

MATERIALS

Sheets of paper, Handout 1.1 Five Core Values

ADVANCE PREPARATION

Write out each of the following core values on separate sheets of paper: Choice, Dignity, Diversity, Equality, Respect.

THIS EXERCISE CAN BE MODIFIED BY:

- Giving groups all the values together and asking them to create separate scenarios to enact each one. This will allow for different interpretations of the same value/s and might be more beneficial for groups that do not have the vocabulary to guess the words easily.

MAKING CONNECTIONS:

- The core values mentioned in this exercise underlie the principle of human rights. For more see Chapter 1 in Module 3.
- Values inform ethics and ethical principles, which can be then codified to guide people's work. See Module 5 for more .

Key Messages

- The basic values of choice, dignity, diversity, equality and respect underlie the concept of human rights. These values affirm the worth of all people. It is important to relate them to sexuality, sexual and reproductive health, and rights in order to work effectively. Without these values, services and advocacy will be ineffective and not operate in the best interests of the people it hopes to serve. For example, affirming a person's *choice* about their sexuality means that if a person chooses to be sexually active then they have the right to access condoms and contraceptives irrespective of marital status. Practioners need to respect this.
- Practioners often use these words but may not understand their implications in practical terms or real situations. This exercise encourages participants to discuss the reasons why these words are important, exactly what they mean to people and how they relate to work on the ground. Being able to articulate the importance of these values concretely helps put them into practice and improves the quality of the service being provided or the communication material being prepared.

TIPS FOR THE FACILITATOR:

- Participants may be unsure how to enact a particular word or have trouble guessing the word for some of the values, especially if they do not understand its meaning. If the whole group cannot guess the word within 5 minutes, ask for synonyms, give them other hints or just tell them the word and have a discussion around it.
- Participants may be confused because of the complexity of ideas in this exercise. Assure them that this is just the beginning, and these concepts will become clearer and more concrete during the training.
- Other issues and topics may emerge during group work. For example, a group might do a skit on diversity illustrating different sexual or gender identities.This might arouse questions from the rest of the group. Avoid addressing these in depth at this point, and assure participants that these issues will be covered later so that the focus remains on the values that inform one's work.

Handout 1.1
Five Core Values

ADAPTED FROM COMMON GROUND: PRINCIPLES FOR WORKING ON SEXUALITY, TARSHI 2000

There are Five Core Values that underlie the principle of Human Rights. They are:

- Choice
- Dignity
- Diversity
- Equality
- Respect

These basic values underlie the concept of human rights and affirm the worth of all people. Choice, dignity, diversity, equality and respect are words used frequently but what do each of them mean in the context of sexuality?

Choice: Choices about one's sexuality should be made freely, and with access to comprehensive information and services. They should respect others' rights. For example, a person can choose to be sexually active before marriage and has the right to access condoms and contraceptives irrespective of marital status.

Dignity: All individuals have worth regardless of their age, caste, class, gender, orientation, preferences, religion and other determinants of status. For example, all people have the right to information and good quality sexual health services regardless of marital status or sexual identity (married, widowed, separated, gay, lesbian, heterosexual etc).

Diversity: Involves acceptance of the fact that women and men express their sexuality in diverse ways and that there is a range of sexual behaviour, identities (homosexual, bisexual, transgendered, intersexed), and relationships.

Equality: All women and men are equally deserving of respect and dignity, and should have access to information, services, and support to attain sexual well-being. For example, whether people have a disability or not, are young, old or HIV positive, they should have the same access to information and services to attain sexual well-being.

Respect: All women and men are entitled to respect and consideration regardless of their sexual choices or identities. For example, it is important to respect sex workers' choice of profession and give them the consideration they deserve when they access health services.

Chapter 1
Sex, Sexuality and Gender

Chapter Objectives for the Facilitator

1. To have participants understand the difference between sex and sexuality, and the difference between sex and gender.
2. To have participants examine the connections between gender and sexuality.
3. To dispel myths around sexuality.
4. To have participants talk comfortably about sexuality and gender issues.

Why a Chapter on Sex, Sexuality and Gender

Sexuality is a central aspect of being human throughout life and 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.

(WHO draft working definition of sexuality, 2002)

Understanding sexuality involves more than just memorising the definition above. It implies identifying a wide range of issues, emotions, experiences and topics included under sexuality. Similarly, an understanding of gender requires appreciating its variability, its construction by society, and that sex, sexuality and gender are not interchangeable concepts.

This chapter addresses the differences between sex, sexuality and gender. It clarifies common misconceptions and answers questions about these topics. For instance, that sexuality is more than the act of sexual intercourse, that gender is socially constructed, and that there can be more than two genders. This chapter gives participants a broad understanding of sexuality and its connections with gender and acts as a starting point for discussions on sexuality, sexual and reproductive health, and rights that come up later in the manual.

Key messages for this chapter

Sex and Sexuality

- Sexuality is more than acts of sex. It can mean a range of experiences that vary from person to person – for example to some it might mean sexual orientation, for others the freedom to express themselves and make choices regarding their body. These varied experiences and issues related to sexuality can impact people's lives in significant ways.

EXERCISES IN THIS CHAPTER:

Exercise 1: Understanding Sex and Sexuality. 60 minutes

Exercise 2: Why Talk About Sexuality. 60 minutes

Exercise 3: Understanding Gender. 30 minutes

Exercise 4: Talking Gender. 45 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Index cards/slips of paper of different colours
Three containers or baskets
Tape

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 1.2
Basic Information on Sex, Sexuality and Gender

Handout 1.3
Understanding Sex and Sexuality

ADDITIONAL RESOURCES:

- Bhasin, K. 2003. *Understanding Gender: Gender Basics.* Women Unlimited. India
- Bridle, S. 1999. 'Gender Outlaw: Interview with Kate Bornstein'. *What is Enlightenment?* http://www.wie.org/j16/kate.asp
- Point of View.1996. *XX/XY: Voices of Women And Men Living With HIV.* India
- San Francisco Sex Information. http://www.sfsi.org
- Sexuality Information and Education Council of the United States. http://www.siecus.org
- Talking About Reproductive and Sexual Health Issues. www.tarshi.net
- TARSHI. 2001. *Common Ground: Principles for Working on Sexuality*. India.
- *Women in Action. Focus: Women and Sexuality.* 1999. Available at: http://www.isiswomen.org/pub/wia/wia199/index.html
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

- Sexual and reproductive health decisions (for example, the decision to have or not have children, when to have them, to get married or not, to choose a sexual partner, or to have a husband/wife chosen by a family or community) cannot be isolated from issues of sexuality. This makes it even more important to understand and address sexuality.
- Addressing sexuality helps reduce fear, myths and misconceptions surrounding the issue. It also enhances people's well-being by helping them lead safer and pleasurable sexual lives.

Sex and Gender

- Gender is socially constructed, which means that it is determined by our social, cultural and psychological surroundings and environment. It is not innate in the same way that our biology (sex) is believed to be. Like gender, sexuality is also socially constructed. A person's expressions and experiences of sexuality are influenced and determined by the social environment.
- Sex was considered to be constant and unchangeable until recently. Now it can be changed through medical intervention (sex reassignment surgery).
- Gender is variable and can change from time to time, culture to culture, and sub-culture to sub-culture.
- The way girls and boys are socialised to be 'feminine' or 'masculine' is called *gendering*.
- Different cultures may value girls and boys differently and assign them different gendered roles, responsibilities and attributes.
- Sexual and reproductive health decisions can be influenced by a person's gender. For example, in a marital relationship, it may be the man who has the power to decide whether to have children or not, when, and how many.

Exercise 1
Understanding Sex and Sexuality

BRAINSTORMING

Instructions

1. Ask participants to come up with a list of words they think are connected with sexuality. Write these words on a flipchart as they are being called out. Be ready to prompt participants for more words. Take 10 minutes to compile a list.

2. After the brainstorm session, ask for questions or comments to begin a 10-15 minute discussion:

   Suggested Questions:

- Are any words missing, what are they and why do you think they were left out?
- What words had you not thought about in relation to sexuality?
- From the list, what do you understand by the term *sexuality*? How would you explain *sexuality* to someone who has never heard the word before?
- Where do the words on this list come from? Are they used and developed locally or borrowed from other cultures/societies?

3. Continue the discussion by distributing Handout 1.2 and asking participants to read through the definitions of sex and sexuality. After this, divide participants into small groups. Ask each group to complete the last column in the handout that asks how each word relates to sexuality. The purpose of this is to understand how sexuality relates to one's personal life and why each element of the definition is important to understanding sexuality.

4. Ask each group to share their examples.

   Suggested Questions:

- Do you understand sexuality differently after this exercise? Can you relate the definition and idea of sexuality to your life more easily?
- The definition of sexuality appears to be long. Why is it important to have such a long definition? What does this detailed definition tell us about sexuality?
- Are there any other examples you want to add to the list?

Purpose of the exercise:

1. To understand sexuality as being more than acts of sex.

2. To develop comfort around discussions of sexuality.

TIME

60 minutes

MATERIALS

Flipcharts, markers, pens/pencils, copies of Handout 1.2 Understanding Sex and Sexuality

ADVANCE PREPARATION

Read through Handout 1.2

Key Messages

- Sexuality is more than acts of sex. It is also different from gender, which refers to how societies view women and men, the differences between them, and to the roles assigned to them.
- Everyone does not experience sexuality in the same way. Being aware of these differences helps cater to individual needs and provide effective services to people.
- Sexuality encompasses many ideas and is subjective. Any definition of sexuality needs to reflect this diversity which is why it would be longer and more complex than expected. The definition of sexuality has been evolving along with our understanding of sexuality.
- Multiple factors are influenced by and influence our sexuality. For example, we cannot assume that all people are motivated by the same reasons to have sex or be in a relationship – some people might make this choice to have children, others for companionship.

THIS EXERCISE CAN BE MODIFIED BY:

- Reading out the definition of sexuality to the group, particularly if the participants have a low literacy level. The definition would have to be read once completely and then repeated line by line, since it can be difficult for participants to retain all the information in one go. Alternatively, selected words and phrases can be discussed at length rather than going through the whole definition.
- Dividing participants into smaller groups to discuss the definition amongst themselves before sharing key points with the larger group. This is useful for larger groups but will require more time to be allotted for this.

MAKING CONNECTIONS:

- Understanding the range of issues in sexuality can help establish its connection to sexual rights. For more see Chapter 3 in Module 3.
- Core values inform and shape how we work with sexuality. For more, see *Setting the Tone* in the Introduction to Module 1.

TIPS FOR THE FACILITATOR:

- Note the kinds of words being used. Do they reflect any values of the group; are participants shying away from sexual terms (*masturbation, sex, vagina, and penis*); are they focusing on a particular manifestation of sexuality (*heterosexual, monogamous*); are they using 'negative' terms (*rape, pain, violence, abuse*) or 'positive' ones (*pleasure, fun, arousal*)? Bring these observations to participants' attention and ask for comments.
- Even after long discussions, it is possible that some participants may not understand the difference between sex and sexuality. Be prepared with simpler explanations and examples or return to this after they have had time to think over the concepts and have more questions.
- Participants may be uncomfortable around the topic of sexuality, especially early in the training. This can manifest as disruptive behaviour, offensiveness, defensiveness, non-participation or use of inappropriate humour to divert attention from their discomfort. Draw their attention to the Ground Rules (see *Preparing to Train* for examples) to remind them of the attitude of respect/ openness they had agreed upon before the training.
- As participants realise that sexuality is much more than acts of sex, they will begin to feel more confident dealing with real or imagined opposition from their communities. They will also begin to feel less inhibited about talking about sexuality.

Exercise 2
Why Talk About Sexuality?

GROUP DISCUSSION

Instructions

1. Hand out three index cards to each participant. Ask them to write answers to the questions below, each on separate cards. In order to maintain anonymity, they should not put their names on the cards. Tell participants that the cards will be read aloud in the next part of the exercise. Encourage them to be as open and honest as possible.

- Index Card 1: *Write one question/concern/fear around sexuality you had as a child.*
- Index Card 2: *Write one question/concern/fear around sexuality you had as an adolescent.*
- Index Card 3: *Write one question/concern/fear around sexuality you had as an adult.*

For example one question/concern/fear around sexuality from adolescence might have been: How does a woman get pregnant, or can two men be in love or have sex with each other?

Ask participants to put each slip into the corresponding containers - all responses to question 1 into the *Childhood* container; the responses to questions 2 and 3 into the *Adolescence* and *Adulthood containers* respectively.

2. Pass the *Childhood* container around and have each participant pick one card at a time and read it aloud. After they have read all the slips, ask for questions and comments:

Suggested Questions:

- When in childhood did such concerns arise? Were they addressed? By whom and when?
- Are the concerns typical of the community/culture you were brought up in? Do you think the responses would differ in urban or rural communities, or from men and women?

3. Now invite participants to read from the *Adolescence* container followed by the *Adulthood* container.

Purpose of the exercise:

1. To explore sexuality in the different stages of life.

2. To explore how information on sexuality is important to dispel myths and improve well-being.

TIME

60 minutes

MATERIALS

Index cards/slips of paper, pens/pencils, 3 containers or baskets

ADVANCE PREPARATION

Label 3 containers 'Childhood', 'Adolescence' and 'Adulthood'

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing the participants into three groups after they have responded to the questions and giving each group one container. Each group can then be asked to summarise the key concerns raised by the questions in their age category and present these summaries to the larger group.
- Reading a few questions aloud randomly from each container or all the responses from any single category. This is useful for training specific groups as in the case of those who are being trained to conduct sexuality education sessions with young people for example; more time can be spent with the *Adolescent* category to help them appreciate the concerns of young people and how to address them.

MAKING CONNECTIONS

- Sexuality can be experienced throughout one's life. For more see Chapter 3 in this Module.
- All people have the right to sexual health and well-being, to information on their bodies, and choices to allow them to lead lives free from fear, pain, and reproductive and sexual ill health. For more see Module 2.

Suggested Questions:

- Compare these responses to the earlier experiences. Are they similar or different?
- Did you have similar questions? When did such concerns arise? Were they addressed? By whom and when?
- Are the responses typical of the community or culture you were brought up in?
- Do they think the responses would differ in urban or rural communities, or from men and women?

4. Finally, ask for questions or comments about the exercise.

Suggested Questions:

- Would your life have been different if you had accurate information about sexuality at the time the questions arose?
- At what age should people receive information on sexuality? Why?

Key messages

- Concerns about sexuality arise early in our lives. Accurate, easy-to-understand sexuality education enhances the quality of people's lives by clarifying misconceptions and helping young people make informed choices. These include protection from unwanted pregnancies, infection and abuse.
- Providing information on sexuality is not the same as teaching someone how to have sex. It includes information on sexual anatomy and physiology, on how sexuality is related to well-being, on how one's sexuality interacts with family or community, how that makes one feel, talking about one's choices in sexual partners and identities and how they can be negotiated etc.

TIPS FOR THE FACILITATOR:

- Linking concepts of sexuality with one's personal experience while maintaining anonymity is important. This allows for sharing and discussion of personal concerns/ issues more openly in later sessions as well.
- This exercise is not meant to answer questions and concerns listed by participants about their sexuality and history. Assure them that many of their queries are likely to be addressed during the course of the training. List any questions on a flipchart as Parking Lot Issues to be addressed later.

Exercise 3
Understanding Gender

POLARISATION

Instructions

1. Ask participants to stand in a straight line at the centre of the room, equidistant from the labelled walls.

2. Read one statement aloud at a time from those below. After each, ask participants to move a step towards the *Society* wall or the *Biology* wall depending on whether they feel that the statement is based on socio-cultural factors or has a biological basis.

   Statements

   a) Girls are gentle, boys are not
   b) Having sex with her husband is a woman's duty
   c) Women can get pregnant, men cannot
   d) Men are good at logical and analytical thinking
   e) Real men don't cry
   f) Women can breast-feed babies, men cannot
   g) Women are creative and artistic
   h) Women have maternal instincts
   i) Men's voices break at puberty, women's voices don't
   j) Men have a greater sex drive than women
   k) Women like to dress up and wear make up
   l) Men should be the wage earners of a family not women
   m) In a heterosexual relationship/marriage, the man has to be older than the woman

3. After all the statements have been read, most people should be closer to the *Society* wall since all but 3 of the 13 statements have a social basis. Have participants discuss their views about all the statements and explain to one another why they felt a certain way about each statement.

4. Ask for any questions or comments.

   Suggested Questions:

- Which statements were controversial, i.e. where all of you did not agree that it was based on biology or society? Why did everyone not agree?
- Most of the statements above are examples of the way society expects people to be and act based on their gender and not based

Purpose of the exercise:

To understand that gender is socially constructed.

TIME

30 minutes

MATERIALS

Two pieces of flipchart paper, one labelled *Society* and the other *Biology*, tape

ADVANCE PREPARATION

Prepare the two charts and stick them on opposite walls of the room

on innate qualities. Do you understand how gender is therefore constructed or created by society? Can you give other examples of how gender is learned by what society creates as gender roles?

Key Messages

- It is important to distinguish between what society has constructed/ created for each gender and what is biological. For example, the idea that men are strong and should not cry is created by society, versus women giving birth which is biological.
- Gender is a social construct. This means that gender roles and attributes vary from society to society, and at different times in history. Gender roles and behaviour are assigned by society and are learned rather than innate.
- Recognising that gender is socially constructed and that gender-based behaviour is learned helps us to understand that behaviour can be changed. For example, recognising that aggression in men is often learned can help us change the way we socialise/ condition boys to be aggressive. Or that women should stay at home and take care of children is based on social norms, and can be countered by encouraging and supporting women if they choose to work.
- As with sexuality and its formal definition, gender is also influenced by the interaction of biological, psychological, social and historical factors.

THIS EXERCISE CAN BE MODIFIED BY:

- Having participants stand in a circle and move out from the circle if they believe the statement is related to socio-culture influences or into the circle if they believe the statement relates to biology. This modification is useful for large groups or if the room is too small for everyone to stand in a line.

MAKING CONNECTIONS

- After going over the basics of sex, sexuality and gender, see Chapter 2 in this Module for sexual and gender identities.
- People often face stigma and discrimination based on their gender or for choosing to act outside their gender roles. For more see Chapter 2 in Module 4.

TIPS FOR THE FACILITATOR:

- Except statements about breastfeeding, pregnancy, and men's voices breaking at puberty, all the statements have a social basis. How the other statements are interpreted may differ from culture to culture, and even in the same society/ culture from a single generation to another.
- Read all statements beforehand and prepare responses to anticipated arguments. The statements about girls being gentle and women having maternal instincts can be contentious. Asking why people believe these statements to have a biological basis and what negative effects these stereotypes can have may help participants understand the importance of being aware of gender as a social construct.
- It is often mistakenly believed that all people have sexual 'instincts' and all women have 'maternal instincts'. Help participants examine how these assumptions can be dangerous. For example, those who believe in sexual instincts may use this argument to absolve abusers of any responsibility by pronouncing their actions as 'beyond their control'. Common terms associated with instinct are 'innate', 'uncontrollable', 'need', 'urge', and 'have to be fulfilled at all costs'.

Exercise 4
Talking Gender

JAM: JUST A MINUTE

PURPOSE OF THE EXERCISE:

To explore gender roles and their connections to sexuality.

TIME

45 minutes

MATERIALS

Flipchart, markers

ADVANCE PREPARATION

None

INSTRUCTIONS

1. Ask participants to form a circle. Choose 3 or 4 statements from the list of 'Statements for the JAM session' below. Explain to participants that they will be given just one minute to talk about a topic/ respond to a statement. During that minute, they cannot repeat ideas, and if they falter during their time, they lose their turn and the next participant in the circle will be given the chance to talk about the topic.

2. Ask for a participant to volunteer to begin the exercise. Note the key words and ideas being used by participants on a flipchart to discuss later. After one minute the next person in the circle must speak on the same topic.

   Statements for JAM session:

   a) To be a man is...
   b) To be a woman is...
   c) Masculinity is...
   d) Femininity is...
   e) A man's role in the family is...
   f) A woman's role in the family is...
   g) A man's role in society is...
   h) A woman's role in society is....
   i) 10 years ago a real woman/man was...
   j) 100 years ago a real woman/man was...

3. After the selected topics have been discussed, have a larger discussion with the group for 20-25 minutes.

   Suggested Questions:

- How did you feel doing this exercise? What are your reactions to the words/ideas listed on the chart?
- What do these words tell you about dominant ideas of gender in society? Do you agree with these ideas? Why? Why not?
- What are the implications, advantages or disadvantages of perpetuating such notions in the context of sexuality, sexual and reproductive health and rights?
- Do you feel men are often left out of conversations that involve

THIS EXERCISE CAN BE MODIFIED BY:

Asking participants to brainstorm responses to some of the statements. The ideas from this session can be written on a flipchart and discussed later.

- Dividing participants into small groups and asking them to discuss two statements in their group which they later share in the larger group.

MAKING CONNECTIONS:

- Gender is closely related to power and how individuals can experience imbalances of power depending on their gender or role in society. For more see Chapter 1 in Module 4.
- While gender roles are based on expectations a culture has of what is appropriate behaviour for men and women, gender identity is an individual's sense of belonging to the category of men or women or neither of the two. For more see Chapter 2 in this Module.

sexuality, sexual and reproductive health and rights? How can they be included?

4. At the end of the discussion, participants can be asked to judge the best speaker on the basis of both content and style of presentation.

Key Messages

- Gender is socially constructed, which means that it is determined by our social, cultural and psychological environment and is not innate like our biology (sex) is believed to be.
- Gender roles relate to expectations a culture has about one's behaviour based on one's biological sex. For example, women should be mothers and stay at home to raise children, and men should be fathers and earn the money in the family. However these roles may not be what all individuals want or desire. Those who move away from these gender roles may be looked down upon by family, friends and community. This can result in stigma and discrimination.
- Different cultures may value girls and boys differently and assign them different roles, responsibilities and attributes.
- Gender is variable and changes from time to time, culture to culture, and sub-culture to sub-culture. Therefore, the way that one participant discusses a statement can differ from another.
- There is no one 'masculinity'. The term 'masculinities' is more accurate because at a given time in a given place, there can be many forms of masculinities. There may however, be one dominant form of (or hegemonic) masculinity that influences the behaviour and attitudes of men and women. For example, in many cultures, a dominant form of masculinity is that men should be bread-earners of families. This can result in pressure on them to fulfil this expectation and restrict them from moving away from this gender-role.

TIPS FOR THE FACILITATOR:

- It may be difficult for participants to articulate their ideas in one minute. Emphasise that there are no right or wrong answers and that this exercise is intended to spark discussions on gender.
- If participants have difficulty starting, it may be helpful to begin the conversation with some examples, such as 'a real woman wants to have children and a family'; or 'In Victorian times/100 years ago a man who had sex with another man was thought to be practicing 'abnormal' behaviour, whereas now such behaviour is becoming more accepted.'

Handout 1.2
Basic Information on Sex, Sexuality, and Gender

- **Agency:** The capacity, ability and tools possessed by individuals or groups to control and make choices in their lives and within society. Using agency, individuals can create new realities, states of being, and situations for themselves through the re-structuring of their realities, regardless of the constraints that may be socially imposed upon them. Even marginalised individuals and groups or those without resources can have agency to create new, acceptable situations and conditions that existing social structures may not have allowed for. For example, even women forced to have sex with their husbands may use resources and skills to prevent this from happening; they may say they are menstruating or change their physical circumstances by placing their child between them to prevent coercion from their husbands.

- **Gender:** A concept that refers to how societies view women and men, how they are distinguished, and the roles assigned to them. People are generally expected to identify with a particular gender, that has been assigned (*gender assignment*) to them, and act in ways deemed appropriate for this gender. While *gender roles* are based on expectations that a culture has of behaviour appropriate for male or female, *gender identity* is an individual's sense of belonging to the category of men or women or neither of the two. We attribute a gender (*gender attribution*) to someone based on a complex set of cues, which vary from culture to culture. These cues can range from the way a person looks, dresses and behaves to the context in which they do so and also on their relationship with and use of power.

- **Patriarchy:** A hierarchical social system of thinking where a dominance of men over women in society results in a marked inequality between them in the political, economic and social domains, among others. It implies that men hold power in all the important institutions of society and that women are deprived of access to such power. It does not imply that women are either totally powerless or totally deprived of rights, influence, and resources (see **Agency** for more).

- **Sex:** The biological difference between females and males present at birth. These include anatomical differences such as the presence of a vagina or penis; genetic differences present in a person's chromosomal makeup; or physiological differences such as menstruation or sperm production. Sex can also be used to describe physical acts of sex that include, but are not limited to, penetrative penile-vaginal intercourse, oral sex, anal sex, masturbation, kissing, among others.

- **Sexuality:** Sexuality as a concept has been examined for many years. There are a number of definitions that cover various components of this concept. While there is no single agreed upon definition, the two definitions of sexuality below promote an understanding of sexuality.

  - *Sexuality is a central aspect of being human throughout life and 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.*

    (WHO draft working definition 2002)

  - *Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values and behaviours of individuals. Its various dimensions include the anatomy, physiology and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings, and relationships. The expressions of sexuality are influenced by ethical, spiritual, cultural, and moral concerns.*

    (SIECUS Report, Volume 24 #3, 1996)

- **Sexual identity:** A concept that refers to how people view themselves sexually in terms of whom they are attracted to. This refers specifically to whether an individual is attracted to people of the same gender, a different gender, more than one gender and which category of these identities they want to adopt for themselves.

Handout 1.3
Understanding Sex and Sexuality

- **Sex:** The biological difference between females and males present at birth. These include anatomical differences such as the presence of a vagina or penis; genetic differences as in a person's chromosomal makeup; or physiological differences such as menstruation or sperm production. Sex can also be used to describe physical acts of sex that includes but is not limited to penetrative penile-vaginal intercourse, oral sex, anal sex, masturbation, kissing, among other acts.

- **Sexuality:** Sexuality as a concept has been examined for many years. There are a number of definitions that cover the various components of sexuality. While there is no single agreed upon definition, the definition of sexuality below provides a basic and fairly comprehensive understanding of sexuality.

  - *Sexuality is a central aspect of being human throughout life and 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.*

    (WHO draft working definition 2002)

Please fill in the last column of this chart by thinking about how this word or phrase might relate to sexuality. For example, people's ***sexual orientation*** can influence how they express their sexuality. In some cases it may mean they can express their sexual orientation openly. If they live in a community or environment in which alternative sexual orientations such as homosexuality are not accepted, this expression of their sexuality might be limited.

TERM	DEFINITION	HOW DOES THIS RELATE TO SEXUALITY?
Sex	The biological difference between females and males present at birth. These include anatomical differences such as a vagina and penis and genetic differences found in a person's chromosomal makeup or physiological differences such as menstruation or sperm production. Sex can also be used to describe physical acts that include but are not limited to penile-vaginal intercourse, oral sex, anal sex, masturbation and kissing, among others.	
Gender identities and roles	*Gender roles* are based on expectations a culture has of behaviour as appropriate for male or female. *Gender identity* is an individual's sense of belonging to the category of men or women or neither of the two.	
Sexual orientation	How individuals consider themselves based on whom they are sexually attracted to, whether to people of the same gender, a different gender, or to more than one gender and which category of these identities they want to adopt for themselves.	
Eroticism, pleasure	Feeling sexual excitement, arousal, enjoyment, and desire from certain actions, images, ideas, etc.	
Intimacy	Feeling of closeness and familiarity with another person.	

TERM	DEFINITION	HOW DOES THIS RELATE TO SEXUALITY?
Reproduction	Having a pregnancy occur and bearing children	
Thoughts	Ideas, opinions and beliefs	
Fantasies	Images or ideas created in the mind.	
Desire	A person, thing or idea that is wanted and hoped for, whether physically, emotionally, or sexually	
Beliefs	Accepting and trusting a fact, opinion, or assertion.	
Attitudes	An active feeling of liking or disliking something.	
Values	Beliefs of an individual or group about the standards of what is worthwhile.	
Behaviours	Actions.	
Practices	To do or perform something habitually or constantly.	
Roles	A function or task/position.	
Relationships	An involvement or connection between two or more people.	

For the following terms, think of one example that illustrates how the interaction of these terms relates to sexuality.

Biological	To do with the physical body.	
Psychological	To do with the mind or emotions.	
Social	To do with society.	
Economic	To do with the financial/monetary/material requirements of life.	
Political	To do with the government, politics and the State.	
Cultural	To do with the shared knowledge, experiences and values of a particular society or community.	
Ethical	To do with rules or standards governing the conduct of a person or members of a profession based on ideas of right and wrong.	
Legal	To do with laws and legislation.	
Historical	To do with how ideas, events, attitudes, and perceptions change and can be influenced by each other as they change through time.	
Religious	To do with having faith in or practicing a particular religion.	
Spiritual	To do with the soul or spirit. Religion is only part of the overall theme of spirituality. Spirituality may include belief in supernatural powers, as in religion, or an emphasis on personal experiences.	

Chapter 2
Sexual Identity and Gender Identity

Chapter Objectives for the Facilitator

1. To introduce participants to the concepts of sexual and gender identity.
2. To familiarise participants with the variety of sexual expression and behaviour.
3. To help participants develop comfort when talking about these issues.
4. To help participants see the difference between sexual behaviour and sexual identity.
5. To prompt participant discussion on how common forms of representation can affect issues of sexuality, sexual and reproductive health, and rights.

Why a Chapter on Sexual and Gender Identity

This chapter focuses on identity, particularly sexual and gender identity, and its role in sexuality, sexual and reproductive health, and rights. Sexual identity refers to the identity people adopt for themselves, based upon whom they are sexually attracted to. Specifically, this is based upon whether they are attracted to people of the same gender, a different gender, or to more than one gender. Gender identity refers to how people perceive their own gender - whether they think of themselves as a man, woman, both, or as a different gender.

Sexual identity is different from sexual behaviour. Sexual behaviour refers to the sexual activity individuals engage in and not how they identify themselves. Behaviours are not always indicative of a particular identity. For instance, engaging in sexual activity with a person of the same gender does not necessarily indicate homosexuality - there are men who have sex with other men (behaviour) who do not think of themselves as homosexual (identity).

In many cultures and communities, there are often prescribed rules for 'appropriate' sexual and gender identities and sexual behaviour. For example it is often 'appropriate' to be a heterosexual woman or man and engage in monogamous, penile-vaginal sex within marriage. Deviation from this norm can often result in discrimination, stigmatisation, abuse, and ridicule. However, having the option to choose and express a gender and sexual identity rather than conforming to external rules is necessary for our self-respect and well-being.

At times these rules are also played out in the way identities are represented. Representations come in the form of language, images, documentation, advertisements, campaigns, reports and brochures, or documentaries and have different purposes ranging from entertainment, to raising awareness, inviting public sympathy, etc. With all these, the interpretation of images and their effect often depends upon the attitudes and background of the audience they are designed for.

In this chapter participants examine and discuss the range of sexual and gender identities and behaviour, as well as the importance of respecting these diverse identities and behaviour while working on sexuality, sexual and reproductive health, and rights. The representation of identities is also addressed and examined in order to develop an appreciation of sexuality and related issues without creating victims or isolating/excluding certain groups.

EXERCISES IN THIS CHAPTER:

Exercise 1: Sex and Gender Identities. 45 minutes

Exercise 2: Varieties of Sexual Expression. 45 minutes

Exercise 3: Good Sex/Bad Sex. 60 minutes

Exercise 4: Reflecting on Sexual Expression. 60 minutes

Exercise 5: Examining Identities. 60 minutes

Exercise 6: Representation in the Mass Media. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipcharts and markers
Pens/pencils
Paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 1.4
Basic Information on Sexual Identity and Gender Identity

Handout 1.5
Varieties of Sexual Behaviour and Expression

Handout 1.6
Sexual Expression Self-Reflections

Handout 1.7
Case Studies for Sexual and Gender Identity

ADDITIONAL RESOURCES:

- Gay Lesbian Bi and Transgender Search Engine. http://www.pridelinks.com
- Glossary of Sexual Terms. http://gender.eserver.org/sex-glossary.txt
- *Human Rights Violations Against Sexuality Minorities In India*: A PUCL-K Fact-Finding Report About Bangalore. 2001
- Humjinsi. http://www.indiarights.org/humjinsi/larzish.html
- Humsafar Trust. http://www.humsafar.org
- Media Awareness Network. *Media Stereotyping*. http://www.media-awareness.ca/english/issues/stereotyping/
- Parents, Families, and Friends of Lesbians and Gays. http://www.pflag.org
- Sangini (India) Trust. http://www.sanginii.org
- Transgender Forum. http://www.tgforum.com
- S. A. White ed. 2003. *Participatory Video - Images That Transform and Empower*. United States: Cornell University.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key messages for this chapter

- Sexual identity and behaviour are not interchangeable concepts. For example, a man having sex with another man need not identify as homosexual or gay. He may identify as heterosexual; he may be attracted to women, be married and have children and at the same time engage in same-sex sexual behaviour.
- Sex (whether a person has male genitalia, female genitalia, or both/neither male and female genitalia), gender identity (whether a person thinks of oneself as a man, woman, both, or as a different gender), and sexual identity (being heterosexual, bisexual, homosexual etc.) refers to different aspects of a person.
- The terms and ideas presented in this manual may not encompass the variety and diversity of people's experiences in different parts of the world, including India where most of the examples are drawn from. This is partly because of language limitations. Exact translations from English to local languages and vice versa are not always possible. This, however, does not mean that these identities and experiences do not exist in a culture. For example, the word gay/homosexual as it is conceptualised in the West does not translate into many local languages. Similarly, there is no English word that can explain the Indian *kothi* identity satisfactorily to a non-Indian audience.
- Every individual has multiple identities, which intersect in unique ways to make the person who s/he is. For example, someone may identify as a woman, a mother, a lesbian, a daughter, and a nationalist. Identities are fluid, changing and personal. Stereotypes focus on only a single identity of an individual and may be used to judge the person unfairly.
- People oppressed on the basis of their sexual or gender identity have formed groups to advocate for rights and/or support.
- Some varieties of sexual behaviour and expression go beyond what is conventionally acceptable. Those engaging in consensual sexual behaviour have the right to do so without fear of being judged or punished for their activities.
- A variety of sexual acts can be safe and pleasurable and need to be discussed while helping people make informed sexual choices.
- Coercive sexual behaviour of any kind, even between regular partners such as married couples, is unacceptable.
- Sexuality and related issues are often subject to stereotypes that can be represented in many forms - language, advertisements, campaigns, images, reports, brochures and documentaries.

Exercise 1
Sex and Gender Identities

GROUP DISCUSSION

Instructions

1. Distribute one chit with an identity to each participant. Ask participants to take a couple minutes to read their chits. For the rest of the exercise they must make these identities their own. For example if a participant is lesbian in real life, she must adopt the identity of a transsexual if that is what her chit says.

2. Ask participants with their assumed identities to 'mingle' and create small groups with other identities with whom they have something in common. The commonalities could be related to a role they have in a community, a gender identity, the kind of work they do, the choices they have etc. If you find that people are not able to establish commonalities, raise questions to get them started. For example, what would a gay man have in common with a lesbian woman in terms of their expectations or limitations in a community?

3. After at least three small groups are formed, ask groups to discuss what they have in common in the context of their identities and prepare to present their discussions to the larger group. Give the groups 10 minutes for these discussions.

4. Bring the groups back together to share their discussions. First each person in the group should introduce themselves and their identity and then a representative from the group should summarise their discussions. After the presentations, ask for questions and comments.

Suggested Questions:

- Are there any identities you do not understand or have never heard of before? If yes, can the person with that identity read out the definition they have?
- Can you name any other sexual or gender identities from your community that were not mentioned in the chits?
- Were there any stereotypes that emerged from the groups? For example, all gay men are promiscuous, transgendered people should only hold entertainment jobs etc.

Purpose of the exercise:

1. To understand and define different sexual and gender identities.

2. To examine common experiences and issues faced by people with different identities.

TIME

45 minutes

MATERIAL

Flipchart, chits of paper, Handout 1.4 Basic Information on Sexual Identity and Gender Identity

ADVANCE PREPARATION

Write the identities from Handout 1.4 on separate chits of paper for each participant, for example 'lesbian', 'female to male transsexual' etc.

THIS EXERCISE CAN BE MODIFIED BY:

- Using it to emphasise stigma and discrimination rather than sexual and gender identities. Additional identities can be included such as unmarried woman, married man, or those relevant to the country/ region participants belong to, to help participants see the effects of stigma and discrimination at a wider level and emphasise their effects.

MAKING CONNECTIONS

- People with disabilities are also sexual and have a variety of sexual and gender identities. For more see Chapter 3 in Module 4.
- People can experience stigma and discrimination for their inability to have children, or for their HIV status, among other issues. See Chapter 2 in Module 4 for more.

Key Messages

- Sexual identity refers to how people define themselves based on whom they are sexually attracted to; whether they are attracted to people of the same gender, a gender other than their own, or to more than one gender.
- Gender identity refers to whether one thinks of oneself as a man, woman, both, or as a different gender. As with sexual identity, many cultures and communities have prescribed rules for appropriate gender identities based on the biological sex of a person.
- Identities are not static. Individuals can identify in many different ways, and can change their sexual and gender identity throughout their lives.
- Many different individuals and identities are subjected to stigma and discrimination. Often the more 'different' a person is from the established norm, the more discrimination they face.
- Stereotypes maintained by societies and communities contribute to stigma and discrimination against certain gender and sexual identities.

TIPS FOR THE FACILITATOR:

- Make sure participants do not mimic behaviour during the exercise, but instead focus on the identity. For example, if they adopt gay as an identity, they should not act effeminate or assume other similar stereotypical actions.
- If participants have difficulty finding something in common between the different identities, give examples to help them. For instance, a woman may experience stigma and discrimination similar to a transgendered person or *hijra*. Both may have less decision-making power in a community, or be confined to certain spaces and roles.
- While participants may be unfamiliar with some of the defined identities or some terms may not be relevant in their countries or communities (for example, *kothi* may be relevant to individuals in Indian sub-continent and not in other areas), it is important to be aware of the diversity of identities specific to certain regions.

Exercise 2
Varieties of Sexual Expression

SMALL GROUP WORK

Instructions

1. Divide participants into groups. Distribute flipchart paper and markers to the groups. Instruct them to list out every kind of sexual behaviour they have heard of, engaged in, seen, or read about. Give them 20 minutes to complete this task.

2. Bring the groups back together and ask representatives from each to present their list to the larger group.

3. After the presentations, distribute Handout 1.5 to participants. Ask for questions and comments.

Suggested Questions:

- How did you feel when you did the listing? What kinds of behaviour did you hear about for the first time? What kinds of behaviour do you think are common in our culture/ community?
- What kinds of behaviour would increase risk of infection or unwanted pregnancies? Do you think these are behaviours only engaged in by heterosexuals or also by non-heterosexuals?

Key Messages

- People engage in a variety of sexual behaviour even if they are not discussed openly.
- Many forms of sexual behaviour and expression can take place between people of different genders and also those of the same gender. For example, oral sex can take place between two men, two women or a man and a woman.
- While some people may prefer not to engage in a certain type of behaviour, this does not mean it is wrong for others to enjoy it if it is consensual. For example, some people may find bondage and discipline unappealing, while others find it pleasurable. As long as there is mutual consent, this should not be judged as 'wrong' behaviour.

Purpose of the exercise:

1. To be aware of the diversity and variety of sexual behaviour and expression.

2. To be comfortable discussing a range of sexual behaviour and expression.

TIME

45 minutes

MATERIALS

Flipcharts, markers, pens/pencils, copies of Handout 1.5 Varieties of Sexual Behaviour and Expression

ADVANCE PREPARATION

Read through Handout 1.5 and make sure you understand all listed terms. Add a few of your own to the list if you wish.

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting it as a large group brainstorm exercise. While participants brainstorm answers, the words can be listed on a flipchart and discussed afterwards.

MAKING CONNECTIONS

- Individuals can find a variety of sexual behaviours and expression pleasurable. For more see Chapter 4 in this Module.
- It is important that the practice of any kind of sexual behaviour is with the consent of partners and with precautions to prevent transmission of STIs including HIV/ AIDS. For more see Chapter 4 in Module 2.

- It is important for people to be aware of different sexual activities and their own reactions to them. This helps them to be prepared and react appropriately when they hear about them during the course of their work.
- Certain types of sexual behaviour are sometimes considered 'unnatural' or against 'nature'. This argument is simplistic because many kinds of behaviour, such as same-sex behaviour are practiced by animals and in 'nature'. Moreover, creating the label 'unnatural' for behaviour does not take into account the fact that human beings engage in a number of activities that animals do not (and therefore are 'unnatural') which are still acceptable, such as wearing clothes, sitting on chairs and travelling on wheels!
- Being aware of the diversity of sexual expression can also help design information and services to help people protect against potential adverse effects/ consequences of these behaviours. For example, with regard to conception, many believe that anal sex is a safe alternative to penile-vaginal sex. They may therefore engage in unprotected anal sex, which not only exposes them to risk of infection, but also does not rule out the risk of conception.

TIPS FOR THE FACILITATOR:

- Be prepared for discomfort by participants, which may manifest as inappropriate humour, silence or outbursts of anger. Let these reactions emerge spontaneously. However, remind the group that the purpose of the exercise is for them to become aware of behaviours to enable them to work more effectively on sexual and reproductive health and rights.
- Pay attention to the terms listed out by the groups. Participants might include sexual or gender identities in the list of sexual expression. Point out that sexual behaviour or expression is different from identity. For example, homosexuality is a sexual identity, not behaviour.
- Make note of the kinds of words being brought up during the exercise. Do they reflect any values of the group or individuals and/or do they focus on any particular kind of sexuality (heterosexual, monogamous)? If so, ask participants why they focused on these and introduce other sexual identities.

Exercise 3
Good Sex / Bad Sex

BRAINSTORMING

Instructions

1. Distribute two slips of paper to each participant. Ask them to write sexual behaviours they consider *Good Sex* on one slip, and what they consider *Bad Sex* on the other. For example, *Good Sex* may elicit responses such as penile-vaginal sex, while *Bad Sex* may elicit responses such as anal sex. After participants have written their responses, ask them to put the slips into the appropriate containers.

2. Collect the two containers. Pass them around and have participants read out the responses for the *Good Sex* category one by one. Write these down on a flipchart. Do the same for the *Bad Sex* responses.

3. Once the listing is complete, ask participants to look at them and react/ make note of their observations. Ask for questions and comments.

   Suggested Questions:

- Is there any behaviour that falls into both categories? What does this mean?
- Is there prejudice or discrimination associated with terms and practices in the bad sex category? Why?
- Do we leave out certain people from health service delivery by labelling their behaviour as 'bad'? Can you give an example from the given list?

Purpose of the exercise:

To understand and identify personal values related to sex and link them to stigma and discrimination.

TIME

60 minutes

MATERIALS

Flipchart, markers, chits of paper, two jars/baskets one marked *Good Sex* and the other *Bad Sex*.

ADVANCE PREPARATION

Prepare two flipcharts. Write *Good Sex* at the top of one flipchart, and *Bad Sex* on the other.

THIS EXERCISE CAN BE MODIFIED BY:

- Giving participants two separate coloured slips of paper (e.g. blue and yellow). They can be asked to write what they consider good sex on the yellow slips and bad on the blue slips. Once they finish, their slips can be pasted on a pre-prepared wall for all to read and comment upon.

MAKING CONNECTIONS

- Individuals have a right to practice and experience their sexuality as they choose. For more see Chapter 3 in Module 3.
- Sex should not be coercive or forced, even between regular partners and/or spouses. For more see Chapter 1 in Module 4.

Key Messages

- All people have the right to express their sexuality freely and are responsible for doing so in a manner that does not harm or violate anyone else.
- One may incorrectly judge others on the basis of what they find right/wrong or are uncomfortable with. Any sexual activity ***between consenting adults*** is their private matter and should be respected as such.
- Judging people creates prejudice, and causes them to be discriminated against. This affects their self-esteem and causes hurt and pain. It can also deprive them of essential services and information.
- Stigmatising people on the basis of perceived or real difference prevents them from accessing services and help when most needed. For example, a hospital may not treat an HIV positive person, based on the assumption that the infection has occurred due to *Bad Sex*. This neglect can make the person more vulnerable to infection, complications or severe illness.

TIPS FOR THE FACILITATOR:

- Some participants are likely to rate an act good while others rate the same act bad. This difference helps people see how subjective sexual preferences and experiences are and so cannot be judged.
- The *Bad Sex* examples may leave many participants feeling awkward. An in-depth discussion of this category is not essential but it is important to have participants reflect on where these ideas of bad sex may have arisen from and how the stigma they create can affect service-provision.
- The discussion can reveal values, judgments and prejudices that, to a large extent, will be challenged by the participants themselves. The facilitator can step in when required.

Exercise 4
Reflecting on Sexual Expression

SELF-REFLECTION

Instructions

1. Distribute Handout 1.6 to each participant and give them 15 minutes to read the list and fill out the chart. Encourage everyone to be honest in listing factors that have influenced their attitudes and factors that have helped them become comfortable with the identities and behaviours listed. Assure participants that this is a private exercise and they will not be expected to share their thoughts with others unless they want to.

2. After 15 minutes, invite participants to talk about how they felt while doing the exercise. Stress that they do not need to discuss anything they are uncomfortable sharing.

Suggested Questions:

- Are there some kinds of behaviour that are more acceptable than others? Why? Who decides what is acceptable?
- Is there a universal standard of what is good or bad? Should there be one? Why? Who would be given the authority to decide what is good/bad?
- Once society or individuals determine that a sexual behaviour is not 'right', does it stop people from engaging in it? Why or why not?

Purpose of the exercise:

To identify opinions and ideas about personal sexual behaviour and expression.

TIME

30 minutes

MATERIALS

Handout 1.6 Sexual Expression Self-Reflections

ADVANCE PREPARATION

Make copies of Handout 1.6 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Asking participants to discuss how their communities or social groups view these kinds of behaviour and whether there are laws, policies or institutions that prohibit or accept these behaviours. They can then examine how these views and laws came about historically and how they can affect people's choices and rights.

MAKING CONNECTIONS

- Sexuality is an individual experience that changes over time and can be experienced in a variety of ways. For more see Chapter 1 in this Module.
- Social and cultural factors can influence how we express our sexuality and the power we have to do so. For more see Chapter 1 in Module 4.

Key Messages

- There are different types of sexual behaviour. People's comfort levels and preferences for these diverse behaviours vary.
- Tolerance and acceptance of various types of sexual behaviour is essential, whether or not we engage in any of these ourselves.
- Social, cultural, and personal factors influence each person differently. What one person may find 'acceptable' may be different from another. In other words, all people do not have the same attitudes toward and/or practice the same sexual behaviour. This should be respected.
- Societal values also affect our comfort level and attitudes toward certain identities and behaviour. These may cause us to feel unnecessary shame and guilt about our own sexual desire and its expression, even when it is safe and consensual.

TIPS FOR THE FACILITATOR:

- Participants may be uncomfortable sharing what they have written for this exercise. Emphasise the ground rules for tolerance and openness before the exercise begins and reassure everyone that they do not need to share anything that makes them uncomfortable.

THIS EXERCISE CAN BE MODIFIED BY:

- Taking one or two case studies and discussing them in a large group rather than dividing the cases among participants. This may be beneficial if the group wants in-depth focus on a particular issue.

MAKING CONNECTIONS

- Sexual and reproductive health are important to overall health and well-being. For more see Module 2.
- Individuals have a right to choose and practice their sexuality. For more see Chapter 3 in Module 3.

- Homosexual and bisexual women and men may experience pressure to get married. Often they do not have anyone they can share their concerns with and may feel isolated, lonely and depressed.
- Making assumptions about people's sexuality on the basis of stereotypical ideas can limit choices about and access to medical and other services. For example, an unmarried woman may be sexually active. She may have a regular male partner, more than one partner, or a woman partner. Any or all of these factors may be overlooked/ignored by a healthcare professional who assumes that she is not sexually active since she is unmarried and therefore does not need to be checked for an STI.
- Use of gender-neutral language while describing a client's partner will give non-heterosexual, non-monogamous clients the message that they can speak freely without being judged.
- All people have the right to express their sexuality freely and are responsible for doing so in a manner that does not harm or violate any one else.

TIPS FOR THE FACILITATOR:

- Participants may have very strong reactions to the case studies. Note if anyone uses discriminatory language, if any prejudices are reflected, if certain topics create discomfort, or if there are any significant reactions to different characters in the case studies. Point out these instances and question their basis. This needs to be done gently and respectfully by the facilitator to prevent participants from feeling that they are being criticised.
- Participants may find it difficult to discuss this topic or believe that all non-heterosexual behaviour is morally wrong. Ask why they believe this, pointing out that morality is relative (it varies from culture to culture, generation to generation, and even from one person to the next) and there is no single or universal standard to live by.

Exercise 6
Representation in the Mass Media

SMALL GROUP WORK

Instructions

1. Divide participants into groups. Distribute the local newspapers, magazines and advertisements to the groups. Ask each group to look through the material and select pictures and/or articles (the facilitator may want to collate the material beforehand to save time) that deal with sexuality and list out their reasons for selecting them. For example, a group may identify a picture of a woman in a seductive pose next to a motorcycle and explain that a woman's body/sexuality is being used to attract a largely male clientele for motorcycles. Give the groups 20 minutes for this task.

2. Bring everyone together and have each small group share their articles and pictures, discussions and explanations. Ask them to tape the pictures on the wall or on a flipchart as they talk about them. After each presentation, ask for questions and comments.

   Suggested Questions:

- How did you feel doing this exercise?
- What messages do these images give about the people or groups being represented? Are these messages accurate and/or stereotypical? What are the advantages and disadvantages of these messages? (For example, what is the advantage or disadvantage of representing homemakers as efficient, perfectly-dressed, always happy mothers?)

3. After all the presentations, ask for general questions or comments.

   Suggested Questions:

- Do you see any similarities between the types of articles and pictures found in newspapers, magazines and advertisements?
- What do you think the role of the media is with respect to the depiction of sexuality?
- Is there a range of identities or genders represented? For example, do you see people portrayed as only heterosexual? Is only

Purpose of the exercise:

To discuss how people are represented in the media and its effects on sexuality and rights.

TIME

60 minutes

MATERIALS

Local newspapers, magazines, advertisements, scissors

ADVANCE PREPARATION

Collect some local newspapers, and an assortment of magazines and advertisements.

THIS EXERCISE CAN BE MODIFIED BY:

- Asking the small groups to find pictures and articles that relate not just to sexuality, but also to gender, sexual and reproductive health. This can begin broader discussions on connections between sexuality, gender and reproductive and sexual health.
- Showing various images and asking participants to call out words that come to mind as they see them. Each image can be pasted on a separate flipchart/ made into a slide presentation. The words can be listed on a flipchart and this can be followed by a discussion using the suggested questions in the exercise Instructions.

MAKING CONNECTIONS

- Some groups and identities are usually represented in a simplistic manner. For example, people with disabilities, if at all represented, are represented as victims. For more see Chapter 3 in Module 4.
- Sexuality is usually associated with young people. Older people's sexuality is often under-represented or not given positive representation. For more see Chapter 3 in this Module.

women's sexuality being highlighted? Are older people or those with disabilities represented as often?

- Do these representations play a role in how we think about sexuality, sex and gender roles? How? Do they perpetuate commonly held ideas or challenge them? Give examples.

Key Messages

- In many instances, articles and pictures found in newspapers, magazines and advertisements reflect the way sexuality, sex, and gender roles are perceived by a community or culture. For example, advertisements from some communities/regions typically show a woman as the 'good housewife' to sell a product; or a man as strong and stable to support a family.
- Images in the mass media represent some value or moral standpoint. For example, articles that advise women on 'How to catch a man' imply that all women want to be with men; do not want to be alone or with other women; and must conform to a particular standard to meet a man.
- Images in the mass media can be interpreted and judged in many ways depending on people's perspective and attitude. For example, a photograph of a 'scantily-clad' woman in an advertisement may seem inappropriate or crude to some, but artistic or erotic to others.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to relate the pictures or articles to sexuality. If so, give examples such as those listed above. The facilitator may also want to begin the exercise by reviewing the definition of sexuality (Exercise 1, Chapter 1, Module1).
- Participants may focus only on heterosexual roles and relationships. It is important to introduce representations of other identities and relationships, such as same-sex sexual relationships.
- Help participants identify those people who are left out of typical representations and the implications for public health and the well-being of those who are left out (older people, those with disabilities or even those who do not conform to media's notions of beauty).

Handout 1.4
Basic Information on Sexual Identity and Gender Identity

The terms below refer to commonly used sexual and gender identities. This list is not exhaustive. These terms and identities are constantly being discussed and examined and therefore their meanings and how they are used as identities change over time. Some people may decide not to use any identification, or may choose to move from one identity to another. A number of identities have been excluded from this list because they cannot be translated into English easily. Ultimately, it is important to understand and recognise that there is a range of sexual and gender identities.

- **Asexual:** An individual who feels no sexual attraction towards other individuals.

- **Bisexual:** An individual who is sexually attracted to people of the same gender and also to people of a gender other than their own.

- **Gay:** A man who is sexually attracted to other men and/or identifies as gay. This term can also be used to describe any person (man or woman) who experiences sexual attraction to people of the same gender.

- **Heterosexual:** An individual who is sexually attracted to people of a gender other than their own and/or who identifies as being heterosexual.

- **Heterosexism:** The viewpoint that all people should be heterosexual and the assumption that this is the 'normal' or 'natural' sexual identity people should have. This viewpoint results in bias against other sexual identities.

- **Hijra:** A term used in the Indian subcontinent, which includes those who aspire to and/or undergo castration, as well as those who are intersexed (please see definition below). Although some *hijras* refer to themselves in the feminine, others say they belong to a third gender and are neither men nor women.

- **Homosexual:** An individual who is sexually attracted to people of the same gender as their own, and/or who identifies as being homosexual.

- **Homophobia:** An intolerance or irrational fear of homosexual people that can manifest itself in discrimination, prejudice, disgust or contempt of homosexual people.

- **Intersexed Person:** An individual born with the physical characteristics of both males and females. These individuals may or may not identify as men or women.

- **Kothi:** A feminised male identity, which is adopted by some people in the Indian subcontinent and is marked by gender non-conformity. A *kothi*, though biologically male, adopts feminine modes of dressing, speech and behaviour and looks for a male partner who has a masculine mode of behaviour, speech and attire. Some believe that this is not an identity but a behaviour.

- **Lesbian:** A woman who is sexually attracted to other women and/or identifies as a lesbian.

- **Man:** A person who identities as a male and may or may not have male genitalia or reproductive organs like a penis or testes.

- **Queer:** A person who questions the heterosexual framework. This can include homosexuals, lesbians, gays, intersexed and transgendered people. To some this term is offensive, while other groups and communities have used it as a form of empowerment to assert that they are not heterosexual, are non-conformist, against a dominant heterosexual framework, and dissatisfied with the 'labels' used on people who do not identify as heterosexual.

- **Sex reassignment:** A complex range of procedures that people undergo to transform from one sex to another. These include hormone therapy, hair transplants or removal, speech therapy and surgeries to change one's sexual and sometimes reproductive organs.

- **Transgendered Person:** An individual who does not identify with the gender assigned to them. They may or may not consider themselves a 'third sex'. Transgender people can be men who dress, act or behave like women or women who dress, act or behave like men. They do not, however, necessarily identify as homosexual.

- **Transsexual Person:** An individual who wants to change from the gender they have been assigned at birth to another gender. Some have surgery, hormonal medication, or other procedures to make these changes. They may or may not identify as homosexual, bisexual or heterosexual. They may be **female to male transsexuals, male to female transsexuals** or choose not to be identified as either.

- **Transvestite:** An individual who dresses in the clothing that is typically worn by people of another gender *for purposes of sexual arousal/gratification*. Transvestites are often men who dress in the clothing typically worn by women. They are also known as cross-dressers.

- **Woman:** A person who identifies as a female and who may or may not have female genitalia and reproductive organs like breasts, a vagina, and ovaries.

Handout 1.5
Varieties of Sexual Behaviour and Expressions

NAME	COMMON TERMS	DESCRIPTION
Anal Sex	Bum-fucking, buggering	Inserting one's penis, dildo, fingers or other objects into a partner's anus.
Analingus	Rimming	Using one's mouth to stimulate a partner's anal area.
Autoerotic asphyxiation		Self-strangulation during masturbation. Partial asphyxiation cuts off air supply to enhance an orgasm. This practice can result in accidental death.
Bestiality		Sexual interaction with animals that can include various types of contact, such as oral, anal, and vaginal intercourse.
Biting	Love, bite, hickey	Biting or sucking a partner's body (usually neck) hard enough to produce a mark or bruise.
Bondage and Discipline		Sexual behaviour that includes parts of sadism and masochism(see below). One partner is bound/restrained, submissive and is 'disciplined' or 'punished' physically or mentally by the dominant partner. This is sexually arousing to the partners and is mutually consensual or negotiated beforehand.
Coprophilia		Sexual pleasure associated with eating faeces.
Cunnilingus	Going down on, eating, licking out, suck off.	A partner uses their mouth/tongue to stimulate a woman's genital area.
Dry sex		Increasing friction of penile-vaginal sex by drying the vagina with cloth or herbs. The friction is said to increase sexual pleasure for the man. Also increases the opportunity for tears and scrapes in the vagina and therefore the possibility of contracting a sexually transmitted infection including HIV.
Erotalia	Talking dirty, telephone sex	Speech that is sexually arousing.
Exhibitionism		Exposure of genitals for sexual gratification.
Fantasy		Imagining things that are sexually arousing.
Fellatio	Giving head, going down on, blow job, sucking off.	A male/ female partner uses their mouth/ tongue to stimulate a man's penis.
Fetishism		Being sexually aroused by an inanimate object, e.g. shoes, underwear, leather etc.
Finger insertion	Fingering, finger-fucking	Inserting one's finger/s into a partner's anus/vagina.
Fist insertion	Fisting, fist- fucking	Inserting one's fist into partner's anus/vagina. This can be done gradually and may begin one finger at a time.

NAME	COMMON TERMS	DESCRIPTION
Flagellation	Whipping, Paddling	Being sexually aroused from whipping a partner or from being whipped.
Frottage	Dry humping	Partners rub their bodies together for mutual sexual pleasure.
Kissing	Smooching, pash off, suck face, tonguey	Partners use their mouths to kiss a partner's mouth or other parts of the body.
Masturbation	Solo sex, wanking, rubbing up, fiddling, jerking off, playing with yourself.	Giving yourself sexual pleasure, usually by touching/ rubbing your genitals. Can also involve fantasy, pornography and/or sex toys.
Mutual Masturbation		Partners sexually stimulate one another's genitals, usually by touching or rubbing with hands or sex toys. Can also refer to watching each other masturbate.
Necrophilia		Being sexually aroused by the thought/sight of a corpse, or by touching or having intercourse with it.
Ozolagnia		Being sexually aroused by the smell of body odour.
Pornography	Porno, stick books, blue movies, X-rated, smut	Using movies/video, and/or reading stories of sexual acts for sexual arousal. Often in combination with masturbation.
Sado - Masochism	S & M	The sex between those who enjoy causing physical and/or emotional pain (sadists) and those who enjoy it being directed at them (masochists). Can involve role play, whips, bondage etc.
Sex, Sexual intercourse.	Making love, fucking, bonking, screwing	A male partner puts his erect penis into a woman's vagina. It can also include any penetrative sexual activity.
Toys	Sex toys, marital aids	'Toys' refers to a wide range of devices used to arouse a person or their partner. Toys include dildos and vibrators.
Sixty-nine		When a couple performs oral sex on each other at the same time.
Tribadism		Rubbing the vulva against partner's thighs/genitals for sexual pleasure.
Troilism	Threesomes, menage-a-trois.	Sexual activity involving three people.
Urolagnia	Golden showers, water sports	Getting sexual pleasure from being urinated on or urinating on a partner.
Voyeurism	Watching, peeping	Getting sexual pleasure from watching others having sex, listening to others' sexual exploits, watching someone bathe etc.

Handout 1.6
Sexual Expression Self-Reflections

Please look through the list of diverse sexual behaviours below. Of these behaviours, please note which you feel personally comfortable with and which you are uncomfortable with. List the factors that influence your attitudes and level of comfort with the various kinds of behaviour.

SEXUAL BEHAVIOURS/ EXPRESSION	COMFORTABLE YES/NO	FACTORS THAT HAVE INFLUENCED MY COMFORT/ DISCOMFORT
Fantasising		
Anal sex		
Oral sex		
Peno-vaginal sex		
Masturbation		
Mutual masturbation		
Sex talk with your partner		
Sex talk with a stranger (on the phone)		
Reading erotica		
Watching erotic films or pictures		
Chatting online about sex		
Any other (please add)		
Any other (please add)		
Any other (please add)		

Handout 1.7
Case Studies for Sexual and Gender Identity

Case study 1

A young man is being pressured by his parents to get married because now he has everything that a married man would require: a good job, an excellent salary, a car and a house. The man is reluctant to marry because he knows that he is not attracted to women. He has been having sex with men for a number of years and wants to enter a long-term relationship with a man.

What issues related to sexuality and identity can you identify in this case study?

Is this young man homosexual? Explain your reasons.

Case study 2

An 18-year-old boy has been having oral sex with different men at common cruising areas in the city. He has a feeling that one of his classmates frequents these places as well but is scared to ask him directly.

What issues are highlighted in this case study?

Is this young man homosexual? Explain your reasons.

Case study 3

A 32-year-old woman goes to the gynaecologist for a routine check-up. She is asked to get some tests done, including an ultrasound of her ovaries. On reading her referral form, the doctor doing the ultrasound looks surprised and asks why she needs to come in for a test when she is unmarried. He resists doing a vaginal scan for the same reason.

What assumptions is the doctor making about the woman's sexuality and her health?

What issues related to gender and sexuality (and rights) can you identify in this case study?

How do you think this could affect the woman's physical and mental health?

Case study 4

A man calls a helpline complaining that he has seen his wife and her friend, a married woman living in the neighbourhood, in a compromising position. They were both half undressed and touching each other 'inappropriately'. He cannot understand why she is interested in another woman when she is sexually satisfied with him.

What would you tell this man?

Is his wife lesbian?

Case study 5

A young man approaches a well-known lawyer to fight his case. He is angry with his brother for accusing him of having undergone a sex reassignment surgery only so that as a male heir, he would get an equal share to the family's ancestral wealth. He has gone through a lot of pain and difficulty to finally look like a man, something he knew he wanted to be even as a child when he dressed and acted like a girl.

What issues related to gender and sexuality (and rights) can you identify in this case study?

What are your views about the brother's actions?

Case study 6

A group in a small town has heard about transgender beauty pageants taking place in Thailand. As people who identify as transgender, they want to hold a pageant in their small community to help people appreciate their identity and also have fun. They go to the local community authorities to get a permit to hold the pageant. The community authorities deny them the permit and tell them they do not want to support such an event.

What issues related to gender and sexuality (and rights) can you identify in this case study?

How can the group advocate so as to get approval to hold the pageant?

Chapter 3
Sexuality Through Life

Chapter Objectives for the Facilitator

1. To describe how sexuality can be experienced throughout one's life, from childhood and adolescence to adulthood and beyond.

2. To dispel myths associated with sexuality and age, particularly sexuality related to young people and sexuality related to older adults.

3. To acknowledge and recognise that sexuality can play a role in physical development, sexual health, identity, and pleasure through the different stages of life.

Why a Chapter on Sexuality Through Life

'My parents don't have sex – they are too old!'

'My daughter is only 13, she doesn't need to know about sex or sexuality.'

'He became a father at the age of 68 – my, what a naughty old man!'

These types of statements are common and reflect the ways in which sexuality is often viewed by individuals or communities - as an issue only for people of reproductive age (those between 15 and 45 years), and considered inappropriate or taboo, particularly for people beyond reproductive age. However, directing discussions about sexuality at a certain age group and making age-related assumptions about sexuality - for instance that older people do not experience sexuality, or younger people do not need sexuality education - overlooks the reality that sexuality is experienced throughout the course of a person's life. People of all ages experience sexual desire, are capable of being sexually active, and need information on sexuality to enjoy lives free of fear, stigma and infection.

This chapter discusses sexuality and sexual and reproductive health through life. Participants explore their perceptions, ideas and expectations of sexuality and sexual and reproductive health through life, as well as the implications on health and well-being when certain age groups are ignored in sexuality interventions.

EXERCISES IN THIS CHAPTER

Exercise 1: Experiences of Sexuality Through Life. 60 minutes

Exercise 2: Charting our Changes. 60 minutes

Exercise 3: What we Learn from Others. 60 minutes

Exercise 4: My Views on Sexuality Through Life. 45 minutes

MATERIALS FOR THIS CHAPTER:

Flipcharts and markers
Pens/pencils
Paper
Index cards/slips of paper
Jars or baskets

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 1.8
  Basic Information on Changes in the Body Through Life
- Handout 1.9
  Phrases and Words Related to Sexuality

ADDITIONAL RESOURCES:

- The Boston Women's Health Collective. 2005. *Our Bodies, Ourselves*. New York: Touchtone.
- Brick. P and Lunquist. J. 2003. *New expectations: Sexuality Education for Mid and Later Life.* New York: SIECUS.
- Irvin, A. 2004. *Positively Informed: Lesson Plans and Guidance for Sexuality Educators and Advocates.* New York: International Women's Health Coalition.
- Older Adult Sexuality Reference. http://instruct1.cit.cornell.edu/courses/psych431/student2000/dp51/index.html
- TARSHI. 1999. *The Red Book – What You Need to Know About Yourself (10-14 Years).* New Delhi: TARSHI.
- TARSHI. 1999. *The Blue Book – What You Need to Know About Yourself (15 + Years).* New Delhi: TARSHI.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key Messages for this Chapter

- Sexuality is part of people's lives from their youth until the end of their lives.
- Some people believe that discussing sexuality with young and older adults is irrelevant, because they do not fall into the reproductive age group, are perceived to be sexually inactive, and consequently have no need for such information. However sexuality is explored, expressed and experienced throughout life.
- Discussing young people's sexuality and sexual and reproductive health is critical, especially in those parts of the world where child marriage is still the norm. However, it is important to remember that a person's first sexual encounter may not always take place within marriage.
- Because men have a longer reproductive life span, their sexuality receives more attention than women's. Once women reach menopause, they are seen as having no reproductive potential; consequently their sexuality and sexual and reproductive health are often ignored.
- Physical changes that take place with ageing affect how people experience their sexuality and its role in their lives. This does not necessarity diminish/undermine their sexuality.

Exercise 1
Experiences of Sexuality Through Life

CATEGORISATION

Instructions

1. Hand out three index cards to each participant. Ask them to write answers to each question below on separate cards. They need not put their names on the slips in order to maintain anonymity. Tell participants that the slips will be read aloud in the next part of the exercise. Encourage them to be as open and honest as possible.

- Card 1: *When did you first hear about sex/sexuality and what was the context?*
- Card 2: *Describe briefly how you currently view your sexuality.*
- Card 3: *Describe briefly what you think your sexual experiences/ sexuality will be 20 years from now.*

2. Ask participants to put each slip into the corresponding containers - all responses to question 1 into the *Past* container; the responses to questions 2 and 3 into the *Present* and *Future* containers respectively.

3. Pass the *Past* container around and have each participant pick one card at a time and read aloud. After they have read all the slips, ask for questions and comments:

Suggested Questions:

- Are the experiences what you expected them to be? How many of these were related to physical changes in your bodies?
- Are the responses typical of the community you were raised/ live/work in? Do you think the responses would be different in rural or urban communities, or if they came from women, men, older or younger people etc.? Why or why not?

4. Now invite participants to read from the *Present* container followed by the *Future* container.

Suggested Questions:

- Compare responses of all three categories. How are they different or similar? Did you expect these responses?
- Are the responses typical of the community you were brought up in? Do you think the responses would be different in rural

Purpose of the exercise:

1. To comfortably discuss sexuality at different stages of life.

2. To appreciate that sexuality is experienced throughout life.

TIME

60 minutes

MATERIAL

Index cards (or three different colour cards), pens/pencils, 3 jars or baskets

ADVANCE PREPARATION

Label 3 jars *Past*, *Present*, and *Future*

or urban communities, or if they were came from women, men, older or younger people etc.? Why or why not?

Key Messages

- Sexuality is personal and subjective. It can be experienced at all stages of life and can change over time. These changes are not negative and do not suggest a diminished sense of sexuality.
- Sexuality is not only about being sexually active and/or reproducing. It is also related to well-being, a person's choices in sexual partners and identities and how they can negotiate them, how their sexuality interacts with their family, community or friends and how that makes them feel etc.
- Different communities talk about and regard sexuality differently; especially in the case of younger and older people. For instance, some believe sexuality should be discussed with young people but is unnecessary for older adults. Speaking about sexuality is important to every person's health and well-being.
- As people grow older, they may develop comfort with their bodies and themselves, which reflects in more satisfying sexual experiences. For example, a woman may feel uninhibited or free after menopause because unwanted pregnancy is no longer a fear, and thus may be able to enjoy sex more.

THIS EXERCISE CAN BE MODIFIED BY:

Dividing participants into smaller groups to discuss the statements. This is beneficial for participants who are uncomfortable doing this exercise in the large group. After small group discussions, participants can share their conversations in the larger group.

MAKING CONNECTIONS

- All people have the right to sexual pleasure, irrespective of age. For more see Chapter 4 in this Module.
- Reproductive health and rights should not focus on those of 'reproductive age' only, and is important throughout our life. For more see Chapter 2 in Module 3.

TIPS FOR THE FACILITATOR:

- Participants may express shock at some of the responses, which seem different from their own. Do not critique an experience or allow others to do so.
- Participants may believe that with age people are likely to develop diseases that affect their sexuality. While ageing does increase the likelihood of developing certain medical conditions, avoid giving a message that age = disease = no sexuality.
- Some participants may regard sexuality of older people with disapproval. Some may be uncomfortable, laugh or make inappropriate comments when the issue arises. Ensure that such comments do not target or disrespect older people.
- Young people may feel awkward with comments about their perceived inexperience. Ensure that no discriminatory assumptions are made about their sexual lives.
- Be aware of participants of different ages and experiences. Stress common factors between these age groups (for example, the need for non-judgmental services at all ages) as well as allow participants to highlight the differences (for example, the requirements of a post-menopausal woman would be very different from a woman going through her first pregnancy).

Exercise 2
Charting Our Changes

CATEGORISATION

Instructions

1. Divide participants into small groups. Each group should receive four to five of the phrases and words from Handout 1.9.

2. Ask the groups to look over their respective phrases and words that relate to sexuality. As a group they should decide which category the statements belong to: *Adolescence, Mid-life*, or *Elder Adults*. After coming to an agreement on all the phrases and their categories, one person from each group should write the phrase or word on the appropriate flipchart pasted on the walls. Let participants know that it is possible to put the words or phrases in more than one category if they believe they pertain to more than one category.

3. After the groups have written all the phrases/words on the charts, ask participants to come back together in the large group and discuss where each phrase was placed. Begin with *Adolescence*; move to *Mid-life*; then to *Elder Adults*. After going over each stage, ask for questions and comments.

   Suggested Questions:

- Do you agree or disagree with where the phrases/words were placed?
- Would you change any of them?
- Are some of the phrases/words in all three categories? What does this tell us about sexuality over our lifetime?
- How can you talk about sexuality with people in these different age groups?
- How can you address the importance of sexuality with communities that find it inappropriate to talk about sexuality with certain age groups?

Purpose of the exercise:

1. To understand and discuss the characteristics and features of sexuality at different stages in life.

2. To dispel myths associated with sexuality and safer sex over our lifespan.

TIME

60 minutes

MATERIALS

Flipchart, markers, Handout 1.9 Phrases and Words Related to Sexuality

ADVANCE PREPARATION

Copy Handout 1.9. On three different pages of the flipchart write *Adolescence*, *Mid-life*, and *Elder Adult*. Tape these pages up in different areas of the room.

THIS EXERCISE CAN BE MODIFIED BY:

- Reading aloud the statements from the list on Handout 1.9 to participants, as a large group and inviting them to say what category each would fit into. After each statement, the facilitator can ask whether others agree or disagree and if it can fit into other categories as well.

MAKING CONNECTIONS

- As we age, our bodies change and this can effect and influence our sexuality. For more on sexual and reproductive anatomy and physiology see Chapter 1 in Module 2.
- Sexual problems for some people may occur due to changes in the body as we grow older, potentially increased risk for illness or certain medications. These problems do not necessarily imply a diminished sexuality. For more on see chapter 5 in Module 2.

Key Messages

- Older people can also feel pleasure and desire.
- It is important to continue to practice safer sex at every stage of life.
- Although we can experience sexuality throughout our lives, there are also physical and emotional changes that occur as we get older that can affect how we view and experience our sexuality.

TIPS FOR THE FACILITATOR:

- To avoid confusion, the facilitator should develop a consensus with the group at the beginning about what age ranges would constitute the *Adolescence*, *Mid-life*, and *Elder Adult* categories.
- Differing backgrounds, religions, and communities of the participants can cause disagreement over which category each word/phrase belongs in. For example, participants from some communities may think that a discussion of masturbation or sexual experimentation in older adults is inappropriate, while others may disagree. The facilitator and participants should respect these differences and the conversation should encourage the expression of varying opinions. It may be appropriate to find out why different ideas are present and whether participants think attitudes can or should be changed.
- Participants may focus on heterosexual, penile-vaginal sex, identities and experiences. Encourage the discussion to include other types of relationships and identities. For example, many participants may put the phrase 'voice deepens' in the *Adolescence* category. This can, however, also occur later in life if someone decides to have a sex change.
- Participants may make assumptions about elder adults. For example, many may assume that all elder adults are in monogamous relationships. If participants make these assumptions, ask about the bases for these ideas and whether non-monogamous or non-heterosexual relationships are also possible for older people.
- Gender differences may emerge from the discussion. The facilitator should be alert to and focus on any comments that suggest bias/difference based on gender and ask why these are important. For example, do people think that only men can masturbate or should be able to at any age?

Exercise 3
What We Learn From Others

ROLE- PLAY

Instructions

1. Divide participants into three small groups. Ask each to create a role-play in which they finish/respond to the following statements:

   Group 1: 'My mother taught me about sex…' and/or 'My father taught me about sex…'

   Group 2: 'My friends/peers taught me about sex…'

   Group 3: 'My community taught me about sex…'

   Encourage groups to interpret these open-ended statements broadly and creatively. For example, the role-plays can be conversations between people, a snapshot of time, pantomime etc. Age groups can also be added into the three statements. For example, 'In adolescence my mother/father taught me about sex…'; 'In adulthood, my friends/ peers…'; 'About older people and sexuality, my community taught me…' etc. Give the groups 20 minutes to create these role-plays.

2. Bring the participants back together and invite each group to perform their role-plays. After each presentation, ask the group for comments or questions.

   Suggested Question:

- Were the experiences in the role-plays similar or different to the messages you received from these groups (parents, peers and society)? How were they similar or different?

3. When all role-plays are complete, ask the group to discuss and compare the three.

   Suggested Questions:

- What aspects of sexuality did each group stress? Were they different or similar?
- Were the lessons learned by parents the same as those from the community or friends?

Purpose of the exercise:

1. To explore how attitudes and values on sexuality are shaped by social and cultural surroundings.

2. To describe how our environment can influence our sexual growth and development.

TIME

60 minutes

MATERIALS

Paper

Pen/pencil

ADVANCE PREPARATION

None

THIS EXERCISE CAN BE MODIFIED BY:

Providing possible answers to the statements and asking participants to create a role-play from these. For example, 'My mother taught me...sex before marriage is wrong', or 'My friends taught me...that it was okay to be a homosexual'. This may be suitable for groups that are uncomfortable sharing personal experiences.

- Asking participants to draw a simple picture of themselves. They should then draw all the factors in their lives that have influenced their sexuality. These influences can be family, friends, society etc. The drawing can be simple, with stick figures and words. When the drawings are completed, participants can present it to the group and discuss their influences.

- Would you add other people/ groups to this list of those who influence us about sexuality? Do these groups continue to influence your sexuality or are your influences different now?

Key Messages

- Different groups and individuals may influence and shape people's sexuality differently. For example, parents may stifle sexual expression, while some teachers might find it comfortable discussing sexuality or vice versa.
- Influences can change over time. For example, while teachers may not continue to influence choices and decisions made on a daily basis for some, what was learned from teachers may continue to impact later choices for others.
- Ideas about sexuality and how to engage with it also change with time and circumstances, reinforcing the notion that sexuality is fluid.

MAKING CONNECTIONS

- Younger and older people can experience stigma, discrimination and marginalisation while trying to access sexuality related information and services. For more see Chapter 2 in Module 4.
- Representations in the mass media, by NGOs etc. of younger and older people and their sexuality can influence our attitudes and opinions on sexuality. For more see Chapter 2 in this Module.

TIPS FOR THE FACILITATOR:

- Participants might avoid the issue of sexuality in their role-plays by focusing on sexual and reproductive health issues. If this happens, shift the focus or ask why this occured. For example, a group may mention that parents generally teach a girl about the connection between getting her period and her fertility, rather than address her feelings and attitudes around this event (such as telling her that having her period means that she has 'become a woman' and now has to be careful to protect herself and dress differently to avoid sexual attention from men).
- Participants in each group may come from different backgrounds, religions and communities and may find creating a scenario with these questions difficult. The facilitator should emphasise that this is an opportunity to collaborate on common themes, involve individual experiences, and open up discussions.
- Participants may focus only on heterosexuality. Shift questions and discussion to broaden the focus. For example, did peers teach them that it is possible to have a same-sex relationship?

Exercise 4
My Views on Sexuality Through Life

POLARISATION

Instructions

1. Tell participants that you will read out a statement and they must decide whether they agree or disagree with this. Designate one side of the room as the *Agree* side and the other as the *Disagree* side. Ask participants to move toward either side, depending on how they feel about the statement. Those who are undecided should move to a third designated spot in the room (the *Don't Know* group).

   Statements for My Views on Sexuality Through Life

   - Talking about sexuality with teens is unnecessary
   - Young people have the right to sexuality education
   - Its normal for people over 50 years of age to be sexually active
   - Its not normal for older men to fantasise about younger women or for older women to fantasise about younger men
   - My community would support my mother talking to my children about sexuality
   - It is not necessary to talk about sexuality with most people as they get older
   - Some cultures allow their children to explore their sexuality openly when they are very young. They let them walk around naked, ask questions etc. This is inappropriate
   - There is a cycle to our sexuality, and with age, a person's sexuality diminishes
   - Older men are allowed to express their sexuality.

2. Ask participants to share why they have chosen to be on a particular side of the room. Discuss the issues for no more than 20-25 minutes or participants may lose interest.

   Suggested Questions:

   - Why do you agree or disagree?
   - Do you think you would change your opinion if the statement reflected a specific gender? For example, is it appropriate to talk with young women about sexuality so they will not get pregnant, but not necessarily with young men?

Purpose of the exercise:

1. To examine and analyse attitudes and opinions toward sexuality throughout a person's life.

TIME

45 minutes

MATERIALS

None

ADVANCE PREPARATION

1. Select three statements from the list of 'Statements for *My Views on Sexuality Through Life*'.

2. Review the statements and be prepared to lead a discussion on the selected topics.

3. Clear the room or part of the room of furniture so that there is space for participants to move around.

3. After discussing the statements, ask for general comments or questions.

Suggested Questions:

- Were there any issues you had not thought of before? What were they and how did they make you feel?
- From these statements and discussions, what are your opinions and thoughts about sexuality through our life?

THIS EXERCISE CAN BE MODIFIED BY:

- Eliminating the *Do Not Know* option in the exercise, and insisting that participants decide to agree or disagree with the statements. This can be difficult for some statements, but encourages participants to form opinions and discuss the positive and negative aspects of each.
- Choosing fewer statements and spending more time discussing them, particularly if participants are having trouble grasping a concept.

Key Messages

- It is common for people of all ages and at all stages of their lives, whether in a relationship or single, to feel sexual desire. Social taboos may, however, prevent people from expressing their desires.
- Different cultures and communities regard sexuality differently, particularly when dealing with younger or elder people. It is important to initiate discussions among different groups.
- Social conditioning can lead people to believe that it is wrong to have sexual feelings unless they are young adults and in a monogamous relationship. This can cause feelings of guilt and shame in many, and can lead to sexual problems.
- Because of the shame and secrecy that surround sexuality, people hesitate to seek help openly. They may therefore resort to seeking help from unreliable sources (for example, from fake/unqualified health practitioners), much to the detriment of their health and well-being.

MAKING CONNECTIONS

- Sexual health and rights are important for people of all ages. For more see Chapter 3 in Module 3.
- Gender and gender roles can influence how sexuality is expressed throughout life. For more see Chapter 1 in this Module.

TIPS FOR THE FACILITATOR:

- These statements may provoke difficult questions and debate from participants. The facilitator should emphasise respect for all ideas and opinions as laid out in the Ground Rules (see *Preparing to Train* for a sample).
- Participants may all agree or disagree with statements, leaving little room for debate. Be prepared with possible arguments and responses to statements before undertaking this exercise. For example, participants may all disagree with the statement that older men are allowed to express their sexuality and believe that the problem lies with women, who do not talk about such topics. The facilitator may ask why women don't talk about these topics, and whether it is to do with stigma related to such conversations.
- Polarisation exercises may discourage quieter participants from speaking. Invite all to express their views from time to time during the exercise.

Handout 1.8
Basic Information on Changes in the Body Through Life

Physical changes occur in the body as people age. A person's life circumstances also affect these changes (for example, income level, nutrition, stress and responsibilities etc.). Below are some common physiological changes people experience through their life.

Menarche: The onset of menstruation, which can occur as early as age 9 and as late as 15 years, but most often around the age of 12. Nutritional standards, family history and psychological factors determine the age of onset of periods for most girls.

Even today in many parts of the world, menarche is marked as a significant coming of age event for girls and is often accompanied by rituals of celebration. However, even girls in urban areas are not usually prepared by their mothers, teachers or other care-takers for menarche. Rules and restrictions may also be imposed on girls once they reach menarche - for example who they can speak to, what they can wear, where they can go etc. - all of which add to feelings of confusion and shame for the young person who may not be able to share her feelings with anyone.

Menstruation: When the lining of the uterine wall, made up of blood and tissue, is shed gradually through the vagina. This shedding occurs because the uterine lining is not required if fertilisation has not occured. Menstruation usually occurs once every four weeks and can last between two to eight days.

Stress, change in routine, anaemia, illness and the side effects of medicines are some of the reasons for irregular menstruation. In certain cultures, rituals of purity are observed even today since menstruating women are considered dirty and not fit to take part in social and religious activities.

Perimenopause: The period before a woman reaches menopause. During this time, the ovaries begin to produce less oestrogen, a hormone that helps to regulate menstruation. Perimenopause can begin to occur a few years prior to menopause. Within the last two years of perimenopause, oestrogen production decreases more rapidly, which can lead to menopausal symptoms such as hot flashes, changes in libido, and vaginal dryness.

Perimenopause and menopause are often thought of as a time when women experience diminished sexual desire. While libido (sexual desire) might decrease, this idea may have more to do with prevailing social attitudes that look down upon women's expression of sexuality, after they have fulfilled their reproductive responsibilities toward the family.

Menopause: Menopause is the time a woman stops menstruating. The ovaries no longer produce eggs and release less oestrogen than before. Menopause can occur naturally as women age, any time between the ages of 40 and 60 years. It is possible for women to experience premature menopause before the age of 40 as a result of medical interventions, such as a hysterectomy, autoimmune deficiencies that can result from chemotherapy or HIV/AIDS, or genetic conditions. A woman is considered to be in menopause when she experience 12 consecutive months without menstruation.

As mentioned, menopause is often thought of as a time when women experience diminished sexual desire. While libido (sexual desire) might decrease, this idea may have more to do with prevailing social attitudes that look down upon women's expression of sexuality, particular those of older women.

Post menopause: The time after a woman has reached menopause until the end of her life. In the post menopause phase, the symptoms experienced in the perimenopausal period, such as hot flashes, can decrease. A woman can experience other physical changes primarily as a result of lower oestrogen levels during post menopause. These include decrease of fat in the genitals, thinning and drying of the vaginal mucous, and a decrease of firmness in the breasts.

Climacteric: When men begin to produce decreased levels of testosterone, usually around the age of 45 to 65. This has been likened with the female menopausal process. Unlike menopause in women, this is not often accompanied by decreased sexual libido.

As both men and women grow older, physical conditions, like diabetes and hypertension, and sometimes the use of additional medications or supplemental vitamins may have side-effects , which can affect sexual interest and performance.

Handout 1.9
Phrases and Words Related to Sexuality

- Able to have an orgasm
- Develops breasts
- Facial hair begins to grow
- Voice deepens
- Should use a condom for protection against sexually transmitted infections (STIs) including HIV/AIDS
- Experiences sexual pleasure
- At risk for a sexually transmitted infection (STI)
- Experiences desire
- Libido decreases
- Experiences menopause
- Can get pregnant
- Experiences menarche
- Experiences perimenopause
- Goes through climacteric
- Has a monogamous relationship
- Can experience sexual abuse
- Has nocturnal emissions
- Enjoys or wants to watch/use pornography/sex toys/erotic literature
- Masturbates
- Participates in sexual experimentation
- Has fantasies

Chapter 4
Pleasure and Eroticism

Chapter Objectives for the Facilitator

1. To have participants identify the role of pleasure and eroticism in sexuality and sexual health.
2. To encourage participants to discuss sexual pleasure and eroticism in a non-judgmental manner.
3. To have participants recognise the importance of integrating pleasure in safer sex messaging.

Why a Chapter on Pleasure and Eroticism

'I am too embarrassed to talk about whether something feels good sexually with my partner. What if my partner laughs at me?'

'Whether I feel pleasure during sex is not important, what is important is that my husband enjoys it.'

'Condoms don't feel good during sex, so I don't like to use them. I would rather enjoy sex.'

'How can I prolong my lovemaking? I have heard of sprays and capsules to enhance sexual performance; are they safe to use? I feel afraid that my partner will lose interest in me if I cannot satisfy her'.

'We engage in anal sex so that my partner does not have to use a condom and I don't get pregnant either. But I was told that anal sex is risky too – how?'

Pleasure is often talked about as an afterthought, as something we can 'indulge' ourselves in after we have taken care of disease, pain and abuse. The topic may also elicit feelings of discomfort or shame, and may be considered inappropriate for discussion. These common reactions to the notion of sexual pleasure indicate the need for more dialogue and an open approach to the subject that can help remove the guilt and shame surrounding the experience of pleasure. Open dialogue promotes an understanding of the range of existing sexual preferences and creates a comfortable environment for people to discuss sex and sexuality. It will be particularly beneficial for people who have been discouraged from articulating their desires, such as women, young people and older adults.

Introducing the notion of pleasure in sexual and reproductive health programmes will improve their efficacy and quality. It is important that pleasure be acknowledged as a common reason people have sex and a factor influencing their sexual choices. These choices can sometimes increase their risk of contracting sexually transmitted infections, including HIV/AIDS, and susceptibility to sexual and reproductive ill-health. Integrating sexual pleasure into sexual and reproductive health programmes acknowledges pleasure as a valid

EXERCISES IN THIS CHAPTER

Exercise 1: Sex for Pleasure? 30 minutes

Exercise 2: Creating A Pleasure Story. 60 minutes

Exercise 3: Demystifying Pleasure. 60 minutes

Exercise 4: Negotiating Pleasure. 45 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Index cards/slips of paper
Assorted items from the training area

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 1.10 Facilitator Copy: Pleasure Myths, Facts and Opinions
- Handout 1.11 Participant Copy: Pleasure Myths, Facts and Opinions
- Handout 1.12 Open-ended Case Study on Pleasure

motivation for sex. These programmes can then educate people on how to maintain the experience of sexual pleasure while practicing safer sex.

This chapter engages participants in discussions on pleasure to remove feelings of discomfort surrounding the topic. It gives them an understanding of the role of pleasure in sexuality and in the realization of sexual and reproductive health and rights. Participants will discover the connection between sexual pleasure and well-being and also understand why and how it is essential to incorporate pleasure into programmes on sexuality and public health.

Key Messages for this Chapter

- Discussing pleasure and sexuality does not need to cause discomfort. People should have the opportunity and voice to express what does and does not feel good sexually.
- Pleasure and eroticism are individual experiences. There is no wrong or right, better or worse in sexual feelings or preferences. One individual may be aroused by certain touches, smells, or thoughts while another may not.
- Different circumstances and conditions can affect or alter how we experience sexual pleasure. For example a chronic disease or disability can change a person's preference or experience of sexual pleasure. Or a woman who has been through menopause and no longer fears pregnancy may be more relaxed and therefore might experience sexual pleasure differently.
- Pleasure and eroticism are important to address in the context of sexual health and well-being in order to help people make their pleasure seeking behaviour safe and with less risk.
- Gender and power influence the way people seek and experience pleasure. For example, in some communities and cultures, men are encouraged to express pleasure and eroticism differently from women- men have the power to negotiate and ask for what may be sexually pleasurable, while women are expected to be more passive and not express what feels good.

ADDITIONAL RESOURCES:

- Betty Dodson Online. http://www.bettydodson.com
- Coalition for Positive Sexuality. http://www.positive.org
- Hendrix-Jenkins A; Clark S; Gerber W; LeFevre J; Quiroga. 2002. *Games for Adolescent Reproductive Health: An International Handbook.* Program for Appropriate Technology in Health (PATH).
- Improving Women's Sexual Lives. http://www.hesperian.org/assets/whx_8.pdf
- The Pleasure Project. http://www.the-pleasure-project.org
- Society for Human Sexuality. http://www.sexuality.org
- Women's Sexual Pleasure and Health. http://www.the-clitoris.com/
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Exercise 1
Sex for Pleasure?

BRAINSTORMING

PURPOSE OF THE EXERCISE:

To explore attitudes and ideas surrounding sex and pleasure.

TIME

30 minutes

MATERIALS

Flipcharts, Markers

ADVANCE PREPARATION

None

INSTRUCTIONS

1. Introduce the exercise to participants by asking them to express ideas, thoughts and opinions in response to the question: 'Why do you think that people have sex?' They should be encouraged to express whatever words/phrases/statements/ideas come to mind. Write each statement/idea on the flipchart as they are said. A few sample statements/ideas can also be listed on a flipchart prior to the session. In this sample list, include statements about pleasure such as 'It feels good', or 'I like to have orgasms from sex' and ask participants to add to this list. Starting with these ready statements can help participants get comfortable with the session.

2. After the group has generated a substantial list of statements and ideas, ask for comments and questions about the list.

Suggested Questions:

- Are there statements/comments on the list that address sex and pleasure? Is consideration of sexual pleasure important?
- Are there any statements on the list you disagree with?
- Why is talking about pleasure and sexual practices important?
- Is talking about sex and pleasure taboo in your communities/cultures? In what circumstances is it acceptable and why? When and why is it unacceptable?
- Do you think this list would be the same if the exercise were done with people from your family or community?

THIS EXERCISE CAN BE MODIFIED BY:

- Introducing a second question into the discussion, such as: 'Is sexual intercourse the only way to achieve sexual pleasure?' Once a comprehensive list of responses is compiled, engage participants in a discussion similar to the previous one.

MAKING CONNECTIONS

- Pleasure is a right not only for adults in a certain age/ability/ health bracket. Young people, older adults, people with disabilities or diseases also want and have the right to experience sexual pleasure. For more on sexuality through life see Chapter 3 in this Module.
- People with disabilities can also experience pleasure and sexuality. For more on disability and sexuality see Chapter 3 in Module 4.

Key Messages

- Pleasure and eroticism need to be recognised as an integral part of many sexual experiences.
- Pleasure is an important consideration in the context of sexual health and safer sexual practices. For example, some people have sex because it feels good, and this must be kept in mind when safer sex practices are being promoted. If this is one of the primary reasons people have sex, they will want a protection method that facilitates pleasure during sex rather than one that diminishes/ is thought to diminish sensations.
- It is okay to talk openly about pleasure and its place in sexual experiences. Such a discussion can reduce shame and guilt and allow for the expression of fears as well as clarify misconceptions around this issue.

TIPS FOR THE FACILITATOR:

- If participants exclude remarks related to pleasure or eroticism, make sure to introduce them into the session.
- Participants may focus on reproduction as the primary reason for sex. Help them see that sex is not only about reproduction. Sexually active people in the reproductive age group have sex for reasons other than procreation.
- Participants may focus on heterosexual relationships (i.e. man-woman sexual interactions and/or penile-vaginal penetration). Expand this focus and introduce other possibilities such as same sex relations.
- Participants may argue that pleasure is a 'luxury' and does not deserve attention when more pressing issues like disease and infection exist. Remind them that denying the role of pleasure in peoples' lives could be why disease has become such a major issue today - if it was acknowledged that people expose themselves to significant risk in pursuit of pleasure, public health messaging could be designed/ created accordingly.

Exercise 2
Creating a Pleasure Story

SMALL GROUP WORK

ADAPTED FROM PATH GAMES FOR ADOLESCENT REPRODUCTIVE HEALTH

Instructions

1. Divide the participants into small groups. Give each group one container of collected items. Ask participants to use the items to create a story titled 'Pleasure and Sexuality'. Every object in the bag should be used in the story and can be used literally or to represent something. For example, if a condom and a rock are present among the items, the group could create a story about a woman who wants to use a condom. Her boyfriend is stubborn and unyielding like the rock saying he finds condoms uncomfortable. The woman is equally stubborn and sticks resolutely to her decision about using protection, which she considers important.

2. Give the groups 30 minutes to create the story. Tell participants there will be two winners: for *The Most Creative Story* and for *The Most Erotic Story*. When telling the story they can hold up each object being used as the story goes along.

3. After each story ask the other participants for reactions and questions.

   Suggested Questions:

- How did you feel doing this exercise? How easy/difficult was it to create a story around sexual pleasure? What was easier to discuss and what more difficult?
- Was pleasure and sexuality depicted positively or negatively in the stories? Did the story describe situations common in your communities?
- Would it have been easier to create a story about violence or abuse? Why/Why not? Do we have greater ease or better language around the issue of abuse and violence than pleasure and sexuality?

Purpose of the exercise:

To comfortably discuss pleasure, eroticism and sexuality.

TIME

60 minutes

MATERIALS

1) Material collected from around the training area. These should include a wide range of objects such as bottles, food items, kitchen tools, magazines, train tickets, receipts, rocks, flowers, etc. Items can also include forms of contraception such as a condom. 2) Bags or containers to store the material.

ADVANCE PREPARATION

Gather the items and divide them into two to three separate containers. Each container should have a variety of objects (around ten items) and also include some form of contraception.

THIS EXERCISE CAN BE MODIFIED BY:

- Instructing participants to relate each object to pleasure in the story rather than allowing for metaphorical interpretations. For example, instead of stubbornness, the rock could represent something the woman likes her partner to rub on her feet for pleasure.
- Asking members of the group to bring in their own materials for the bags. Stress that these items need not be personal. Alternatively, people could be asked to pick up one item from the training area that symbolises pleasure to them.

MAKING CONNECTIONS

- People may derive sexual pleasure from a variety of sexual behaviour and practices. Individual preferences and practices must be respected as long as they are consensual and do not harm others. For more see Chapter 2 in this Module.
- Experiences of sexual violence and abuse can affect how people experience or approach sexual pleasure. For more see Chapter 1 in Module 4.

Key Messages

- How each person understands and experiences sexual pleasure is individual and subjective.
- What is considered 'appropriate' for a person or community can affect ideas of pleasure and sexuality. For example, in some cultures women are discouraged from speaking openly about what feels sexually 'good' or 'bad'. This makes them uncomfortable talking about sexuality and pleasure.
- It can be enjoyable and exciting to talk about pleasure and sexuality. However, the language around pleasure is limited. Language that is more familiar is from popular erotic literature and films, and is often derogatory. Since people do not discuss sexual pleasure openly, they may find it difficult to think about or describe it in a positive way, which may contribute to the discomfort felt during such a conversation.

TIPS FOR THE FACILITATOR:

- Participants may be uncomfortable sharing thoughts and ideas about sexual pleasure. In this case, do not force them to participate. Encourage them to speak up while in the smaller groups.
- Participants may create stories linked only to penile-vaginal sex within marriage. Encourage integration of other forms of sexual experiences into the discussion, such as same sex eroticism and fantasy. Conversely, they may create stories that describe sexual pleasure only in the context of 'illicit' behaviour. For example, a married man has an affair or a woman decides to become a sex worker 'to fulfil their desires'. Point out that sexual pleasure can be experienced during different interactions and not just 'illicit' situations.
- Participants may focus on stories in which men experience more pleasure than women, validating men's pursuit of sexual pleasure and ignoring a similar motivation in women. Make sure these biases are avoided and there is discussion around such judgements.
- If participants find it difficult to create a story suggest an outline or a framework to the story.

Exercise 3
Myths, Facts and Opinions on Sexuality and Pleasure

Instructions

1. Distribute Handout 1.11 to the participants. Ask each participant to read one statement from the handout aloud and respond to it: Do they think the statement about pleasure is a fact or myth? Or what is their opinion on the statement? After each has responded, ask the others whether they agree or disagree and why. It is not necessary to let the group know immediately whether the statement is a myth or fact. First allow for conversation and discussion.

2. After the group discussion, tell the participants why the statement is a myth or fact. Bring up issues that were not introduced or talked about by the group (refer to Handout 1.10. Have the rest of the participants read out their statements one by one and follow the same process. After everyone has read out the statement ask for general questions or comments.

Suggested Questions:

- Were you surprised by any of the statements? Did you believe some to be either myths or facts and discover the opposite to be true?
- Are there any other statements you commonly hear or wonder about regarding sexuality and pleasure? What are these?

Purpose of the exercise:

1. To dispel myths and misconceptions about pleasure and sexuality.

2. To explore opinions and ideas about sexuality and pleasure.

TIME

60 minutes

MATERIALS

Flipchart, markers, index cards/slips of paper, Handout 1.10 Facilitator Copy: Pleasure Myths, Facts and Opinions, Handout 1.11 Participant Copy: Pleasure Myths, Facts and Opinions

ADVANCE PREPARATION

Copy or write he statements from Handout 1.11 on separate index cards. Make copies of Handout 1.11 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Linking it to a discussion of sexual problems and their medicalisation (Chapter 5 in Module 2). Emphasise that the sexual response cycle is only a model and not a set way in which each person will or should experience pleasure. Some questions to pose for participants after going over the model of sexual response could be: Were you surprised that the sexual response has been studied and that there is a 'scientific' process to describe sex and pleasure?

MAKING CONNECTIONS

- People derive sexual pleasure in a variety of ways and this must be respected as long as this is consensual and does not harm others. For more see Chapter 2 in this Module.
- While sexuality and pleasure are not only bodily experiences, knowledge of our sexual anatomy and physiology helps enhance the experience of sexual pleasure. For more see Chapter 1 in Module 2.

Key Messages

- Pleasure is an individual feeling. There are no rules on how to experience sexual pleasure.
- Men and women may experience pleasure differently. It is important to address the concerns and experiences of both.
- All individuals have the right to experience sexual pleasure and express this in any manner they feel comfortable, as long as they do not infringe on another's rights.
- Pleasure can be experienced in many different ways: Through penetrative sex, manual stimulation, hugging, kissing, lying next to each another etc. Pleasure is experienced not only through physical experiences, but mental and emotional ones too.

TIPS FOR THE FACILITATOR:

- Participants may want to share their own personal experiences related to the statements. Acknowledge these contributions, but stress that each person's sexual pleasure cannot be addressed in this exercise.

Exercise 4
Negotiating Pleasure

CASE STUDIES/ROLE-PLAYS

INSTRUCTIONS

1. Distribute the case studies chosen from Handout 1.12 to each participant. Give them 5-10 minutes to read over the case studies and related questions.

2. Begin with one case study and invite participants to describe what they see as the next steps for the character.

   Suggested Questions:

- Does the character have options and choices?
- What is the best choice for the character to make?

3. Have two participants volunteer to carry out a conversation that could develop between characters in the case study. The conversation can be used to demonstrate how to share and negotiate pleasurable and safe sexual practices. After the role-play ask for questions and comments:

   Suggested Questions:

- Do you agree with the way the conversation unfolded? Do you think the conversation was unrealistic? Have you had to negotiate sexual pleasure in a similar way?
- Do you think it is necessary for us to get rid of barriers to pleasure before we can talk about sexual pleasure? For example, address sexually transmitted infections with people before discussing pleasure. Why?

4. Ask participants to consider a scenario in which the roles are reversed.

   Suggested Question:

- Would changing gender roles allow for different choices or make the conversation different between the characters? How?

5. Move to the next case study and conduct a similar exercise with the same questions as above.

PURPOSE OF THE EXERCISE:

1. To discuss the ways in which pleasure and eroticism can be negotiated in relationships or situations.

2. To recognise the diversity of actions and experiences people may find pleasurable.

3. To examine the links between sexuality and behaviour from a public health point of view.

TIME

60 minutes

MATERIALS

Handout 1.12 Open-ended Case Study on Pleasure

ADVANCE PREPARATION

Choose 1-3 of the four case studies from Handout 1.12 and make copies of the case studies for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into three small groups and asking each group to read one of the case studies and present the situation and discussions.
- Conducting fewer case studies. This may allow for a more in-depth discussion about a given scenario and is especially useful if there is limited time in the session.

MAKING CONNECTIONS

- Sexual problems can also affect how a person negotiates or talks about what is sexually pleasurable. For more see Chapter 5 in Module 2.
- Any discussion or negotiation about sexual pleasure should also include safer sex practices. This will reduce the likelihood of acquiring a sexually transmitted infection including HIV/AIDS. For more on see Chapter 4 in Module 2.

Key Messages

- Negotiating pleasure is the process of reaching agreement on safer and more pleasurable sexual decisions.
- Comfort around acknowledging and articulating one's desires is crucial to negotiating for pleasure and safety.
- Some people believe that the elimination of disease or risk of contracting STIs including HIV/AIDS, violence or fear of violence is essential before one can focus on sexual pleasure. Acknowledging pleasure is however, necessary to effectively address and balance sexual pleasure with risk.

TIPS FOR THE FACILITATOR:

- Participants may assume that negotiations only happen within heterosexual relationships. Introduce other options or ask participants whether they assume the meaning of the word 'partner' in a case study means a partner of another gender. Does it make a difference if they assume there are only heterosexual relationships?
- If group members are uncomfortable with each another, they may feel awkward role-playing intimate situations. Ask them to then act out the part of other members of the family/society. This may help identify societal values and influences that directly or indirectly influence partners and make participants more comfortable with the exercise.

Handout 1.10
Facilitator Copy: Pleasure Myths, Facts and Opinions

- **It is my right to experience sexual pleasure.**

  FACT: All individuals have the right to experience and express sexual pleasure in any manner they feel comfortable, as long as they do not infringe on others' rights.

- **Women have sex for love; men have sex for pleasure.**

  MYTH: Individuals have sex for diverse reasons and these cannot be categorised based on gender. Many societies have such mistaken ideas about men and women's preference for sex as reflected in this statement. All people have the right to choose to have sex for any number of reasons, regardless of their gender.

- **Men can always be aroused by the idea of sex and can get an erection immediately.**

  MYTH: Men are not always sexually aroused. Even if they are aroused they may not get an erection immediately. This does **not** mean there is something wrong or that they do not desire their partners.

- **All people feel sexual desire in the same way.**

  MYTH: In the same way that sexuality is an individual experience, desire is experienced differently by each person and even for the same person at different times, depending on various factors (life circumstances, health, stress levels, relationship issues etc).

- **Women can have an orgasm only through penetrative sex.**

  MYTH: Women can experience orgasms through clitoral stimulation and stimulation of other parts of their bodies, not just through (vaginal or anal) penetrative sex.

- **It is possible to sustain a marriage or relationship without sexual pleasure.**

  OPINION: For some people, sexual pleasure must be part of a healthy relationship. Others feel that this is not essential to maintaining a marriage/relationship. Again, this varies for people at different times in their lives.

- **The aim of sex is to have pleasure.**

  OPINION: Some people have sex to experience pleasure, while others may enjoy it for the feeling of intimacy or power or for procreation. People can also experience sexual pleasure from acts other than sex, for example touching each another or watching erotic films or reading sexually explicit literature.

- **You can experience pleasure only if you are monogamous or married.**

  MYTH: Many people experience pleasure in a variety of sexual situations, not all within a marriage or a monogamous relationship. There should not be moral judgements imposed on these choices and experiences.

- **Pleasure is an integral part of well-being.**

  FACT: Pleasure is essential to well-being, whether it be sexual, emotional, physical or mental.

- **Sex is the only way to achieve pleasure.**

  MYTH: Pleasure can be experienced in many different ways: Through penetrative sex, manual stimulation, hugging, kissing, lying next to each another etc. Pleasure is experienced not only through physical experiences, but mental and emotional ones too.

- **Disease and pain must be eliminated before we can address pleasure in a public health dialogue.**

  OPINION: Some people believe pleasure to be a 'luxury' and that the elimination of disease or risk of contracting STIs including HIV/AIDS, violence or fear of violence is essential before one can focus on sexual pleasure. Others believe that sexual pleasure is necessary to well-being. Acknowledging pleasure is necessary to effectively address and balance sexual pleasure with risk.

- **Sexual pleasure derived from causing or receiving pain during sex (such as sadomasochism) is abnormal/unnatural.**

  MYTH: Sexual pleasure is experienced in different ways. Any kind of sexual activity is acceptable as long as it is consensual and does not harm anyone. It is wrong to categorise certain sexual practices as wrong or abnormal.

- **Young people have a right to experience sexual pleasure.**

  FACT: Young people have the right to experience sexual pleasure and should have access to information and contraception to protect themselves.

- **The use of toys and technology is acceptable for the attainment of pleasure.**

  FACT: Individuals may enjoy using toys, technologies, food, or other 'aids' to experience pleasure. As long as the use of these methods is consensual, there is nothing wrong in enjoying them. The usual precautions related to cleanliness and hygiene will protect against infection and injury and enhance the experience of pleasure.

- **Pleasure can be experienced between people of the same gender.**

  FACT: Homosexual, transgendered, transsexual, intersexed, queer, and heterosexual people can all experience sexual pleasure. People can choose to practice and experience pleasure differently with people of the same or different gender.

- **Men need sex more than women.**

  MYTH: In some societies it is erroneously believed that men's desires should be considered before women's and that only men should experience sexual pleasure. However, all people, regardless of their gender can have sexual desires and have the right to express themselves sexually.

- **It is acceptable to have different fantasies and notions of pleasure.**

  FACT: Fantasies and desires are individual and experienced differently. They are not 'wrong' as long as they do not infringe on others' space or rights in any way.

- **People past the reproductive age should not be allowed to experience sexual pleasure and talk openly about it.**

  MYTH: Older adults experience sexual desire and should have the space to discuss it. In many cultures this is taboo and it is believed that after a certain age people should not be involved in sexual activity. This causes many older adults to repress their desires or feel guilty for experiencing them, to the detriment of their well-being.

- **Penile-vaginal sex is the only normal and acceptable way to have sex and experience pleasure.**

  MYTH: There are many ways to experience sexual pleasure, including oral sex, anal sex, cuddling after sex, massaging a partner etc.

- **It is not good to have sex during pregnancy.**

  MYTH: Though penile-vaginal intercourse is sometimes not advisable in the first three and last two months of a pregnancy, pleasure can be given and received through activities other than intercourse. It is important for any sexual activity to be consensual, and also that care be taken. Unless there are clear instructions from the doctor to abstain as in the case of a difficult pregnancy, there is no reason a couple cannot be sexually active throughout the woman's pregnancy. Activities like mutual masturbation and oral sex can be engaged in until the end of term.

- **Women can experience multiple orgasms.**

  FACT: Some women can experience one orgasm after another if stimulation continues. However not all women experience multiple orgasms and this is not a sign of a problem.

- **Using alcohol or drugs can increase sexual pleasure.**

  OPINION: Some people believe that alcohol and drugs increase sexual pleasure but for many they can lead to sexual problems. This depends on the quantity of alcohol consumed, whether the person is a frequent drinker or not, etc.

Handout 1.11
Participant Copy: Pleasure Myths, Facts and Opinions

Please state whether you think each statement is a myth, a fact, or a matter of opinion.

- It is my right to experience sexual pleasure.
- Women have sex for love; men have sex for pleasure.
- Men can always get aroused by the idea of sex and can therefore get an erection immediately.
- All people feel sexual desire in the same way.
- Women can have an orgasm only through penetrative sex.
- It is possible to sustain a marriage or relationship without sexual pleasure.
- The aim of sex is just to have pleasure.
- You can only have pleasure if you are monogamous or married.
- Pleasure is an integral part of well-being.
- Sex is the only way to achieve pleasure.
- Disease and pain must be eliminated before we can address pleasure in a public health dialogue.
- Sexual pleasure derived from causing or receiving pain during sex (such as sadomasochism) is abnormal/unnatural.
- Young people have a right to experience sexual pleasure.
- It is acceptable to use toys, technologies and other objects to experience pleasure.
- Pleasure can be experienced between people of the same sex.
- Men need sex more than women.
- It is acceptable to have fantasies and different ideas about pleasure.
- People past the reproductive age should not be allowed to experience sexual pleasure and talk openly about it.
- Penile-vaginal sex is the only normal and acceptable way to have sex and experience pleasure.
- It is not good to have sex during pregnancy.
- Women can experience multiple orgasms.
- Using alcohol or drugs can increase sexual pleasure.

Handout 1.12
Open-Ended Case Study on Pleasure

Case 1.

Amrita and her husband Sanjeev have been married for five years. They are happy: Sanjeev has a job he enjoys and Amrita is content staying home for the time being and caring for their two children. The couple has discussed having more children but have decided that this is not the right time for this. Even though they have maintained an active sexual relationship, after the birth of their children they have not used any kind of contraception. Now that they decided to postpone having more children, Amrita thinks they should start using contraceptive protection. She has suggested condoms since she is concerned that the oral contraceptive will make it hard if she wants to conceive later. Sanjeev does not like using condoms; he feels they hurt and reduce the sensation during sex. Because of their lack of agreement over this issue, their sexual life has turned cold. Both Amrita and Sanjeev are frustrated and realise that something needs to change.

How can they negotiate this situation better?
What are other options?
How would you handle this situation?

Construct a role-play and dialogue between Sanjeev and Amrita.

NOTE FOR THE FACILITATOR:

- Go through the chapter on contraception and list the contraceptive choices that exist for the couple.
- Help participants identify the issues related to pleasure for both partners as well as options to change this situation. For example, Amrita's fear of a pregnancy can inhibit her sexual responses and reduce pleasure. To change this, Amrita and Sanjeev need more information, i.e. that the oral contraceptives do not affect a woman's return to fertility once she discontinues them; that there are a variety of textured condoms that can enhance pleasure, or that they can engage in non-penetrative activities that can also be pleasurable until they agree on a contraceptive option.

Case 2.

Andy is 23. He and his partner have a wonderful sex life. Lately however, his partner has become distant and unresponsive in bed. Andy notices that his partner also avoids being touched as intimately as before. Andy is not sure what to do. Should he confront his partner, try out some new moves in bed or find someone else? He loves being in this relationship and does not want it to break up. He approaches his friend for help.

Create a role-play between Andy and this friend.

NOTE FOR THE FACILITATOR:

- The case study does not specify the gender of Andy's partner. Observe the attitude and assumptions participants have made, reflected in their role-play. Have they assumed that Andy's partner is a woman? Highlight the disadvantages of this assumption.
- List out possible reasons for the change in Andy's partner's behaviour before conducting the exercise.

Case 5

Neetu has been with her partner Amit for many years and the two of them are happy. Lately, however, Neetu has been dissatisfied with their sex-life: It feels distant and unsatisfying. She does not know how to broach the subject comfortably with her partner. They have never really talked about sex before. Amit is also the only sexual partner Neetu has ever had, which makes this discussion even more difficult for her. She also wants to talk about using new types of protection and is unsure about how to do this. She loves her partner very much but is intimidated by the idea of this conversation. How should she go about it?

Construct a role-play and dialogue between Neetu and Amit on sexual pleasure.

NOTE FOR THE FACILITATOR:

- Help participants discuss possible reasons for Neetu's hesitation about talking to Amit. This would include taboos about discussing one's own pleasure; fear that he may have other partners which may be related to Neetu's desire for newer forms of protection; fear that the current form of protection is inadequate or reduces pleasure for either of them.

MODULE 2
Sexual and Reproductive Health

Introduction

While sexuality is not restricted to the physical body, it is largely experienced and expressed through the body. In addition, achieving individual health and well-being requires a full understanding of our bodies, how our bodies work, how we can protect ourselves from infection, and what can be done to eliminate misinformation around these issues that lead to stigma and discrimination.

Module 2 is an information-based module that provides this basic understanding. It includes information on human sexual and reproductive anatomy and physiology, conception, contraception, abortion, infertility, sexual problems, sexually transmitted infections (STIs) and HIV/AIDS. Beyond a basic understanding of facts, the chapters explore attitudes and ideas on these issues and also link them to values and human rights. For example, it includes discussions surrounding an individual's right to have/not have children and the rights of HIV positive people to marry.

Module 2
Sexual and Reproductive Health

Chapter 1: Sexual and Reproductive Anatomy & Physiology

- Exercise 1: Quiz: Sexual and Reproductive Anatomy and Physiology — 15 minutes
- Exercise 2: Creating the Anatomy — 60 minutes
- Exercise 3: Identifying the Anatomy — 60 minutes
- Exercise 4: Sexual and Reproductive Physiology — 60 minutes

Chapter 2: Conception, Contraception, Abortion

- Exercise 1: Quiz: Conception, Contraception and Abortion — 15 minutes
- Exercise 2: Conception Basics — 75 minutes
- Exercise 3: Charting Contraception Choices — 30 minutes
- Exercise 4: Abortion Basics — 30 minutes
- Exercise 5: My Views on Abortion and Contraception — 60 minutes

Chapter 3: Infertility & Assisted Reproductive Technologies

- Exercise 1: Demystifying Infertility — 45 minutes
- Exercise 2: Infertility Basics — 60 minutes
- Exercise 3: Looking at Options: Fertility Treatments — 60 minutes
- Exercise 4: Case Studies: Options To Deal With Infertility — 60 minutes

Chapter 4: HIV/AIDS, STIs and RTIs

- Exercise 1: HIV/AIDS Basics — 60 minutes
- Exercise 2: HIV/AIDS: Testing, Treatment, Care and Support — 60 minutes
- Exercise 3: My Views on HIV/AIDS — 60 minutes
- Exercise 4: Quiz: STIs and RTIs — 15 minutes
- Exercise 5: Talking About STIs/RTIs — 45 minutes
- Exercise 6: Examining Attitudes Associated With HIV/AIDS and STIs — 45 minutes

Chapter 5: Sexual Problems

- Exercise 1: Demystifying Sexual Problems — 45 minutes
- Exercise 2: Medical Solutions, the Only Answer? — 60 minutes
- Exercise 3: My Views on Sexual Problems — 60 minutes
- Exercise 4: Case Studies on Sexual Problems — 60 minutes

Assessment for Module 2 Sexual and Reproductive Health

At the end of this module the facilitator can conduct an assessment. This assessment can be used to evaluate increase in participant knowledge, changes in attitudes, preferences for different exercises, and opinions on the facilitator's skills. For this module, an assessment can be done using the following tools:

- Administering the quizzes after the sessions as post-test assessments.
- Using the facilitator preparation exercises for this module found in Chapter 1 *Preparing to Train.*
- Adapting one of the sample assessment forms found in Chapter 2 *Preparing to Train.*
- Developing a new assessment depending on the type of information the facilitator wants to uncover.

Sample Training Schedule

A blank template of a training schedule as well as a sample seven-day training schedule can be found in *Preparing to Train*. Depending on the focus of the training and the topics it aims to cover, the facilitator can fill in the blank schedule with exercises from this module or in combination with exercises from other modules.

Chapter 1
Sexual and Reproductive Anatomy and Physiology

Chapter Objectives for the Facilitator

1. To have participants identify and describe the parts and functions of the human sexual and reproductive anatomy.
2. To have participants explore the different beliefs associated with sexual and reproductive anatomy and physiology.
3. To facilitate participant discussion on mental and emotional health in relation to sexual and reproductive anatomy and physiology.

ADDITIONAL RESOURCES:

- Birds and Bees. http://www.birdsandbees.org
- EngenderHealth. 2003. *Comprehensive Counselling for Reproductive Health: Trainer's Manual*. New York: EngenderHealth.
- Family Health International. *Contraceptive Technology and Reproductive Health Series Modules*. Available at: http://www.fhi.org/en/RH/Training/trainmat/Modules/index.htm
- Reproductive Health Online, a service of JHPIEGO, an affiliate of Johns Hopkins University. http://www.reproline.jhu.edu
- Irvin, A. 2004. 'Chapter 3: Anatomy, Physiology and Puberty'. *Positively Informed: Lesson Plans and Guidance for Sexuality Educators and Advocates*. New York: International Women's Health Coalition.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

This chapter gives participants an overview of the human sexual and reproductive organs (anatomy) and how these organs work (physiology). The chapter also explores the mental and emotional connections people have with their bodies and links anatomy and physiology to cultural, social and religious beliefs associated with these topics.

Key Messages for this Chapter

- An accurate understanding of the body and its functions empowers people and helps them make better decisions about their sexuality and sexual and reproductive health.
- People do not always enter into sexual relationships with reproduction in mind. The body can provide pleasure and sex can be independent of reproduction.
- Sexual pleasure is experienced through different parts of the body. An understanding of this should go hand in hand with understanding the body's reproductive functions. For example, a woman's breasts can be used for breast-feeding, but are also a source of sexual pleasure.
- In today's world sexuality is equated with youth, beauty and having a perfect body. For young people especially, the pressure to conform to prevalent standards of beauty can be immense. Those who do not conform may feel unattractive, and this affects their self- and body image. This is also true for people with disabilities.
- Body image can influence how people behave and express their sexuality, and how they treat their bodies. For example, if a woman feels good about the way she looks she may be more comfortable expressing her sexuality and take better care of her health and body.
- There is a connection between the body and emotional health. For example, if a woman has a mastectomy (removal of her breasts) it may impact her sexual expression and how she feels about her body and self.

Exercise 1
Quiz: Sexual and Reproductive Anatomy and Physiology

QUIZ

Instructions

1. Distribute copies of Handout 2.2 to each participant. Explain that this quiz will not be 'graded' and the level of performance has no bearing on participation in the training. The quiz will be used to ensure that gaps in participant information are addressed during the training. The quiz can also be distributed the day before beginning the chapter in order to tailor the information and chapter exercises to the needs and strengths of the group. The facilitator can choose to give participants the option of responding anonymously to the quiz. Give them 10 minutes to answer the questions.

2. Have participants return the quizzes and correct the answer sheets during a break or while the group works on the next exercise. Note areas of knowledge and gaps.

Purpose of the exercise:

1. To have participants assess their own knowledge and beliefs about human sexual and reproductive anatomy and physiology.

2. To evaluate participant knowledge, understanding and beliefs and to note gaps in information and misconceptions to be addressed in the topics in question.

TIME

10 minutes

MATERIALS

Handout 2.1 Facilitator Copy: True and False Quiz on Sexual and Reproductive Anatomy and Physiology, Handout 2.2 Participant Copy: True and False Quiz on Sexual and Reproductive Anatomy and Physiology, pens/pencils

ADVANCE PREPARATION

Make copies of Handout 2.2 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into two teams and conducting the exercise like a game using the questions from Handout 2.1. Each correct answer can earn the team a point and the winning team can be given a prize at the end.
- Combining this quiz with the other true/false and myth/fact exercises from this module into a larger quiz that can be played at the beginning/ end of the module.

MAKING CONNECTIONS:

- People with disabilities also have a right to information on sexual and reproductive anatomy and physiology. For more see Chapter 3 in Module 4.
- As we move from childhood to adulthood, our bodies can change. These are not always negative changes and do not necessarily diminish our sexuality. For more see Chapter 3 in Module 1.

Key Messages

- Emphasise that this exercise is not being graded. While this does not diminish its seriousness, participants should not worry about any areas or questions they are unsure of and answer the questions to the best of their ability.

TIPS FOR THE FACILITATOR:

- Before handing out the quiz, participants should be given a brief introduction to the exercise and its purpose in order to alleviate discomfort or fears about the format.
- It may be beneficial for the facilitator to give participants the quiz a few hours or one day before starting the chapter. This way, the training can be tailored to participant needs. For example, if the group has extensive knowledge of anatomy, it may be best to focus on some of the attitude exercises in the chapter.
- Making the quiz anonymous can reduce pressure on the participants and will still allow the facilitator to assess the information levels of the group.
- The quiz can be administered again at the end of the chapter to assess what participants have learned or subjects they still need information on.

Exercise 2
Creating the Anatomy

SMALL GROUP WORK

Instructions

1. Divide participants into four groups. Hand out flipchart paper, newspapers, markers and tape to the groups. Assign two groups to use the material to construct a woman's sexual and reproductive anatomy and two groups to construct a man's sexual and reproductive anatomy. Participants can interpret the assignment in any way they are comfortable with: they can tape flipchart paper and newspaper together and draw the outline of the body of one volunteer from the group and then complete the anatomy; they can each draw sexual and reproductive anatomy on separate sheets of paper etc. Give the groups 20-30 minutes to complete the assignment.

2. Bring the groups back together and have participants present their work. Ask them to share how they developed their anatomies. After all the presentations, ask for questions and comments.

Suggested Questions:

- How did you feel doing this exercise? Uncomfortable, embarrassed etc.?
- How did your group choose a method to create the anatomy? Did your approach have a connection to your comfort levels discussing the sexual and reproductive anatomy?
- If it was a mixed group, did either the men or women dominate the exercise? Why?
- What are the benefits to having accurate information on how the body works?
- Have any individuals been left out in these drawings? What about intersexed or transgendered people?

Purpose of the exercise:

1. To explore personal attitudes and ideas about the physical body.

2. To discuss links between cultural and social beliefs and sexual and reproductive anatomy and physiology.

TIME

60 minutes

MATERIALS

Flipchart, newspapers, markers, tape

ADVANCE PREPARATION

Review Handout 2.3 Facilitator Copy: Diagrams of the Human Sexual and Reproductive Anatomy and Its Physiology (All 3 Diagrams and 1 Key for Male Anatomy)

THIS EXERCISE CAN BE MODIFIED BY:

- Collecting objects from around the training area, such as string, bottles, food, and clothing and using these to construct a model of sexual and reproductive anatomy and physiology. This can be good for low-literacy groups, people in rural communities, or groups who only need a refresher on this information.

MAKING CONNECTIONS

- Comfort about talking about the body is an important part of sexuality and well-being. For more see Chapter 1 in Module 1.
- Knowledge of our bodies can help us experience pleasure. For more see Chapter 3 in Module 1.

Key Messages

- It is common to experience discomfort when talking about sexual and reproductive anatomy. Many cultures and communities may also consider it inappropriate to have such discussions.
- The manner in which groups choose to draw the sexual and reproductive anatomy may be significant. Drawing each organ separately rather than outlining the body of someone in the group may indicate the discomfort some people feel around talking about the body.
- Silence and discomfort when talking about these issues can lead to misinformation and perpetuate myths around conception, contraception, sexual and reproductive health. This can affect an individual's mental and emotional health.
- Individuals working in the field of sexuality, sexual and reproductive health need to be comfortable talking about sexual and reproductive organs. This will enable them to impart information in a matter-of-fact manner to their audience and break through the shame and the silence around the topic.
- Possessing certain physical characteristics is not always associated with a particular gender identity. For example, an individual may identify as a man but not have a penis, or may identify as transgendered and have a penis. Individuals have a right to express their gender identity and should not be forced to conform to the 'traditional' gender categories.

TIPS FOR THE FACILITATOR:

- Participants may focus on just the reproductive anatomy, for example depicting only the vagina but not the clitoris. If this occurs point it out and ask groups why they think this happened.
- Men may feel uncomfortable being asked to depict women's organs and vice versa. To promote comfort, participants can be divided into groups based on gender. Integrating the groups on the other hand, can also lead to discussions on how men represent women and vice versa. Facilitators can use their discretion to decide how they want to divide up the participants.

Exercise 3
Learning Human Anatomy

LECTURETTE AND GROUP WORK

Instructions

1. Introduce the exercise, explaining that participants will be labelling and discussing different parts of the sexual and reproductive anatomy. While this may be a review for some, emphasise that this exercise is intended to ensure that all participants are at the same level of understanding.

2. Distribute Handout 2.4 (all 3 Diagrams). Begin with either the male or female external anatomy and continue to the corresponding internal anatomy. Go through each labeled part in the diagrams and invite participants to name the body part. If participants do not know the answer, tell them the name. Ask them to label their diagrams accordingly.

3. After each part has been labelled correctly, ask participants to describe the structure and function of each part. For example, 'the clitoris is a tiny, pea-sized organ above the urinary opening, hidden within the folds of the vagina, where the inner lips join. It is extremely sensitive to touch and when stimulated becomes firmer and slightly bigger. The only purpose of the clitoris is to provide sexual pleasure.' Fill in information not mentioned by participants from Handout 2.3.

4. After going over the diagrams of male and female anatomy, ask for questions and comments.

Suggested Questions:

- What information was new to you? How does knowing about the parts and functions of the body affect your understanding of sexuality?
- Are there other names for parts of the sexual and reproductive anatomy? For instance some may know other words for penis or clitoris. What impact does using these types of words have in discussions of sexuality and health?
- After going through this exercise, do you feel more comfortable with the sexual and reproductive parts? Would you feel comfortable going home and using a mirror to look at your own genitals, if you have not done so before?

Purpose of the exercise:

1. To identify and label the parts of human sexual and reproductive anatomy.

2. To describe the function of each part of the human sexual and reproductive system.

3. To explore feelings of self-image related to anatomy and physiology.

TIME

60 minutes

MATERIALS

Handout 2.3 Facilitator Copy: Diagrams of the Human Sexual and Reproductive Anatomy and Its Physiology (all 3 Diagrams and Key for Male Anatomy), Handout 2.4 Participant Copy: Diagrams of the Human Sexual and Reproductive Anatomy and Its Physiology (all 3 Diagrams)

ADVANCE PREPARATIONS

Make copies of Handout 2.4; review Handout 2.3.

THIS EXERCISE CAN BE MODIFIED BY:

Using markers and pencils to colour the diagrams indicating areas participants are familiar or unfamiliar with. Unfamiliar areas can be reviewed in a large group and all participants can be given a copy of the Handout 2.3 to review by themselves.

MAKING CONNECTIONS

- Disabled people also have the right to information about sexual and reproductive anatomy. For more see Chapter 3 in Module 3.
- As we grow older our bodies can change. This does not however necessarily diminish our sexuality. For more see Chapter 3 in Module 1.

5. End the session by giving participants markers or pencils and asking them to shade in or colour parts of the body that give them pleasure. If they are comfortable ask them to share what they shaded or coloured and why.

Key Messages

- Having an accurate and clear understanding of the body and its functions is empowering and valuable for a discussion on sexual and reproductive health and sexuality.
- Language used for sexual anatomy can be negative and derogatory, taking away from positive feelings of sexual well-being and pleasure. For example, using negative names for a woman's breasts can make her feel ashamed and uncomfortable with this part of her body and feel embarrassed by pleasure she derives from them.
- Incomplete information or misinformation about our bodies can sometimes lead to worry or fear. It can also make individuals hesitant to seek help when they have health care needs that require attention.
- Sexuality is not restricted to our bodies or to certain body parts alone. But sexuality may be largely expressed and experienced through our bodies, including our external/physical anatomy where we experience pleasure and sensations.

TIPS FOR THE FACILITATOR:

- Lecturette exercises can be information-heavy and dull. Ensure that participants are engaged by asking questions and taking breaks if necessary.

Exercise 4
Sexual and Reproductive Physiology

SMALL GROUP WORK

Instructions

1. Divide participants into small groups. Distribute Handout 2.5 to each group. Ask each group to discuss ways in which different body parts function as sexual and reproductive organs. For example, for a woman's breasts, they can say that their reproductive function is lactation, which allows a mother to nurse her child. At the same time, the breasts also give and feel sexual pleasure. Give the group 10 minutes to discuss and identify the body parts.

2. Bring the participants back together in a large group and invite them to share their discussions. Afterwards ask for questions and comments.

Suggested Questions:

- Are there other parts of the body you believe share a dual role of being sexual and reproductive? Are there any parts of the anatomy that have only a sexual function?
- Is it important to learn about sexual physiology? Why?
- Do you feel comfortable talking about sexual pleasure and parts of the body that can give sexual pleasure with people in your community? Is it a taboo topic? How can these discussions be made more comfortable and less taboo?
- What if a person does not have some of these body parts? For example, a woman who has had breast removal or mastectomy? How does this change their sexuality, if at all or diminish their 'womanhood'/'manhood'/'personhood'?

Purpose of the exercise:

To discuss the similarities and differences in sexual and reproductive physiology.

TIME

45 minutes

MATERIALS

Handout 2.5 Sexual and Reproductive Physiology

ADVANCE PREPARATION

Make copies of Handout 2.5 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Discussing and conducting the discussion in a large group rather than in smaller groups. This may be suitable for groups more comfortable with the topic.

MAKING CONNECTIONS:

- There are similarities as well as differences between sexual and reproductive health and rights. For more see Chapters 2 and 3 in Module 3.
- Information about the body is useful for all people: those in the reproductive age-group, younger and older people. All people have the right to this information. For more see Chapter 3 in Module 1.

Key Messages

- It is important to recognise sexual functions and pleasure that can be derived from parts of the body. This is separate from but can go hand in hand with understanding reproductive functions of the body.
- Mastectomies or other procedures can change sexual and reproductive physiology. This does not necessarily mean there is a diminished sexuality or that a person is less of a woman or man or sexual being.
- Sexuality is not restricted to our bodies or to certain body parts. However, sexuality is largely expressed and experienced through our bodies, and it is therefore important to know about sexual anatomy and physiology.

TIPS FOR THE FACILITATOR:

- Participants may only focus on the reproductive functions of the body and particularly the role of women in reproduction. Emphasise that beyond this, the body also provides sexual pleasure. People can also choose not to reproduce and still express their sexuality and experience sexual pleasure.
- Participants may be uncomfortable or try to avoid a discussion of the body in relation to pleasure and sexuality. Introduce questions if participants continue to avoid the topic, for example, 'Do you think it is wrong to talk about the sexual role of the body? Why?' 'Can the body serve sexual as well as reproductive functions?'

Handout 2.1 Facilitator Copy: Quiz on Sexual and Reproductive Anatomy and Physiology

Please write if the statement below is true (T) or false (F)

- **The fallopian tubes are two small tubes through which an egg travels into the uterus.**
  TRUE: During ovulation, an egg is released from an ovary and travels down through the fallopian tube into the uterus.

- **The primary sex gland for men is the testes.**
  TRUE: Testes produce sperm and male hormones called androgens. The testes are two egg-shaped organs located in two hanging sacs called the scrotum. The scrotum is located behind the penis.

- **Penile size can be increased with exercise, massage or medicine.**
  FALSE: Penile size cannot be increased with medicine, massage or exercise and the size and length of a person's penis is not an indication of fertility, sexual potential, or strength.

- **Having an erection in the morning means that a man is over-sexed.**
  FALSE: Many men throughout their lifespan will wake up with an erection and this does not mean they are over-sexed. These reflex erections occur during sleep and have been observed even in infancy.

- **The clitoris regulates female hormone production.**
  FALSE: The clitoris is a pea-sized organ in women situated above the urethra (urinary opening), where the inner lips of the vagina join. The function of the clitoris is for sexual pleasure, not hormone production.

- **Semen is not made up of blood. The quality and quantity of semen varies in men.**
  TRUE: Semen is a thick, white/off-white coloured fluid that comes out of the penis and is made up of sperm and other substances including sugar, water, enzymes and proteins, but NOT blood. The amount and quality of semen varies from man to man, and the amount produced can vary over time for the same man as well.

- **When semen comes out of the penis at night, this is called a nocturnal emission and is a common and normal occurrence, unrelated to sexual feelings or desires.**
  TRUE: Nocturnal emissions, also called wet dreams or 'night fall', are a normal and common occurrence that usually begins sometime during puberty.

- **A woman's breast size can be increased with massage and massage oils.**
  FALSE: Massaging breasts will not increase their size. Breast size and shape can change over time with age, with changes in weight or muscle mass, from taking certain hormonal contraceptives or from surgery.

- **The size of a woman's breasts can indicate her interest in sex or her ability to receive or give sexual pleasure.**
  FALSE: A woman's breast size has no bearing on her interest in sex or ability to experience or give sexual pleasure.

- **The vulva is made up of a woman's external genitals that include the outer lips, inner lips, mons pubis, clitoris, clitoral hood, and vaginal opening.**
  TRUE: These organs are included in the vulva and vary in colour, shape and size from woman to woman.

- **The G-spot is the source of a woman's sexual pleasure.**
  FALSE: The G-spot is named after Grafenberg, the person who discovered it . It has been described as a small nodule of tissue in the vagina that swells when a woman is aroused and can cause heightened sexual pleasure. However the existence of this spot and its function is not wholly agreed upon. Women have different sources/zones of pleasure, which may/not include nipples, clitoris and vagina.

- **Circumcision is a practice that removes a man's external genital organs.**
  FALSE: Circumcision is a procedure performed on a man to remove the foreskin covering the penis. This is a cultural tradition for some religions and communities and has become a commonplace practice in many developed countries as well since it promotes genital hygiene and may decrease the risk of infections.

- **The hymen is a delicate tissue in the vaginal passage that stays intact until the first act of sexual penetration.**
  FALSE: The hymen is a delicate tissue located outside the opening of the vaginal passage. It is so delicate that it may tear in childhood during cycling or exercising. It may also tear from using tampons, during masturbation or exercise. In some women, it can be stretched without tearing. Some women are born without a hymen. An intact or unbroken hymen or the appearance of blood during intercourse, are not signs of virginity.

- **A hysterectomy is a surgical removal of the uterus.**
  TRUE: A hysterectomy is the surgical removal of the uterus and can be total (which includes the removal of the ovaries and tubes) or partial (removal of the uterus and sometimes the cervix). If the ovaries are removed (oophorectomy) during a hysterectomy, the woman will experience a sudden loss of the hormone oestrogen. This can cause menopausal symptoms and is also known as 'surgical menopause'. Hysterectomies are sometimes performed for health reasons, for example in cases of uterine cancers. Female to Male transsexuals may also undergo this surgery as part of the transition process.

- **It is normal for a woman's genitals to produce fluids and have a distinctive smell.**
  TRUE: Fluids secreted by the vagina and cervix clean the vagina. If a woman has an infection, the colour and smell of the fluid can change. If this happens, medical treatment is sometimes required.

- **A woman is dirty when she is menstruating.**
  FALSE: Menstruation is the periodic shedding of the uterine lining that usually occurs once a month if an egg has not been fertilised after ovulation. A woman can begin menstruating during puberty and will continue to menstruate until menopause. There is nothing dirty about this process and women should not be ashamed of it. However there are various rituals and practices among some communities that isolate and deny women basic rights during menstruation.

- **The prostate gland produces one of the fluids for semen.**
  TRUE: The prostate gland is located just below the bladder and is the size of a walnut. It acts as both a reproductive and sexual organ. It secretes and stores a fluid that is part of semen. Some people derive sexual pleasure from the massaging or stimulation of the prostate gland.

- **The main male hormone is testosterone and the main female hormone is oestrogen.**
  TRUE: The primary male hormone is testosterone, produced in the testicles. The primary hormone in women is Oestrogen, produced mainly in the ovaries, the corpus luteum and during pregnancy in the placenta.. Oestrogen promotes the development of a woman's secondary sexual characteristics like breasts, and regulates the menstrual cycle. However, small quantities of oestrogen are also produced in the male body just as small amounts of testosterone are produced in the woman's body.

- **Men can find stimulation of their nipples pleasurable.**
  TRUE: Both women and men can find simulation of their nipples pleasurable.

- **Reproductive organs can also be sexual organs.**
  TRUE: Organs that are part of the reproductive anatomy can also be sexual and provide people pleasure. For example, the prostate gland or a woman's breasts. The prostate gland stores and secretes a fluid that makes semen, necessary for fertilisation. At the same time, some men find its stimulation sexually pleasurable. Similarly, breasts can produce milk to feed a baby and also provide sexual pleasure to many women.

Please write a few lines in response to the following questions:

- **Do you believe that how we feel about our body can affect our sexuality and sexual interactions? Why or why not?**

- **Do you believe that women in your community are taught to hide or be ashamed of their bodies?**

- **Do you think it is important to talk about sexual anatomy and physiology to young people? Why or why not?**

- **What are some words commonly used in your communities to describe parts of the anatomy? What attitudes/values do these words reflect? How do you think these words affect the way we deal with our bodies?**

Handout 2.2 Participant Copy: Quiz on Sexual and Reproductive Anatomy and Physiology

Please write if the statement below is true (T) or false (F)

- The fallopian tubes are two small tubes through which an egg travels into the uterus.
- The primary sex gland for men is the testes.
- Penile size can be increased with exercise, massage or medicine.
- Having an erection in the morning means that a man is over-sexed.
- The clitoris regulates female hormone production.
- Semen is not made up of blood. The quality and quantity of semen varies in men.
- When semen comes out of the penis at night, this is called a nocturnal emission and is a common and normal occurrence, unrelated to sexual feelings or desires.
- A woman's breast size can be increased with massage and massage oils.
- The size of a woman's breasts has a bearing on her interest in sex and the ability to receive or give sexual pleasure.
- The vulva is made up of the external female genitals that include the outer lips, inner lips, mons pubis, clitoris, clitoral hood, and vaginal opening.
- The G-spot is the source of a woman's sexual pleasure.
- Circumcision is a practice that removes a man's external genital organs.
- The hymen is a delicate tissue in the vaginal passage that stays intact until the first sexual penetration.
- It is normal for a woman's genitals to produce fluids and have a distinctive smell.
- A woman is dirty when she menstruates.
- The prostate gland produces one of the fluids for semen.
- The main male hormone is testosterone and the main female hormone is oestrogen.
- Men can find stimulation of their nipples pleasurable.
- Reproductive organs can also be sexual organs.

Please write a few lines in response to the following questions:

- Do you believe that how we feel about our body can affect our sexuality and sexual interactions? Why or why not?

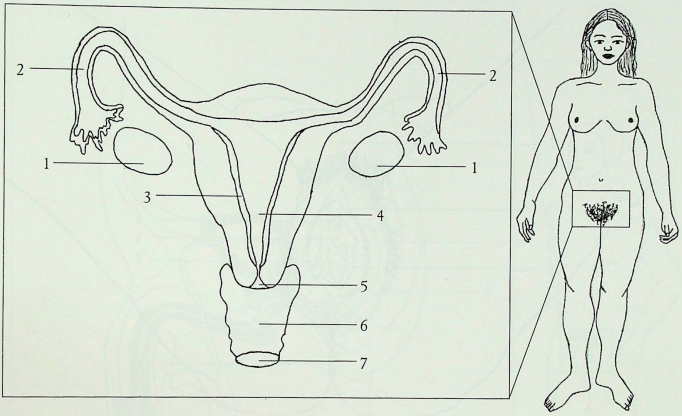
- Do you believe that women in your community are taught to be ashamed of their bodies?

- Do you think it is important to talk about sexual anatomy and physiology to young people? Why or why not?

- What are some other words commonly used in your communities to describe parts of the anatomy? What attitudes or values do these words reflect? How do you think they affect the way we perceive our bodies?

Handout 2.3 Facilitator Copy: Diagrams of the Human Sexual and Reproductive Anatomy and its Physiology

A Woman's Internal Anatomy



1. Ovaries: Two organs each about the size of a walnut, located slightly below either side of the uterus. The ovaries have two purposes: to produce ova (eggs) and to produce hormones, including oestrogen, progesterone, and testosterone.

2. Fallopian Tubes: Connect the uterus to the ovaries. When an ovary releases an egg it travels through the fallopian tube into the uterus. This is where fertilisation occurs.

3. Endometrium: The uterine lining. This lining will thicken and grow during ovulation to prepare for a fertilised egg. If there is no egg fertilised it will be shed during menstruation.

4. Uterus: An organ in which a fertilised egg will attach and develop during pregnancy. Menstruation occurs when the endometrium that lines the uterus sheds if the egg is unfertilised.

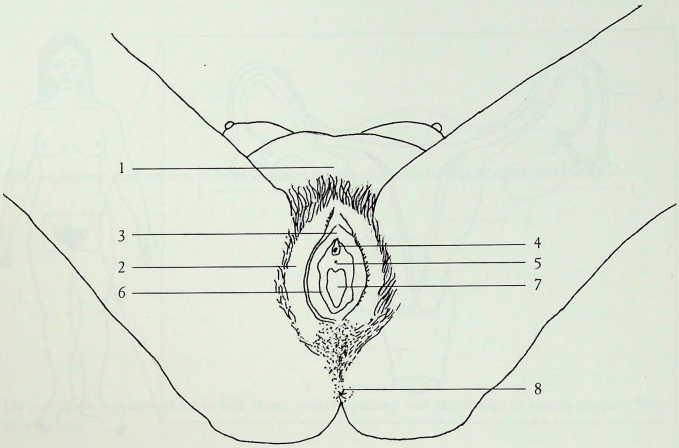
5. Cervix: The opening of the uterus. During conception sperm pass through the small opening of the cervix into the uterus to meet the egg in the fallopian tube. The cervix opens during childbirth to allow a baby to come out.

6. Vagina: Leads from the vulva to the uterus. It produces fluids that keep the vagina lubricated, clean and prevent infection. It stretches during sex and when giving birth. It is a sexual and reproductive organ. The first 2 inches of the vaginal passage has nerve endings that give pleasure during sexual stimulation.

7. Vaginal opening: Opening of the vagina.

Handout 2.3 Facilitator Copy: Diagrams of the Human Sexual and Reproductive Anatomy and its Physiology

A Woman's external Anatomy



The vulva is made up of woman's external genitals, that includes the outer lips, inner lips, mons pubis, clitoris, clitoral hood and vaginal opening

1 Mons pubis (mons veneris): The hairy part of the vulva on top of the pubic bone.

2 Outer lip (labia majora): The fatty folds of skin that protect the inner parts of the vulva.

3 Clitoris: A pea-sized organ located above the urethra (urinary opening), where the inner lips of the vulva join. The role of the clitoris is for sexual pleasure.

4 Urinary opening: The outer part of the urethra that carries urine from the bladder to the outside of the body.

5 Vaginal opening: Opening of the vagina.

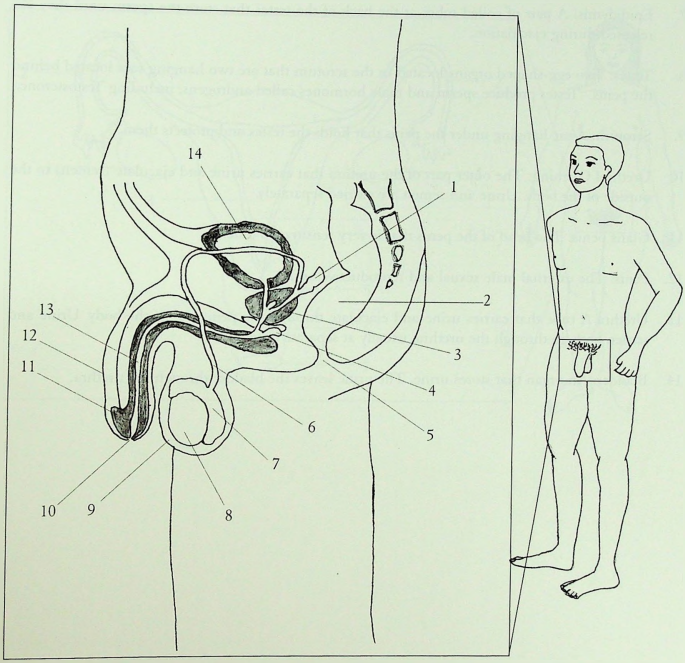
6 Inner lip (labia minora): Inner folds of skin that are without hair and sensitive to touch. They cover the vaginal opening and vary in size from woman to woman.

7 Hymen (if present): a delicate tissue located outside the opening of the vaginal passage. It is so delicate that it may tear in childhood during cycling or exercising. It may also tear from using tampons, during masturbation or exercise. In some women, it can be stretched without tearing.

8 Anus: The outside opening for the intestine where stool or faeces leaves the body.

Handout 2.3 Facilitator Copy: Diagrams of the Human Sexual and Reproductive Anatomy and its Physiology

A man's Internal Anatomy



1. Seminal Vesicle: Pair of glandular sacs that secrete some of the fluid that makes up semen.

2. Rectum: Connects the colon to the anus. Receives faeces from the colon. The rectum holds the faeces until it leaves the body.

3. Prostate: Located just below the bladder and is the size of a walnut. It acts as both a reproductive and sexual organ. It secretes and stores a fluid that is part of semen. Some people derive sexual pleasure from the massaging or stimulation of the prostate gland. A muscle at the bottom of this gland prevents urine from being released during ejaculation.

4. Cowper's gland: Two pea sized glands at the base of the penis that secrete a clear fluid before and during sexual arousal and before ejaculation. This fluid is also known as pre-cum.

5. Anus: The outside opening for the intestine where stool leaves the body.

6. Vas Deferens: A tube that carries sperm from the epididymis during ejaculation.

7. Epididymis: A pair of coiled tubes at the back of the testes that store the sperm until they are released during ejaculation.

8. Testes: Two egg-shaped organs located in the scrotum that are two hanging sacs located behind the penis. Testes produce sperm and male hormones called androgens, including Testosterone.

9. Scrotum: A sac hanging under the penis that holds the testes and protects them.

10. Urethral Opening: The outer part of the urethra that carries urine and ejaculate (semen) to the outside of the body. Urine and semen are carried separately.

11. Glans penis: The head of the penis that is very sensitive to touch.

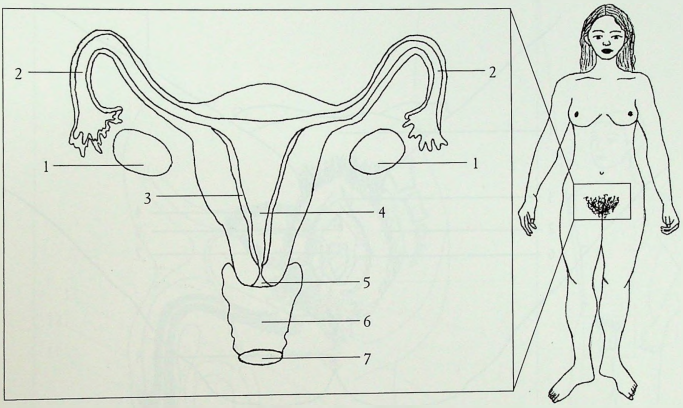
12. Penis: The external male sexual and reproductive organ.

13. Urethra A tube that carries urine and ejaculate through the penis out of the body. Urine and semen both go through the urethra, usually at separate times.

14. Bladder: An organ that stores urine. The urine leaves the bladder through the urethra.

Handout 2.4 Participant Copy: Diagrams of the Human Sexual and Reproductive Anatomy and its Physiology

A Woman's Internal Anatomy



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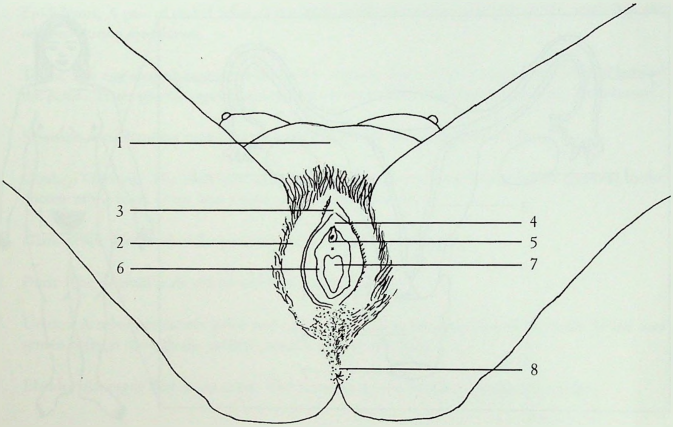
Handout 2.4 Participant Copy: Diagrams of the Human Sexual and Reproductive Anatomy and its Physiology

A Woman's External Anatomy



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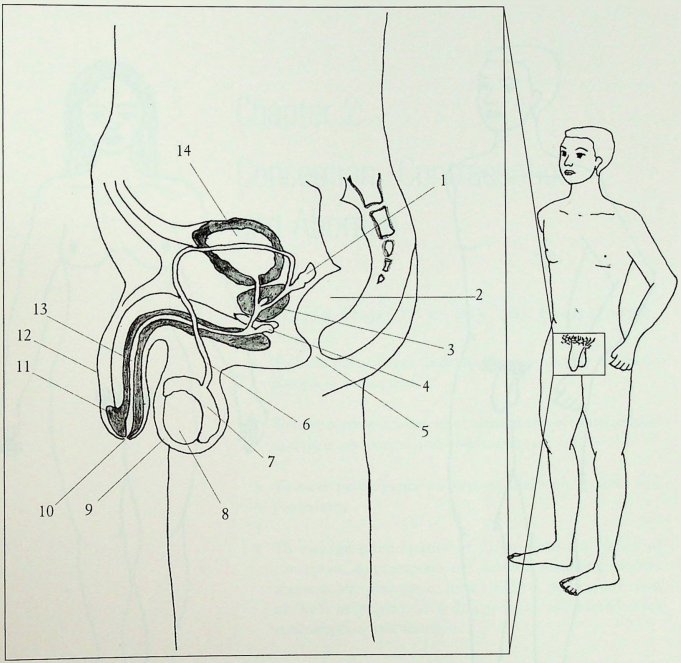
Handout 2.4 Participant Copy: Diagrams of the Human Sexual and Reproductive Anatomy and its Physiology

A man's Internal Anatomy



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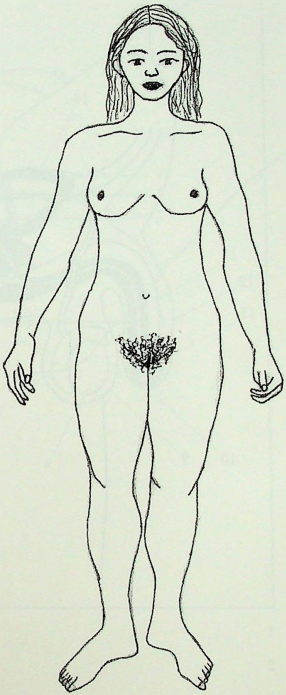
Handout 2.5
Sexual and Reproductive Physiology



Chapter 2
Conception, Contraception and Abortion

Chapter Objectives for the Facilitator

1. To have participants understand and describe the basic process of conception.

2. To have participants describe current forms of contraception and their advantages and disadvantages.

3. To have participants understand abortion options and procedures.

4. To engage participants in discussions on issues of conception, contraception and abortion, including selective abortion, the pressure to have children, particularly sons, as well as stigma and disapproval associated with contraception and abortion.

Why a Chapter on Conception, Contraception and Abortion

'There was never any discussion of how a baby is made in my house. In fact, it was not until I was in my early 20's that I really understood how pregnancy happened let alone how to prevent it.'

'My friends and people in my town don't speak about how to not get pregnant, and if they do it is only to mention condoms. There are not many other options that we know about.'

'I am afraid to talk about abortion because it is a topic everyone gets so angry about. I am not even sure I can get an abortion in my country legally.'

How pregnancy occurs, how to prevent it and what to do if it is unwanted are common concerns and questions faced by people of various genders and identities, whether they are sexually active or not.

Pregnancy has social and personal implications and plays a central role in people's lives in many cultures and communities. The premium on pregnancy can perpetuate practices like withholding information on how to prevent an unwanted pregnancy, discouraging the provision of contraceptives for adolescents, and unavailability of abortion options if a woman wants to end a pregnancy. Such practices violate the rights of people to information and sexual and reproductive choices.

And what of a woman who does not want to have a child, or has a daughter and no sons, or a couple in a homosexual relationship that wants to have children? Do they have the space and opportunities to make these choices freely? Should and are these choices available to them?

To answer these questions and to examine issues surrounding conception, contraception and abortion, it is necessary to first have basic information on how a pregnancy occurs, available methods to prevent a pregnancy, and options to end an unwanted pregnancy. Since this information is not easily available, many misconceptions and myths abound. This information serves as a first step to engage in the dialogue around issues of sexual and reproductive choices and rights.

This chapter gives participants basic information on conception. Arguments regarding these topics, many of which participants may have to grapple with in the course of their work, are contentious and may have no simple answers.

EXERCISES IN THIS CHAPTER:

Exercise 1: Quiz: Conception, Contraception and Abortion. 15 minutes

Exercise 2: Conception Basics. 75 minutes

Exercise 3: Charting Contraception Choices. 30 minutes

Exercise 4: Abortion Basics. 30 minutes

Exercise 5: My views on Abortion and Contraception. 60 minutes

MATERIALS REQUIRED FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Index cards/slips of paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 2.6
Basic Information on Conception

Handout 2.7
Basic Information on Contraception

Handout 2.8
Basic Information on Abortion

Handout 2.9
Facilitator Copy: Quiz on Conception, Contraception, Abortion

Handout 2.10
Participant Copy: Quiz on Conception, Contraception, Abortion

ADDITIONAL RESOURCES:

- Feminist Women's Health Centre. http://www.fwhc.org
- Go Ask Alice. http://www.goaskalice.columbia.edu/Cat7.html
- International Women's Health Coalition. 'Chapter 3: Anatomy, Physiology and Puberty', *Positively Informed: Lesson Plans and Guidance for Sexuality Educators and Advocates*.
- IPAS. Abortion Methods. http://www.ipas.org/english/womens_health/abortion_methods/default.asp
- The Medical Termination of Pregnancy Act, 1971. (India). Available at: http://www.mp.nic.in/health/mtp%20Act.pdf
- Planned Parenthood. http://www.plannedparenthood.org
- Reproductive Health Online, Johns Hopkins University. http://www.reproline.jhu.edu/
- Sen, A. 2003. 'Missing Women Revisited', *British Medical Journal*. Volume 127, 6 December.
- World Health Organization. 2003. *Safe Abortion: Technical and Policy Guidance for Health Systems*. WHO: Geneva.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key Messages for this Chapter

- Conception, contraception and abortion should be understood for the integral role they play in sexuality, sexual and reproductive health, and rights.
- Understanding the basic processes of conception, contraception, and abortion provides a foundation for further discussion on the social norms and pressures influencing these choices.
- Technical/scientific language on conception should be balanced with a cultural, social and ethnic understanding of the process so as to be accessible to more people.
- Various contraceptive options are available to individuals, some of which use medical interventions and others that do not. The advantages and disadvantages of each option differ for each person.
- Contraception options must also be viewed in terms of sexual and reproductive rights. Individuals have the right to information and access to contraception options, and also the right to sexual well-being and to determine whether and when to have a child.
- Low awareness about the legal status and availability of abortion options can sometimes lead women to seek unsafe, illegal abortions that contribute to high rates of maternal mortality and morbidity.
- Often the responsibility of preventing unwanted pregnancies falls unfairly on women. At the same time, women are often seen only as child-bearers/reproducers and their opinions/desires are overlooked in the reproductive decision-making process.

Exercise 1
Quiz: Conception, Contraception, and Abortion

QUIZ

Instructions

1. Distribute copies of Handout 2.10 to each participant. Explain that this quiz will not be 'graded' and the level of performance has no bearing on participation in the training. The quiz will be used to ensure that gaps in participant information are addressed during the training. The quiz can also be distributed the day before beginning the chapter in order to tailor the information and chapter exercises to the needs and strengths of the group. The facilitator can choose to give participants the option of responding anonymously to the quiz. Give them 10 minutes to answer the questions.

2. Have participants return the quizzes and check the answer sheets during a break or while the group works on the next exercise. Note areas of knowledge and gaps.

Purpose of the exercise:

1. To have participants assess their own knowledge and understanding of conception, contraception, and abortion.

2. To evaluate participant knowledge and understanding of conception, contraception, and abortion.

3. To make note of the myths and misconceptions and gaps in information to be addressed.

TIME

15 minutes

MATERIALS

Handout 2.9 Facilitator Copy: Quiz on Conception, Contraception, Abortion, Handout 2.10 Participant Copy: Quiz on Conception, Contraception, Abortion, pens/pencils

ADVANCE PREPARATION

Make copies of Handout 2.10 for each participant

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into two groups and conducting the exercise like a quiz game using the questions from Handout 2.9. Each correct answer can earn the group a point. Score can be kept and the winning team can be given a prize at the end of the game.
- Combining this quiz with other quizzes and myth/fact exercises from this module into a larger quiz game played at the start or end of the module.

MAKING CONNECTIONS

- Basic information on human sexual and reproductive anatomy and physiology is required before learning about conception, contraception and abortion. For more see Chapter 1 in this Module.
- Both the right to conceive and access to contraception are reproductive rights. For more see Chapter 2 in Module 3.

Key Messages

- Emphasise that this exercise is not a 'graded' test and participants should answer the questions to the best of their ability. The quiz should, however, be taken seriously.

TIPS FOR THE FACILITATOR:

- It may be beneficial to give the quiz a day/ few hours before starting the chapter. That way, the training can be tailored to participant needs. For example, if the group has extensive knowledge of contraception, it may be best to focus on some of the perspective/attitude exercises instead.
- Making the quiz anonymous can reduce pressure on the participants and still be useful in obtaining an idea of the group's knowledge level.
- The quizzes can be administered again at the end of the chapter to assess what participants have learned or subjects they still need information on.

Exercise 2
Conception Basics

LECTURETTE AND DEBATE

Instructions

1. Introduce the topic of conception to the group. Spend the first 15 minutes going over the process of conception as outlined in Handout 2.6. While this may be a review for some participants, emphasise that a basic introduction is important to ensure that everyone is at the same level of understanding.

2. After going over the basics of Handout 2.6 ask for questions or comments.

   Suggested Questions:

- List out terms you have heard people use to describe pregnancy or conception. Do these terms reflect social attitudes toward pregnancy? What are the implications of using 'slang' terms? For example does saying that a woman is 'in trouble' to describe that she is pregnant have a moral implication?
- How do culture, religion, and communities influence the knowledge and understanding of conception and pregnancy?
- People often use medial terminology when talking about conception. How can you convey technical information in an easy manner that takes into account the socio-cultural context of the audience?

3. Now introduce the debate exercise. Divide the participants into two groups. Designate one group as the 'Agree to both statements' and the other group as the 'Disagree to both statements'. Read out the two statements:

   Statement 1: The most important thing a person can do is having children.

   Statement 2: People should have children only if they are married.

   Give the groups 20 minutes to construct arguments to support the viewpoint designated to them. Encourage participants to use personal experiences, and/or common attitudes from their communities in their arguments.

Purpose of the exercise:

1. To understand and describe the process of conception.

2. To analyse the role of pregnancy and child bearing in different communities and social groups.

TIME

75 minutes

MATERIALS

Handout 2.6 Basic Information on Conception

ADVANCE PREPARATION

Handout 2.6

4. Now, invite each group to present their arguments in 5 minutes, after which, open the floor for a freer debate, asking questions and highlighting points when appropriate. Make sure that one group/side does not dominate the discussion.

Suggested Questions:

- Is having children important to people in your community or the communities you work with? Why/ why not? Do you think or do people in your community believe there is something wrong if a person does not want to have children or considers adoption?
- Do you think a man and a woman should raise a child together? Why? What if an individual wanted to raise a child, or a homosexual person/couple wanted to do so?

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting the second part of the exercise as a polarisation rather than a debate. Ask participants to move to the *Agree/ Disagree* side of the room depending on their opinion of the statement. Have a discussion on the statements using the questions above as guidelines.

Key Messages

- Whether to have a child or not is an individual choice. All people, irrespective of marital status, sexual and gender identity, whether they have a disability or not have the right to make this choice. It is their reproductive right.
- People who choose not to have children or are unable to have children are often stigmatised. This is particularly so with women, who may be ostracised or regarded poorly in these situations.

MAKING CONNECTIONS

- Women who cannot have children often face stigma and discrimination. For more see Chapter 3 in this Module.
- All people, irrespective of marital status, whether with a disability or not, etc. have the right to decide whether to have children or not, how many, and when. For more see Chapter 2 in Module 3.

TIPS FOR THE FACILITATOR:

- Participants may experience discomfort at having to argue a side of the debate they disagree with. Encourage them to learn to argue a side they disagree with in order to understand their own position and the opinion of others better. It also illustrates the difficulties experienced in arguing for reproductive rights and thinking of how this can be done effectively.
- Participants might get emotional during this discussion, especially if they have experienced stigma for not having children. Be alert to this and do not push people to speak unless they are willing to.
- Participants may ask technical questions about conception which are not covered in the handouts. Put them in the Parking Lot for later discussion if required.

Exercise 3
Charting Contraception Choices

CATEGORISATION

Instructions

1. Divide the participants into two groups. Distribute the index cards equally between the groups. Ask participants to decide whether the forms of contraception on the index cards should be categorised as *Very Effective*, *Somewhat Effective*, or *Taking a Big Chance* at preventing pregnancy. For each method they should also write one advantage and one disadvantage on the index card. For example, male condoms are highly effective for the prevention of pregnancy and a major advantage is that they also protect against STIs and HIV. A disadvantage might be that it disrupts spontaneity during sex. After each method has been discussed, the groups can tape each index card to the appropriate categories on the flipchart or walls.

2. When all the cards are up, go through each category of efficacy and read aloud the methods. With each method, first invite participants to describe the method. After a method is described, read out the advantages and disadvantages. Invite participants to add to the list. Make sure to correct any misclassification of a method. For example if condoms were put in the, *Somewhat Effective* group, it should be stressed that in fact condoms are 98% effective and should therefore be in the *Very Effective* category. Also, fill gaps in information on the description or advantages and disadvantages of each method from Handout 2.7. After looking at each category ask for questions and comments.

   Suggested Questions:

   - Do you have any questions about the methods? Are there some of these methods unavailable in your communities?

3. After this, begin a discussion on how contraception options may play a role in sexuality and rights.

   Suggested Questions:

   - Take a method from each category of efficacy. How does this method, with its pros and cons, relate to sexuality and rights? For example, from the *Very Effective* category, contraceptive pills (OCPs) provide women with choice and the ability to prevent

Purpose of the exercise:

1. To describe contraceptive methods and their efficacy.

2. To discuss what contraception options and choices mean for sexuality and rights.

TIME

60 minutes

MATERIALS

Flipchart, tape, index cards/slips of paper with different forms of contraception written out from Handout 2.7 Information on Contraception.

ADVANCE PREPARATION

Write out the contraception methods without their descriptions from Handout 2.7 onto separate index cards/slips of paper; create 3 flipcharts with the titles *Very Effective*, *Somewhat Effective*, *Taking a Big Chance*. Review Handout 2.7.

unwanted pregnancies. It can also be said, however, that a focus on OCPs continues to put the onus on women and does not recognise the importance of male responsibility in contraception.

Key Messages

- Knowledge of contraception options and methods is important for the prevention of unwanted pregnancies.
- Having contraception options allows women and men to make choices on how they wish to have and space children, and protect themselves against STIs including HIV.
- It is important for two people to consider the need to protect themselves against STIs including HIV/AIDS when considering the most appropriate form of contraception.
- Contraception decisions are an individual preference that depend upon the needs and comfort of each person, and should not be forced upon anyone. Not all methods are appropriate for everyone, as highlighted in some of the advantages and disadvantages in the chart.
- Women are often left out of decisions about birth control. Those with more power by virtue of their gender (men), social status (parents-in-law) or educational background (doctors in the public health system) can influence and control the kind of contraception a woman uses or does not use.

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting this as a large group exercise rather than in two smaller groups. The facilitator can go through each method and invite participants to describe its efficacy. A discussion of each method and its advantages and disadvantages can follow.

MAKING CONNECTIONS

- While making a contraceptive choice, it is important to consider that not all contraception methods provide protection against STIs including HIV/AIDS. For more see Chapter 4 in this Module.
- People who want to choose contraception should be given information and support in a non-judgmental manner. For more see *Setting the Tone* in the Introduction to Module 1.

TIPS FOR THE FACILITATOR:

- Participants may put a contraceptive method in the wrong category of efficacy. Make corrections if this happens. A copy of the Handout 2.7 should be handed to participants at the end of this exercise for future reference.
- Participants may want to know the medical details of each method. If the facilitator is unsure of these details, or if time is limited, put the questions in the Parking Lot to be discussed later.

Exercise 4
Abortion Basics

LECTURETTE

Instructions

1. Begin the exercise by giving a 15-minute presentation on the different abortion methods and options from Handout 2.8.

2. After giving an overview of the types of abortion methods ask for questions.

Suggested Questions:

- Were there any options you were unfamiliar with?
- Are all these options available in the countries/areas/communities in which you live?

Key Messages

- There are a variety of abortion options available, including medical and surgical abortions, that can be performed depending on how advanced the pregnancy is.
- Whether to have an abortion or not should be the woman's choice. However, it often depends less on her preference than on types of options available and the wishes and opinions of her family, peers, culture, and community.
- Even if women know that abortion is legal in their country, many opt for unsafe or 'back-street' abortions for fear of being identified or judged by their community. These unsafe abortions can lead to increased rates of maternal mortality and morbidity.
- Having an abortion is often an unpleasant physical and emotional experience for a woman. It is important to have counselling for women considering abortions and for those opting to have them. This provides them with information and support through the decision-making process and abortion procedure when done in a non-judgmental and respectful manner.

Purpose of the exercise:

1. To understand options for abortion.

2. To discuss and debate the issues surrounding abortion.

TIME

30 minutes

MATERIALS

Flipchart, markers

ADVANCE PREPARATION

Review Handout 2.8 Basic Information on Abortion and be prepared to give a short lecture on the topic. Check whether abortion is legal in your country and what methods are commonly available locally.

THIS EXERCISE CAN BE MODIFIED BY:

- Distributing Handout 2.8 and giving participants 5-10 minutes to read through the handout and formulate any questions they may have. They can then be asked a series of questions about the handout. For example: 'Were you unfamiliar with any of the options mentioned?' 'Are all of these available where you live/work?' 'How can we educate others about these abortion options?'

- Coercive abortions take place in many parts of the world. Many of these are performed on women to eliminate female foetuses, on disabled women and those with learning difficulties thought to be incapable of rearing children, teens and single women. Such coercive methods violate women's reproductive rights.
- Abortion is a heavily debated issue with two main sides to the debate, pro-choice (supports abortion as a right of the woman) and anti-choice (opposes abortion as a choice for the woman to make).
- Those who are pro-choice believe in the right of a woman to an abortion because it is her body and her right to choose whether to have or to not have a child.
- The anti-choice side of the debate opposes abortion because they believe it is taking a life. A woman's social, physical, mental or emotional circumstances and reproductive rights are not taken into consideration by this view.

MAKING CONNECTIONS

- Basic information on human sexual and reproductive anatomy and physiology is required before learning about abortion. For more see Chapter 1 in this Module.
- Some women who have an abortion face stigma from their families and communities even though they are exercising their reproductive rights. For more see Chapter 3 in Module 3.

TIPS FOR THE FACILITATOR:

- Exercise 5 *My Views on Abortion* in this chapter can follow this exercise. Ask participants to withhold comments and opinions on abortions and various options until that exercise is complete.
- Abortion can be a very difficult issue for discussion, and strong opinions are likely to be expressed. Emphasise respect, listening and open discussion during this topic.

Exercise 5
My Views on Abortion

POLARISATION

Instructions

1. Choose at least 3 statements from the list below. Read out one statement at a time. Designate one side of the room as the *Agree* side and the other as the *Disagree* side. Ask the participants to move towards either side of the room based on their opinion of the statement. Those who are undecided should move to a third designated spot in the room (the *Don't Know* group).

   Statement 1: Abortion should be the woman's choice.

   Statement 2: Abortion should be legal and free.

   Statement 3: If a woman is raped it is okay for her to have an abortion.

   Statement 4: Sex selective abortion should be a woman's choice.

   Statement 5: It is okay to have an abortion if tests indicate the possibility that the foetus will have a disability.

   Statement 6: Young people have the right to have an abortion without parental consent.

2. After the participants have chosen a side, invite them to share the reasons for this choice. Discuss the issue for no more than 20-25 minutes or participants may become uninterested.

   Suggested Questions:

- Why do you agree or disagree?
- Do you think your opinion is similar to that of your community?

3. After going through all the selected statements, ask for general comments or questions.

   Suggested Questions:

- Were there any issues you had not thought of before? What were they and how did they make you feel?
- From these statements and discussions, what are your opinions and thoughts about abortion and reproductive health and rights?

Purpose of the exercise:

1. To discuss opinions on abortion, including selective abortion.

2. To analyse stigma associated with abortion.

TIME

60 minutes

MATERIALS

Flipchart, markers

ADVANCE PREPARATION

None

THIS EXERCISE CAN BE MODIFIED BY:

- Asking for reactions and discussing fewer statements. This can allow for deeper and longer discussions of the issues and opinions.
- Combining two of the statements and asking whether people agree or disagree. It becomes more difficult to take sides on a statement when there are more nuances to consider. Participants will need to grapple with and analyse their opinions around abortion more carefully in this situation.

MAKING CONNECTIONS

- There are overlaps between sexual and reproductive rights, but also differences. For more see Chapters 2 and 3 in Module 3.
- People with disabilities have the right to decide whether or not they want to have children. For more see Chapter 3 in Module 4.

Key Messages

- The right to abortion is a reproductive right that all women have, regardless of age, marital status, disability status etc.
- Because women bear more of the physical and emotional consequences of a pregnancy their reproductive rights are given higher priority than those of men. The choice to have a child, or not, or to have an abortion or not, is the woman's to make.
- Abortion is a heavily debated issue with two main sides to the debate: pro-choice supporters that believe a woman has the right to an abortion because it is her body and choice about whether to have a child or not, and anti-choice supporters, who oppose abortion because they believe it is taking a life. The latter view does not take a woman's social, physical, mental or emotional circumstances and reproductive rights into consideration.

TIPS FOR THE FACILITATOR:

- Participants may be uncomfortable discussing this topic or have very strong opinions on it. Be prepared for heated arguments. Prevent participants from attacking one another's ideas in a disrespectful manner. Encourage openness to others' views and opinions.
- Issues of morality may come into the debate. Emphasise that morality is a relative term. Help participants to consider the advantages of addressing abortion as a health and rights issue as opposed to one of morality.
- Some participants may feel it important to consider a partner in decisions about abortion. While it is important to involve men in the decision making process, ultimately the choice of whether to have an abortion or not is the woman's as it is she who bears the consequences of the pregnancy. Even in marital situations, a woman should be able to choose whether to have a child or an abortion.

Handout 2.6
Basic Information on Conception

Below are some terms commonly used when talking about conception:

- **Amenorrhoea:** The absence of menstrual periods that can be caused by pregnancy, menopause, breast-feeding, hormone imbalance, excessive dieting or exercise and stress, among other factors.

- **Conception:** The moment a fertilised egg attaches itself to the lining of the uterus and pregnancy begins.

- **Embryo:** A fertilised egg growing in the uterine lining becomes an embryo.

- **Endometrium:** The uterine lining, which will thicken and grow during ovulation to prepare for a fertilised egg. In the absence of fertilisation, the endometrium is shed during menstruation.

- **Fertilisation:** When an egg (ovum) meets and merges with a sperm in the fallopian tube.

- **Ovulation:** The process by which an egg (ovum) is released by the ovary. The process begins with the growth of 10 to 20 ovarian follicles. Most of these follicles will not mature and are reabsorbed by the body, but one follicle will produce a mature egg that will be released during ovulation. Ovulation begins when hormones are released from the pituitary and hypothalamus glands in the brain.

- **Oestrogen:** A hormone produced by the ovaries which among other things, signals the egg in the ovary to be released.

- **Ovaries:** Two organs, each about the size of a walnut, located slightly below either side of the uterus. The ovaries have two purposes: to produce eggs (ova) and hormones, including oestrogen and progesterone, and testosterone.

- **Progesterone:** A hormone produced by the ovaries. Among other things, oestrogen signals the lining of the uterus (endometrium) to thicken and grow in preparation for a fertilised egg.

- **Zygote:** After an egg is fertilised it changes its surface to prevent other sperm from entering. This fertilised egg is called a zygote.

How does pregnancy occur?

Pregnancy begins with fertilisation. The process of fertilisation starts with ovulation - a woman's ovary releasing an egg (ovum). Just before ovulation, the uterine wall begins to thicken with tissue and blood in preparation. After the egg is released, it travels into the fallopian tube, where it stays for **three to four** days. If a woman has sex with a man during this period and he ejaculates into her, the ejaculated semen will travel into the woman's vagina and uterus, and head up toward the fallopian tubes. Most sperm will die while travelling up toward the fallopian tubes, but some will make it up to the fallopian tube and try to meet the egg. When the two meet and merge, fertilisation occurs. The fertilised egg then travels down the fallopian tube and attaches itself to the uterine wall, which will nourish the egg with blood and nutrients for the next nine months, and secrete increased levels of the hormone progesterone. This is when pregnancy has occurred.

What happens if the egg is not fertilised or attached to the uterine wall?

If pregnancy does not occur the thickened uterine wall (endometrium) is not needed to nourish an egg and is shed. This lining, composed of tissue, blood, and mucous, will come out of a woman's vagina little by little for a period of two to eights days. This is called menstruation.

Can a woman get pregnant from pre-cum or if a man ejaculates near her vagina?

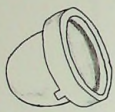
Yes, a woman can get pregnant any time sperm enters the vulva or is inside the vagina. This means that ejaculation near the vagina can also lead to pregnancy. This is possible when the vaginal lubrication (wetness) in the woman provides a medium for the sperm to swim into the woman's body. There is no way of knowing the probability that pregnancy will occur when semen comes in contact with the vulva or vagina. Pregnancy can be determined using a home pregnancy test or more accurately through a pregnancy test done in a laboratory.

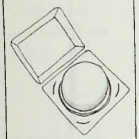
Handout 2.7
Basic Information on Contraception

The chart below outlines general information on different forms of contraception. However, this list is not exhaustive in the facts or details of each method. Many of these methods may not be available everywhere. Often the most appropriate option for an individual should be discussed with a health care provider. If the chart notes that efficacy is 99% this means that 99 out of 100 people using the method properly each time will not get pregnant. Because of new developments in contraceptive technology, information can change on a regular basis. Therefore, up-to-date information on any of these and other forms of contraception, their availability and cost should be sought from health care providers in your area.

* For more on this and the studies associated with nonoxynol-9 and HIV transmission, please see the World Health Organization website at http://www.who.int/reproductive-health/stis/nonoxynol9.html.
** Progestin is a synthetic hormone used to affect a woman's body in the same ways as the hormone progesterone.

BARRIER METHODS

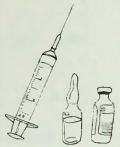
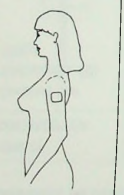
FORM OF CONTRACEPTION	DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Cervical Cap 	A thimble-shaped device made of thin soft latex (rubber) or silicone, with a flexible rim that fits over the cervix. It is a physical barrier to block the cervix and prevent sperm from reaching the egg and to hold chemical spermicide to kill sperm. Similar to a diaphragm, the cap is smaller and can be left in longer (up to 48 hours).	84-91% in women who have not given birth. 68-74% effective for women who have given birth vaginally.	Reusable after washing with soap and water. Can be inserted 6 hours prior to intercourse and left in up to 48 hours for multiple acts of intercourse if more spermicide is added. Does not interrupt intercourse. Few side effects. Can be discontinued at any time. Does not affect fertility.	Does not reduce risk of STI and HIV transmission. Some people may have allergic reactions to spermicides/ the latex. May be difficult for some women to insert. Need a health care provider to fit the cap (they come in different sizes). If a woman is at higher risk of HIV infection using spermicides that contain nonoxydol-9 may increase the likelihood of transmission.*	Before using check for holes, tears or cracks. Apply spermicide to the cervical cap, and then insert it into the vagina and place the cap onto the cervix so the cervix is completely covered and the cap fits snuggly. Leave the cervical cap in place for at least 8 hours after sex.	Should not be used if a woman is using other vaginal medications, like treatments for yeast infection, or during a woman's menstrual period. The cap should be replaced every year. A woman should also have her cap refitted if she has had a child vaginally, gains or loses more than 9 kgs, or had an abortion or a miscarriage, as these can affect the way the cap fits.

FORM OF CONTRACEPTION	DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Diaphragm 	A thin, circular dome with a flexible rim made of soft latex (rubber) or silicone. It a physical barrier to block the cervix and prevent sperm from fertilising an egg and to hold chemical spermicide to kill sperm.	86-94%	Reusable after washing with soap and water. Can be inserted 6 hours prior to intercourse and left in up to 24 hours for multiple acts of intercourse. Few side effects. Does not affect fertility.	Does not reduce risk of STI and HIV transmission. Some people may have allergic reactions to the latex or spermicides. May be difficult for some women to insert. Need a health care provider to fit the cap (they come in different sizes).If a woman is at higher risk of HIV infection using spermicides that contain nonoxydol-9 may increase the likelihood of transmission.*	Before using check for tears, cracks, or holes. Apply spermicide to the diaphragm and then insert it deep into the vagina. The front rim should be tucked behind the pubic bone. Make sure it covers the cervix.	Should not to be used if a woman is using vaginal medications such as for yeast infection, or during her period as it can increase the risk for toxic shock syndrome. Must replace after 3 years. A woman should also have her diaphragm refitted if she has had a child vaginally, gains or loses more than 9 kgs, or had an abortion or a miscarriage, as these can effect the way the cap fits.
Female condoms 	A polyurethane pouch that has a flexible ring at both ends. It is approximately 3 inches wide and 7 inches long.	79- 95%	Reduces the risk of STI and HIV transmission. Can be used by those with latex allergies. Can be inserted up to 8 hours prior to intercourse. Can increase pleasure for both partners because the rim of the outer ring stimulates the clitoris and testes during sex. Does not affect fertility.	Can be expensive. There can be a noisy/crackling sound during intercourse. It may be difficult to insert.	Add lubricant. Insert the closed end of the condom deep into the vagina to cover the cervix. The open end stays outside the vagina to partially cover the labia. After sex, remove the condom by twisting the outer ring and pulling it out gently to avoid spilling any semen.	Do not use the male and female condom together. Recommendations for the female condom indicate a single usage for each condom. However there is research being done to study whether disinfecting and cleaning a female condom can allow for multiple usage.

FORM OF CONTRACEPTION	DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Male condom 	A sheath of latex or plastic that is worn on the penis. Comes rolled up in a wrapper.	85-98%	Reduces the risk of STI and HIV transmission (only the latex variety). May help delay ejaculation. Usually inexpensive and easily accessible. Available in various textures, flavours, sizes, colours and brands. Does not affect fertility.	May break or rip if used incorrectly. Can disrupt spontaneity during sex. If stored incorrectly (in warm/ moist conditions) the condom can begin to disintegrate if. Some people may have allergic reactions to the latex.	Put the condom on after the penis is erect. Squeeze the air out of the closed end of the condom and place it on the head of the penis. Hold it in place and unroll it completely on to the penis. Let go of the tip when unrolled. After sex, the man should withdraw before the penis goes soft in order to avoid spillage of semen.	Necessary to check expiry date and whether electronically tested. Latex condoms should not be used with oil-based lubricants (like lotion or oil). Using water-based lubricants with the condom can reduce condom failure (such as breakage). Do not use a male and female condom together. Use the condom only once.
Intra-uterine device (IUD) - (hormonal and non-hormonal) 	A small, flexible device (sometimes T-shaped) inserted into the uterus. There are 2 types of IUDs - non-hormonal (also known as a Copper T) and hormonal. An IUD works at preventing fertilisation by altering the uterine environment. A hormonal IUD also contains progestin** that thickens cervical mucous making it more difficult for sperm to enter the uterus to fertilise an egg.	92-99%	The non-hormonal IUD can be left in place for up to 10 years. The hormonal IUD can be kept in place for up to 5 years. Does not interrupt intercourse. The progestin** in the hormonal IUD can help relieve menstrual cramps and bleeding.	Does not reduce risk of STI and HIV transmission. In the first few months after insertion, some women may experience cramps or backaches. It can increase menstrual bleeding, cramping or spotting between menstrual periods. Needs to be inserted by a health care provider in clean hygienic surroundings. Increased risk for pelvic inflammatory disease (PID) in the first 20 days after insertion.	A health care provider will insert the IUD. Variants are available for different durations - 3,5,7 or even 10 years.	If any side effects are experienced within the first month after insertion, a health care provider should be contacted. Make sure the IUD is in place regularly by checking the 2 small strings that hang down from the IUD into the upper vagina. Fertility can return a month after an IUD is removed.

HORMONAL METHODS

FORM OF CONTRACEPTION	DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Combined Oral Contraceptive Pills (COCs) 	Contain the hormones of oestrogen and progestin.** The combination of these 2 hormones primarily work to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.	92-99%	Easy to administer. There are many types of COCs to choose from. Reduces menstrual flow for some women. Can decrease the risk of some diseases such as PID, some cancers, or benign breast disease. Does not interrupt intercourse. Increased dosages can also be used as emergency contraception (more later in this chart).	Does not reduce risk of STI and HIV transmission. Must be taken everyday, and requires a regular supply. Can cause temporary side effects such as nausea and break-through bleeding which usually last the first three months.	Take one pill every day for 21-25 days depending on the type of COC. A doctor/ health care provider can help determine which COC is best for each woman and when to start the pills.	Should not be used by women who have blood clots, have migraine headaches or women over 35 years who smoke. Once COCs are stopped, regular fertility levels will return in approximately 3 months. It may take a month or two for periods to become regular after stopping. COCs can be used by women who are breastfeeding, after 6 months of regular breastfeeding.
Implants 	Small, plastic tubal implants that are inserted under the skin of a woman's arm. These implants slowly release hormones that primarily work to thicken cervical mucous to prevent sperm from entering the uterus and prevent ovulation.	99%	Lasts for 3 to 5 years. Does not interrupt intercourse.	Does not reduce risk of STI and HIV transmission. Some severe side effects have been reported. Can cause weight gain, irregular bleeding, and lower abdominal pain. Can be visible through the skin.	A health care provider will insert the implant under the skin in minor surgery. The implants are inserted within the first 7 days of a menstrual cycle.	Return to regular fertility after the implants are removed can take between 8-10 months.

FORM OF CONTRACEPTION	DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
injectable 	An intramuscular injection contains progestin** and is given every 12 weeks. The shot slowly releases the hormone into the body. This primarily works to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.	97-99%	For some injectables, protection against pregnancy can last for 3 months. Does not interrupt intercourse. Decreased risk for some cancers. Decrease in menstrual flow and in menstrual cramps. Can be used for women who are breastfeeding.	Does not reduce risk of STI and HIV. A health care provider must administer the shot. Possible side effects include weight gain, irregular bleeding, breast tenderness, headaches, mood swings, loss of bone density that can increase the risk for osteoporosis.	A health care provider will administer the shot in the arm or buttocks.	On average, it takes a woman 4 months to return to regular levels of fertility after discontinuing an injectable. Some women may stop having their period or have large gaps in between menstrual cycles when on an injectable.
Mini-pill	A progestin** only pill. It primarily works to thicken the mucous around the cervix to prevent sperm from entering the uterus. Also prevents ovulation.	87-99%	Easy to administer. Does not interrupt intercourse. Can be used by women who cannot take oestrogen. Women who are breastfeeding can use the mini-pill.	Does not reduce risk of STI and HIV transmission. Must be taken at the same time everyday. Women may have irregular periods or spotting in between periods.	Take one pill every day at the same time.	Should not be used by women who have certain conditions or diseases such as liver disease or breast cancer. Fertility will return immediately or within a few months after discontinuing the mini-pill.
The patch 	A small adhesive patch. It contains oestrogen and progestin** which are gradually released into the blood and primarily work to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.	99%	Does not interrupt intercourse. Can reduce menstrual flow for some women. Can decrease the risk of some conditions and diseases such as PID, some cancers, or benign breast disease.	Does not reduce risk of STI and HIV transmission. Visible on the skin. Can cause possible skin irritations and temporary side effects such as nausea and spotting in between periods that usually last for the first three months of use.	A new patch is applied each week for 3 weeks and no patch is worn on the 4th week. Some studies have shown that the patch may increase the risk of blood clots as compared to regular COCs. The patch can be worn on the lower, upper torso or arms, abdomen, buttocks.	Women who have blood clots, are breast-feeding, have migraine headaches or women over 35 years who smoke should not use the patch. Efficacy is also lower for women who weigh over 90 kilograms.

FORM OF CONTRACEPTION	DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Spermicides 	Pessaries, foams, creams, gels, suppositories, or tablets that are placed in a woman's vagina. They contain chemicals that kill sperm.	71-82%	Available in many forms. Can be left in for 6-8 hours.	Does not reduce risk of STI and HIV transmission. May weaken latex condoms making them less effective. Can have an unpleasant taste or smell. If a woman is at higher risk of HIV infection using spermicides that contain nonoxydol-9 may increase the likelihood of transmission.*	Put the spermicide deep into the vagina. Must be inserted 10-15 minutes prior to intercourse. Leave it in place for 6-8 hours after having sex. Do not douche (squirt water or other solutions, such as vinegar, baking soda, or douching solutions into the vagina) after insertion.	Most effective when used in conjunction with other barrier methods, but used on its own, it is better than no contraception method.
Vaginal ring 	A soft, plastic, flexible ring that a woman inserts into her vagina. The ring slowly releases oestrogen and progestin** hormones into the body that primarily work to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.	92-99%	Does not interrupt intercourse. Can reduce menstrual flow for some women. Decreases the risk of some conditions and diseases such as PID, some cancers, or benign breast disease.	Does not reduce risk of STI and HIV transmission. Some side effects can include, irregular bleeding, breast tenderness, headaches, nausea, and weight gain. It may be difficult to insert.	Insert a new ring once a month. The ring is placed anywhere in the vagina during the first 5 days of the menstrual period and remains there for three weeks. It is removed at the beginning of the fourth week. A new ring is inserted at the end of the fourth week.	The ring should not be removed during sexual intercourse. Women who have blood clots, are breast-feeding, have migraine headaches or women over 35 years who smoke should not use the vaginal ring.

NON-HORMONAL / NON-CHEMICAL METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Abstinence Defined as either choosing to abstain from any sexual activity, or refraining from any penetrative sexual acts (such as anal or vaginal sex), while participating in other sexual acts (such as oral sex).	100% if abstaining from any sexual activity	Nothing to purchase. Can be discontinued at anytime. Reduces the risk of STI and HIV transmission.	Potential to transmit some STIs, such as syphilis if there is skin to skin contact during sexual activity other than intercourse.	Can include periodic abstinence, in which an individual refrains from sexual activity from time to time (such as when a woman is ovulating), or constant abstinence in which an individual refrains from sexual activity at all times.	Requires the cooperation of both partners, which may not be possible at all times.
Basal Body Temperature A fertility awareness method (FAM), where a woman takes her body temperature each morning to determine the fertile phase in her menstrual cycle. During the fertile period, pregnancy can be prevented by voluntarily avoiding sex or using other forms of contraception.	With other FAMs 75-99%	Nothing to purchase. Can help a woman better understand her reproductive physiology.	Does not reduce risk of STI and HIV transmission. Takes time to learn the fertile phase and requires a commitment to checking everyday.	Each morning as soon as a woman wakes up, she records her temperature with a sensitive thermometer. A temperature rise indicates that ovulation has occured. The fertile period lasts for 3 consecutive days after this increase in temperature.	Women are advised to not eat, drink, or smoke before taking their temperature. May be difficult to use this method during times of stress, illness or lack of sleep because these factors can affect body temperatures.
Breast Feeding/LAM (Lactational Amenorrhoea Method) *Exclusive* breastfeeding for the 1st 6 months after childbirth produces prolactin, a hormone that suppresses ovulation.		Nothing to purchase. Can be discontinued at anytime.	Does not reduce risk of STI and HIV transmission. Will only last for 6 months after delivery and only if the woman is exclusively breastfeeding.	Requires that a woman has not had a period since delivery. A woman must breastfeed at least six times a day (every four hours) from both breasts. Protection lasts for 6 months after giving birth.	Women who have HIV/AIDS may be advised to not breastfeed (5-20% chance of HIV transmission through breast feeding).

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Calendar (rhythm) Method A fertility awareness method (FAM), this requires recording and calculating the number of days in a woman's menstrual cycle to determine the fertile phase in the cycle. During the fertile period, pregnancy can be prevented by voluntarily avoiding sexual intercourse or using another contraceptive method.	With other FAMs 75-99%	Nothing to purchase. Can help a woman better understand her reproductive physiology.	Does not reduce risk of STI and HIV transmission. Takes time to learn the fertile phase and requires a commitment to recording the menstrual cycle each month.	Keep a written record of each menstrual cycle, counting from the first day of one menstrual period up to, but not including, the first day of the next. Keep records of 6 cycles. To find the start of the fertile days take the shortest cycle recorded and subtract 18. To find the end of the fertile phase, take the longest cycle recorded and subtract 11.	This method may be difficult to use for women with irregular periods.
Cervical Mucous Method A fertility awareness method (FAM)., this requires checking the texture, colour and quality of the mucous and secretions in the vulva to determine a woman's fertile phase. During the fertile period, pregnancy can be prevented by voluntarily avoiding sexual intercourse or using another contraceptive method.	With other FAMs 75-99% Efficacy varies.	Nothing to purchase. Can help a woman better understand her reproductive physiology.	Does not reduce risk of STI and HIV transmission. Takes time to learn the fertile phase and requires a commitment to check the cervical mucous everyday.	Check the mucous each day for several months. Pre-ovulation mucous is yellow/ white, cloudy and sticky. Ovulation secretions are clear and slippery and can be stretched between the fingers. During the fertile phase (after ovulation) the mucous is thick and cloudy. After the fertile phase there may be little/no mucous.	Not recommended for women with abnormal discharge.

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Coitus Interruptus Withdrawal method in which the man completely removes his penis from the woman's vagina before he ejaculates.		Nothing to purchase.	Does not reduce risk of STI and HIV transmission. Can be highly ineffective at preventing pregnancy because pre-ejaculatory fluid secreted from the penis after erection also contains sperm that can enter the vagina during penetration. Can interfere with sex and make partners worry about withdrawing 'in time'.	Before ejaculating a man will remove his penis from the woman's vagina. A man must be able to anticipate and control his ejaculation.	Requires that both partners to cooperate.

PERMANENT METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Tubectomy or Tubal Ligation A surgical procedure that blocks the fallopian tubes. The procedure prevents an egg from travelling from the ovary to the uterus and sperm from reaching the egg to fertilise it.	Nearly 100%.	Does not interrupt intercourse. Permanently prevents pregnancy.	Does not reduce risk of STI and HIV transmission. Can be emotionally difficult for women who see it as an inability to have more children. Complications such as infection can occur from the surgery. Reversal is difficult and requires a highly skilled medical practitioner.	There are surgical and non-surgical options. In the surgical procedure the fallopian tubes are cut, sewn or tied. In a non-surgical procedure small metal implants are inserted into the fallopian tubes. Over time scar tissues grows over these implants and blocks the fallopian tubes. The patient can leave soon after these procedures are completed.	Does not effect menstrual periods, ability to have an orgasm, and nor does it cause menopause.

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Vasectomy A surgical procedure that seals the vas deferens preventing sperm from getting into semen. After a vasectomy, a man still produces semen but there is no sperm it.	Nearly 100% effective at preventing pregnancy.	Does not interrupt intercourse. Permanently prevents pregnancy. Complications are rare.	Does not reduce risk of STI and HIV transmission. Can be emotionally difficult. Reversal surgeries are not highly successful.	A health care provider will cut and seal the two vas deferens. Can be done by the standard method or the no-scalpel technique (non-invasive).The patient can leave soon after the procedure is completed.	Takes around 15-30 ejaculations after the operation to clear out the sperm already in the vas deferens – during this time an alternative contraception should be used. Does not affect ability to have an erection, ejaculation, or the ability to have an orgasm.

OTHER

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE	OTHER INFORMATION
Emergency Contraceptive Pills (ECPs) Also known as the 'morning-after pill'. ECPs are higher dosages of the hormones found in regular oral contraceptive pills. They can be taken up to 5 days after unprotected sex or contraceptive failure to prevent pregnancy. EC works to prevent fertilisation, inhibit ovulation or alter the uterine lining preventing implantation of an egg.	Up to 94% effective if taken within 24 hours. It is up to 79% effective if taken within 5 days.	Easy to use. The side effects are short-term.	Does not reduce risk of STI and HIV transmission. ECPs can only be used up to 5 days after unprotected sex or contraceptive failure. Some side effects are nausea, or vomiting, breast tenderness, late or early onset of the next period with heavier or lighter flow.	A woman takes one dosage of ECPs as soon as possible after unprotected sex / contraceptive failure and the second dosage 12 hours later. Dosage depends on the type of regimen being used. Some COCs in higher dosages can also be used as emergency contraceptives. A copper bearing IUD can also be used an emergency contraceptive.	ECPs do not cause an abortion and should not be confused with the abortion pill (for example, RU-486). If a woman is already pregnant when she takes EC, it will not interrupt the pregnancy. If EC is taken mistakenly during a pregnancy, it will not harm the foetus. Taking EC will not harm a woman's ability to become pregnant in the future.

Handout 2.8
Basic Information on Abortion

What are an induced abortion and a spontaneous abortion?

An abortion is the induced or spontaneous termination of a pregnancy. A spontaneous abortion occurs when a pregnancy terminates without any medical or surgical intervention, as in the case of a miscarriage. Induced abortions involve surgical or medical procedures for termination of the pregnancy.

How late in a pregnancy can you have an induced surgical abortion?

Countries have different laws on abortion and up to what week certain abortion procedures can be performed. Abortion was legalised in India over 30 years ago (see http://www.mp.nic.in/health/mtp%20Act.pdf for the full text of the Medical Termination of Pregnancy Act, 1971). Please check the laws in your country for information on which methods are available and till what stage in a pregnancy. In addition, keep abreast of medical developments in the field as well as the socio-legal implications of abortion in your region.

Up to 7 weeks

Manual Vacuum Aspiration (MVA) can be performed up to 7 weeks after a woman's last menstrual period. This procedure can be done under local or general anaesthesia and is safe and highly effective (95-97% efficacy). During a MVA a speculum holds open the vagina. Small instruments called dilators are then used to gradually open up a women's cervix. A small tube with an attached syringe is inserted into her uterus, which will create a vacuum. This vacuum will suction out and remove the contents of the uterus into the syringe container. The procedure takes between five and ten minutes.

Up to 14 weeks

Dilation and Suction Curettage (D&C) can be performed between six and fourteen weeks after a woman's last menstrual period. This procedure is done under local or general anaesthesia and is safe and effective. A speculum holds open the vagina after which small instruments called dilators are gradually used to open up the women's cervix. A small tube attached to a suction machine is then inserted into the woman's uterus. The machine is turned on and the tube suctions out the contents of the uterus. Once this is over, the machine is turned off and a spoon shaped instrument called a curette is moved along the walls of the uterus to remove any remains of the uterine contents.

Between 14 and 24 weeks

Dilatation and Evacuation (D&E) can be performed between 14 and 24 weeks after a woman's last menstrual period. D&E is generally a two-day procedure: on the first day the cervix is dilated and on the second day the uterine contents are removed. To dilate the cervix, small instruments called dilators are used and may be left inside for many hours to gradually open the cervix wide enough. After the cervix has opened sufficiently, a small tube connected to a suction machine is inserted into the woman's uterus. The machine is turned on and removes the uterine contents. Instruments are also moved along the sides of the uterus to remove any remaining tissue from the uterus.

What are the side effects from induced surgical abortion procedures?

Patients may feel groggy from anaesthesia, and uterine bleeding and cramps are common. Sanitary pads are needed for the bleeding. Some patients may also feel faint, or nauseous.

When can an induced medical abortion be performed?

In India, Mifepristone and Misoprostol are two common drugs sold through chemist outlets on prescription. While the former is registered for use in the first 49 days (7 weeks) of pregnancy, the latter has been endorsed for use for the first 56 days (8 weeks) of pregnancy.

What does an induced medical abortion involve?

A medical abortion uses a combination of two hormonal drugs - an anti-progesterone and prostaglandin, which can be used through various routes namely by mouth, by injection intramuscularly/intravenously or vaginally. A woman first takes the anti-progesterone (Mifeprestone), which prevents the hormone progesterone from being produced in her body. Without progesterone the lining of the uterus will begin to shed and is unable to hold a fertilised egg. Twenty-four to forty-eight hours after the anti-progesterone is taken the woman will take the prostaglandin (often Misoprostol). The prostaglandin causes the uterus to contract, the cervix to open and the uterine contents to be expelled from the woman's body.

What are the side effects from induced medical abortions?

Cramping and bleeding are common, and are often taken to mean that the drugs are working. Other side effects include nausea, dizziness, diarrhoea, vomiting, and back pain.

What are unsafe abortions?

According the World Health Organization (WHO) definition, an unsafe abortion is 'a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimum medical standards, or both.'

How many women die from unsafe or illegal abortions each year?

According to the WHO 80,000 women worldwide die every year from unsafe or illegal abortions.

Handout 2.9 Facilitator Copy: Quiz on Conception, Contraception, and Abortion

- ***What is conception?***

  Conception is when an egg (ovum) is fertilised by a sperm.

- ***Please define pregnancy.***

  Pregnancy occurs when the fertilised egg attaches to the uterine wall and begins to secrete increased levels of certain hormones that thicken the uterine wall and cause a woman to stop having her menstrual periods.

- ***What is oestrogen?***

  Oestrogen is a hormone produced in a woman's ovaries and signals the ovaries to release an egg. The release of the egg is called ovulation.

- ***How long can sperm live inside a woman's body?***

  Sperm can live in a woman's body for up to 6 days.

- ***What are two options for non-hormonal contraception?***

  Answers can include the male condom, female condom, cervical cap, non-hormonal intra-uterine device.

- ***Can a woman get pregnant if she has intercourse during her period?***

  There is a very small chance of this happening. Sperm can live up to 6 days in the cervical mucus of a woman's vagina and ovulation can sometimes occur soon after the last day of a woman's period. It is also possible for the woman to ovulate during her period, though this is not very common.

- ***What are an induced and a spontaneous abortion?***

  A spontaneous abortion occurs when a pregnancy terminates without any medical or surgical interventions, as in a miscarriage. Induced abortions involve surgical or medical procedures to terminate a pregnancy.

- *What is a medical abortion?*

A medical abortion uses a combination of two hormonal drugs, an anti-progesterone and prostaglandin, to end a pregnancy. It can be used to end a pregnancy up to 6-8 weeks of pregnancy in India. Please check legal status and availability of this procedure in your region.

- *What are some side effects from an abortion?*

Side effects can include cramping and bleeding, nausea, dizziness, diarrhoea, vomiting, and back pain.

- *Approximately how many women die each year worldwide from unsafe or illegal abortions?*

According to the WHO, approximately 80,000 women die each year from unsafe or illegal abortions.

- *True or false: If a woman has an abortion she will be unable to have children in the future.*

False. If a woman has a safe abortion without severe complications, she can still get pregnant in the future.

- *Name three types of hormonal contraception options.*

Answers can include oral contraceptive pills, hormonal intra-uterine device, injectables.

- *Are any male hormonal contraceptive pills available?*

No, there are currently no male oral contraceptive pills; however there is research being done to develop such an option.

- *What are emergency contraception pills?*

Emergency contraceptive pills are pills with higher dosages of the hormones found in regular oral contraceptive birth control pills. These can be taken up to five days after unprotected sex or contraceptive failure to prevent pregnancy.

- *Can a woman get pregnant from performing oral sex on a man and swallowing the ejaculate?*

No. A person cannot get pregnant from performing oral sex on a man and swallowing the ejaculate.

Handout 2.10 Participant Copy: Quiz on Conception, Contraception, Abortion

- What is conception?
- Please define pregnancy.
- What is oestrogen?
- How long can sperm live inside a woman's body?
- What are two options for non-hormonal contraception?
- Can a woman get pregnant if she has intercourse during her period?
- What are an induced and a spontaneous abortion?
- What is a medical abortion?
- What are some side effects from an abortion?
- Approximately how many women die each year worldwide from unsafe or illegal abortions?
- True or false: If a woman has an abortion she will be unable to have children in the future.
- Name three types of hormonal contraception options.
- Are any male hormonal contraceptive pills available?
- What are emergency contraception pills?
- Can a woman get pregnant from performing oral sex on a man and swallowing the ejaculate?

Chapter 3
Infertility and Assisted Reproductive Technologies

Chapter Objectives for the Facilitator

1. To have participants understand infertility and its possible causes.
2. To have participants understand treatments for infertility and the benefits and disadvantages of options such as assisted reproductive technologies, adoption and surrogacy.
3. To explore attitudes about infertility and options available to deal with infertility.
4. To explore the attitudes and stigma associated with infertility in the communities that participants live and work in.

Why a Chapter on Infertility and Assisted Reproductive Technologies

'I wanted to have a child so badly and tried so hard to. I prayed, I ate well, I did not smoke or drink. But I never could bear a child and I know my husband blamed me and so did his family. I continue to hope that it will happen soon, but as each day passes I worry more and more that my husband will leave me and I will be left with nothing. Having a child is the most important thing in my community. Without this, you are considered incomplete and useless.'

In many parts of the world, including India, bearing a child is often thought of as an essential contribution to one's family and community. For some, a child represents an additional pair of hands to work and contribute to the household income, while others see children as a means to pass on the family name and legacy. Either way, the desire to have children and a family is common. This emphasis put on childbearing can make it difficult for those who have problems or are unable to have children. They endure personal, community and family frustrations, stigma, and at times, even abuse or violence.

According to the World Health Organization more than 80 million people worldwide experience infertility problems and a majority of them live in developing countries (World Health Organization. 2001. *Current Practices and Controversies in Assisted Reproduction*). Men and women can be infertile for various reasons. These can include medical conditions such as abnormalities in hormonal productions; as a consequence of an untreated sexually transmitted infection; or unexplained reasons.

A number of options exist for those who experience infertility, including adoption, surrogacy, and assisted reproductive technologies (ARTs). ARTs are treatments or procedures that use human eggs and sperm to bring about conception with the help of medical intervention. ARTs have been increasingly used worldwide, including in developing countries. However, these have not erased the stigma and discrimination that individuals, particularly women, face when they are unable to bear a child. In fact the introduction of ARTs and the continued emphasis on bearing children gives rise to many issues and questions: when and how should ARTs be used? Why is stigma associated with infertility? How can a balance be established between efforts to provide women with reproductive choices, and the promotion of ARTs, which have a success rate of below 30%? Should ARTs be a priority in areas with limited resources?

This chapter on infertility and assisted reproductive technologies addresses some of these questions and the issues around them. It

EXERCISES IN THIS CHAPTER

Exercise 1: Demystifying Infertility. 45 minutes

Exercise 2: Infertility Basics. 60 minutes

Exercise 3: Looking at Options: Fertility Treatments. 60 minutes

Exercise 4: Case studies: Options To Deal With Infertility. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Index cards/slips of paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 2.11
Basic Information on Infertility

Handout 2.12
Basic Information on Options for Infertility

Handout 2.13 Facilitator Copy: Myths and Facts on Infertility and Assisted Reproductive Technologies (ARTs)

Handout 2.14 Participant Copy: Myths and Facts on Infertility and Assisted Reproductive Technologies

Handout 2.15
Case Studies on Adoption, Surrogacy and Assisted Reproductive Technologies (ARTs)

ADDITIONAL RESOURCES:

- Centres for Disease Control and Prevention. Assisted Reproductive Technologies: Home. http://www.cdc.gov/reproductivehealth/ART/index.htm
- For information on Male Infertility see Centre for Male Reproduction and Vasectomy Reversal. www.malereproduction.com
- Reproductive Health Outlook: Infertility. http://www.rho.org/html/infertility_keyissues.htm#geographic
- Reproductive Science Centre. http://www.rscbayarea.com/articles/micromon.html
- World Health Organization. 2002. *Current Practices and Controversies in Assisted Reproduction*. Geneva: World Health Organization. Available at http://www.who.int/reproductive-health/infertility/report_content.htm
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

also addresses the attitudes, stigma and discrimination associated with infertility in many parts of the world, and how this is greatly affected by gender and related to reproductive rights.

Key Messages for this Chapter

- For the purposes of this manual, Infertility has been defined as the inability to have a pregnancy occur after 12 months of unprotected sex. The cause for this can be in the man, the woman or in both. *Primary infertility* occurs when a person has never been able to have a pregnancy occur, even after 12 months of unprotected intercourse. *Secondary infertility* refers to a situation where, people who have previously had a child are unable to conceive again, even after 12 months of unprotected intercourse.
- The causes of infertility vary. They can include but are not limited to congenital conditions, consequences of untreated reproductive tract infections (RTIs) or sexually transmitted infections (STIs), poor reproductive health services and/or poor nutrition.
- Women may experience the negative consequences/stigma of infertility more than men, especially in countries where motherhood is highly valued. In such cases, women who do not have children may suffer stress and ridicule from the community, and sometimes even abuse and violence.
- Options exist for people who experience infertility, and want to have a child. These include assisted reproductive technologies (ARTs), adoption or surrogacy.
- ARTs can be successful in treating infertility and individuals should have access to this option. However, ARTs can also be misused, and have ethical and social implications.
- Individuals have the reproductive right to have children, and should have access to ARTs should they want them. They also have the right to not having a child if they do not want to access any of these options.
- Economic, cultural and social issues can affect people's access to health services that provide ARTs, or give them the opportunity for adoption or surrogacy.
- The use of ARTs has clashed with population control policies in many countries around the world. It may be difficult to get support for ARTs if there is an emphasis on population control. Moreover, public health programmes focus more on HIV/AIDS, STIs, diseases such as malaria, sanitation etc. Therefore resources for the treatment of infertility may be limited. A denial of such services and options is a violation of a person's right to have children and access services enabling them to do so.

Exercise 1
Demystifying Infertility

GROUP EXERCISE

Instructions

1. Distribute Handout 2.14 to each participant. Give participants 5 minutes to read through the Handout and decide whether each statement is a myth or a fact.

2. Review each answer separately by asking participants to share their responses to each statement. Ask for questions or comments and discuss each statement briefly.

   Suggested Questions:

- If the statement was a myth, do you think that people in the communities you live or work in believe this to be a fact?
- How could you dispel these myths and clarify misconceptions about infertility?

3. After all the statements have been reviewed and discussed, ask for general questions or comments.

   Suggested Questions:

- Are there any additional ideas or statements about infertility you need clarification on?
- How do you think myths about infertility affect women and men who cannot have children? For example, one myth is that a woman's inability to get pregnant is her fault and not that of her partner. This affects her self-esteem adversely and she may also be excluded or punished by her community for not conceiving.

Purpose of the exercise:

1. To discuss personal ideas and attitudes about infertility.

2. To discuss common myths about infertility and facts that can be used to dispel them.

TIME

45 minutes

MATERIALS

Handout 2.13 Facilitator Copy: Myths and Facts on Infertility, Handout 2.14 Participant Copy: Myths and Facts on Infertility, pens/pencils

ADVANCE PREPARATION

Review Handout 2.13, make copies of Handout 2.14 for participants

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting it as a quiz game by dividing participants into two groups and reading out statements from Handout 2.13. Each correct answer can earn the group points. Keep score and declare the team with the higher score as the winner at the end of the exercise.
- Combine this exercise with the other myth/fact exercises and pre-tests from this module to conduct a larger quiz game or assessment at the start or end of the module.

MAKING CONNECTIONS

- Basic information on human sexual and reproductive anatomy and physiology, as well as on conception is required before learning about infertility. For more see Chapters 1 and 2 in this Module.
- Infertility is often caused by uncured or untreated sexually transmitted infections. For more see Chapter 4 in this Module.

Key Messages

- There are many myths related to infertility. The perpetuation of these myths can alienate people in their communities, lead to emotional abuse from family or community, and cause increased stress and pressure to have children, particularly on women.
- Infertility is often the result of medical conditions, which may be congenital, the consequence of poor reproductive healthcare, or the effects of a reproductive tract infection or sexually transmitted infection.
- A common myth is that women are responsible for infertility, particularly if they decide to delay pregnancy with contraceptives.
- Women are usually more stigmatised for infertility. This stigma falsely focuses on their 'lack of femininity' if they cannot bear a child, and can result in their ostracism from society. Femininity and motherhood are not connected: a woman may not have a child and still be feminine.
- Reproduction and childbearing is not the only role for a woman in society. If a woman cannot have a child it should not affect her status within her family or community.
- Infertility can be a problem for people who want to have children. However not all people want to have children and have a right to make this choice.

TIPS FOR THE FACILITATOR:

- Some communities believe that faith, prayer and destiny can impact the ability to have or not have children. Take note when these arguments are used. Ask questions to examine these ideas, such as why and what participants think the role of faith or destiny is; how this may alienate women and help to perpetuate myths and negative attitudes towards those who do not have children; or whether such attitudes are harmful and can increase stigma for those concerned.

Exercise 2
Infertility Basics

LECTURETTE

Instructions

1. Introduce the topic to participants, explaining that it is only a brief overview of infertility. For some, this information may be a review and for others it may be new. It is important to have some basic knowledge of the issues and ensure that all the participants are at the same level of understanding. Begin the lecturette with the points in Handout 2.11. After the lecturette, ask for questions or comments from the group.

Suggested Questions:

- Are there any causes or reasons for infertility you are unclear about? Are there any other causes that are not listed here?
- Did you think some of these causes were myths?
- How can awareness of the facts about infertility help you discuss this issue with people from your community?

Purpose of the exercise:

1. To understand and describe causes of infertility.

2. To dispel myths that may exist about infertility the participants' communities.

TIME

45 minutes

MATERIALS

Flipchart, markers, Handout 2.11 Basic Information on Infertility

ADVANCE PREPARATION

Review Handout 2.11. Copy bullet points from the handout onto a flipchart.

THIS EXERCISE CAN BE MODIFIED BY:

- Combining this lesson with Exercise 3 in this Chapter (*Looking at Options: Fertility Treatments*) and asking participants in groups to create 'lessons' to teach each other about infertility and options to deal with infertility.
- Distributing Handout 2.11 to participants and giving them 5-10 minutes to read it over before asking them a series of questions about the information in the Handout. For example: 'Name 3 reasons for infertility in men'; 'Name 3 reasons for infertility in women'; 'How can we educate others about the reasons for infertility?'

MAKING CONNECTIONS

- Basic information on human sexual and reproductive anatomy and physiology, as well as on conception is required before learning about infertility. For more see Chapters 1 and 2 in this Module.
- To conceive and have a child is a reproductive right. For more see Chapter 2 in Module 3.

Key Messages

- Infertility is often the result of a medical condition affecting either a woman or man, or both of them.
- Improved health services can decrease infertility among men and women. Diagnosing and early treatment of sexually transmitted infections (STIs) and reproductive tract infections (RTIs), regularising a woman's menstrual cycle, or treating a man's low sperm count, are some ways of doing this.
- Knowing the facts about infertility can help to dispel myths and the stigma related to it. It can also lead to the initiation of discussion about infertility in communities and social groups.

TIPS FOR THE FACILITATOR:

- Some participants may still believe some myths to be true. One such example is the belief that infrequent menstrual periods are a cause of infertility. Encourage people to share their beliefs and discuss facts that can dispel these myths.
- Participants may find a lecture on this issue dull. Try to keep the session brief and concise to hold the participants' attention.
- Facilitators may not be able to respond to some questions that may arise. Put these inquiries into the Parking Lot and try to address them later after doing research and finding answers to the questions.

Exercise 3
Looking at Options: Fertility Treatments

TEACHING A CLASS

Instructions

1. Divide the participants into groups. Hand each group a copy of Handout 2.12. Explain that the handouts describe different options to deal with infertility including assisted reproductive technologies (ARTs). Ask groups to read over the options and discuss them among their groups. They should also answer the following questions:

- Was there anything that you do not understand about these options?
- What are 2 benefits and 2 disadvantages to each of these methods?

Give participants 20-25 minutes to create the presentations.

2. Ask participants to return to the larger group and have each present their benefits and disadvantages and any questions they may still have. Write the points up on a flipchart and answer the questions as they arise.

3. After presentations are complete, ask for any other questions or comments.

Suggested Questions:

- Should people who want children consider adoption or surrogacy if they are unable to have children biologically?
- How is access to options to deal with infertility connected to reproductive rights?
- Would any/all of these options be available to people in your community? Would they be accepted as good alternatives for people who experience infertility?

Purpose of the exercise:

1. To understand and describe options for those experiencing infertility, including adoption, surrogacy and assisted reproductive technologies (ARTs).

2. To discuss the benefits and disadvantages of common options for dealing with infertility.

3. To discuss access options that deal with infertility and how this is related to reproductive rights.

TIME

90 minutes

MATERIALS

Flipchart, pens/pencils, markers, Handout 2.12 Basic Information on Assisted Reproductive Technologies.

ADVANCE PREPARATION

Make copies and review Handout 2.12.

THIS EXERCISE CAN BE MODIFIED BY:

- Distributing Handout 2.12 to participants and giving them 5-10 minutes to read through it and formulate any questions that come to mind. A series of questions can then be asked about the Handout. For example: 'Name 3 types of ARTs'; 'If you had a sister/brother who was interested in getting one of these procedures done what would you say to her/ him?'
- Having a longer debate about the benefits and disadvantages of ARTs. Participants can be divided into two groups, one to discuss the advantages and the other the disadvantages. The two groups can then debate the issue.

Key Messages

- People who are infertile have options if they want to have children. They can consider assisted reproductive technologies, adoption or surrogacy, if appropriate and affordable. They may consider not having a child as an option too.
- Adoption and surrogacy can also be used for people who are able to bear children. These options are not just for people who experience infertility.
- There are both advantages and disadvantages to using reproductive technologies. Benefits include more options and choices in reproductive health. ARTs can also be used as an advocacy tool to promote better prenatal and women's healthcare.
- Disadvantages of ARTs can include potential misuse for selective abortion, adverse effects on the rights of disabled people (by advocating for termination of a pregnancy if the child is likely to be born with some 'deficiency'), or viewing the foetus as more important than the woman who is considered only as a 'reproducer'. In addition, these options are expensive and therefore may be available only to people of a higher socio-economic group, leaving out those who cannot afford these options.

MAKING CONNECTIONS

- To conceive and have a child is a reproductive right. For more see Chapter 2 in Module 3.
- People who cannot have children often face stigma and discrimination in their communities and families. For more see Chapter 2 in Module 4.

TIPS FOR THE FACILITATOR:

- The information in this exercise can be difficult to understand and absorb. Keep the exercise brief and do an energiser at the end of the exercise.
- Some ART's are complex and it is important to emphasise to participants that this exercise is intended merely to provide an overview of options for people who want children.
- Participants should be aware of these options to deal with infertility in order to discuss the benefits, disadvantages and consequences of these methods.
- Participants may want to check which options that are available, accessible and acceptable in their communities.

Exercise 4
Case Studies: Options To Deal With Infertility

CASE STUDY

Instructions

1. Divide participants into three groups. Distribute one case study from Handout 2.15 to each group. Give groups 20-30 minutes to read and discuss the case and answer the corresponding questions.

2. Ask participants to return to the larger group and invite each group to give a 3-5 minute overview of the case study and their discussion. After each presentation, ask for reactions and questions.

Suggested Questions:

- Do you agree with the conclusions of the group? Would you suggest an alternative?
- Have you encountered any similar situations in your work/ life? How was it dealt with?
- Would people in your communities or families feel differently about this situation?

Purpose of the exercise:

To discuss attitudes to adoption, surrogacy and ARTs, and the implications of these attitudes.

TIME

90 minutes

MATERIALS

Handout 2.15 Case Studies on Adoption, Surrogacy and Assisted Reproductive Technologies (ARTs).

ADVANCE PREPARATION

Make copies of Handout 2.15.

THIS EXERCISE CAN BE MODIFIED BY:

- Choosing only one case study and reading it together as a large group. This may benefit groups that want to look specifically at one option to deal with infertility.

MAKING CONNECTIONS

- People who cannot have children often face stigma and discrimination in their communities and families. For more see Chapter 2 in Module 4.
- Options for infertility are often available to people with money and opportunities. For more on power, see Chapter 1 in Module 4.

Key Messages

- Surrogacy, adoption and ARTs are options for those who experience infertility and want to have a child. It is important not to abuse these methods, for example using them for sex selection. Surrogacy and adoption are also options for fertile couples.
- It can be emotionally stressful for people to undergo these procedures. This includes the person receiving any of these treatments, the partner, the possible surrogate mother, and/or their families.
- Reproductive health decisions are not made in a vacuum and are influenced by family, cultural, religious, social and economic factors. Therefore making decisions on adoption, surrogacy or ARTs can be difficult and are not just based on the wants of an individual or couple trying to have a child.
- Adoption, surrogacy, and ARTs are not always accepted options by communities/families/social groups and people who use these options can be looked down upon. But it is an individual's reproductive right to have children and choose any of these options.

TIPS FOR THE FACILITATOR:

- Some participants may believe that surrogacy can be an option only if the surrogate is related to the parents. Make sure to introduce other legitimate possibilities, such as using an unknown or unrelated surrogate.
- Some participants may argue that it is dangerous to adopt a child from unknown parents because of unknown genetic predispositions. While there is a genetic predisposition to certain conditions, it has not been proven that behaviour/conditions such as criminal behaviour or alcoholism is linked to one's genes. It may be worthwhile to point out that if participants are worried about predispositions to disabilities or chronic illnesses, the same uncertainties would exist even if they were to have their own biological child, unless they underwent some sort of genetic testing beforehand.

Handout 2.11
Basic Information on Infertility

For more on statistics and details on the information found below, please see the World Health Organization's *Current Practices and Controversies in Assisted Reproduction*. Available at http://www.who.int/reproductive-health/infertility/report.pdf.

What is infertility?

For the purposes of this chapter, Infertility has been defined as the inability to have a pregnancy occur after 12 months of unprotected sexual intercourse. The reason for this can be in the man, the woman or in both. *Primary infertility* occurs when a person has never been able to have a pregnancy occur, even after 12 months of unprotected intercourse. *Secondary infertility* refers to situation in which people who have previously had a child are unable to conceive again, even after 12 months of unprotected intercourse. Some people do not agree with the medical definition of, or even the term Infertility. These discussions are important and need to be followed through, especially while working from a rights perspective. However, these are new and ongoing debates and are beyond the scope of this manual.

How common is infertility?

Infertility affects more than 80 million people worldwide. In general, one in ten couples experience primary or secondary infertility, but infertility rates vary between countries from less than 5% to more than 30%. Between 8% and 12% of couples around the world have difficulty conceiving a child at some point in their lives.

What are some statisitcs on infertility?

- Approximately 80% of people succeed in creating a pregnancy in the first year of trying.
- Approximately 10% of people succeed in creating a pregnancy in the second year of trying.
- Approximately 10% of people fail to create a pregnancy and seek assistance. From this 10%: 30% of this are men with a problem, 30% of this are women with a problem, 30% of this are both men and women with a problem, and in 10% of the cases the reasons are unknown.

Can infertility be treated or cured?

Infertility can be treated in some cases. For example a low sperm count can be increased with medication or with changes in lifestyle, such as decreasing alcohol consumption or wearing looser clothing. In cases when the cause of infertility cannot be diagnosed, treatment may not be possible.

What are some of the causes of infertility in men and women?

In the chart below are some causes of infertility in men and women. A doctor must be consulted to know if there is a medical reason for infertility. This list is not exhaustive but has been included to provide some reasons for infertility.

CATEGORIES OF INFERTILITY IN WOMEN	WHAT IS IT?	CAN BE AFFECTED BY:
Ovulatory Problems	Ovulation is the process by which the ovaries release an ovum (egg), which travels down the fallopian tube to the uterus. This usually occurs once a month. During this process the egg has the potential to be fertilised by a sperm and attach to the wall of the uterus resulting in a pregnancy. Irregular, sporadic or no ovulation can make it difficult for women to conceive. As women age, ovulation can start to decline making it more difficult to have children.	· Abnormalities in the thyroid gland, which is a small gland located underneath the voice box that produces hormones. · Overproduction of prolactin, which is the hormone leading to the production of breast milk. · Excess testosterone (male hormone) · Effects of cancer or cancer treatment · Physical stress · Psychological stress · Lifestyle changes such as dietary changes, shifting living situations into new time zones, and increased alcohol consumption
Cervical Factors	Cervical factors impede the ability of the sperm to pass through the mouth of the uterus because of damage to the cervix.	· Inadequate or inhospitable mucous in the cervix. · Cervical narrowing or 'stenosis' · Infections of the cervix from common STIs such as chlamydia and gonorrhoea. · Sperm allergy where the immune system attacks the sperm and does not allow it to travel to fertilise the egg.
Pelvic And Tubal Factors	These factors include any disruption of normal pelvic and tubal activity, such as scarring in the fallopian tubes.	· Scar tissue or adhesions. · Endometriosis - where the endometrial lining grows outside the uterus and attaches to other organs such as the ovaries and fallopian tubes.
Uterine Factors	Unfriendly/inhospitable conditions in the uterus that prevent sperm from travelling up to the fallopian tubes or prevent implantation of the fertilised egg.	· Benign tumours called fibroids in the uterus. · Thin or abnormal uterine lining · Anatomic problems such as uterine fibroids, polyps, abnormal shape of the uterus.
Unexplained	Approximately 10% of women experiencing infertility do so from unexplained causes. This simply means that the results of common tests to diagnose the cause of infertility show normal results and a cause for the infertility is not determined.	

CATEGORIES OF INFERTILITY IN MEN	WHAT IS IT?	CAN BE AFFECTED BY:
Low Sperm Count	There are not enough sperm in the semen to travel through the fallopian tube to fertilise an egg. Normal sperm count varies from 20 to 150 million sperm per millilitre. The normal volume of ejaculate varies from 1.5 to 5 millilitres.	· Swollen varicose vein in the scrotum. · Hormonal problems in the testicles or pituitary gland that produces testosterone. · Effects from cancer treatments such as radiation or chemotherapy. · Use of tobacco, alcohol, drugs such as marijuana · Testicular injury, such as sports or work injury, or congenital. · Structural problems including blocked ejaculation due to a vasectomy, or retrograde ejaculation. · Short-term illness or infection in adulthood like mumps. · Physical stress · Psychological stress · Too much heat around the genitals from tight clothing, saunas or hot tubs. · Medications · Genetic factors like Klinefelter syndrome. · Inexplicable reasons
Abnormal Sperm Shape	This happens when over 40% of sperm in the semen have a shape and structure different from the usual shape (oval head, mid-piece, and tail) that prevents them from moving forward to the fallopian tubes and fertilising an egg.	· Varicocele · Use of drugs and smoking · Heat around the genitals from tight clothing, saunas or hot tubs. · Infrequent ejaculation · Infection
Low Sperm Motility	Refers to the inability of more than 50% of the sperm in the semen to move forward through the vagina and cervix to the fallopian tube to fertilise an egg.	· Swollen varicose vein in the scrotum. · Too much heat to genitals from tight clothing, saunas or hot tubs.
Unexplained	Approximately 10% of men experiencing infertility do so from unexplained causes. This simply means that common tests to diagnose the cause of infertility show normal results and a cause is not found for the infertility.	

Handout 2.12
Basic Information on Options for Infertility

What are some options for individuals who experience infertility and want to have a child?

Individuals can adopt a child, opt for a surrogate, or assisted reproductive technologies (ARTs).

What is adoption?

Adoption refers to the process whereby an individual or couple take on the guardianship of a child that is not biologically theirs. Laws of the country usually govern eligibility and other conditions for adoption.

What is surrogacy?

Surrogacy is when a woman acts as a 'carrier' (or surrogate) for a person unable to conceive or carry a child to term. The surrogate bears a pregnancy and delivers the baby for another person/couple, after which the child would be legally adopted by the individual/couple for whom she carried the baby.

What is artificial insemination?

Artificial insemination (AI) is a general term used for assisted reproductive technologies (ARTs). AI is a procedure in which a qualified reproductive health specialist injects sperm into a woman's reproductive tract. There are different types of AI: intracervical (in the cervical canal), intrauterine (in the uterine cavity), intrafollicular (in the ovarian follicle) or intratubal (in the fallopian tubes) injections.

What is egg or sperm donation?

Egg donation is when eggs are donated, fertilised by sperm, and then placed into the uterus of a woman who is unable to produce eggs herself. Sperm donation refers to the process by which a man gives his sperm to be used to fertilise an egg. It is also possible to freeze embryos for future implantation. This is often used for people who may have cancer and are on chemotherapy that can often decrease fertility.

What are some forms of ARTs and procedures that may help a woman get pregnant?

Some common ARTs and procedures are described below. Please note that these may not be offered or available in all countries or regions. The information here is intended to provide an introduction to available options.

ASSISTED REPRODUCTIVE TECHNOLOGIES

IUI–intrauterine insemination.	Sperm is concentrated and then injected into a woman's uterus. Increasing the number of sperm injected into the fallopian tube improves the possibility of a pregnancy.
ICSI–intracytoplasmic sperm injection	Usually used when men have a low sperm count, poor sperm motility, or sperm shape is not normal. In this process a single sperm is injected into the egg.
IVF–in vitro fertilisation	A woman's eggs are harvested, mixed with sperm and re-implanted into her uterus. Multiple eggs are implanted.
Gamete intrafallopian tube transfer (GIFT)	A laparoscope is used to recover the eggs from the ovary, sperm is mixed with the eggs, and then both are transferred back into the ends of the fallopian tube.
Zygotic intrafallopian tube transfer (ZIFT) Sometimes called	A laparoscope is used to place embryos into the ends of the fallopian tubes.
Tubal Embryo ***Transfer (TET)***	Part of the outer layer of the fertilised egg will be dissolved to enable the egg to have a greater opportunity to attach to the uterine wall.

Handout 2.13 Facilitator Copy: Myths and Facts on Infertility and Assisted Reproductive Technologies (ARTs)

Instructions for participants: Indicate whether each statement below is a Myth or a Fact. Write (M) for a myth and (F) for a fact.

- **Painful periods can cause infertility.**

  MYTH. Painful periods are common in many women. They are neither a sign of infertility nor an indication that a woman will be infertile.

- **Having irregular periods can cause infertility.**

  MYTH. Irregular menstruation does not cause infertility. Regular periods are important in that there are more opportunities to be fertile and get pregnant, but irregular periods are not a sign of infertility.

- **If a woman is unable to conceive, there is a greater likelihood of something being wrong with her rather than with her partner.**

  MYTH. When people seek assistance for infertility, the cause can be the woman, the man, both, or unknown. In 30% of cases men have a problem, in 30% of cases women have a problem, in 30% both men and women have a problem, and in 10% of the cases the reasons are unknown.

- **Prayer and faith can help a woman get pregnant.**

  MYTH. Faith and belief are important and personal aspects to many people's lives. However with infertility, particularly if the causes are medical or unknown (for example low sperm count or blocked fallopian tubes), these cannot be cured solely with prayer.

- **Masturbation causes a loss of semen and can prevent a man from impregnating a woman.**

  MYTH. Masturbation is an enjoyable and harmless activity and does not cause loss of semen that would prevent a woman from getting pregnant. Semen that contains sperm is constantly being produced in the testes. Production is constant, and masturbation will not deplete the supply.

- **If a woman relaxes and concentrates hard enough on getting pregnant it will happen**

  MYTH. Concentrating hard on getting pregnant cannot mitigate the medical causes of infertility, which may or may not respond to treatment. Stress reduction and relaxation exercises may help the woman/couple cope better with their situation and with any treatment they are undergoing.

- **If you enjoy sex you are more likely to get pregnant.**

  MYTH. Sexual pleasure and ability to get pregnant are not connected.

- **A woman conceives only if both she and her partner have an orgasm.**

  MYTH. While sexual pleasure is important, even if a man or woman does not have an orgasm and a man ejaculates into or near a woman's vagina, there is a possibility of pregnancy. A man's pre-cum also contains sperm and can cause pregnancy.

- **Using any form of contraception will limit the chances of getting pregnant in the future.**

  MYTH. Using hormonal contraceptive methods such as oral contraceptive pills or injectables will prevent a pregnancy. When stopped, fertility returns within a short period. The length of time to return to normal fertility levels depends on the individual and type of contraceptive. Contraceptives such as condoms, however, are a one-time preventative and do not affect a person's ability to get pregnant the next time they have unprotected sex.

- **Fertility and femininity are strongly linked.**

  MYTH. The ability of a woman to have a child is not connected to her femininity. Nor is her desire to have a child or decision to not have a child. People have the right to choose whether they want a child or not, regardless of gender.

- **A woman is fertile and able to conceive approximately 14 days prior to her next menstrual period and 4-6 days before she begins ovulation.**

  FACT. This is when most women are most easily able to get pregnant.

- **People who cannot conceive can face stigma and discrimination.**

  FACT. Stigma and discrimination can affect people who are unable to have children, particularly women. There are cases of women being emotionally, mentally or physically abused by their husbands and families for not being able to have children, treated violently by their community, and are blamed for the lack of children when the cause may in fact lie with her partner.

- **If a woman and man cannot have a child, it is usually the woman's fault.**

  MYTH. Infertility can result from the woman, the man or from both. Families and communities often blame the woman for problems in conception, even when the cause can just as easily lie in the man.

- **Sometimes the causes of infertility cannot be determined.**

  FACT. About 10% of infertility cases are due to unexplained reasons.

- **One of the main preventable causes of infertility is sexually transmitted infections.**

  FACT. Sexually transmitted infections (STIs) are one of the primary causes of infertility and can be prevented. STIs such as chlamydia and gonorrhoea are examples of STIs that if left untreated can cause infertility in men and women.

- **When a man is infertile, this may be a result of low sperm count.**

  FACT. A low sperm count is one reason a man may be infertile.

- **In vitro fertilisation is when a man's sperm and a woman's eggs are mixed together outside of the woman's body and inserted into the woman.**

  FACT. With in vitro fertilisation (IVF) a woman's eggs are harvested (removed from her ovaries), fused with sperm, and re-implanted into the woman's uterus. In many cases, multiple eggs are implanted.

- **People in same-sex relationships can use assisted reproductive technologies (ARTs) to have a child.**

  FACT. ARTs, such as in vitro fertilisation or intrauterine injection, can be used by same-sex people or single women to have a child.

- **Assisted reproductive technologies (ARTs) are a simple and easy way to have a child.**

  MYTH. Some ART procedures can be painful and uncomfortable. Certain medications and hormonal injections can have side effects and cause discomfort. Procedures to remove the eggs and to re-implant them into the woman can be particularly uncomfortable and painful. Since the success rates of such procedures are low, the stress and disappointment of a failed attempt can add to the stress.

- **Assisted reproductive technologies (ARTs) will work for everyone who tries them.**

  MYTH. Most ARTs and fertility procedures have a less than 30% success rate.

- **Technologies to determine the sex of a child are common.**

  FACT. Pre-implantation genetic diagnosis can be used to determine the sex of the child. This procedure determines if there are any genetic abnormalities by removing a single cell from the embryo and testing it. This practice could be ethically dangerous.

- **Assisted reproductive technologies (ARTs) are usually more accessible to people in a higher socio-economic groups.**

  FACT. ARTs are an expensive option for people and are more easily available to people with a higher disposable income.

- **Some countries/religions/communities allow people to divorce or take another wife if the woman cannot have a child.**

  FACT. Some communities place a high importance on childbearing and the burden of this falls on a woman. If a woman is unable to have a child, some families and communities allow and encourage the man to take another wife to fulfil this child-bearing function.

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  FACT. Some communities place a high importance on childbearing and the burden of this falls on a woman. If a woman is unable to have a child, some families and communities allow and encourage the man to take another wife to fulfil this child-bearing function.

Handout 2.14 Participant Copy: Myths and Facts on Infertility and Assisted Reproductive Technologies

Instructions for participants: Indicate whether each statement below is a Myth or a Fact. Write (M) for a myth and (F) for a fact.

- Painful periods can cause infertility.
- Having irregular periods can cause infertility.
- If a woman is unable to conceive, there is something wrong with her and not her partner.
- Prayer and faith can help a woman get pregnant.
- Masturbation causes a loss of semen and can prevent a man from impregnating a woman.
- If a woman relaxes and concentrates hard enough on getting pregnant it will happen.
- You are more likely to get pregnant if you enjoy sex.
- A woman conceives only when both she and her partner have an orgasm.
- Using any form of contraception will limit a woman's chances of getting pregnant in the future.
- Fertility and femininity are strongly linked.
- A woman is fertile and able to conceive approximately 14 days prior to her next menstrual period and 4-6 days before she begins ovulation.
- People who cannot conceive face stigma and discrimination.
- If a woman and man cannot have a child it is usually the woman's fault.
- The causes of infertility sometimes remain unknown.
- A main preventable cause of infertility is sexually transmitted infections.
- When a man is infertile, this may be a result of a low sperm count.
- In vitro fertilisation is when a man's sperm and a woman's eggs are mixed together outside the body and then inserted into the woman's womb.
- People in same-sex relationships can use assisted reproductive technologies (ARTs) to have a child.
- Assisted reproductive technologies (ARTs) are a simple and easy way to have a child.
- Assisted reproductive technologies (ARTs) will work for everyone who tries them.
- Assisted reproductive technologies (ARTs) can be used to determine the sex of the child.
- Assisted reproductive technologies (ARTs) are usually more accessible to people of a high socio-economic group living in urban areas.
- Some countries/religions/communities allow people to divorce or take another wife if the woman cannot have a child.

Handout 2.15
Case Studies on Adoption, Surrogacy and Assisted Reproductive Technologies (ARTs)

Case Study 1: Adoption

Deepa and Satish have been married for 7 years. They enjoy each other's company and are happy together. They both are also doing well financially and socially: they can afford a flat in the city, have a small and supportive set of friends, and are at the peak of their careers

For about a year now they have been trying unsuccessfully to have a baby. They have discussed getting some tests done, but have decided that they should be fair to each other, and avoid finding out who is responsible for this problem. They have now decided in consultation with friends that they should adopt a child, and have registered with a few adoption agencies.

Their request came through recently, and they will bring a baby home next week. She is a lovely, chubby 8 month old baby. Deepa is very excited and has been telling everyone and shopping for the baby. Satish is also really happy and is already planning a welcome party.

However, Deepa's mother is very angry and upset. She feels the adoption is the wrong move for the couple to make and that the decision has been influenced by their friends who have children of their own. She thinks that both Deepa and Satish should undergo tests and take medication and that Deepa should also go with her to an alternative religious practitioner who assures results for 'couples like them'. She cannot believe that Deepa will die childless and will never know the pleasure and pain every woman must go through to become a 'real' woman.

Deepa had tried to convince her mother that the adoption is a good idea through constant discussion, but without any luck. Now when she tells her that the baby is being brought home next week, Deepa's mother has begun a fast and is threatening dire consequences if Deepa and Satish go ahead with this plan. She has sworn that the day the baby comes home will be the last day Deepa will see or hear from her. Deepa is angry with her mother, has no intention of changing her plans to bring the baby home, but is also a little scared that her mother may in fact do something to harm herself.

Questions:

- What should Deepa and Satish do? What do you think of Deepa's mother's reaction to the adoption?
- How can Deepa and Satish negotiate this situation?

Case Study 2: Surrogacy

Tara is afraid. She has heard her in-laws discussing a possible second marriage for her husband Gajender who is the only son of a rich, educated and quite liberal family of landowners. They have been married for 6 years now, and have been unable to have a child. The liberal attitude of her in-laws has enabled Tara to enjoy many liberties: she has not had to keep her head covered all the time and her opinion is sought on matters of property and other such issues. She has even been allowed to call over some of the little girls around their farm and offer them some basic literacy classes in the afternoon. Ever since the talk of a second marriage began, Gajender even talks to her less. He keeps looking at her with a lot of love, but also something else, perhaps sadness.

A little boy comes to study with Tara every day. His mother Namo loves Tara a lot, always praising and thanking her profusely for tutoring her son. Tara decides she needs to take steps to prevent her husband's second marriage and asks Namo to be her real sister by bearing her a child: to save her life and her marriage; to repay Tara for the knowledge and education she gives her son. In turn she will give Namo whatever she asks. She and Gajender will send her son to school and pay for everything. They will get Namo a small house and meet her daily living requirements for food, clothing, medication, and anything else that is required. Tara says she will also arrange everything and no one will ever know about it. At the beginning of the pregnancy Tara will hire Namo and she can be around the house. Later the two of them can go off to the city where Namo can have the baby and they can tell everyone that Tara has delivered the child. All she has to do is conceive Gajender's baby, care for herself during her pregnancy, and deliver the baby for Tara.

Namo is stunned: How will she ever do this? What if someone gets to know? What if it becomes public? But Namo also feels she owes Tara a lot for the support and attention she has provided her son. Also, Tara has offered to take care of everything during the pregnancy. Namo considers the good blessings she will be earning by giving a child to a childless woman: in a sense it is God's work.

Tara has spoken to Gajender, who was initially angry and resistant to the idea. He suggests they consider adoption, but Tara is determined he must have a biological child, to take the name of the family further. She is sure his mother will get a new wife for him otherwise. Gajender tries to reason with Tara, telling her Namo may not get pregnant after one try and that it may take repeated tries. Tara says she is willing to take that chance.

After some time though, Tara's pleas and urging melt his objections. He cannot see his wife suffer like this and he is ready to do what she says.

Questions:

- If you were Namo would you do this for Tara? Do you think that Gajendar should go along with the plan?
- Does it make a difference whether Namo has sex with Ganjendar or is artificially inseminated?
- If Tara and Gajendar approached you at your local NGO and asked for advice, what would you tell them?
- What are the pros and cons of this arrangement?

Case Study 3: Assisted Reproductive Technologies

Manish is one of the country's top young, upcoming executives. His charming wife, Ruchi is also a senior executive in a consulting company. After repeated failed attempts at getting pregnant, they have decided to go to a clinic and take tests to determine the reason for this. The tests show that Manish has a very low sperm count. Family and friends are a little surprised: Manish is over 6 feet tall, handsome, and seems healthy.

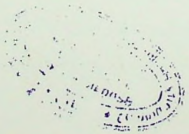
Ruchi and Manish make an appointment at an IVF clinic at the biggest hospital in the city. The clinic tells them the IVF procedure is a relatively small and simple procedure: they will mix Manish's sperm and Ruchi's eggs and then insert this back into Ruchi. This sounds simple enough and the couple decide to go ahead with the plan.

They have been warned that it may take up to 6 attempts to get Ruchi pregnant. After the first time both Ruchi and Manish have a good laugh over the entire process; it is funny how she goes for her egg, and he puts some sperm in a cup. But after 7 months and six tries, the couple have run out of their good humour. Manish travels a lot and is unable to keep the next appointment. The new dates clash with Ruchi's other travel plans. They are both feeling stressed, even though they try to keep each other's spirits up. Manish is also being ribbed by his friends who keep joking about him and his infertility. Every month close friends and relatives call up to ask if there is any good news. The procedure is also costing them a small fortune.

They are unsure about whether they want to continue this process, or try other options. Both want a child of their own, but are aware that this might not happen. They are worried about what being childless would mean for them in the community.

Questions

- What should Ruchi and Manish do? Should they continue with the IVF?
- Do you agree with the choice for IVF that Ruchi and Manish made?



Chapter 4

HIV/AIDS, Sexually Transmitted Infections and Reproductive Tract Infections

Chapter Objectives for the Facilitator

1. To have participants understand basic information on HIV/AIDS including routes of transmission, prevention, care and support and treatment.

2. To have participants learn basic information on Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs).

3. To facilitate participant discussion on issues of stigma and discrimination associated with HIV/AIDS and STIs/RTIs.

4. To facilitate participant discussion on ways to approach and talk about HIV/AIDS, STIs and RTIs in their communities.

Why a Chapter on HIV/AIDS and Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs)

- *The highest rate of new cases of STIs in the world occur among people between the ages of 15 and 49 years in South and Southeast Asia (Source: http://www.avert.org/stdstatisticsworldwide.htm)*
- *Some 340 million curable STIs are estimated to occur worldwide every year. Many millions of incurable viral STIs, including an estimated 5 million HIV infections, also occur annually. (Source: http://www.avert.org/stdstatisticsworldwide.htm)*
- *An estimated 6.7 million people live with HIV/AIDS in South-East Asia (2005), the second highest number of cases in the world after sub-Saharan Africa. (Source: http://w3.whosea.org/en/Section10/Section18/Section348_9917.htm)*
- *Approximately 40.3 million people around the world are living with HIV/AIDS. (Source: http://www.avert.org/worldstats.htm)*
- *The Indian National AIDS Control Organization (NACO) estimates that 5.134 million people were living with HIV in India in 2004. Only South Africa has more people living with HIV. (Source: http://www.avert.org/indiaaids.htm)*

STIs including HIV/AIDS continue to affect millions of people around the world and impact certain regions and countries more than others. Despite this situation, many people and communities continue to react to these issues with indifference, discomfort, fear and anger, and stigmatise and discriminate against infected people. This creates obstacles to providing information for prevention of transmission and to adequate treatment and care for people with HIV/AIDS and STIs. Reducing the risk of transmission and providing treatment and care for people living with these infections is crucial to health and well-being.

This chapter gives participants basic knowledge of HIV/AIDS, STIs, and reproductive tract infections (RTIs), including how these infections are transmitted, and how they can be prevented and treated. This information provides a foundation for participants to discuss several issues including addressing social implications like gender inequality, stigma and discrimination and denial of rights experienced by people with HIV/AIDS and STIs, the focus on fear and abstinence in most prevention messages, and the right to information and access to services.

EXERCISES IN THIS CHAPTER

Exercise 1: HIV/AIDS Basics.
60 minutes

Exercise 2: HIV/AIDS: Testing, Treatment, Care and Support.
60 minutes

Exercise 3: My Views on HIV/AIDS.
60 minutes

Exercise 4: Quiz: RTIs/STIs.
15 minutes

Exercise 5: Talking About RTIs/STIs.
45 minutes

Exercise 6: Examining Attitudes Associated With HIV/AIDS and STIs.
45 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart, Markers, Pens/pencils
Small paper bags, Candy/chocolate, gum, sweets

HANDOUTS FOR THIS CHAPTER:

Handout 2.16
Basic Information on HIV/AIDS

Handout 2.17
Basics of HIV/AIDS Quiz

Handout 2.18
Frequently Asked Questions

Handout 2.19
Basic Information on STIs and RTIs

Handout 2.20 Facilitator Copy:
STIs and RTIs Quiz

Handout 2.21 Participant Copy:
STIs and RTIs Quiz

Handout 2.22 Facilitator Copy:
Talking About STIs and RTIs

Handout 2.23 Participant Copy:
Talking About STIs and RTIs

ADDITIONAL RESOURCES:

- Avert-International AIDS Charity. www.avert.org
- The Body: The Complete HIV/AIDS Resource. http://www.thebody.com
- Holmes, W. 2003. *Protecting the Future: HIV Prevention, Care and Support Among Displaced and War Affected Populations.* New York: International Rescue Committee.
- Joint United Nations Programme on HIV/AID. http://www.unaids.org
- National AIDS Control Organization. Government of India. http://www.nacoonline.org
- Solidarity & Action Against The HIV Infection in India (SAATHII). http://www.saathii.org
- Welbourn, A. 1995. *Stepping Stones: A Training Package in HIV/AIDS, Communication and Relationship Skills.* London: ActionAid.
- Teaching-Aids At Low Cost (TALC). http://www talcuk.org
- WHO Regional Office for South and Southeast Asia. http://www.whosea.org
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key messages for this Chapter

- Knowledge of HIV transmission, prevention, treatment, and care is important to reduce risk of transmission and spread of the infection, and decrease the stigma and discrimination associated with HIV/AIDS.
- Many STIs and RTIs are curable, however if left untreated they can have a serious impact on the health and well-being of people, by causing infertility, ectopic pregnancies or some cancers. STIs can also increase the risk of HIV transmission.
- It should not be assumed that HIV is transmitted only in certain 'high risk groups' (such as sex workers or intravenous drug users). Infection can occur in people who are young or old, monogamous or non-monogamous, heterosexual, bisexual, or homosexual, women, men or transgendered people.
- People have a right to confidentiality and privacy when they receive health care, including counselling and treatment for HIV/AIDS, STIs and RTIs. People also have the right to keep their HIV status confidential. Fear of their status being revealed may keep many from getting tested.
- Placing blame on individuals and discovering who are the primary 'infectors' of HIV/AIDS or STIs is counterproductive and leads to stigma and discrimination.
- A variety of factors cause infection: lack of information, lack of access to condoms or other protection, and inability to negotiate safer sex, among others.
- While the information in this chapter is current at the time of publication, knowledge and development of HIV treatments and recommended therapies are constantly being revised. It is important to review the most current treatments and options available in your country/region.

Exercise 1
HIV/AIDS Basics

QUIZ GAME

Instructions

1. Divide participants into two or three groups/teams. Encourage them to name their teams and write the names down in the columns on the flipchart for scoring.

2. Explain the game and the scoring to participants. For every correct answer, a team gets 10 points. If a team cannot answer a question, it is passed on to the next team, which gets 5 points if they answer correctly.

3. Read out one question at a time and give each team time to discuss their response before they answer. Clarify questions and doubts as they come up so that participants are clear about the information.

4. Once you have gone through all the questions, announce the winners, give the prizes to the appropriate groups, and distribute Handout 2.17.

Purpose of the exercise:

To understand the difference between HIV and AIDS, the routes and conditions of transmission of the virus, and prevention.

TIME

60 minutes

MATERIALS

Flipchart, markers, Quiz questions from Handout 2.17 Basics of HIV/AIDS Quiz, prizes for the winners

ADVANCE PREPARATION

1. To keep score, make a column for each team playing the game on a flipchart.

2. Keep some prizes ready for the winning team and the runners-up.

3. Review and make copies of Handout 2.16 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Combining this quiz with the other true/false and myth/fact exercises from this module into a larger quiz game. This can be played at the beginning of the module (to determine what topics participants need information on) or end of the module (to review and/or assess how much participants have learned).

Key Messages

- Knowledge of HIV/AIDS including modes of transmission, prevention, treatment, and counselling is essential. This gives people information to reduce the risk of transmission and spread of the disease.
- There are many myths and misconceptions about the modes of transmission of HIV and its effects on the body. These lead to fear and discrimination.
- People with HIV/AIDS often experience stigma and discrimination. It is necessary to work to reduce this stigma in order to reduce rates of transmission as well as to protect the rights of people to live lives with dignity and respect.

MAKING CONNECTIONS

- A basic understanding of human sexual anatomy and physiology is essential to understand the mechanism of HIV transmission. For more see Chapter 1 in this Module.
- People with HIV/AIDS are often subject to stigma, discrimination and marginalisation. For more see Chapter 2 in Module 4.

TIPS FOR THE FACILITATOR:

- Make sure to review any information and handouts before starting this exercise to have a clear understanding of HIV/AIDS and to answer questions from participants.
- Do not spend too much time on any single question even if you feel that clarification is required. Participants may lose interest when the discussion focuses only on one issue. Note areas that require more discussion on a flipchart (in a Parking Lot) and address these issues at some point during the training.
- There may be participants in the training who work on HIV/AIDS and so have extensive knowledge on the topic. Encourage them to contribute additional information from the field but do not let them dominate the group. Encourage everyone to participate in the game.

Exercise 2
HIV/AIDS: Prevention, Testing, Treatment, Care and Support

TEACHING THE CLASS

INSTRUCTIONS:

1. Divide the participants into four groups. Assign one group *Transmission and Prevention*, another *Testing*, the third *Treatment*, and the fourth *Care and Support*. Give each group a copy of their specified topic from Handout 2.18. Ask them to review their handout and prepare a 5-10 minute presentation on the topic. The presentation can be in the form of a role-play, a brief lecturette, or a question answer session, as long as all the information on the handout is covered. For example, the group assigned to *Testing* can do a role-play in which a person visits a clinic to find out their HIV status and learns about the testing options and procedures. Presentations should not exceed 5 minutes to allow ample time for questions and comments. Give groups 30 minutes to create their presentations.

2. Bring the groups back together and invite the *Transmission and Prevention* group to begin the presentations, followed by *Testing*, *Treatment*, and ending with the *Care and Support* group. After each presentation, make sure to add any information that is left out or to correct misinformation. Ask for questions and comments.

   Suggested Questions:

- Is there any information you are still unclear about?
- Were there any negative portrayals of HIV/AIDS in the presentation? How could these be eliminated?

3. After going through all presentations ask for general questions or comments.

   Suggested Questions:

- Could you communicate this information to the communities you work with? Would the information need to be modified in any way and if so how and why?
- Do you think learning about HIV/AIDS testing, treatment, care and support are important to the work you do? Why?

PURPOSE OF THE EXERCISE:

1. To understand testing and treatment options available for HIV/AIDS.

2. To describe the kind of care and support necessary for those living with HIV/AIDS.

TIME

90 minutes

MATERIALS

Flipcharts, markers, Handout 2.18 Frequently Asked Questions: Transmission of HIV and its Prevention; Testing for HIV/AIDS; Treatment of HIV/AIDS; Care and Support for HIV/AIDS

ADVANCE PREPARATION

Make copies of all four sections of Handout 2.18

Key Messages

- New treatments and recommended therapies are constantly changing and being revised. It is important to review the most current treatments and options available in your country/region in addition to laws and policies that may affect them.
- There are 4 routes of transmission of HIV: 1) unprotected sex with an infected person; 2) infected mother to child; 3) through contaminated blood and blood products; and 4) sharing of unsterilised infected needles, syringes etc.
- There are 2 tests for HIV: the antibody test (example, ELISA) and the antigen test (example, Polymerase Chain Reaction). The antibody test is the more common and standard test for HIV.
- People undergoing testing need to understand the 'window period' and the potential for a false-negative test during this time.
- Antiretroviral (ARV) treatment can help stem progression of the HIV virus. There are various free/subsidised ARV therapy schemes available through the governments of different countries and states.

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting a four-part lecturette - *Prevention and Transmission*, *Testing*, *Treatment*, and *Care and Support*. Each part can consist of a 10-minute lecturette followed by 10 minutes for comments and questions, and another 15-20 minutes after all the lecturettes for general questions.

MAKING CONNECTIONS

- Stigma and discrimination often prevent people from seeking voluntary counselling and testing services. Stigma needs to be addressed before we can expect people to come forward for testing and treatment. For more see Chapter 2 in Module 4.
- People living with HIV/AIDS have the same rights as individuals who are not HIV positive. For more see Chapter 1 in Module 3.

TIPS FOR THE FACILITATOR:

- Some information in Handouts 2.18 overlap with information in Handout 2.16. This is necessary to give participants complete information for the presentations.
- There may be participants who have extensive knowledge about HIV/AIDS. If appropriate ask them to contribute any additional relevant information. Divide such participants equally among the four presentation groups, and request them to be the presenters to guarantee clear and accurate presentations.
- Information on HIV/AIDS is frequently changing, with new treatment options, research, governments changing their policies and financial support for HIV/AIDS related programming etc. Check that the information on the handouts is current before starting this exercise.
- Participants may ask questions during this exercise that are out of the scope of the Handouts/ beyond the facilitator knowledge. Write these on a flipchart (in a Parking Lot) to return to later in the training.

Exercise 3
My Views on HIV/AIDS

POLARISATION

Instructions

1. Read out one statement at a time. Designate one side of the room as the *Agree* side and the other as the *Disagree* side. Ask participants to move toward either side, depending on how they feel about the statement. Those who are undecided should move to a third designated spot in the room (the *Don't Know* group).

   Statements for My Views on HIV/AIDS:

- Mandatory HIV testing for couples getting married is a good policy
- All people entering the country/ migrating from different parts of the country should be screened for HIV
- A doctor has the right to tell a person their partner's HIV status without the partner's consent
- HIV positive women should not be allowed to have children
- Needle exchange programmes will encourage drugs use
- HIV positive people should be encouraged to disclose their status for the good of others
- Women are to blame for the spread of the HIV infection since they are the ones who primarily infect men with HIV

2. After participants have chosen a side, invite them to share why they have made their choice.

   Suggested Questions:

- Why do you agree or disagree? Do you think your opinion is similar to that of others in your community?

3. Conduct a polarisation and discussion with the above questions for three of the statements. Afterwards, ask for general comments or questions.

   Suggested Questions:

- Were there any issues you had not thought of before? What were they and how did they make you feel?
- From these statements and discussions, what are your opinions and thoughts about the connection between human rights and HIV/AIDS?

Purpose of the exercise:

1. To identify and discuss attitudes related to HIV/ AIDS.

2. To discuss issues of human rights and HIV/ AIDS.

TIME

60 minutes

MATERIALS

None

ADVANCE PREPARATION:

1. Select three statements from the list below.

2. Go through the key messages in order to be prepared to lead a discussion on the selected topics.

3. Stick charts on opposite walls of the rooms, one saying *Agree* and the other *Disagree*.

Key Messages

- Mandatory testing before marriage has been supported by some groups, however this policy can be harmful: the person being tested may be in the window period so the test result will be inaccurate; the test does not ask for consent; it makes false assumptions that people cannot get infected after marriage and that it will protect women from infection (if a woman tests positive, there may be no support systems in place to help her afterwards); the tests can breed stigma and discrimination against those who test positive.
- Non-judgmental counselling may help people decide to disclose their positive status to others. However, this is an individual's choice and needs to be respected. No third party has the right to breach patient confidentiality. Doctors' primary allegiance is to their patients/clients and not to the patients' partners. If doctors maintain confidentiality and earn the trust of HIV positive people, they may be in a better position to prepare positive people to reveal their status to their partners.
- The right to have children or not is the reproductive right of all women regardless of their HIV status. While HIV positive women need help to reduce the risk of transmission to their children during childbirth, preventing women from choosing to have children is a violation of their rights.
- While efforts should be made to help people overcome addictions if they want to, the detoxification/de-addiction process is a long one. In the meanwhile, providing injecting drug users with information about the harmful effects of sharing needles and providing disposable syringes can help them protect themselves from infections including HIV.
- Placing blame on individuals and discovering who are the primary 'infectors' of HIV is counterproductive and leads to stigma and discrimination. A variety of factors contribute to HIV infection: lack of information; lack of access to condoms or other protection; and inability to negotiate safer sex, among others.

THIS EXERCISE CAN BE MODIFIED BY:

- Asking for reactions to fewer statements, and allowing for longer discussions.
- Complicating the statements, for example, combining statements 1 and 2. Questions with many issues become more difficult to answer and participants may have to grapple and analyse their opinions more carefully.

MAKING CONNECTIONS

- The rights of all people must be respected, irrespective of their HIV status and how they got the infection, whether through unsafe sex or blood transfusion. For more see Chapter 1 in Module 3.
- Stigma and discrimination also diminish the quality of life of people living with HIV/AIDS. For more see Chapter 2 in Module 4.

TIPS FOR THE FACILITATOR:

- Try and anticipate all possible arguments for every statement before undertaking this exercise.
- Do not spend more than 10-15 minutes per statement to keep the interest of the group.
- Make note of the areas that require more discussion on a flipchart and make time to address these issues during the training.

Exercise 4
STIs / RTIs Basics

QUIZ GAME

Instructions

1. Divide the participants into two or three teams. Encourage them to name their teams and write the names down in the columns on the flipchart for scoring.

2. Explain the game and the scoring to participants. For every correct answer, a team gets 10 points. If a team cannot answer a question, it is passed on to the next team, which gets 5 points if they answer correctly.

3. Read out one question at a time and give each team time to discuss their response before they answer. Clarify questions and doubts as they come up so that participants are clear about the information.

4. Once you have gone through all the questions, announce the winners, give them prizes, and distribute Handout 2.17.

Purpose of the exercise:

To understand the basics of Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs).

TIME

15 minutes

MATERIALS

Handout 2.20 STIs and RTIs Quiz Game, Prizes

ADVANCE PREPARATION:

1. To keep score, make a column for each team playing the game on a flipchart.

2. Keep some prizes ready for the winning team and the runners-up.

3. Review Handout 2.19 and 2.20.

THIS EXERCISE CAN BE MODIFIED BY:

- Combining this quiz with the other true/false and myth/fact exercises from this module into a larger quiz game. This can be played at the beginning of the module (to determine what topics participants need information on) or end of the module (to review and/or assess how much participants have learned).

Key Messages

- Information about STIs and RTIs can help better protect and prevent these infections.
- Talking about these can decrease stigma and therefore reduce fear of accessing treatment services and increase general health and well-being.
- STIs and RTIs have significant impact on people's sexual and reproductive health, particularly that of women. Some of these infections can also increase the risk of transmission of HIV/AIDS.

MAKING CONNECTIONS

- Untreated STIs can result in serious conditions including infertility. For more see Chapter 3 in this Module.
- Sexual and reproductive rights include the rights of all people to live lives free of infection, fear and discrimination. For more see Chapters 2 and 3 in Module 3.

TIPS FOR THE FACILITATOR:

- Make sure to review any information and handouts before starting this exercise to have a clear understanding of STIs and RTIs and to answer questions from participants.
- Do not spend too much time on any single question even if you feel that clarification is required. Participants may lose interest when the discussion focuses on one issue. Note areas that require more discussion on a flipchart (in a Parking Lot) and address these issues at some point during the training.
- Some participants may work on STIs and RTIs and therefore have extensive knowledge on the topic. Encourage them to contribute additional relevant information but do not let them dominate the discussion. Encourage everyone to participate in the quiz.

Exercise 5
Talking About STIs / RTIs

CASE STUDIES

Instructions

1. Divide participants into small groups. Distribute Handouts 2.19 and 2.23 to each group. Assign each group one of the cases and ask them to read the case and discuss the questions. Give groups 10-15 minutes.

2. Bring the groups back together and ask them to share their discussions and approaches to their case. After all the presentations, ask for questions or comments.

Suggested Questions:

- Why do you think it is important to talk about STIs and RTIs? Are they discussed and addressed by the communities you live in and work with?
- Were there any moral judgments about the characters being made during the case presentations? Were you making any judgments about the people in these cases?
- Were any assumptions made about the type of relationships these characters are in? Did you assume, for instance, that they were all in heterosexual or homosexual relationships? Did you assume that the men/women would always be faithful in the relationships and therefore not transmit an infection to their partner/s? How can these assumptions affect the attitudes about, and treatment of STIs and RTIs?
- Are there any obstacles people face to getting tested and treated for STIs and RTIs? What might these be and how can they be overcome? For example it might not always be possible for a person to tell a partner that they have an infection, because of power dynamics in the relationship, gender inequalities, or lack of access to appropriate health services.

Purpose of the exercise:

1. To know and understand common STIs and RTIs.

2. To examine how discussions about STIs and RTIs can be had with different groups and communities.

TIME

45 minutes

MATERIALS

Handout 2.19 Basic Information on Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs), Handout 2.23 Participant Copy Case Studies of STIs and RTIs, pens/pencils

ADVANCE PREPARATION

Make copies of the handouts for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Eliminating the cases and only distributing Handout 2.19 to participants and asking for any questions or comments after they have read through it. This may be best for groups with an extensive knowledge on STI/RTIs.

MAKING CONNECTIONS

- It is important to talk about sexuality to learn how to protect oneself from STIs and unwanted consequences of unprotected sex. For more see Chapter 1 in Module 1.
- Comprehensive and accurate sexuality education for young people can help dispel myths about STIs/RTIs. For more see Chapter 2 in Module 5.

Key Messages

- Many STIs are curable with medications. It is important to discuss STIs and RTIs because if left untreated, they can have serious health consequences such as infertility, ectopic pregnancies and some cancers. Certain STIs can also increase the risk of HIV transmission.
- If a person has an STI, their partner/s also need to be treated for the infection, or the infection can be transmitted back to the person from their untreated partner/s ('presumptive treatment' to prevent the 'ping-pong effect').
- While it may be important to ascertain a person's sexual history in order to test and treat their partner/s as well, beware of asking intrusive and insensitive questions and making assumptions about the person.
- It is important to avoid moral judgments about people who have an STI or RTI. Any person, whether in a monogamous or non-monogamous relationship, married, heterosexual, bisexual, or homosexual, woman, man or transgender, can get infected.

TIPS FOR THE FACILITATOR:

- Emphasise that the information for this exercise is basic and meant for non-medical professionals. Stress that unless a person is a qualified medical practitioner, s/he should not attempt to treat or prescribe medication to anyone with a possible Sexually Transmitted Infection (STI).
- Do not use pictures or graphic descriptions of STIs to 'put people off' from unprotected sex and increase fear-based messages about sex. The information in this chapter is meant to provide knowledge about the existence of such infections, the adverse effects of these infections, and the importance of seeking treatment and protection to reduce risk of transmission. Ultimately, however, individuals have the right to make choices about their bodies and sexual behaviours.

Exercise 6
Examining Attitudes Associated With HIV/AIDS and STIs

PARTY GAME

PURPOSE OF THE EXERCISE:

1. Discuss the stigma and discrimination associated with STIs and HIV/AIDS.

2. Discuss ways in which this stigma and discrimination can negatively affect people living with an STI or HIV/AIDS, and how to change these attitudes.

TIME

45 minutes

MATERIALS

Small folded slips of paper for each participant, marker/pen, 5-10 pieces of candy/chocolate/gum, small bags/packets

ADVANCE PREPARATION

Fold as many slips of paper as the number of participants. On one , write an H, on one write an S, and on two slips write C. Leave the rest of the slips blank. Place a folded slip in each bag with 5 to 10 pieces of candy/chocolate/sweets. Have as many bags ready as the number of participants for the exercise.

INSTRUCTIONS:

1. Ask each participant to take a bag. Participants should not look at the slip of paper in the bag. Give everyone 2-3 minutes to walk around the room and swap sweets with others, paying attention to the people they exchange with. Participants can interact with as many or few people as they want.

2. Ask participants to sit down and unfold their slips of paper. Have the person with H on their slip stand up and go to the corner of the room, away from other participants. This person is HIV positive. Ask anyone who exchanged sweets with this person to stand up.

3. Now ask the person with S on their slip of paper to stand up. This person has an STI. Ask this person to also go to the corner of the room away from other participants. Ask anyone who exchanged sweets with this person to stand up if they are not already standing. At this point the majority of people should be standing in the room.

4. Ask the people with C on their piece of paper to sit down. These people have used condoms and are therefore uninfected. The participants in the corner of the room with the original H and S should give you their bags of sweets. They will stand there for the rest of the exercise. Distribute the sweets from their bags to the seated participants with C's in their bags.

5. Ask for comments and questions.

Suggested Questions:

- If this exercise represents the spread of HIV/AIDS and STIs, what does it tell you about the spread of the disease? How can the spread or risk be reduced?
- How do the people standing in the corner feel about being separated from the group? How did you feel being the person with the STI or HIV/AIDS? Do you think people with STIs or HIV/AIDS feel discriminated against?

THIS EXERCISE CAN BE MODIFIED BY:

- Using only H as the example and eliminating the S from the slips of paper. This may be useful for groups that work in HIV/AIDS.

MAKING CONNECTIONS

- Stigma and discrimination can be as debilitating as the infection itself. For more see Chapter 2 in Module 4.
- Use of condoms is one way to protect people from HIV/AIDS and other STIs, as well as unwanted pregnancies. For more see Chapter 2 in this Module.

- How do the people still standing feel towards those who infected them? Do they blame those with H or S in their slips?
- Is there stigma associated with HIV/AIDS or STIs? If so, does this contribute to spread of the infections or hamper prevention strategies? How?

Key Messages

- STIs including HIV can infect anyone. Unlike this game, in many real-life situations people are able to make more informed decisions about their choices in sexual interactions to reduce the risk of transmission.
- People with STIs or HIV/AIDS experience stigma and discrimination in many communities. People with STIs such as Chlamydia or Gonorrhoea may not be discriminated against in the way a person with HIV/AIDS is, but shame and 'unclean' behaviour is still associated with these STIs. Because people are afraid of being alienated or ostracised, they may avoid being tested and treated.
- Advocacy and education with correct information on HIV/AIDS and STIs to communities can help reduce this discrimination and stigma.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to equate the abstract discrimination and stigma in this exercise to real-life experiences. Emphasise that this is only a demonstration to elicit discussions and not equal to the actual discrimination and stigma people with HIV/AIDS might experience.
- Focus on the stigma and discrimination faced by people with STIs including HIV more than on how the infections spread.

Handout 2.16
Basic Information on HIV/AIDS

I. The Immune system

What is the Immune System?

The **immune system** is the body's network of cells and substances that protect a person from infective agents such as viruses, bacteria, parasites, fungi, and tumour cells. **White blood cells** are a major component of the immune system. There are several different types of white blood cells: one is called **lymphocyte,** which can be of two kinds- **B-cells** and **T-cells**. These two types of cells form part of the immune response for the specific infections that the body has already experienced or developed immunity to. This immune response is called **acquired immunity**.

What are B-cells?

B-cells are a variety of lymphocytes and their role is to react to a specific part of an infecting agent called an **antigen**. The antigen acts like a nametag identifying the infecting agent. B-cells react by producing **antibodies,** a response necessary to defend the body. In addition to attacking the infecting agent, B-cells also create memory cells that remain in the body for years and act as a historical record of the attack, adding to the body's acquired immunity. For example, when children receive polio drops or diphtheria shots, B-cells create a historical record of the infection thus immunising the body against these infections in later life.

What are T-cells?

Another variety of lymphocytes, the T-cells, like B-cells, react to antigens. It is the job of the T-cell to attract other immune cells to the area where the infection/antigen is located to help destroy it. T-cells help watch over the body and alert the rest of the immune system when there is an infection. T-cells also aid in attacking the infecting agent. There are two types of T-cells, **CD4 cells**, also called helper cells or T-4 cells; and **CD8 cells**, also called suppressor cells or T-8 cells. CD4 cells attach themselves to the infecting agent making it easier for CD8 cells to attack that agent. HIV mainly targets CD4 cells and as a result limits the body's ability to protect itself.

II. HIV

What is HIV?

HIV stands for Human Immuno-deficiency Virus. This name has been derived in the following way: H for **Human**, because this virus can only infect human beings; I for **Immuno-deficiency**, because the virus weakens the body's immune system, resulting in a diminished immune response to other infecting agents; and V for **Virus,** because this organism is a virus, which means that it has the ability to reproduce itself over and over again by taking over healthy cells. In the case of HIV, the virus takes control of CD4 cells and reproduces itself through these infected cells. Each infected CD4 cell can make thousands of copies of the virus until the cell dies. A person infected with HIV creates millions of new HIV viral particles every day. HIV by itself is not an illness and while it can lead to AIDS, this progression can take several years. An HIV infected person can lead a healthy life for years.

What are retroviruses?

Most viruses store their genetic material as DNA. However HIV belongs to a class of viruses called retroviruses in which the genetic material is in the form of RNA. It uses an enzyme called *reverse transcriptase* to become part of the host cells' DNA. This allows many copies of the virus to be made in the host cells. Medicines that have been developed to inhibit HIV replication are called anti-retrovirals (ARVs) and the treatment is called anti-retroviral therapy (ART).

III. AIDS

What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. It has been named this for the following reasons: A for **Acquired** because it is not a genetic condition, but rather, a disease that is contracted by an individual through one of four transmission routes; I for **Immune** because it affects the body's immune system; D for **Deficiency** because it weakens the immune system; and S for **Syndrome** because a person with AIDS may experience a wide range of different diseases and infections. AIDS severely weakens the body's defences making it possible for other diseases, known as **Opportunistic Infections (OI),** to successfully manifest themselves.

IV. HIV/AIDS Life Cycle

What happens when a person is first infected with HIV?

After a person has been infected with HIV, the virus will begin to attack CD4 cells and multiply rapidly in the body. During the first 2 to 8 weeks the immune system fights back and a person may feel like they have the flu. Within three months of infection, the body's immune system produces **antibodies** to combat the virus. Most common HIV tests look for the presence of these antibodies. When a person is said to be HIV positive, this indicates the presence of these antibodies in their blood.

What is the window period?

HIV tests do not look for the presence of HIV in the body; they look for the presence of antibodies produced by the immune system when it encounters HIV. It may take up to three months for the body to produce enough HIV antibodies to produce a positive test result. This three-month period between infection and a positive test is known as the **window period**. During this time a person is already infected and capable of spreading HIV.

How does a person with HIV remain healthy?

It may take up to 8 or 10 years for a person with HIV to develop symptoms. During this time the virus weakens the body's immune system, but the body still has a strong enough defence against Opportunistic Infections. An HIV positive person can continue to lead a healthy life for many years by following a proper eating regimen, avoiding harmful behaviour such as drug or alcohol use, and using anti-retroviral treatment (ART).

How does a person go from HIV positive to having AIDS?

AIDS is said to have occurred when HIV has damaged the immune system, leaving a person's body vulnerable to infection and disease. A common indicator to determine when HIV has developed into AIDS is when a person's CD4 count falls below 200. Those with AIDS may also experience one or more Opportunistic Infections, such as pneumonia, tuberculosis or certain cancers.

However, the definition of AIDS has changed dramatically over the years. A person may have HIV for a long time and remain healthy, even if their CD4 count is below 200. Plus, with improved treatment, including Anti Retroviral Therapy, and testing options, Opportunistic Infections can be treated and the CD4 count built up, changing the earlier definition of AIDS (CD4 below 200 and one/more OI).

V. Transmission of HIV

How is HIV transmitted?

There are four routes of transmission for HIV: 1) **unprotected sex** with an infected person; 2) **infected mother to child,** either during pregnancy, delivery or through breastfeeding; 3) through **contaminated blood and blood products** (including organ and tissue transplants); and 4) **sharing of unsterilised infected needles,** syringes and other medical equipment like dentists' instruments.

How can a person find out if they have HIV?

The most common HIV tests look for the presence of HIV antibodies in a person's blood or saliva. Within three months of infection with HIV, the body's immune system is able to produce a detectable level of HIV antibodies. When these antibodies are present, a person tests positive. ELISA (Enzyme Linked Immuno Sorbent Assay) is a commonly used antibody test.

What is a false negative test result?

If a person goes in for an antibody test in the window period - during which there are barely any antibodies to HIV in the body - s/he may get a negative result. This is a false negative result because the person is infected with HIV, but the test does not show this. Therefore it is recommended that if a person is not sure of their last unsafe exposure, they should get a second test done after three more months, during which they should not expose themselves to infection.

What are the conditions for transmission of HIV through unprotected sex?

One person must be infected with HIV to pass it to another person. Unprotected penetrative vaginal intercourse is the most common route of HIV transmission, while anal sex - whether male-to-male or male-to-female poses a higher risk for transmission. It is rare but possible to acquire HIV through oral sex, particularly if the person has ulcers or sores in their mouth. Kissing and other non-penetrative sexual activities do not pose a risk for HIV transmission.

What can decrease the spread of HIV through sex?

Correct and consistent use of condoms significantly reduces the transmission of HIV. At present, condoms are the most effective method of HIV prevention through the sexual route. **Treatment and prevention of STIs can reduce the risk of HIV transmission.** STIs particularly not only increase a person's susceptibility to getting HIV, they also increase an HIV positive person's infectivity, making the spread of the disease easier.

What are the conditions for transmission from mother to child?

An HIV positive mother can pass the virus to her child either during pregnancy, delivery, or through breastfeeding. Most often a foetus is protected from infection while in the uterus, but the presence of some STIs such as syphilis can increase the likelihood of infection. Transmission between mother and child is most likely to occur during delivery when there is a high chance of the baby's blood coming in contact with the mother's blood. HIV is also present in breast milk; different studies have found results ranging from a 5% to a 20% chance that the baby may become infected through breast milk. When there is no healthy alternative to breastfeeding, infected mothers are encouraged to breastfeed their children to prevent them from dying of malnutrition or water-borne diseases instead. The risks of HIV infection through breastfeeding and the risk of death due to malnutrition need to be balanced and carefully considered in such situations.

What can reduce the risk for transmission of HIV from mother to child?

The primary tool to prevent transmission from mother to child is the use of antiretroviral medicines during pregnancy and delivery. This method, combined with safe delivery practices and counselling and support for infant feeding methods can significantly reduce the transmission of the virus between mothers and their infants. It is crucial for pregnant women to know if they are HIV positive.

Why do people now prefer to use the term parent-to-child transmission instead of mother-to-child transmission?

It has been argued that the term mother-to-child transmission puts the onus of infection of a child on the mother, which may often not be the case. Parent-to-child transmission implies that the child could have got infected through the father via the mother. The use of this term holds both parents responsible for taking the necessary precautions to prevent transmission of infection to the child in case one or both parents are HIV positive.

How can person find out if a baby has HIV?

Most common HIV tests do not test for the virus itself, but for the presence of HIV antibodies. Since all infants carry their mother's antibodies for the first several months of life, it is difficult to determine if an infant born to an HIV positive mother has HIV. All the babies of HIV positive women will have HIV antibodies in their systems for 9 to 18 months, therefore testing infants at 9 months and again at 18 months is recommended. In addition, all infants born to HIV positive mothers should receive regular check-ups for up to 18 months. Due to the complications in determining if the infant is HIV positive, the infant's health and nutrition must be carefully monitored and the use of preventative medicines may be necessary.

What are the conditions for transmission HIV through blood or blood products?

Injection drug use, blood transfusion, and needle sticks are the primary methods of transmitting HIV through blood or blood products. Sharing injecting needles and/or syringes for drug use is a very effective way of transmitting HIV. When infected blood is drawn into a needle while using a syringe and that needle is than used by someone else, the second person is effectively injecting HIV directly into his or her blood.

Transfusion of blood infected with HIV, organ or tissue transplants are all ways of getting HIV. Those subjected to needle stick injuries or blood splashes to the eyes or mouth in the healthcare setting are at low risk of contracting HIV.

What can be done to prevent the transmission of HIV through blood or blood products?

Single-use and proper disposal of syringes and needles can drastically reduce the spread of HIV among injecting drug users. Strict criteria and testing of blood for transfusion and organ and tissue donation can help reduce the risk of HIV transmission, as can blood safety and precautionary guidelines in healthcare settings to avoid risk incidents.

Are there times when people with HIV are more infectious or able to transmit HIV easier?

People are more infectious when they have a greater viral load or concentration of the HIV virus in their blood. The viral load is highest when a person first contracts HIV, before the body has had a chance to build a defence/create antibodies to the virus, and later during the progression of the virus when the immune system weakens and displays signs of damage. A person with an STI is also more likely to transmit HIV when they participate in unprotected sex, due to the higher concentration of HIV in their semen or vaginal fluids, as well as other conditions that lead to higher infectivity.

Can a mosquito spread HIV?

Mosquitoes cannot spread HIV. Extensive research on this question has proven this.

Is HIV a strong or fragile virus?

HIV is a fragile virus. It can only survive in moist conditions, which is why it is transmitted through bodily fluids such as blood, semen, vaginal secretion or breast milk. It cannot penetrate through unbroken skin and condoms. HIV is sensitive to fluctuations in temperature and the presence of oxygen. One place that HIV has been known to survive for a long time is in drug injection syringes since these are airtight and often contain blood from the injector.

VI. Life With HIV/AIDS

How many people are living with HIV/AIDS around the world?

Approximately 40.3 million people are living with HIV/AIDS worldwide (2005).

If a person is HIV positive, what should they do to protect their health?

Knowing one's HIV status is fundamental to protecting a one's health and the health of their sexual partner/s and children. It is important to remember that a person can live a healthy, full life with HIV if they take care of their health. This can be done by finding support networks to provide emotional support, as well as information on nutrition, medical treatment and how to live a healthy life.

Why is nutrition so important to protecting the health of a person with HIV?

As HIV progresses in a person, weight loss typically occurs. HIV changes the way a body processes food in two key ways. First HIV reduces the body's ability to absorb nutrients. Secondly, people living with HIV mainly lose muscle weight instead of fat. When the body of a person with HIV runs out of energy rich foods, it uses the energy stored in muscles. Healthy people access fat for extra energy when the food stores in their bodies are diminished. The shrinking of muscles goes unnoticed initially, because the fat around the muscles is not lost. Muscles are made up of protein, and it is therefore important that an HIV positive person eat protein rich foods.

Additionally, it is important to eat lots of carbohydrates since the body uses a lot of energy in its fight against HIV. Energy foods such as rice, bread, and potatoes and foods with fats and oils, provide what is known as complex sugars to supply energy. If an HIV positive person does not eat enough energy foods and protein-rich foods, they will lose important muscles and not fat. This is called wasting, which weakens the body and makes it more difficult to combat disease.

What is a CD4 count and a viral load test and why are they important?

Since HIV mainly targets the CD4 cells in a body's immune system, the CD4 count indicates how many CD4 cells are healthy, and how strong a person's immune system is. Most people without HIV have about 700 to 1000 CD4 cells, whereas HIV infected people are considered to have 'normal' CD4 counts if the number is above 500. A value below 200 could indicate that a person needs to go on ARVs if they are not already on them.

Viral load is a measure of the active HIV found in a small sample of blood. This can range from greater than 750,000 to less than 50 and the lower this figure, the better the health status of the person. CD4 counts and viral load tests are used as health indicators for people with HIV, to help determine when to take certain medicines and to gauge the progression of HIV.

What are Opportunistic Infections?

HIV attacks the immune system, making it harder for a person to fight off other infections. These infections are called 'Opportunistic Infections' or OIs, as they occur because of the weakened immune system. Common OIs include Tuberculosis (TB), Pneumocystis Carinii Pneumonia (PCP), Oropharyngeal Candidiasis (thrush), and Kaposi's sarcoma (a form of skin cancer). The CD4 count is a good indicator of the OIs a person may contract, so it is important for HIV positive people to monitor their CD4 counts. Based on this, their health care providers can guide them on which OIs to anticipate and what can be done to prevent OIs.

What medicines do people with HIV need to take?

There is presently no cure for HIV. Treatment is available, however, to treat Opportunistic Infections (OIs) and slow the progression of HIV. There are three different kinds of medicines for people with HIV. Firstly, there are prophylactic medications to prevent Opportunistic Infections such as PCP. Secondly there are medicines to treat Opportunistic Infections, and lastly there are medicines used to slow the progression of HIV, known as antiretrovirals (ARVs). Different ARVs work in different ways to stop the spread of the virus, but they do not eliminate HIV.

What is Highly Active Antiretroviral Therapy (HAART)?

HAART is a combination of anti-HIV drugs, known as antiretrovirals (ARVs), which needs to be taken daily to slow the progression of HIV. Not every HIV positive person needs to take HAART. Health care officials use CD4 counts and viral load tests to determine when to start HAART. Once a person begins HAART, s/he cannot stop the treatment. There are many side effects and issues of treatment adherence and drug resistance to be taken into consideration before initiating HAART. So it is important for a person considering HAART to talk to their health care provider and learn about advantages and disadvantages of this treatment.

Are traditional medicines and ayurvedic treatments more effective than ARVs for combating HIV?

Traditional ways of combating disease may often provide practical tools to assist a person with HIV to stay healthy. However they should be seen as complementary tools and not replacements for ARVs.

Handout 2.17
Basics of HIV/AIDS Quiz

NOTE FOR THE FACILITATOR: ANSWERS TO THE QUESTIONS BELOW CAN BE FOUND IN HANDOUT 2.16. DEPENDING ON THE NUMBER OF PARTICIPANTS AND THEIR LEVEL OF AWARENESS, YOU MAY WISH TO ADD MORE QUESTIONS AFTER GOING THROUGH HANDOUT 2.16 OR MODIFY THE ONES GIVEN HERE AS WELL.

What do HIV and AIDS stand for?

What is the difference between HIV and AIDS?

What is the immune system?

What are antibodies?

What are T-cells?

What are CD-4 Cells?

What are the routes of transmission of HIV?

What is the Window Period?

Can HIV infect married men and women? Please explain.

How do they test for HIV?

What is meant by 'viral load' in the context of HIV/AIDS?

If you have sex, what is the best protection against transmission of HIV/AIDS?

How can the risk of mother to child transmission HIV be reduced?

Can you tell by looking at someone if they have HIV?

How many people are living with HIV/AIDS around the world?

You can get HIV from sharing a toilet: True or false.

Can insects or mosquitoes transmit HIV?

What are Opportunistic Infections?

Is there a cure for AIDS?

Handout 2.18
Frequently Asked Questions: Transmission of HIV and its Prevention

Please note that the information provided in this handout is very general. Information on HIV is continually changing and it is important to make sure that the information you have is current, particularly for new treatments or drug options, laws and policies, controversies and campaigns in a region and country. If anyone in your group is working on these issues, ask them to give you the information they have and use in their work. Add any other information you feel is important when you make your presentation. If you have not been working regularly on these issues, find out what is available in your state/country/region.

How is HIV transmitted?

There are four routes of transmission for HIV: 1) **unprotected sex** with an infected person; 2) **infected mother to child,** either during pregnancy, delivery or through breastfeeding; 3) through **contaminated blood and blood products** (including organ and tissue transplants); and 4) **sharing of unsterilised, used infected needles,** syringes and other medical equipment like dentists instruments.

What are the conditions for transmission of HIV through unprotected sex?

One person must be infected with HIV to pass it to another. Unprotected penetrative vaginal intercourse is the most common route of HIV transmission, while anal sex - whether male-to-male or male-to-female - poses a higher risk for transmission. It is rare but possible to acquire HIV through oral sex, particularly if the person has ulcers or sores inside their mouth. Kissing and other non-penetrative sexual activities do not pose a risk for HIV transmission.

What can decrease the spread of HIV through sex?

Presently condoms are the most effective method of HIV prevention through the sexual route. **Correct and consistent condom use significantly reduces the transmission of HIV. Treatment and prevention of STIs can reduce the risk of HIV transmission.** STIs not only increase a person's susceptibility to getting HIV, they also increase an HIV positive person's infectiousness making spread of the disease more likely.

What are the conditions for transmission from mother to child?

An HIV positive mother can pass the virus to her child either during pregnancy, delivery, or through breastfeeding. Most often a foetus is protected from infection while in the uterus, but the presence of some STIs such as syphilis can increase the likelihood of infection. Transmission between mother and child is most likely to occur during delivery when there is a higher chance of the baby's blood coming in contact with the mother's blood. HIV is also present in breast milk; different studies have found results ranging from a 5% to a 20% chance that the baby may become infected through breast milk. When there is no healthy alternative to breastfeeding, infected mothers are encouraged to breastfeed their children to prevent them from dying of malnutrition or water-borne diseases instead. The risks of HIV infection through breastfeeding and the risk of death due to malnutrition need to be balanced and carefully considered in such situations.

What can reduce the risk for transmission of HIV from mother to child?

The primary tool to prevent transmission from mother to child is the use of antiretroviral medicines during pregnancy and delivery. This method, combined with access and utilization to safe delivery practices, and counselling and support for infant feeding methods can significantly reduce transmission of the virus between mothers and their infants. It is crucial for pregnant women to know if they are HIV positive.

What are the conditions for transmission HIV through blood or blood products?

Injection drug use, blood transfusion, and needle sticks are the primary methods of transmitting HIV through blood or blood products. Sharing injecting needles and/or syringes for drug use is an effective way of transmitting HIV. When infected blood is drawn into a needle via a syringe, and the same needle is used by someone else, HIV is injected directly into his/ her blood.

A person who receives blood infected with HIV through a transfusion, organ or tissue transplants, can also contract the virus. Needle stick injuries or blood splashes to the eyes or mouth that often takes place in the healthcare setting subject people to a relatively low risk of infection.

What can be done to prevent the transmission of HIV through blood or blood products?

Single-use and proper disposal of syringes and needles can drastically reduce the spread of HIV among injecting drug users.

Strict criteria and testing of blood for transfusion and organ and tissue donation can help reduce the risk of HIV transmission as can blood safety and precautionary guidelines in healthcare settings to avoid low risk incidents.

Are there times when people with HIV are more able to transmit HIV ?

A person is more infectious when there is a greater viral load or concentration of the HIV virus in their blood. There is a greater viral load in the body when a person first contracts HIV, before the body has had a chance to build a defence/create antibodies to the virus, and later during the progression of the virus, when the immune system is weakened. A person with an STI is also more likely to transmit HIV when they participate in unprotected sex, due to the higher concentration of HIV in their semen or vaginal fluids, as well as other conditions that lead to higher infectivity.

Can a mosquito spread HIV?

Extensive research done on this issue has proved that mosquitoes do not transfer HIV. HIV cannot survive outside the human body for long.

Handout 2.18
Frequently Asked Questions: Testing for HIV/AIDS

Please note that the information provided in this handout is very general. Information on HIV is continually changing and it is important to make sure that the information you have is current, particularly for new treatments or drug options, laws and policies, controversies and campaigns in a region and country. If anyone in your group is working on these issues, ask them to give you the information they have and use in their work. Add any other information you feel is important when you make your presentation. If you have not been working regularly on these issues, find out what is available in your state/country/region.

What happens when a person is first infected with HIV?

After a person has been infected with HIV, the virus will begin to attack CD4 cells and multiply rapidly in the body. During the first 2 to 8 weeks while the immune system is fighting back, a person may feel like they have the flu. Within three months of infection the body's immune system is able to produce **HIV antibodies** to combat the virus. Most common HIV tests look for the presence of these antibodies. It is only when these antibodies are present in the blood that a person tests positive for HIV.

How does someone find out if they have HIV?

The most common HIV tests look for the presence of HIV antibodies in a person's blood or saliva. It may take several days to get the results of some tests since they have to go to labs, while other 'rapid tests' can provide results in 30 minutes. Common antibody tests include ELISA (Enzyme Linked Immuno Sorbent Assay) and Western Blot (this is also used as a confirmatory test).

What is the window period?

HIV tests look for the presence of antibodies produced by the immune system when it comes in contact with HIV. It may take up to three months for the body to produce enough HIV antibodies to show up in the test. This three-month period between the time of contracting the infection and when a person tests positive on an HIV antibody test is known as the **window period**. During this time a person is already infected and capable of spreading HIV to another individual.

What is a false negative test result?

If a person goes in for an antibody test in the window period - during which there are not enough antibodies to HIV in the body to show up in the test - s/he may get a negative result. This is a false negative result because although the person is infected, the test does not show this. It is therefore recommended that if a person is unsure of their last unsafe exposure, a second test should be done after another three months. During this time they should not expose themselves to any additional risk of infection.

What are VCT clinics?

These are Voluntary Counselling and Testing clinics, intended to provide confidential counselling and testing for HIV. Many communities have set up these up to encourage people to get more

information about HIV/AIDS, determine their HIV status and get treatment if necessary. They are also called Voluntary Confidential Counselling and Testing (VCCTs) clinics in some countries.

How can a person find out if a baby has HIV?

The most common HIV tests do not test for the virus itself but for the presence of HIV antibodies. Since all infants carry their mother's antibodies for the first several months of life, it is difficult to determine if an infant born to an HIV positive mother has HIV. All infants born from HIV positive women will have HIV antibodies in their system for 9 to 18 months, so a test is recommended for such infants at 9 months and then again at 18 months. All infants born to HIV positive mothers should receive regular check-ups for up to 18 months, and their health and nutrition must be carefully monitored. Preventative medicines may be necessary in some instances.

How does a person with HIV remain healthy?

It may take up to 8 or 10 years for a person with HIV to develop symptoms. During this time the virus weakens the body's immune system, but the body still has a strong enough defence against Opportunistic Infections. An HIV positive person who is otherwise in good health - through healthy eating habits, practice of safer sex, and the use of anti-retroviral treatment (ART) - can continue to lead a healthy life for many years.

Handout 2.18
Frequently Asked Questions about Treatment for HIV/AIDS

Please note that the information provided in this handout is very general. Information on HIV is continually changing and it is important to make sure that the information you have is current, particularly for new treatments or drug options, laws and policies, controversies and campaigns in a region and country. If anyone in your group is working on these issues, ask them to give you the information they have and use in their work. Add any other information you feel is important when you make your presentation. If you have not been working regularly on these issues, find out what is available in your state/country/region.

Is there a cure for HIV/AIDS?

There is no cure yet for HIV/AIDS nor any vaccine against HIV/AIDS.

Is there any treatment to help people living with HIV/AIDS?

There are three types of medicines people with HIV can take: (1) Preventative Medications, used to prevent Opportunistic Infections. (2) Medicines to treat Opportunistic Infections. (3) Medicines used to slow the progression of HIV, known as antiretrovirals (ARVs).

What is Antiretroviral Treatment (ART)?

Antiretroviral treatment is medication people living with HIV/AIDS can take to slow down the progression of the virus and reduce levels of HIV in the blood and need to be taken for the rest of a person's life. However this treatment will not remove HIV from the blood or act as a cure.

How do Antiretroviral (ARV) medications work?

HIV is a virus that spreads through the body by infecting healthy immune system cells and replicating itself. These replicated cells then infect new healthy immune system cells. The ARTs available consist of drugs that work in different ways to slow down the replication of the HIV virus. These drugs are known as antiretrovirals, anti-HIV drugs, or HIV antiviral drugs.

What is HAART?

HAART stands for Highly Active Antiretroviral Therapy and refers to treatment with a combination of three or more anti-HIV drugs. It has been found that the reduction of the replication of HIV over a long period of time is more effective if a person takes more that one type of antiretroviral drug at a time.

What are the different types of antiretroviral drugs?

There are four classifications of antiretroviral drugs that work against HIV in different ways: 1) Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs); 2) Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs); 3) Protease Inhibitors; and 4) Fusion or Entry Inhibitors.

Are there many ART drugs currently available?

There are a number of different antiretroviral drugs currently available around the world. The number of ARVs and types available vary from country to country.

Are there any side effects from antiretroviral treatments?

Yes, most of the drugs have side effects that include tiredness, abdominal pain, constipation, fevers, headaches, nausea, seizures, and rashes among others.

What is a CD4 count and a viral load test and why is it important?

Since HIV mainly targets the CD4 cells in a body's immune system, the CD4 count indicates how many CD4 cells are healthy and consequently, how strong a person's immune system is. Most people without HIV have about 700 to 1000 CD4 cells. HIV infected people are considered to have 'normal' CD4 counts if the number is above 500. A value below 200 could indicate that a person needs to go on ARVs if not already on them.

Viral load is a measure of the active HIV found in a small sample of blood. The figure can range from higher than 750,000, to less than 50 and the lower this figure, the better the health status of the person. CD4 counts and viral load tests are used as health indicators for people with HIV. They are used to determine when to take certain medicines and to gauge how far HIV has progressed.

When do people begin ART?

There is debate about when antiretroviral treatment should begin. Some doctors and researchers argue that it should be when the CD4 count is at a certain level (below 200), while others believe it can begin with a CD4 count as high as 350. It is generally believed that the viral load should be measured in the blood before starting treatment. When CD4 tests are unavailable, other guidelines for treatment can be used which depend on stage of the infection and different infection symptoms. There are also personal factors to be considered like the availability of money to consistently pay for treatments, ability to continue without ARTs etc., and each individual must decide on the best approach to their management of HIV before beginning treatment.

What are Opportunistic Infections?

HIV attacks the immune system making it harder for a person to fight off other infections. These infections are called 'Opportunistic Infections' or OIs because they strike when the immune system is weakened. Common OIs include Tuberculosis (TB), Pneumocystis Carinii Pneumonia (PCP), Oropharyngeal Candidiasis (thrush), and Kaposi's Sarcoma (a form of skin cancer). The CD4 count is a good indicator of the OIs a person may contract, so it is important for HIV positive people to monitor their CD4 counts. Based on this, their health care providers can guide them on which OIs to anticipate and what can be done to prevent OIs.

Is there treatment for Opportunistic Infections?

Yes, there are drugs to treat many of the common Opportunistic Infections people with HIV/AIDS acquire. Preventative medicines and improved access to treatment can help reduce these infections and the progression of HIV. The drugs used to treat Opportunistic Infections are also used by people with the same infection who may not be HIV positive. For example a person with TB who is not HIV positive will receive the same medication as an HIV positive person who has developed TB.

Handout 2.18
Frequently Asked Questions about Care and Support for HIV/AIDS

Please note that the information provided in this handout is very general. Information on HIV is continually changing and it is important to make sure that the information you have is current, particularly for new treatments or drug options, laws and policies, controversies and campaigns in a region and country. If anyone in your group is working on these issues, ask them to give you the information they have and use in their work. Add any other information you feel is important when you make your presentation. If you have not been working regularly on these issues, find out what is available in your state/country/region.

If a person is HIV positive, what should be done to protect their health?

Knowing one's HIV status is a fundamental tool to protect a person's health and the health of their sexual partners and children. It is important to remember that a person can live a healthy, full life with HIV if they take care of their health. This can be done by finding support networks to provide emotional support, as well as information on medical treatment, nutrition and how to live a healthy life.

Is ARV treatment available to everyone?

In many developing countries, ARV therapy is unavailable in certain areas or too expensive for many people. Other obstacles can limit access to treatment such as lack of adequate storage facilities (it is necessary to keep some ARV drugs at colder temperatures), lack of clean drinking water (some ARVs require drinking litres of clean drinking water); and lack of adequate health care facilities or workers to supply doses of the ARVs in a timely manner necessary for adherence to the drugs (failure to stick to an ARV regimen can result in drug resistance to some of the HIV strains). It is important to note, however, that these factors are no excuse for the failure to provide treatment options for people in all settings and areas.

Does good nutrition play a part in HIV/AIDS?

Yes, as HIV progresses in a person, weight loss typically occurs. HIV changes the way a body processes food in two key ways. First HIV reduces the body's ability to absorb nutrients. Secondly, people living with HIV mainly lose muscle weight instead of fat. When the body of a person with HIV runs out of energy rich foods, it uses the energy stored in muscles. Healthy people access fat for extra energy when the food stores in their bodies are diminished. The shrinking of muscles goes unnoticed initially, because the fat around the muscles is not lost. Muscles are made up of protein, and it is therefore important that an HIV positive person eat protein rich foods.

Additionally, it is important to eat lots of carbohydrates since the body uses a lot of energy in its fight against HIV. Energy foods such as rice, bread, and potatoes and foods with fats and oils, provide what is known as complex sugars to supply energy. If an HIV positive person does not eat enough energy foods and protein-rich foods, they will lose important muscles and not fat. This is called wasting, which weakens the body and makes it more difficult to combat disease.

Does counselling play a part in HIV/AIDS care and support?

Counselling is considered very helpful in the care and support of persons living with HIV/AIDS, their families, and the communities they live in. Counselling provides social and psychological support, and has been shown to help people cope with being HIV positive and understanding what it means to live with HIV/AIDS. It also helps reduce the risk of transmission to others, and other decisions that may affect the family and community when a person has AIDS or may be close to dying.

Sex workers/intravenous drug users/truck drivers are the main carriers of the HIV virus, and are the main cause of HIV: True or False?

False. It is not a particular group, but certain types of behaviour (for example unprotected anal sex with person/s whose HIV status is not known) that puts a person at risk for HIV/AIDS. HIV can infect a sex worker, truck driver, married woman in a monogamous relationship or a child receiving transfusion.

Is a person living with HIV/AIDS (PLWHA) just waiting to die?

No. PLWHAs are active members of society who may live life with some challenges, but should not be seen as 'patients' or 'sick' persons.

Can HIV/AIDS affect married men and women?

Yes, being married does not protect a person from HIV/AIDS.

Can you tell by looking at someone if they have HIV?

No. It can take up to 8-10 years before someone with HIV begins to show symptoms. Also, the 'symptoms' that may appear are to do with Opportunistic Infections.

Do complementary medicines and ayurverdic treatments work to treat HIV/AIDS?

Some complementary treatment and ayurvedic medicines may be beneficial to people while others may be ineffective. Some may even be harmful. It is important to recognize that alternative forms of healing and treatment do exist, and that communities find these beneficial and appropriate. Traditional ways of combating disease may often provide practical tools to assist a person with HIV to stay healthy. However they should be seen as complementary tools and not replacements for ARVs.

What is palliative care?

Palliative care is given to a person nearing the end of life. It is meant to ease the pain people experience when they are dying. Palliative care can consist of medicinal or physical therapies that make people more comfortable, and emotional and/or spiritual support to seriously ill people and their loved ones as they prepare for death.

How many people are living with HIV/AIDS around the world?

Approximately 40.3 million people are living with HIV/AIDS worldwide (2005). Check local figures from National or State AIDS Control organisations in your region. Global figures can be obtained from the UNAIDS website (www.unaids.org) or office in your region.

Handout 2.19

Basic Information on Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs)

RTI/STI NAME	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION	CONSEQUENCES IF UNTREATED
Bacterial Vaginosis (BV)	A RTI in women caused by an imbalance or overgrowth of certain bacteria in the vagina that disrupts the normal bacterial balance. Not passed from person to person, but more common among sexually active people.	Unusual vaginal discharge that is grey in colour and has an unpleasant smell, it appears particularly after sex. Some may feel itching around the vagina and/or burning during urination while some report no symptoms at all.	Antibiotics and vaginal creams.	Avoid scented soaps and douching (washing or rinsing out the vagina by forcing water or other mixtures of fluids into the vaginal cavity); using a condom may lower risk because of the effect semen can have on bacteria in the vagina; keep the vulva dry and clean.	Increased risk for other reproductive tract problems such as pelvic inflammatory disease (PID); if a woman is pregnant BV has been associated with premature labour; increases susceptibility to HIV and other STIs.
Chancroid	A bacterial STI that is transmitted through contact with sores on the vagina, penis, rectum or anus.	Small blister or sores that turn into painful ulcers on the genitals, anus, mouth or lips and can bleed easily.	Antibiotic treatment.	Use a condom during oral, anal or vaginal intercourse to reduce the risk of transmission. Avoid sexual intercourse or contact with the sores until they are healed and fully treated.	The sores can rupture and drain pus, which can be very painful; can increase risk for transmission of HIV.
Chlamydia	A bacterial STI transmitted through anal, oral or vaginal sex.	Could be asymptomatic in both men and women. If symptoms occur it is usually discharge from the penis, swollen testicles or pain during urination for men. Symptoms in women: unusual vaginal discharge, painful urination, pelvic pain, or abnormal bleeding during menses or after sexual intercourse.	Antibiotic treatment. All sexual contacts should be screened for chlamydia.	Use a condom during oral, anal or vaginal intercourse to reduce the risk of transmission; sexual partners should also be tested and treated so as to avoid re-infection.	Women can develop PID, ectopic (tuball) pregnancy or infertility,. If pregnant, chlamydial infections can lead to premature delivery and the infant can develop infections like conjunctivitis or pneumonia. Men can develop sterility and epidydimitis which is a painful condition of the testicles that can lead to infertility if left untreated.

RTI/STI NAME	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION	CONSEQUENCES IF UNTREATED
Cytomegalovirus (CMV)	Viral infection that spreads through bodily fluids (saliva, blood, tears, breast milk, semen, urine); commonly spread from a woman to a fetus. Though not primarily an STI, it can also spread through close personal contact or vaginal, anal and oral sex. Complications with CMV occur more often in people with compromised immune systems (like those with HIV, on chemotherapy).	In healthy adults usually asymptomatic but can transmit the infection to others. Some symptoms can manifest in swollen glands, fatigue, or fever.	Once someone is infected, the virus remains in the body for life, but most of the time it remains dormant. There is no cure. There are some medications being tested and vaccines being developed to prevent CMV.	No direct intervention to prevent CMV. Using a condom can help reduce risk of transmission during sex, but it can also be acquired through saliva, kissing or oral sex. Infants infected just before or after birth can transmit the disease to others, so proper hand washing and diaper changing can reduce risk.	Complications and serious infections such as eye infections can develop mainly with people who are immuno-suppressed, such as those on chemotherapy or with HIV. Babies born with CMV can develop serious infections or develop blindness, deafness or epilepsy. Often there are no long-term health consequences for healthy adults.
Donovanosis	A bacterial STI. Found mainly in tropical regions, like parts of South India.	Reddish ulcers near genitals that can bleed on contact.	Antibiotic treatment	Use a condom during oral, anal or vaginal intercourse. Avoid sexual contact when there are visible sores.	Ulcers can grow together and result in permanent scarring and depigmentation of the genitals.
Genital Herpes	A viral STI caused by the herpes simplex virus (HSV). There are two subtypes: HSV-1 and HSV-2. Herpes spreads through skin contact with an infected individual. The virus can be spread through contact with blisters and sores during an outbreak as well as when there are symptoms.	Can be asymptomatic although infected people can still transmit the virus. For those with symptoms, they include painful blisters or sores on the genitals, around the buttocks or thighs, or mouth; fever, swollen glands.	There is no cure. People can experience outbreaks of sores that will vary in severity and frequency from one person to another. Symptoms can be treated with oral or topical medications.	Use a condom during oral, anal or vaginal intercourse. Avoid intercourse when one partner is having an outbreak of sores.	Recurrent outbreaks. 1st time infection during pregnancy can put the woman at risk of miscarriage/ preterm labour. If 1st episode occurs during delivery, there is risk of herpes transmission to the baby. In some cases, contact with sores can lead to damage to the baby's nervous system. People with low immunity may suffer infections of various organs including kidneys, eyes, brain etc .

RTI/STI NAME	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION	CONSEQUENCES IF UNTREATED
Gonorrhoea	Bacterial STI that can infect the vagina, penis, cervix, urethra, anus or throat. It is spread through oral, vaginal or anal sex.	If symptoms do occur they can include unusual discharge from the penis/ vagina, pain when urinating, painful bowel movements.	Antibiotic treatment.	Use a condom during oral, anal or vaginal intercourse.	Increased risk of contracting HIV.In women: PID, increased risk for ectopic pregnancy, infertility and chronic pelvic pain. If a woman is pregnant it can cause spontaneous abortion, pre-term delivery, and blood or eye infections in the baby. In men: epididymitis which is a painful condition of the testicles that can lead to infertility if left untreated.
Hepatitis B-HBV	Transmitted though the exchange of blood or other body fluids including semen and vaginal fluids, sharing needles and from infected mother to child. Not transmitted through kissing, breastfeeding, or sharing eating utensils.	Yellow skin and eyes, dark urine, severe tiredness, weight loss, abdominal pain, loss of appetite, nausea and vomiting.	There is a vaccine to protect against HBV. There is no cure for HBV. Often in healthy people it will go away on its own in 4-8 weeks. A small percentage of people will develop chronic HBV. Symptoms can be treated with medications.	Vaccination against Hepatitis B. If infected do not donate blood. Using a condom can reduce the risk of transmission; also test blood before transfusion, use disposable syringes, find out about immunization for mother to child transmission .	Chronic hepatitis, liver cancer, cirrhosis. If a woman is pregnant Hepatitis B can be transmitted to the foetus.
Hepatitis C-HCV	Contracted through unprotected vaginal, penile or anal sex with infected person, sharing infected needles, contact with infected blood, blood transfusions of infected blood etc .	Yellowing of the eyes and skin, headaches, muscle aches, dark urine, tiredness, loss of appetite, nausea and vomiting, generalised itching.	There is no cure. Many people infected with HCV become chronic carriers. Medications and treatments can help with symptoms.	If infected do not donate blood, organs, sperms, tissues. Use a condom during oral, anal or vaginal intercourse. Avoid sharing needles.	Chronic hepatitis C; cirrhosis of the liver, cancer of the liver. There is a low risk of a pregnant woman transmitting HCV during pregnancy or birth.

RTI/STI NAME	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION	CONSEQUENCES IF UNTREATED
HIV-(Human Immunodeficiency Virus)	There are four routes of transmission for HIV—1) unprotected sex with an infected person; 2) infected mother to child, either during pregnancy, during delivery or through breastfeeding; 3) through contaminated blood and blood products (including organ donation and tissue transplants); and 4) sharing/use of unsterilised infected needles, syringes and other medical equipment like dentists' instruments.	People may have no symptoms while infected, however early symptoms can include: rapid weight loss over a month, swollen glands, fatigue, skin blotches, persistent fever, diarrhoea for several weeks, thrush on the tongue, persistent yeast infections.As the infection progresses, the immune system is affected and the person may experience Opportunistic Infections.	There is no cure. However, there are medications that slow down the spread of the virus and treat common/ Opportunistic infections that are caused by the virus.	Correct and consistent condom use are presently the most effective method of significantly reducing risk of transmission of HIV through the sexual route. Treatment and prevention of STIs can reduce the risk of HIV transmission. STIs not only increase a person's susceptibility to getting HIV, they also increase an HIV positive person's infectiousness making it more likely for them to spread the infection.	HIV causes AIDS (Acquired Immunodeficiency syndrome). AIDS is said to have occurred when HIV has damaged the immune system, leaving a person's body vulnerable to infection and disease. Please see Handouts 2.16 and 2.18 for detailed information.
HPV (Human Papilloma Virus) & Genital Warts	An STI caused by HPV. There are over 70 types of HPV. Some types may cause genital warts. These are called low-risk types of HPV. It is very common among people who are sexually active. When HPV infects the genital area, it affects the the vulva, vagina, cervix, rectum, anus, penis, or scrotum. Some types may cause cell changes that sometimes lead to cervical and other cancers. These are called high-risk types of HPV. Most types of HPV seem to have no harmful effects at all.	Genital warts are small, flesh coloured and look like small cauliflower florets on the genitals, anus, and in some cases in the mouth and/or throat. These warts can be itchy and grow in clusters. Many other forms of HPV can be asymptomatic. Cell changes of high-risk HPV strains can be detected through Pap tests for women.	Genital warts are oftentimes curable, with freezing chemical agents applied to the sores, lasers to burn them off, or surgery. Many forms of HPV have no known cure or will go away on their own. Pap tests can detect pre-cancerous cell changes in women.	Using a condom during oral, anal, or vaginal intercourse can reduce the risk of transmission. Often many forms of HPV can be transmitted through skin-to-skin contact as well. Regular Pap tests for women to check for cellular changes in the cervix helps identify and check the infection in time. A vaccine to prevent high risk HPV have been developed and should be in the market soon.	Genital warts if untreated can disappear, stay the same, or grow in size and in number. They can cause sores and bleeding – which can increase the risk of HIV infection. Some forms of HPV have links to cervical and other cancers.

RTI/STI NAME	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION	CONSEQUENCES IF UNTREATED
Lymphogranuloma Venereum (LGV)	Caused by a specific type of chlamydial bacteria strain. Transmitted through anal, oral or vaginal sex.	Small, painless genital ulcers that can develop between 3 to 30 days after exposure; swelling of the lymph nodes in the groin; inflammation or bleeding of the rectum.	Antibiotic treatment.	Using a condom during oral, anal or vaginal intercourse can reduce the risk of transmission.	Fistulas (an opening between the rectum and the vaginal, scarring and narrowing of the rectum, enlargement of the genitals. Can increase the risk of HIV transmission.
Molluscum Contagiosum	Contracted by skin-to-skin contact. Not necessarily through sexual contact. In adults usually transmitted through sexual intercourse. Can also be transmitted through sharing of towels or clothing that come into contact with the lesions.	Small, smooth hard bumps with a white dimpled centre that is painless and usually around the groin, thighs or lower abdomen, or anywhere in the body.	Often the bumps heal and disappear without treatment. The bumps can also be scraped off or treated with a topical ointment.	Using a condom during oral, anal or vaginal intercourse can reduce the risk of transmission. Avoid use of clothes or towels of infected person.	Infection of the sores and spreading if untreated.
Pubic Lice	Transmitted by close body contact with an infected person. It can also spread through sharing of bedding, clothing or towels.	Itching in the genital area or anus, visible tiny white eggs (nits) on pubic hair, mild fever.	Medications and topical lotions can eliminate the lice. Clean and change all clothing and linens that were in contact with affected areas.	Every person who was in close contact with the infected person (family, friends, sexual partners) should be treated.	There are rarely complications. Scratching may make the skin raw and increase risk of secondary infection.
Scabies	A small mite that goes under a persons' skin. It is spread through prolonged skin to skin (including sexual contact) contact with an infected person. It can also spread through sharing of bedding, clothing or towels.	Sever itchiness in areas that the mites have burrowed to lay eggs seen as small bumps or rashes usually around the genitals, breasts, webs of the hands, thighs, elbows and lower adomen.	Medications and topical lotions can eliminate the scabies. Clean and change all clothing and linens that were in contact with affected areas.	All those in close contact with the infected person (family, friends, sexual partners) should be treated.	There are rarely complications.

RTI/STI NAME	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION	CONSEQUENCES IF UNTREATED
Syphilis	A bacterial STI that is transmitted through direct contact with sores that the infection produces on the vagina, penis, rectum, anus, lips or mouth.	There are 3 stages of syphilis: primary stage symptoms include a painless ulcer on genitals, anus or mouth; secondary stage symptoms include skin rashes, headaches, weight loss, hair loss, malaise, and muscle aches. Tertiary stage has no symptoms but the infection remains in the body. It may damage the internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints.	Antibiotic treatment. Easy to treat in the early stages of the infection.	Avoid sexual intercourse until the sores are healed and fully treated. Using a condom can reduce the risk during anal, oral or vaginal sex. However syphilis can still be transmitted if the condom does not cover the sores.	Increased risk of HIV transmission. Complications of the nervous system and cardiovascular system such as heart disease. If a woman is pregnant it can cause spontaneous abortion, and if passed to the foetus, the infant can be born with damage to the brain or heart, as well as develop anaemia, swollen liver, fevers and rashes.
Trichomoniasis	An STI transmitted through a parasite and more common in women. Transmission through penile-vaginal intercourse or vulva-to-vulva contact with an infected partner.	Often asymptomatic but if symptoms do occur, they are unusual discharge, painful urination, itching and burning in the genitals.	Topical and oral medications can treat and cure.	Using a condom during oral, anal or vaginal intercourse can reduce the risk of transmission.	In pregnant women can cause premature labour and low birth weight. May increase the risk of HIV susceptibility.
Vaginal yeast infection (candidiasis, candida moniliasis)	An RTI that is caused by an overgrowth of yeast naturally found in the body. Occurs when the usual environment in the vagina changes. Often the reasons are unknown but can be from antibiotic use, associated with diabetes or problems affecting the immune system.	White clumpy vaginal discharge that can also have an odour; redness or burning in the genital area; itchiness in the internal or external genitals; vaginal pain during intercourse; burning urination.	Topical creams and vaginal suppositories (medication inserted into the vagina where it melts) can cure the infection.	Avoid sexual intercourse until treatment is completed. Avoid scented soaps, synthetic underwear, and douches (washing or rinsing out the vagina by forcing water or other mixtures of fluids into the vaginal cavity).	No complications are known except for severe discomfort from serious infections. Cranberry juice and yogurt are two foods that may help prevent the occurrence of yeast infections and aid in their treatment.

Handout 2.20 Facilitator Copy: STIs and RTIs Quiz

What are RTIs?

RTI stands for Reproductive Tract Infection. RTIs refer to infections that affect the reproductive tract. RTIs are caused by an overgrowth of organisms that are normally present in the vagina or when bacteria or micro-organisms are introduced into the reproductive tract during sexual contact or through medical procedures.

What are the types of RTIs?

Three types of RTIs exist: sexually transmitted, endogenous, and iatrogenic. These often overlap in the ways in which they are transmitted. Endogenous infections occur from an overgrowth of organisms that are normally found in the reproductive tract. Iatrogenic infections occur when an outside intervention (usually medical, such as insertion of an IUD or use of unsterilised equipment) introduces bacteria or micro-organisms into the reproductive tract or pushes an infection that is already present in the vagina into the upper genital tract. Sexually transmitted RTIs are transmitted through sexual contact.

What are STIs?

STI stands for Sexually Transmitted Infection. STIs refer to infections that are transmitted through sexual contact.

Are STIs the same as RTIs?

No, some STIs can be RTIs, but not always. Similarly, some RTIs are also STIs but not always. In many cases, STIs have more serious health consequences.

Name two Sexually Transmitted Infections (STIs):

There are a number of STIs that include Chlamydia, Gonorrhoea, Herpes, Trichomoniasis, and Chancroids. Please see Handout 2.19 for a full list of possible STIs.

Are most STIs curable?

Yes, many STIs are curable using antibiotics.

Is HIV/AIDS an STI?

Yes, HIV/AIDS is also considered an STI because transmissions can occur through the sexual route.

Is there a relationship between STIs and HIV transmission?

Yes. A person with an STI has an increased risk of acquiring HIV as well as an increased risk of transmitting HIV.

How can the risk of most STI transmission be reduced?

A person can reduce the risk of STI transmission by using a condom during sex; getting screened and tested for STIs (both if symptoms do and do not exist since many STIs can be asymptomatic); and getting treatment for themselves and their partner/s. It is important to abstain from sexual contact during the course of treatment and during outbreaks of some STIs such as herpes.

What are two common symptoms for many STIs?

An unusual discharge, pain during urination, ulcers or sores around the genitals and skin irritations are the symptoms of an STI. For additional symptoms please see Handout 2.19.

What does an asymptomatic STI mean?

Asymptomatic means that most people will not have symptoms if they have the STI. For example, nearly 70% of women who have chlamydia or gonorrhoea are asymptomatic. Because people feel fine and have no symptoms of infection, they may delay getting tested and subsequently treated for the STI.

If a woman is pregnant an STI can cause complications: True or false?

True. If a woman is pregnant, certain STIs can cause her to go into pre-term delivery or the baby can develop adverse health conditions such as conjunctivitis, brain damage or even death.

If untreated, what are some of the consequences of an STI?

Infertility, pelvic inflammatory disease in women, some cancers, epididymitis, and ectopic pregnancy are some consequences. For more please see Handout 2.19.

How many new STI cases are reported each year?

According to estimates from 1999, the WHO reported 340 million new cases of curable STIs worldwide between people of age 15-49.

Which area of the world had the highest number of new infections?

South and Southeast Asia had the largest number of new infections worldwide among people between the ages of 15-49.

Once cured of an STI, you cannot contract it again: True or False?

False. Even if you have been treated and cured of an STI, you can contract this or any other STI again.

How can a person find out if they have an STI or RTI?

By getting tested by a health care provider. It is important to get screened and tested for STIs even if symptoms are not present.

People who have STIs are promiscuous and lack good morals: True or false?

False. A person can get an STI from a regular sexual partner, from two partners or from twenty. The 'moral correctness' of a person's life and choices should not be judged by anyone.

Handout 2.21 Participant Copy: STIs and RTIs Quiz

- What are RTIs?
- What are the types of RTIs?
- What are STIs?
- Are all STIs RTIs?
- Name two Sexually Transmitted Infections (STIs):
- Are most STIs curable?
- Is HIV/AIDS an STI?
- Is there a relationship between STIs and the transmission of HIV?
- How can the risk of most STI transmission be reduced?
- What are two common symptoms of many STIs?
- What does an asymptomatic STI mean?
- If a woman is pregnant an STI can cause complications: True or false?
- What are some of the consequences of an untreated STI?
- How many new cases of STI are reported each year?
- Which area of the world had the highest number of new infections?
- If you have been cured from an STI you cannot contract this again: True or false?
- How can a person find out if they have an STI or RTI?
- People who have STIs are promiscuous and lack good morals: True or false?

Handout 2.22 Facilitator Copy: Talking About STIs and RTIs

Case Study1

Akash has been seeing Shruti for many years. They are unmarried but have been having sex since they started dating. Recently Akash has been experiencing pain when he urinates. He is not sure why this is happening, but thinks it may have some connection to his pants being too tight. He has never experienced these symptoms before.

Questions:

- If Akash approached you, what would you say to him?
- What would you recommend he do?
- Are there services in your community that Akash could use? Are they accessible? Would he be comfortable going to these facilities?
- Would your reaction be different if Akash was below 18 years of age and approached you?

Case Study 2

Sunita started taking birth control pills a few months ago so that she and her husband can have sex without a condom. They find sex more comfortable and pleasurable without a condom. Right before her period, however, she developed an unusual discharge. She wonders if this is from the birth control pills or something else.

Questions:

- If Sunita approached you with this problem what would you tell her?
- What would you recommend she do?
- Are there services in your community that Sunita could use? Are they accessible? Would she be comfortable going to these facilities?
- Would your reaction be different if Sunita was below 18 years of age and approached you?

Case Study 3

Gautam is in a monogamous relationship with his lover. A few months ago they began to have sex without a condom or other protection. Within a few weeks he developed a sore on his mouth, which went away after a week or so. Gautam forgot about the sore, but a few months later he developed a fever and rash and began to get worried. He didn't connect the two illnesses, but his partner is concerned.

Questions:

- If Gautam approached you, what would you tell him?
- What would you recommend he do?
- Are there services in your community that Gautam could use? Are they accessible? Would he be comfortable going to these facilities?
- Would your reaction be different if Gautam was below 18 years of age and approached you?

Case Study 4

Twinkle usually uses protection when she has sex, but the other day she spotted some fluid-filled blisters on her genitals and wonders if she has contracted some infection from one of her sexual partners.

Questions:

- If Twinkle approached you what would you tell her?
- What would you recommend she do?
- Are there services in your community that Twinkle could use? Are they accessible? Would she be comfortable going to these facilities?
- Would your reaction be different if Twinkle was below 18 years of age and approached you?

Case Study 5

Rita makes an annual trip to the doctor to get a physical examination. She has a Pap smear as a part of this visit. Her most recent Pap test shows an abnormal result. She is upset and worried and does not know what to tell her boyfriend.

Questions:

- If Rita approached you what would you tell her?
- What would you recommend she do?
- Are there services in your community that Rita could use? Are they accessible? Would she comfortable going to these facilities?
- Would your reaction be different if Rita was below 18 years of age and approached you?

Handout 2.23 Participant Copy: Talking About STIs and RTIs

Case Study1

Akash has been seeing Shruti for many years. They are unmarried but have been having sex since they started dating. Recently Akash has been experiencing pain when he urinates. He is not sure why this is happening, but thinks it may have some connection to his pants being too tight. He has never experienced these symptoms before.

Case Study 2

Sunita started taking birth control pills a few months ago so that she and her husband can have sex without a condom. They find sex more comfortable and pleasurable without a condom. Right before her period, however, she developed a strange discharge. She wonders if this is from the birth control pills or something else.

Case Study 3

Gautam is in a monogamous relationship with his lover. A few months ago they began to have sex without a condom or other protection. Within a few weeks he developed a sore on his mouth, which went away after a week or so. Gautam forgot about the sore, but a few months later he developed a fever and rash and began to get worried. He didn't connect the two illnesses, but his partner is concerned.

Case Study 4

Twinkle usually uses protection when she has sex, but the other day she spotted some fluid-filled blisters on her genitals and wonders if she has contracted some infection from one of her sexual partners.

Case Study 5

Rita makes an annual trip to the doctor to get a physical examination. She has a Pap smear as a part of this visit. Her most recent Pap test shows an abnormal result. She is upset and worried and does not know what to tell her boyfriend.

Chapter 5
Sexual Problems

Chapter Objectives for the Facilitator

1. To have participants identify the different sexual problems that people may face and the possible causes for these problems.

2. To dispel myths associated with sexual problems that exist among participants and their communities.

3. To have participants understand how to talk about sexual problems with partners and their community.

Why a Chapter on Sexual Problems

Sexuality is much more than acts of sex. It has many components: beliefs, attitudes, behaviours, and identities. Yet sex and sexual activity are a part of one's sexuality, and the physical act of sex is comprised of a complicated set of physiological processes that occur within thinking, feeling people. Considering this complexity makes it easier to appreciate that sexual problems occur frequently. In most cases, solutions to these problems exist. What makes arriving at these solutions difficult is that talking about sexual problems - whether impotence or painful intercourse – is difficult and embarrassing for most people.

Furthermore, the focus on solutions to sexual problems and what is often termed 'sexual dysfunction' has been to address physical and physiological factors. This approach ignores important factors beyond the physical that contribute to sexual problems. These can include psychosocial factors like relationships, gender, religion, ethnicity, and social environment. For instance, women often lack the language or space to express what they enjoy sexually and what practices they find painful - both of which can lead to sexual problems. Poor health care services, lack of education on sexual and reproductive anatomy and physiology can also play a part in sexual problems.

In some instances, changes in sexual responses and needs can be mistaken for sexual problems. For example, occasional erectile difficulty or painful intercourse may not always signify a sexual problem. For those with problems, however, it is vital to keep communication open and have information and services available. Communication helps dispel myths and misconceptions, which prevent an easy resolution to many sexual problems. For example, it is falsely believed that the 'cure' for all sexual problems is only through medication. Those in the business of 'curing' sexual problems also often assume that everyone experiences pleasure only in penile-vaginal intercourse, which excludes and invalidates other sexually pleasurable experiences.

This chapter explores what constitutes a sexual problem and examines how these may stem from social and cultural

EXERCISES IN THIS CHAPTER

Exercise 1: Demystifying Sexual Problems
45 minutes

Exercise 2: Medical Solutions, the Only Answer?
60 minutes

Exercise 3: My Views on Sexual Problems
60 minutes

Exercise 4: Case Studies on Sexual Problems
60 minutes

MATERIALS REQUIRED FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 2.24
Basic Information on Sexual Problems

Handout 2.25
Facilitator Copy: Myths and Facts on Sexual Problems

Handout 2.26
Participant Copy: Myths and Facts on Sexual Problems

Handout 2.27
A New View of Women's Sexual Problems

Handout 2.28
Case Studies on Sexual Problems

ADDITIONAL RESOURCES:

- A New View of Women's Sexual Problems. http://www.fsd-alert.org
- HERA Action Sheets. Available at: http://www.iwhc.org/docUploads/HERAActionSheets.PDF
- Masters, W.H., Johnson, V.E. 1966. *Human Sexual Response*. Boston: Little, Brown.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

environments. It also looks at current trends to medicalise sexuality - whether by Western science or indigenous therapies - and how these may harm rather than resolve the sexual concerns of people. Finally, the chapter explores the connections between sexual problems and pleasure, infertility, and sexual health.

Key Messages for this Chapter

- Most information that people have about sexual problems is incomplete or inaccurate. It is important to dispel these myths and misconceptions.
- Sexual problems can be very common and discussing them need not cause shame or discomfort.
- Shame, embarrassment and fear around sexual problems drives people to seek help through clandestine practitioners who take advantage of situations by prescribing expensive, ineffective or even harmful infusions, oils, potions or powders.
- In heterosexual relationships, the reasons for sexual problems can be found in the man, the woman or in both. Assumptions based on prevailing ideas in society, that blame one or the other are inaccurate and harmful. It is also possible that the problem is not because anything is 'wrong' with either partner but because of other factors such as unresolved relationship issues or past experiences of abuse.
- Some common sexual problems include early ejaculation, erection problems in men, painful intercourse and an inability to experience orgasm in women.

Exercise 1
Demystifying Sexual Problems

MYTH AND FACTS

Instructions

1. Distribute copies of Handout 2.26 to participants. Give them 5-10 minutes to read over the statements and write down whether each statement is a myth or a fact.

2. Review each statement separately by inviting participants to answer whether they thought it is a myth or a fact. After each statement ask for questions or comments and make sure to include the points mentioned in Handout 2.25.

   Suggested Questions:

- If you thought the statement was a myth/fact are there people in your communities, social networks that think differently?
- How could you dispel misconceptions about this statement? For example, it is a myth that a woman is 'frigid' if she has pain during sex. What can be done to dispel this myth and promote better understanding of women's sexuality?

3. After reviewing all the statements ask for questions or comments.

   Suggested Questions:

- Are there any additional ideas about sexual problems that you want clarity on?
- How do you think these myths affect women and men differently? (For example if a woman cannot have an orgasm is it accepted as usual/common? Whereas if a man cannot have an orgasm it is thought of as a problem)

Purpose of the exercise:

1. To dispel myths and misconceptions about sexual problems.

2. To identify facts about sexual conditions and problems.

TIME

45 minutes

MATERIALS

Handout 2.25 Facilitator Copy: Myths and Facts on Sexual Problems, Handout 2.26 Participant Copy: Myths and Facts on Sexual Problems, pens/pencils

ADVANCE PREPARATION

Review Handout 2.25; Make copies of Handout 2.26 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into groups to discuss the statements, rather than asking them to fill out the handout individually. This may help ease discomfort since people may find it easier to broach the issue in a small group rather than with all participants. After the groups have discussed all the statements, bring them back together and invite participants to share the statements they thought were myths.

Key Messages

- Many ideas and a lot of the information about sexual problems may be false. It is important to understand the basis of sexual problems and work to dispel myths around these.
- Sexual problems can be very common and need not be a cause of shame or discomfort.
- Not all sexual problems need medical interventions. However, medical examination may be needed on occasion to diagnose the cause of some sexual problems.
- In any relationship, the reasons for sexual problems can be found in either or both partners and/or caused by factors in their relationship. Assuming that the problem is because of a particular partner is unfair and does not help to resolve the problem.

MAKING CONNECTIONS:

- Sexual problems can sometimes affect sexual pleasure. This does not mean that an individual is incapable of experiencing sexual pleasure, but may mean trying different or new sexual behaviours or talking about the issue with the partner/s. For more see Chapter 4 in Module 1.
- Knowledge of sexual and reproductive anatomy may help in understanding sexual problems. For more see Chapter 1 in this Module.

TIPS FOR THE FACILITATOR:

- Discussing sexual problems may be uncomfortable for some participants. Encourage participants to speak openly and freely and reiterate that there is no need for shame or discomfort when discussing these issues.
- Participants may make jokes or laugh during this exercise. If necessary go over the ground rules for the training and emphasise respect for others.

Exercise 2
Medical Solutions: The Only Answer?

TEACHING THE CLASS

Instructions

1. Divide the participants into four groups. Distribute copies of Handout 2.24 and Handout 2.27 to each participant. Assign each group to one of the Women's Sexual Problems sections in Handout 2.27 (for example one group will be assigned 'I. Sexual Problems due to Socio-Cultural, Political, or Economic Factors', another group will be assigned 'II. Sexual Problems Relating to Partner and Relationship' etc.). Each group should read the handouts and create a 5-minute 'lesson' to be presented to the entire group. This lesson should provide the rest of the group with a solid understanding of the causes of sexual problems assigned to them. Encourage groups to be creative - using flipcharts, drawing diagrams, acting out a role-play etc. For example a group could do a role-play of a patient going to the doctor and learning about a problem and any available treatments or reasons for its occurrence. They can use examples of different sexual problems listed in Handout 2.24. Give participants 25-30 minutes to create the presentations.

2. Bring participants back together and invite groups to make their presentations one by one. After each presentation, add any information that has been left out by the group or correct any misinformation. Following each presentation ask for questions and comments.

   Suggested Questions:

- Was there anything in the presentation you did not understand?
- What do you think of issues and causes of sexual problems the group presented? Had you heard of these sexual problems before?

3. After all the presentations, have the group discuss what they have learned.

   Suggested Questions:

- Why do we talk about sexual problems as medical issues only? Does it make it easier for us to talk about the subject?

Purpose of the exercise:

1. To learn the specific names, descriptions and causes of each sexual problem.

2. To comfortably discuss sexual problems.

TIME

60 minutes

MATERIALS

Flipchart, pens/pencils, markers
Handout 2.24 Basic Information on Sexual Problems, Handout 2.27 A New View of Women's Sexual Problems.

ADVANCE PREPARATION

Make copies and review Handouts 2.24 and Handout 2.27.

THIS EXERCISE CAN BE MODIFIED BY:

- Asking participants to convey some common myths about sexual problems and dispel them in their presentation.
- Distributing Handout 2.27 to each participant, giving them 5 minutes to read through it and clarifying any questions they may have. Then participants can be asked a series of questions about the handout. For example: 'Name 3 types of sexual problems'. 'If you had a partner/ knew someone that was experiencing one of these problems how would you react?'

MAKING CONNECTIONS:

- Gender roles for men and women can influence the stigma and silence around sexual problems. For more see Chapters 1 and 2 in Module 1.
- A sexual problem does not mean that a person has diminished sexuality. For more see Chapter 1 in Module 1.

- What are the drawbacks of making sexual problems a medical issue? Do other factors contributing to sexual problems get ignored? Give examples.
- What are the dangers of medicalising sex and pleasure? For example, is there any danger to thinking a pill will cure all problems when having sex?

Key Messages

- Even though Handout 2.27 focuses on women's sexual problems, men may also face problems due to similar reasons. Men often stay silent about their sexual problems because socio-cultural ideas of masculinity expect them to be invulnerable and imply that they are weak if they seek help for sexual problems.
- The reason for using a manifesto on women's sexual problems is to highlight the specific problems faced by women in intimate situations. These issues are not focused on/neglected by the medical community and/or by society.
- Sexual problems are quite common and do not need to be a cause of shame. People need to feel more comfortable and free of stigma while discussing their sexual problems.

TIPS FOR THE FACILITATOR:

- Participants may be shy discussing this topic and may want to simply read out the information from the handout during their presentation. Encourage them to be creative and to help increase their comfort with the topic.
- It may be helpful to write the sexual problems from Handout 2.24 on a flipchart prior to the exercise and describe them briefly before the presentations.

Exercise 3
My Views on Sexual Problems

OPINIONS CONTINUUM

Instructions

1. Ask participants to stand in one line across the room. Designate one end of the line as *Strongly Agree* and the opposite end of the line as *Strongly Disagree*.

2. Read out 3-6 statements from the list of statements below. After each, ask participants to put themselves on the line based on whether they strongly agree, strongly disagree or fall somewhere in between.

   Statements on Sexual Problems:

- It is okay to take medication to help improve a sexual problem like impotence.
- It is okay to use pleasure enhancing sprays and creams to prolong an erection during sex.
- There is too much talk about sexual problems in the media.
- Women's sexual problems are related to emotion and feelings while those of men are a result of physical problems.
- It is better to just keep trying to have sex rather than seeking a doctor's help with a sexual problem.
- The most important part of sex is having an orgasm.
- All sexual problems are caused by physical conditions and can be treated by medicines alone.
- Sexual problems are a part of ageing and need to be accepted as such rather than trying to get treated for them.

   After participants have moved on the line, invite them to explain their position and why they have chosen to stand at a particular point in the line. Spend 15-20 minutes discussing the statement and issues that arise before moving onto another statement.

3. After reading and discussing the statements ask the participants to return to their seats and invite questions and comments on the exercise.

Purpose of the exercise:

1. To examine the various opinions and ideas about sexual problems among participants.

2. To discuss the relationship between sexual problems, society and culture.

TIME

60 minutes

MATERIALS

None

ADVANCE PREPARATION

None

THIS EXERCISE CAN BE MODIFIED BY:

- Proposing fewer sexual problem statements. This can allow for a deeper discussion of certain topics or be useful if time for the session is limited.
- Dividing participants into groups, and giving each group one of the statements. Groups should come up with 3-5 key points/reactions about this statement and present these during the large group discussion.

MAKING CONNECTIONS:

- Gender roles can influence the way women and men approach and view sexual problems. For more see Chapter 1 in Module 1.
- Sexual pleasure is an individual preference and can be experienced in many ways. For more see Chapter 4 in Module 1.

Suggested Questions:

- Did the exercise raise any new questions for you about sexual problems?
- How can you dispel myths and increase people's comfort in talking about sexual problems?
- Do you think there is equal consideration of men's and women's sexual problems?

Key Messages

- Taboos around discussions of sexual problems or the blame placed primarily on women for these problems makes it harder to overcome sexual problems and discuss them openly. A person with a sexual problem should not be stigmatised.
- Someone experiencing a sexual problem may still be capable of experiencing sexual pleasure since there are a variety of ways to experience pleasure. Sexual pleasure and preferences are individual and can change over time, similar to the way sexuality is individual and fluid.
- Women's sexual problems are often overlooked. Viewing them through the framework of men's sexual problems can make them feel embarrassed or inhibit their ability to talk about their problems. At the same time, cultural norms that expect men to 'know-it-all' and be in control also prevents them from seeking help with sexual problems.

TIPS FOR THE FACILITATOR:

- Participants may be uncomfortable talking about sexual problems. Introduce icebreakers before the exercise to increase comfort levels.
- Make sure that the discussion on sexual problems does not degenerate into a man vs. woman issue where each group feels more marginalised than the other. Both women and men face shame and guilt around sexual problems and need consideration.

Exercise 4
Case Studies on Sexual Problems

CASE STUDIES

Instructions

1. Divide participants into four groups. Give two groups Case study 1 from Handout 2.28 and the other two groups Case Study 2. Ask the groups to discuss the case study and corresponding questions. Give groups 20-30 minutes to discuss the case and questions.

2. Bring participants back to the larger group and invite each group to share their discussion. After all the groups are done, ask for questions or comments.

Suggested Questions:

- Were there common or similar discussions between the groups? What were they?
- Were there any common factors that contributed to the issue faced by the couple: cultural, gender related, class etc.?
- How can you increase people's comfort levels in talking about sexual problems? How can you reduce and remove the stigma associated with such problems?
- How are sexual problems related to sexuality and sexual health and rights?

Purpose of the exercise:

1. To analyse and discuss sexual problems as related to 'real-life' problems.

2. To examine attitudes toward sexual problems.

TIME

60 minutes

MATERIALS

Handout 2.28 Case Studies on Sexual Problems

ADVANCE PREPARATION

Make copies of Handout 2.28 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Asking participants to read through the case studies and do a role-play that answers questions associated with the cases.
- Choosing one of the case studies and reading it in a larger group rather than dividing participants into smaller groups with separate case studies. This may be beneficial for groups uncomfortable with the topic or with limited time for the exercise.

MAKING CONNECTIONS:

- Sexual problems are not the same as infertility, nor do they cause infertility. For more see Chapter 3 in this Module.
- All people have the right to sexual well-being. For more see Chapter 3 in Module 3.

Key Messages

- It is important for partners to discuss their sexual problems. This can help break down commonly held myths and misconceptions about sexual problems and also enhance sexual pleasure.
- Gender and other socio-cultural factors influence the way sexual problems are dealt with. For example, some women do not voice their problems for fear that their husbands will leave them. Others may believe that sexual pleasure is not as important as getting pregnant and do not acknowledge their disatisfaction when they do not feel pleasure/experience pain during sex.
- Talking about and seeking help for sexual problems helps alleviate the problem, reduces shame and low self-esteem of those facing the problem, and promotes the sexual well-being of individuals and couples.
- While not all sexual problems require medical intervention, seeing a doctor and undergoing tests helps to rule out any possible physical causes of the problem.
- Relationship counselling or consulting a sex therapist are other ways of addressing sexual problems. It is important to find a counsellor and therapist that is qualified, sensitive and non-judgmental.

TIPS FOR THE FACILITATOR:

- Conducting an icebreaker prior to this exercise may help reduce participant discomfort around the discussion of sexual problems.
- Participants may feel that conversations about sexual problems between couples should remain private, and that discussing them in this exercise is inappropriate. Emphasise the importance of building comfort around such discussions and enabling others to do the same, particularly when working on sexuality and sexual health.

Handout 2.24
Basic Information on Sexual Problems

What are sexual problems?

A person is said to have a sexual problem when s/he is continually or repeatedly unable to enjoy either physical or emotional sexual stimulation or experiences. This is based on an individual's own standards of acceptable sexual response and satisfaction.

What is the cause of sexual problems?

A number of factors can contribute to sexual problems. These can include 1) emotional or psychological factors including stress, fear, or former experiences of abuse 2) interpersonal factors such as fear and/or poor communication with a partner or peer pressure 3) community factors including cultural pressures or gender relationships; or 4) physiological or biological factors including medical conditions and infections, physical injury or hormonal changes in the body. Contrary to popular belief, many sexual problems can be successfully resolved by addressing the first three issues, and fewer people may require medical intervention to solve their problems.

What are some kinds of sexual problems?

Below is a list of some commonly described sexual problems.

- **Erectile Dysfunction/Impotence:** The inability to maintain or achieve an erection. ED/impotence can result from physical conditions such chronic illness, diseases, or aging of the body, or from psychological causes that can range from dislike of sex or sexual partner to effects of abuse. Impotence can occur at any age and has different manifestations.
- **Premature ejaculation:** Described as ejaculation before a person wants to ejaculate with minimal sexual stimulation and/or ejaculation very soon after penetration.
- **Retarded ejaculation:** Described as the inability or involuntary delay in ejaculation after a prolonged period of sexual stimulation. This is different from *Ejaculatory Incompetence* in which a man is unable to ejaculate even after prolonged stimulation.
- **Retrograde ejaculation**: A condition in which the neck of the bladder does not close properly. This causes a man to ejaculate backwards into the bladder instead of out through the urethra. A man may experience an orgasm but not experience the accompanying ejaculation.
- **Anorgasmia:** A persistent inability or involuntary delay in reaching orgasm for women even after prolonged sexual stimulation.
- **Dyspareunia or painful sex:** A condition in which women experience pain during sexual activity, either during penetrative sexual activity or non-penetrative genital stimulation. The pain can be felt either in the vaginal opening or deep within the vagina.
- **Vaginismus:** A condition in which women have difficulty allowing penile penetration during sexual activity because they experience pain during the penetration. It is usually caused by the involuntary contractions of the vaginal muscles.
- **Inhibited Sexual Desire:** A number of factors may inhibit a person's sexual desire temporarily or in the long term. Anyone can experience this due to stress, illness, weakness, or psychosocial factors.

What is meant by the medicalisation of sexual problems?

The medicalisation of sexual problems has resulted in the creation of definitions of normalcy for sexual activity (based in part on the sexual response cycle described below). Any activity outside these norms is considered abnormal and needs to be 'treated', 'cured', or 'corrected' with medications and drugs. For example, if men cannot maintain an erection during sexual excitement, they are prescribed medications to 'fix' this problem. While Western medicine is often blamed for this medicalisation, indigenous practitioners are also known to depend heavily on medication in the form of herbal powders and capsules, oils and lotions to treat sexual problems.

This approach to sexual problems and sexuality ignores that people experience sexuality and sexual activity differently, that not all people experience sexual pleasure in the same ways, and that issues of interpersonal relationships, gender, class, religion, ethnicity, and social environment can play a role in how sexuality is experienced. For more information see Handout 2.27 A New View of Women's Sexual Problems.

What is the sexual response cycle?

U.S. based gynecologist William Masters and psychologist Virginia Johnson pioneered research into the nature of human sexual response and the diagnosis and treatment of sexual disorders and dysfunctions from 1957 until the 1990s. The sexual response cycle is a model developed from a research study conducted by Masters and Johnson on sexual physiology in the 1960s. The aim of the study was to determine how people react physically to sexual experiences - which hormones in the body are involved in sexual desire, what happens to one's genitals and bodies during arousal and orgasm etc. The outcome of their research was the sexual response cycle model.

The purpose of describing the stages of the sexual response cycle created by Masters and Johnson (and supplemented since its original development) is not to suggest that sexual response in people is a mechanical process experienced in the same way by all people, but rather to provide a background on how sexual problems have been defined, and to emphasise that while there may be common experiences in sexual activity, pleasure and sexuality remain highly subjective and individual.

Sexual Response Cycle:

Stage 1: *Desire:* (Libido) Signs that a person finds something or someone appealing sexually.

Stage 2: *Excitement:* (Arousal) Physical signs include vasocongestion (rush of blood)of the vaginal walls, increase of breathing rate, erection of the nipples, clitoral erection, vaginal lubrication, elevation of the uterus and stretching of the vagina and changes in the colour, size and shape of the labia in women. In men, there is penile erection, ascension of the testes, a drawing back of the foreskin, and emission of pre-ejaculatory fluid (a transparent fluid also called pre-cum).

Stage 3: *Plateau:* Levels of arousal are maintained. This stage can be brief or long and people have varying preferences for how long this phase is maintained.

Stage 4: *Orgasm:* This is characterised by rhythmic muscular contractions, usually accompanied by a sense of satisfaction and release.

Stage 5: *Resolution:* This is the return to pre-excitement or an un-aroused state. Men experience a Refractory Period, which is the period between return to un-aroused state and getting a second erection. Women can have multiple orgasms if the sexual stimulation continues.

Handout 2.25 Facilitator Copy: Myths & Facts on Sexual Problems

- **Men are more sexual than women.**

  MYTH. Women are just as sexual as men.

- **If a man cannot ejaculate he has a medical problem.**

  MYTH. If a man cannot ejaculate it may be a medical problem; however it may also happen because of other reasons. In addition, one instance of this situation does not indicate a sexual problem.

- **If a man cannot ejaculate, it is the fault of his partner.**

  MYTH. Sexual problems are not the fault of the person experiencing them or their partner. There can be medical, psychological or societal reasons for them.

- **Women are frigid if they cannot have sex or find it painful.**

  MYTH. Painful sex or the inability to have penetrative sex can be caused by medical, social or psychological factors. Frigidity is an inaccurate description, and also has derogatory connotations of a woman 'being cold' and 'unresponsive' sexually.

- **Sexual pleasure may be reduced by focusing on performance.**

  FACT. Focusing on reaching orgasm or 'performing' well may sometimes decrease sexual pleasure and arousal and preventing the person from reaching orgasm. In such cases, it can be defined as a sexual problem.

- **Sex is perfect the first time it is experienced.**

  MYTH. The first time an individual has sex can be pleasurable, painful, uncomfortable or anything in between. There is never any right or wrong way to experience sex and if it is a painful or uncomfortable experience it can result from many factors.

- **Masturbation does not cause sexual problems like erectile dysfunction or premature ejaculation in men.**

  FACT. Masturbation is a safe and enjoyable activity that is not harmful in any way. Both men and women masturbate. Masturbation does not affect one's sex life negatively. It is a legitimate sexual activity in its own right and does not cause weakness, stunted growth, pimples, or any psychological problems.

- **If a woman is not satisfied in a heterosexual relationship, it is because the man's penis is not big enough for her.**

  MYTH. If the penis is about 2 inches long when erect, a man can arouse and satisfy his partner. This is because the first 1.5-2 inches of a woman's vagina has the maximum nerve endings, responsible for sensation. More than the vagina, it is the clitoris, located outside the vagina, above the urethra (urinary opening) that is sensitive to stimulation. The length of the penis has nothing to do with a woman's ability to experience sexual pleasure. It is technique, not size, that matters.

- **If a woman doesn't feel pain the first time she has sex with a partner, it means that she has had sex before.**

  MYTH. Often people think that women will experience pain the first time they have sex because the hymen, a thin and highly elastic membrane present in the vagina, will rip from penetration of the penis. The hymen may, however, tear during the course of running, cycling or exercising, or at any point in life; not necessarily related to sexual activity. It is also possible that an intact hymen stretches during intercourse but does not tear. Therefore the presence or absence of an intact hymen and/or pain during intercourse does not indicate whether or not a woman has had sex before. There is no 'proof of virginity' for either a woman or a man.

- **The longer a man takes to ejaculate, the better, because his partner will feel more pleasure and enjoyment.**

  MYTH. Sexual pleasure is subjective and cannot be generalised. Some partners may feel more pleasure if a man takes a long time to ejaculate while others may not.

- **A man's failure to get an erection can be attributed to a combination of physical and psychological problems.**

  FACT. Inability to get an erection can be because of psychological problems such as nervousness about not being able to 'perform' or discomfort with a partner, as well as physical problems related to health conditions or the side-effects of medications or drugs.

- **Women who masturbate are over-sexed and their partners will find it difficult to satisfy them.**

  MYTH. Masturbation is not a sign of being 'over-sexed'. Both men and women masturbate. Masturbation is one of the safest sexual practices, and a way of experiencing pleasure without the risk of unwanted pregnancies or contracting STIs including HIV/AIDS. Sex therapists believe that if one is able to have a healthy sexual relationship with one's own body, chances are that they will enjoy sex with a partner more.

- **Women may experience pain during sex for reasons other than infections or injury.**

  FACT. Pain during sex can be from physical causes, and also emotional and psychological ones, such as discomfort with a partner or the partner's sexual technique.

Handout 2.26
Participant Copy: Myths & Facts on Sexual Problems

State whether each statement is a Fact or a Myth and why.

- Men are more sexual than women.
- If a man cannot ejaculate, he has a medical problem.
- If a man cannot ejaculate, it is his partner's fault.
- Women are frigid if they cannot have sex or find it painful.
- Sexual pleasure can be reduced if the focus is on 'performance'.
- Sex is perfect the first time one has it. If not, then the man has a problem.
- Masturbation does not cause sexual problems like erectile dysfunction and premature ejaculation in men.
- If a woman is not satisfied in a heterosexual relationship, it is because the man's penis is not big enough for her.
- If a woman doesn't feel pain the first time she has sex with a partner, it means that she has had sex before.
- The longer a man takes to ejaculate, the better, because his partner will feel more pleasure and enjoyment.
- A man's failure to get an erection can be attributed to a combination of physical and psychological problems.
- Women who masturbate are over-sexed and their partners will find it difficult to satisfy them.
- Women may experience pain during sex for reasons other than infections or injury.

Handout 2.27
A New View of Women's Sexual Problems
by The Working Group on A New View of Women's Sexual Problems.
(From: http://www.fsd-alert.org)

Introduction

In recent years, publicity about new treatments for men's erection problems has focused attention on women's sexuality and provoked a competitive commercial hunt for "the female Viagra." But women's sexual problems differ from men's in basic ways, which are not being examined or addressed. We believe that a fundamental barrier to understanding women's sexuality is the medical classification scheme in current use, developed by the American Psychiatric Association (APA) for its Diagnostic and Statistical Manual of Disorders (DSM) in 1980, and revised in 1987 and 1994. It divides (both men's and) women's sexual problems into four categories of sexual "dysfunction": sexual desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders.

These "dysfunctions" are disturbances in an assumed universal physiological sexual response pattern ("normal function") originally described by Masters and Johnson in the 1960s. This universal pattern begins, in theory, with sexual drive, and proceeds sequentially through the stages of desire, arousal, and orgasm.

In recent decades, the shortcomings of the framework, as it applies to women, have been amply documented. The three most serious distortions produced by a framework that reduces sexual problems to disorders of physiological function, comparable to breathing or digestive disorders, are:

1) A false notion of sexual equivalency between men and women. Because the early researchers emphasized similarities in men's and women's physiological responses during sexual activities, they concluded that sexual disorders must also be similar. Few investigators asked women to describe their experiences from their own points of view. When such studies were done, it became apparent that women and men differ in many crucial ways. Women's accounts do not fit neatly into the Masters and Johnson model; for example, women generally do not separate "desire" from "arousal," women care less about physical than subjective arousal, and women's sexual complaints frequently focus on "difficulties" that are absent from the DSM.

   Furthermore, an emphasis on genital and physiological similarities between men and women ignores the implications of inequalities related to gender, social class, ethnicity, sexual orientation, etc. Social, political, and economic conditions, including widespread sexual violence, limit women's access to sexual health, pleasure, and satisfaction in many parts of the world. Women's social environments thus can prevent the expression of biological capacities, a reality entirely ignored by the strictly physiological framing of sexual dysfunctions.

2) The erasure of the relational context of sexuality. The American Psychiatric Association's DSM approach bypasses relational aspects of women's sexuality, which often lie at the root of sexual satisfactions and problems—e.g., desires for intimacy, wishes to please a partner, or, in some cases, wishes to avoid offending, losing, or angering a partner. The DSM takes an exclusively individual approach to sex, and assumes that if the sexual parts work, there is no problem; and if the parts don't work, there is a problem. But many women do not define their sexual difficulties this way. The DSM's reduction of "normal sexual function" to physiology implies, incorrectly, that one can measure and treat genital and physical difficulties without regard to the relationship in which sex occurs.

3) The levelling of differences among women. All women are not the same, and their sexual needs, satisfactions, and problems do not fit neatly into categories of desire, arousal, orgasm, or pain. Women differ in their values, approaches to sexuality, social and cultural backgrounds, and current situations, and these differences cannot be smoothed over into an identical notion of "dysfunction"—or an identical, one-size-fits-all treatment.

Because there are no magic bullets for the socio-cultural, political, psychological, social or relational bases of women's sexual problems, pharmaceutical companies are supporting research and public relations programs focused on fixing the body, especially the genitals. The infusion of industry funding into sex research and the incessant media publicity about "breakthrough" treatments have put physical problems in the spotlight and isolated them from broader contexts. Factors that are far more often sources of women's sexual complaints—relational and cultural conflicts, for example, or sexual ignorance or fear—are downplayed and dismissed. Lumped into the catchall category of "psychogenic causes," such factors go unstudied and unaddressed. Women with these problems are being excluded from clinical trials on new drugs, and yet, if current marketing patterns with men are indicative, such drugs will be aggressively advertised for all women's sexual dissatisfactions.

A corrective approach is desperately needed. We propose a new and more useful classification of women's sexual problems, one that gives appropriate priority to individual distress and inhibition arising within a broader framework of cultural and relational factors. We challenge the cultural assumptions embedded in the DSM and the reductionist research and marketing program of the pharmaceutical industry. We call for research and services driven not by commercial interests, but by women's own needs and sexual realities.

Sexual Health and Sexual Rights: International Views

To move away from the DSM's genital and mechanical blueprint of women's sexual problems, we turned for guidance to international documents. In 1974, the World Health Organization held a unique conference on the training needs for sexual health workers. The report noted: "A growing body of knowledge indicates that problems in human sexuality are more pervasive and more important to the well-being and health of individuals in many cultures than has previously been recognized." The report emphasized the importance of taking a positive approach to human sexuality and the enhancement of relationships. It offered a broad definition of "sexual health" as "the integration of the somatic, emotional, intellectual, and social aspects of sexual being."

In 1999, the World Association of Sexology, meeting in Hong Kong, adopted a Declaration of Sexual Rights."[7] In order to assure that human beings and societies develop healthy sexuality," the Declaration stated, "the following sexual rights must be recognized, promoted, respected, and defended":

- The right to sexual freedom, excluding all forms of sexual coercion, exploitation and abuse;
- The right to sexual autonomy and safety of the sexual body;
- The right to sexual pleasure, which is a source of physical, psychological, intellectual and spiritual well-being;
- The right to sexual information...generated through unencumbered yet scientifically ethical inquiry;
- The right to comprehensive sexuality education;
- The right to sexual health care, which should be available for prevention and treatment of all sexual concerns, problems, and disorders.

Women's Sexual Problems: A New Classification

Sexual problems, which The Working Group on A New View of Women's Sexual Problems defines as discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience, may arise in one or more of the following interrelated aspects of women's sexual lives.

I. SEXUAL PROBLEMS DUE TO SOCIO-CULTURAL, POLITICAL, OR ECONOMIC FACTORS

A. Ignorance and anxiety due to inadequate sex education, lack of access to health services, or other social constraints:

1. Lack of vocabulary to describe subjective or physical experience.
2. Lack of information about human sexual biology and life-stage changes.
3. Lack of information about how gender roles influence men's and women's sexual expectations, beliefs, and behaviors.
4. Inadequate access to information and services for contraception and abortion, STD prevention and treatment, sexual trauma, and domestic violence.

B. Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality, including:

1. Anxiety or shame about one's body, sexual attractiveness, or sexual responses.
2. Confusion or shame about one's sexual orientation or identity, or about sexual fantasies and desires.

C. Inhibitions due to conflict between the sexual norms of one's subculture or culture of origin and those of the dominant culture.

D. Lack of interest, fatigue, or lack of time due to family and work obligations.

II. SEXUAL PROBLEMS RELATING TO PARTNER AND RELATIONSHIP

A. Inhibition, avoidance, or distress arising from betrayal, dislike, or fear of partner, partner's abuse or couple's unequal power, or arising from partner's negative patterns of communication.

B. Discrepancies in desire for sexual activity or in preferences for various sexual activities.

C. Ignorance or inhibition about communicating preferences or initiating, pacing, or shaping sexual activities.

D. Loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, e.g., infertility or the death of a child.

E. Inhibitions in arousal or spontaneity due to partner's health status or sexual problems.

III. SEXUAL PROBLEMS DUE TO PSYCHOLOGICAL FACTORS

A. Sexual aversion, mistrust, or inhibition of sexual pleasure due to:

1. Past experiences of physical, sexual, or emotional abuse.
2. General personality problems with attachment, rejection, co-operation, or entitlement.
3. Depression or anxiety.

B. Sexual inhibition due to fear of sexual acts or of their possible consequences, e.g., pain during intercourse, pregnancy, sexually transmitted disease, loss of partner, loss of reputation.

IV. SEXUAL PROBLEMS DUE TO MEDICAL FACTORS

Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes. Such problems can arise from:

A. Numerous local or systemic medical conditions affecting neurological, neurovascular, circulatory, endocrine or other systems of the body;

B. Pregnancy, sexually transmitted diseases, or other sex-related conditions.

C. Side effects of many drugs, medications, or medical treatments.

D. Iatrogenic conditions.

Conclusion

This document is designed for researchers desiring to investigate women's sexual problems, for educators teaching about women and sexuality, for medical and nonmedical clinicians planning to help women with their sexual lives, and for a public that needs a framework for understanding a rapidly changing and centrally important area of life.

For more information visit: http://www.fsd-alert.org

Handout 2.28
Case Studies on Sexual Problems

Case 1:

Sapna married Karun a few months ago. The marriage was arranged by her family, but Sapna has strong feelings for Karun and believes she is lucky to have him as her husband. She believes they will be happy together and as time passes and she gets to know him better, she gets even more excited over her chosen husband. Karun feels the same towards Sapna and is thankful his family found him a kind and easy-going woman to share his life with. Despite their strong feelings for each other, Sapna and Karun have been having problems in their sex life. Every time they have sexual intercourse, Sapna experiences pain and discomfort. She is not sure what the cause of this discomfort is. Even thinking about her genitals and 'that part of her body' is something she has never done before, aside from the time of her monthly periods. Because of her discomfort, Sapna has begun to avoid sex with Karun and when it takes place, she tries to be impassive though her body language and face reflect her pain. Sapna thinks this problem will go away after some time and plans to avoid mentioning it to Karun.

Karun, however, has noticed the way Sapna reacts when they have sex and the way she tries to avoid the prospect of having intercourse. At first he thought it was because Sapna was uncomfortable with him since they were still getting to know each other, and her lack of sexual experience. But her unhappiness and discomfort has not dissipated over the past few months and Karun has begun to worry. He feels it is affecting him and his sexual performance. He can see how distraught Sapna is during sex, so he ejaculates very quickly and makes sure that sex is over quickly. He does not find such hurried and intercourse pleasurable, but thinks that if they just continue to have sex Sapna will become comfortable and eventually enjoy it.

- What are your impressions and thoughts on this scenario?
- How can the couple deal with this situation?
- What would a discussion between the two involve? What factors may play a part in the way this situation is discussed – for example are there psychological, cultural, or gender factors that would influence the talk?
- How can this situation be changed or resolved? What other issues are involved in this? Does knowledge of the body, sexual pleasure etc. have anything to do with it?

Case 2:

Ravi and Ritu have been together for many years. They are both in their mid-40's and live in a comfortable apartment in the city. Since their two children are both in college abroad, Ravi and Ritu are alone for many months at a time. Both have important and stressful jobs that keep them out of the house well into the evening. When they do get home they are both usually tired from the stress and work of the day and will simply have a meal together and chat a bit before going to sleep. Lately Ritu has been feeling anxious about their sex life. She thinks they are growing distant from each other and have sex too infrequently. She is concerned not only because this infrequency is affecting their relationship, but also because she likes to have sex and is disappointed when Ravi is too tired or uninterested. He has not been initiating sex at all.

Ravi, on the other hand, knows the real reason that they are not having as much sex is because lately he has been having trouble getting an erection. The last couple of times he and Ritu started to be intimate, he was unable to get an erection and began to feel embarrassed. Instead of telling Ritu what was going on, he said he was tired and turned over to go to sleep. Ravi has considered going to the doctor about the situation, but is also scared to admit to his problem and thinks it will go away on its own. Also, he knows if he has to take any medication for it, Ritu will need to know, and he is not sure he wants that.

- What are your impressions and thoughts about this scenario?
- How can the couple deal with this situation?
- What would a discussion between the two involve? What factors may play a part in the way this situation is discussed – for example are there psychological, cultural, or gender factors that would influence the talk?
- Do gender roles play a part in this situation? How?

MODULE 3
Sexual and Reproductive Rights

Introduction

In the previous two modules, *Basics and Beyond* focused on examining a range of issues that constitute sexuality, followed by information and issues concerning sexual and reproductive health. Module 3: Reproductive and Sexual Rights now takes a look at these topics in the context of human rights. It discusses how rights can be used to affirm the health and well-being of people, particularly with regard to sexuality and sexual and reproductive health.

Sexual and reproductive rights evolved from the human rights system and are still in the process of being defined and developed. Therefore, to understand sexual and reproductive rights, it is necessary to first look at human rights as a framework and understand what is meant by a rights-based approach. The first chapter in Module 3 looks at the human rights system and framework. It also introduces documents, treaties and conventions that have contributed to the growth and development of human rights over the years.

At the end of this module, participants will be able to effectively and concretely discuss human rights, and more specifically articulate and describe sexual and reproductive rights and relate it to their daily work. They will also analyse and note the benefits as well as the limitations to the human rights system, particularly in the context of sexual and reproductive rights.

Module 3
Sexual and Reproductive Rights

Assessment for Module 3 Sexual and Reproductive Rights

At the end of this module the facilitator can conduct an assessment. This assessment can evaluate increases in participant knowledge, changes in attitudes, preferences for different exercises, and/or opinions on the facilitator's skills. For this module, an assessment can be done using the following tools:

- Using the modification of Exercise 4 in Chapter 3 of this Module.
- Adapting one of the sample assessment forms found in Chapter 2 in *Preparing to Train*.
- Using the facilitator preparation exercises for this module found in Chapter 1 in *Preparing to Train*.
- Developing a new assessment depending on the type of information the facilitator is looking to discover.

Sample Training Schedule

A blank template of a training schedule as well as a sample seven-day training schedule can be found in the Introduction of *Preparing to Train*. Depending on the focus of the training and the topics it aims to cover, the facilitator can fill in the blank schedule with exercises from this Module or in combination with exercises from other Modules.

Chapter 1
Human Rights

Chapter Objectives for the Facilitator

1. To inform participants about the basics of human rights.
2. To briefly outline the history of the human rights system and structure including the charters, treaties, conventions, agencies, and governing bodies included in this structure.
3. To discuss a rights-based approach to sexuality, sexual and reproductive health, and advocacy.

Why a Chapter on Human Rights

Everyone has the right to life, liberty and security of person. (Article 1 of the Universal Declaration of Human Rights)

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. (Part of Article 2 of the Universal Declaration of Human Rights)

These two sections from the Universal Declaration of Human Rights (UDHR) are only a small portion of this landmark document written and adopted by the United Nations General Assembly nearly sixty years ago. Since then, the human rights system has expanded and developed, as have the ways in which people use and recognise human rights. This growth includes the adoption of a number of treaties and charters, integration of human rights into legislation and laws, the creation of civil society groups to advocate for human rights, and discussions at international conventions on the rights of various groups and populations. While there have been gains in human rights over the past years, a great deal of work still needs to be done.

This chapter provides a basic understanding of human rights, why a human rights framework can be an effective approach to health and advocacy, how to use the human rights system and its framework, and how to make linkages and discuss connections between human rights, sexuality and sexual and reproductive health.

EXERCISES IN THIS CHAPTER

Exercise 1: Human Rights Tree.
90 minutes

Exercise 2: Universal Declaration of Human Rights.
90 minutes

Exercise 3: Human Rights Treaties and Conferences.
60 minutes

Exercise 4: Case Studies on Human Rights.
60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Paper (coloured or white)
Tape
Scissors
Index cards/slips of paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 3.1
  An Overview of Human Rights
- Handout 3.2 Facilitator copy:
  Universal Declaration of Human Rights
- Handout 3.3 Participant copy:
  Universal Declaration of Human Rights
- Handout 3.4
  Human Rights Treaties and World Conferences
- Handout 3.5
  Case Studies on Human Rights

ADDITIONAL RESOURCES:

- Beijing Conference Declaration and Platform of Action. Available at: http://www.un.org/womenwatch/daw/beijing/platform/
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Available at: http://www.un.org/womenwatch/daw/cedaw/cedaw.htm
- Human Rights Resource Centre. http://www.hrusa.org/
- International Covenant on Civil and Political Rights. Available at: http://www.unhchr.ch/html/menu3/b/a_ccpr.htm
- International Covenant of Economic, Social and Cultural Rights. Available at: http://www.unhchr.ch/html/menu3/b/a_cescr.htm
- International Conference on Population and Development. Available at: http://www.unfpa.org/icpd/summary.htm
- For the ratification history of various countries see, http//www.ohchr.org/english/countries/ratification
- The United Nations and Human Rights. http://www.un.org/rights/dpi1774e.htm
- For selected films see, http://www.asiasrc.org/films.php and Appendix B

Key Messages for this Chapter

- Human rights as a system encompasses a wide range of rights, from the right to health to the right to freedom from torture. All these rights are essential to individual well-being and dignity.
- The creation of a human rights system is an important way of upholding and making States accountable to respect, protect and fulfil these rights for all people.
- While human rights have been placed into a codified system, they are not just a conceptual/ theoretical system but can be concretely applied to each person's life.
- If the facilitator is unfamiliar with regional policies on human rights or the human rights doctrines and treaties signed by their respective countries, it may be useful to do research on these issues before conducting the exercises.

Exercise 1
Human Rights Tree

SMALL GROUP WORK

ADAPTED FROM THE UNIVERSITY OF MINNESOTA HUMAN RIGHTS LIBRARY
(http://www.hrusa.org/workshops/1-28-2005/TreeActivity.shtml)

Instructions

1. Divide participants into small groups. Give each group scissors, markers, tape and paper. The participants will use these materials to construct a human rights tree. To construct the human rights tree, first instruct participants to draw a trunk for the tree. They should then use the paper to cut out leaves for the trees (these do not need to be perfectly shaped). On each leaf, ask participants to write one right necessary to lead lives equal in respect and dignity. These rights can range from the right to health to the right to own property, the right to vote etc. Give participants 20-25 minutes to construct their tree.

2. After they complete the trees, invite each group to come up and present their tree to the large group and explain the process and contents of their tree. After all the presentations, ask for questions and comments.

Suggested Questions:

- Are there similarities between the trees? Are some rights on all the trees? Why? Do these common rights indicate something about the communities, countries, and states we come from or our general needs? Would it be different for groups from another country or region?
- Are all these rights equally important, with no single right being more important than another? Do these rights support and have connections with each other?
- Should people always have these rights? What would happen if they were taken away?

3. Keep these human rights trees up on the walls throughout the training to refer to and observe whether ideas and attitudes about rights change or evolve during the training.

Purpose of the exercise:

1. To understand and describe the concept of human rights and relate it to our own life and needs.

2. To understand and discuss a rights-based approach to health and advocacy.

TIME

90 minutes

MATERIALS

Paper, scissors, tape, markers, pen/pencils, Handout 3.1 An Overview on Human Rights

ADVANCE PREPARATION

Make copies of Handout 3.1

THIS EXERCISE CAN BE MODIFIED BY:

- Asking participants to take the trees back to their small groups and add roots, which can symbolise what is needed to sustain and fulfil human rights, such as economic stability, universal health care etc. Encourage participants to make these roots personal. For example, someone may feel that to realise the right to health they need a hospital or clinic closer to home and a government that will build such a clinic. Each group can then share the roots and completed tree with the larger group.
- Asking participants as a larger group to categorise the various rights on the trees as sexual rights and/or reproductive rights, or to think about which categories these kinds of rights fit into, such as civil rights, social rights, economic rights etc. This can help participants observe overarching themes of human rights.

4. Distribute Handout 3.1 to each participant and read through this with them. Ask for questions or comments.

Suggested Questions:

- Do you understand these basics of human rights and how they are organised?
- Can you see connections between these rights and the rights you wrote down on your human rights trees? Do you see how this system can uphold the rights you wrote on your trees?
- Are there any flaws in the way the system has been defined and set up?

Key Messages

- While human rights have been arranged into a codified system, they are not just a theoretical framework and do apply to each person's life. This can be seen in the links between what is written on the trees and the formal system outlined in Handout 3.1.
- Human rights as a system encompasses a wide range of rights, from the right to health to the right to freedom from torture. They are all essential to individual well-being and dignity.
- Human rights are not the same as laws. Ideally, laws help to protect and fulfil human rights, but this is not always so. For example, some countries in South and Southeast Asia do not have laws that recognise or provide protection against marital rape, which violates the right of an individual to live a life free from violence and abuse.

MAKING CONNECTIONS:

- Human rights underlie the values we apply to our personal and professional lives. For more see *Setting the Tone* in the Introduction to Module 1.
- Human rights influence guiding principles for work and advocacy in sexuality, sexual and reproductive health. For more see Chapter 1 in Module 5.

TIPS FOR THE FACILITATOR:

- Some participants may be quiet during this exercise particularly if they are unfamiliar with what is meant by human rights. Encourage everyone to participate, perhaps by having each member of the group articulate two rights they believe should be on the tree.
- Groups may become more concerned with the aesthetic appearance of their trees than the content. Emphasise that the focus needs to stay on the content. It may be useful to distribute pre-made leaves to the groups to help get them started and to avoid this situation.

Exercise 2
The Universal Declaration of Human Rights

SMALL GROUP WORK

PURPOSE OF THE EXERCISE:

1. To discuss and describe the Universal Declaration of Human Rights.

2. To connect the Articles in the Universal Declaration of Human Rights to sexuality.

TIME

90 minutes

MATERIALS

Flipchart, markers, Handout 3.2 Facilitator Copy: Universal Declaration of Human Rights, Handout 3.3 Participant Copy: Universal Declaration of Human Rights

ADVANCE PREPARATION

Make copies of Handouts 3.3, read through Handout 3.2

INSTRUCTIONS

1. Divide the participants into 5 groups. Distribute Handouts 3.3 to each group. Assign each group 6 of the 30 Articles. The first group should get Articles 1-6, the second Articles 7-12 and so forth.

2. Ask groups to read the handout, which includes the preamble to the Universal Declaration of Human Rights (UDHR) along with the 30 Articles that make up the UDHR. Instruct the groups to examine the preamble and the 6 Articles assigned to them and discuss how each Article relates to sexuality. Give the groups 30 minutes to discuss and analyse the Articles.

3. Bring the participants back to the large group and invite each group to present their discussions. The facilitator may want to have groups present in chronological order: beginning with the group that had Articles 1-6, proceeding to the group that had Articles 7-12, and so on. During each presentation, the facilitator may want to write out the main idea of the Article and the connection made to sexuality on the flipchart. After each presentation, ask for comments or questions.

   Suggested Questions:

   - Do you agree with the connections the group made between their Articles and sexuality? Can you think of other examples that connect sexuality with the Articles presented by this group?

4. After all the group presentations, ask for general comments and questions.

   Suggested Questions:

   - In what ways do you think these rights and their connections to sexuality relate to your life?
   - Are there any Articles in the UDHR you consider particularly relevant to your life and needs? For example, do you live in a country with limited freedom of expression, manifesting as interference in what newspapers publish? In this case, Article 19, which promotes freedom of opinion including the ability

to receive and impart information in the media, would be particularly relevant to you.

- Are there limitations to these Articles and rights? For example, the UDHR uses a language of male pronouns, such as 'this right includes freedom to change *his* religion or belief'. Does this type of language limit women and transgendered people and their ability to claim rights?

THIS EXERCISE CAN BE MODIFIED BY:

- Giving groups fewer Articles in the UDHR to read individually and discussing the remaining Articles with the group as a whole. This can be beneficial for groups having difficulty with connections between the Articles and sexuality.

Key Messages

- It is possible to relate sexuality to human rights. In other words, individuals have the right to express their sexuality, so long as they do not infringe on the rights of others.
- While the UDHR is a formal document with formal language, it is applicable and relevant to people's lives.

MAKING CONNECTIONS

- Sexuality is more than acts of sex. It is an important part of being human and impacts people's lives in significant ways. For more see Chapter 1 in Module 1.
- Applying human rights to advocacy can be effective in promoting rights for marginalised people. For more see Chapter 3 in Module 5.

TIPS FOR THE FACILITATOR:

- Participants may be unsure about how to relate sexuality to some of the Articles, particularly those addressing nationality and economic rights. Try to encourage them to think broadly about the issue and how marginalised people might benefit from this right. If they continue to struggle, refer to Handout 3.2 for examples to get the group started.
- Participants may keep connections to sexuality basic and narrow. If so, offer suggestions for broader interpretations. For example, participants may look at sexuality only in terms of heterosexual relationships and relate each Article in the UDHR to that aspect of sexuality. It may help to ask whether those who desire same-sex relationships, transgendered people or the ideas of pleasure can fit into the Articles. Facilitators can look to Handout 3.2 for examples.
- Participants may be overwhelmed by the amount of information and its complexity. Assure them that this exercise is meant as a first step in understanding rights and it will become clearer as they do further exercises in the chapter.
- Assure participants that the intention of this exercise is to spark their thinking about the connections between rights and sexuality. Whether the State can or should be held accountable if sexual rights are not respected, fulfilled or protected is a larger discussion to be had later in Chapter 3.

Exercise 3
Human Rights Treaties and Conferences

SMALL GROUP WORK

Instructions

1. Divide participants into two groups. Distribute Handout 3.4 to each participant. Assign one group to *Treaties* and the other to *Conferences*. Ask participants to read their assigned information on the handout and fill in the empty column with an example of how the treaty or convention can be applied to or used in their work. Give groups 15-20 minutes.

2. Bring participants back together and begin with the *Treaties* group. Ask the group to read the treaty and the one example of how the treaty can be applied to their work. After the *Treaties* group presentation, ask the *Conferences* group to do the same. After both groups have presented ask for questions and comments.

Suggested Questions:

- Do you understand the purpose of each of these treaties and why governments came together in the world conferences?
- Do you see the value of these treaties when trying to apply a rights-based approach to advocacy and work?
- Can you give other examples from your work where you could apply or use the ideas from these treaties or conferences?

Purpose of the exercise:

1. To discuss the various documents and conferences that support the human rights system.

2. To discuss how the codified human rights system can be relevant to advocacy.

TIME

60 minutes

MATERIALS

Handout 3.4 Charters and Conferences for Human Rights

ADVANCE PREPARATION

Make copies and review Handout 3.4 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Asking participants to do the exercise individually as a self-reflection. They can share examples among the larger group once they are done.
- Asking the group to find out if and when their country ratified the various treaties. The group can discuss the consequences and benefits of having a country ratify or not ratify each treaty, and how this information can be used in advocacy. Participants will probably need access to computer and Internet facilities in order to complete this assignment.

MAKING CONNECTIONS

- Applying human rights to advocacy can be effective in promoting rights for marginalised people. For more on advocacy campaigns see Chapter 3 in Module 5 and for more on stigma and discrimination see Chapter 2 in Module 4.
- Understanding reproductive rights and sexual rights as they relate to the treaties and conferences can increase understanding of human rights. For more see Chapters 2 and 3 in this Module.

Key Messages

- The creation of a human rights system is an important means for upholding rights and making States accountable.
- There are methods for the NGO community, organisations, and individuals to appeal against human rights violations.
- The 1994 International Conference on Population and Development (ICPD) held in Cairo was significant in the field of sexuality, sexual and reproductive health and rights. ICPD emphasised a shift from population control and demography to sustainable development. Reproductive rights and health, as well as sexual health were included in the Programme of Action.
- The Fourth World Conference on Women in Beijing in 1995 continued to focus on the status of women worldwide and reaffirmed that reproductive rights are human rights, and that all women should have access and potential to realise these rights.

TIPS FOR THE FACILITATOR:

- Groups may experience difficulty finding examples from their work that apply to the given treaty or conferences. Encourage participants to think broadly about the work they do, and the community they work with for examples.
- Some participants may be working with the human rights system already. Encourage them to share their experiences for the benefit of other participants.

Exercise 4
Case Studies on Human Rights

CASE STUDIES

Instructions

1. Divide participants into small groups. Distribute one case study to each group. Give groups 20-30 minutes to read the case and answer the questions associated with it.

2. Ask participants to return to the larger group and invite each small group to share their case study and discussion. After each presentation, ask for comments and questions from the other participants.

Suggested Questions:

- Do you agree with the conclusions of the group? Would you suggest an alternative?
- How can a rights-based approach help to improve the situation of the characters?

Purpose of the exercise:

1. To identify human rights issues in real-life situations.

2. To understand the benefits of a rights-based approach to health and advocacy.

TIME

60 minutes

MATERIALS

Handout 3.5 Case Studies on Human Rights

ADVANCE PREPARATION

Make copies of Handout 3.5 for each participant

THIS EXERCISE CAN BE MODIFIED BY:

- Choosing one or two cases and discussing them as a single group rather than in smaller groups. This may be beneficial for groups that are still unsure about human rights or to those who want to focus on a particular issue, such as HIV/AIDS.

MAKING CONNECTIONS

- In addition to violation of rights, marginalised people often face stigma and discrimination. For more see Chapter 2 in Module 4.
- Acceptance and understanding of various gender and sexual identities can reduce human rights abuses and violations. For more see Chapter 2 in Module 1.

Key Messages

- Human rights are not just theories. Human rights can be found in and applied to real-life experiences and issues.
- A rights-based approach includes looking at the needs and choices of individuals and empowering them so they can make choices and exercise their rights.
- All persons have the right to live without fear of coercion or violence. In addition, they also have the right to access services, and life in a healthy environment.
- The formal human rights system has its advantages and limitations. Knowledge of the language and system of human rights can help activists and healthcare providers plan and implement programmes in a more inclusive and effective manner.
- Human rights can be tools to direct governments and agencies to provide proper services and care for its population. They are meant as guidelines for countries to create policies and programmes to respect individuals' rights.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to relate human rights violations to the issues and characters in the case studies. It may be beneficial to review the basics of human rights prior to the exercise.
- The facilitator may want to create case studies based on recent real-life instances from their society/region to help participants relate human rights to their specific contexts.

Handout 3.1
An Overview of Human Rights

How can you define human rights?

Human rights are a kind of promise/ undertaking containing two elements: what has been promised (for example, equality, non-discrimination, access to education) and a binding duty to respond and make the promise a reality.

Human rights are the freedoms and standards we must have in our lives to live in dignity and respect. They are universal, indivisible, interlinked and inalienable.

- **Universal:** This means that rights are not a privilege that some people have, but something all people are entitled to regardless of where they live, what caste they belong to, whether they are female or male, etc.
- **Indivisible:** This means that a hierarchy of rights cannot be created where some rights are considered more important than another. For example, you cannot claim that the right to vote is more important than the right to health.
- **Interlinked:** Rights have connections and reinforce each another. You cannot have the full potential of one right without another. For example, in order to achieve a right to health you must also have the right to economic stability and to earn a wage.
- **Inalienable:** These rights and freedoms cannot be challenged or taken away from a person and each person is born with the same rights.

Are there limits to these rights and/or how an individual can carry out these rights?

In living, carrying out, or trying to achieve these rights, you cannot unfairly infringe upon the rights of someone else.

- For example, an individual has the right to own property. However if when exercising this right an individual unfairly takes away or steals another person's property, s/he is now infringing on the other person's right to own property. Defining what a fair limit is and how far an individual or the State can go before infringing on another person's right, is also the subject of rights debates. For example, governments often claim that they are protecting public morality and vulnerable people in enforcing criminal laws against sex outside of marriage. However, the European Court of Human Rights, an international human rights body, has told governments that using the criminal law to do this - if no other harm, such as rape is involved - violated rights of privacy and non-discrimination.

What is a rights-based approach?

A rights-based approach considers the needs and well-being of each person, rather than the overall outcomes of a population to assess if the approach is appropriate.

- For example: A rights-based approach to health would work to guarantee that every individual has access to health services that respond to their needs, and will allow them to assess the right services to use based on their needs and choices. Every person has a fundamental value which must be

respected in her/his decision-making and the context in which this decision is being made. This contrasts with an approach that focuses on the population as a whole rather than the individual. In this case, demographic goals of a population are emphasised when providing health services, such as reducing the rate of sexually transmitted infections or the number of births.

Human rights as a formal system in national and international law does have some limitations and disadvantages. It can be complex for people to understand and apply effectively, especially in the context of sexuality and reproductive health. Moreover, sexual rights are still evolving and are only partly formalized. Even reproductive rights for that matter, are just beginning to be set into a formalized system. Additionally, given the complex nature of sexuality, human rights applications to sexuality may also be limited in some situations or leave further questions as to how they can be enforced and upheld.

How are rights enforced and supported?

It is the duty of the State (i.e. the nation or Government) to respect, protect, and fulfil these rights.

- **Respect**: This means that the State and its agents cannot violate, abuse, or deny a person's rights.
- **Protect**: This means the State must prevent a third party from violating, abusing, or denying a person's rights and if this happens, it must have a legal or other mechanism to respond to the harm, including penalties to the third party for such actions.
- **Fulfil**: This means the State must take steps to organize all of its structures - including budgets, administration, legal structures etc - so that it can respond to rights needs. It will also work to improve conditions or create infrastructure to allow for people to access a right if they are not able to already do so.

Example: If looking at the right to vote, a State must **respect** that right by not preventing any person from voting, such as women or non-landowners. To **protect** this right, the State must ensure that there are no barriers against any person who is able and willing to vote: for example if one party decides to use scare tactics and threaten people at the polls the State must prevent this from happening and punish the party that does this. **Fulfilling** this right to vote means that there must be structures to establish who can vote and why; such as laws in place that allow for women and non-landowners to vote, or programmes put in place that will improve the access people have to polling stations.

Can human rights be put into different categories?

Human rights are often discussed in the following categories. These categories, however, are not fixed categories for all cases.

- **Civil and Political Rights (CP)**–Civil rights may include the right to equality or to a fair trial. Political rights may include the right to participate in government and assemble peacefully, be free from torture, or be free to express an opinion and be equal before the law.
- **Economic, Social, Cultural Rights (ESC)**–Economic rights may include the right to a decent standard of living. Social rights can include favourable working conditions. An example of cultural rights is the right to education.
- **Environmental and Development Rights (ED)**–Environmental rights can include the right to clean and potable water. Development rights can include the right to be free from poverty and discrimination.

How can human rights violations be reported and monitored?

Human rights issues can be brought up and challenged in at least three ways: on a national/domestic level, on a regional level, or an international level. In some cases it is necessary to begin at the national level before moving to other human rights systems, but in general advocacy, one can use all three at the same time.

- **National/domestic:** A country's local and national judicial system as well as special commissions that address human rights.
- **Regional:** Formal human rights systems and mechanisms set up for the regions of the Americas, Europe and Africa.
- **International:** The United Nations is the international system for human rights. Governments came together to form the United Nations and following its formation agreed to set up various standards on rights through the United Nations, along with processes and mechanisms to support and monitor these rights. These include international treaties and laws overseen by independent experts, as well as the Office of the High Commissioner for Human Rights that has a presence in the United Nations, as well as offices in a number of other countries. These country-based offices do monitoring and advocacy for human rights at the country level.

Key players in advancing rights

These entities can drive forward new issues and standards, as well as fulfil existing international laws and standards.

- **Special Rapporteurs:** These rapporteurs are independent experts on various issues (such as violence, housing etc.) of the UN system and are mandated to 1) write general reports submitted to a governmental human rights body; 2) go on two country missions each year to assess the rights conditions and prepare a report; 3) take up communication and complaints and when applicable take these up with respective governments. They can use any applicable international human rights standard in making their case.
- **Treaty Committees:** These are groups of experts with oversight over each treaty on rights. The UN system has created a number of treaties (also referred to as charters, protocols, and covenants). Treaties, covenants and conventions are all international formal legal documents. These documents outline agreements between States that sign them. Every country that ratifies a treaty has agreed to the responsibilities laid out in the treaty/covenant and will make them part of their domestic legal obligations. Every country that ratifies must also send in a report on how this treaty is being followed. NGOs and other civil society groups can send in a shadow report to contradict or highlight areas that may be missed in the country report. Treaty committees can also hear complaints from individuals that claim human rights violations. For example the Committee on CEDAW can look into violations against women in relation to particular rights. See Handout 3.5 for more information on the various treaties.

Handout 3.2
Facilitator Copy: Universal Declaration of Human Rights (UDHR)

When was the Universal Declaration of Human Rights adopted and what does it contain?

The Universal Declaration of Human Rights was adopted in 1948. There are 30 articles in the document that summarise the human rights individuals have. The articles in the UDHR include:

- life , liberty, security of person
- no discrimination on the grounds of race, colour, politics, religion, sex, country or other status
- legal rights - innocent until proven guilty
- freedom of movement within country, right to leave your own country
- right to nationality
- right to marry freely, not coerced
- property ownership
- freedom of thought, conscience and religion
- take part in government of country
- right to work, equal pay, vacation, rest
- standard of living for health, food, clothing, social services
- education – free at elementary and fundamental stages

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, Therefore THE GENERAL ASSEMBLY proclaims THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1.

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Example connection to sexuality: All people irrespective of sexual and gender identity (whether heterosexual, homosexual, bisexual, woman, man or transgender etc.) can claim equal right to lives of dignity.

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Example connection to sexuality: 1) A woman, man, transgender, transsexual person all have entitlement and should have access to the rights of the UDHR. 2) A child of a sex worker can claim the same rights as a child of someone who is not in sex work.

Article 3.

Everyone has the right to life, liberty and security of person.

Example connection to sexuality: People with HIV/AIDS or other sexually transmitted infections should not be excluded from these rights.

Article 4.

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Example connection to sexuality: A person's sexual behaviours and identity should not put them in a situation of servitude or slavery.

Article 5.

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Example connection to sexuality: Women should not be forced or coerced into sexual activity, even if they are in a committed relationship or marriage.

Article 6.

Everyone has the right to recognition everywhere as a person before the law.

Example connection to sexuality: Whether woman, man or transgender, everyone has the right to legal recourse at all times irrespective of their caste, class, socio-cultural background and choice of profession/source of livelihood.

Article 7.

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Example connection to sexuality: A transgendered person is entitled to a life free from stigma and discrimination and equal access to information, care and support services.

Article 8.

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Example connection to sexuality: If a hijra is beaten because of her gender identity she has a right to the same legal redressal, as any other individual that has been beaten or abused.

Article 9.

No one shall be subjected to arbitrary arrest, detention or exile.

Example connection to sexuality: People who practice anal sex should not be detained or harassed by law enforcers because they are suspected to be homosexual. In India, Section 377 of the Penal Code penalises sexual behaviour 'against the order of nature'. Some law enforcers have used this section to harass and detain men 'suspected' of being homosexual.

Article 10.

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Example connection to sexuality: A person's sexual history should not be used against her/him in the determination of her/his rights and obligations. For example, the misconception/assumption that a prostitute cannot be raped or violated because she is always willing to have sex can lead to an unfair judgment in the favour of her violator.

Article 11.

(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defense.

(2) No one shall be held guilty of any penal offence on account of any act or omission, which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Example connection to sexuality: A man who is homosexual should not be assumed to be a paedophile just because he prefers to have sex with men.

Article 12.

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Example connection to sexuality: 1) No one has the right to watch another person bathe/dress/have sex without their knowledge and permission. 2) A woman should not be in fear of bodily harm or invasion of private space of her body by other people irrespective of what she wears in public.

Article 13.

(1) Everyone has the right to freedom of movement and residence within the borders of each state.

(2) Everyone has the right to leave any country, including his own, and to return to his country.

Example connection to sexuality: People of alternative sexualities have a right to live in their own country without fear of persecution or return to their home without fear of persecution for their sexuality.

Article 14.

(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.

(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Example connection to sexuality: A person who is being persecuted and tortured for being a lesbian in one country, may be allowed to seek asylum in another more tolerant country.

Article 15.

(1) Everyone has the right to a nationality.

(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Example connection to sexuality: Transgendered, intersexed people should be able claim a nationality as they have transitioned from one sex to another and do not fall into the gender categories created by the State.

Article 16.

(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

(2) Marriage shall be entered into only with the free and full consent of the intending spouses.

(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Example connections to sexuality: 1) In many countries of South and Southeast Asia including India it is impossible for a same-sex couple, or trangender/transsexual couple, to have a marriage officially recognized by the State. It is therefore also very difficult for them to adopt children or use assisted reproductive technologies. 2) In many countries of the region, child marriages still exist, which are in violation of the 'in full age' and 'with full and free consent' clauses.

Article 17.

(1) Everyone has the right to own property alone as well as in association with others.

(2) No one shall be arbitrarily deprived of his property.

Example connections to sexuality: 1) In some countries women are denied property inheritance and it is instead given to a male member of the family who may be further removed from the deceased. 2) An individual who undergoes a gender reassignment from female to male should not be falsely accused of doing it for inheritance purposes.

Article 18.

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Example connection to sexuality: A person has the right to think about their sexuality and how they want to practise it in the manner that makes the best sense to them.

Article 19.

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Example connection to sexuality: All people have the right to information regarding their sexual and reproductive anatomy and physiology and contraceptive choices irrespective of marital status or nationality.

Article 20.

(1) Everyone has the right to freedom of peaceful assembly and association.

(2) No one may be compelled to belong to an association.

Example connection to sexuality: Gay pride parades and demonstrations, as well as sex workers festivals and celebrations should be allowed without fear of or actual prosecution.

Article 21.

(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

(2) Everyone has the right of equal access to public service in his country.

(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Example connections to sexuality: 1) Transgender people should be allowed to hold positions in the government. 2) Some countries have only recently allowed women to vote. In India, 'eunuchs' were granted voting rights in 1994.

Article 22.

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Example connections to sexuality: 1) Sexuality can change with time and as a person develops. They have a right to change the way they practise and experience sexuality throughout their lives. 2) Individuals have the right to education irrespective of HIV status.

Article 23.

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

(2) Everyone, without any discrimination, has the right to equal pay for equal work.

(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Example connection to sexuality: Women should be able to work late at their employment and not be harassed or assaulted when they leave their workplace late at night.

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Example connection to sexuality: Women should be able to work late at their employment and not be harassed or assaulted when they leave their workplace late at night.

Article 24.

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Example connection to sexuality: People who work in the 'sex industry', such as those who perform in sex shows or films, also have the right to periodic breaks with pay.

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Example connections to sexuality: 1) People are able to enjoy and practice their sexuality in manner they choose, irrespective of marital status. 2) Right to adequate health implies that all people, including those with disabilities have the right to access sexual and reproductive healthcare services. 3) Children have the right to be safe and free of sexual abuse within as well as outside the home and family.

Article 26.

(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children.

Example connection to sexuality: Many educational systems do not support sexuality education for young people or for people with disabilities. Nor do existent 'life skills education' or 'family life education' programmes promote understanding, tolerance and respect for the needs of those considered 'different', like people with disabilities, homosexuals, transgender people etc.

Article 27.

(1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Example connection to sexuality: People who identify as homosexuals should not be denied roles in theatre and musicals because of their sexual identity.

Handout 3.3
Participant Copy: Universal Declaration of Human Rights (UDHR)

When was the Universal Declaration of Human Rights adopted and what does it contain?

The Universal Declaration of Human Rights was adopted in 1948. There are 30 articles in the document that summarise human rights individuals have. As a brief summary, the articles in the UDHR include:

- life, liberty, security of person
- no discrimination for race, colour, politics, religion, sex, country
- legal rights–innocent until proven guilt
- freedom of movement within country, among countries
- right to nationality
- right to marry freely, not arranged
- property ownership
- freedom of thought, conscience and religion
- take part in government of country
- right to work, equal pay, vacation, rest
- standard of living for health, food, clothing, social services
- education–free at elementary and fundamental stages

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, Therefore THE GENERAL ASSEMBLY proclaims THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

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(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28.

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29.

(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

(2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30.

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

TREATIES	HIGHLIGHTS	POLITICAL CLIMATE TIME PERIOD	ONE EXAMPLE FROM YOUR WORK:
Universal Declaration of Human Rights	The UDHR, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights make up the Bill of Human Rights.	· Adopted 1948. · End of World War II that included Nazi violence and the atomic bomb. These events prompted countries to draft the UDHR to prevent further human rights violations. · Europe struggles against Fascism. · De-colonisation begins to accelerate.	
International Convention on the Elimination of All Forms of Racial Discrimination	Contains a definition of racial discrimination applicable to employment, education and denial of services. The definition states, 'Any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.'	· Adopted 1965, in force in 1969. · Beginning of the Cold War. · The civil rights movement in the United States is gaining power and influence. · Many African/Asia countries achieve self-determination. · Feminist movement begins in the United States.	
International Covenant on Civil and Political Rights	Meant as a supporting document that would give legal force to the UDHR. Stresses rights such as non-discrimination on the basis of sex, race, among others, choice of government, freedom of belief and expression, freedom from torture, equality in marriage.	· Adopted 1966, in force in 1976. · Start of the Cold War. · Western nations supported civil and political rights while Communist nations supported economic, social and cultural rights.	
International Covenant on Economic, Social and Cultural Rights	Meant as a supporting document that would give legal force to the UDHR. It stresses non-discrimination on the basis of sex and race among others, in the right to health care, housing, work, the family and education.	· Adopted 1966, in force in 1976. · Start of the Cold War. · Western nations supported civil and political rights while Communist nations supported economic, social and cultural.	

TREATIES	HIGHLIGHTS	POLITICAL CLIMATE TIME PERIOD	ONE EXAMPLE FROM YOUR WORK:
International Convention on the Elimination of All Forms of Discrimination Against Women	Major document forbidding discrimination against women. The definition of discrimination includes deliberate discrimination and discrimination in public and private life. The document also includes the right of women to vote, to have family planning education, right to decide the number and spacing of children, and have access to education and services that allow for these decisions.	· Adopted 1979, in force in 1981. · Human rights violations gain attention through the apartheid movement, Cambodian genocide, and Vietnam War. · Interpreted in 1992 to cover violence against women.	
Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Meant to further emphasise and call for the abolition of torture that was first laid out in the ICCPR. Contains a clear definition of torture-'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.'	· Adopted 1984, in force in 1989. · Tiananmen Square incident in China, 1989. · Fall of the Berlin Wall. · Marcos dictatorship ends in the Philippines.	
Convention on the Rights of the Child	Most widely ratified treaty. Includes protection from abuse, violence, abusive employment, disease, famine, sale, and abduction; freedom from fighting in wars; right to education and health care.	· Adopted 1989, in force in 1990. · Many reports were published leading up to the Convention on children as refugees and in armed conflicts, high rates of infant mortality, abuse in jobs, and lack of health care and education.	

CONFERENCES:

A number of conferences have been organised globally for governments and increasingly for NGOs, to enforce and bring forth human rights claims for marginalised people and groups. These include those in the chart below. These conferences have created consensus documents that are not legally binding.

CONVENTIONS	HIGHLIGHTS	YEAR	EXAMPLE OF HOW CONNECTED TO YOUR WORK:
Conference on Environment and Development in Rio de Janeiro (Earth Summit)	Emphasis on poverty reduction and connection between sustainable development and the environment. Influenced other conferences to look at the links between population, rights, women, the environment, and development. NGOs begin to have an impact on the outcomes of international conferences.	1992	
Conference on Human Rights in Vienna	The focus was to strengthen human rights instruments and adherence mechanisms since the adoption of UDHR. Called for a special rapporteur on Violence Against Women and also focused on the rights of indigenous people, migrants and children. Established High Commissioner on Human Rights within the UN.	1993	
International Conference on Population and Development in Cairo	Emphasised a shift from population control and demography to sustainable development. Reproductive rights and health, as well as sexual health were included in the Programme of Action, along with access to health, immigrant policy, closing the gender gap, and abortion.	1994	
Social Development in Copenhagen	Focus on globalisation, the world economy, poverty and reaching nations and countries that are commonly neglected and overlooked that face the hardest economic situations.	1995	
Fourth World Conference on Women in Beijing	Focus on the status of women worldwide and reaffirming that reproductive rights are human rights and that all women should have access and potential to realise these rights, in development and in peace.	1995	
World Conference Against Racism in Durban	Attention to debt cancellation for impoverished countries as a legacy of racism. Called for special measures to be strengthened to end race discrimination.	2001	

Handout 3.5
Case Studies on Human Rights

Case Study 1

It took Arti three years and a lot of love and support from her friends and family to accept her HIV status. She no longer feels the shame and hurt she felt in the early days of her diagnosis. Doctors told Arti that there are medications she can take that can help her stay healthy longer, but she has not followed up on that information. She now wants to know where she could get these medications since she wants to improve her health. Unfortunately, when she returns to the clinic that diagnosed her as HIV positive, she discovers that it has closed down. Arti lives in a fairly remote village which has only one clinic—the one that has now closed down. She decides to ask one of her co-workers where she could go to get the medication. When she asks the co-worker about the clinic she tells her that she is HIV positive. The co-worker is not sure about a clinic but says she will try to find out for her.

The next day when Arti comes into work, she is asked by her supervisor to come into his office. He informs her that they are cutting back on staff and will need to fire her. Arti is shocked and asks why this is happening and who else is being fired. Since she is insistent, the boss tells her that only she is being let go, because of her poor performance over the past year. Arti explains that she has always done her job well and never received any complaints before. She also tells her boss that she needs the job to help support her family, but her boss is unresponsive to her pleas. Arti goes home dejected and upset and not sure what she should do next: she has no job, needs money to get the medicines she needs for her HIV treatment, and is also unsure where to get these medicines. She feels alone and confused about what to do.

Questions:

- Are any of Arti's rights being violated? Which ones?
- What would the responsibility of the State be in the context of Arti's rights?
- Discuss how any of the conventions or treaties of human rights may pertain to Arti's situation.

Case Study 2

Ahmed is a transgendered person living in a large city. While it has been difficult to identify as a transgender, Ahmed is happy with his life and has friends and a community he is comfortable with and is content to remain in the city for the years to come. With this in mind, Ahmed decides to purchase an apartment. He has set his sight on one: a modest apartment in a good neighbourhood and is up for sale. Ahmed needs a loan to buy the flat and decides to try his luck with a local bank.

Ahmed goes to the bank with his request. The loan officer at the bank asks Ahmed to fill out the loan application and tells him that the process of getting the loan should be fairly straightforward because the loan amount is not very large. Also, Ahmed has documents to show that he will be able to repay the loan effortlessly. Ahmed begins to fill out the form, but has a problem with the section that asks for gender, and has only male and female as options. Ahmed does not consider himself to be exclusively male or female and cannot tick one or the other category. Ahmed communicates his dilemma to the loan officer and asks if he can add another category. The loan officer is confused, and tells Ahmed that he must choose one of the gender options in order to get the loan. Again Ahmed protests and tries to explain the situation, but the loan officer will not listen and simply tells Ahmed to make a choice or forget about the loan.

Questions:

- Are any of Ahmed's rights being violated? Which ones?
- What would be the responsibility of the State be in the context of Ahmed's rights?
- Discuss how any of the conventions or treaties of human rights may pertain to Ahmed's situation.

Case Study 3

Bhuvana is a thirty-year-old woman who has just got married. She wants to have a child, but is in no hurry: she and her husband would like to wait and have children once they are more settled in their new home. She decides to go and speak to a health care worker about contraception. She goes to the health centre that week and speaks to a nurse there. The nurse is very kind and they speak about her new marriage and home. The nurse asks Bhuvana about her plans to start a family. Bhuvana tells the nurse that she and her husband plan to delay having children. The nurse frowns, and tells Bhuvana that she is getting older and should have a child as soon as possible. Bhuvana explains again that she wants children, but later. The nurse doesn't look happy when she gives Bhuvana a pack of contraceptive pills. Bhuvana starts to ask how they should be taken and whether there are other contraceptive options; she doesn't like to take pills and usually forgets medications – but the nurse has already left the room and tells her to come back in a month. Bhuvana is left holding the pill pack and confused.

Questions:

- Are any of Bhuvana 's rights being violated? Which ones?
- What would be the responsibility of the State, if any, in Bhuvana's case?
- Discuss how any of the conventions or treaties of human rights may pertain to Bhuvana's situation.

Chapter 2
Reproductive Health and Rights

Chapter Objectives for the Facilitator

1. To have participants understand what reproductive rights mean.
2. To have participants discuss the connections between reproductive rights and reproductive health.
3. To have participants examine the differences and overlaps between reproductive health and rights, and sexual health and rights.
4. To shift participants from a conceptual understanding to practical application of a rights-based approach to advocacy.

Why a Chapter on Reproductive Health and Rights

'The protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and the spacing of their children' Proclamation 16, International Conference on Human Rights at Teheran on 13 May 1968.

The first explicit mention of reproductive rights in a formal human rights document can be found in the Declaration of the International Conference on Human Rights in Teheran, Iran, 1968. Over time, the definition of reproductive rights was refined at other human rights conferences. Most importantly, the International Conference on Population and Development in Cairo (1994), and the United Nations Fourth World Conference on Women in Beijing (1995), established reproductive rights as basic human rights deserving of recognition. In essence, reproductive rights concern the rights of people to reproduce, or not reproduce, free of discrimination, coercion and violence. Reproductive rights are meant to create the conditions in which reproduction can be controlled by women and men. These rights are borne out of reproductive health that emphasises the 'physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life' (WHO. For more see Handout 3.6).

Reproductive rights and reproductive health are often discussed at the same time as sexual rights and sexual health. While there are overlaps, it is important that they be recognized as different concepts. For example, individuals can choose to lead a sexual life whether or not they want to reproduce. At the same time, reproductive rights may merge or overlap with sexual rights, as when making a choice to have children or not. This decision could be influenced by the choice to be sexually active or not in the context of a heterosexual relationship, unlike in the case of a same-sex couple contemplating alternative reproductive technologies.

This chapter discusses reproductive health and rights. It also highlights the overlaps and distinctions between sexual and reproductive health and rights, and engages participants in discussion and analysis of these topics.

EXERCISES IN THIS CHAPTER:

Exercise 1: My Reproductive Rights. 60 minutes

Exercise 2: Case Studies on Reproductive Health and Rights. 60 minutes

Exercise 3: Acting Out Reproductive Health and Rights. 60 minutes

Exercise 4: Advocating for Reproductive (and Sexual) Rights. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 3.6
  Basic Information on Reproductive and Sexual Health and Rights
- Handout 3.7
  Questions on Reproductive Rights
- Handout 3.8
  Case Studies on Reproductive Rights
- Handout 3.9
  Reproductive Health and Rights Role-play Scenarios

ADDITIONAL RESOURCES:

- Chandiramani. R. 2005. 'Mapping the Contours: Reproductive Health and Rights and Sexual Health and Rights in India'. *Where Human Rights Begin*. Edited by Wendy Chavkin and Ellen Chesler. New Jersey: Rutgers University Press.
- Eldis Health Resource Guide. http://www.eldis.org/health/
- HERA Action Sheets. Available at: http://www.iwhc.org/document.cfm?documentID=52
- International Women's Health Coalition. http://www.iwhc.org/
- MDGenderNet. Gender Equality & the Millennium Development Goals. http://www.mdgender.net/
- Mertus, J., Flowers, N., Dutt, M. 1999. *Local Action Global Change - Learning About Human Rights of Women and Girls*. New York: UNIFEM and The Center for Women's Global Leadership.
- International Planned Parenthood Federation, UNAIDS, UNFPA, World Health Organization. 2005. *Linking Sexual and Reproductive Health and HIV/AIDS; An Annotated Inventory*. Available at: http://www.who.int.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key Messages for this Chapter:

- Individuals have the right to make reproductive choices based on their circumstances, needs, desires and preferences.
- Individuals have the right to make their reproductive choices free of fear or coercion from family, society and the State (for example, as in the case of population policies).
- Reproductive rights mean having access, options, and services related to reproduction as well as the right to choose when, how and with whom these options and services are accessed.
- Reproductive health and rights encompass a wide range of services, choices and information that should be available to a person. It is the responsibility of the State to ensure that these services are in place.
- Do men also have reproductive rights? It is important to remember that the rights of any single person cannot infringe upon those of another. The reproductive rights of women are given priority over those of men because women bear more of the physical and emotional consequences of a pregnancy. Therefore the choice to have a child or not, or to have an abortion or not, is hers to make.
- Sexual rights can be examined and considered separately from reproductive rights and vice versa. An individual can choose to lead a sexual life without the intention or aim of reproduction. At the same time, reproductive rights merge with sexual rights in many instances. For example, the choice of when to have children is connected to when and how a person chooses to be sexually active in a heterosexual relationship. However, sex may not be a consideration in the case of a same-sex couple who may choose alternative reproductive technologies to have a child.
- Understanding the links and applications of the formal human rights language and its concepts, including the language and concepts of reproductive rights, is important when providing services and making policies. For example, provisions for contraception can apply and use the concept of bodily integrity as outlined in the rights framework to make sure women receive full information on the possible side effects of new forms of contraception before they choose them.

Exercise 1
My Reproductive Rights

PARTY GAME

ADAPTED FROM LOCAL ACTION GLOBAL CHANGE – LEARNING ABOUT HUMAN RIGHTS OF WOMEN AND GIRLS.

Instructions

1. Divide the participants into two groups and have them stand face to face in a line across the room. Read out one question at a time from Handout 3.7 and allow participants 3 minutes to discuss it with the person facing them. After 3 minutes, ask participants from one line to move one place to their left to face another person in the opposite line. The other line remains stationary through the whole exercise. Read out another question and allow new partners to discuss the questions for 3 minutes before moving onto the next question. Ideally each participant should have an opportunity to speak to every other.

2. Continue moving the line and asking new questions until you finish all questions. Have the group return to their seats to discuss the exercise.

   Suggested Questions:

- What did you learn from this exercise? What questions were easier to discuss? Why?
- Were there any questions you had not thought of before? How did you react when you heard them?
- In your discussions, who was considered to have a greater say in questions related to reproduction (ie, men, women, family, community etc.)? Why? What does this mean?

3. Give participants copies Handout 3.6 and have them read it over. Ask for their reactions.

   Suggested Questions:

- Can you relate the questions and answers from the exercise to these definitions?
- Can you describe experiences in your life or any practical examples that come to mind relating to these definitions?

Purpose of the exercise:

To understand and discuss what is meant by reproductive rights.

TIME

60 minutes

MATERIALS

None

ADVANCE PREPARATION

Read Handout 3.6 Basic Information on Reproductive and Sexual Health and Rights and make sure you understand all aspects of the definitions.

Read Handout 3.7 Questions on Reproductive Rights and select 7-10 questions. Think of possible responses to the questions and how they relate to reproductive rights as described in the definitions.

THIS EXERCISE CAN BE MODIFIED BY:

- Discussing the questions as a large group rather than in pairs. This modification works with participants who are more comfortable speaking openly in the large group. It can also lead to a deeper discussion of some points and topics.

MAKING CONNECTIONS

- Reproductive rights include the rights of people to choose whether to reproduce or not. This includes the right to access to information on preventing pregnancies, how pregnancy occurs and how to end an unwanted pregnancy. For more see Chapter 2 in Module 2.
- There are options available for women and men who have trouble having a child and would like to reproduce. For more see Chapter 4 in Module 2.

Key Messages

- Reproductive health and rights are related to 'lived' experiences of people and are not merely theories.
- Reproductive rights mean having access, options, and services related to reproduction as well as the choices of when, how and with whom these options and services are accessed.
- Reproductive rights also include the right to choose not to reproduce.
- Experiences in reproductive health and rights can be different among individuals. Varied individual, interpersonal and socio-cultural factors impact whether or not reproductive rights are affirmed.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to relate their personal experiences to the definitions of reproductive health and rights. It may help to begin the discussion with an example of how these definitions relate to a sample response. For example, reproductive rights are being exercised when an un/married person chooses to have a child or to not have one; not being allowed to make this choice is a violation of their reproductive rights.
- Participants may be uncomfortable discussing personal experiences with others. Conduct an icebreaker before the exercise to encourage comfort within the group, and emphasise that participants need to discuss only what they feel comfortable sharing.
- It is important to have a solid understanding of reproductive rights before conducting this exercise. The facilitator may want to review Handout 3.6 as well as some of the additional resources offered at the beginning of the chapter.

Exercise 2
Case Studies on Reproductive Rights

CASE STUDIES

Instructions

1. Divide participants into small groups. Give a copy of one case study to each participant, with instructions to read the case and related questions and discuss the questions among the smaller groups. Give groups 20 minutes.

2. Bring the groups back together into the large group. Ask one representative of each group to read out the case study and questions and then summarise the group discussions.

3. After each presentation, participants from other smaller groups can ask questions or offer comments. Do not spend more than 20 minutes per presentation and discussion.

   Suggested Questions:

   - What did you think of the case study?
   - Did you agree or disagree with the group analysis of the case? Do you think there are other answers or issues to be raised?

4. Go through this process with each small group. Ask for general comments or questions at the end.

   Suggested Questions:

   - Are there common themes or similarities between the case studies and each group's analysis?
   - Are any of these cases similar to your own experiences or those of your community?

Purpose of the exercise:

To understand issues related to reproductive rights.

TIME

75 minutes

MATERIALS

Handout 3.8 Case Studies on Reproductive Rights, Handout 3.6 Basic Information on Reproductive and Sexual Health and Rights

ADVANCE PREPARATION

Make required modifications to the case studies based on your audience. Make copies from Handout 3.6 and Handout 3.8 for participants.

THIS EXERCISE CAN BE MODIFIED BY:

- Discussing one or two case studies together as a large group rather than dividing the participants into smaller groups. This can be beneficial for groups that are still unsure about what is meant by reproductive rights and health.

MAKING CONNECTIONS

- Individuals have the right to be free of infection and have access to health services to ensure this freedom. For more see Chapter 4 in Module 2.
- It is important to discuss sexuality and sexual rights with reproductive rights. For more see Chapter 3 in this Module.

Key Messages

- Reproductive rights affirm the rights of men and women to have information on and access to safe, effective, affordable, and acceptable methods of family planning. This includes the right to appropriate healthcare services for women in order for them to have a safe pregnancy and childbirth.
- Sexual and reproductive rights issues are often associated with inequalities of gender and sexuality. For example, a woman may not have the same reproductive freedoms as a man, or liberty to make choices about when and how to have children, because of gender dynamics prevalent in communities. Similarly, she may not be able to choose her partner and if, when, and how to have sex.
- Reproductive rights give people the right to be able to make informed choices about contraception without coercion.
- Individuals should have access to healthcare and facilities that allow them to realise sexual and reproductive health and rights and also offer protection from infections that could potentially affect their well-being.

TIPS FOR THE FACILITATOR:

- Pay attention to the manner in which case presentations are made: Do they use discriminatory language; do they reflect any prejudices; what are the areas of discomfort? Make sure to address these when they come up.
- Be prepared to address queries on injectables and implants since they are mentioned in one of the case studies. If necessary review Chapter 2 and Handout 2.7 in Module 2.
- It is important to have a solid understanding of reproductive rights before conducting this exercise. The facilitator should read over the handouts and information on reproductive rights prior to conducting the exercise and may also want to read additional resources offered at the beginning of the chapter.

Exercise 3
Acting Out Reproductive Rights

ROLE-PLAYS

Instructions

1. Divide participants into three or four small groups. Assign each group a scenario from Handout 3.9 and ask them to create a short role-play that will address their scenario. Give them 10-15 minutes to create the role-play.

2. Bring the groups back together and invite each to come up and present their role-play. After each presentation ask for questions and comments.

Suggested Questions:

- What did you think of the portrayal and resolution of the role-play?
- Do you agree or disagree with the central theme?
- Do these issues or situations typically arise in your community?

3. At the end of all presentations, ask for general comments and questions.

Suggested Questions:

- How do these scenarios and role-plays illustrate issues of reproductive health and rights?
- How could you advocate for an understanding of reproductive rights in your community and having people understand its value in their daily lives?

Purpose of the exercise:

1. To understand issues related to reproductive rights and health.

2. To discuss arguments that surround reproductive health and reproductive rights.

TIME

60 minutes

MATERIALS

Handout 3.9 Role-play Scenarios for Reproductive Health and Rights, Handout 3.6 Basic Information on Reproductive and Sexual Health and Rights

ADVANCE PREPARATION

Make copies of the scenarios of Handouts 3.9 and 3.6

THIS EXERCISE CAN BE MODIFIED BY:

- Inviting two volunteer participants to act out selected role-plays for the large group rather than creating small groups. This may be more appropriate for more advanced groups who are comfortable and confident with issues surrounding reproductive health and rights.
- Having participants conduct a role-play reflecting both sides of an argument rather than trying to come up with a resolution to the case. This may be more appropriate for less advanced groups who are experiencing difficulty in finding a resolution to the situation.

MAKING CONNECTIONS

- Knowledge of human rights basics can help with an understanding of reproductive rights. For more see Chapter 1 in this Module.
- Both the similarities and differences between sexual and reproductive rights should be considered. For more see Chapter 3 in this Module.

Key Messages

- Individuals have the right to make choices related to reproduction based on their circumstances, preferences, wants and needs.
- Individuals have the right to make reproductive choices free from fear or coercion from family, society and the State.
- Reproductive health and reproductive rights encompass a wide range of services, choices and information that should be available to people and are the responsibility of the State to provide.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to resolve their role-play or arrive at a group consensus. Emphasise that the resolution is not intended to illustrate the best or most appropriate action, but rather to elicit conversation and discussion of the situation.
- Participants may have difficulty connecting reproductive health and rights to the scenarios and situations. If necessary, use the definitions provided in Handout 3.6 and review them with the group.

Exercise 4
Advocating for Reproductive (and Sexual) Rights

SMALL GROUP WORK

Instructions

1. Divide participants into small groups. Hand each group three pieces of flipchart paper and markers. Ask participants to imagine they are working for the Ministry of Health in their country or community and have been given unlimited funds from the Ministry to **expand, promote and create an ideal situation to fulfil reproductive and sexual health and rights.** Their job is to map out the ideal plan to accomplish this task, the specific requirements and steps they would need to take in order to achieve this goal. In this plan they should answer three questions and write these answers on the three pieces of flipchart paper: What are the reproductive health and rights goals they want to achieve and some requirements/needs to achieve them; what sexual health and rights goals do they wish to achieve and some requirements/needs to achieve them; and what goals can be categorised as both sexual and reproductive health and rights. Give groups 15-20 minutes.

2. When the small groups have completed their task, bring them together and invite them to display their flipcharts. Ask a representative from each group to read their charts and discuss the process that led to the decision about ideal goals and the needs to achieve these goals. After all the presentations, ask for questions and comments from other participants.

   Suggested Questions:

   - Do you agree with the goals presented here? Do you agree with the ways in which sexual and reproductive health and rights were categorised?
   - Are there other ways these goals could be achieved? If money were no longer an obstacle, what else could stand in the way of your trying to achieve your objectives? For example, would it be easy to get women and men to come forward to be checked for sexually transmitted infections (STIs)? Would a community outreach programme providing education on STIs help?

3. After all presentations are over, highlight similar goals and needs among them and differences in the way sexual and reproductive rights were categorised. Ask for questions or comments.

Purpose of the exercise:

1. To identify differences and overlaps between sexual and reproductive rights.

2. To describe methods and arguments to advocate and promote better sexual and reproductive rights.

TIME

60 minutes

MATERIALS

Flipchart paper, makers, pens, Handout 3.6 Basic Information on Reproductive and Sexual Health and Rights.

ADVANCE PREPARATION

Make copies of Handout 3.6 for participants if they do not have it.

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting this as a large group exercise instead of one with small groups.
- Focusing more on creating an advocacy plan with specific steps for a one-year plan to promote sexual and reproductive health and rights.

MAKING CONNECTIONS

- Sexual rights and reproductive rights sometimes overlap, but there are also differences to consider. For more see Chapter 3 in this Module.
- Campaigns and advocacy movements have been successful in improving reproductive rights and health. For examples see Chapter 2 in Module 5.

Suggested Questions:

- What are the differences and overlaps between sexual and reproductive health and rights?
- Do you think sexual and reproductive health and rights should be dealt with separately, or addressed at the same time? What are the advantages and disadvantages to consider?
- Is using a rights approach to health useful for advocacy? Why? How?

Key Messages

- There are similarities and differences between sexual and reproductive health and rights. It is important to recognise these when advocating for the needs and well-being of communities and individuals.
- An individual can choose to lead a sexual life without the intention or aim of reproduction. At the same time, reproductive rights merge with sexual rights in many instances. For example, the choice of when to have children is connected to when and how a person chooses to be sexually active in a heterosexual relationship. However, sex may not be a consideration in the case of a same-sex couple who may choose alternative reproductive technologies to have a child.
- The reproductive rights of women are given more priority than those of men because women bear most of the physical and emotional consequences of a pregnancy. Therefore they have the right to choose whether to have a child or not.
- Advocating for improved reproductive and sexual health rights requires a clear understanding of individual rights and concerns as well as the community's perspective on these issues.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to identify the similarities and differences of sexual and reproductive health and rights, especially if they have not been introduced to sexual rights at the time of doing this exercise. Review Handout 3.6 if required.
- Make sure that participants do not just list points from the sexual and reproductive health and rights definitions in ideal goals, but base goals on needs of their communities and issues relevant to their lives.
- Encourage participants to make arguments for advocacy that are specific rather than general/vague. For example instead of an approach being 'talk to the community' have participants explain if this means to put up posters, create a media campaign or hold open forums with community leaders?

Handout 3.6
Basic Information on Reproductive and Sexual Health and Rights

Reproductive Health is defined by the WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

(http://www.who.org/html/definition_.htm)

Reproductive Rights are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. *(ICPD Programme of Action, para 7.3)*

Sexuality is a central aspect of being human throughout life and 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, religious and spiritual factors. *(WHO working definition 2002)*

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. *(WHO working definition 2002)*

The WHO 2002 definition says that ***sexual rights*** embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- *the highest attainable standard of sexual health, including access to sexual and reproductive health care services;*
- *seek, receive and impart information related to sexuality;*
- *sexuality education;*
- *respect for bodily integrity;*
- *choose their partner;*
- *decide to be sexually active or not;*
- *consensual sexual relations;*
- *consensual marriage;*
- *decide whether or not, and when, to have children; and*
- *pursue a satisfying, safe and pleasurable sexual life.*

The responsible exercise of human rights requires that all persons respect the rights of others.

How are reproductive health and rights different from sexual health and rights?

Reproductive health refers to health in the context of reproduction, not only of heterosexual people of the reproductive age group (between 15 to 45 years), but also people who are younger, older, lesbian, gay, with disabilities and non-procreative. Health-related issues of infertile people and those who seek assisted reproductive technologies are also part of reproductive health.

Sexual health refers to health around sexual matters independent of reproduction, and deals with issues like the prevention and cure of sexually transmitted infections (STIs), including HIV/AIDS, and sexual problems. Sexual health is a sexual right in itself, but it is also a necessary condition for the fulfilment of sexual rights.

Reproductive rights are about the rights of people to reproduce or not, free of discrimination, coercion and violence. They are meant to create the conditions under which women and men can control their reproduction.

Sexual rights refer to the rights of all people to decide about matters related to their sexuality freely and responsibly. Because they deal with sexuality independent of reproduction, they are wider in their scope. In addition to safety from violence, they offer the promise of a right to pleasure and life enriching experiences. Because of their de-linking from reproduction, sexual rights also include the right to diverse forms of sexual expression, identity and practice. Therefore sexual rights also apply to people practicing non-heterosexual and non-reproductive sexualities and actively bring men into the picture.

Why is the 1994 International Conference on Population and Development (ICPD) that was held in Cairo significant in the context of reproductive rights?

The 1994 International Conference on Population and Development (ICPD) held in Cairo was significant in the context of reproductive rights. The conference was a turning point as it marked international recognition that a woman's right to reproductive health was a fundamental human right. It was also the first conference to put into place an explicit call for women's empowerment and gender equity, laying down guidelines for this in its Programme of Action (PoA). The PoA included recognition of women's participation in development, and the connection between this and population growth. In the area of reproductive health and rights, ICPD's PoA also included the right of couples to plan and space their children, non-coercive family planning, integration of family planning efforts into basic reproductive health care, and a general confirmation that successful efforts towards sustainable population growth would include attention to individual family planning needs rather than a general focus on demographic targets. It also emphasised gender equity and sexuality as being essential to women's health rights and stated that comprehensive reproductive health care should include information on family planning, prevention of STIs, prenatal and postnatal care, choice of contraception, prevention of infertility, and prevention of unsafe abortions.

179 governments and over 1,500 NGOs from 113 countries attended the ICPD. Women's groups were instrumental in raising awareness of the gender inequities in development and other arenas, and worked to push forth an agenda for women's empowerment and access to reproductive health services as a human right. Funding estimates were given to each country and the ultimate objective was to have family planning and reproductive health services available to people no later than 2015.

What is the background on the Fourth World Conference on Women in Beijing in 1995?

The Fourth World Conference on Women (also known as the Beijing Conference) built upon the momentum created by ICPD and emphasised the importance of a gender perspective in policies and programmes. The Platform of Action for Beijing addressed issues related to the social and political empowerment of women, including their right to accessible health services that included reproductive health services. 189 governments and nearly 5,000 representatives from NGOs around the world attended the conference. A central focus for the conference was that rights are universal and need to be implemented by all nations. It also highlighted the political, social and economic inequities faced by women around the world and the need for change in attitudes and practices that cause these inequities.

Handout 3.7
Questions on Reproductive Rights

1. What do you think is a good example of a 'reproductive right'?

2. How has a reproductive health choice impacted your life in any way? Give an example or two if you feel comfortable sharing.

3. What messages does your community/society give people about:

   i. Abortion

   ii. Adoption

4. Does your society/community treat women with children differently from women without children?

5. Do you think you/people in your community could be married and not have children?

6. Do you think you/people in your community could stay single and have children?

7. Do you think women and men face similar pressures to be:

   i. Married

   ii. Parents

8. Who usually makes contraceptive choices: a woman, her partner, family, neighbours, any others?

9. Reproductive health is only a concern for people in a sexual relationship: Agree or Disagree?

10. Choosing not to have children is also a reproductive right. Agree or disagree?

Handout 3.8
Case Studies on Reproductive Rights

Case Study 1

A woman calls a helpline for advice. She has been married for 2 years and is still not pregnant. Her in-laws are unhappy about this and want her to have a medical check-up to make sure nothing is wrong with her. Her husband constantly puts pressure on her to have sex with him and she gives in to him against her own will frequently.

Are anyone's reproductive rights being violated here? If yes, whose and how?
What issues related to gender and sexuality can you identify in this case study?

Case Study 2

A woman married for 4 months is pregnant by accident (her husband's condom broke during sex). She is not ready for a child yet and wants an abortion. At first her husband agrees, but upon reflection feels that they should go ahead with the pregnancy. The woman does not agree, but her husband threatens to tell all their relatives and friends about the pregnancy in an effort to prevent her from having the abortion.

Are anyone's reproductive rights being violated here? If yes, whose and how?
What issues related to gender, sexuality and rights can you identify in this case study?

Case Study 3

The staff of a rural hospital has been given a brief introduction to a new contraceptive called Norplant. They have also been told to encourage women who come in for a post-natal check-up or an abortion to adopt this form of contraception. However, they were not told about the possible side effects and any contraindications to look out for before prescribing the contraceptive.

What are the potential reproductive rights violations that women who visit this hospital may face?
How can this violation be avoided?

Case Study 4

A woman lives in a remote village. She has recently been experiencing unusual vaginal discharge accompanied by an itching and stinging sensation. She is initially worried, but assumes it will stop by itself. After a week and a half, the symptoms are still present and she is now quite uncomfortable. However the nearest medical clinic is 2 hours away and since she has a job during the day, getting to the clinic will be difficult. The pressure is also on her to maintain her job, since her husband lost his job a month back. The woman decides to wait longer and hopes that the symptoms subside.

What issues related to reproductive health and rights are highlighted in this case study?
Are there any reproductive rights being violated in this case? What are they? How can this violation be avoided?

Handout 3.9
Role-play Scenarios for Reproductive Health and Rights

Scenario 1:

Create a role-play that addresses and responds to the statement: The responsibility for contraception is a woman's and hers alone. The role-play should illustrate agreement and disagreement with the statement and should have a resolution to the scenario, in which one side of the argument wins over the other.

Scenario 2:

Create a role-play that addresses and responds to the statement: The decision about whether and when to have children should be exercised in consultation with one's family (in-laws, parents etc.) The role-play should illustrate agreement and disagreement with the statement and should have a resolution to the scenario, in which one side of the argument wins over the other.

Scenario 3:

Create a role-play that addresses and responds to the statement: A government approach to population control that has target numbers for population control measures (such as sterilisation) as its goal is the best way to tackle the problem of over population. The role-play should illustrate agreement and disagreement with the statement, and should have a resolution to the scenario in which one side of the argument wins over the other.

Scenario 4:

Create a role-play that addresses and responds to the statement: A couple has the choice to not have children and they can exercise this right. The role-play should illustrate agreement and disagreement with the statement and should have a resolution to the scenario in which one side of the argument wins over the other.

Chapter 3
Sexuality, Sexual Health and Rights

Chapter Objectives for the Facilitator

1. To have participants understand the meaning of sexual rights.
2. To have participants understand the connection between sexuality and sexual rights.
3. To have participants relate sexual rights to their lives and work.

Why a Chapter on Sexuality, Sexual Health and Rights

Anjali was hesitant and fearful when she went to the doctor's office. She did not like doctors and was embarrassed about the reason for her visit. But she summoned the courage to tell the doctor that she wanted birth control pills. The doctor smiled at her and asked how long she had been married. Anjali hesitated and then told the doctor she was not married, but she still needed birth control. The doctor looked concerned and asked her what she needed birth control for if she was unmarried- she shouldn't be in a sexual relationship if she was single, that was not what 'good women' did. Even if she was married, she should be thinking about having children. No, the doctor announced, there really was no need for Anjali to get birth control and asked if there was anything else she needed. Anjali left the office feeling unsure and confused about the visit, without the birth control pills she wanted.

Anjali's experience is not uncommon. However situations such as the one described above should have an entirely different outcome. Anjali should have received information on her sexual health, been given the opportunity to make decisions about her sexual and reproductive choices without guilt or shame, and explore and practice her sexuality and sexual identity. These choices and information are part of Anjali's sexual rights – rights that are fundamental and will ensure her health and well-being.

Sexual rights are in the early stages of being defined, and many uncertainities still exist on how these rights should be upheld, defined and achieved. Sexual rights have historically been linked to reproductive health and rights. While links between the two frameworks exist, assuming that they are identical or interchangeable, fails to recognise essential differences between them. The question and challenge is to bring the discussion of sexual rights and health together with reproductive rights and health to highlight their similarities, and at the same time acknowledge that all sexuality and sexual activity is not based upon reproduction.

In this chapter participants consider such questions after first understanding what sexual health and rights mean. The chapter also makes connections between sexual health and rights and offers perspectives on how to include these issues in advocacy campaigns.

EXERCISES IN THIS CHAPTER

Exercise 1: Defining Sexual Health and Sexual Rights. 60 minutes

Exercise 2: Freedom To/ Freedom From. 30 minutes

Exercise 3: Quick Questions to Sexuality and Sexual Rights. 45 minutes

Exercise 4: Case Study on Sexuality, Sexual Health and Sexual Rights. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Index cards/slips of paper
Watch/timer
Tape

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 3.6
  Basic Information on Reproductive and Sexual Health and Rights
- Handout 3.10
  Imagining a Right to Sexuality
- Handout 3.11
  List of Phrases for Freedom From/ Freedom To
- Handout 3.12
  Questions on Sexual Health and Rights
- Handout 3.13
  Case Study of Maya

ADDITIONAL RESOURCES:

- Chandiramani. R. *Mapping the Contours: Reproductive Health and Rights and Sexual Health and Rights in India* in Where Human Rights Begin Edited by Wendy Chavkin and Ellen Chesler, Rutgers University Press, New Jersey, 2005
- CREA, SANGAMA and TARSHI. A Conversation on Sexual Rights In India. 2004
- Durbar Mahila Samanwaya Committee. http://www.durbar.org/
- Eldis Health Resource guide, http://www.eldis.org/health/
- Mertus, J., Flowers, N., Dutt, M. 1999. *Local Action Global Change - Learning About Human Rights of Women and Girls*. New York: UNIFEM and The Center for Women's Global Leadership.
- G. Misra and R. Chandiramani, eds. *Sexuality, Gender and Rights; Exploring Theory and Practice in South and Southeast Asia* SAGE. 2005
- Of Veshyas, Vamps, Whores and Women. http://www.vampnews.org/
- For selected films see, http://www.asiasrc.org/films.php and Appendix B

Key Messages for this Chapter

- While there is no explicit definition of sexual rights in any international document (like the Universal Declaration of Human Rights), various definitions of sexual rights have been developed and used. These definitions include the right to sexual and reproductive self-determination, to bodily integrity, to sexual desires and fantasies, and to sexual relations with a chosen partner without stigma or shame.
- Sexual rights are important to ensure sexual health and well-being.
- Sexual rights are different from reproductive rights and health (see Handout 3.6 for more), and there is a growing movement to ensure that these two concepts are discussed separately even while noting the common themes and ideas that exist between them.
- Sexual health is a sexual right in itself. For the 2002 WHO working definition of Sexual Health, see Handout 3.6

Exercise 1
Defining Sexual Health and Sexual Rights

GROUP DISCUSSION

Instructions

1. Divide the participants into four small groups. Divide and distribute the slips of paper with the words and phrases from Handout 3.6 equally among groups. Give 20 minutes to participants to read over the words and phrases, define each word or phrase, and explain its relevance and connection to sexuality.

2. Bring the groups back together. Have each read aloud their words/phrases and connections to sexuality. While this is being read, write key points on a flipchart. Following each presentation, ask for questions and comments.

   Suggested Questions:

- Does the rest of the group agree with the definitions presented?
- Would you add or remove any parts of the definition or include other connections to sexuality?

3. After discussing all the words and phrases, introduce the WHO working definition of sexuality on the flipchart.

   Suggested Questions:

- Do you agree with the definition by the WHO? Is anything missing from it?
- Could you use this definition for advocacy work within your organisation/ community? How?

4. Next, introduce the WHO working definition of sexual health written on the flipchart.

   Suggested Questions:

- Is the definition of sexual health comprehensive? Is anything missing?
- How are the definitions of sexuality and sexual health related?
- Why do you think words in the definitions such as pleasure, well-being, or gender identities have been included?

Purpose of the exercise:

1. To understand and define sexuality and sexual health.

2. To describe the connections between sexuality, sexual health and sexual rights.

TIME

60 minutes

MATERIALS

Flipchart, markers, pens, slips of paper with sexuality definition words and phrases (see below), Handout 3.10 Imagining a Right to Sexuality, Handout 3.6 Basic Information on Sexuality and Sexual Rights

ADVANCE PREPARATION

1. Copy the words and phrases from the World Health Organization (WHO) working definition on sexuality onto separate slips of paper or index cards.

2. On two separate flipcharts, write out the WHO definition of sexuality and the WHO working definition of sexual health from Handout 3.6.

Exercise 1
Defining Sexual Health and Sexual Rights

GROUP DISCUSSION

Instructions

1. Divide the participants into four small groups. Divide and distribute the slips of paper with the words and phrases from Handout 3.6 equally among groups. Give 20 minutes to participants to read over the words and phrases, define each word or phrase, and explain its relevance and connection to sexuality.

2. Bring the groups back together. Have each read aloud their words/phrases and connections to sexuality. While this is being read, write key points on a flipchart. Following each presentation, ask for questions and comments.

Suggested Questions:

- Does the rest of the group agree with the definitions presented?
- Would you add or remove any parts of the definition or include other connections to sexuality?

3. After discussing all the words and phrases, introduce the WHO working definition of sexuality on the flipchart.

Suggested Questions:

- Do you agree with the definition by the WHO? Is anything missing from it?
- Could you use this definition for advocacy work within your organisation/ community? How?

4. Next, introduce the WHO working definition of sexual health written on the flipchart.

Suggested Questions:

- Is the definition of sexual health comprehensive? Is anything missing?
- How are the definitions of sexuality and sexual health related?
- Why do you think words in the definitions such as pleasure, well-being, or gender identities have been included?

Purpose of the exercise:

1. To understand and define sexuality and sexual health.

2. To describe the connections between sexuality, sexual health and sexual rights.

TIME

60 minutes

MATERIALS

Flipchart, markers, pens, slips of paper with sexuality definition words and phrases (see below), Handout 3.10 Imagining a Right to Sexuality, Handout 3.6 Basic Information on Sexuality and Sexual Rights

ADVANCE PREPARATION

1. Copy the words and phrases from the World Health Organization (WHO) working definition on sexuality onto separate slips of paper or index cards.

2. On two separate flipcharts, write out the WHO definition of sexuality and the WHO working definition of sexual health from Handout 3.6.

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing it into two smaller exercises to be done one after another. This can break up the information for participants and allow for more discussion.
- Dividing the participants into small groups and distributing some words and phrases from the WHO definition to each group. Ask participants to relate each word to sexuality and present these connections to the rest of the group.

5. Distribute Handout 3.10 to each participant. Ask for final questions or comments.

Suggested question:

- Why is the choice of words so important in these definitions?
- Why is it important to have a definition of sexuality and sexual health?

Key Messages

- The definition used by the World Health Organization (WHO) is a working definition. Other organisations and groups have additional definitions for sexual rights which can be found in Handout 3.10
- Each word in the WHO definition was chosen carefully so that the definition of sexuality would be as comprehensive as possible and could be used effectively in advocacy.

MAKING CONNECTIONS

- It is important to understand the basic human rights framework and how sexual rights relate to this. For more see Chapter 1 in this Module.
- For a clearer conceptual understanding of connections and differences between sexual and reproductive health and rights see Chapter 2 in this Module.

TIPS FOR THE FACILITATOR:

- As in the exercise on Understanding Sexuality (Chapter 1, Module 1), participants may need to be reminded that the definition of sexual health is long and complex because it has to include the various elements that constitute sexual health.
- Participants may get confused and tired after this lengthy exercise. Take a break in the middle or right after the session if necessary, to give people time to absorb the information.

Exercise 2
Freedom To/ Freedom From

SMALL GROUP WORK

Instructions

1. Distribute the cards/slips with the statements from Handout 3.11 to the participants. Try to give each person at least one card/slip.

2. Go around the room and ask each participant to read the statement on their card aloud and to describe what the statement means to them and whether it should be categorised as a 'freedom to' or 'freedom from'. For example, the term 'Education on Sexuality' might mean being given accurate information on safer sexual practices, which would be categorised as the 'Freedom to Education on Sexuality'. The cards/slips should then be taped to the appropriate flipchart in the front of the room. Go through all the statements and then ask for questions or comments.

   Suggested Questions:

- Are there any statements in the *Freedom To...* category you disagree with? Are there any statements in the *Freedom From...* category you disagree with?
- Could some of the statements be placed in both categories? For example, sexual entertainment and material could be 'freedom to purchase, use and sell such material', but also 'freedom from such material in the office or personal space' if it makes a person uncomfortable.

3. After the statements have been discussed, explain that these statements help define sexual rights.

   Suggested Questions:

- Considering that these statements are related to sexual rights, should any statements be moved into another category?
- Can you make any connections or identify differences between these statements and those found in the Universal Declaration of Human Rights? Are these statements more specific or more general? Why do you think this is so?

Purpose of the exercise:

To understand what sexual rights mean.

TIME

30 minutes

MATERIALS

Flipchart, markers, tape, Handout 3.6 Basic Information on Sexuality and Sexual Rights (Chapter 2, Module 3), Handout 3.11 List of Phrases for Freedom From/ Freedom To

ADVANCE PREPARATION

Copy each statement from Handout 3.11 onto index cards or slips of paper. Prepare two flipchart pages, one with the title *Freedom To...* and one with the title *Freedom From...* Tape the two flip charts up at the front of the room.

THIS EXERCISE CAN BE MODIFIED BY:

- Following the discussion of *freedom from* or *freedom to* statements, with the question of who should have access to the rights listed on the flipcharts. For example, who should have the freedom to education on sexuality? Should it only be adults or adolescents as well?
- Reading aloud the statements from Handout 3.11 rather than handing them out to participants and asking the participants as a large group which category it should be put into and why.

MAKING CONNECTIONS

- It is important to understand the basic human rights framework and how sexual rights relate to this. For more see Chapter 1 in this Module.
- Sexual rights and reproductive rights overlap, but there are also differences that should be considered between the two. For more see Chapter 2 in this Module.

Key Messages

- Sexual rights are important to guarantee all aspects of sexual health and well-being.
- There is no explicit consensus on a definition of sexual rights in any international document (like the agreed upon definition of human rights in the UDHR), but the Beijing Conference put forth a Platform of Action on sexual rights that states, 'to have control over and decide freely and responsibly on matters related to their sexuality.' Since then there have been definitions put out by World Health Organization, International Women's Health Coalition, among other advocacy and rights groups to create a more inclusive definition. Handouts 3.6 and 3.10 discuss some of these definitions.
- The rights found in the working definitions of sexual rights are more specific than those found in the Universal Declaration of Human Rights.

TIPS FOR THE FACILITATOR:

- Participants' responses for the placement of cards may be predictable. The facilitator should challenge them to consider alternative placements. For example, the group may put the phrase 'have children' in the 'Freedom To' category, however it can also be put if the 'Freedom From' category.
- Participants may find it difficult to connect the statements to sexual rights even after going through the exercise of categorising them. Ask them to give examples of how each statement relates to sexual rights or use examples such as those given in the instructions. Review the definitions of sexual rights in Handout 3.6 if confusion still exists.
- This can be a quick exercise completed in less than 30 minutes to have participants begin to think about what sexual rights are and how to apply them.

Exercise 3
Quick Questions on Sexual Health and Rights

ADAPTED FROM LOCAL ACTION GLOBAL CHANGE – LEARNING ABOUT HUMAN RIGHTS OF WOMEN AND GIRLS.

PARTY GAME

Instructions

1. Divide the participants into two groups and have them sit face to face in a line across the room. Read out one question at a time from Handout 3.12 and allow participants 3 minutes to discuss it with the person facing them. After 3 minutes, ask participants from one line to move one place to their left to face another person in the opposite line. The other line remains stationary throughout the exercise. Read out another question and allow new partners to discuss the questions for 3 minutes before moving onto the next question. Ideally each participant should have an opportunity to speak to every other.

2. After going through the questions ask participants for comments and reactions to what they learned and heard.

Suggested Questions:

- Were you surprised by some of the comments and answers from your partners? Were they similar or different from your own reactions?
- After going through these questions do you see connections between the ideas of sexual rights and your own needs and experiences? If yes, how, and if no, why not?
- How do you think some of the experiences relate to sexuality and sexual rights? Give an example.

Purpose of the exercise:

1. To become comfortable around communicating and listening to experiences of sexuality.

2. To understand the connections between sexuality, attitudes and sexual rights.

TIME

45 minutes

MATERIALS

Watch/timer, Handout 3.12 Questions on Sexual Health and Rights

ADVANCE PREPARATION

Arrange chairs in two lines facing each other.

THIS EXERCISE CAN BE MODIFIED BY:

- Choosing one or two statements from the list, and inviting participants to share how they responded to this statement and opening up discussion around it. A good question to start with may be, 'When was the first time you exercised one or more of your sexual rights, if ever?' The answers to this question can help indicate whether the group has really begun to understand the concept of sexual rights.
- Conducting a group discussion rather than having participants talk to each other in pairs. Some of the suggested questions given in the Instructions can be used to start to the discussion.

MAKING CONNECTIONS

- Having a solid understanding of sexuality, sex and gender is important to understand the scope of sexual rights. For more on these topics see Chapters 1 and 2 in Module 1.
- There are similarities as well as divergence between sexual and reproductive health and rights. For more see Chapter 2 in this Module.

Key Messages

- Different people express their sexuality differently. This does not mean, however, that one person's expression is better or more acceptable than another's.
- Sexual rights and sexuality are not just theories. They can be applied to people's lives, experiences, and needs.

TIPS FOR THE FACILITATOR:

- Participants may be uncomfortable sharing experiences and answering questions about sexual rights and sexuality, even with one person. It may be useful at the start of the exercise to review the ground rules of the training, emphasising confidentiality and non-judgmental attitudes and/or to do an icebreaker.
- It is not necessary to ask questions in the listed order or spend the same amount of time on each question. Use discretion and judgment of the group dynamics and comfort levels to get discussions going and keep the attention and interest of the group. Questions can also be modified to suit the audience.
- Participants should begin to see the connections between sexuality and sexual rights and how these relate to their personal lives. If they are still unsure about these connections, the facilitator needs to address the confusion. If the definition is the cause, it may need to be reviewed. If there are difficulties adapting it to personal experiences, the facilitator may want to take one of the statements as an example and explain how it can relate to sexuality and sexual rights.

Exercise 4
Case Study on Sexuality, Sexual Health and Rights

CASE STUDY AND DEBATE

Instructions

1. Distribute a copy of the case study to each participant. Give them a few minutes to read the case. Divide participants into two groups: one group will argue for Maya returning to her first husband, while the other will argue for Maya remaining with her current husband. Each group should spend 15 minutes constructing an argument for their side of the debate.

2. Bring the groups back together and begin the debate by giving each side a few minutes to present their arguments. Then allow for a more open discussion, making sure each side is given an equal chance to defend/argue their position. After debating for 15-20 minutes, ask whether anyone has been convinced by the other side of the argument and wants to switch sides. Allow people to get up and move to the other side of the room.

   Suggested Questions:

- For those who switched sides, why did you switch?
- If no one switched, why not? Are the other side's arguments non-persuasive?

3. Bring the group together by discussing Maya's rights and potential violations of her sexual rights presented in this scenario.

   Suggested Questions:

- How does Maya's story relate to sexual rights? Can you list any violations of her rights?
- Does this case illustrate similar situations you have encountered in your community or work?
- How could Maya challenge her position?

Purpose of the exercise:

1. To examine potential challenges and obstacles to addressing sexuality and sexual rights.

2. To analyse the role of sexual rights in real life scenarios.

TIME

60 minutes

MATERIALS

Handout 3.13 Case Study of Maya

ADVANCE PREPARATION

Make copies of Handout 3.13 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting a simple polarisation exercise by summarising the case and asking those who believe that Maya should return to Samar to stand to one side of the room, and those who believe she should stay with Hakeem, to the other. After discussing reasons for participants' choices, engage in a discussion of Maya's sexual rights.
- Using the exercise to assess this module by asking participants in small groups to analyse the case and present points on how the case highlights various issues from this module: gender and sexual identity, pleasure, and sexual rights etc. Peer and facilitator evaluation of the presentations can help determine whether the knowledge and perspectives from the modules have been acquired.

Key Messages

- Sexual rights play a role in real life situations and circumstances such as the case study of Maya.
- Many groups/communities place a stronger emphasis on family and community than on the individual. In such cases, it may be challenging for participants to understand the value of human rights, which place the individual at the centre.
- Culture and religion can also play a role in the decisions made by a family and community. While these must be respected, it is also important to examine whether any single person or group's rights are always sacrificed in the name of a 'higher good' and how interests of both communities/groups and an individual can be preserved.
- In some countries and states, tension exists between rights and the strength of communal laws and customs. Discussing how to integrate and balance these is important.

MAKING CONNECTIONS

- There are similarities as well as divergence between sexual and reproductive health and rights. For more see Chapter 2 in this Module.
- Sexuality, sexual rights and health have been advocated for in various campaigns and movements. For more on such campaigns see Chapter 2 in Module 5.

TIPS FOR THE FACILITATOR:

- Participants may experience discomfort at having to argue a side of the debate they disagree with. The facilitator should encourage them to learn to argue a side they might disagree with in order to understand their own position and the opinion of others better. It also illustrates the difficulties experienced in arguing for sexual rights and how this can be done effectively.
- Participants may feel strongly about the case but not focus on the sexual rights of the characters. The facilitator should ask questions about Maya's sexual rights and whether they are being violated. Participants need to be urged to think of constructive solutions within the constraints of the situation.

Handout 3.10
Imagining a Right to Sexuality

Below are some definitions and declarations on sexual rights developed by various groups and international bodies.

HERA (Health, Action, Empowerment, Rights, & Accountability) Action Sheet on Sexual Rights, 1998

What are sexual rights?

Sexual rights are a fundamental element of human rights. They encompass the right to experience a pleasurable sexuality, which is essential in and of itself and, at the same time, is a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality.

Sexual rights include:

- The right to happiness, dreams and fantasies.
- The right to explore one's sexuality free from fear, shame, guilt, false beliefs and other impediments to the free expression of one's desires.
- The right to live one's sexuality free from violence, discrimination and coercion, within a framework of relationships based on equality, respect and justice.
- The right to choose one's sexual partners without discrimination.
- The right to full respect for the physical integrity of the body.
- The right to choose to be sexually active or not, including the right to have sex that is consensual and to enter into marriage with the full and free consent of both people.
- The right to be free and autonomous in expressing one's sexual orientation.
- The right to express sexuality independent of reproduction.
- The right to insist on and practice safe sex for the prevention of unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS.
- The right to sexual health, which requires access to the full range of sexuality and sexual health information, education and confidential services of the highest possible quality.

For more, see www.iwhc.org/global/un/unhistory/hera.cfm

International Planned Parenthood Federation (IPPF): Charter On Sexual And Reproductive Rights, 1995

1. **The Right to Life** which means, among other things, that no woman's life should be put at risk by reason of pregnancy.

2. **The Right to Liberty and Security of the Person** which recognises that no person should be subject to female genital mutilation, forced pregnancy, sterilisation or abortion.

3. **The Right to Equality, and to be Free from all Forms of Discrimination** including in one's sexual and reproductive life

4. **The Right to Privacy** meaning that all sexual and reproductive health care services should be confidential, and all women have the right to autonomous reproductive choices.

5. **The Right to Freedom of Thought** which includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues.

6. **The Right to Information and Education** as it relates to sexual and reproductive health for all, including access to full information on the benefits, risks, and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.

7. **The Right to Choose Whether or Not to Marry and to Found and Plan a Family**

8. **The Right to Decide Whether or When to Have Children**

9. **The Right to Health Care and Health Protection** which includes the right of health care clients to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.

10. **The Right to the Benefits of Scientific Progress** which includes the right of sexual and reproductive health service clients to new reproductive health technologies which are safe, effective and acceptable.

11. **The Right to Freedom of Assembly and Political Participation** which includes the right of all persons to seek to influence communities and governments to prioritise sexual and reproductive health and rights.

12. **The Right to be Free from Torture and Ill-treatment** including the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.

For the whole charter, see:http://www.ippf.com/ ContentController.aspx?ID=6653

World Association of Sexology Declaration of Sexual Rights, 1999

Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love. Sexuality is constructed through the interaction between the individual and social structures. Full development of sexuality is essential for individual, interpersonal, and societal well being. Sexual rights are universal human rights based on the inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected, and defended by all societies through all means. Sexual health is the result of an environment that recognizes, respects and exercises these sexual rights.

1. The right to sexual freedom. Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation and abuse at any time and situations in life.
2. The right to sexual autonomy, sexual integrity, and safety of the sexual body. This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.
3. The right to sexual privacy. This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual rights of others.
4. The right to sexual equity. This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.
5. The right to sexual pleasure. Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well being.
6. The right to emotional sexual expression. Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.
7. The right to sexually associate freely. This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.
8. The right to make free and responsible reproductive choices. This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.
9. The right to sexual information based upon scientific inquiry. This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.
10. The right to comprehensive sexuality education. This is a lifelong process from birth throughout the life cycle and should involve all social institutions.
11. The right to sexual health care. Sexual health care should be available for prevention and treatment of all sexual concerns, problems and disorders.

Sexual Rights are Fundamental and Universal Human Rights

For more see: http://www.worldsexology.org/about_sexualrights.asp

World Health Organization Working Definition of Sexual Rights, 2002

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

For more see: http://www.who.int/reproductive-health/gender/sexual_health.html

Handout 3.11
List of Phrases for Freedom To /Freedom From

- Bodily integrity
- Sexual and reproductive health
- Confidentiality in health services
- Make decisions in reproduction free from coercion and discrimination
- Any sexual thought, fantasy or desire
- Sexual entertainment and material
- Stigma and discrimination
- Government intervention
- Education on sexuality
- Choose a partner
- Be sexually active
- Consensual sexual relations
- Have children
- Sexual pleasure
- Violence
- Abuse
- Marriage
- Harassment

Handout 3.12
Questions on Sexual Health and Rights

1. When was the first time you exercised one or more of your sexual rights, if ever?
2. Has a sexual choice impacted your life in any way? In what way?
3. Does the community or society you live in convey any messages on pre marital sex to you?
4. Does the community or society you live in convey any messages on non-monogamous relationships?
5. Do you think men and women face similar pressures of abstaining from sex until marriage? In what other areas related to sexuality do you find similarities and differences?
6. Do you think men and women deal equally with the expectation of being in a sexual relationship and how so?
7. Sexual health is about having 'healthy' or 'good' sex: do you agree or disagree?
8. Sexual health is of concern only to those in a sexual relationship: do you agree or disagree?
9. To avoid rape or sexual harassment, women should not dress in revealing clothes: do you agree or disagree?
10. Do you think marriage keeps a society together?
11. Do you think sexual pleasure is a right? Why?
12. Homosexuals should access separate sexual health services from heterosexuals: do you agree or disagree?
13. Do you think forced sexual activity is acceptable in marriage? Why or why not?
14. Transgender people also have the right to information on sexuality and sexual pleasure; do you agree or disagree and why?
15. If a husband has sex with his wife against her wishes, it is a violation of her sexual rights; do you agree or disagree and why?
16. People with disabilities can and do have sexual desires; do you agree or disagree and why?

Handout 3.13
Case Study of Maya

Maya is a young woman who married Samar at the age of 18. Samar is a kind man and treats Maya well. The two are content living together in a moderately-sized village among their friends and family. Soon after they are married, Samar decides he isn't earning enough money and wants to be a better provider for Maya. He decides to take a job abroad for the next year, which will pay him more money than his current job. The only drawback is that he will be far from home and probably unable to return to visit until the end of the year. He reassures Maya that at least they will be able to talk to each other once a month.

Maya is upset over Samar's departure, but knows this is a good plan and thinks one year will go by quickly. She can use the time to get to know Samar's family and get used to her new home. During the first few months of Samar's move, he is regular about keeping in touch and they speak to each other at the beginning of every month. He seems satisfied with his job, although it is difficult to be apart from Maya and his family. Then one month, Samar's call does not come. This is just the beginning of many months of silence. Maya is worried but assumes her husband is busy or does not have the money to call. After 6 months, however, she begins to think something is wrong. She tracks down the company he was working with, and contacts them to ask about Samar and his whereabouts. The company is unsure about him and take a few weeks to let her know that that Samar left with some other workers for a site visit a couple months ago and has still not returned. According to the company, the group travelled through a rather dangerous area of civil unrest and didn't even show up for the site visit. Their whereabouts are still unknown and the company has been trying to locate them by talking to some groups and the police. They tell Maya they are confident about finding them, and that she should just be patient. Maya is confused and upset, but decides there is no choice but to wait. Six more months go by, and the company still has no news for Maya. There is no word from Samar either. Suddenly, she gets another call from the company that inform her that Samar is presumed dead.

Upon hearing this news, Maya's family decides to wait to make sure Samar does not return before they find Maya another match – after all, she is still young and needs a family. Three years go by before they finally decide to arrange another marriage for her. They find a suitable husband in a neighbouring village and the couple are married within a few months. Maya likes her new husband Hakeem, who is a good man and makes a fair wage working in a nearby factory. She is happy with her life, although she continues to feel sadness over her previous life and the loss of Samar. Her life with Hakeem, however, is comfortable, and within a few months she becomes pregnant. The couple is overjoyed and eager to have their first child together. Eight months into her pregnancy, there is some surprising news: Samar has returned home! A rebel group had held him captive for three years, but he had finally been released and returned home.

Maya is overwhelmed by the news and unsure what to think or do. Samar wants her to return to him and his family is also urging her to do the same. But Maya's new husband Hakeem loves her and because she is carrying their baby, he thinks her only option is to stay with him. People in the village and surrounding areas also discuss the situation and advise Maya on what she must do. Some think she should stay with Hakeem, while others say she was never truly divorced from Samar and according to the law, is still his wife and should return to him, even if she is carrying Hakeem's child. Yet another group thinks Maya should return to Samar, but the child once born should be raised by Hakeem and his family. The family and villages decide to hold a meeting to decide Maya's fate. They will discuss issues pertaining to the case and debate the options before coming up with a decision for Maya. Maya is unsure what to do and feels like the decision is out of her control.

MODULE 4
Beyond Basics

Introduction

Once basic topics related to sexuality, sexual and reproductive health and rights have been addressed and understood (Modules 1-3), participants can begin an exploration of more complex issues and their impact: issues of power, stigma, marginalisation, and disability, in the context of sexuality.

The chapters in Module 4: Beyond Basics explore this complex range of issues often overlooked in the context of sexuality. An exploration of these topics will help to avoid stigmatising and marginalising people and include all groups and populations in discussions and programming.

At the end of this module, participants will be able to analyse and examine issues of stigma and marginalisation and discuss power and violence, and issues concerning people with disabilities in the context of sexuality and sexual and reproductive health and rights.

Module 4: Beyond Basics

Chapter 1: Sexuality & Power

Chapter 2: Challenging Stigma and Discrimination

Chapter 3: Sexuality & Disability

Assessment for Module 4 Beyond Basics

At the end of this module the facilitator can conduct an assessment. This assessment can evaluate increase in participant knowledge, changes in attitudes, preferences for different exercises, and opinions on the facilitator's skills. For this module, an assessment can be done using the following tools:

- Using the modification of Exercise 6 in Chapter 1 of this Module
- Adapting one of the sample assessment forms found in Chapter 2, *Preparing to Train.*
- Using the facilitator preparation exercises for this module found in Chapter 1, *Preparing to Train*
- Developing a new assessment depending on the facilitator's requirements

Sample Training Schedule

A blank template of a training schedule as well as a sample seven-day training schedule can be found in the Introduction of *Preparing to Train.* Depending on the focus of the training and the topics it aims to cover, the facilitator can fill in the blank schedule with exercises from this Module or in combination with exercises from other Modules.

Chapter 1
Sexuality and Power

Chapter Objectives for the Facilitator

1. To have participants define and understand the concept of power.
2. To have participants connect the concept of power to issues of sexuality, sexual and reproductive health and human rights.
3. To dispel myths and introduce facts about existing forms of sexual violence and abuse.

Why a Chapter on Sexuality and Power

What do we mean by power? What are the different forms of power?

Is power merely to have control over something, and if so what are the factors contributing to this control?

Can choice and consent also be part of power exchanges?

Do influences beyond the individual, such as community and family contribute to one's power?

Answers to the questions above will differ depending on the person, group or community being asked. This is because power is not a rigid or simple concept. Power is changeable and complex, and differs according to its context and relationship with the individual, community, and larger environment.

This chapter examines power and its connection to sexuality, sexual and reproductive health and human rights. It examines the role and influence of power in the lives of people and communities we work with. For example, sexual assault and abuse – whether in the form of gender-based violence, rape, intimate partner violence, or child sexual abuse – can be better understood through the lens of power differentials. This lens provides an understanding of the motives for such actions and is essential to addressing and changing them.

However, we must recognise that power is not always abusive. When consensual, exchanging power can also be affirmative and contribute to sexual pleasure. Abuse occurs when a power exchange loses the elements of consent and choice.

This chapter covers a number of concepts related to power, such as power that comes from having certain opportunities, to power examples in situations of gender-based violence and child sexual abuse, among others. ***The notion of power is the common thread connecting all these topics.*** The chapter also examines the ways in which power is expressed, how power influences roles being played out, how it can be assessed and adjusted for more equality, and how it relates to the issues surrounding sexuality, sexual and reproductive health and rights.

EXERCISES IN THIS CHAPTER:

Exercise 1: Understanding Sexuality and Power. 60 minutes

Exercise 2: Who Has the Power. 60 minutes

Exercise 3: Abuse of Power: Sexual Violence and Harassment. 60 minutes

Exercise 4: Abuse of Power: Intimate Partner Violence. 60 minutes

Exercise 5: Abuse of Power: Child Sexual Abuse. 60 minutes

Exercise 6: Creating Power Dynamics. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Index cards/slips of paper
Pens/pencils

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 4.1
Abuse of Power: Sexual Violence and Harassment

Handout 4.2
Intimate Partner Violence Scenario

Handout 4.3
Facilitator Copy: Myths and Facts About Child Sexual Abuse

Handout 4.4
Participant Copy: Myths and Facts About Child Sexual Abuse

Handout 4.5
Creating Power Dynamics Scenarios

ADDITIONAL RESOURCES:

- CARE. 2005. *Protecting Women's Rights, or Protecting Women – CARE's First Regional Meeting on Violence Against Women Bangkok*.
- CREA. 2005. *Building Alliances Globally To End Violence Against Women – The Global Dialogue Series*
- Mertus, J., Flowers, N., Dutt, M. 1999. *Local Action Global Change - Learning About Human Rights of Women and Girls*. New York: UNIFEM and The Center for Women's Global Leadership.
- Mezey, Gillian C.; King, Micheal B. Ed. 1993. *Male Victims of Sexual Assault*
- The Population Council. 2001. *Power in Sexual Relationships: An Opening Dialogue Among Reproductive Health Professionals*. New York: The Population Council.
- Renzetti, Claire M; Edleson, Jeffrey L et al. 2001. *Sourcebook on Violence Against Women*. Thousand Oaks: Sage Publications.
- Tulir-Centre for Prevention and Healing of Child Sexual Abuse. www.tulircphcsa.org
- Vishaka v. State Of Rajasthan (1997.08.13) (India Sexual Harassment). Available at: http://www.pria.org/intervention/Supreme.htm
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key Messages for this Chapter

- Power operates under many influences and is experienced in different ways. These experiences vary with age, class, caste, gender, educational status, disability, access to services, and HIV status among others.
- There are many players/people who influence an individual's decisions and thereby hold some power in their lives. These can be community, family, and larger political or legal systems.
- Power imbalances are not confined to certain genders and sexual identities. For example, women are not always the ones who experience gender-based violence; transgendered people can also face this form of violence.
- Changing political climates and the people we are connected to can continually alter how we view and experience the power dynamics in our lives.
- Power can manifest itself in inequalities, violence, and abuse. However not all power is abusive or negative. Power exchanges can also provide sexual pleasure. It is in non-consensual situations that power is abused.
- Choice and power are never absolute and all choices are based on the situations and contexts of people's lives.

Exercise 1
Understanding Sexuality and Power

SMALL GROUP WORK

Instructions

1. Divide the participants into two groups. Give the groups 15 minutes to discuss and list out answers to the following questions:

   Group 1: What do you think you have the power to do in your life? What do you think has power over you in your life? What gives you power?

   Group 2: Where/when has power been used against you in your life? Where/when have you used power over others in your life? What denies you power?

2. Bring the groups back together to present their list and ideas. Write these on a flipchart and after all the group presentations, ask for questions and comments:

   Suggested Questions:

- Do you agree or disagree with the comments from each group? Do you have any comments or statements to add?
- What can you say about power from these lists? Is it always positive or always negative? Can you define what power is from these lists?
- Which players (people, organisations, political entities) from these lists are involved in the power one may/may not have?

3. After this discussion, ask participants to return to their groups and relate their questions to sexuality. Give the groups 15 minutes to answer the following new statements:

   Group 1: What do you think you have the power to do in your life with respect to your sexuality? What/who do you think has power over your sexuality?

   Group 2: Where/when has power been used against your sexuality? Where/when have you used your power over others especially in the context of sexuality?

4. Bring the groups back together to present their responses. Write these out on the flipchart. After presentations, ask for questions and comments.

Purpose of the exercise:

1. To define the concept of power.

2. To relate the concept of power to sexuality.

TIME

60 minutes

MATERIALS

Flipchart, markers

ADVANCE PREPARATION

None

THIS EXERCISE CAN BE MODIFIED BY:

- Creating examples and answers for questions and distributing these to the groups, rather than having them come up with their own. Participants can then decide what questions these statements answer and why.

MAKING CONNECTIONS:

- People who engage in sexual behaviour that is not considered the norm may feel marginalised and experience less power than others. For more see Chapter 1 in Module 1 and Chapter 2 in this Module.

Suggested Questions:

- What can you say about power and its relationship to sexuality from these lists? Is it always positive or negative? Who are the people involved in the power you may/may not have?
- Do you think you have more or less power when it comes to issues related to your sexuality compared to other areas of your life?

Key Messages

- Power can mean many things, from having access to services (like anti-retroviral therapy or expensive infertility treatment), to being able to express emotions, ideas and needs.
- Power is expressed and experienced in many individual ways, can change over time and can be difficult to assess. Changing political climates and the people in our lives can continually alter how we view and experience power dynamics.
- Power can manifest itself in inequalities, violence, and abuse, but not all power is abusive or negative. Power exchanges can manifest as consensual sexual behaviour and provide sexual pleasure. It is only when consent and choice are removed that power is abusive.

TIPS FOR THE FACILITATOR:

- Participants may initially find it difficult to answer the questions. Giving examples to get the groups going may help.
- While power disparities can contribute to gender inequality, ensure that no discussion becomes a man-bashing exercise. Men may also lack power, particularly around gender issues and sexuality.
- Make sure ideas of gender are included in discussions and that ideas about power are inclusive. For example, the discussion should not centre only on a heterosexual/male-female context. Ensure that the experiences of transgendered, transsexual, and homosexual people are also taken into account.

Exercise 2
Who Has the Power

GROUP EXERCISE

ADAPTED FROM LOCAL ACTION GLOBAL CHANGE – LEARNING ABOUT HUMAN RIGHTS OF WOMEN AND GIRLS.

Instructions

1. Ask participants to hold hands and stand in a single line in the middle of the room. Explain that you will read out a series of statements one at a time. Participants should consider the statement and follow the instruction based on their answers. They must hold hands as long as possible.

Statements for Power

- If you are married take one step forward.
- If you are a man take one step forward.
- If you are under the age of 30 take one step back.
- If you have children take one step forward.
- If you have a daughter take one step back.
- If you own a home take one step forward.
- If you have been seriously ill in the last year (not just a cold or flu) take one step back.
- If you have a disability take one step back.
- If you do not have health insurance take one step back.
- If you own a car step forward.
- If you have a Masters degree take one step forward.
- If you did not go to college take one step back.
- If you grew up in a city or urban area take one step forward.
- If you have travelled abroad take one step forward.
- If you have ever been judged negatively for a reproductive or sexual health choice take one step back.

2. After reading all the statements out, ask participants to look around at the others in the line and observe the following.

- Who is still holding hands? Who is ahead of the others in the line? Why?
- Note where people stand: what does this tell us about power and opportunity? What about power and equality?

3. Now ask participants to run to a specified place in front of them, such as a section of a wall, and grab a space for themselves against the wall.

Purpose of the exercise:

1. To identify the role of power in daily life.

2. To discuss how power relates to opportunity, equality and access to services.

TIME

60 minutes

MATERIALS

None

ADVANCE PREPARATION

Review *Statements for Power* in Instruction 1. Add or modify the statements if required.

Suggested Questions:

- Who reached the wall first and why? Did the statements reflect advantages you can have in society that allowed you to get to the wall first or later?
- Can you see why some of the statements moved you forward, while others moved you back? Do you disagree with any of the instructions? For example, do you agree with the statement 'If you are married take one step forward'? Why or why not?
- Which statements were related to sexuality? How do you think power and sexuality relate to one another after this exercise?

THIS EXERCISE CAN BE MODIFIED BY:

- Asking fewer questions during the exercise and spending more time on a discussion.

MAKING CONNECTIONS

- Gender roles and how gender is constructed in society can contribute to the opportunities and power an individual has. For more see Chapters 1 and 2 in Module 1.
- Human rights aim to give all people the same opportunities and allow them to be on the 'same point on the line'. For more see Chapter 1 in Module 3.

Key Messages

- Power has many influences and is experienced differently by each person. These experiences can vary with age, class, caste, gender, educational status, disability, HIV status and access to services.
- Those with greater opportunities because of their social groups and/or their family/caste/class/race enjoy more benefits and power to make choices in their lives.
- Those people who lack access to opportunities may be 'left behind'. Human rights speak of equal access to opportunities for all people and help give people from different walks of life a level playing field.
- Choice is never absolute. Choices are influenced by various factors.
- People with less power in society still have agency. Agency refers to the ability by individuals or groups to control and make choices within the constraints of their lives in society.
- It is difficult at times to maintain equality as reflected by difficulties faced by participants trying to hold hands through the exercise while being pulled in different directions by those ahead/behind them.

TIPS FOR THE FACILITATOR:

- Make sure participants do not see this exercise as a judgement of them as fortunate or unfortunate, but rather a chance to examine opportunities and power people have in society.
- It may be difficult to discuss the idea of agency, as this is not an easily understood concept. If this happens, the facilitator may want to include it later, or go over the definition separately.

Exercise 3
Abuse of Power: Sexual Violence and Harassment

SITUATIONAL STATEMENTS

Instructions

1. Distribute one statement from Handout 4.1 to each participant. Invite one person at a time to read out their statement and identify whether they believe it describes an instance of sexual violence or harassment and why. After everyone has responded, ask for general questions or comments. If the participants' analyses are incomplete/incorrect, clarify according to the information in Handout 4.1.

   Suggested Questions:

- Do you agree or disagree with the answer? Why?
- Do you think the situation would be different if the gender of the characters was reversed? How and why?

2. Go through all the statements asking the same questions as above. At the end, ask for general questions or comments.

   Suggested Questions:

- What do the characters feel or experience that defines the situation as sexual violence or harassment? Are these situations common to the communities you live in or work with?
- How can you advocate for change in these types of situations?

Key Messages

- ***Sexual harassment*** is any unwelcome behaviour of a sexual nature perpetrated by one individual on another. Sexual harassment may be verbal or physical, repeated or done only once. It can occur between people of different genders or those of the same gender and may occur in a variety of relationships. Sexual assault can be part of sexual harassment.
- Sexual harassment can manifest in many forms. Two main categories are *quid pro quo harassment* and *hostile environment harassment*. *Quid pro quo* is when an employer has power to control an employee's benefits and demands that the employee engage in sexual activities to get/ keep these benefits.

Purpose of the exercise:

1. To identify and discuss instances of sexual violence, including rape and sexual assault, and its relationship to power.

2. To identify and discuss instances of sexual harassment in the workplace, at school, and its connection to power.

TIME

60 minutes

MATERIALS

Index cards/slips of paper, Handout 4.1 Abuse of Power: Sexual Violence and Harassment

ADVANCE PREPARATIONS

Write out the situational statements given on Handout 4.1 on separate pieces of paper or index cards.

- *Hostile environment sexual harassment* may manifest in behaviour/ language that creates an uncomfortable, offensive, shameful, or embarrassing environment for a particular worker through unwelcome behaviour of a sexual nature, which may interfere with work ability, such as through the display of inappropriate posters, emails or computer screensavers.
- Other important factors to take into account when determining if a situation is harassment are whether someone has the freedom to act, feels comfortable, and is in an equal situation of power. Economic benefits are not always involved.
- Sexual violence and harassment are not universal concepts and people can define their individual limits/boundaries around them. What one individual considers sexual harassment may not be threatening to another.
- To ensure respect for workers, workplaces should create guidelines for sexual harassment, with clear definitions of harassment, and repercussions for any breaches. A sexual harassment committee can also be formed to address and maintain these guidelines.
- ***Rape*** is any forced genital or sexual penetration and can occur in circumstances in which the person is either unknown, an acquaintance, or within a relationship such as marriage.
- ***Sexual assault*** and ***sexual abuse*** are used interchangeably, but may mean different things under the law. They can include rape or any other form of undesired sexual contact which can include, but is not limited to forced kissing and unwanted touching of a person's body.

THIS EXERCISE CAN BE MODIFIED BY:

- Going through fewer statements. This allows for a longer discussion on specific issues of relevance to the group.
- Having two participants act out the statements in role-play and asking the others whether they consider these instances of sexual violence or harassment.

MAKING CONNECTIONS

- Human rights treaties and conventions have discussed violence and violation of rights. For more see Chapter 1 in Module 3.
- Sexual violence can impact sexual and reproductivel health. For more on see Module 2.

TIPS FOR THE FACILITATOR:

- Be prepared for participants to disclose or share their own experiences of abuse or harassment. Acknowledge their experience, and if possible/required, provide them with referrals for help.
- Men are the more common perpetrators of rape and sexual harassment of girls and women, so this exercise can create gender division and tension in the group. Remind participants that women are also capable of committing sexual harassment and abuse and men can also experience harassment and abuse.

Exercise 4
Abuse of Power: Intimate Partner Violence

CASE STUDY

Instructions

1. Read aloud to the participants the scenario from Handout 4.2. Then ask participants for questions or comments.

   Suggested Questions:

- Does this case represent intimate partner/ domestic violence? How so?
- Would you think differently if the roles were reversed or if the characters were two men or two women in a relationship? Did you assume this scenario was one of married couples? Could the characters also have been unmarried or dating?
- Is this example familiar in your community or work? How would you define intimate partner violence?

2. Now, take a flipchart sheet and write the name or draw a figure representing Sheena from the scenario in the centre of the paper. Ask participants to describe the effects of each experience of violence on her. Does it affect her physical health, her mental health, and/or her sexuality? If so, how? Write responses on the flipchart around the name/ figure. Spend 20 minutes on this exercise.

3. After generating a comprehensive list of the possible effects of intimate partner/domestic violence, ask for comments and questions.

   Suggested Questions:

- What obstacles may prevent Sheena from leaving or changing her situation? For example, does she need support from her family, or a safe place to live?
- How could you advocate to change Sheena's situation and to stop the violence she experiences?

Purpose of the exercise:

1. To identify and discuss instances of violence in intimate relationships.

2. To discuss the connection between intimate partner violence and sexuality, reproductive and sexual health and rights and advocacy approaches to improve these circumstances.

TIME

60 minutes

MATERIALS

Flipchart, markers, Handout 4.2 Intimate Partner Violence Scenario

ADVANCE PREPARATION

None

Key Messages

- Intimate partner violence can be in the form of physical, sexual, mental or emotional abuse, or a combination of these. It is not limited to men and women in marriage. There can be violence in same sex relationships, and also between unmarried couples.
- Intimate partner violence can cause physical symptoms like chronic pain, illness and even broken bones. Mental health effects can range from increased stress to thoughts of suicide. Reproductive health effects include irregular periods or increased incidence of spontaneous abortion. Intimate partner violence can also affect a person's experience and expression of sexuality.
- Intimate partner violence is linked to family, community and society. A person may be unable to leave an abusive relationship because of lack of support from the family, pressure from the community to stay in the relationship, or because there are no services or opportunities for self-reliance without the partner.
- Developing a safety plan for people experiencing intimate partner violence can help them create options for dealing with such situations. These plans can include preparing or safely storing important documents like marriage certificates, bank account information, medical records, passports and school records for children, jewellery and spare keys to the house and/or bank locker etc. In addition, identifying safe places to move to (with relatives, friends, or an NGO) if and when the person is ready to do so is also important.
- Whether or not to leave a violent relationship is a choice to be made by the person experiencing this violence. Those experiencing violence are in the best position to assess and decide if and when to leave. It can be difficult to leave a relationship; even one that is violent. Forcing or coercing someone into leaving before they are ready to is also a violation of their rights. People choose to stay for a variety of reasons that may be emotional, economic, social and familial.

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into small groups and distributing a copy of the scenario to each. Groups can be asked to discuss the scenario and the suggested questions. Bring them back together after 15 minutes to present the highlights of their discussions.

MAKING CONNECTIONS:

- Human rights treaties and conventions have addressed issues of violence. For more see Chapter 1 in Module 3.
- People who experience intimate partner violence can also face stigma and discrimination in their communities. For more see Chapter 2 in this Module.

TIPS FOR THE FACILITATOR:

- This exercise and topic may create discomfort among participants, particularly if either they or someone close to them has experienced violence. Be alert to any signs of distress/discomfort among them.
- Some participants may consider domestic violence or intimate partner violence a family problem, not to be interfered with. Emphasise the right of people to live free from fear and violence.

Exercise 5
Abuse of Power: Child Sexual Abuse

MYTH OR FACT

Instructions

1. Introduce the topic to the participants. Distribute the index cards/slips of paper with statements from Handout 4.4. Ask participants to read their statements aloud one at a time. After each statement, ask the group if they believe it to be a myth or a fact. The facilitator should fill in any gaps in information and give relevant information provided in Handout 4.3. It may be useful to write some key points on the flipchart beforehand.

2. After going through all the statements, ask for questions or comments.

Suggested Questions:

- Are there any other ideas about child sexual abuse you want to share? Are these myths or facts?
- Why are there so many myths associated with child sexual abuse?
- How does child sexual abuse relate to the concept of power? Does it imply and involve an imbalance of power in any relationship?

Key Messages

- Child sexual abuse exists all over the world, in different cultures and communities.
- Child sexual abuse includes any exploitative sexual activity by a person who, by virtue of their power over a child, due to age, strength, position or relationship uses the child to meet their sexual or emotional needs.
- It is important to know the signs and issues related to child sexual abuse, to identify abusive situations, and to address them. Being on the alert for signs of child sexual abuse, such as changes in a child's behaviour in school, increased aggression, bruises, STIs or urinary tract infections, or changes in the way children interact with adults and the way they use language can help identify and prevent child sexual abuse.

Purpose of the exercise:

1. To discuss and develop awareness of issues surrounding child sexual abuse.

2. To learn facts about child sexual abuse and how it relates to power.

TIME

60 minutes

MATERIALS

Flipchart, markers, index cards/slips of paper, Handout 4.3 Facilitator Copy: Myths and Facts About Child Sexual Abuse, Handout 4.4 Participant Copy: Myths and Facts About Child Sexual Abuse

ADVANCE PREPARATION

Review Handout 4.3; write out each of the statements from Handout 4.4 on separate index cards/slips of paper.

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into small groups and asking each to go over a few statements and decide if this is a myth or fact and why. Participants can then share their opinions and discuss the statements in the large group.
- Giving Handout 4.3 to participants to take with them rather than going over the topic. This may be best for groups with survivors of abuse who may not want to discuss the issue at length or are already aware of the issues.

- Parents should speak with children about 'good' and 'bad' touch and make sure children are comfortable telling them if someone touches them inappropriately. Children who have been abused need to be reassured that the abuse was **not** their fault.
- Incest and abuse are different. Incest is sexual activity between individuals with familial relations. While abuse can occur between family members, it can also occur between non-family members.
- Paedophilia and child sexual abuse are not the same. Paedophiles are individuals who derive sexual pleasure and excitement only from fantasising or engaging in sexual activity with children. Child sexual abusers are individuals who have sexual relationships with adult partners and at the same time engage in sexual activity with children, which can include contact and non-contact behaviour such as fondling, kissing, forcing them to perform oral sex, or making them watch sexual acts, listen to excessive talk about sex or pose for sexual photos etc.

MAKING CONNECTIONS

- Human rights treaties and conventions have addressed children's rights and their protection. For more see Chapter 1 in Module 3.
- Children with disabilities may be more vulnerable to abuse because they are in close contact/proximity with care-providers and may not have the ability to communicate this abuse to anyone. For more see Chapter 3 in this Module.

TIPS FOR THE FACILITATOR:

- People may react emotionally to this topic, particularly if they have experienced sexual abuse or if they know someone who has. Be alert to this possibility and take breaks during the exercise if necessary or allow for extra time to discuss issues.
- Some participants may be defensive about these issues and feel that this could not happen in their communities or social groups. Point out that abuse is not spoken about openly even though it can occur in any community. This is why talking about CSA and doing an exercise such as this one is important.

Exercise 6
Creating Power Dynamics

CASE STUDIES AND SCENARIOS

Instructions

1. Divide participants into four groups. Hand each a copy of one of the case study scenarios from Handout 4.5. Alternatively, the same case study could be given to all four groups to work with (This will highlight different interpretations and manifestations of violence in the same context.) Give participants 25-30 minutes to go through their case study and create a scenario that addresses the theme and questions given to them.

2. Have participants return to the larger group. Ask each to present the case created by them. After each presentation, ask for questions and comments.

Suggested Questions:

- What did you think of this case? Do you think it appropriately addresses the theme?
- Have you heard of situations like this before? Are they common in your community? If so, what is the common attitude towards these types of situations?
- How can the characters in this case change their realities and the imbalance of power?

3. After all presentations, ask for general comments and questions.

Suggested Questions:

- How do these cases demonstrate the use of power? Is power used in positive or negative ways?
- How does power relate to human rights in these cases? Are any rights being violated?
- Is it possible for these situations to occur among people with different genders and sexual identities? For example, if the intimate partner violence case scenario featured a woman as being abused by a man, could roles be reversed? Or could such a situation exist in a same sex relationship?

Purpose of the exercise:

To discuss how sexuality and power can be used to promote improved sexual and reproductive health.

TIME

60 minutes

MATERIALS

Handout 4.5 Creating Power Dynamics Scenarios

ADVANCE PREPARATION

Make copies of Handout 4.5 for participants

THIS EXERCISE CAN BE MODIFIED BY:

- Selecting only one case study scenario and discussing it in the large group. This can be beneficial for groups focused on a specific issue in their work, for example child sexual abuse
- Using the exercise as an assessment for this module. This can be done by asking participants in small groups to create scenarios that incorporate the points and questions given to them in addition to ideas from the rest of the module on disability, stigma and discrimination.

MAKING CONNECTIONS:

- Women often experience gender-based violence, but those who do not conform to prevalent gender norms in a society can also face violence and lack of power. For more see Chapter 2 in Module 1.
- Individuals in positions of limited power also can face stigma and discrimination. For more see Chapter 2 in this Module.

Key Messages

- Power and its effects can be experienced in many different situations and circumstances.
- Power imbalances are not confined to certain genders and sexual identities. For example, women are not the only ones who experience gender-based violence. This can also affect homosexual men, or trangendered people.
- Individuals can experience multiple kinds of power imbalances simultaneously. For example, a disabled woman in a lower caste can experience marginalisation and a lack of power based on her gender, disability and her caste.
- Power can manifest itself in inequalities, violence, and abuse. However not all power is abused or negative.

TIPS FOR THE FACILITATOR:

- It may be difficult for participants to create a case study from the short description. Reassure them that there is no right or wrong approach and the scenario should simply address the theme and questions.
- Participants may find it difficult to find commonalities between case studies. Try to focus on the inequality or who has control in the scenarios to illustrate different instances of power.
- If participants are unsure about what is meant by gender-based violence or intimate partner violence, it may be beneficial to go over terms and definitions beforehand. It can also be effective to forgo any definitions and encourage participants to interpret the terms themselves, to enable them to identify their own ideas and perhaps misconceptions behind these terms.

Handout 4.1
Abuse of Power: Sexual Violence and Harassment

1. After lunch every day, Anuja goes up to the sink to wash her dishes. Ali always gets up at the same time and washes his dishes standing right beside her, often touching the side of her body.

   This can be considered sexual harassment if it is unwelcome and makes Anuja uncomfortable in her work environment. However, all depends upon Anuja's feelings and level of comfort or discomfort in the situation.

2. Meera walked into the meeting room one day and noticed a new calendar with scantily dressed women up on the wall.

   This may or may not be regarded as sexual harassment depending upon how Meera feels about the calendar. Whether a situation can be considered sexual harassment or not often depends on the individuals involved. For instance, one person may find a situation uncomfortable and threatening while another may not. This can change from context to context.

3. Amrindar's sense of humour is considered unusual at his work-place. He likes to tell sexually explicit jokes and uses explicit language while telling them.

   This may or may not be sexual harassment depending on how the office workers feel about Amrindar's behaviour. One person may find a situation uncomfortable and threatening while another may not. This can also change from context to context. For example, telling the same jokes at an office party may be acceptable to Amrindar's co-workers versus telling them during a work meeting, which may upset them. For this situation to not be considered sexual harassment, all of Amrindar's co-workers must be comfortable with his behaviour.

4. Gautam's schoolmates make fun of the size of his muscles and joke about the size of his penis.

   This may or may not be sexual harassment depending on the context of this school and whether there is a power play involved in this behaviour, for example, if Gautam is a new student or being teased by older students. Young people tease each other and may also be cruel in ways that are not sexual. If in the space of a classroom, this creates an uncomfortable and hostile environment for Gautam to function in, it would be considered sexual harassment.

5. Chetan is Kamila's boss and finds her very attractive. One day he tells her that the office is cutting back on employees and if she doesn't have sex with him she will lose her job.

   This is quid pro quo sexual harassment. Chetan is using his power as an employer to force sexual activity on Kamila and threatening to remove her from her job if she does not agree.

6. Sonal is a social worker attached to several villages in the district. Her work involves discussing contraceptive options with women and men. A community leader approaches her one evening when she is on her way home from a neighbouring village and tells her that her work is inappropriate and threatens her. Though it is not openly stated, the leader makes sexually suggestive remarks while threatening her.

   Even though she is out of an office situation and works in the 'field', this behaviour creates a threatening and uncomfortable atmosphere in which she has to carry out her duties. Therefore this is sexual harassment. It also involves power dynamics (by virtue of the leader's position in the community and Sonal's gender) and threatens Sonal and her work.

7. A woman wears a new sexy outfit to go out with her friends. She dances with a man she finds attractive most of the night. Later, he drives her home and then forces her to have sex with him.

   This is rape. Regardless of what a woman wears and how she acts with a person, if she does not consent to sex, it is rape.

8. A man follows a woman walking home at night. He takes her money and then fondles her breast and kisses her.

   This is sexual assault. It is a crime and a violation against the woman.

9. A gay man works in a small office where no one knew his sexual identity until recently. Now every day someone makes a comment or a joke about queer people whenever he is in the room.

   This can qualify as sexual harassment, because it creates an environment for the worker in which he is uncomfortable about his sexuality.

10. A woman goes out with a man and then goes home to his place. At first she says she wants to have sex and is responsive to him. But as things progress, she changes her mind and decides she doesn't want to have sex after all. She asks the man to stop. The man forces her to have sex anyway.

    This is rape. Even if someone originally wants to have sex, they can change their mind at any time. If a person forces another person to have sex at any time, it is rape.

11. A man is walking home at night when two men approach him, begin to hit him and ask for his wallet. He obliges, and then the men ask him to have sex with them. The man does not want to, but the two men force him to have sex with them.

    This is rape. Men can also experience rape and should not be made to have sex without consent.

12. A woman is married and likes to hold hands with her husband, hug him, and kiss him. At work lately one of her co-workers has begun to hug her when she leaves for the day and also grabs her hand when he talks to her. She is uncomfortable with this.

    If the woman is uncomfortable with the touching it is sexual harassment. A person can welcome and enjoy touching and engaging sexually with a particular person(s) and not with another.

13. A man believes that he has the right to have sex with his wife whenever he wants and that it is her duty to provide it. Even when she refuses, he insists on having sex with her.

    If he forces his wife to have sex against her will, it is marital rape. Just because they are married does not mean that either partner can force the other to have sex. Each sexual encounter even between spouses should be consensual. Being married or in a relationship with a person does not mean one is always willing to have sex; there are times when they may not want to and this should be respected.

14. A woman goes out for a birthday party at a restaurant. A man at the party sits next to her most of the night and gets her drinks. He laces one of the drinks with a drug that makes her sleepy and groggy. She wakes up the next morning without her clothing and a condom wrapper lying beside her. She doesn't remember having sex and goes to the doctor for an examination. The doctor confirms that she had sex that night and that there are minor tears and bruises on her body.

    This is rape. There have been many cases when drugs have been used to impair a person's ability to make decisions clearly and people have taken advantage of this impairment. This is called date rape when two people went out with each other willingly but one was forced/ coerced/ deceived into having sex by the other against their will or knowledge.

Handout 4.2
Intimate Partner Violence Scenario

Aryan and Sheena have been together for many years, but recently Sheena has been having doubts about their relationship. While she thinks Aryan can be a loving partner, the past few years have also brought out another side of his personality she does not like. It began with criticism of her housekeeping abilities. Aryan would criticise Sheena in a mean and hurtful way - he would say she didn't cook well, but then eat most of the meal and leave barely any for her; he would throw his clothes at her saying they were still dirty just after she had cleaned and folded them; he would spit on the floor of their home saying it was still dirty and she should clean it better. Sheena put up with his 'moods' and tried to improve. Then one day, Aryan came home in an especially angry mood - he had a bad day at work and his food was cold since he got home late. He threw the plate and food at Sheena and then slapped her a few times across the face. This kind of hitting continued for many months but after each episode Aryan would apologise and say he would not do it again. He then tried to make up with Sheena by having sex, even if she didn't really want to.

Handout 4.3
Facilitator Copy: Myths and Facts about Child Sexual Abuse

Instructions for participants: Indicate whether each statement below is a Myth or a Fact. Write (M) for a myth and (F) for a fact.

- **Only girls are vulnerable to child sexual abuse.**

  MYTH: Both boys and girls are vulnerable to sexual abuse. However, since most available research on child sexual abuse focuses on the abuse of girls, statistics show a higher number of girls are abused than boys. Existent research on boys shows that boys tend to report abuse differently, denying it often or behaving as though they enjoyed it. This suggests that more boys are abused than we know, and more research is needed to get an accurate picture of the situation.

- **An abuser can be someone who knows or is related to the children they abuse.**

  FACT: Many times an abuser can be a relative or friend of the family.

- **Child sexual abuse (CSA) can include both contact and non-contact sexual behaviour.**

  FACT: CSA can include fondling, kissing, being forced to perform oral sex, rape or other penetrative sex, made to watch sexual acts, forced to listen to inappropriate talk about sex, sexually fondled while being bathed, shown sexual movies or other pornography, made to pose for sexual photos etc.

- **Paedophiles and child molesters are the same.**

  MYTH: Child sexual abusers can belong to the categories of either paedophiles or child molesters. Paedophiles are sexually fixated on children alone, while child molesters are people who have sexual relationships with adult partners and at the same time engage in sex with children as well.

- **Child sexual abuse only happens in Western countries.**

  MYTH: This is a popular misconception. Child sexual abuse is a universal problem, affecting millions of children across the world. Although this is a problem worldwide, more reporting and research is available from Western countries. Presently, extensive data on the prevalence of child sexual abuse in India is not available but this does not mean that it does not occur in the country.

- **Children with a disability can also be sexually abused.**

  FACT: Children with disabilities are easy targets for abusers (if they are not mobile, they cannot move away from an abuser, for example), they may be unable to report the abuse because they cannot communicate or be understood by their care-providers or worse still if they are being abused by those who also care for their daily needs. Considering that almost 12 million children in India are disabled, the possible prevalence of sexual abuse of disabled children in India is alarming. This is even more of a problem because of societal denial of child sexual abuse, and because disabled children are often viewed as 'asexual' and hence not protected from possible abuse like their non-disabled siblings and peers may be and are denied any information on sexuality. That disabled children cannot be abused, since abusers find them unattractive and feel sorry for them is another damaging myth.

Handout 4.5
Creating Power Dynamics Scenarios

Case 1

Create a case study to present to the group that highlights sexual harassment and power. The case study should address the following points and questions:

- What is sexual harassment? Give an example of sexual harassment.
- How does sexual harassment relate to power?
- How can this relationship be changed and altered to create a more even balance of power?

Case 2

Create a case study to present to the group that highlights gender-based violence and power. The case study should address the following points and questions:

- What is gender-based violence? Give an example of gender-based violence.
- How does gender-based violence relate to power?
- How can this relationship be changed and altered to create a more even balance of power?

Case 3

Create a case study to present to the group that demonstrates child sexual abuse and power. The case should address the following points and questions:

- What is an example of child sexual abuse?
- How does child sexual abuse relate to power?
- How can this relationship be changed and altered to create a more even balance of power?

Case 4

Create a case study to present to the group that highlights domestic violence/intimate partner violence and abuse. The case should address the following points and questions:

- What is domestic violence/intimate partner violence and abuse? Give an example of domestic violence/intimate partner violence and abuse.
- How does domestic violence/intimate partner violence and abuse relate to power?
- How can this relationship be changed and altered to create a more even balance of power?

Chapter 2
Challenging Stigma and Discrimination

Chapter Objectives for the Facilitator

1. To have participants understand issues related to stigma, discrimination, and marginalisation in the context of sexuality.

2. To have participants recognise the adverse effects of stigma, discrimination and marginalisation on health and well-being.

Why a Chapter on Challenging Stigma and Discrimination

Fanny Ann Eddy, 30, was found dead on the morning of September 29, 2003. She was alone late the previous night, working in the Sierra Leone Lesbian and Gay Association's offices. Her assailant or assailants apparently broke into the premises, raped and stabbed her repeatedly and broke her neck. Eddy had founded the Sierra Leone Lesbian and Gay Association in 2002. The group provided social and psychological support to a fearful and underground community. Eddy herself was a visible and courageous figure, who lobbied with government ministers to address the health and human rights needs of men who have sex with men and women who have sex with women.
Eddy and her organization documented harassment, beatings and arbitrary arrests of lesbian, gay and transgender people in Sierra Leone. As Scott Long, director of the Lesbian, Gay, Bisexual and Transgender Rights Project at Human Rights Watch said, 'Now, she has been murdered in the offices of the organization she founded, and there is grave concern that she herself has become a victim of hatred.' (Human Rights Watch. http://hrw.org/english/docs/2004/10/04/sierra9440.htm)

This account may provide an extreme example, yet it illustrates the very real pain, persecution, violence and even death that discrimination and stigma can cause. Unfortunately, Fanny Ann Eddy's experience is not uncommon; there are many such examples of stigmatisation and hatred throughout the world. People are subject to ridicule and hurt on a daily basis if they are seen as different and therefore not as good as/lesser than the rest of society. These may be disabled people, young/unmarried sexually active people, people with more than one sexual partner, bisexuals, sex workers, older sexually active people, intersexed people, those who are HIV positive, people with mental illness, and a range of other identities and practices that 'mainstream' society considers inappropriate or wrong.

Besides infringing upon their rights to freedom of expression, bodily integrity, and at times even to life, discrimination and stigma have other implications. Stigmatised or marginalised people are often forced to adopt ways of living that can increase their vulnerability. For example, transgendered people in many countries are marginalised, resulting in restricted access to information, services and social support. They may not receive timely medical care, and resort to unsafe medical practices through unqualified practitioners, jeopardising their health, well-being and even their lives.

Failure to understand and accept the range of sexual and gender identities and behaviour perpetuates stigma and discrimination.

EXERCISES IN THIS CHAPTER:

Exercise 1: Stigma and Identities. 45 minutes

Exercise 2: Stigma Mapping. 60 minutes

Exercise 3: Acting Out Stigma and Discrimination. 60 minutes

Exercise 4: Stereotyping Identities. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 4.6
Stigma and Identities

Handout 4.7
Acting Out Stigma and Discrimination

Handout 4.8
Stereotyping Identities Case Studies

This chapter increases participant awareness of diverse identities and choices, and emphasises rights for all people regardless of their identity or sexual behaviour. It also provides participants an opportunity to examine the consequences of stigma, discrimination and marginalisation and explore strategies to eliminate these attitudes and treatment.

ADDITIONAL RESOURCES:

- Action Plus. 2004. *People's Panchayat on Resisting Stigma and Discrimination*. New Delhi: Action Plus.
- Croll, E. 2000. *Endangered Daughters - Discrimination and Development in Asia*. London: Routledge.
- Durbar Mahila Samanwaya Committee. http://www.durbar.org/
- Kidd, R., Clay, S. 2003. *Understanding and Challenging HIV Stigma: Toolkit for Action*. USA: The CHANGE Project, ICRW.
- Of Veshyas, Vamps, Whores and Women. http://www.vampnews.org/
- Stewart, C. 1999. *Sexually Stigmatized Communities - Reducing Heterosexism and Homophobia: An Awareness Training Manual*. California: Sage Publications.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key Messages for this Chapter

- ***Stigma*** is a mark of shame or discredit to an individual or group and can be attributed to anyone who is considered different and/or 'deviant'.
- ***Discrimination*** means unfair treatment of a person or group on the basis of their identity, practices, race, caste, appearance etc.
- ***Marginalisation*** or the social process of becoming/being made marginal (especially as a group within the larger society) is a means to keep someone away from power, because of the choices they make in their identities, practices or appearance.
- ***Stereotyping*** is an oversimplified conception, opinion, or image of people or things. Judging others on the basis of stereotypes leads to prejudice, which is a precursor to stigma, discrimination and marginalisation.
- Ethnicity, gender, class, sexual identity, caste, disability are just some variables that can be used to stigmatise and discriminate.
- Culture regulates the lives of all people, but it does not do this uniformly. Some people/groups are regulated more than others. For example people who appear 'different' may be more regulated because they do not 'fit' into socially and culturally prevalent norms in terms of the way they look (fair, dark, tall, fat, thin etc.), behave or live.
- Most people engage in a variety of sexual behaviours other than those considered conventional/normal/common even if they do not talk about it. Those engaging in sexual behaviour with mutual consent, without threat or coercion, have the right to do so without fear of being judged or punished. On the other hand, coercive sexual behaviour of any kind, even between regular partners or married partners, is wrong and unacceptable.
- In today's melting-pot world, we are influenced by more than one set of cultures, traditions, and practices; we have multiple identities. Therefore stigma can be experienced at multiple levels. For example, a woman with a disability who loves other women could face triple discrimination because of her gender, disability and sexual identity.

Exercise 1
Identities

GROUP EXERCISE

Instructions

1. Distribute Handout 4.6 to each participant. Ask everyone to write the various identities listed in the handout in the concentric circles, based on the level of stigma and discrimination they experience in their societies/communities. For example, identities that experience the least amount of discrimination will fall into the inner most circle, whereas the outer most circle will have the most marginalised identities. Give participants 10-15 minutes to fill out the handout.

2. Invite participants to present their handouts and explain the basis upon which they categorised identities. After 4-5 people have shared their views, ask for questions or comments.

Suggested Questions:

- Were there similarities among the least marginalised people? The most marginalised? How does society stigmatise some of these identities?
- What do the similarities indicate about certain identities? Are there some groups such as married men that experience the least stigma and most opportunities in society?
- Are there stereotypes associated with any of these identities? How would these stereotypes cause discrimination or marginalisation of those concerned?
- Who creates these stereotypes and decides what is 'normal'? Why/How are these stereotypes and this marginalisation maintained? For example, do media images of certain identities help to perpetuate these attitudes or do laws or customs in a community maintain this marginalisation?

Purpose of the exercise:

To examine stereotypes related to various identities and how these can stigmatise, discriminate and marginalise.

TIME

45 minutes

MATERIAL

Flipchart, Handout 4.6 Stigma and Identities

ADVANCE PREPARATION

Make copies of Handout 4.6 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Having participants fill out the handout in small groups. It can be useful for large groups and those from similar communities to discuss how they perceive stigma in their communities.

MAKING CONNECTIONS

- People of different sexual and gender identities have the right to express their sexuality free from fear and stigma. For more see Chapter 2 in Module 1.
- People with disabilities may experience double stigma and discrimination for their sexual or gender identity as well as for their disability. For more see Chapter 3 in this Module.

Key Messages

- Sexual identity refers to how people define themselves based on whom they are sexually attracted to - whether they are attracted to people of the same gender, a gender other than their own, or to many genders.
- Gender identity refers to whether a person thinks of themselves as a man, woman, or a different gender. As with sexual identity, many cultures and communities have prescribed rules for appropriate gender identities based on the biological sex of a person.
- Though they are connected, stigma, discrimination and marginalisation are different; a person can experience one without the other. For example, a person may be stigmatised for being a lesbian but because of other factors in her life (income, class, caste, race) she may not be marginalised.
- Often the more 'different' a person appears from the 'norm' in society, the greater the discrimination and marginalisation faced.
- Stereotypes maintained in society and communities contribute to stigma and discrimination against certain gender and sexual identities.
- Stigma and discrimination can result in violence, abuse or denial of services and information for individuals.

TIPS FOR THE FACILITATOR:

- Participants may not be familiar with some of the identities listed. If necessary, go through the identities beforehand and discuss any questions they might have about the identities.
- Participants may express discomfort around some identities, especially those that are new to them or those considered 'wrong' according to their culture/religion. Be sensitive to this and encourage participants to participate in the exercise in the spirit of learning and respect for people's sexual identities, even if they do not fully understand them.

Exercise 2
Stigma Mapping

SELF-REFLECTION

Instructions

1. Hand out paper and pens to the participants and give them 3-5 minutes to write out answers to the following questions:

   Questions 1: List three identities, preferably related to sexuality and gender, found in the community you work or live in.

   Question 2: List three words you would use to describe your identity.

2. On the other side of the paper ask participants to draw or chart out areas in their community or neighbourhood in which people of different identities (including the ones they listed as responses to both questions above) may be stigmatised or discriminated against. For example, they may draw a local clinic where unmarried women (seen as not sexually active) face stigma and discrimination when they go for a routine gynaecological check-up. Give participants 10-15 minutes to map out their communities.

3. Ask participants to get into pairs and discuss each other's drawings for 10 minutes. Then open up the discussion to the larger group.

   Suggested Questions:

- What did you learn from this exercise? What common factors exist between the maps and identities?
- How do you think people who are discriminated against in these spaces feel? How do you feel in spaces you consider marginalising or stigmatising?
- Have you ever either intentionally or unintentionally treated someone differently because you saw them as different from yourself? How did they react? How do you think they felt?

Purpose of the exercise:

To identify and discuss places, locations and sites in people's lives where stigma and discrimination are experienced.

TIME

60 minutes

MATERIAL

Paper, pens

ADVANCE PREPARATION

None

THIS EXERCISE CAN BE MODIFIED BY:

- Having the participants map out their community together. This may be appropriate for groups from the same community or area.
- Asking participants to list out areas in which people face stigma and discrimination instead of having them draw a map. A discussion can follow the listing.

MAKING CONNECTIONS

- People with HIV/AIDS are especially vulnerable to stigma and discrimination in various locations in a community. For more see Chapter 4 in Module 2.
- People who experience violence or abuse may feel stigmatised by being wrongly blamed for the abuse. For more see Chapter 1 in this Module.

Key Messages

- Often the more 'different' a person is from the norms in society, the greater the discrimination and marginalisation they face. For example, migrants from North East India may face more discrimination in any other part of the country than their North Indian counterparts based on the superficial difference in their looks.
- People can experience stigma and discrimination in different places and situations, including while accessing health services or applying for a job, for example.
- Stereotyping of people is the first step to discrimination and marginalisation.
- Though they are connected, stigma, discrimination and marginalisation are different; a person can experience one without the other.

TIPS FOR THE FACILITATOR:

- Participants may use adjectives such as kind, friendly, or happy to identify themselves. Encourage them to use words and phrases related to other aspects of their identity, such as their gender, sexuality, caste/class, age or even nationality.
- Participants may find it difficult to map out their communities or may focus on the aesthetic appeal of their picture. Emphasise that there is no right or wrong way to construct this map and the important part of the exercise is to identify the sites of stigma in one's community.

Exercise 3
Acting Out Stigma and Discrimination

ROLE-PLAY

Instructions

1. Divide participants into small groups. Distribute one role-play scenario from Handout 4.7 to each group. Ask groups to develop a 5-minute role-play from their scenario. Give groups 20 minutes to do this.

2. Bring the groups back together and invite each to perform their role-plays. After each role-play, ask for questions or comments.

Suggested Questions:

- How was stigma and discrimination portrayed in the role-play? Do you think this kind of stigma is common? Have you experienced or observed this form of stigma and discrimination in your community?
- What are the effects of this kind of discrimination on those experiencing it, the community they live in, and services related to sexuality and sexual and reproductive health?
- How can you advocate to change attitudes that cause such stigmatisation?

3. After all the role-plays, ask for general questions and comments.

Suggested Questions:

- Were there any common forms of stigma and discrimination among the role-plays?
- Why was it important to do this exercise? What did you learn from it?

Purpose of the exercise:

To identify stigma in day-to-day situations and experiences.

TIME

60 minutes

MATERIAL

Handout 4.7 Acting Out Stigma and Discrimination

ADVANCE PREPARATION

Make copies of Handout 4.7

THIS EXERCISE CAN BE MODIFIED BY:

- Giving participants specific identities and asking them to perform everyday scenes like going to the market, visiting the doctor, getting admission in a school etc. using these identities. This can emphasise the stigma people face in daily experiences that participants may not recognise.

MAKING CONNECTIONS

- How sexual and gender identities are represented can reflect opinions and attitudes in a community or culture. For more see Chapter 2 in Module 1.
- Women and men who cannot have a child can also experience stigma and discrimination. For more see Chapter 3 in Module 2.

Key Messages

- While extreme forms of stigma and discrimination resulting in violence or abuse sometimes get public attention, day-to-day subtle discrimination and marginalisation can also have devastating effects. For example, if homosexuals are denied jobs because of their sexual identity, it can have a multiple impact: apart from diminishing their ability to be financially stable, it can cause low self-esteem and emotional distress.
- Often people may be discriminated against unintentionally. It is important to raise consciousness on how people can stigmatise and marginalise others in their daily actions and environments.
- Marginalisation often results in exclusion of those most in need of care, information and services. For example, by refusing to acknowledge that sexual activity is common among young people or between men, these groups are denied information and access to sexual health services which would help them stay safe and healthy.

TIPS FOR THE FACILITATOR:

- Look out for the underlying messages/opinions/attitudes being acted out by the participants during the role-plays. For example, are affirmative messages and attitudes presented or only messages of pity and disempowerment ? Point these out and stress that even when people are stigmatised or discriminated against they can still be strong and assertive.
- Participants may create stereotypical portrayals of characters in their role-plays, such as all gay men are weak and effeminate, or all single people want to get married. Emphasise that such labelling and stereotyping can lead to prejudice and discrimination, particularly when people begin to act according to such rigid characterisations.

Exercise 4
Stereotyping Identities

CASE STUDIES

Instructions

1. Divide participants into small groups. Give each group a case study from Handout 4.8. Ask participants to read their case study and answer the questions following it. Give them 25-30 minutes to discuss the case.

2. Bring participants back to the large group. Ask each small group to present a 3-5 minute summary of their discussion of the case. After each presentation, ask for questions and comments.

   Suggested Questions:

- Are the attitudes or stereotypes reflected in the case common in your community?
- What are the possible effects of this type of stereotyping? How would you advocate to change these attitudes?

3. When group presentations are over, ask for general comments and questions.

   Suggested Questions:

- How do these cases illustrate stereotypes in society of the roles that men and women are expected to play? Are they positive or negative?
- How do these stereotypes impact people in their day-to-day lives?
- How does this relate to human rights and sexuality?

Purpose of the exercise:

1. To discuss common stereotypes and reactions to these stereotypes.

2. To explore the origin of these stereotypes, how people and communities use them and their effects on individuals.

TIME

60 minutes

MATERIALS

Handout 4.8 Stereotyping Identities Case Studies

ADVANCE PREPARATION

Make copies of Handout 4.8

THIS EXERCISE CAN BE MODIFIED BY:

- Reading through and discussing some of the cases as a large group rather than breaking up into small groups. This may be useful to focus on specific issues and for in-depth discussions.

MAKING CONNECTIONS

- There are a range of sexual and gender identities. For more see Chapter 2 in Module 1.
- Ethical guidelines are useful to effectively address sexuality, sexual and reproductive health concerns, especially for marginalised people. For more see Chapter 2 in Module 5.

Key Messages

- Stereotypes of gender and sexual identities are commonly found and used by communities who do not understand the diversity of identities.
- Stereotypes can lead to prejudice, fear, shame, stigma and discrimination. They limit access to information and services to large groups of people by assuming that they do not deserve or require the information.
- Stereotypes and prejudice stem from lack of information about people who are considered different from oneself; some examples could include people with disabilities, those with different gender identities from one's own or those in the sex industry (sex workers, bar dancers and performers in peep shows, live sex shows, etc).
- In order to decrease stereotypes and allow people to live with respect and dignity, it is important to broaden knowledge and understanding of different identities and choices and be aware of the rights of all people.

TIPS FOR THE FACILITATOR:

- Participants may find some representations in the cases appropriate and believe they do not need be challenged or changed. For example, they may think sex work can never be a choice and should be given up for other forms of work. Emphasise choice in all identities, and explain that discussing sex work only in negative terms omits the role that power and choice can have in people's lives and in their decision-making.

Handout 4.6
Stigma and Identities

- **Heterosexual:** An individual who is sexually attracted to people of a gender other than their own and/or who identifies as being heterosexual.

- **Bisexual:** An individual who is sexually attracted to people of the same gender **and** to people of a gender other than their own, and/or an individual who identifies as being bisexual.

- **Homosexual:** An individual who is sexually attracted to people of the same gender as their own, and/or who identifies as being homosexual.

- **Asexual:** An individual who is not sexually attracted to other individuals.

- **Transgendered person:** An individual who does not identify with her/his assigned gender. Transgendered people may or may not identify as homosexual, bisexual or heterosexual. For example transgendered people can be men who dress, act or behave as women do, but do not necessarily identify as homosexuals.

- **Transsexual:** An individual who wants to change from the gender they are born as to another gender. Surgery, hormonal treatments, or other procedures can be used to make these changes. People in this group may or may not identify as homosexual, bisexual or heterosexual.

- **Intersexed person:** An individual born with some or all physical characteristics of both males and females. They may or may not identify as men or women.

- **Lesbian:** A woman who is sexually attracted to other women and/or identifies as a lesbian.

- **Gay:** A man who is sexually attracted to other men and/or identifies as gay. This term can also be used to describe any person (man or woman) who experiences sexual attraction to people of the same gender.

- **Queer:** Those who question the heterosexual framework of identity and relationships. This can include homosexuals, lesbians, gays, intersexed and transgendered people as well as heterosexuals. To some this term is offensive, while other groups and communities have adopted it as a statement of empowerment to assert that they are against a dominant heterosexual framework, and dissatisfied with the labels used to categorise people on the basis of sexuality.

- **Transvestite:** An individual who dresses in the clothing typically worn by people of another gender for sexual arousal and gratification. Often transvestites are men who dress in the clothing typically worn by women.

- **Female to male transsexual:** A person born as a woman who wants to change her gender to become a man. Surgery, hormonal treatments, or other procedures may be used to make these changes. This individual may or may not identify as homosexual, bisexual or heterosexual.

- **Male to female transsexual:** A person born as a man who wants to change his gender to become a woman. Surgery, hormonal treatments, or other procedures may be used to make these changes. This individual may or may not identify as homosexual, bisexual or heterosexual.

- **Married woman:** A woman who is in a committed relationship with another person that is legally recognised by the state/country she lives in.

- **Married man:** A man who is in a committed relationship with another person that is legally recognised by the state/country he lives in.

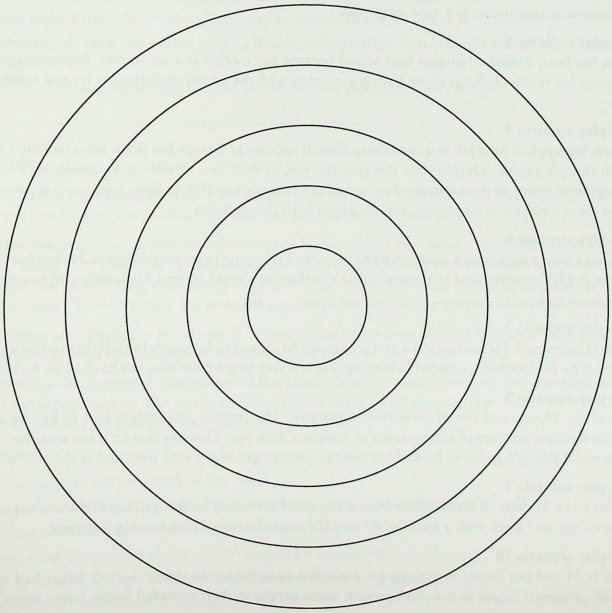
- **Unmarried woman:** A woman who is not in a committed relationship with another person, which is legally recognised by the state/country, she lives in.

- **Single person:** A person not married or in any committed relationship with another person.

- **Sexually active man:** A man who engages in sexual activities.

- **Sexually active woman:** A woman who engages in sexual activities.

- **Sex worker:** A person who negotiates and performs sexual services for remuneration. Some use this term to mean only prostitution, while others use the term to refer to those in the sex industry such as porn actors, bar girls, striptease dancers, performers in peep shows, live sex shows etc. This is not the social or psychological characteristic of a class of women, but an income-generating activity or form of employment for women, men and transgendered people.



Handout 4.7
Acting Out Stigma and Discrimination

Instruction for participants: highlight possible stigma and discrimination faced by characters in the scenario/s given to you.

Role-play scenario 1
Mr. and Mrs. Sharma decide to ask their tenants to leave well before their lease expires. This is because they have been hearing rumours that the two men are lovers.

Role-play scenario 2
Onima is a single parent with two children. She is employed by an NGO working on issues of domestic violence. One day she sees her children fighting with some other children. When she goes to stop them she hears the reason for the fight: one of the neighbour's children was calling her a slut and immoral. The child said he had heard his parents say this about her, because she is single and has children.

Role-play scenario 3
Tanya is well qualified for the job she has applied for at an agency and initial email and telephone communication between them has been positive. After two rounds of face-to-face interviews and many attempts to follow up, however, she has not got an affirmative response from them. Finally she is called for a meeting with the manager who seems uncomfortable. Tanya is told that they need a 'womanly' woman for the job, not a woman who behaves and dresses like a man. The organisation is very traditional and cannot accommodate her 'type' of person.

Role-play scenario 4
Meeta has been denied admission into school because her mother is a sex worker. Representatives of the group her mother belongs to are having a meeting with the school authorities to try and resolve the issue.

Role-play scenario 5
Jaishree has applied for a job in a consulting firm. It appears as though her skills, however, don't really match the job profile. Despite this she gets the job, as well as a flexible time option because the management wants to demonstrate their sensitivity towards her HIV positive status and support her. At the same time, some employees are not happy with this decision.

Role-play scenario 6
Joseph is a single man from a medium sized town, and is hoping to get married soon. He has found out that he is HIV positive and is unsure about whether he should inform his family and community about his status.

Role-play scenario 7
Aslam is intersexed. He had joined a group of eunuchs (*hijras*) in his youth but left them a few months ago since he did not feel a sense of belonging. He is trying to get a job now but has had no luck so far.

Role-play scenario 8
Amir is the 16-year-old son of conservative parents. His parents are sending him to live for a few months with his relatives in nearby town to 'toughen' him up. They say that he is too sensitive - cries when awful things happen to him, if his sister or parents get angry with him, and is shy and 'weak'.

Role-play scenario 9
Sundar has a Masters in Social Work from a respected university in the country. He wants to go back to his village and work with a local NGO on HIV related issues. He is hearing impaired.

Role-play scenario 10
Sasha is 24 and her family is looking for a suitable man for her to marry. Sasha's father had a brief episode of mental illness in his youth, which some people in their extended family know about.

Handout 4.8
Stereotyping Identities Case Studies

Case Study 1

Rajeev is a sixteen-year-old boy living in a large city. He goes to school, spends time with his friends, and loves spending time at home with his family. Rajeev likes to take care of himself. He is well dressed and makes sure his nails are clean and filed and his hair is well groomed. He waxes his arms and chest (even though he has barely any hair yet), and likes using his sister's moisturizers and creams. His family thinks it is funny that he spends more time grooming himself than his sister, and teases him about his 'effeminate' ways, sometimes telling him that if he doesn't change he will never get married. Rajeev also gets teased at school for the way he looks and behaves. There are three boys who especially pick on him, call him names and sometimes throw paper or garbage at him. They say that he is gay, a girl, and shouldn't be allowed in school.

Rajeev reacts strongly to the teasing sometimes, but does not want to change the way he acts or dresses. But he feels if he doesn't, he will always have to deal with this kind of ridicule and abuse.

Questions:

- Does Rajeev's behaviour mean he is gay?
- How did the stereotypes displayed by his family and school mates get created?
- Do you think Rajeev should change the way he dresses or acts in school or at home?
- What impact do these stereotypes have on Rajeev's relationships with is family/friends and in society in general?
- How can these stereotypes (gender and sexual identity stereotypes) be changed?

Case Study 2

Soni has chosen a life partner in Ali. They studied together at the University and have been going out since their first year of post graduation. Now they have decided to marry.

Soni is the daughter of a prominent, well-respected Hindu family. She has a sister, brother and a large extended family. The girls of her family are said to be as dutiful as they are beautiful and the boys are considered 'real men': strong, courageous and highly regarded in their businesses as honest and upright. Ali comes from a Muslim family, not as wealthy as Soni's but very well-respected in their home-town.

Soni's parents are unhappy at her choice of husband. Her father even tells her that once she returns to her family, away from her college, she will change her mind.

Ali's mother is also distressed. She has heard that Soni's family is class-conscious, and knows them to be loud and argumentative. The family tries to convince Ali to forget the marriage, but so far it has not worked and Ali has not changed his mind.

Questions:

- What stereotypes are presented in this case?
- How do the stereotypes displayed by the families of caste/race/religion get created?
- Who and what create these stereotypes/representations?
- Do you think the parents have a good reason to be concerned?
- How do these stereotypes affect relationships and society in general?
- How can these stereotypes be changed?

Case Study 3

Neetu is a mother of two (a daughter and son) and a sex worker. She has been in sex work for the past ten years and finds it a good way to earn money for her children and maintain her independence. There are other women she trusts and loves in the brothel she works in, and her *Madam* treats her children and her well.

Over the past year, Neetu has begun to take her children to school in the mornings before going back home to rest for the evening. One day she goes to drop off her children and another parent approaches her and offers to rescue her children and her from the 'horrible life they are living'. Neetu is confused: she has never spoken to this parent before and has no idea who she is, or why she thinks Neetu needs rescuing. The parent explains that her son told them what Neetu does, and says that she has seen reports on the news and in magazines about the hard and horrible life of sex workers. She wants to help change this. The parent offers Neetu a job in her family's business.

Neetu thanks the parent for the offer, and tells her she is content with her work. Leaving it would mean many other problems for her children and her. At present she wants to stay where she is. The parent is shocked and yells at Neetu, calling her names like *slut*, *whore*, and an irresponsible parent. She vows to rescue Neetu 's children from this situation, and tells Neetu to be prepared for this.

Questions:

- What stereotypes are presented in this case?
- What factors contribute to the creation of these representations/stereotypes acted out by the other parent?
- Who do you think is right in this case? Neetu or the parent?
- What effects do these representations have on the society in general?
- How can these stereotypes be changed?

Chapter 3
Disability and Sexuality

Chapter Objectives for the Facilitator

1. To familiarise participants with the meaning of disability.
2. To encourage discussion about sexuality of disabled people, and what contributes to stigma and discrimination.
3. To familiarise participants with barriers faced by people with disabilities that prevent them from exercising their sexual and reproductive rights.

Why a Chapter on Disability and Sexuality

'While most parents feel proud when their daughters reach this milestone, I felt terrified when my daughter got her period. Since she's mentally retarded, it means she has to learn to do one more thing – care for herself when she has her period. It also means she can get pregnant. But I'll worry about that later – now she's so proud that she can manage mostly without my help. I wish that was all she had to learn about taking care of herself in this world!'

This quote reflects the experience of many parents and care-providers of disabled people. Parents and other care-providers are often anxious about coping with the sexuality of adolescents with disabilities. Some believe that providing information on the body/sexuality to their growing children will complicate rather than enhance their lives. To avoid what they see as the 'inevitable disappointment' associated with unfulfilled desires, care-providers consciously ignore signs of sexuality in their wards. This leads to the de-sexualisation of disabled people. Many parents also feel that their children – especially their daughters – are more vulnerable to sexual abuse, and take extra precautions to protect them.

Sexuality is often misunderstood as having to do only with sexual intercourse. While this is a part of sexuality, it often may not be the most compelling/important factor. Sexuality extends beyond the physical sensations of our bodies. It is also a reflection of how people feel about themselves and how they want to express themselves with others. Still, these aspects of sexuality are often neglected in the context of disabled people (who are labelled either 'asexual' or 'over-sexed'), thus overlooking their sexual and reproductive concerns and rights.

Thus, disabled people are often denied sexuality education and their sexual concerns are deemed inappropriate/ignored. Women with disabilities generally have fewer opportunities to explore their sexuality. Structural barriers include lack of facilities to ease mobility for wheelchair users, lack of familiarity with sign language by hospital/clinic staff or a lack of sexuality education material in Braille, and so on.

This chapter outlines some of the issues that people with disabilities face around their sexuality. The focus is on the rights of people with disabilities to express their sexuality, access information and exercise choices for their sexual well-being. It emphasises that all humans are sexual beings, regardless of whether they are sexually active or not, have a disability or not, are young or old.

EXERCISES IN THIS CHAPTER

Exercise 1: Reflecting on Disabilities. 30 minutes

Exercise 2: Debating Sexuality and Disabilities. 60 minutes

Exercise 3: My Views on Sexuality and Disabilities. 60 minutes

Exercise 4: Including People With Disabilities. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pen/pencils
Paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

Handout 4.9
Basic Information on Disability and Sexuality

Handout 4.10
Reflecting on Disabilities

Handout 4.11
Debating Sexuality and Disabilities

Handout 4.12
My Views on Disability and Sexuality and Reproductive Rights

Handout 4.13
Integrating Disability Related Concerns in Our Work

ADDITIONAL RESOURCES:

- Disability Resource Network. http://www.drnbc.org/
- Disability World. Webzine. Available at: http://www.disabilityworld.org/Aug-Sept2000/Women/MIUSA.htm
- J. Morris. ed.1996. *Encounters with Strangers: Feminism and Disability.* London: The Women's Press.
- Nelson, J. 1996. The Invisible Cultural Group: Images of Disability. In P. Lester (Ed.), *Images That Injure: Pictorial Stereotypes in the Media.* (pp. 119 - 125). Westport, CT: Praeger.
- World Health Organization. 2002. *Towards a Common Language for Functioning, Disability, and Health.* Available at: http://www3.who.int/icf/beginners/bg.pdf
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key Messages for this Chapter

- People with disabilities do not form a homogeneous group. For example, those with visual, hearing or speech impairments, intellectual disabilities, autism, restricted mobility or so-called 'medical disabilities' all encounter barriers of different kinds. Different disabilities also have varying implications with respect to sexuality.
- Words like *impairment*, *handicap*, and *disability* have different connotations. The term *impairment* implies a physical limitation. Visual impairment, for instance, means that a person's eyesight falls below the determined standard. *Disability*, on the other hand, refers to the social impact on a person with any physical/mental impairment. This includes stigma, discrimination, pity, or non-inclusion. Disability imposes a barrier to accessing spaces and services available to others. The term *handicap* has a negative connotation by focusing on what a person is 'lacking', as opposed to the obstacles they encounter in a disabled-unfriendly society.
- Sexuality is often associated with youth and physical fitness. The social definition of sexuality is narrow, and children, older people and those with mental disabilities are typically viewed as asexual beings. Sexual desirability is also linked to physical appearance. This can affect the way people with disabilities perceive their bodies and sexuality.
- While disabled people are often considered asexual, certain groups such as the intellectually disabled are regarded as 'oversexed'. One reason for this may be that some people with intellectual disabilities are unable to recognise and practice 'socially appropriate' behaviour.
- To protect children with disabilities, parents may de-sexualise them. Girls and women with disabilities have fewer opportunities to explore their sexuality.
- Disabled people can experience stigma and discrimination at multiple levels. For example, disabled people may face additional stigma on account of their sexuality (if they are homosexual, bisexual, intersexed, transgendered), or HIV status.
- While it is important to highlight the additional disadvantage women with disabilities face, this should be done in a manner that affirms their right to speak for themselves. Otherwise there is a risk of disempowering them even more.
- Disabled people have the right to information and services related to sexuality, sexual and reproductive health. Involving them in the planning and implementation of these services will ensure better quality, effectiveness and appropriateness.

Exercise 1
What if...

SELF-REFLECTION

ADAPTED FROM PRICE J. 2002. SEXUALITY, DISABILITY AND RIGHTS. TEACHING NOTES FOR SEXUALITY AND RIGHTS INSTITUTE (TARSHI-CREA). ADAPTED FROM GALLER. R. 1984. THE MYTH OF THE PERFECT BODY. IN C. VANCE (ED.) *PLEASURE AND DANGER: EXPLORING FEMALE SEXUALITY*. LONDON, PANDORA PRESS.

Instructions

1. Distribute Handout 4.10 to participants and give them 15 minutes to reflect and write down their responses.

2. After 15 minutes, ask participants for their responses to the questions and summarise them on a flipchart. Reassure participants that they may share their responses only if they feel comfortable doing so.

3. After going through all the questions, ask participants for reactions to the exercise.

Suggested Questions:

- How did you feel when you did this exercise? What was difficult to discuss and why?
- What issues came to mind for the first time? How did these make you feel?
- Do you think these issues are relevant to your community or culture?
- Why was it important to do this exercise?

Key Messages

- This exercise is meant to help participants consider how they would experience their sexuality if they had a disability. However, an exercise of this sort can in no way capture the actual experience of a person with a disability.
- Different types of disabilities affect people differently depending on their personal experiences, values, and support from family, friends and society etc.
- People with disabilities are sexual beings and should be recognised as such. They have an equal right to information on sexuality and freedom from abuse, infection and unwanted pregnancies as those without a disability.

Purpose of the exercise:

1. To explore issues affecting people with disabilities.

2. To be comfortable around discussing sexuality of disabled people.

TIME

45 minutes

MATERIALS

Handout 4.10 Reflecting on Disabilities, paper and pens

ADVANCE PREPARATION

Review Handout 4.9; Make copies of Handout 4.10 for participants

- Social and cultural restrictions around sexuality are greater for people with disabilities. For example, parents and care-providers of disabled people often disregard their concerns around sexuality. Where family honour is evaluated through a woman's sexuality, parents feel increased pressure to secure a future for their daughters with disabilities. Paradoxically, this extra pressure leads parents to believing it is 'better' or 'easier' to have girl children with disabilities, as controlling a boy's sexuality is considered more difficult.
- Anyone can acquire a disability in the course of their life (for example, through an accident or illness). This may or may not change their experiences and desires regarding sexuality.

THIS EXERCISE CAN BE MODIFIED BY:

- Turning the questions around and asking participants to reflect on their reactions to encountering a person with a disability at a party, wedding, in bed with another person, in a movie theatre or gynaecologist's office. Participants can then be asked to consider why disabled people are not seen in public spaces and what societal barriers prevent them from accessing such spaces and services. See handout 4.8 for more.

MAKING CONNECTIONS

- People with disabilities face stigma and discrimination, especially in the context of their sexual and reproductive lives. For more see Chapter 2 in this Module.
- Sexuality is an individual experience for each person – younger or older, with a disability or not. For more on understanding sexuality see Chapter 1 in Module 1.

TIPS FOR THE FACILITATOR:

- Help participants appreciate the barriers faced by disabled people in their daily lives and see how these are related to society's prejudice and indifference.
- Pay attention to the words being brought up by the participants during the exercise. Do they reflect pity and sympathy (e.g. *'suffering* from a disability' or *'confined* to a wheelchair') rather than a respectful recognition of the rights of disabled people? Do not encourage feelings of pity towards people with disabilities.
- Be prepared to deal with discomfort of some participants, which may manifest as inappropriate humour, silence or outbursts of anger. Remind the group that the purpose of the exercise is to build awareness of the possible experiences of disabled people and their impact on their sexuality and sexual and reproductive health.
- Participants may not be forthcoming in their answers with a group. Reassure participants that they do not need to share anything that they are uncomfortable about. This exercise is intended to help participants establish comfort with disability and sexuality.
- Note if the group is focusing on only one particular kind of disability. If so, shift the discussion to other disabilities. Observe if there is more discomfort in discussing the sexuality of people with certain disabilities.
- Make sure to refocus the conversation if participant focus is only on disabilities in general rather than disabilities and sexuality.
- Address the issue of body image and how this affects people with disabilities. This could be linked to topics like the emotional and physical adjustments people would have to make if they had an arm or leg amputated due to an accident/gangrene or a breast removed due to cancer.
- Use visual images or films that focus on people with disabilities and sexuality to increase comfort, stimulate conversations and increase understanding. See Appendix B for a list of films.

Exercise 2
Debating Sexuality and Disability

ROLE-PLAY AND DEBATE

PURPOSE OF THE EXERCISE:

To understand and discuss issues surrounding disability and sexuality.

TIME

90 minutes

MATERIALS

Handout 4.11 Debating Sexuality and Disabilities

ADVANCE PREPARATION

Make copies of Handout 4.11

INSTRUCTIONS

1. Divide participants into five groups. Each group represents one of the roles/stakeholders provided in Handout 4.11. Distribute the description of one role to each of the groups. Ask the groups to create a strategy that will uphold the position of their stakeholder group and get the desired outcome indicated in the handout. Give them 15 minutes to create their strategies.

2. Ask one representative from each stakeholder group to come up to the 'negotiating table' to debate the issue. **At the end of the debate, the case must be resolved, and a final decision must be made.** Allow 20 minutes for debate and negotiation. After the first round, invite another set of representatives from each group to come up and carry out the same exercise. Each participant should have the opportunity to come up to the negotiating table to debate.

3. After all the debates ask for comments and questions.

Suggested questions:

- How did you feel when you did this exercise? What did you find difficult to discuss and why?
- Do you think the kind of disability a person has is relevant to their rights? For example, does a person with an intellectual disability have the same rights as a person with a physical disability?
- Do you think these issues are relevant to your communities/ cultures? Why was it important to do this exercise?

KEY MESSAGES

- The implications for people with different disabilities differ according to factors such as gender, class, location (urban/rural) and support systems. These also determine how two people with the same disability navigate their lives in mainstream society.
- People with disabilities should also be recognised as sexual beings. They have rights to information and safety from abuse,

infection and unwanted pregnancies. To realize these, they must be given age/stage appropriate information on sexuality.

- Disabled people have to be taught skills to protect themselves from unwanted sexual advances as well as communicate to their care-providers if they are being abused.
- Masturbation is a safe way of pleasuring oneself and should not be discouraged because a person is disabled. People with intellectual disabilities may require repeated instruction about when, where (and maybe even how) they can masturbate. People with a visual impairment may need to learn how to stay aware of surroundings while masturbating so as to ensure their privacy.
- Disabled people can also be attracted to people of the same or another gender. Those who are homosexual/bisexual/intersexed/ transgendered may face double discrimination.
- Involving people with disabilities in the planning and implementation of sexuality and sexual and reproductive health services ensures that they are more effective and useful for them.

THIS EXERCISE CAN BE MODIFIED BY:

- Having only one representative from each designated stakeholder group take part in the role-play. This may be more appropriate for larger groups where time is limited, and to have a more in-depth discussion afterwards.
- Debating both scenarios given in Handout 4.10. This may take more time, but will allow participants to be exposed to different issues related to sexuality of disabled people.

MAKING CONNECTIONS

- Sexuality education for people with disabilities often omits information on anatomy and physiology, contraception or protection against STIs, HIV/AIDS, among other issues. Module 2 has information on these topics.
- All people have the right to sexual well-being and the pursuit of sexual pleasure, irrespective of age, gender and whether they have a disability or not. For more see Chapter 3 in Module 3 and Chapter 4 in Module 1.

TIPS FOR THE FACILITATOR:

- Make sure that participants stick to their assigned roles and arguments whether they agree with them or not. The objective is to help them appreciate the many facets of an issue, the different resolutions and debates that can emerge during discussion, and the advantages of being aware of options. Emphasise the importance of listening to different views rather than censoring dissenting voices.
- Be prepared to deal with discomfort of participants, which may manifest as inappropriate humour, silence or outbursts of anger. Remind the group that the purpose of the exercise is to increase awareness of sexual and reproductive health concerns of disabled people and to improve the effectiveness of work in this area.
- Debate 2 is complicated and may bring up previously unexplored issues. It is more suitable for use by an experienced facilitator, equipped to tackle the issues.
- Note if the words being used during the exercise reflect values that convey pity for disabled people (for example '*confined* to wheelchair', '*victim* of circumstance') as opposed to empathy and recognition of their sexual and reproductive rights (for example, 'rights of wheelchair users to access abortion clinics').
- Avoid focusing on a particular kind of disability. Introduce discussion about other kinds of disabilities and observe if there is more discomfort in discussing the sexuality of people with certain disabilities.
- Address issues of body image and how this affects the sexuality of disabled people. Link this to feelings and adjustments that people may have to make if they their arm or leg were amputated due to an accident or a breast removed due to cancer.

Exercise 3
My Views on Sexuality and Disabilities

POLARISATION EXERCISE

Instructions

1. Give instructions for the exercise: Designate one side of the room as the *Agree* side and the other as the *Disagree* side. You will read out a statement and participants must move to one or the other side of the room depending on whether they agree or disagree with the statement. Those who are undecided should move to a third designated spot in the room (the *Don't Know* group).

2. Now, invite them to share why they have chosen to be on their side of the room.

   Suggested Questions:

- Why do you agree or disagree?
- Do you think you would change your opinion if the statement did not concern a person with a disability? How? Why?

3. Continue the discussion until the topic has been sufficiently discussed and analysed, but do not spend more than 15-20 minutes on a statement or participants may lose interest.

4. After discussing three different statements ask for general comments or questions.

   Suggested Questions:

- Based on these discussions, what are your opinions and thoughts about disability, sexuality and sexual and reproductive rights?
- Have you thought about these issues before? If yes, have your views changed? How?

Purpose of the exercise:

To understand that people with disabilities have the same sexual and reproductive rights as those without disabilities.

TIME

60 minutes

MATERIALS

Handout 4.12 My Views on Disability and Sexuality and Reproductive Rights

ADVANCE PREPARATION

1) Clear the room of furniture to make space for participants to move around. 2) Select three statements from Handout 4.12. 3) Read through key messages so as to be prepared to lead a discussion on the selected topics.

Key Messages

- People with disabilities have sexual desires and concerns. These concerns must be acknowledged and addressed.
- While some disabilities are more severe and may interfere with expression of sexuality, many disabled people can and do live full and meaningful sexual and reproductive lives. They have the right to do so, and it is society's responsibility to ensure that barriers to claiming these rights are removed.
- While people with physical disabilities (visual or hearing impairment, or the loss of /inability to use limbs) may require assistance in performing their routine daily tasks, most are capable of making independent decisions. These include the decision to be sexually active, choice of sexual partner (whether that be a person of the same or another gender), and whether or not to marry or have children.
- Those with severe intellectual disabilities may be able to perform their daily tasks, but may be unable to participate in any communication/ decision-making. Their desires must be taken into consideration as much as possible if a care-provider/parent is making decisions on their behalf.

THIS EXERCISE CAN BE MODIFIED BY:

- Having participants discuss different statements in small groups before sharing with the larger group. This allows for a range of issues to be discussed and can help quieter participants share their ideas more comfortably in the small groups.
- Eliminating the *Do Not Know* option in the exercise, and insisting that participants decide to agree or disagree with the statements. Though difficult at times, it encourages participants to clarify their own views and discuss the positive and negative aspects of each issue.

MAKING CONNECTIONS

- All people have the right to sexual well-being irrespective of age, gender and whether they have a disability. For more see Chapter 3 in Module 3.
- People with disabilities also have reproductive health concerns and reproductive rights. For more see Chapter 2 in Module 3.

TIPS FOR THE FACILITATOR:

- Note language that reflects views that disabled people are incapable of making their own decisions such as 'How can we *allow* a person with a disability to get married?' Challenge these ideas with examples. For instance, ask participants to consider people with specific disabilities of varying degrees (those with hearing impairment, both hearing and visual impairment, loss of a limb, unable to use one's legs, paralysed waist down etc.) and whether this changes their opinions.
- In addition to the facilitator, participants may also challenge one another about whether they would marry or be sexually involved with a person with a disability. The facilitator should emphasise respect for all ideas and opinions as laid out in the Ground Rules found in *Preparing to Train*.
- Many ideas and topics unrelated to the statement or exercise may come up during discussions. The facilitator may want to note any that require more discussion on a flipchart and allot time to address these (such as in the Parking Lot) later.

Exercise 4
Including People With Disabilities

ROLE-PLAYS

Instructions

1. Divide the group into three groups. Assign each group one scenario from Handout 4.13 and ask them to use the scenario and associated questions to create a role-play. Give groups 20 minutes for this.

2. Invite each group to present their role-play. After each role-play ask for comments and reactions.

Suggested Questions:

- What did you think of this role-play and how the groups dealt with the issue?
- How did the group resolve the issue? Would you have resolved it differently?
- Have you encountered similar situations in your work place? If yes, what did you do?

3. After all the role-plays, ask for general question or comments. Note some of these responses on a flipchart.

Suggested Questions:

- How realistic do you think it is to incorporate concerns of people with disabilities in your own work?
- Do you have any disabled people working with you? If not, why? (Some examples: because you did not think of it; there is no one with a disability in the community; your place of work is not equipped for disabled people and is inaccessible to them; the work requires a lot travel and so you need 'able-bodied' people only, etc.)
- If you have people with disabilities in your work place, did you have to make any adjustments to accommodate them? What were these?
- Who will you have to convince in your work place and community before you can create programmes specifically for people with disabilities? Who are your allies in this? What barriers would you encounter?

Purpose of the exercise:

1. To discuss the barriers faced by people with disabilities to access sexuality and reproductive health related information and services.

2. To examine how disabled people can be included in work related to sexuality, sexual and reproductive health and rights.

TIME

60 minutes

MATERIALS

Handout 4.13 Integrating Disability Related Concerns In Our Work

ADVANCE PREPARATION:

Go through the questions in Handout 4.13 and make a note of discussion points beforehand. Think of examples from work contexts that participants come from that can be used in the discussion.

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into groups and asking them to brainstorm and discuss the suggested questions above. They can then focus on their own work and how to integrate information and services for people with disabilities. This may be more appropriate for groups trying to build up services for people with disabilities.

MAKING CONNECTIONS

- Representing people with disabilities in advocacy campaigns in a balanced and respectful way is important. For more see Chapter 3 in Module 5.
- The experiences of people with disabilities and the barriers they face may change through their life. For more see Chapter 3 in Module 1.

Key Messages

- People with disabilities are often excluded from policies or services. Examine why the rights of disabled people to sexual and reproductive health information and services have been overlooked.
- Some ways of including issues related to disability are simple, cost effective and do not require policy level changes. For example, advocacy and awareness materials could include some information specific to people with disabilities or how people with disabilities can access services. These materials could be provided in a more accessible format, for example, large print, Braille, audio tape, pictures etc.
- It is important to train all staff on the rights of disabled people to equality and accessible information and services. For example, if a woman with visual impairment comes to a clinic for a gynaecological check-up, all staff, from the receptionist to the doctors, must communicate decisions that are being made including telling the woman what they are doing, where they are taking her, who will be in the room during the procedure, and any other information that sighted people take for granted.
- Do not make assumptions about the sexual concerns of people with disabilities. For example, disabled people can be attracted to people of the same or another gender. Similarly, it is not essential that they be married to be sexually active.
- Barriers faced by people with different disabilities vary and even two people with the same type of disability will have differing concerns. Do not generalise or put all people with disabilities into one homogenous category.
- Not all disabilities are visible (for example a hearing impairment) and this must be kept in mind, along with an awareness of the kinds of assistance differently disabled people may require.

TIPS FOR THE FACILITATOR:

- Encourage participants to come up with examples from their work and environment that would include people with many types of disabilities.
- Help participants examine barriers to the provision of sexual and reproductive health services for disabled people that may have been inadvertently created by them. For example, the location of a clinic on a top floor with no elevator/ramp would limit access for wheelchair users.
- Encourage participants to begin the exercise by expressing their fears and doubts, and then assist them to look for ways to overcome real and perceived obstacles. Many barriers to incorporating the issues of disabled people in the work place are fear-related and are about not knowing enough about the issue, or wanting to avoid harming anyone.

Handout 4.9
Basic Information on Disability and Sexuality

People with disabilities do not form a homogeneous group, nor do they have the same experiences. For example, those with visual, hearing or speech impairments, intellectual disabilities, autism, restricted mobility or so-called 'medical disabilities' all encounter different obstacles, to be overcome differently.

The definitions of different forms of disability vary. For the purposes of this manual, we have kept to simple and general definitions. For further clarity, facilitators may want to examine common definitions in legal and state documents in their country/region.

Hearing Impairment refers to the full or partial loss of the ability to detect sounds. This can range from a mild loss to complete deafness. The term 'hearing impairment' is preferred to the word 'deafness' because it includes different degrees of hearing loss.

Orthopedic Impairment is when individuals lack or lose the capacity to move themselves and/or objects from one place to another.

Mental Impairment (also known as Mental Handicap or Mental Retardation) is a pattern of slow acquisition of basic motor and language skills during childhood, and a significantly below-normal intellectual capacity as an adult. It ranges from mild to severe. One common test of mental impairment is an intelligence quotient (IQ) below 70. The preferred term for 'mental impairment' is 'intellectual disability'.

Mental Illness is different from a mental disability. It results in a disruption in a person's thoughts, feelings, moods, and ability to relate to others. As opposed to intellectual disability, mental illness is generally curable or treatable and the affected person can function independently in society.

Speech Impairment ranges from poor articulation such as slurring/stuttering, to a complete inability to speak.

Visual Impairment means that a person's eyesight falls below a determined standard for sight and can range from partial to complete loss of vision.

Multiple Disabilities is a term that refers to more than a single disability in a person. An example of this is a person with *Cerebral Palsy* (the result of brain damage prior to or shortly after birth), who faces difficulties of coordination, movement, posture, speech and/or impairment of mental functioning.

There are a number of different kinds of disabilities and degrees of impairment that people may experience (for example, Down's Syndrome, Autism, Dyslexia, problems due to Motor Neuron Disease, Multiple Sclerosis or Spinal Cord injuries, to name a few). Describing all of them is beyond the scope of this handout.

Words like *impairment*, *handicap*, and *disability* have different connotations. The term *impairment* implies a physical limitation imposed on a person's life. For example, visual impairment means that a person's eyesight falls below the determined standard. The term handicap connotes a deficiency and evokes feelings of pity. This is in conflict with a rights-based approach, which advocates that people with disabilities be treated with respect and dignity, not pity. *Disability*, on the other hand, refers to the social impact that a person faces due to any physical/mental impairment. This includes stigma and discrimination, pity or non-inclusion, and barriers to accessing the spaces and services available to others.

Like gender and sexuality, disability is also socially constructed. This means that the social and cultural environment disables people more than their impairment. For example, hearing impaired people are 'disabled' because others in 'mainstream' society do not know sign language and cannot communicate with them. Most of society does not consider the need to learn sign language, reflecting the barrier of indifference faced by a hearing impaired person and disabled people in general. This attitude prevents them from claiming their rights.

Such attitudinal barriers also include a tendency to consider disabled people asexual and childlike. This denies their right to privacy and bodily integrity, and prevents them from accessing information and sexual and reproductive health services. By infantilising people with disabilities they are excluded from decision-making processes and from being involved in planning and implementing programmes meant for them. Conversely stereotyping all disabled people as 'perverted' or 'oversexed' perpetuates the belief that they need to be controlled and protected.

A rights-based approach to sexual and reproductive health advocates for the recognition of each individual as unique, with unique requirements and desires. It also calls for access to sexual and reproductive health services to all people regardless of their dis/ability status and for people with disabilities to be consulted in matters affecting their sexual and reproductive lives.

Handout 4.10
Reflecting on Disabilities

ADAPTED FROM PRICE J. 2002. SEXUALITY, DISABILITY AND RIGHTS. TEACHING NOTES FOR SEXUALITY AND RIGHTS INSTITUTE (TARSHI-CREA). ADAPTED FROM GALLER. R. 1984. THE MYTH OF THE PERFECT BODY. IN VANCE. C (ED.) *PLEASURE AND DANGER: EXPLORING FEMALE SEXUALITY*. LONDON, PANDORA PRESS.

Take 15 minutes to reflect and write down responses to the following questions:

1. Do you know anyone with a disability? How did you feel when you first met them? How would you feel if you were in their place?

2. Close your eyes and imagine you have a disability. How do you see yourself going about your daily activities with the disability? How would you feel when:
   a. You attend a party?
   b. You attend a wedding?
   c. You enter a room full of strangers?
   d. You were being intimate with your partner? How would you feel about your body with the disability? How would it affect your sexual life?

3. Would you find it easier if you were born with a disability, or if you acquired one later in life due to an accident/infection/cancer surgery, etc.? Why?

4. How would being a homosexual/bisexual/intersexed/transgendered person with a disability impact your life?

Handout 4.11
Debating Sexuality and Disabilities

Debate 1: Sexuality Education for Students With Disabilities

Parent 1 of a Student with a Disability

You are the parent of a child with a disability who attends a school for people with disabilities in your community. It is the beginning of a new school year and an announcement is made at the school that students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was not a part of the previous curriculum. According to the school administration, this will provide a more comprehensive education for the students.

You think your child should not receive this sort of education, because children with disabilities are not sexual and do not need sexuality education. You feel it will give children ideas they did not have before. In addition, you feel it is your job to teach your child about sexuality, not that of the school. With the school curriculum you will have no control over what your child learns about sexuality and it could promote ideas that you do not agree with. You fear that this education could also lead people to abuse your child and you want to protect your child from this kind of abuse. You decide to create a group of concerned parents and make sure that the new curriculum does not get taught.

As a concerned parent you are committed to the values and beliefs that are described above. You are scheduled to have a meeting with a teacher, a parent who support the curriculum, a disability rights organisation, and a school administrator.

Discuss and derive strategies for resolution of the case. Other groups may disagree with your point of view and position. Your strategy should be formulated keeping the following considerations in mind:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position, consider other options, and agree to others' viewpoints?

Parent 2 of a Student with a Disability

You are the parent of a child with a disability who attends a school for people with disabilities in your community. It is the beginning of a new school year and an announcement is made that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was not a part of the previous curriculum. According to the school administration, this will provide a more comprehensive education for the students.

You are very happy with this change in curriculum and eager for your child to receive sexuality education. You hope that the course includes information on how children can protect themselves from infections, as well as what being a sexual person is about, even with a disability. You think that your child and the others in the school have a right to this education and should not be 'protected' from sexuality because of a disability.

As a parent who supports this curriculum you are committed to the values and beliefs described above. You are scheduled to have a meeting with a teacher, a parent concerned over the curriculum, a disability rights organisation, and a school administrator.

Discuss and derive strategies for resolution of the case. Other groups may disagree with your point of view and protest against your position. Your strategy should be formulated after considering following points:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Is your position negotiable; will you consider other options; and are you ready to agree to other's view- points?

Teacher

You are a teacher in a school for people with disabilities in your community. It is the beginning of a new school year and an announcement is made that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was excluded from the previous curriculum. According to the school administration, this will provide a more comprehensive education for the students.

As a teacher in this school you are not very comfortable with this new curriculum. You think it will make many of the parents uncomfortable and also force you to address issues and ideas with your students that you are not entirely at ease discussing. You think it is more important to focus on education that will assist students to live more independently and you are not sure that sexuality education is really part of that, especially for students between the ages of 10-14. However, you do admit that some of your students are smart and have expressed interest in this type of information, but are not sure they should receive it.

As a teacher in this school you are loyal to your group and committed to the values and beliefs described above. You are scheduled to have a meeting with a parent opposed to the curriculum, a parent who supports the curriculum, a disability rights organisation, and a school administrator.

Discuss and derive strategies for resolution of the case. Other groups may not agree with your point of view and protest against your position. Your strategy should be formulated after considering the following points:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Will you negotiate on your position at all? Will you consider other options, and will you agree to other's view- points?

Disability Rights Organisation

It is the beginning of a new school year and an announcement is made at a school for people with disabilities in your community that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education, absent in the previous curriculum. According to the school administration, this will provide a more comprehensive education for the students.

Your organisation is thrilled that this new curriculum is being introduced. You have provided your input and consulted with the school administrators interested in introducing this to the students. You think the curriculum will open up discussions on sexuality in schools for people with disabilities and hopefully even initiate a broadened perspective in the community. You think this will also ensure the right of choice and practice of sexuality among people, including those with disabilities. You know that people with disabilities are often perceived as non-sexual, and are protected and prevented from being sexually active. Your organisation believes that people with disabilities have a right as others do, to information and protection against abuse, infection and unwanted pregnancies. You are therefore committed to supporting and ensuring the use of this curriculum.

As a disabilities rights organisation you are loyal to your group and are committed to the values and beliefs described above. You are scheduled to have a meeting with a parent opposed to the curriculum, a parent who supports the curriculum, a teacher in the school, and a school administrator.

Discuss and derive strategies for resolution of the case. Other groups may not agree with your point of view and protest against your position. Your strategy should be formulated keeping the following considerations in mind.

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Will you negotiate on your position at all? Will you consider other options, and will you agree to other view-points?

School Administrator

You are a school administrator for a school for people with disabilities. It is the beginning of a new school year and an announcement is made that the students will be taught a new health/life skills curriculum. The new curriculum includes education on sexuality that was excluded from the previous curriculum. According to the school administration, this will provide a more comprehensive education for the students.

As the school administrator you were initially nervous about the new curriculum, but after discussing it with others you have decided this will be important and beneficial for the students. You have worked hard to make sure the curriculum touches on key messages and information relevant to people with disabilities and are sensitive to the barriers faced by such students between the ages of 10-14. You think sexuality education for people with disabilities will help them know what inappropriate sexual advances can be made on them and what they can do to protect themselves.

You are loyal to your group and are committed to the values and beliefs described above. You are scheduled to have a meeting with a parent opposed to the curriculum, a parent who supports the curriculum, a teacher in the school, and a school administrator.

Discuss and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position. Your strategy should be formed after considering the following points:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Is your position at all negotiable? Will you consider other options, and will you agree to other view-points?

Debate 2: Teaching People With Disabilities About Sexual Pleasure

Man with a Physical Disability

You are a man with a disability and it has come to your attention that a local disability rights organisation is about to begin a programme that will provide sexuality education for disabled people that also focuses on sexual pleasure. As part of this focus, the programme will include information on masturbation as a safe and suitable way for people with disabilities to sexually satisfy themselves. The organisation has adapted the programme to suit your community from similar ones being run in some European countries. The organisation believes in the benefits of the programme and to this end, they are organising a meeting to discuss it with different stakeholders in your community.

You are opposed to this new programme. Although you are a person with a physical disability you do not think there should be promotion of masturbation. You think it is also insulting to you and others with disabilities to be viewed as needy and unable to find sexual partners. You want to stop this programme from being introduced into your community and decide to make your stand clear both to the disability rights organisation and community members discussing the issue.

As a concerned person with a disability you are committed to the values and beliefs described above. You are scheduled to have a meeting with others including people with disabilities who support the programme, the disability rights organisation introducing the programme, a community leader, and a care-provider for a person with an intellectual disability to discuss the issue.

Discuss and derive strategies for resolution of the case. Other groups may not agree with your point of view and protest against your position. Before formulating your strategy, you should consider the following points:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Is your position at all negotiable? Will you consider other options and will you agree to other viewpoints?

Woman with a Physical Disability

You are a woman with a physical disability and it has come to your attention that a local disability rights organisation is about to begin a programme that will provide sexuality education for disabled people that also focuses on sexual pleasure. As part of this focus, the programme will include information on masturbation as a safe and suitable way for people with disabilities to sexually satisfy themselves. The organisation has adapted the programme to suit your community from similar ones being run in some European countries. The organisation believes in the benefits of the programme and to this end, they are organising a meeting to discuss it with different stakeholders in your community.

You are very excited about this new programme and think it will be a great way to teach people about sexual pleasure and to improve the attitudes toward people with disabilities in your community. As a person with a physical disability you find it hard to talk about your desires. You do not know how to pleasure yourself and would like to learn more about it. You want to participate in the programme when it comes to the community. You have some concerns about whether women will also participate in this programme and whether your family will allow you to attend.

As a person with a disability who supports the programme, you are committed to the values and beliefs described above. You are scheduled to have a meeting with others, including people with disabilities that oppose the programme, the disability rights organisation promoting this programme, a community leader, and a care-provider for a person with an intellectual disability to discuss the issue.

Discuss and derive strategies for resolution of the case. Other groups may not agree with your point of view and protest against your position. Your strategy should therefore take the following points into consideration:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position at all? Will you consider other options, and will you agree to other view-points?

Care-provider for a Person with an Intellectual Disability

You are the care-provider for a person with an intellectual disability and it has come to your attention that a local disability rights organisation is about to begin a programme that will provide sexuality education for disabled people that also focuses on sexual pleasure. As part of this focus, the programme will include information on masturbation as a safe and suitable way for people with disabilities to sexually satisfy themselves. The organisation has adapted the programme to suit your community from similar ones being run in some European countries. The organisation believes in the benefits of the programme and to this end, they are organising a meeting to discuss it with different stakeholders in your community.

As a care-provider for a person with an intellectual disability you disagree with this programme and oppose its introduction into the community. You cannot imagine a person coming into your home and telling your child about masturbation. It is harmful to them and also unnecessary: people with disabilities, especially intellectual disabilities, have a hard enough time trying to understand simple ideas and getting through their day without introducing something like masturbation into their lives. You plan to gather together other care-providers and oppose this programme.

As a care-provider you are committed to the values and beliefs described above. You are scheduled to have a meeting with others, including people with disabilities that oppose the programme, disabled people that support it, the disability rights organisation introducing the programme, and a community leader to discuss the issue.

Discuss and derive strategies for resolution of the case. Other groups may not agree with your point of view and protest against your position. Your strategy must therefore take the following points into account:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position at all? Will you consider other options, and will you agree to other viewpoints?

Community Leader

You are a community leader and it has come to your attention that a local disability rights organisation is about to begin a programme that will provide sexuality education for disabled people that also focuses on sexual pleasure. As part of this focus, the programme will include information on masturbation as a safe and suitable way for people with disabilities to sexually satisfy themselves. The organisation has adapted the programme to suit your community from similar ones being run in some European countries. The organisation believes in the benefits of the programme and to this end, they are organising a meeting to discuss it with different stakeholders in your community.

As a community leader you recognise that people with disabilities have rights and should be allowed to have the information and services that will assist them to lead healthy and full lives. However, this programme also sounds very radical to you and may anger many people in the community. While you personally have no problem with it, you think it may be best to not support it. It would be wise to stay neutral on the subject as it is also an election year and you do not want to anger any of your constituents or voters.

You are scheduled to have a meeting with others including people with disabilities that oppose the programme, disabled people that support it, the disability rights organisation introducing the programme, a care-provider, and a community leader to discuss the issue.

Discuss and derive strategies for resolution of the case. Other groups may not agree with your point of view and protest against your position. Your strategy should therefore be formulated taking the following points into consideration:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you will to negotiate on your position at all? Will you consider other options, and will you agree to other viewpoints?

Disability Rights Organisation

You are part of a disability rights organisation planning to begin a new programme that provides sexuality education for disabled people that also focuses on sexual pleasure. As part of this focus, the programme will include information on masturbation as a safe and suitable way for people with disabilities to sexually satisfy themselves. Your organisation has adapted the programme to suit your community from similar ones being run in some European countries. It believes this will be a beneficial programme and to this end is organising a meeting to discuss the programme with different stakeholders in your community.

Your organisation thinks this is an excellent programme and has modelled it to be culturally sensitive and address the barriers faced by people with disabilities in your specific community. You think that all people including those with disabilities have the right to understand and express their sexuality, and this programme will help facilitate these rights. You plan to start the programme with an orientation for parents, teachers and some adults with disabilities and then over time offer the whole programme to those interested in participating.

You know that people with disabilities are often viewed as non-sexual, and are protected and prevented from being sexually active. Your organisation believes that disabled people have a right to information on sexuality and safety from abuse, and also that sexual pleasure can be experienced safely through masturbation. Therefore you are committed to supporting and ensuring the introduction of this programme.

As a staff member of a disabilities rights organisation, you are loyal to your group and committed to the values and beliefs described above. You are scheduled to have a meeting with others including people with disabilities who oppose the programme, disabled people who support it, a care-provider, and a community leader to discuss the issue.

Discuss and derive strategies for resolution of the case. Other groups may not agree with your point of view and protest against your position. Your strategy should therefore take the following points into account:

- Who are your allies among the other stakeholder groups?
- Who are your opponents among the other stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you ready to negotiate on your position at all? Will you consider other options, and will you agree to other viewpoints?

Handout 4.12
My Views on Disability and Sexuality and Reproductive Rights

Designate one side of the room as the *Agree* side and the other as the *Disagree* side. Ask participants to move toward either side of the room, depending on whether they agree/ disagree with the statement you read out to them. Those who are undecided should move to a third designated spot in the room (the *Don't Know* group).

Read one statement at a time and allow time for discussion between those with different views before moving on to other statements:

a) People with physical disabilities can only marry or have relationships with other people with disabilities.

b) People with intellectual disabilities should not get married.

c) People with disabilities should not be allowed to have children.

d) Women with disabilities should be sterilised.

e) People with congenital disabilities (disabilities they were born with) should not have children since there is a chance that their children will also have the same disability.

f) Genetic testing should be done during pregnancy to identify congenital disabilities, which will help people decide whether or not to continue with the pregnancy.

g) It is a myth that people with disabilities are more vulnerable to sexual abuse.

h) Disabled people can be sexually attractive to both disabled and non-disabled people.

i) People with disabilities can be heterosexual/homosexual/ bisexual/transgendered just like people who are not disabled.

Handout 4.13
Integrating Disability Related Concerns In Our Work

Scenario 1

What situation would a person with a hearing impairment face if they went into a Government Hospital or any facility with no arrangements for sign language?

- What barriers will there be for this person? How can these barriers be overcome?
- Whose support can be used from local organisations and the community to tackle these issues?

Scenario 2

What are the ideal conditions under which a person using a wheelchair/paralysed from the waist down would be able to access an abortion clinic?

- What barriers will there be for this person? How can these barriers be overcome?
- Whose support can be used from local organisations and the community to tackle these issues?

Scenario 3

You are an inspector from the Ministry of Welfare assigned the task of checking whether the family counselling centres in your city are friendly towards disabled people. What will you be checking for and what do you find?

- What barriers for a disabled person will you be looking out for? How can these barriers be overcome?
- Whose support can be used from local organisations and the community to tackle these issues?

MODULE 5
Making it Work

Introduction

Regardless of whether participants work in reproductive health interventions, sexuality education programmes, or sexual health clinics, integrating the ideas and information in this manual into their work can make it stronger and more effective. It can be a challenge however, to apply the ideas and concepts in this manual to the work and advocacy we do. How have individuals or organisations successfully accomplished this before? What lessons can we learn from the successes and challenges of other campaigns and programmes? What principles do we need to apply to be effective and respectful of the people we work with?

Module 5: Making it Work, addresses these questions. It brings together topics from the other modules and illustrates how these can be used effectively to improve work in fields of sexuality, reproductive and sexual health, and rights. Participants finish this module with tools to take back to their own work, including how to incorporate values and principles into their work, ethical considerations, lessons from successful advocacy campaigns, and discussions on issues that affect populations around the world.

Chapters in Module 5
Making it Work

Assessment for Module 5 Making it Work

At the end of this module the facilitator can conduct an assessment. This assessment can evaluate the increase in participant knowledge, changes in attitudes, preferences for different exercises, and opinions on the facilitator's skills. For this module, an assessment can be done using the following tools:

- Using the modification of Exercise 3 in Chapter 2 of this Module
- Using the modification of Exercise 2 in Chapter 3 of this Module
- Adapting one of the sample assessment forms found in Chapter 2 *Preparing to Train*
- Using the facilitator preparation exercises for this module found in Chapter 1 *Preparing to Train*
- Developing a new assessment depending on the type of information the facilitator is looking to discover

Sample Training Schedule

A blank template of a training schedule as well as a sample seven-day training schedule can be found in the Introduction of *Preparing to Train*. Depending on the focus of the training and the topics it aims to cover, the facilitator can fill in the blank schedule with exercises from this Module or in combination with exercises from other Modules.

Chapter 1
Values and Principles

Chapter Objectives for the Facilitator

1. To have participants understand and explore their personal values and principles.

2. To have participants examine some guiding principles for working on sexuality, sexual and reproductive health, and rights.

Why a Chapter on Values and Principles

Programmes and services must consider local and cultural sensitivities. In order to be effective and accessible, the development, implementation, and evaluation of programmes and services must be consonant with the cultural and community context.

Different women and men have different needs, identities, choices, and life circumstances. Therefore, all women and all men do not have the same sexual concerns. Programmes must cater to the diversity among and within groups of people they serve.

Also, programmes need to consider that people may have special needs based on different factors such as urban or rural location, sexual orientation, illness, culture, age, or disability.

(from the Common Ground: Principles for Working on Sexuality, TARSHI 2001)

Working on issues of sexuality, sexual and reproductive health, and rights requires an awareness of social values, as both personal and cultural values give meaning to people's lives and shape their behaviour and attitudes. This includes how people choose to express their sexuality and their reproductive or sexual health choices. At times these values influence people's health and well-being. For example, in many parts of the world there is a 'culture of silence' around talking about sexual issues. Consequently, many people, especially women, do not seek professional help for sexual health concerns, to the detriment of their health and well-being.

In this chapter, participants will look at personal, professional, community, and cultural values. They will examine how these can change over time and how they are shaped by experiences, belief systems, and social and cultural surroundings. Acquiring clarity about these values allows for more effective work and advocacy and can be helpful in the resolution of value conflicts in ways that increase the autonomy of individuals and communities.

EXERCISES IN THIS CHAPTER

Exercise 1: Principles to Guide Us. 90 minutes

Exercise 2: Clarifying Our Values. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pen/pencils
Sheets of paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 5.1
  Guiding Principles for Working on Sexuality
- Handout 5.2
  Case Studies on Clarifying Our Values

ADDITIONAL RESOURCES:

- American Medical Student Association. *Principles Regarding Sexuality*. http://www.amsa.org/about/ppp/sex.cfm
- TARSHI. 2001. *Common Ground: Principles for Working on Sexuality*. India.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

Key Messages for this Chapter

- The basic values of choice, dignity, diversity, equality and respect underlie the concept of human rights. These affirm the worth of all people.
- It is important to relate the values of choice, dignity, diversity, equality and respect to sexuality, sexual and reproductive health and rights in order to be able to work more effectively in these fields.

Exercise 1
Principles to Guide Us

SMALL GROUP WORK

Instructions

1. Divide participants into small groups. Distribute Handout 5.1 to each group and ask them to discuss each principle in the context of their work and answer the following questions:

- Give two to five examples of how you can use these principles in your day-to-day work. For example, as a nurse it is essential to have a non-judgmental approach to care in order to offer the best treatment options to patients.
- Give two to five advantages of these principles in your day-to-day work.
- Give groups 45 minutes to complete their lists.

2. Bring groups back together and invite a representative from each to present their examples and advantages to the larger group. After group presentations are complete, ask for questions and comments.

Suggested Questions:

- Were there common examples or connections to the principles presented by the groups? What were these?
- Do these examples indicate that principles are useful in the work you do whether this is direct health care or advocacy etc.?

Purpose of the exercise:

1. To discuss guiding principles for working on sexuality, sexual and reproductive health, and rights.

2. To identify methods and advantages to using guiding principles in day-to-day work.

TIME

90 minutes

MATERIALS

Flipchart paper, markers, and tape, Handout 5.1 Guiding Principles for Working on Sexuality

ADVANCE PREPARATION

Make copies of Handout 5.1 for each participant; review Handout 5.1

THIS EXERCISE CAN BE MODIFIED BY:

- Using the exercise as an assessment at the end of this module. Ask participants in small groups to develop 10 Guiding Principles for working on sexuality with a rights perspective. Their Guiding Principles should incorporate sexuality, gender, core values, and human rights. For each of the Guiding Principles, groups should give at least one example from their work which they can apply to the principles. Have groups present their guidelines and discuss them to determine whether the participants have acquired knowledge that fulfils the objectives from the module. A peer-assessment form can be given to the non-presenting groups to evaluate the other groups. A sample evaluation/ assessment form can be found in *Preparing to Train*.

MAKING CONNECTIONS:

- Guiding principles can be incorporated into advocacy campaigns and movements. For more see Chapter 3 in Module 5.
- Respect for diversity and choice creates an environment free of stigma and discrimination. For more see Chapter 2 in Module 4.

Key Messages

- Because core values that underlie the human rights system can sound abstract, it may be difficult to establish a connection between these values and work on sexuality and/or sexual and reproductive health. It is therefore useful to articulate some guiding principles based on these values and how these can be used tangibly in work situations.
- Guiding principles that promote sexual well-being can be integrated into different strategies and mechanisms to address issues of sexuality. For instance, these can be used to develop or evaluate curricula, policies, programmes, publications and services on sexuality.

TIPS FOR THE FACILITATOR:

- The example of Guiding Principles in Handout 5.1 may be too abstract and participants may find it difficult to relate them to their day-to-day work. If this occurs, encourage them to think of the advantages and disadvantages of these principles instead.
- Sharing examples of how guiding principles apply to different work and advocacy environments benefits all group members. Encourage each participant to contribute at least one example of how the guiding principles apply to their work - even if they are not working directly with issues of sexuality or sexual and reproductive health.

Exercise 2
Clarifying Our Values

CASE STUDIES

Instructions

1. Divide the participants into small groups. Assign each group three to four of the case studies from Handout 5.2. Give the groups 20-30 minutes to read the case studies and answer the corresponding questions.

2. Ask participants to return to the larger group and invite each small group to share their cases studies and discussions. After each presentation, ask for reaction and questions from other participants.

Suggested Questions:

- Do you agree with the conclusions of the group? Would you suggest an alternative?
- How did the application of the Guiding Principles help characters in the case?

Purpose of the exercise:

To identify and clarify the practical applications of the Guiding Principles.

TIME

60 minutes

MATERIALS

Handout 5.2 Case Studies on Clarifying Our Values

ADVANCE PREPARATION

Make copies of Handout 5.2 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Choosing one or two cases to read together and discuss as a larger group. This can be helpful for groups having trouble with the concepts of the Guiding Principles and/or to focus the group on an issue that is pertinent to them.

MAKING CONNECTIONS

- Core values that underlie the human rights system can also be linked and applied in the context of sexual and reproductive rights. For more see *Setting The Tone* in Introduction to Module 1 and Chapters 2 and 3 in Module 3.
- There are a variety of contraception options available to women aside from those in some of the cases. For more see Chapter 2 in Module 2.

Key Messages

- Developing Guiding Principles before conducting a project/ program/campaign can help people work effectively in a day-to-day context.
- Although core values can seem unconnected and difficult to apply in daily work, principles based on them and followed by organisations/workers can ensure that these values are carried out in the work being done.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to apply the Guiding Principles to the case studies. Encourage them to read through Handout 5.2 before going through the cases.

Handout 5.1
Guiding Principles for Working on Sexuality

BASED ON COMMON GROUND: PRINCIPLES FOR WORKING ON SEXUALITY, TARSHI 2001

Affirmative Approach to Sexuality: Sexuality is a complex, yet pleasurable and enriching part of people's lives. It can also have unwanted negative consequences and place one at risk of pain, disease, and violence. Messages received by people about sexuality mostly focus on its negative aspects and evoke feelings of fear, shame or guilt. Most programmes centre only on the importance of safer sex. They focus on unwanted pregnancy, STIs, and HIV, for example, as dangerous consequences of sexuality without acknowledging that pleasure is an equally important component of sexuality. Using a positive, affirming approach to sexuality, rather than one based on fear, addresses both the pleasure and safety aspects of sexuality. A perspective that affirms sexuality encourages safer sexual practices, relationships and greater well-being.

Autonomy and Self-Determination: Autonomy means the ability and right of individuals to make choices and decisions. Women and men have the right to make their own free and informed choices about every aspect of their lives, including their sexuality. Making decisions on behalf of others does not encourage autonomy.

For women and men to make informed choices, they must have complete information about options.

Responsiveness to Changing Needs: Women's and men's needs for information on sexuality and services change over time and throughout their life cycles. With the social, cultural, and technological changes that take place over time, emerging options, issues, and concerns will also differ. The sexual concerns of people also change in keeping with corresponding physical, emotional, and social changes.

For example, an older woman going through menopause requires specific gynaecological interventions that differ from those needed by a younger woman.

Comprehensive Understanding of Sexuality: Issues of sexuality are complex and affect many aspects of a person's life. Programmes and services must take this into account and integrate emotional, psychosocial and cultural factors in planning and service delivery.

For example, people with low self-esteem may not feel entitled to negotiate safer sexual behaviour. Improving their self-esteem will enhance their desire and capacity to take care of themselves.

Confidentiality and Privacy: Sexuality touches upon intimate aspects of people's lives. Everyone has a right to privacy and confidentiality. If people feel that their privacy and confidentiality are threatened, this will deter them from seeking information and services. This means that people have the right to seek anonymity, to not feel under compulsion to share information, and also the right to demand that information about them not be divulged to a third party. Services and programmes must ensure these rights.

For example, counselling and health services must be provided in spaces where confidentiality is maintained and people feel safe enough to speak about their concerns without being overheard.

Cultural Sensitivity: Cultural perceptions about issues of sexuality differ among different groups and communities. Programmes and services must consider local and cultural sensitivities. In order to be effective and accessible, the development, implementation, and evaluation of programmes and services must be consonant with the cultural and community context. Considering cultural practices, traditions, beliefs and values of a community, and using culturally appropriate language enhances community acceptance of sexuality programmes and services.

Diversity: Different women and men have different needs, identities, choices, and life circumstances. Therefore, their sexual concerns also differ. Programmes must cater to the diversity among and within the groups of people they serve.

Programmes also need to take into consideration the special needs of people based on different factors such as urban or rural location, sexual orientation, illness, culture, age, or disability.

Gender Equity: Programmes based on gender equity recognise the need to provide for women and men, girls and boys, to have equitable access to information, services and education that promote sexual well-being. Messages and programmes must cater to needs specific to each gender, but without perpetuating stereotypes or double standards about gender and sexuality. For example, programme staff should be careful in their words and actions to not perpetuate the stereotype that young men rather than women need to learn about sexuality, and also that women need to know about contraception.

Prevent Violence, Exploitation and Abuse: Many people experience their sexuality or initiation into sexual activity in violent, exploitative and abusive circumstances. Programmes and services must emphasise that consent and equity between partners are necessary conditions for healthy sexual relationships. Consensual sexual relationships are based on mutual respect and concern for one's own and one's partners' physical, mental and sexual well-being.

Non-Judgmental Services and Programmes: People have different value systems, based upon which they make sexual choices. Providers and educators must respect the values that others hold and refrain from imposing their own values and judgements upon them. A non-judgmental atmosphere encourages people to discuss their sexual concerns and access sexuality and sexual health information and services. For example, both an unmarried sexually active young woman and an unmarried sexually active homosexual older man need to be ensured acceptance and comfort before they visit a sexual health clinic.

Accessible Programmes and Services: Accessibility entails more than availability of services. It includes issues of quality, activity, confidentiality, staffing, and capacity to cater to a range of needs. Women and men are more likely to use and be responsive to programmes and services that are non-threatening, provided by skilled and sensitive staff, available at times that do not conflict with their other obligations/ schedules, and provided in safe, accessible locations. For example, a sexual health clinic for young people is more accessible if it is located in a place well connected by public transport and known to offer a range of services. If the clinic is known to offer only treatment for STIs, chances are that not many young people will go there.

Handout 5.2
Case Studies on Clarifying Our Values

Case Study 1

School A is well known and respected in the city. It has recently taken the decision to introduce sexuality education for students who are 14 years and older. The school authorities have approached a local NGO that is well respected in the community and has experience working on these issues to help with the instruction. However, discussions between the school authorities and NGO staff have been stalled because the school is not comfortable with the NGO's request that school staff be absent from the classrooms during the sessions. The NGO thinks this will help students talk freely about their concerns. The NGO staff has also said that they will respond to any questions by the students, including those on abortion and masturbation, and they may include a condom demonstration if the need arises.

Questions:

- Do you agree with the NGO's approach? Why or why not?
- What Guiding Principles and values is the NGO trying to uphold with its policy for the school?
- How could the issue between the two be resolved?

Case Study 2

Kavita is confused about some changes in her body and decides to speak to her sister-in-law about them. Kavita tells her sister-in-law that she has had to undergo repeated abortions because of her husband's refusal to use condoms and oral contraceptive pills do not suit her. After the third abortion two years ago, she has not become pregnant again. This concerns Kavita and her husband since they are now ready to start a family. A few months ago, she began experiencing abdominal and lower back pain and excessive bleeding during her periods and sometimes even between her periods. When the pain and bleeding became too difficult for her, Kavita went to a doctor who examined her and told her that her intrauterine device (IUD) had been dislodged. The IUD had pierced the uterine wall, which was the cause of all her problems. Kavita was confused: How could she have an IUD inside her without knowing about it? She had never asked for one. Her sister-in-law mentions that a neighbour had warned her that a local abortion facility was inserting IUDs into women when they came in for an abortion. Maybe this had happened to Kavita?

Questions:

- What should Kavita do in this situation?
- Do you think it was appropriate for the clinic to put in the IUD after Kavita's third abortion?
- What Guiding Principles and values would help you examine this case?

Case Study 3

Dr. Goyal is annoyed with the students in his class. He has been conducting this course for the past two decades and has had no complaints in the past. He always prepares his lessons from well-respected medical textbooks. In the past few years, a number of students seem to be out to challenge him. Every time he gives them some information, one of his students will confront him with some new information from the Internet. He wonders how people can rely on the Internet? He has heard that it has so much information from so many sources? How can anyone be sure that this information is valid and reliable? He wonders why his students no longer take him seriously.

Questions:

- What do you think of Dr. Goyal's situation? Do you think he needs to adapt to the changing needs of his students?
- What Guiding Principles and values would help him in his work?

Case Study 4

Ruchika has been working as a healthcare worker in a government run mother and child clinic for the past five years. She is fed up with one of her patients, Kavita, who has had two abortions in the past six months. 'Why doesn't she get that good-for-nothing husband of hers to use a condom?' she asks her colleague Mariam in frustration. Mariam tells her that it is not easy to talk about these things and to persuade a husband to use condoms, but Ruchika is not convinced. She feels that Kavita is lazy and unaware of the harm she is causing her body by going in for repeated abortions. She has decided that the next time Kavita comes in for an abortion, she will take matters into her own hand and fit her with an intrauterine device (IUD). After all, she has her client's best interests at heart.

Questions:

- Do you agree with Ruchika in this case? Do you think she is violating any of the Guiding Principles or values?
- What other options should Ruchika consider?

Case Study 5

Manoj and Meera were engaged to be married. Manoj is HIV positive. A few months before the wedding, the hospital that had done Manoj's HIV test disclosed his positive status to Meera's relatives. They were very upset and cancelled the marriage immediately. Manoj filed a complaint at the High Court claiming that his right to confidentiality was breached by the hospital.

Questions:

- Do you agree that Manoj's confidentiality was breached?
- What are the consequences to revealing information like HIV status without permission?
- What Guiding Principles and values are present in this case?

Case Study 6

Ramya, a 32-year-old woman goes to the gynaecologist for a routine check-up. The doctor on duty asks Ramya why she has come for a check-up when she is unmarried. Ramya says that she has read that women should undergo routine gynaecological check-ups after the age of 30 years, which is why she is here. The doctor looks concerned and asked again why she needs a check-up if she is not married.

Questions:

- Should the doctor be asking Ramya such questions?
- What Guiding Principles and values should the doctor think of in this situation?

Case Study 7

A 10 year-old-girl calls a telephone helpline and asks, 'What is a condom?' The counsellor hesitates, unsure of how to respond. The counsellor feels that s/he has a moral obligation to prevent the caller from engaging in sexual activity at such a young age and therefore does not provide the information to the girl.

Questions:

- Should the counsellor give the child the information? Why or why not?
- What Guiding Principles can help the counsellor make this decision?
- How could this situation be resolved?

Case Study 8

Asha did not want to go to the doctor but since she was in unbearable pain, there was no choice. The doctor noticed that she had bruises on her arms and that she was walking with difficulty. Asha was then referred to another room in the hospital where the doctor gave her ample time and attention. Asha relaxed under the doctor's care and felt comfortable enough to answer the doctor's questions. Soon Asha poured out her entire story to the doctor and counsellor in the room. She told them about the abuse she had endured throughout the three years of her marriage. After nearly two hours at the hospital, she left feeling more hopeful than she had in a long time.

Questions:

- How did the doctors help Asha tell her story?
- What Guiding Principles are being used in this case?

Case Study 9

The Health Minister inaugurated the new voluntary counselling and HIV testing centre and STI clinic last week. The clinic is situated right next to the busy interstate bus station. The entrance is near the large cafeteria frequented by travellers and students from the college across the road. The Minister took a personal interest in setting up the clinic and insisted on its location. He also ensured that several discreet signboards were placed in the bus station, cafeteria and college campus about the new facility, and had some handouts printed that provided information about the clinic's facilities that assured confidential and non-judgmental services. Some of his colleagues were unhappy about its proximity to the college campus.

Questions:

- Do you think the counselling centre should remain at its location? Why?
- What Guiding Principles and values can be discussed from this case?
- How can this case be resolved?

Case Study 10

Dilip was very nervous about going to the voluntary counselling and HIV testing centre and STI clinic across the road from his college campus. His partner had insisted that they both go in for a check-up. He knew that his partner had other relationships before him and was afraid of what the tests would reveal. More than that, he was afraid of how his partner and he would be treated by the clinic staff. Would they judge them for being there? Would they look at them strangely? Would they turn them away saying that they were too young to be there? If the tests reveal that one or both of them have any infection, will the clinic staff want to inform Dilip's parents or the college authorities? His fears were allayed when he read the information handout about the clinic and its activities. He felt reassured enough to take a chance and visit the clinic.

Questions:

- How should the staff treat Dilip when he goes to the clinic?
- What Guiding Principles should the staff uphold that will address Dilip's fears?
- What in the information handouts do you think could have convinced Dilip to go to the clinic?

Chapter 2
Ethics in Practice

Chapter Objectives for the Facilitator

1. To have participants understand what is meant by ethics.
2. To have participants discuss personal and professional ethics and ethical guidelines regarding sexuality, sexual and reproductive health and rights.

Why a Chapter on Ethics in Practice

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. (Excerpted from The Nuremberg Code, 1947)

When people are questioned about ethics in their everyday practice, they often think they have a moral compass guiding both their personal and professional decisions, and that discussions about ethics are unnecessary because this compass will guide them toward just and appropriate answers. Yet, 'moral' ideals vary and it is often difficult to ascertain whose compass we should follow. Moreover, morality as a concept is often mistaken for ethics. Ethics are the rules or standards governing the conduct of a person or of members of a profession and are based on ideas of right and wrong. Morals are based on personal convictions, rather than on actual evidence, and have to do with the judgment of human action and character, which arises from a personal sense of right and wrong. Perhaps what is morally right for one person may not be so for another. Ethics, on the other hand, are more formal and codified in principles, and are thus less subjective.

But can the codes that govern ethics be applied to our personal lives as well? Or are the ethics we follow in our day-to-day lives different? How do our personal and professional ethics intersect, particularly when working with sexuality, sexual and reproductive health, and rights? Can ethical guidelines help to guide us in more difficult/complex situations that are less black and white? In such situations, ethical guidelines can help direct us to the answers or options, while taking into account the highest interests of all those concerned.

Historically ethical principles have guided professional medical activities for centuries. The Hippocratic Oath binds all doctors by the principle, 'above all else, do no harm'. The Nuremberg Code

EXERCISES IN THIS CHAPTER:

Exercise 1: Understanding Ethics. 60 minutes

Exercise 2: What Ethics Guide you? 60 minutes

Exercise 3: Case Studies on Ethical Dilemmas. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers
Pens/pencils
Paper

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 5.3
  Basic Information on Ethical Principles
- Handout 5.4
  Sample Ethical Guidelines
- Handout 5.5
  Ethics in Practice Case Studies

ADDITIONAL RESOURCES:

- American Psychological Association. *Ethical Principles of Psychologists and Code of Conduct*. Available at: http://www.apa.org/ethics/code2002.html
- Center for Enquiry Into Health and Allied Themes. http://www.cehat.org/
- Feminist Sexual Ethics Project. http://www.brandeis.edu/projects/fse/index.html
- A. Jesani, T. Barai-Jaitly. (Eds.) 2005. *Ethics in Health Research – A Social Science Perspective*. India: Centre for Studies in Ethics and Rights.
- National Association of Social Workers. *Code of Ethics of the National Association of Social Workers*. Available at: http://www.socialworkers.org/pubs/code/code.asp
- TARSHI. 2003. *Guidelines for Good Helpline Practice*.
- For selected films see, http://www.asiasrc.org/films.php and Appendix B.

the principle, 'above all else, do no harm'. The Nuremberg Code (1947), part of which is quoted in the previous page, was an attempt to continue this obligation to do no harm and prevent further violations of human rights following accounts of doctors and researchers performing cruel and inhumane experiments on people in the Nazi concentration camps during the Second World War. The Nuremberg Code, and the subsequent Declaration of Helsinki (1964) (see Appendix A for how to access the document) began to lay out ethical principles for medical practice and experimentation, which include informed consent, beneficence, and the absence of coercion. These ethical guidelines and principles continue to be used today, and efforts have been made to make them relevant to different aspects of life and work.

This chapter on ethics explores the nuances and grey areas of ethics that people may be faced with, particularly when working on issues of sexuality, sexual and reproductive health, and rights. It provides discussion and debate as tools to recognise the fluid and dynamic nature of ethics.

Key Messages for this Chapter

- Ethics are the rules or standards governing the conduct of a person or the conduct of the members of a profession and are based on notions of right and wrong.
- Ethical principles provide the foundation for specific guidelines laid out in codes of ethics. They contain the essential values/core concepts that can guide the resolution of ethical dilemmas.
- Crosscutting issues such as confidentiality, beneficence, respect and non-exploitation run through the ethical concerns of training, funding, service delivery and research.
- Ethics are dynamic. They can change for individuals and groups in different situations and over time. For example, as new drugs and procedures to treat HIV/AIDS are developed, ethical questions arise about how they should be tested, who should get these drugs, how much they should cost, and how they should be distributed.

Exercise 1
Understanding Ethics

SMALL GROUP WORK

INSTRUCTIONS

1. Divide participants into four groups. Give each group Handout 5.3, some flipchart paper and markers. Assign one of the following topics to each group: research, service delivery, training, fund-raising and funding. Ask small groups to first define the four ethical principles below and then discuss concrete examples of how the area of work given to them can be informed by these ethical principles. Further information on these principles can be found in Handout 5.3:

   1) Respect and protection of rights
   2) Anonymity and confidentiality
   3) Beneficence
   4) Non-exploitation

   Give participants 25-30 minutes to do this exercise.

2. Bring groups back together and invite each to come up and present their topic and discussion. After all these presentations are complete, ask for questions and comments.

   Suggested Questions:

- How did the groups describe the ethical concepts in the different areas of work (research, service delivery, training, fund-raising and funding)? Were the approaches similar or different from each other? For example, did every group define non-exploitation in the same way? Did some define it only as warning people of possible harm? Did others define it as taking steps to make sure people were not harmed in addition to warning them of possible harm?
- Are there similarities or differences between how these issues relate to the topics of research, service delivery, training and funding?
- Do you think it is important to consider these issues in the types of work you do or in your personal life?

PURPOSE OF THE EXERCISE:

1. To understand what is meant by ethics.

2. To discuss professional ethics that guide work in the areas of sexuality, reproductive and sexual health and rights.

TIME

60 minutes

MATERIALS

Flipchart, markers, Handout 5.3 Basic Information on Ethical Principles

ADVANCE PREPARATION

None

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting the exercise as a large group brainstorming exercise rather than dividing participants into small groups. This may be beneficial if the group has more experience in a particular area (for example if all of them are involved in training NGOs).

Key Messages

- Ethics are a code of conduct that guide and influence personal and professional behaviour and actions.
- Crosscutting principles such as confidentiality, beneficence, respect and non-exploitation run through the ethical concerns of training, funding, service delivery and research. However, there can be differences depending on the focus of the work being done. For example, while confidentiality must be maintained in all areas of work, the approach differs between people in service-delivery and those involved in research and more removed from direct services.

MAKING CONNECTIONS

- Values inform ethics and ethical principles, and these principles can be codified to guide people's work. For more see Chapter 1 in this Module.
- Ethical principles can be applied to day-to-day work on sexuality, sexual and reproductivel health, and rights. For more on guiding principles in advocacy see Chapter 3 in this Module.

TIPS FOR THE FACILITATOR:

- Participants may find it difficult to make connections between the four ethical principles and their application in the different areas of their work. It may be beneficial to give some examples.
- Participants may find it difficult to define the four issue areas. In this instance, begin the exercise by defining the terms using Handout 5.3.

Exercise 2
What Ethics Guide You?

JAM: JUST A MINUTE

Instructions

1. Ask participants to stand in a circle. Give each person 60 seconds to answer the question/s below. Responses should focus on personal experiences and feelings about the question and not on participants' professional lives. Write the main points from each participant on a flipchart. Ask these questions again using other terms from Handout 5.3 (i.e., boundaries, being non-judgmental etc.).

   Question 1: 'The concept of confidentiality for me means...'

   Question 2: 'I think confidentiality is/is not important in my personal life because...'

2. After everyone has completed their answers, ask for comments or questions.

   Suggested Questions:

   - Were there common themes that emerged? Were there any ideas you disagreed with?
   - Can you see how ethics can be changeable and dynamic depending on individual backgrounds and identities?

3. Repeat this exercise asking the participants to focus on their professional experiences and feelings about the question/s and not on their personal lives. Write the main points from each participant on a flipchart. Ask these questions again using other terms from Handout 5.3 (i.e., boundaries, being non-judgmental etc.).

   Question 3: 'The concept of confidentiality in my line of work means...'

   Question 4: 'I think confidentiality is/is not important in my work because...'

4. After everyone has responded to the statements, ask for comments or questions.

Purpose of the exercise:

1. To identify personal and professional ethics.

2. To discuss using personal and professional ethics when working with sexuality, sexual and reproductive health and rights.

TIME

60 minutes

MATERIALS

Handout 5.3 Basic Information on some Common Ethical Principles, Handout 5.4 Sample Ethical Guidelines, watch/timer.

ADVANCE PREPARATION

Make copies of Handout 5.4 for participants.

THIS EXERCISE CAN BE MODIFIED BY:

- Creating a set of ethical guidelines as a group rather than conducting the JAM sessions. Ask participants to brainstorm and come up with a set of ethical guidelines for working on sexuality, sexual and reproductive health, and rights. Write these guidelines on a flipchart and place this in front of the training room.
- Dividing participants into small groups and asking them to discuss the questions among their group. Ask the small groups to get back together and share their discussions.

MAKING CONNECTIONS

- Values inform ethics and ethical principles, and these principles can be codified to guide people's work. For more see Chapter 1 in this Module.
- The basic values of choice, diversity, equality and respect (*Setting the Tone*, Introduction to Module 1) affirm the worth of all people and serve to enhance ethical guidelines. Such respect for diversity and choice creates an environment free of stigma and discrimination. For more see Chapter 2 in Module 4.

Suggested Questions:

- Were there common themes that emerged? Were there any ideas you disagreed with?
- Do you feel it is important to have guidelines for the workplace given that different people have different personal ethics, which may clash with professional ethics?

5. End by distributing Handout 5.4 to participants and ask them to read it.

Key Messages

- Ethics are a set of codes that help determine appropriate conduct and when laid out in specific guidelines are called codes of ethics. They contain the essential values and core concepts that can guide the resolution of ethical dilemmas.
- Professional and personal ethics can guide people in situations when it is difficult to know what is the 'right' course of action. Since people with different backgrounds and values may work together, it is important for organisations to have a written code of ethics to guide people in their work. It is equally important for all people in the organisations to be aware of why they are expected to follow this code of ethics, in order to help them appreciate and apply them better.
- Ethics are dynamic. They are not absolute, and can change for individuals and groups in different situations and over time. For example, as new drugs and procedures to treat HIV/AIDS are developed, ethical questions arise about how they should be tested, who should get these drugs, how much they should cost, and how they should be distributed.

TIPS FOR THE FACILITATOR:

- It may be difficult for participants to talk about ethics in 60 seconds. Emphasise that there are no right or wrong answers and the exercise is intended to spark a discussion on ethical guidelines.
- If participants have difficulty providing answers, it may be helpful to start with some examples. Think of personal examples you can use to illustrate each of the principles in Handout 5.3.
- Participants may use the terms and concepts of ethics, morals and values interchangeably. The facilitator should avoid this and work to define these terms

Exercise 3
Ethical Dilemmas

CASE STUDIES

Instructions

1. Divide the participants into small groups. Distribute Handout 5.5 and assign each small group one case study. Give the groups 20-30 minutes to discuss the cases and answer the questions associated with them.

2. Ask participants to return to the larger group and invite each small group to share the case study and their discussion. After each presentation, ask for reaction and questions from other participants.

Suggested Questions:

- Is this a situation you have experienced in your workplace or community? How was this resolved?
- Do you agree with the conclusions of the group? Would you suggest an alternative?
- Did you notice the use/abuse of ethics in these case studies? Please give examples.

3. After discussing the case studies ask for general comments or questions.

Suggested Questions:

- Has discussing these cases and the ethics associated with them helped you understand your own personal and professional ethics better and how you would deal with certain situations? Why or why not?
- Can discussions with colleagues and others in your field help you in resolving your ethical dilemmas?

Purpose of the exercise:

1. To identify ethical issues in real-life situations.

2. To discuss approaches and practices that can be used in dealing with issues of sexuality, sexual and reproductive health, and rights.

TIME

60 minutes

MATERIALS

Copies of Handout 5.5 Ethics in Practice Case Studies

ADVANCE PREPARATION

Make copies of case studies from Handout 5.5 for each participant.

THIS EXERCISE CAN BE MODIFIED BY:

- Choosing one or two case studies and discussing them as a large group. It can be useful to concentrate on one or two issues pertinent to the group such as HIV/AIDS or gender violence.
- Giving each participant a case study and using the exercise as an assessment tool.

MAKING CONNECTIONS

- People who live with HIV/AIDS can also face stigma and discrimination because of the myths and lack of information about it. For more on basics of HIV/AIDS, see Chapter 4 in Module 2. For more on stigma see Chapter 2 in Module 4.
- New assisted reproductive technologies (ARTs) and infertility options are being developed and made available. New ethical questions will arise with these developments. For more see Chapter 3 in Module 2.
- There are links between ethical dilemmas and sexual and reproductive rights. For more see Chapters 2 and 3 in Module 3.

Key Messages

- Crosscutting principles such as confidentiality, beneficence, respect and non-exploitation run through the ethical concerns of training, funding, service delivery and research. However, there can be differences depending on the focus of the work being done. For example, while confidentiality must be maintained in all areas of work, the approach differs between people in service-delivery and those involved in funding and more removed from direct services.
- Ethical obligations may differ in each specific situation. For example, confidentiality or privacy may mean different things to different communities - some may think privacy means having members of the family present at medical or counselling sessions as this increases client comfort and feasibility, while others may not. In such a situation, a client needs to be consulted about what is comfortable for them, and a discussion should be had about the implications of their decision.
- Having ethical guidelines in professional work can help guide workers in situations that are difficult to resolve.

TIPS FOR THE FACILITATOR:

- Participants may have very strong opinions about these cases and the proper way to handle them. Allow for discussion but discourage participants from adopting moral positions.

Handout 5.3
Basic Information on Ethical Principles:

Below are some common ethical principles prescribed for and used by Mental Health Professionals, Social Workers and Doctors, among others.

- ***Anonymity*** is the expectation that information an individual has disclosed as a client, patient or study participant has no identifiers (including names, initials, occupation etc) that can link them to the information they have given.

- ***Beneficence*** requires providers to do what will further the patient's/client's interests.

- ***Competence*** requires that individuals work within the boundaries of their abilities, based on their education, training, supervised experience, consultation, study, or professional experience, and continually strive to increase their knowledge and skills.

- ***Confidentiality*** is not the same as anonymity. It pertains to the protection of information disclosed by an individual in a relationship of trust with the expectation that it will not be divulged to others without permission. Confidentiality should involve discretion and respect for a person's privacy. It could involve not revealing the identity of patients/clients/research subjects or their personal information to any unauthorised person/s.

- ***Informed consent*** is a procedure to ensure that a person knows about the potential risks and benefits of a treatment/research trial/study/procedure before agreeing to participate in it. A person can be said to have given consent if they have full awareness and understanding of the facts and implications of a treatment/research trial/study/procedure. A person must be in possession of all of their faculties and judgment at the time of giving consent.

- ***Non-exploitation***, means not taking advantage or abusing a client or group directly or indirectly through the use of information or power.

- ***Being non-judgmental*** means ensuring that one's personal judgments, opinions, values and attitudes do not impinge on and influence the work one is doing, whether it is counselling, care-providing, advocacy or preparing information, education, or communication material.

- ***Maintaining boundaries*** means maintaining a sense of 'separateness' in a relationship. Those unable to maintain appropriate boundaries in their relationships with clients may feel disturbed and upset, lose objectivity, express sympathy rather than empathy, offer advice, become overly familiar, and unintentionally increase the clients' dependence on them.

- ***Non-malfeasance*** advocates the principle to 'do no harm'.

- ***Respect and protection of rights*** means that a person cannot violate, abuse, or deny another's rights, and is also obliged to prevent a third party from violating, abusing, or denying a person's rights.

Handout 5.4
Sample Ethical Guidelines

THE FOLLOWING SAMPLE HAS BEEN EXCERPTED FROM TARSHI *GUIDELINES FOR GOOD HELPLINE PRACTICE, 2003.*

> *Remembering that the basic values of choice, diversity, equality and respect affirm the worth of all people will serve to enhance ethical guidelines*

- **Confidentiality**

  Guaranteed confidentiality is essential to ethical obligations and ensures improved service delivery. For example, a woman worried about the implications of disclosing her HIV status, will find it easier to share her concerns if she is reassured that all conversation will be kept confidential.

- **Maintaining boundaries**

  Boundaries refer to a sense of 'separateness' between individuals and emerge within the framework of every relationship. It is important to maintain boundaries in any client-provider relationship in order to prevent exploitation of the client and to maintain good quality of the service.

- **Recognising capabilities**

  It is essential to recognise professional capabilities and limits, and refer people to other services and assistance when necessary.

- **Being non-judgmental**

  It is necessary to ensure that personal judgments, opinions, values and attitudes do not impinge on and influence professional work.

- **Resisting the commonsense bias**

  The commonsense bias refers to a belief that a certain behaviour and way of dealing with situations is logical and sensible, or that things are obvious, irrefutable, and true until proven otherwise. This approach is problematic and should be avoided.

- **Being aware of specific social and cultural environments**

  It is important to recognise that attitudes, belief systems and concerns differ across cultures and sub-cultures.

Handout 5.5
Ethics In Practice Case Studies

Case Study 1

In 1972, Japan introduced the Eugenic Protection Law Revision Bill to its legislative body. The revision bill aimed to add onto the Eugenic Protection Law (EPL). The EPL was passed in 1948 and contains provisions to, 'prevent birth of inferior descendents from the eugenic point of view, and to protect life and health of mother, as well' (Article 1). The Revisions Bill proposed to augment the original EPL with regard to abortion access. The bill contained a clause that allowed for selective abortion of a foetus with severe disabilities. In 1996, this eugenic provision of the Revision Bill was repealed and the Eugenic Protection Law was revised to allow only voluntary abortion. This part of the EPL was subsequently renamed the 'Maternal Protection Law'.

For more on this topic please see, http://www.lifestudies.org/disability01.html

Questions:

- What are the implications of this law?
- Does this case raise any ethical issues, either with the proposed Revision Bill or the original EPL?
- Should a woman be able to abort a foetus with a disability?
- What ethical guidelines could you create to adequately address this issue?

Case Study 2

In the late 1990's, the number of HIV/AIDS cases in Thailand was on the rise and the country began to recognise the need to address this situation. Thus the government decided to take a number of measures to increase awareness and accessibility to services for prevention. One of the measures was a mandatory reporting of names of and addresses of HIV/AIDS patients. A number of NGOs and activist groups protested against the provision and succeeded in abolishing the measure.

For more on this topic please see, http://www.avert.org/aidsthai.htm.

Questions:

- Does mandatory reporting of HIV/AIDS patients raise any ethical issues?
- Should mandatory reporting be a means of reducing the risk of HIV transmission?
- Would you support/protest such measures in your community? Why?

Case Study 3

In 1992 the Vietnamese government proposed a policy that required prostitutes, drug users, homosexuals, prisoners, and foreigners who planned to spend more than three months in Vietnam to be tested for HIV. It further stated that citizens who tested HIV positive would be prohibited from getting married.

For more on this topic please see, http://www.etext.org/Politics/GLU/Library/IGLHRC/Vietnam

Questions:

- Does this policy raise any ethical issues?
- Should these groups be targeted for HIV/AIDS prevention? What about other groups affected by HIV?
- What are the implications of this policy on individuals?
- What ethical guidelines could you create to adequately address this issue?

Case Study 4

The number of new HIV/AIDS cases reported in Singapore in 2004 showed a significant rise. As a result, the government considered two measures to stem the increase: mandatory testing of couples who planned to marry, and increased screening of HIV/AIDS for all pregnant women. Pregnant women were already being offered the option of HIV testing but this new provision enforced testing all women unless they opted out. However, it was stated that if the number of pregnant women who opted out became too high, compulsory testing would be considered.

For more on this topic, please see http://www.avert.org/hiv-testing-pregnancy.htm or http://www.medicalnewstoday.com/medicalnews.php?newsid=21115

Questions:

- Does this policy raise any ethical issues?
- Should these groups be targeted for HIV/AIDS prevention? What about other groups affected by HIV?
- What ethical guidelines could you create to adequately address this issue?

Case Study 5

A study in the late 1990's was conducted in rural Indian villages to discover how sexual relationships were negotiated between men and women in the village. The researchers were surprised when the women requested that they be interviewed in the presence of their husbands and friends. This seemed unconventional but the researchers obliged and reworked the methodology of the study to do partner interviews.

For more on this topic, please see http://www.unescap.org/esid/psis/population/journal/2001/v16n2a11.pdf#search='Joshi%201997%20ORG%20Marital%20Sexual%20Relationships'

Questions:

- Does this case raise any ethical issues?
- Do you think the flexibility of the researchers toward the people in their study demonstrated ethical considerations? Why?
- What ethical guidelines could you create to adequately address this issue?

Case Study 6

Prior to 2002, abortion in Nepal was illegal. A doctor working in a village at the time was confronted with a problem when a woman who had been raped came to her clinic for help. The woman was married and her husband was away when a neighbour came to her home and raped her. The rape resulted in a pregnancy and although abortion was illegal in Nepal, the woman decided to get one done anyway. The doctor she spoke with agreed to perform the abortion when she heard the story. A few days after the procedure, the woman arrived at the same doctor's office with a fever and infection. At the same time her neighbours had reported the woman's illegal abortion to the police, who arrived at the doctor's office asking her to complete a report stating that the woman had an abortion. The doctor decided to not give a report attesting to the abortion and told the police that the woman simply had a bad infection and needed hospitalisation. While this report was false, the doctor felt it was necessary to avoid a situation in which the woman would be arrested and severely punished.

For more on this topic, please see http://www.hsph.harvard.edu/Organizations/healthnet/SAsia/repro/aruna.html

Questions:

- Does this case raise any ethical issues?
- Although the doctor broke the law, was she acting ethically?
- Should the doctor have reported the rape to the police? What would you have done as an advocate had the woman approached you?
- In the light of such laws, what kind of ethical guidelines could you create to adequately address this issue?

Case Study 7

In the late 1990s, India and a number of other Asian countries were the site of testing for a sterilisation process that used the drug Quinacrine. Originally used to treat malaria, Quinacrine was found to be a non-operative way of sterilizing women. Quinacrine pellets were inserted into a woman's uterus, causing inflammation in the uterus which subsequently permanently scarred the fallopian tubes and prevented a woman from having children. During the height of the testing of this procedure in India, the majority of women undergoing it were poor and from underprivileged communities. They did not know the procedure had lasting effects and had initially gone to their health care provider for insertion of an intrauterine device (IUD) rather than sterilisation. Researchers and health care providers involved in the administering of Quinacrine argued that this was necessary to provide more options for safer and less invasive sterilisation procedures and ultimately more contraceptive choices for women.

For more on this topic, please see http://www.hsph.harvard.edu/grhf-asia/suchana/9999/quinacrine.html

Questions:

- Are there any ethical issues to be considered here?
- Do you think the testing of Quinacrine was done ethically?
- Are there violations of human rights that need to be considered?
- What kind of ethical guidelines could you develop to address this issue?
- Would you support/protest against such measures in your community? Why?

Case Study 8

A rural community trying to address the needs of girls with developmental disabilities (mental or physical disabilities, such as cerebral palsy, autism or mental retardation that arise before adulthood and usually last a lifetime) decided to let them receive care in an institution in the area. In the mid 1990's, reports emerged from the institution about the kind of treatment being administered to the girls, particularly when managing their menstruation. The institution decided to have the girls undergo hysterectomies (surgical removal of the uterus) to avoid teaching them how to manage themselves during their periods. Women's groups protested against this enforced sterilisation. The institution stopped after performing hysterectomies on 14 girls.

For more on this topic, please see http://www.biopolitics-berlin2003.org/doc_rt.asp?p=1&id=159

Questions:

- Are there any ethical issues to be considered here?
- Do you think that the hysterectomies were a proper solutions? What else could have been done?
- Are there violations of human rights that need to be considered?
- Would you support/protest such measures in your community? Why?

Case Study 9

India has the lowest girl child ratio in the world. According to the 2001 census, there are 933 girls for every 1000 boys. Many have termed this 'the missing girls syndrome' and attribute it to sex-selection practices. New reproductive technologies (NRTs) such as sonogram/ultrasound (use of high-frequency sound waves to create images of structures inside the body), and amniocentesis (analysis of a small sample of fluid taken from the uterus through a needle inserted in the abdomen) among other procedures, were introduced into India in the 1970s. By the 1980s these procedures, expensive in other countries, had become considerably low-cost in cities and small villages throughout India. The tests were marketed to help ascertain the health of the foetus and also determine the sex. In many cases, it was the sex of the foetus that the couple wanted to determine, and if it was female, they would often abort it. Many hospitals promoted the procedure and claimed it to be beneficial for potential parents.

For more on thins topic, please see http://www.whrnet.org/docs/otherpoints-picard-0601.html

Questions:

- Are there any ethical issues to be considered here?
- Do you think the use of these NRTs should be stopped?
- Are human rights being violated if NRTs are used or denied?
- What kind of ethical guidelines could you develop to address this issue?

Case study 10

An NGO in a city near many rural villages decides to start a fund to help girls in the villages receive better education. While girls belonging to the higher classes were educated, those of the lower classes were often denied education. The NGO decided to raise money and present it to the girls' parents to provide for their education. The NGO had already cultivated a relationship of mutual respect with many of the women. After raising some money, the NGO met them and handed over the money, intended for the education of their daughters. The women thanked the NGO and told them that they would prefer this money go to their sons as they would be making money for the family and bringing an improved status to them. Educating the girls, on the other hand, would not improve their position within the community and might, in fact, be detrimental to their marital prospects. The NGO tried to explain their position and how education would improve the situation of girls' lives by providing them options. But the women insisted that such a programme would cause more harm than benefit.

Questions:

- Are there any ethical issues to be considered here?
- Do you think the NGO should still give the money for the girls, or should it go for the boys instead?
- What kind of ethical guidelines could you develop to address this issue?

Chapter 3
Learning From Others

Chapter Objectives for the Facilitator

1. To have participants examine sexuality, sexual and reproductive health and human rights campaigns.

2. To understand how concepts and ideas discussed in earlier modules can be used for advocacy, and to increase awareness and knowledge.

Why a Chapter on Learning from others

'No one told me what the injection was for till after they had given it to me. It was only later that I realised it was to prevent pregnancy. I suffered heavy bleeding, dizziness and pain for over two months before things settled down. When it was time for the next shot, I put my foot down and said I would not take it. Thankfully my husband supported me and now I have an intrauterine device (IUD) which is suiting me so far'.

'No lesbian may have been picked up and flung into jail because of Section 377 of the Indian Penal Code... But it is used to blackmail lesbians, force them to consent to marriage and be invisible'.

Advocacy campaigns for the right to control one's body, to express and choose one's sexuality, and to control one's sexual and reproductive health and choices have been successful in different parts of the world. They have helped build public awareness, highlighted the abuse of rights, and ensured that people from all social groups have the opportunity to live in healthy environments free of coercion and stigma. These campaigns have used various approaches and tackled different issues including working toward changing legislation, increasing the type of information given to communities, to name just two. While not all advocacy campaigns have been successful, they have played a role in creating awareness and knowledge about sexuality, sexual and reproductive health and rights, and allowed others to build upon that foundation of awareness.

This chapter will examine and discuss different advocacy movements and campaigns that have focused on issues of sexuality, sexual and reproductive health, and rights. A closer look at these campaigns will help consolidate the topics, information and discussions in this manual, and generate ideas on how we can improve the integration of sexuality, sexual and reproductive health, and rights in our own work and campaigns.

EXERCISES IN THIS CHAPTER

Exercise 1: Negotiating With Other Stakeholders. 75 minutes

Exercise 2: Representing an Issue in Advocacy. 90 minutes

Exercise 3: Campaigns for Sexuality, Sexual and Reproductive Health and Rights. 60 minutes

Exercise 4: Sharing Campaign Stories. 60 minutes

MATERIALS FOR THIS CHAPTER:

Flipchart
Markers

HANDOUTS REQUIRED FOR THIS CHAPTER:

- Handout 5.6 Negotiating With Other Stakeholders
- Handout 5.7 Representing an Issue in Advocacy
- Handout 5.8 Campaigns for Sexuality, Sexual and Reproductive Health and Rights

ADDITIONAL RESOURCES:

- Akhtar, F. 1995. *Resisting Norplant: Women's Struggle in Bangladesh Against Coercion and Violence.* Bangladesh: Narigrantha Prabartana.
- Campaign for Lesbian Rights. 1999. *Lesbian Emergence, A Citizens' Report.* New Delhi: CALERI
- International Lesbian and Gay Association. 1999. India: The Campaign for Lesbian Rights. Available at: http://www.ilga.org
- SAMA. 2003. *Unveiled Realities - A Study on Women's Experiences with Depo-Provera, an Injectable Contraceptive.* New Delhi.
- S.N.D.T. Women's University Library. Campaigning Against Injectables. http://www.gendwaar.gen.in/IN/campaigns.htm
- Voices Against 377. 2004. *Rights For All: Ending Discrimination Against Queer Desire Under Section 377.* New Delhi.
- Women's Network for Unity. http://womynsagenda.org/program./sexworker/SW/swnu.htm!
- For selected films see, http://www.asiasrc.org/films.php and Appendix B

Key Messages for this Chapter

- The underlying messages conveyed by these featured campaigns are the right of all people to bodily integrity (to control one's own body and the choices about one's body with without fear, shame, or coercion), the right to make decisions and choices freely, and freedom from fear or any negative side effects from these choices.
- There is no formula for a good advocacy campaign. However there are common factors that can help guide a good campaign. These include recognition of the basic rights issues at stake, the audience one is trying to reach and making use of different spaces to speak to different people about the issues.
- Because issues of sexuality and sexual and reproductive health can often be contentious, campaigning to successfully bring about change can take time. Campaigns can meet a great deal of opposition but can still result in changes and improvements.
- Because issues of sexuality and sexual and reproductive health are sensitive and value laden, they can elicit strong emotions in the campaigners as well as the audience. It is useful to keep in mind the values discussed in the Introductory Exercise: Setting the Tone in Module 1 and the Ethical Guidelines in the previous chapter, to help guard against misrepresentation of people/groups and violation of the principles of confidentiality, anonymity, beneficence, respect and non-exploitation.
- Advocacy campaigns are contextual - they are influenced by the political atmosphere, legal and economic systems in different communities and countries, and prevalent social values. Campaigns may therefore have to be modified to fit these different environments and contexts.

Exercise 1
Negotiating With Other Stakeholders

ROLE-PLAY AND DEBATE

Instructions

1. Divide participants into five small groups. Each group represents one of the roles/stakeholders provided for in Handout 5.6. Distribute one of the descriptions of these roles/stakeholders to each small group.

2. Ask the groups to read the scenario and their assigned role and give them 15 minutes to create a strategy that will best argue their position in the given scenario and get their desired end result. Participants should make sure they address the questions on the handout.

3. Bring the groups back together and ask for one or two representatives from each group to come to the 'negotiating table' to debate the issue. Have representatives from each role/stakeholder first present their position on the case and arguments. After each group has put forth their arguments allow everyone to discuss and negotiate. **At the end of the debate there must be a resolution to the case and a decision must be made to resolve the scenario.** Allow 30 minutes of debate and negotiation.

4. After the negotiations and resolutions, ask for general questions or comments.

   Suggested Questions:

- Was it easy or hard to argue your position? Why? Did each group leave the negotiation with their desired solution? Why or why not?
- Did your role reflect your point of view or views commonly found in your community?
- What are the benefits of examining the arguments of your 'opposition' prior to advocacy? What are the advantages and disadvantages of compromise?
- What have you learned through this exercise that you can use in your own work/advocacy?

Purpose of the exercise:

1. To explore ways to debate and argue an advocacy position.

2. To understand the importance of knowing the tactics and arguments of an opposing group while engaging in advocacy.

TIME

75 minutes

MATERIALS

Handout 5.6 Negotiating With Other Stakeholders

ADVANCE PREPARATION

Make copies of Handout 5.6

THIS EXERCISE CAN BE MODIFIED BY:

- Creating small negotiating groups that include one person from each stakeholder group. These groups can be created after the stakeholder groups have spent time on discussion and formulation of a strategy. Give participants 30 minutes for these small negotiation groups to come to a resolution, after which resolutions are presented to the larger group. This can illustrate the different ways in which people may negotiate and the different approaches possible with the same information and tools.
- Debating both the scenarios. This may take more time, but will allow the participants to be exposed to different campaign strategies and ideas.

MAKING CONNECTIONS

- Censoring sexuality education can include denying information on contraception and abortion, which is a violation of people's right to information and reproductive choices. For more see Module 3.
- Sexual and gender identities are not fixed and it is possible for individuals to change identities over time. For more see Chapter 2 in Module 1.

Key messages

- Having a solid rationale and arguments to support an advocacy effort/campaign is important, particularly when discussing the issue with opponents or people unfamiliar with the topic.
- While it may be difficult to argue a position different from one's own, this can benefit an advocacy effort/campaign by understanding how to counter the arguments and positions of the other side.
- Freedom of expression and the right to information allows for access to books, movies, television shows, radio and other mass media as well as sexuality education and sexual and reproductive health information. Restrictions or limitations on this information and the ability to use, observe, or consume products, ideas, images, or 'things' runs counter to our right to information. Limitations can also be detrimental to those it intends to 'protect'. For example, sexuality education in schools may be restricted or emphasise abstinence to 'protect' young people from STIs including HIV/AIDS, and unwanted pregnancy. However, incomplete information can lead to more harm by denying young people information to protect themselves and ensure their well-being.
- Freedom of expression provides opportunities for all perspectives, opinions and viewpoints on an issue to be aired, and for people to have comprehensive information from which they can make their own choices.

TIPS FOR THE FACILITATOR:

- Make sure participants maintain their assigned roles and arguments. While they might not agree with their role, they need to keep to them to illustrate the many facets of an issue. Being informed on options and opinions is crucial in a decision-making process.

Exercise 2
Representation in Advocacy

SMALL GROUP WORK

Instructions

1. Divide participants into small groups. Hand each group flipchart paper, markers, pens, and a campaign scenario from Handout 5.7.

2. Ask participants to read their campaign scenario and give them 30 minutes to create a piece of advocacy or information-based material they would use in their campaign. For example they can develop a poster, an information pamphlet, a commercial, a song etc. Have them imagine that they have unlimited resources and access to any spokespeople, materials, or images they may want. Each group should create only one piece of material that they will then present to the larger group. Their presentation can be as simple as an outline of what they want to do.

3. Bring the groups back together and invite each to share the piece of material they created. After each presentation, ask for questions or comments.

   Suggested Questions:

- Do you think this campaign material will be successful? Will the audience understand the message? Would it appeal to diverse audiences and communities?
- How did the group present their issue and advocate for change? Were there negative images and ideas? Did their materials use images of 'victims' rather than promote empowerment?
- Was there any disagreement in the group over how to represent these issues in a campaign?

4. After the presentations, ask for general comments and questions.

   Suggested Questions:

- Did the groups have any common approaches toward their campaign materials?
- In what way does representation play a part in advocacy for sexual and reproductive health and sexuality?

Purpose of the exercise:

1. To analyse advocacy programmes on issues of sexual and reproductive health, sexuality and rights.

2. To discuss whether the methods in the advocacy programmes are affirming in their approach.

TIME

90 minutes

MATERIALS

Flipchart, markers, pens, Handout 5.7 Representating an Issue in Advocacy

ADVANCE PREPARATION

Make copies of scenarios from Handout 5.7

THIS EXERCISE CAN BE MODIFIED BY:

- Conducting the exercise as a large group activity in which the participants discuss one or two of the campaign scenarios and brainstorm potential ideas and strategies.
- Showing some examples of effective as well as weak campaigns and having participants analyse the pros and cons of each.

MAKING CONNECTIONS

- The human rights system and its basic principles can help inform successful campaigns. For more see Chapter 1 in Module 3.
- Often certain sexual and gender identities are represented in very specific, limiting and stereotypical ways. For more on see Chapter 2 in Module 1.

- What assumptions, if any, does your campaign make about a particular group? How are these assumptions harmful/useful?

Key Messages

- Even if material is distributed on a smaller, community size scale (rather than through mass media), it can still influence attitudes and reactions to an issue. For example, to have a brochure on rape and sexual abuse that portrays women only as victims without any power over their lives may influence people in the community to regard/treat them as victims without power to make changes or make decisions about their own lives. Such messages can have a similar impact on women who have experienced rape or abuse.
- It is important to represent issues in sexuality, sexual and reproductive health and rights without bias so as to avoid further stigmatisation and discrimination. For example, representing HIV/AIDS as an infection that only infects 'high-risk groups' like sex workers, women in prostitution and truck drivers can further ostracise them in a community. This portrayal also fails to promote safer sex among people who are not part of these groups and so not considered to engage in high-risk behaviour.

TIPS FOR THE FACILITATOR:

- Small groups may focus too much on the aesthetic appeal of their campaign material rather than concentrating on the message and ideas it conveys. Stress that just an outline will suffice and the content matters more than the design/ quality of the drawing or poster.

Exercise 3
Campaigns for Sexuality, Sexual and Reproductive Health and Rights

CASE STUDIES

Instructions

1. Divide participants into small groups. Distribute one case study from Handout 5.8 to each group. Ask participants to spend 25-30 minutes reading the case and corresponding questions, and preparing to come back to the larger group with a presentation on the case. Alternatively, each group can be given Campaign 5, which is a modification of the exercise, and asked to devise steps and a plan for a successful campaign in their community on the topic and issues presented in the case.

2. Bring the groups back together and invite each to present their case. After each presentation, ask for questions and comments.

   Suggested Questions:

- What did you think of this campaign? Do you think it was/ could be successful?
- How can you use the lessons of this campaign in your own work?

3. After the presentations are over, ask for general questions and comments.

   Suggested Questions:

- Can you give an example of how you could use tools from these campaigns in your own work?
- Are any common tools or methods used in these campaigns? What is similar or different about the way they have been used?
- Have you heard of similar campaigns in your community or country? How would you modify these campaigns to suit your community?

Purpose of the exercise:

1. To discuss campaigns and movements on sexuality, sexual and reproductive health, and rights.

2. To examine how movements have advocated for sexuality, sexual and reproductive health and rights.

3. To analyse the successes and challenges of these campaigns and how similar ideas and lessons from them could be used in one's own work.

TIME

60 minutes

MATERIALS

Handout 5.8 Campaigns for Sexuality, Sexual and Reproductive Health and Rights

ADVANCE PREPARATION

Make copies of Handout 5.8

THIS EXERCISE CAN BE MODIFIED BY:

- Discussing one or two campaigns as a larger group. This may be beneficial if the group wants to focus on a case study that addresses their work specifically.
- Using the exercise as an assessment for the module. After each group presents their case to the larger group, peer and facilitator evaluation can be done. For sample assessment forms see Chapter 2 in *Preparing to Train*.

MAKING CONNECTIONS

- Often sexual and gender identities can be stigmatised and marginalised. For more on stigma and marginalisation see Chapter 2 in Module 4. For more on sexual identities see Chapter 2 in Module 1.
- Various contraception options are available and these should be offered with proper information, including potential side effects and whether they reduce the risk for transmission of STIs including HIV/AIDS. For more see Chapter 2 and 4 in Module 2.

Key Messages

- Campaigns for sexuality, sexual and reproductive health, and rights are varied and have different objectives – for example to change legislation, increase awareness on an issue, or protest a violent act against specific groups/identities.
- Successful campaigns take on a variety of forms, but are likely to be successful if they clearly identify the goals of the campaign, the audience for whom messages are meant, and define indicators to measure their success.

TIPS FOR THE FACILITATOR:

- Participants may focus only on larger movements and campaigns. Emphasise that change can successfully be brought about on a smaller, local level too, and it is equally important to raise awareness and improve well-being, rights and health at this local level.
- If participants have been involved in an advocacy campaign before, time can be allotted to hear about it in the larger group, and analyse its strengths and challenges.
- Participants may want to speak only about their own experiences with campaigns and issues relevant to these. Emphasise that learning about other experiences can help them learn successful techniques and approaches that can be used in their own campaigns.

Exercise 4
Sharing Campaign Stories

GROUP DISCUSSION

Instructions

1. Invite participants to share personal experiences and stories from past or current campaigns or movements they have participated in. Initiate a discussion of experiences and lessons learned.

   Suggested Questions:

- What tools were common in these campaigns?
- What tools or methods would you take from any of these experiences?
- Were the campaigns successful or not? What contributed to this?

Purpose of the exercise:

1. To share personal experiences with advocacy or awareness campaigns.

2. To discuss tools and lessons that can be learned from other experiences and campaigns.

TIME

60 minutes

MATERIALS

Flipchart, markers

ADVANCE PREPARATION

None

THIS EXERCISE CAN BE MODIFIED BY:

- Dividing participants into small groups and having them discuss experiences of campaigns.

Key Messages

- Discussing experiences with campaigns can improve future efforts and campaigns.
- Common advocacy tools and methods can be used for a variety of issues and goals.

MAKING CONNECTIONS

- Values inform ethics and ethical principles. For more see *Setting The Tone* in Module 1.
- A rights-based approach to advocacy will empower and broaden the scope of a campaign and its goals. For more see Chapter 1 in Module 3.

TIPS FOR THE FACILITATOR:

- This exercise is designed to be a free-flowing conversation among participants. However, ensure that those who want to speak and share their thoughts and experiences are given the opportunity.
- Some participants may have not participated in any large-scale campaigns, but even small advocacy efforts can be shared and learned from.
- After training on these issues, participants may be more critical of others' campaigns. Remind them of the ground rules and the importance of respecting all participants who share their stories, even if they disagree with the way the campaigns were run.
- The purpose of critically analysing campaigns is to enhance learning. It should be done with this attitude rather than one of judgment and disapproval.
- Encourage participants to think of constructive solutions to ethical dilemmas currently faced by them in their work.

Handout 5.6
Negotiating With Other Stakeholders

Scenario 1: Mass Media and Censorship

Women's Advocacy Group:

It has come to your attention that a new film has been made by a woman filmmaker and is ready to be released in theatres. The two main characters of the film are married women who live in a fairly conservative community. After meeting each other at a common friend's party, they begin to have a sex with each other and develop a relationship outside of their marriages. While the film has no nude scenes, the women do kiss often and touch each other like lovers would.

Your organisation is very enthusiastic about the film and anxiously awaiting its release. From what you hear of the filmmaker, she is smart and her film is very well made. You have been waiting for some movie of this kind to come to your country and challenge conservative notions of sexual identity and sexual behaviour that can be quite oppressive. You have heard that many women who identify as lesbians are discriminated against in their communities. You hope such a film will open the minds of people to the rights people have to express their sexuality. You are prepared to do whatever it takes to ensure that the film gets released and people go to see it.

As a member of the women's advocacy group you are loyal to your group and committed to the values and beliefs described above. You have to attend a meeting called by the government censor board to discuss whether they should allow the film to be screened. The meeting will be attended by other stakeholders in the community including a representative of the censorship board, the filmmaker, a parent of a young person, and an NGO that works on HIV/AIDS prevention.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position, so your strategy should be created keeping the following points in mind:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position at all? Will you consider other options or agree to other's viewpoints?

Open-minded Parent:

It has come to your attention that a new film has been made by a woman filmmaker and is ready to be released in theatres. The two main characters of the film are married women who live in a fairly conservative community. After meeting each other at a mutual friend's party, the two women begin to have a sex with each other and develop a relationship outside of their marriages. While the film has no nude scenes, the women do kiss often and touch each other like lovers would.

You are very excited that such a film has been made in your country. While you do not identify as a lesbian you think it is important to know and understand the range of sexual identities and behaviour that exists. This is especially so for your child, who is at an impressionable age and would benefit from seeing such a film. Also, the film can give you the chance to bring up other sensitive issues to discuss with your child. You decide to get some other parents from your neighbourhood together to get them to see the film with their children.

As an excited parent you are loyal to your group and committed to the values and beliefs described above. You have to attend a meeting called by the government censor board to discuss whether they should allow the film to be screened. The meeting will be attended by other stakeholders in the community including a representative of the censorship board, the filmmaker, a representative of a women's advocacy group, and an NGO that works on HIV/AIDS prevention.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore your strategy should take the following points into account:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options and agree to other viewpoints?

Community Health Organisation that does HIV/AIDS Prevention Work:

It has come to your attention that a new film has been made by a woman filmmaker and is going to be released in theatres. The two main characters of the film are married women who live in fairly conservative community. After meeting each other at a mutual friend's party the two women begin to have a sex with each other and develop a relationship outside of their marriages. While the film has no nude scenes, the women do kiss often and touch each other like lovers would.

While your organisation does not have religious affiliations, it does believe that lesbianism and same-sex relationships are morally wrong. People were born males and females and it is only natural to have heterosexual relationships. This kind of film might give people the wrong ideas and begin to undo the work you have done to promote safer sexual behaviour between men and women. Your organisation has a strong history of activism and decides to protest against the film's release. You have decided that if it is necessary, you will use violence to prevent people from seeing the film.

As a member of the health organisation you are loyal to your group and committed to the values and beliefs described above. You have to attend a meeting called by the government censor board to discuss whether they should allow the film to be screened. The meeting will be attended by other stakeholders in the community including a representative of the censorship board, the filmmaker, a parent of a young person, and a member of a women's advocacy group.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore your strategy should take the following points into account:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options and agree to other viewpoints?

Filmmaker:

You are a woman filmmaker who has just completed a film and are ready to release it in theatres. The two main characters of the film are married women who live in a fairly conservative community. After meeting each other at a mutual friend's party the two women begin to have sex with each other and develop a relationship outside of their marriages. While the film has no nude scenes, the women do kiss often and touch each other like lovers would.

You are very proud of your film and believe you have presented a controversial issue in your country in a tasteful and rather moderate way. Your objective was not to make a film that was extremely risqué since you want people to feel comfortable viewing it. You think the more people come to see the film, the greater the chances of people beginning to understand different sexual identities. Hopefully, it will create greater tolerance in this conservative country. You are not willing to change the film in any way, especially after working to ensure that it was not overtly offensive.

As a woman filmmaker you are loyal to your group and committed to the values and beliefs described above. You have to attend a meeting called by the government censor board to discuss whether they should allow the film to be screened. The meeting will be attended by other stakeholders in the community including a representative of the censorship board, a member of a women's advocacy group, a parent of a young person, and an NGO that works on HIV/AIDS prevention.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore your strategy should be formulated taking into account the following points:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options or agree to other viewpoints?

Government Censorship Board:

It has come to your attention that a new film has been completed by a female filmmaker and is ready to be released in theatres. The two main characters of the film are married women who live in fairly conservative community. After meeting each other at a mutual friend's party, the two women begin to have a sex with each other and develop a relationship outside of their marriages. While the film has no nude scenes, the women do kiss often and touch each other like lovers would.

As the government censorship board, you believe it is your duty to protect the public from films that could be distasteful and clash with the moral codes of people in your country. While many may think that love between two women is acceptable, you do not agree, and certainly will not promote such behaviour. Therefore, after briefly viewing the film you consider forbidding it from being released. There has been pressure however from a powerful section of the film industry to have the film released.

As a member of the government censorship board you are loyal to your group and committed to the values and beliefs described above. You have called a meeting to discuss whether they should allow the film to be screened. The meeting will be attended by other stakeholders in the community including a representative of a women's advocacy group, the filmmaker, a parent of a young person, and an NGO that works on HIV/AIDS prevention.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore your strategy should be formulated after taking the following points into account:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options or agree to other viewpoints?

Scenario 2: Sexuality education

Parent

It is the beginning of a new school year and an announcement is made at local schools that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was absent from the previous curriculum. According to the principal/head of the school, this curriculum will provide a more comprehensive education for the students.

You think that your child is too young to receive sexuality education. You also feel that it is not the job of the school to teach your child about sexuality, but the responsibility of you and your spouse. The school curriculum could promote ideas you do not agree with and you will have no control over what your child learns about sexuality. You decide to create a group of concerned parents to make sure that the new curriculum does not get taught.

As a concerned parent you are loyal to your group and committed to the values and beliefs described above. You are scheduled to have a meeting with a teacher, an official from the Ministry of Education, a representative of a youth advocacy organisation, and a young person from the school to decide whether to introduce this new curriculum.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore your strategy should be formulated taking the following points into consideration:

- Identify your allies potential among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options or agree to other viewpoints?

Teacher

It is the beginning of a new school year and an announcement is made at local schools that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was absent from the previous curriculum. According to the principal/head of the school, this curriculum will provide a more comprehensive education for the students.

You are unhappy with this change in curriculum because it means you must learn new information, including topics on sexuality, and how to teach it. Plus students will probably ask questions you are not entirely comfortable answering and make comments you may not want to respond to. You already anticipate some parents being displeased with the inclusion of sexuality in the curriculum, and expect that they will complain to you. You would prefer to use the old curriculum and are prepared to refuse to teach the curriculum and remove yourself from any health/life skills teaching if the management insists that the new curriculum be used.

As a teacher in the school, you are loyal to your group and committed to the values and beliefs described above. You are scheduled to have a meeting with a concerned parent, an official from the Ministry of Education, a representative of a youth advocacy organisation, and a young person from the school to decide whether to introduce this new curriculum.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore you should consider the following points while formulating your strategy:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Will you negotiate on your position? Will you consider other options or agree to other viewpoints?

Representative of the Ministry of Education

It is the beginning of a new school year and an announcement is made at local schools that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was absent from the previous curriculum. According to the principal/head of the school, this curriculum will provide a more comprehensive education for the students.

As an official from the Ministry of Education you fully support this new curriculum and you had provided funding and input to ensure that it would be culturally appropriate to the schools and work to broaden perspective on sexuality. You and the authors of the curriculum have worked hard to make sure it touches on key messages and important information. You see sexuality education as essential to young people's education and will firmly stand by the curriculum.

As an official from the Ministry of Education, you are loyal to your group and committed to the values and beliefs described above. You are scheduled to have a meeting with a teacher, a concerned parent, a representative of a youth advocacy organisation, and a young person from the school to decide whether to introduce the new curriculum.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore your strategy should be formulated after taking the following points into consideration:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options or agree to other viewpoints?

Youth Advocacy Organisation

It is the beginning of a new school year and an announcement is made at local schools that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was absent from the previous curriculum. According to the principal/head of the school, this curriculum will provide a more comprehensive education for the students.

Your organisation is thrilled about the introduction of this new curriculum. You have provided input on it, and consulted with the authors and the Ministry of Education. While the curriculum is not perfect, it is a first step. It will open up discussions on sexuality in schools and hopefully begin the process of broadening perspectives in the communities and the idea that people have the right to choose and practice their sexuality. Without this curriculum, students will be denied their right to sexuality education. This fact alone makes you committed to supporting and ensuring its use.

As a representative of the youth advocacy organisation, you are loyal to your group and are committed to the values and beliefs described above. You are scheduled to have a meeting with a teacher, a concerned parent, an official from the Ministry of Education, and a young person from the school to decide whether to introduce the new curriculum.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest your position; therefore your strategy should be formulated keeping the following points in mind:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options or agree to other viewpoints?

Young Person From the School

It is the beginning of a new school year and an announcement is made at local schools that the students will be taught a new health/life skills curriculum. The new curriculum includes sexuality education that was absent from the previous curriculum. According to the principal/head of the school this curriculum will provide a more comprehensive education for the students.

At first you are excited about the new curriculum. A class about sex is likely to be more interesting than other subjects. Also, you don't have the opportunity or feel comfortable talking about these issues at home. You aren't even sure what is meant by sexuality. But after thinking about it, you suddenly decide you would rather not have this new curriculum. Classes will probably stay the same, which means that boys and girls will have to discuss these issues together, which makes you uncomfortable. You are also worried that you may say something that will make you stand out. Perhaps the school should stay with the curriculum it had before.

As a young person from the school, you are loyal to your group and committed to the values and beliefs described above. You are scheduled to have a meeting with a teacher, a concerned parent, the ministry of education, and a representative of a youth advocacy organisation to decide whether to introduce the new curriculum.

Discuss the case and derive strategies for its resolution. Other groups may not agree with your point of view and protest against your position; therefore your strategy should be formulated taking the following points into account:

- Identify your allies among the other role/stakeholder groups.
- Who are your opponents among the other role/stakeholder groups? How can you strategise to counter their objections?
- What are your options for resolution? Are you willing to negotiate on your position? Will you consider other options or agree to other viewpoints?

Handout 5.7
Representing an Issue in Advocacy

Scenario 1

In September 2000, the United Nations General Assembly convened the Millennium Summit that brought together 189 United Nations member states. One of the notable outcomes of this meeting was the unanimous adoption of the Millennium Declaration, a document that reaffirmed the values and goals of the United Nations. The Declaration recognised the challenges and work that must be done by nations around the world to improve conditions for its people and hasten development. To provide a more detailed approach to achieving the goals outlined in the Declaration, in 2001 the UN Secretariat and various UN agencies worked in collaboration to create what are now known as the Millennium Development Goals (MDGs). These MDGs act as guidelines for nations to reach the goals addressed in the Declaration, and while broad and ambitious, they give specific time-bound targets and indicators for nations to follow.

Eight MDGs have been established. For the purpose of this exercise however, your group is an organisation that wants to create advocacy or information-based material that only addresses one of these MDGS: **promoting gender equality and empowering women.** This material is intended to raise awareness in your community and help to achieve this MDG. You must define who your community is (for example, a small rural village, a large city population etc.), and then create any material you feel will appropriately address this issue for them (for example, an educational brochure, a poster, a song etc.). In this material you should include issues of sexuality, sexual and reproductive health and rights. Only one piece of material is needed, and you must create an outline of what it will specifically look like: for example, will there be women on the poster; what will the women look like; will the women be well known or ordinary?

Scenario 2

In September 2000, the United Nations General Assembly convened the Millennium Summit that brought together 189 United Nations member states. One of the notable outcomes of this meeting was the unanimous adoption of the Millennium Declaration, a document that reaffirmed the values and goals of the United Nations. The Declaration recognised the challenges and work that must be done by nations around the world to improve conditions for its people and hasten development. To provide a more detailed approach to achieving the goals outlined in the Declaration, in 2001 the UN Secretariat and various UN agencies worked in collaboration to create what are now known as the Millennium Development Goals (MDGs). These MDGs act as guidelines for nations to reach the goals addressed in the Declaration, and while broad and ambitious, they give specific time-bound targets and indicators for nations to follow.

Eight MDGs have been established. For the purpose of this exercise however, your group is an organisation that wants to create advocacy or information-based material that only addresses one of these MDGS: **improved maternal health.** This material is intended to raise awareness in your community and help to achieve this MDG. You must define who your community is (for example, a small rural village, a large city population etc.), and then create any material you feel will appropriately address this issue for them (for example, an educational brochure, a poster, a song etc.). In this material you should include issues of sexuality, sexual and reproductive health and rights. Only one piece of material is needed, and you must create an outline of what it will specifically look like: for example, will there be women on the poster; what will the women look like; will the women be well known or ordinary?

Scenario 3

In September 2000, the United Nations General Assembly convened the Millennium Summit that brought together 189 United Nations member states. One of the notable outcomes of this meeting was the unanimous adoption of the Millennium Declaration, a document that reaffirmed the values and goals of the United Nations. The Declaration recognised the challenges and work that must be done by nations around the world to improve conditions for its people and hasten development. To provide a more detailed approach to achieving the goals outlined in the Declaration, in 2001 the UN Secretariat and various UN agencies worked in collaboration to create what are now known as the Millennium Development Goals (MDGs). These MDGs act as guidelines for nations to reach the goals addressed in the Declaration, and while broad and ambitious, they give specific time-bound targets and indicators for nations to follow.

Eight MDGs have been established. For the purpose of this exercise however, your group is an organisation that wants to create advocacy or information-based material that only addresses one of these MDGS: **combat HIV/AIDS.** This material is intended to raise awareness in your community and help to achieve this MDG. You must define who your community is (for example, a small rural village, a large city population etc.), and then create any material you feel will appropriately address this issue for them (for example, an educational brochure, a poster, a song etc.). In this material you should include issues of sexuality, sexual and reproductive health and rights. Only one piece of material is needed, and you must create an outline of what it will specifically look like: for example, will there be HIV positive people on the poster; what will they look like; will they be well known or ordinary?

Handout 5.8
Campaigns for Sexuality, Sexual and Reproductive Health and Rights

Campaign 1

Established in 2000 by a group of sex workers in support of sex workers rights, the Women's Network for Unity (WNU) is a grassroots representative collective of Phnom Penh, Cambodia. WNU has approximately 5000 members from 13 provinces and cities in Cambodia. Initially WNU used NGOs as the primary means for conducting advocacy initiatives, but in 2003 opted to elect members of the collective to act as representatives for the sex workers and the network directly. This allowed for community development and self-representation.

Since its inception, WNU has been an instrument to address the challenges encountered by sex workers in Cambodia, and ensure their right to live free of exploitation, social stigma and in safe and healthy environments. The Network has taken on a variety of projects and initiatives that use peer education, advocacy, and public education programmes to meet their goals. They have worked to improve attitudes and approaches to HIV/AIDS prevention, which has resulted in one of the most successful strategies to reduce HIV/AIDS, improve client negotiation skills, sex worker rights, and reduce violence against sex workers.

In early 2004, WNU began a campaign against the drug trials for an HIV/AIDS drug, Tenofovir. The drug was being tested for its efficacy in preventing HIV transmission. The Network heard reports from its members about recruitment for the trials being directed toward sex workers. Potentially unethical practices were involved: sex workers were being told that the drug had no side effects or minimal ones that could be treated easily; they were not being told the name of the drugs or their mode of impact; and recruiters were them that the drug was effective only for sex workers. In addition, many of the sex workers reported that they were not informed that the drugs were experimental and the long-term impact the drugs had on HIV/AIDS were unknown. The Network protested against this approach and also requested full insurance to protect them from future illness.

In August 2004 the Prime Minister of Cambodia halted the trials, citing claims that the practice violated human rights, and urged the people of Cambodia to refuse to participate. The announcement was welcomed by WNU, 'we are very happy with this order as we don't want to take part in this drug test. There is no safety guarantee for us,' said the director of WNU Kao Tha.

For more on this topic see: http://news.bbc.co.uk/2/hi/health/3562704.stm, http://womynsagenda.org/programs/sexworker/SW/swnu.html

Questions:

- What was the objective of this campaign? What issues of sexuality, sexual and reproductive health, and rights is it trying to address?
- What was the message of this campaign?
- How was the campaign successful? What more could have been done to achieve its goals?
- How can you use the lessons/tools of this campaign in your own work?
- Are you aware of any similar campaigns in your community, country or other countries in your region? How successful have they been and why?

Campaign 2

In Mumbai, India, in December 1998 hardliners of a political party went on the rampage after the screening of the Deepa Mehta film *Fire*, which portrays a lesbian relationship between two unhappy sisters-in-law. They tore down posters, vandalised cinemas and threatened moviegoers. There were spontaneous country-wide protests against such acts of violent discrimination and in New Delhi, India it led to the birth of Campaign for Lesbian Rights (CALERI). CALERI was made up of a group of individuals and organisations working in the area of human rights, women's, gay (male homosexual) and lesbian issues. *Fire* sparked the formation of CALERI, but the group's work and activism aimed to address broader issues and prejudices around lesbian rights. CALERI began their activist work by developing a year long public campaign strategy that would include raising public awareness for lesbian rights, addressing the suppression of women's sexuality, and promoting discussion and debate on how to articulate a space for lesbian rights into the women's movement in India.

The first steps of the CALERI campaign began with public demonstrations protesting the attacks on *Fire*. This was followed by a variety of public awareness raising and education efforts, that included distributing leaflets, conducting and scripting street plays, writing public memoranda against laws and policies that discriminated against lesbians in India, and conducting meetings and workshops with women's groups and NGOs. Members of CALERI also developed and published a bilingual report called 'Lesbian Emergence' to raise public consciousness and awareness of these issues among NGO activists and individuals. This report continues to inform people's work in the field.

For more on this topic see: *Lesbian Emergence - Campaign for Lesbian Rights*. Caleri. 1999. New Delhi.

Questions:

- What was the objective of this campaign? What issues of sexuality, sexual and reproductive health and rights is it trying to address?
- What was the message of this campaign and how was it communicated? Who was the audience?
- How do you think the campaign was successful in raising awareness? What more could have been done to achieve its goals?
- Would a campaign like this be successful in your region? Why or why not?
- What kind of advocacy and awareness raising approaches did the campaign use? How can you use the lessons and tools of this campaign in your own work?
- What obstacles would you face if you had to execute a campaign like this and how could you overcome them?
- Are you aware of any similar campaigns in your country or other countries in your region? How successful have they been and why?

Campaign 3

Section 377 of the Indian Penal Code reads: *Whoever voluntarily has carnal intercourse against the order of nature with any man, woman, or animal, shall be punished with imprisonment of either description for a term which may extend to 10 years and also be liable to fine.* As an explanation has been provided to the section, *'penetration is sufficient to constitute... carnal intercourse'*, being interpreted to include anal and oral sex.

Although the definition could also be interpreted to include married couples engaging in oral and anal sex, this law has been used primarily to harass and threaten men who have sex with other men and those who identify as homosexual.

Several groups have been calling for the removal of Section 377 in India. One group, the NAZ Foundation India Trust, a well-known NGO working on HIV/AIDS related issues, petitioned the Delhi High Court for this removal contending that penal action under Article 377 comes in the way of its anti-HIV/AIDS campaigns. Another group is Voices Against 377 (VA377), based in New Delhi, India, which is a coalition of individuals and organisations from a wide range of perspectives working to raise awareness on issues related to Section 377, and advocate for the decriminalisation of adult, consensual, same-sex desiring behaviour. VA377 has worked toward their goal in a variety of ways, which include participating in protests against violence, conducting trainings on sexuality, and working to build awareness with media and other social groups. The coalition launched the 'Million Voices Campaign' in December 2004, which is a nation-wide campaign to collect a million expressions on sexual rights.

In February 2006, the Supreme Court of India rejected an earlier Delhi High Court order (in response to the NAZ Foundation petition) that homosexuality and gay relationships constituted an 'unnatural offence'. The Court stated that 'Indian society was not ready for it', and sent the matter back to the court for reconsideration. This is seen as a positive step in the direction of reading down or repealing of the law and ensuring that same-sex adult consensual relationships are not penalised anymore. At the time of publication of this manual, Section 377 was still part of the Indian Penal Code, and VA377 continues to advocate for its removal and widen the awareness of issues concerning sexuality and gender.

For more on this topic see: Voices Against 377. *Rights For All: Ending Discrimination Against Queer Desire Under Section 377.* New Delhi. and http://www.sodomylaws.org/world/india/innews048.htm

Questions:

- What is the objective of this campaign? What issues of sexuality, sexual and reproductive health and rights is it trying to address?
- What is the message of this campaign and how was it communicated? Who was the audience?
- How successful do you think the strategies being used in this campaign have been? What more could the campaign have done to achieve its goals?
- Would a campaign like this be successful in your region? Why or why not?
- What obstacles would you face if you had to execute a campaign like this and how could you overcome them?
- What kind of advocacy and awareness raising approaches did the campaign use? How can you use the lessons/tools of this campaign in your own work?
- Are you aware of any similar campaigns in your community, country or other countries in your region? How successful have they been and why?

Campaign 4

Norplant is a contraceptive for women. It consists of six small, plastic tubes implanted under the skin of a woman's arm. These tubes slowly release hormones that prevent pregnancy and can be left in for three months at a time. Norplant was set to be tested in trials in Bangladesh and other parts of South and Southeast Asia beginning in the early 1980's. Marketing for these Norplant trials first began in Bangladesh in 1981 with advertisements in Bengali-language newspapers that promised sterility for five years, reversible when the implants were removed. The advertisements mentioned nothing about the product's experimental nature or possible adverse health conditions associated with it.

Women's groups were concerned over the testing of Norplant in Bangladesh, particularly because it is such an invasive type of contraceptive and was still in the nascent stages of testing. Another concern was that participants were not adequately informed of its possible adverse side effects. Bangladeshi women's groups and concerned doctors, pharmacists and health care workers protested to the Minister of Health who subsequently postponed the trials.

In 1985, Norplant was brought back into Bangladesh, this time in the context of an explicit clinical trial. There were no public announcements and advertising campaigns about Norplant and no details of the trial and the participants. Bangladeshi social workers became aware of the women being recruited from slums for the trial. The social workers had little cooperation from the organisations conducting the trials to improve on the education and information being given to the women. As a result the workers started to go into slum areas themselves to locate women who had the implants and discuss their implications.

For more on this topic see: Akhtar, F. 1995. *Resisting Norplant: Women's Struggle in Bangladesh Against Coercion and Violence.* Bangladesh: Narigrantha Prabartana.

Questions:

- What was the objective of the campaign? What issues of sexuality, sexual and reproductive health and rights is it trying to address? How was it successful?
- What was the message of this campaign and how was it communicated? Who was the audience?
- How was it successful? What more could the campaign have done to achieve its goals?
- Would a campaign like this be successful in your region? Why or why not?
- What obstacles would you face if you had to execute a campaign like this and how could you overcome them?
- What kind of advocacy and awareness raising approaches did the campaign use? How can you use the lessons/tools of this campaign in your own work?
- Are you aware of any similar campaigns in your community, country or other countries in your region? How successful have they been and why?

EXERCISE MODIFICATION

Campaign 5

Until recently, abortion has been illegal in Sri Lanka, except when a woman's life is in danger. This has resulted in up to 1,000 illegal and unsafe abortions daily. There have been attempts to legalise abortion since as early as 1995, such as a single introduction of legislation into the Penal Code that would legalise abortion only in cases of rape and incest. But these all failed when legislators opposed the initiatives, citing moral reasons.

Women's groups and activists in Sri Lanka, including INFORM, a human rights based NGO in Colombo, Sri Lanka have campaigned for legalisation of abortion. In 2004, a proposed bill came into the Sri Lankan legislature called the Women's Rights Bill, which has an indirect reference to abortion rights: 'Women shall enjoy equal rights in all areas of private life including rights within the family and their private lives, and the right to control their bodies and rights relating to child birth.' Many activists are hoping that the bill passes through the legislature.

Option 1

Questions:

- What is the objective of this campaign? What issues of sexuality, sexual and reproductive health and rights is it trying to address?
- What would you do to make this a successful campaign in your community?
- How would the campaign meet its goals?
- Are you aware of any similar campaigns in your community, country or other countries in your region? How successful have they been and why?

Option 2

Plan a yearlong campaign around this issue keeping in mind the following:

- What obstacles would you face if you had to execute this campaign and how could you overcome them?
- Who would your allies and adversaries be in this campaign?
- What steps would you take toward your goal/s?
- Are you aware of any similar campaigns in your community, country or other countries in your region? How successful have they been and why?

Appendices

APPENDIX A

Some relevant international documents related to rights and ethics

Beijing Conference Declaration and Platform of Action.
http://www.un.org/womenwatch/daw/beijing/platform/

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).
http://www.un.org/womenwatch/daw/cedaw/

Convention on the Rights of the Child (CRC). www.unicef.org/crc

Declaration of Helsinki. http://www.wma.net/e/policy/b3.htm

International Conference on Population and Development (ICPD).
http://www.unfpa.org/icpd/summary.htm

International Convention on the Elimination of all forms of Racial Discrimination (CERD). http://www.ohchr.org/english/law/cerd.htm

International Covenant on Civil and Political Rights (ICCPR).
http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

International Covenant of Economic, Social and Cultural Rights (ICESCR). http://www.unhchr.ch/html/menu3/b/a_cescr.htm

Universal Declaration of Human Rights (UDHR).
http://www.un.org/Overview/rights.html

APPENDIX B

Sample listing of films related to sexuality, sexual and reproductive health and rights

Showing documentaries, feature films, or television programmes and having a discussion about them is an interesting and non-threatening way of addressing some of the contentious and difficult issues contained in this manual. This also allows participants to visually engage with an issue making it more 'real' for them. Using films in trainings help relieve the boredom and monotony of sessions, makes learning fun and also gives facilitators a break.

A sample list of English and regional language films is presented in the following pages. Please note that this is a sample list to illustrate the idea that facilitators can choose from a variety of films. Facilitators can also use current television serials to illustrate particular themes. The Internet is an excellent source for information and reviews on various.

This list is not exhaustive. Facilitators need to choose films carefully, keeping in mind the objective of screening it, the audience and the availability of the film in their region.

THE ACCUSED (ENGLISH), 1988

Director: Jonathan Kaplan, 110 minutes

The Accused takes a powerful and thought provoking look at human nature and individual moral conscience, and a judicial process that treats the person who is raped like a criminal. It highlights the consequences of not only rape, but the judicial system as well.

AFTER SUNSET (ENGLISH NARRATIVE AND VOICE OVER), 2000

Director: Tahir Khilji, 40 minutes

The film illuminates the rarely-seen side of Lahore, that emerges when the light of the day has faded. Massage boys talk about their lives and their work, not always as masseurs. This film offers a glimpse into the dynamics of a marginalized group, struggling to survive against great social odds and health challenges.

AIMEE AND JAGUAR (GERMAN – ENGLISH SUBTITLES), 1999

Director: Max Färberböck, 125 minutes

A story about love between two women set in 1943 Berlin, against the backdrop of the Second World War.

ALL ABOUT MY MOTHER (SPANISH – ENGLISH SUBTITLES), 1999

Director: Pedro Almodovar, 102 minutes

Cecilia Roth overcomes her grief at the loss of her son and becomes caregiver to a colourful extended family: a pregnant nun, a transvestite prostitute and two troubled actresses.

AASTHA (IN THE PRISON OF SPRING) (HINDI – ENGLISH SUBTITLES), 1997

Director: Basu Bhattacharya, 132 minutes

A middle class homemaker is introduced to sex work through a chance encounter. Oblivious to her husband, she is torn between the pleasures her new life afford her and the guilt-ridden awareness of her sexuality.

ASTITVA (HINDI – ENGLISH SUBTITLES), 2000

Director: Mahesh Manjrekar, 113 minutes

The humdrum life of a homemaker is disturbed when she is informed of a significant inheritance from her long ago music teacher which causes her husband to wonder if the teacher and his wife had an affair.

BANDIT QUEEN (HINDI – ENGLISH SUBTITLES), 1995

Director: Shekhar Kapur, 119 minutes

The movie tells the story of the bandit queen Phoolan Devi who was sent to prison in 1983 and got free in 1994. During five years she was prosecuted by the Indian police and turned into a legend.

BENAQAAB (MARATHI AND HINDI – ENGLISH SUBTITLES), 2002

Director: Chelam Zulfani, 50 minutes

Benaqaab is about the sex workers' movement in Sangli, a small town in Maharashtra. The film unmasks the problems that sex workers face, including exploitation, violence, and lack of access to health and legal services, and harassment from police, madams and pimps, as well as their strength as a collective.

BOUND (ENGLISH), 1996

Directors: The Wachowski Brothers, 1 hour/ 44 minutes

His girlfriend and her lesbian lover outwit a gang leader in this gangster movie with a twist.

BOLO BOLO (ENGLISH), 1991

Director: Gita Saxena, 30 minutes

Focusing on the South Asian community of Toronto, this video is a tool for facilitators, educators, community workers and anyone interested in organising around issues of health, sexuality and cultural identity.

BOYS DON'T CRY (ENGLISH), 1999

Director: Kimberly Pierce, 118 minutes

Based on the true story of Brandon Teena, (a transgendered teen who preferred life in a male identity until it was discovered he was born biologically female), the film looks at the hatred that being different can generate in small town America.

BROKEBACK MOUNTAIN (ENGLISH), 2005

Director: Ang Lee, 134 minutes

An award-winning film based on the E. Annie Proulx story about a forbidden and secretive relationship between two cowboys and their lives over the years.

CHANDNI BAR (HINDI – ENGLISH SUBTITLES), 2002

Director: Madhur Bhandarkar, 150 minutes

This Bombay film delves into travails of Mumtaz, a small town girl, whom circumstances forced to leave her hometown and led her to become a bar dancer in Mumbai

CHOCOLATE BABIES (ENGLISH), 1996

Director: Stephen Winters, 83 minutes

A film about a group of queer men and women who launch an assault campaign on conservative politicians who refuse to support a hospice in their New York neighbourhood.

THE CLOSET (FRENCH – ENGLISH SUBTITLES), 2001

Director: Francis Veber, 85 minutes

Francois, a dull and lonely accountant meekly endures office jokes and backroom whispers that he is about to be fired. Funnily enough, a rumour that he is gay starts spreading which ends up being advantageous for Francois.

DANCE ME TO MY SONG (ENGLISH), 1998

Director: Rolf de Heer, 98 minutes

An uplifting story of a woman in a wheelchair, whose carer is vying for the attentions of the same man she is interested in.

DIKSHA (INITIATION) (HINDI), 1991

Director: Arun Kaul. 135 minutes

A story about a learned Acharya who has to find out which of his two young disciples has 'impregnated' his widowed daughter and to decide the daughter's fate. He does not have many choices – for the prescribed Hindu punishment for this is death.

EROTIQUE (GERMAN), 1994

Directors: Lizzie Borden, Monika Treut, and Clara Law, 90 minutes

Three women filmmakers examine sexuality in this anthology. Segment 1, 'Let's Talk About Sex' is the story of an aspiring actress whose day job is as a phone-sex operator. Segment 2, 'Taboo Parlor' tells the story of two lesbians, who, for variety pick up a man for sex. Segment 3 'Wonton Soup' is about an Australian-Chinese man who tries to rekindle his affair with a Chinese woman by returning to their roots.

EUNUCHS: INDIA'S THIRD GENDER (ENGLISH), 1991

Director: Michael Yorke, 40 minutes

This documentary looks at eunuchs and attitudes towards them in India, where they are treated with a mixture of disgust, fear and respect. The film contrasts the traditional mannerisms, lifestyles and attitudes of the rural hijras, who are still regarded respectfully, and that of their more marginalised urban counterparts.

EVERYTIME YOU LOOK AT ME (ENGLISH), 2004

Director: Alrick Riley, 90 minutes

Chris and Nicky are two people who fall in love, though the odds are stacked against them, in this contemporary story starring two disabled actors in lead roles for the first time.

FAREWELL, MY CONCUBINE (CANTONESE), 1992

Director: Chen Kaiage, 154 minutes

The story of two Peking Opera superstars who meet as young boys, and who, for the next 50 years, are linked by their stage roles and their lives are played out against social upheavals.

FIRE (ENGLISH AND HINDI), 1996

Director: Deepa Mehta, 104 minutes

The film portrays the love between two unhappy sisters-in-law in a New Delhi middle-class family. This film sparked off protests in India and led to advocacy for lesbian rights and freedom of expression.

FISH AND ELEPHANT (CHINESE - ENGLISH SUBTITLES), 2001

Director: Li Yu; 106 minutes

A film about two women in a relationship, who have to deal with one of their mothers trying to arrange boyfriends for her. And the other woman's former girlfriend reappears, after having killed her own abusive father.

FLESH AND PAPER (ENGLISH), 1990

Director: Pratibha Parmar, 26 minutes

In 1986, Suniti Namjoshi and Gillian Hanscombe published a selection of poems entitled Flesh and Paper. The poems are a dialogue between the two women as friends, poets and lovers. This film features an interview with Suniti Namjoshi, and discussions by others about her life and work with readings of her poetry.

FRESH KILL (ENGLISH), 1993

Director: Shu Lea Cheang, 80 minutes

The story of two young lesbian parents, Shareen and Claire who are raising their five-year-old daughter Honey in a converted garage on Staten Island.

FRIENDS IN HIGH PLACES (ENGLISH), 2001

Director: Lindsey Merrison, Burma, 86 minutes

Guided by two lively 70-year olds, the director explores the role of the spirit mediums of the Nat cult in Burma. The spirit mediums are often homosexual men, who communicate with the spirits and take on their flamboyant characteristics in ecstatic rituals.

FUNERAL PARADE OF ROSES (JAPANESE – ENGLISH SUBTITLES), 1969

Director: Toshio Matsumoto, 105 minutes

Scandalous when it first appeared, *Funeral Parade of Roses* is still seen as a sensational depiction of the gay subculture, as it existed in the Tokyo in the late '60s. The film is about a gay son who kills his mother and sleeps with his father in this Japanese version of the Oedipus legend.

GULABI AAINA (THE PINK MIRROR) (HINDI – ENGLISH SUBTITLES), 2004

Director: Sridhar Rangayan, 40 minutes

The film pits two Indian drag queens against a westernized gay teenager in a battle to woo a handsome hunk. Using the Bollywood soap idiom of song, dance and drama the film also explores other veiled issues related to the Indian gay community including HIV/AIDS.

HEATHER ROSE GOES TO CANNES, 1998

Director: Christopher Corin, 52 minutes

Heather Rose has Cerebral Palsy, uses a wheelchair and communicates through a voice machine. She co-wrote and starred in the feature film Dance Me to My Song, which was invited to the Cannes Film Festival. This is the story of Heather's journey to the festival, her struggles and her ultimate success.

I LIKE YOU, I LIKE YOU VERY MUCH (JAPANESE – ENGLISH SUBTITLES), 1995

Director: Hiroyuki Oki, 58 minutes

A love triangle between three men in the liberal enclave of Kochi City, Japan that forces each of the men to question his sexuality and identity.

IN THE FLESH (HINDI – ENGLISH SUBTITLES), 2002

Director: Bishakha Dutta, 53 minutes

A documentary film that provides an intimate insider's account of what it is really like to be in prostitution by following the lives of three people in prostitution.

KAMA SUTRA (ENGLISH), 1997

Director: Mira Nair, 114 minutes

The story set in 16th century India, centers on Maya, a servant girl working for a princess, Tara. Maya has always been forced to subsist on hand-me-downs from Tara, but on the eve of the princess' wedding, she sees a chance for revenge by catching the groom's eye.

KHUSH (ENGLISH), 1991

Director: Pratibha Parmar, 24 minutes

Khush deals with the lives of South Asian lesbians and gay men as they negotiate their existence in Britain, North America, and India. In their interviews, these men and women explore what it means to be queer and of color in their particular locale.

KING OF DREAMS (ENGLISH), 2001

Director: Amar Kanwar, 30 minutes

This is a film about men and sexuality in India and explores what it means to be a man who is sexual.

KORE (ENGLISH), 1994

Director: Tran T. Kim-Trang, 17 minutes

By focusing on the blindfold, Kore explores the eye as purveyor of desire, sexual fear, and the fantasy of blindness.

LADYBOYS (ENGLISH), 1992

Director: Jeremy Marre, 60 minutes

A made-for-BBC look at two teenage Thai boys as they try to escape rural poverty by becoming successful *katoi*, or female impersonators.

LAN YU (MANDARIN – ENGLISH SUBTITLES), 2001

Director: Stanley Kwan, 87 minutes

This movie tells the story of a wealthy businessman who flits from one relationship to the next, passing time until the day comes when he will marry and have children. Then he meets Lan Yu, a poor student and wakes up 'the morning after' a night with him to find that everything is different.

THE LOVER (ENGLISH), 1992

Director: Jean-Jacque Annaud, 115 minutes

A poor French teenager engages in an affair with a wealthy Chinese heir in 1920s Saigon. For the first time in her young life she has control, and she wields it deftly over her besotted lover throughout a series of clandestine meetings.

LISTEN TO MY VOICE (ENGLISH NARRATIVE AND VOICE OVER), 2004

Director: Tahir Khilji, 15 minutes

A look at why a group of Pakistani men choose to have sex with other men and the violence they subject themselves to by doing so.

MACHO DANCER (ENGLISH), 1988

Director: Lino Brocka, 136 minutes

Abandoned by his American lover, a teenager from the mountains journeys to Manila in an effort to support his family. With a popular callboy as his mentor, he enters the glittering world of male strippers, prostitution, drugs, sexual slavery, police corruption and murder.

MAJMA (HINDI – ENGLISH SUBTITLES), 2001

Director: Rahul Roy, 54 minutes

The film explores male sexuality and gender relations in the 'instability' of working class lives.

MANDI (HINDI – ENGLISH SUBTITLES), 1983

Director: Shyam Benegal, 167 minutes

This film is based on a classic Urdu short story 'Aanandi' by Pakistani writer Ghulam Abbas. It deals with a brothel at the heart of a city, in an area that some politicians want for its prime locality. They rally against the brothel and its inhabitants in the name of morality, and soon everyone in the area jumps on the bandwagon.

THE MAN IN HER LIFE, [ANG LALAKI SA BUHAY NI SELYA] (FILIPINO), 1997

Director: Carlos Siguion-Reyna, 96 minutes

Disappointed with her boyfriend who only wants sex but no 'real relationship' nor marriage, this is the story of a woman who decides to marry a gay man who, she is convinced, is definitely different.

MANJUBEN TRUCK DRIVER (HINDI AND GUJARATI – ENGLISH SUBTITLES), 2002

Director: Sherna Dastur, 52 minutes

On the Indian highway as a woman truck driver, Manjuben inhabits a male world. She owns and drives a truck. A film about freedom, about identity, and about desires.

MARKOVA: COMFORT GAY (ENGLISH AND TAGALOG – ENGLISH SUBTITLES), 2000

Director: Gil Portes, 97 minutes

An unconventional true story of Walter Dempster Jr, otherwise known as Markova. Escaping the torment of growing up with an abusive older brother, he and his friends found further suffering at the hands of Japanese soldiers, forced into sex work to survive. But even after the war, Markova's struggle continued.

MATRUBHOOMI: A NATION WITHOUT WOMEN (HINDI), 2004

Director: Manish Jha, 98 minutes

Perhaps the first full-length feature film on female infanticide made in India, it addresses the implications of millions of 'missing girls' in the country.

MA VIE EN ROSE (FRENCH – ENGLISH SUBTITLES), 1998

Director: Alain Berliner, 86 minutes

This is a film about six-year old Ludovic who believes that he was meant to be a little girl and that the mistake will soon be corrected.

MIDNIGHT DANCERS (FILIPINO – ENGLISH SUBTITLES), 1994

Director: Mel Chionglo, 118 minutes

Three young and good-looking brothers live with and support their parents in Manila; they dance at the male Club Exotica and work as callboys.

MONSOON WEDDING (HINDI AND ENGLISH), 2001

Director: Mira Nair, 116 mins

An exuberant family drama set in Punjabi culture, where ancient tradition and dot-com modernity combine in unique ways, this film also address sexual abuse.

NORTH COUNTRY (ENGLISH), 2005

Director: Niki Caro, 126 minutes

This is a fictionalised account of the first major successful sexual harassment case in the United States, Jenson vs. Eveleth Mines, where a woman who endured a range of abuses while working as a miner filed and won the landmark 1984 lawsuit.

OLIVER (MANDARIN – ENGLISH SUBTITLES), 1983

Director: Nick de Ocampo

A documentary of the life of Oliver, a male sex worker at a Manila bar who is married with children and supports his family with his earnings doing male-to-male sex shows.

THE OUTSIDERS/ THE OUTCASTS (MANDARIN – ENGLISH SUBTITLES), 1986

Director: Yu Kan-Ping, 102 minutes

The film is about teenage boys abandoned by their families because they are gay, and the efforts of an aging photographer to provide a home and family for them. This Taiwanese film is said to be the first film with a homosexual theme to be licensed by the Republic of China.

PARIS IS BURNING (ENGLISH), 1990

Director: Jennie Livingston, 76 minutes

A story of street-wise urban survival, gay self-affirmation, and the pursuit of a desperate dream – to live for a brief dazzling moment in a fantasy world of high fashion, status and acceptance.

PARAMA (BENGALI – ENGLISH SUBTITLES), 1985

Director: Aparna Sen, 139 minutes

This is a story about a 40-year-old married woman, who falls in love with a younger man, an expatriate photo-journalist.

PHILADELPHIA (ENGLISH), 1993

Director: Jonathan Demme, 125 minutes

One of the first and few mainstream films addressing the stigma and discrimination of HIV positive people.

PRISCILLA QUEEN OF THE DESERT (ENGLISH), 1994

Director: Stephan Elliott, 103 minutes

An Australian film about two drag queens, and a transsexual woman driving across the outback from Sydney to Alice Springs in a large bus they have named Priscilla.

QUILLS (ENGLISH), 2000

Director: Philip Kaufman, 124 minutes

Based on the life of the Marquis de Sade whose erotic stories whip up all of France into a sexual frenzy, until a conservative doctor tries to put an end to the fun, inadvertently stoking the excitement to a fever pitch.

A QUEER STORY (CHINESE – ENGLISH SUBTITLES), 1997

Director: Shu Kei, 111 minutes.

This Hong Kong comedy-drama chronicles the upcoming wedding of marriage counselor. The fact that he is gay does not stop his parents from continuing to pressure him. But marriage is only a part of Law's problems.

SHANGHAI PANIC (MANDARIN – ENGLISH SUBTITLES), 2002

Director: Andrew Cheng, 87 minutes.

A film about the lives of four Shanghai teenagers – sexuality, drugs, HIV and other 'panics' amongst a group of clubbing friends.

SHINJUKU BOYS (ENGLISH), 1995

Directors: Longinotto and Williams, 53 minutes.

This documentary is set in the New Marilyn nightclub in Tokyo, Japan where the hosts are women who have chosen to live as men. They can only make their living as hosts in a nightclub with other 'wannabes' like them.

SIXTH HAPPINESS (ENGLISH), 1997

Director: Warris Hussein, 98 minutes

Disabled activist Firdaus Kanga scripted this autobiographical British drama based on his novel, *Trying to Grow* about romantic and other challenges he faced growing up with brittle bone disease in a middle-class Bombay family.

STRAIGHT FOR THE MONEY (ENGLISH), 1994

Director: Hima B., 60 minutes

Hima B. interviews eight lesbian and bisexual women in San Francisco – lap-dancers and peep-show dancers in strip clubs – who talk about their motivations, aspirations, and identities as queer women whose jobs make them 'straight for the money.'

THE SNAKE BOY, (CHINESE – ENGLISH SUBTITLES), 2002

Director: Michelle Chen, Xiao Li, 60 minutes

The story of a homosexual jazz musician in Shanghai, who comes to terms with his sexuality and his music.

SOMETHING LIKE A WAR (ENGLISH), 1991

Director: Deepa Dhanraj, 60 minutes

A documentary about the Indian government's family planning programme and the consequent violations of women's reproductive rights.

SPACKED OUT [MO YAN KA SAI] (CANTONESE – ENGLISH SUBTITLES), 2000

Director: Lawrence Ah Mon, 91 minutes

A documentary style film about four teenage girls in Hong Kong, who spend their time shopping, partying, and experimenting with sex and drugs until trouble strikes and harsh reality sets in.

SUGAR SWEET (JAPANESE – ENGLISH SUBTITLES), 2002

Director: Desiree Lim, 67 minutes

Naomi pays the bills by directing lesbian porn. Her male bosses think her work is 'too gay'; her friends think she's a sell out. When she gets a chance to direct a popular matchmaking show and help a friend suffering lesbian bed death romantic sparks fly.

TALES OF THE NIGHT FAIRIES (BANGLA – ENGLISH SUBTITLES), 2003

Director: Shohini Ghosh, 74 minutes

Five sex workers – four women and one man – along with the filmmaker/narrator embark on a journey of storytelling. The film explores the power of collective organising and resistance while reflecting upon contemporary debates around sex work.

TRANSAMERICA (ENGLISH), 2005

Director: Duncan Tucker, 103 minutes

A pre-operative male-to-female transsexual takes an unexpected journey when she learns that she fathered a son, now a teenage runaway hustling on the streets of New York.

THE TWIN BRACELETS (CANTONESE – ENGLISH SUBTITLES), 1990

Director: Yu-Shan Huang, 100 minutes

A young woman in an oppressive Chinese fishing village seeks love and escape in the arms of her childhood girlfriend against a backdrop of customs and mores that treat women as property with no human rights.

TWINKLE [KIRA KIRA HIKARU] (JAPANESE – ENGLISH SUBTITLES), 1992

Director: George Matusoka, 103 minutes

The story about a woman and a gay doctor who decide on a marriage of convenience to satisfy their parents. The arrangement falls apart when the doctor's student boyfriend becomes jealous, the woman decides she wants to have a baby, and her parents find out about her husband's homosexuality.

TWO OR THREE THINGS I KNOW ABOUT THEM (CANTONESE – ENGLISH SUBTITLES), 1991

Director: Anson Mak, 39 minutes

An experimental four-part video that deals with the issues and concerns of an emerging lesbian community in Hong Kong.

UNLIMITED GIRLS (HINDI – ENGLISH SUBTITLES), 2002

Director: Paromita Vora, 94 minutes

An exploration of engagements with feminism told through diverse characters in a chat room. The film uses a personally reflective tone and mixes non-fiction and fiction, to ask questions about feminism in our lives: why must women lead double lives, being feminist but not saying they are.

UTSAV (HINDI AND URDU), 1983

Director: Girish Karnad, 145 minutes

The film is based on the 6th century A.D. Sanskrit play 'The Golden Toy Chariot' by the famous Indian playwright Bhasa. It is the story of a palace courtesan who falls in love with a married and penniless man while hiding from the amorous attentions of the king's brother-in-law.

THE VIENNA TRIBUNAL (ENGLISH), 1994

Director: Gerry Rogers, 48 minutes

The film highlights personal testimonies at the Global Tribunal on Violations of Women's Rights which was held in conjunction with U.N. World Conference on Human Rights in Vienna in 1993. It makes a powerful case for why women's rights need to be seen as human rights.

VIVA L'AMOUR (MANDARIN – ENGLISH SUBTITLES), 1994

Director: Tsai Ming-Liang, 119 minutes

This film is about a seductive real estate agent, a street merchant, and their encounters in one of the thousands of vacant, anonymous apartments that fill Taipei, Taiwan, while a shy young gay man spies on the couple, creating a love triangle.

THE WEDDING BANQUET (ENGLISH AND MANDARIN – FRENCH SUBTITLES), 1993

Director: Ang Lee, 104 minutes

To satisfy his nagging parents, a gay landlord and a female tenant agree to a marriage of convenience, but his parents arrive to visit and things get out of hand.

WHEN FOUR FRIENDS MEET (HINDI – ENGLISH SUBTITLES), 2000

Director: Rahul Roy, 43 minutes.

The film examines views of masculinities and gender roles and expectations through the eyes of four young working-class men in New Delhi, India.

YANG + YIN: GENDER IN CHINESE CINEMA (CANTONESE AND MANDARIN – ENGLISH SUBTITLES), 1995

Director: Stanley Kwan, 80 minutes

This documentary shows how gender and sexuality are dealt with in Chinese movies. The film examines male bonding and phallic imagery; same-sex bonding and physical intimacy; and the phenomenon of Yam Kim-Fai, a Hong Kong actress who spent her life portraying men on and off the screen.

SOURCES:

www.geocities.com/WestHollywood/Heights/5010/wfilms.html

www.jagori.com

www.solarispictures.com/ga.htm

www.us.imdb.com/search

www.hkmdb.com

www.bayswan.org/swfest/tales.html

http://www.imdb.com/

www.infochangeindia.org/documentary

www.longyangclub.org/denver/qac/s/qacs.html

TARSHI (Talking About Reproductive and Sexual Health Issues) is a not-for-profit organization based in New Delhi, India, that works on issues of sexuality and reproductive health. TARSHI believes that 'all people have the right to sexual wellbeing and to a self-affirming and enjoyable sexuality'. TARSHI works towards expanding sexual and reproductive choices in people's lives in an effort to enable them to enjoy lives of dignity, freedom from fear, infection, and reproductive and sexual health problems. TARSHI works towards achieving this vision through the following:

The Helpline: Provides information, counselling, and referrals on sexuality and sexual and reproductive health issues

Public Education: Through publications, public events, campaigns and sessions in schools and colleges, raises awareness of sexuality and rights issues

Training: On helpline counselling skills and on sexuality, reproductive health and rights issues

The Sexuality and Rights Institute: An annual two-week long conceptual course focusing on the interface between sexuality and rights, conducted in collaboration with CREA (Creating Resources for Empowerment in Action). For more, please visit www.sexualityinstitute.org

The South and Southeast Asia Resource Centre on Sexuality: Increases knowledge and scholarship on issues of sexuality and sexual health and sexual well being in the South and Southeast Asia region. For more, please visit www.asiasrc.org

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