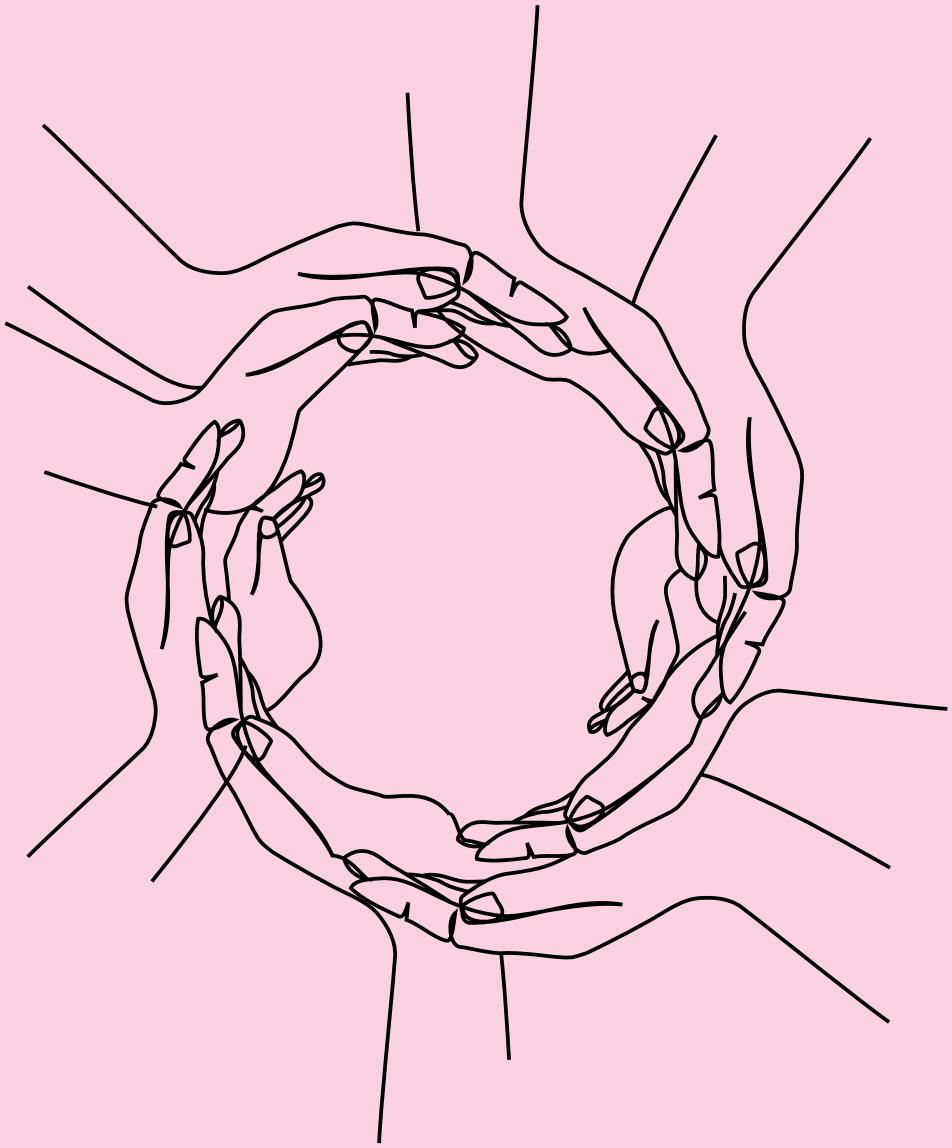
ENFOLD PROACTIVE HEALTH TRUST

DEMYSTIFYING SEXUALITY HANDBOOK

–

FOR STUDENTS, TEACHERS AND PRACTITIONERS OF PUBLIC HEALTH



For use in conjunction with Demystifying Sexuality Reference Book[1]
Looking at sexuality with a Rights-based, Restorative and Gender Transformative Lens

enfold

Published - July 2022 by Enfold Proactive Health Trust

Enfold Proactive Health Trust
No. 22, 3rd Main Road, Ashwini Layout, Ejipura,
Inner Ring Road, Koramangala,
Bengaluru, 560047, India
T: +91 99000 94251
www.enfoldindia.org

DEMYSTIFYING SEXUALITY HANDBOOK

– FOR STUDENTS, TEACHERS AND PRACTITIONERS OF PUBLIC HEALTH

–

For use in conjunction with
Demystifying Sexuality Reference Book – Looking at Sexuality from a Rights-based, Restorative and Gender Transformative Lens

TABLE OF CONTENTS

ACKNOWLEDGEMENT

Many of the case studies in this Handbook draw from the lived experiences of people's lives. Enfold acknowledges and honours all children, young people, families and individuals who chose to overcome their inhibitions, reposed their faith and trust in social workers, and reached out for support to resolve challenges they were facing in the area of sexuality or sexual violence, despite personal, familial and social barriers. We applaud them for breaking the silence and thank them for sharing their struggles, hopes and successes in this area of their lives. We sincerely hope that this Handbook serves as a resource to empower more individuals to find answers they may have been seeking, and also the courage to seek support in ways that help them heal and grow through their journeys.

This Handbook has been adapted for use by students, teachers and practitioners of Public Health from Enfold's Demystifying Sexuality Handbook for Students, Teachers and Practitioners of Social Work, published originally in July 2021.

Enfold is deeply grateful to all the social work professionals who contributed to the drafting of the Demystifying Sexuality Handbook for Students, Teachers and Practitioners of Social Work, July 2021. We remain thankful to the following faculty from Martin Luther Christian University, Shillong, Meghalaya for conceptualising the content and flow of this handbook -

Dr. Ardonister Lyngdoh (Assistant Professor, School of Social Work and Associate Dean, Academics); Mr. Arwan Lyngdoh (Assistant Professor, Department of Allied Health Sciences); Dr. Lavinia Mawlong (Assistant Professor, Centre for Gender Equity and Diversity Education and Research and Assistant Dean, Academics); Dr. Marbabiang Syiemlieh (Assistant Professor and Associate Dean, School of Social Work); Ms. Naphibanmer Wankhar (Assistant Professor, Department of Allied Health Sciences); and Dr. R. Jennifer War (Associate Professor, Centre for GENDER and Dean, Academics).

Special thanks to Enfold team members and consultants, Arlene Manoharan and Neeraja Sajan, for their extensive contribution in refining the structure and content of the Handbook for Students, Teachers and Practitioners of Social Work by contributing case studies, reflective questions, suggested activities and discussion points, and for also pointing to linkages with the child protection and justice systems including existing policies, and laws. Special thanks also to Dr. Kranti Suresh Vora for adapting the handbook for students, teachers and practitioners of Public Health by adding relevant introduction, information and activities to the chapters.

Arlene Manoharan has a Masters degree in Social Work, with specialisation in Family and Child Welfare from Tata Institute of Social Sciences (TISS). She has over thirty one years of experience in the field of professional social work. She authored case studies on women survivors of domestic violence as a contribution to a TISS publication in 1997 - 'Shades of Courage - Women and Section 498 A (IPC)' - while at the Special Cell for Women in Distress, Police Commissioner's Office, Mumbai (a Field Action Project of TISS). She initially worked with children in street situations in various civil society organisations over 9 years. She then worked at the Centre for Child and the Law (CCL), a research centre of the National Law School of India University (NLSIU), for 19 years.

At CCL-NLSIU, as a Research Fellow, she headed the Juvenile Justice Program and also led the Centre as Centre Coordinator for 2 years. She engaged in action research, working at the grassroots within government run child care institutions while also undertaking research, training, teaching and advocacy to inform the formulation and reform of policy and laws relating to children as well as their effective implementation, at both, the local and national levels. She is a national level trainer at various academic and training institutes, and was a member of various statutory and other committees. She has conducted training for Child Welfare Committees, Juvenile Justice Boards, State Commissions for Protection of Child Rights (SCPCRs), government functionaries, NGOs and law teachers at the state and national levels. She also developed the curriculum, authored the self-instruction material and taught modules of NLSIU's PG Diploma on Child Rights Law. She has also published extensively. She currently works as an independent child protection specialist while consulting part-time as the Head of the Restorative Practices team at Enfold.

Neeraja Sajan, PhD scholar, TISS, Mumbai, is a sociologist and intersex studies scholar who has been working for and researching various aspects of the rights of and issues faced by intersex persons in India since 2014. In 2021, she was awarded a Fulbright-Nehru Doctoral Research Fellowship to pursue part of her doctoral research in the US. Her research focuses on intersection of medicine, healthcare and intersex persons rights. Her work and allyship to the intersex community was formally recognised when the co-founders of Intersex Human Rights India (IHRI), a support platform and group for intersex persons, invited her to be a member. Her work led to her being a panellist at the first national seminar on the rights of intersex people in India, organised by NIMHANS, Bengaluru and Solidarity Foundation, Bengaluru (an NGO) in 2017, and the first national LGBTI Health Symposium organised by PGIMER, Chandigarh. Among her work are the guidelines on the rights of intersex persons for law, policy, healthcare and media professionals and general public which she co-authored in collaboration with Solidarity Foundation in 2019. She has also reviewed 'Guidelines on the Rights of Intersex Children,' authored by the Centre for Child and Law, National Law School of India University & Solidarity Foundation in 2019. She brought her experience and perspectives gained through her work to make this handbook a practical guide for professional social workers and students of social work in their work as to how to incorporate intersectionality, positionalities, inclusiveness and understanding in often overlooked aspects of sexuality and diverse identities.

Dr. Kranti Suresh Vora, Additional Professor, Indian Institute of Public Health, Gandhinagar, is an obstetrician and public health professional. Dr. Vora has worked in the area of reproductive health and public health since 2004. She did her masters in public health from Johns Hopkins University, USA, and PhD from the University of Maryland, College Park, USA. Dr. Vora has worked with international organisations and academic institutions for improving reproductive and child health in Southeast Asia. She was a visiting fellow at Canberra University, Australia for 4 years. She has worked in countries such as Afghanistan and Bangladesh. She is teaching and mentoring

master's and doctoral students in Public Health from India, UK, Canada, Sweden and USA. She brings knowledge and understanding acquired over the years to ensure this handbook is a practical guide for public health professionals and students to navigate this rarely discussed subject.

We thank Enfold Team members - Kushi Kushalappa - Head, Support and Rehabilitation Team; Swagata Raha - Head, Research Team and Co-head, Restorative Practices Team; Sakshi Aggarwal, Project Manager (Suvidha Project) and Dr. Sangeeta Saksena - Co-founder, Enfold, for bringing in nuances in the practical applications discussed in this Handbook, especially in the context of child sexual abuse, laws and rights, gender equity and sexuality.

This Handbook is part of a project aimed at preventing gender-based violence by developing and implementing a formal curriculum for teachers and students of undergraduate and graduate studies in social work, psychology, education, special education, nursing, public health and allied disciplines. As envisaged in the project, this curriculum is based on gender equity, personal safety and sexuality education, and has been developed using rights-based, restorative and gender transformative approaches. We are grateful to the Ford Foundation for supporting this project.

INTRODUCTION

This Handbook on Demystifying Sexuality and Public Health is meant for use by both, practising professionals and students of public health, in conjunction with the Demystifying Sexuality Reference Book (henceforth referred to as the Book), published by Enfold Proactive Health Trust in June 2021. The Book focuses on topics that are often overlooked in conventional education. However, the knowledge and understanding of these topics, especially for public health professionals, cannot be emphasised enough, due to the considerable lack of comprehensive human sexuality training in public health education and among public health professionals in India. Such education can support people, especially those from marginalised communities with little or no access to sexuality education, to live better lives by enabling individuals to not just resolve problems related to sex and sexuality, but to also experience pleasure without guilt and enjoy sexual wellness. Improved understanding of human sexuality would help inform activities of public health professionals ranging from implementation of health programs to informing policies that are inclusive of sexually marginalised communities.

This Handbook lays out appropriate Case Scenarios based on the issues and themes featured in various chapters in the Book, with questions for self-reflection and group discussion. Each chapter also contains a list of suggested activities that may be undertaken. This is intended to support the users in understanding the topic in greater depth and to enable the application of the same in their respective work settings.

As a Public Health Educator, you may first want to identify your own sexual script, and then assess and reflect on your own feelings, attitudes and notions of sexuality, bodily and sexual autonomy, implicit bias and sexual oppression, if any, and your understanding of how the development and expression of sexuality are impacted by social norms, oppression and violence. This may serve to prevent the reinforcement of bias and prejudice and exacerbate the social shame and stigma around sexuality in the classroom. You may then facilitate discussions on the topics in each Chapter, by using the Case Scenarios and the accompanying questions that are suggested to facilitate self-reflection and discussion in the classroom. You could prepare for the session by listing core messages that would need to be either arrived at through group discussion, or relayed to the students in response to the suggested questions, as well as other questions that may come up in the classroom, by relying primarily on the content in the Book. Some additional core messages that may be conveyed have been provided in the Annexures accompanying each chapter of the Handbook, and may be circulated to the students after the session, should you deem it fit. These additional core messages are not comprehensive, and should not be used in isolation. During the classroom discussion, you may also consider inviting the students to identify and discuss the application of specific public health principles and methods in each Case Scenarios. An initial list of Suggested Activities has also been included after many Case scenarios. These activities (or a customised version of the activity based on their specific field setting) may also be assigned to the students, as appropriate. You may consider adding suitable activities for self-reflection as well as for research, individual

assignments, group work, networking, advocacy, etc., based on what you think the students are capable of doing at their respective levels of learning.

As a Public Health Student, you may want to engage with the content of the Book and this Handbook in a reflective manner, placing it within the frame of your own journey of self-reflection as well as the public health principles and program/ policy work that you are learning as part of your ongoing education.

Adopting an intersectional lens and understanding positionalities is an integral aspect of the public health domain, and therefore, needs to be applied in all aspects of the public health profession. Public Health professionals, faculty and students can keep in mind their own positionality and ensure that it does not hinder them from giving their best professionally. The effectiveness of this Handbook will increase when the Case Scenarios are reflected on while using the intersectional framework and positionality, as well as public health principles and methods.

BACKGROUND

The global understanding of sexual health has evolved over time, including in its relationship to reproductive health. In 1975, sexual health was defined by the WHO as "the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love" (WHO, 2022).

In 1994, twenty years later, sexual health was included in the definition of reproductive health in the International Conference on Population and Development (ICPD): "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (WHO, 2017). Implicit in this definition was the ability of people "to have a satisfying and safe sex life" and the capability and freedom to reproduce if and when desired. Here, the stated purpose was "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases". In the last two decades, major advances were made in the clarity about sexuality as well as recognition of the immense global health burden – including extensive mortality and morbidity – associated with sexual and reproductive health conditions, including HIV and other sexually transmitted infections (STIs); undesired pregnancies; unsafe abortions; infertility; maternal conditions; gender-based violence and sexual dysfunction. There is improved awareness about the impact of stigma, discrimination and poor quality of care on sexual and reproductive health.

A framework for sexual health programs has contextualised five multi-sectoral factors that influence sexual health: (i) laws, policies and human rights; (ii) education; (iii) society and culture; (iv) economics; and (v) health systems (Mitchell et al., 2021). Sexual health, human rights and the law need to assist governments and policy-makers in improving sexual health by aligning relevant laws and policies with national and international health and human rights

obligations. For the alignment of policies with human rights, public health professionals have to be aware of different aspects of sexuality, know the related definitions and understand sexuality.

Sexuality is a central aspect of being human 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, 2022).

Sexual rights are important as the fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights are certain human rights that are already recognised in international and regional human rights documents and other consensus documents and national laws (WHO, 2022).

RIGHTS CRITICAL TO THE REALISATION OF SEXUAL HEALTH INCLUDE (WHO, 2022):

1. the rights to life, liberty, autonomy and security of the person;
2. the rights to equality and non-discrimination;
3. the right to be free from torture or cruel, inhuman or degrading treatment or punishment;
4. the right to privacy;
5. the rights to the highest attainable standard of health (including sexual health) and social security;
6. the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage;
7. the right to decide the number and spacing of one's children;
8. the rights to information, as well as education;
9. the rights to freedom of opinion and expression; and
10. the right to an effective remedy for violations of fundamental rights.

PUBLIC HEALTH APPROACH TO SEXUALITY

Public health approaches to sexuality are focused on the medical and biological sectors, with their attention largely on adverse health outcomes and concomitant risks. This risk-focused approach has come to be viewed as the standard for public health, eclipsing other aspects of sexuality, even though health is seldom—if ever—the primary reason for engaging in sex. Most importantly, the conflation of sexual wellbeing and sexual health obscures the diversity of experiences—not clearly addressed in definitions of sexual health—that people identify as relevant to their broader wellbeing. This truncated perspective limits the public health professional's ability to understand and address sexual issues. The absence of a sharp distinction between sexual wellbeing and sexual health has created ambiguity in policy rhetoric, and hindered the conceptualisation of sexual wellbeing as a valid outcome of public health interventions. For more than a decade, advocates and thought leaders have acknowledged the need to expand the scope of inquiry and intervention in public health from a singular focus on sexual health to attention on sexual wellbeing as a distinct concept (Mitchell et al., 2021).

Why is sexual wellbeing vital to public health?
(Mitchell et al., 2021)

Sexual wellbeing is a marker of health equity

Within the field of public health, population wellbeing approaches seek to establish measurable and achievable goals toward equity. Sexual wellbeing is an appropriate marker of population wellbeing, given inequities related to sexuality and sexual expression. These inequities include systemic and pervasive racial and ethnic discrimination, gender-based violence, sexual identity-based violence, and STIs and HIV. A sexual wellbeing approach recognises the transgenerational traumas that mark the unique needs of marginalised people. This recognition supports the implementation of population health approaches that are anti-oppressive, intersectional, and culturally and contextually adapted.

Sexual wellbeing is a meaningful population indicator of wellbeing

As population wellbeing continues to be a goal of public health, sexual wellbeing emerges as an important component of overall wellbeing. Sexual wellbeing provides important insights into population wellbeing over the entire life course. Data on sexual wellbeing would add new dimensions to community engagement in health issues, address structural determinants of health at local levels, and link local and larger public health policy and practice related to sexual and reproductive health.

Sexual wellbeing captures population trends distinct from sexual health measures

Sexual wellbeing incorporates outcomes that are distinct from biomedical sexual health outcomes and include the ability to choose a partner and express sexual choices without fear. Tracking such indicators of sexual wellbeing shows key population trends to broader wellbeing.

Sexual wellbeing refocuses the ethics, form, and practices of public health

Acknowledging sexual wellbeing as a driver for public health defies the structural origins of sexual inequities and leads to an understanding that sexual wellbeing is experienced by people in relation to contexts and surroundings. Assessment of sexual wellbeing, at individual and community levels, is required. Public health surveillance is well established in sexual health prevention and control (eg, for STIs). However, expansion to sexual wellbeing relocates such surveillance into areas outside the public health function. Such surveillance is important to channelise resources on vulnerable populations. This also requires redesigning of relationships between communities and public health entities to create trust (Mitchell et al., 2021).

FRAMEWORK FOR SEXUAL WELLBEING

The framework proposed locates sexual wellbeing in relation to sexual health, and two other pillars, sexual pleasure and sexual justice—each needed to address the structural determinants of sexual inequities. The interconnections of these three pillars, and the conceptual overlap with sexual wellbeing is described in the framework.

Sexual Health Framework

The framework follows key issues identified

in the definition of sexual health by the World Health Organisation: fertility regulation, prevention and management of sexually transmitted infections (STIs, including HIV), sexual violence prevention, and sexual functions (including sexual desire and arousal) (WHO, 2022).

Sexual Health

Sexual health is defined as "physical, emotional, mental, and social wellbeing in relation to sexuality". It is centered within an interconnected framework of sexual health influences, including attention to human rights and positive approaches to sexuality (WHO, 2022).

Sexual Pleasure

Sexual pleasure is associated with both, sexual health and sexual wellbeing, but its distinct relevance to public health is increasingly recognised. The current definition of sexual pleasure addresses the physical and psychological satisfactions of sexual experience, and key enabling factors, such as self-determination, consent, safety, privacy, confidence, and the ability to communicate and negotiate sexual relations. For the operationalisation of sexual pleasure, two key elements are vital: events/key sexual occasion-the repertoire, timing, and spacing of sexual practices, existence of orgasm, use of contraception and people/personal dynamics-communication, ability of negotiation, and trust.

Sexual Justice

Sexual justice refers to the efforts made to ensure social, cultural, and legal supports for equitable, person centered sexual and reproductive experiences. Public health contributes to the promotion of equal access to distributive and restorative justice, combatting historical restrictions on the basis of ethnicity, sexual and gender identity. Public health has played a central role in addressing violence and discrimination linked to sexuality among people living with HIV. Public health practice adopts restorative approaches that address adverse sexual experiences/trauma through the life course, and its effects on sexual wellbeing. Sex positivity is central to a public health concept of sexual wellbeing (Mitchell et al., 2021).

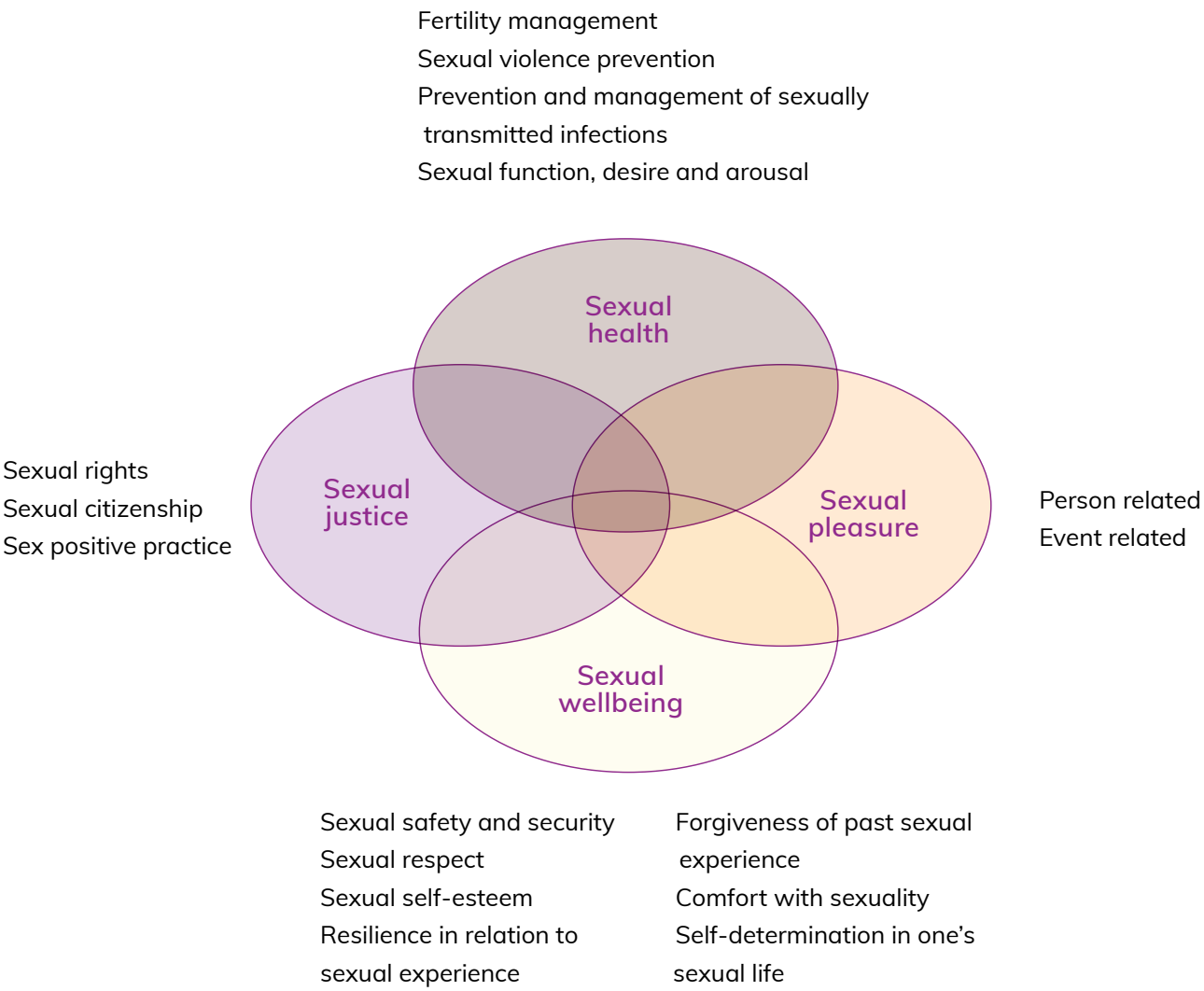


Figure: Framework for public health aspects of sexual wellbeing (WHO, 2017).

CHAPTER 1

Diversity in Sex, Gender and Sexuality

Individuals who live with multiple and diverse genders and sexualities tend to have varying perceptions about their sexual wellbeing. Often, these perceptions can be influenced by a number of concerns, for example, problems related to their own (or their partner's) well-being. Some of these could be health-related such as sexually transmitted diseases, chronic diseases, or even psychological and psychosocial problems. Currently, only psychologists can address this concern, sexologists, sex therapists, or health care providers are not allowed, nor are they encouraged to seek training to attend to and diagnose these concerns. An individual's perception of sexual issues is very subjective in nature as everyone is different and unique. The physical characteristics of sexual organs, sexual performance and/or satisfaction, gender identity, and sexual orientation have been identified as key concerns. Professionals in the healthcare industry need to be more aware of their own beliefs and reactions to the many facets of sexuality, as well as whether or not these values and responses are in accordance with both human rights and the existing laws.

Here are some suggestions for activities you may consider assigning to students as a supplement to the content in the Book.

Suggested Activities

Activity 1

Assess yourself on the level of your comfort as regards talking about sex and sexuality in your personal life with family and friends, and in your professional life with your colleagues as appropriate. Write a few paragraphs about what you think is 'normal' in the context of sex and sexuality. What has shifted in your thoughts, feelings and attitudes after reading Chapter 1 of the Book?

Activity 2

Design and conduct a short survey to find out what people in your family, or your friends circle were told about the similarities and differences between the bodies of different sexes, as well as the bodies of people of different genders. Collect information about the doubts, thoughts and feelings they have about people from different genders, including the trans community. Reflect on these and bring doubts or concerns you may have to the classroom discussion. Remember to respect privacy and maintain confidentiality by changing the identities of the people you are referring to and not revealing any identifying information.

Activity 3

Prepare a list of words or phrases commonly used to describe people of different sexes and genders. Reflect on these and think about whether these are empowering or stigmatising. Discuss this with your classmates and try to find positive language that could be used to replace disparaging or stigmatising terms.

Activity 4

As a public health student, or faculty member, assess your own understanding about the

human body and sexuality. Are there any gaps? Are there topics you would like to know more about? Are there topics you would like to discuss but feel awkward to do so? Do you have any fears or anxieties about sex and sexuality? Refer to Reflection activities in the Demystifying Sexuality Reference Book – Looking at sexuality with a rights-based, restorative and gender transformative lens June 2021. Reflect on how your own attitude towards human sexuality has, or can influence your professional work. If you are comfortable, you may maintain a journal through this course, an exercise that would enable you to document and reflect on the shifts in your thinking, values and beliefs surrounding human sexuality.

CHAPTER 2

Structure and Function of Sexual and Reproductive Systems

Young adults go through a significant amount of change during their adolescent years, which includes physical, emotional and social changes as they transition from their childhood to adulthood period. Oftentimes, they are not prepared for these new changes, for example, many young females around the world have acknowledged the fact that there is a knowledge gap and misconceptions about menstruation. Young males, too, have misconceptions about their bodies. Knowledge about the diversity in sexual and gender identities is sorely lacking. This shows that adolescents require information, knowledge, and skills in order to make wise decisions about their bodies and their lives, learn how to handle or prevent issues and know where to look for support when needed. Adolescents can acquire knowledge and awareness through effective sexuality and reproductive health education. Moreover, this can act as an aid as they form their values around gender equity, diversity and human rights. It also fosters attitudes and abilities needed for building healthy and wholesome relationships. Sexual health needs to be discussed before reproductive health - as our reproductive phase begins much later, while we remain sexual beings throughout our entire lives.

A deep-seated unease about adolescent sexuality still exists throughout the world, and this contributes significantly to social and legal restrictions on the dissemination of sexuality education. Adolescent sexuality education should and must be included in the nation's agenda, as a method to increase community level understanding and support for rights and value based expression of a person's sexuality. The issues that could cause opposition to sexuality education or impede its implementation and advancement must be recognised and addressed at the regional, national, community and individual levels.

CASE 1: LAKSHMI AND MEENA

You have recently joined an NGO that works on empowering women and girls as a project manager. As part of a Women's Day celebration, the NGO organised an awareness program for all the girls attending the tailoring classes that they conduct for girls aged 15-18 years of age on 'Respect for One's Body - Celebrating Womanhood'. The speaker showed videos about female anatomy and asked the girls if they had any queries. Lakshmi, a 16 year-old girl who hails from a traditional family, and has never been to school, is confused but awkward to ask a question during the session, as no one talks about these things with her in her family or extended family. Though she is shy, she connects well with you, as you have developed a good rapport with the girls, while conducting literacy classes and life skills education. After the session, she brings a close friend of hers - Meena, who also attends the tailoring class, along with her, to you and asks you to explain more.

Questions for Reflection and Discussion

1. Are you confident of having this conversation with these two young girls? How would you handle this situation if

you are not fully confident?

2. What is reproductive health? How has it been defined? Do you know the terms used in sexuality education?
3. Are you yourself comfortable using the names of the human sexual and reproductive organs while talking with your colleagues, friends, family members? Do you think it is important for public health professionals to familiarise themselves with these terms and use them in both, one's professional capacity, as well as in one's personal life and private capacity while engaging with people? Consider breaking the silence and broach the subject with someone you are comfortable with, by talking about the human sexual and reproductive systems and what you feel about them. Notice your own feelings. Reflect on what work you may need to do yourself to be confident to talk about sex and reproductive systems as a professional.
4. What are the biological terms that are used to describe the various parts of the genitalia in the local language?
5. Lakshmi tells you that both their families are very traditional, and so family members would beat them if they heard they were talking about these things with others. Knowing this, would you still provide Lakshmi and Meena information about reproductive health? If so, why? If no, why not? Are there any ethical concerns you may need to take into consideration?
6. Prepare a list of common myths about the structure and function of sexual and reproductive systems. Pair up with a fellow classmate and discuss these myths in the light of the content provided in the Book.

Suggested Activities

Activity 1:

Do a mini-survey to find out whether there is age-appropriate and child-friendly resource material available in your local language that could be used for personal safety and sexuality education of people of different ages.

Activity 2:

Consider working in groups to talk about these terms and find suitable words in your own language that could be used - words that describe these body parts accurately and are not violating a person's dignity.

Annexure 2: Additional Core Messages for Case 1: Lakshmi and Meena

1. According to the World Health Organisation (WHO), "Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the

reproductive system and to its functions and processes. 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." (WHO, 2022)

2. See Chapter 2 of the Book for information about anatomy for the answer to question 1. However, for translation of these terms into the local language, either contact a gynaecologist or contact an NGO working in the field of reproductive health, sex and sexuality.
3. Encourage the use of words that do not imply shame or 'being dirty' or unclean. If there are no respectful words, then consider using the English anatomical words. In this context, it is important to note that the origin of some anatomical words in English are cloaked in shame as well. For example, the word 'pudendum' means 'to be ashamed' in Latin. Until recently, it was the anatomical word for female external genitalia. In 2019, this word was removed from the second edition of the Terminologia Anatomica (WHO, 2022).
4. Yes, it is important for public health professionals to use the terms applicable to the various parts of the human anatomy in both professional and personal life, so as to model respect for the human body, and help remove the embarrassment or shame while talking about it.
5. Sexual and reproductive health is a basic human right. All human beings should have access to age appropriate scientific information about reproductive health and be educated about their right to reproductive health. Greater awareness of reproductive health can significantly increase gender equality, maternal and neonatal health and enhance choices related to family planning. It can also reduce risky behaviours and prevent unwanted pregnancies or sexually transmitted diseases.

CHAPTER 3

Diversity in Sex, Gender and Sexuality

Increased activism, greater visibility and access to information and scientific research has led to a deeper understanding of health care requirements for the LGBTQIA+ community. The healthcare industry is steadily getting better equipped and the approach to providing health care for the community is also changing. Compared to their cisgender counterparts, transgender or gender nonconforming people take more drugs and have a higher prevalence of mental health problems. Members of the LGBTQIA+ community experience several unique stressors throughout their life, resulting in poorer mental and physical health outcomes - for example, proximal stressors (such as negative thoughts about one's identity) and distal stressors (such as harassment, discrimination and violence). It is important that these issues are recognised and addressed not only at a family and community level, but also at a policy and legal framework level.

CASE 1: 'A'

A 28-year-old trans man 'A', comes to you as a project associate working with an NGO and tells you he has been disowned by his family due to his gender identity. He has nowhere to go except seek shelter with some transgender people whom he had befriended a long time ago. They are all living together in a rented place, as all of them have also been disowned by their family members. They are ostracised and are being looked upon with disgust in their locality. The neighbours are not happy with them staying there, although the owner himself has no problem with them. They are going through a difficult time trying to gain acceptance and employment. Though they feel a sense of solidarity amongst them, they are all dejected, facing sustained rejection from their own families, neighbourhood and the wider society.

Questions for Reflection and Discussion

1. What can a public health professional do to support 'A' and his friends?
2. Shunned and discriminated transgender people living together have been found to be HIV/AIDS high risk groups. Their rejection in society may force them to take up sex work to earn a living. What support can be extended to them in such a situation? Which kind of organisations could be roped in?
3. What are the policies and systems in place in your State to support the LGBTQIA+ community?
4. How will you explain the development of gender identity to a person with a trans identity?

CASE 2: ANITA

A child named Anita, aged two years, was brought to a hospital by her parents. Anita is an intersex child. The parents have been referred to you, a public health professional working in the hospital, for psycho-social assistance. They report that they have decided to raise the child as a girl and want to perform a 'sex-corrective' surgery to change the appearance of the child's genitalia to one associated with the female sex.

Questions for Reflection and Discussion

1. What are the issues in this scenario?
2. Do the parents have a right to choose the sex and gender of the child?
3. Which of the rights enshrined in the UN Convention on the Rights of the Child, 1989 (UNCRC) are being deprived/ violated in this situation?
4. As a public health professional, how will you ensure that the child and parents can find the right support?

CASE 3: TARIK

Tarik, who is 26 years of age, confronted his gay friend, Amrit, saying that being gay is a sin. He argued that people are not born gay, but learn behaviours after being influenced by various external factors that may cause people to take it up as a lifestyle. He also quoted verses from the scripture to support his views. He goes on to say that though scientific studies indicate that it could be inborn, he firmly believes that humans are bound to make mistakes and that no scientific research undertaken by humans can be absolute.

Questions for Reflection and Discussion

1. What key points would you bring up if you had a chance to discuss this issue with Tarik, if he were a student who had expressed such views in your class?

Suggested Activities

Activity 1:

Consider and come up with ideas to educate people about the LGBTQIA+ community. Ask students to conduct research to find relevant websites and videos that offer information on this topic that are based on science and upholds human rights - such as the UN High Commissioner for Human Rights report on "Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity" (OHCHR, 2011). The report was submitted on 17 November, 2011 to the Human Rights Council pursuant to its resolution 17/19, in which the Human Rights Council requested the United Nations High Commissioner for Human Rights to commission a study detailing discriminatory laws and practices, as well as acts of violence against people based on their sexual orientation and gender identity. The resolution also asked the UN High Commissioner for Human Rights to examine how international human rights law can be applied to stop violence and other related human rights violations based on sexual orientation.

Activity 2:

Either on your own, or in a group, study the United Nations Office of the High Commissioner on Human Rights Intersex Fact Sheet (OHCHR, 2011), and reflect on it.

Activity 3:

Do some research and prepare a resource bank of people hailing from across any part of the spectrum of sex, gender and sexuality who are role models for the LGBTQIA+ community, both from within India and abroad.

Activity 4:

Reflect on and think about barriers or challenges that may come in the way of a public health worker being an ally of the LGBTQIA+ community? What are your views on this? In what way can you address these challenges and overcome these barriers in order to effectively work with individuals and the community on this issue? How would you develop programs for the same?

Annexure 3: Additional Core Messages for Case 1: 'A'

1. While similar situations are a reality for thousands of trans people in India, there have been efforts in different parts of the country to bring about a change. A group of trans women in Tamil Nadu are successfully running a dairy farm, while in other places, there are trans women running restaurants etc. The dairy farm was set up with the help of the then District Collector, and many organisations, social workers and activists are supporting trans people to set up their own business in dairy farming. Make a few suggestions on how students of public health can support trans persons to start or collaborate in a venture.

Additional Core Messages for Case 2: Anita

1. The sex and gender of any human being, even a child, cannot be decided by others. It is only the individual - the person - who can and should self-identify their gender and affirm their sex. The surgery being proposed in the scenario is termed as intersex genital mutilation, which has been condemned as torture by the United Nations Committee against Torture - a body of 10 independent experts that monitors the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment by its States parties (Committee against Torture, 2011) and intersex people and activists around the world. As mentioned in the Book, in April 2019, in a landmark order, the Madras High Court banned unnecessary sex reassignment surgeries on intersex babies in Tamil Nadu. Unless there is a threat to the child's life, no medical intervention should be carried out. Instead, the family can be provided counselling as to how to raise children in a gender neutral fashion, how to address inquisitive and insensitive questions from family, neighbours, etc. Later counselling should also be offered to the child as the child is growing up. This would enable them to have a better understanding of the sex variation they have and to navigate the challenges they may face growing up in a society which focuses mostly on heteronormative binary identities of male/female sex and man/woman gender identities, which can be very traumatic. Any medical intervention in adolescence and adulthood should only be carried out with the person's express wish and informed consent.

Additional Core Messages for Case 3: Tarik

1. While everyone has a right to practise their own religion, no one has the right to deny someone else of their right to their own identity and way of life. Religious beliefs should not be used to discriminate against,

exclude, deny rights, stigmatise, or harm anyone else. It is the duty of every social worker, public health worker and every responsible citizen to sensitise and educate people that members of the LGBTQIA+ community are citizens with equal dignity and rights.

CHAPTER 4

Development of Gender Identity and Sexual Orientation

CASE 1: JAGDEESH

Jagdeesh is a 30-year-old IT professional with a high paying job. His parents have been pressuring him to get married. His neighbour, Maya, has been friends with him since school. When Maya expresses romantic interest in him indirectly, Jagdeesh discourages her - telling her that he may not be good husband material. He is however unable to express what he really feels and why he doesn't want to get married to her. Jagdeesh subsequently succumbs to parental pressure and gets married to Maya. A year later, Maya is frustrated, because she believes that Jagdeesh is not interested in having sex as he is impotent. She feels cheated, their relationship deteriorates and they get a divorce three years later.

Jagdeesh later meets Ameen, a 40 year-old bachelor, at his workplace. Jagdeesh felt very comfortable and happy spending time with Ameen. For the first time in his life, he felt he had met a 'soulmate'. Ameen also feels the same way about Jagdeesh. They soon began to enjoy a sexual relationship. Jagdeesh is not sure how to proceed, as he is concerned about how his parents and extended family will feel about their same-sex relationship. Jagdeesh approaches you, a social worker, who lives in the same neighbourhood. He is wondering if he should attend spiritual discourses or go for counselling.

Questions for Reflection and Discussion

1. How would you support Jagdeesh to express himself in a more assertive and respectful way?
2. Why do you think Jagdeesh could not tell Maya why he thought he is not good husband material?
3. Discuss various options for responding to critical comments from family and colleagues that a person in Jagdeesh's situation could consider?

CASE 2: BANTEI

The following is a story shared by a 21 year old Khasi named Bantei, living in Guwahati, who identifies himself as gay, and a member of the LGBTQIA+ community. At home, he would apply makeup. His relatives would ridicule him and call him 'hijra'. They felt that he had let his clan title down. They accused him of being a sex worker and once beat him in public at a taxi stand. He felt ashamed and humiliated as he had been made a laughing stock in his community. He started recording the verbal abuse that he faced from his family members and kept it as evidence. He expressed that he did not feel safe at home, or outside the home, as he did not feel safe to walk on the road on his own, for fear of being judged or beaten. He has started avoiding gatherings and even stopped going to church.

A month earlier, Bantei had attempted suicide and was admitted in the Intensive Care Unit of a hospital. He reported that he also had suicidal ideation when he was in his teens and had attempted to jump off a building. He narrated that when he sits in his room alone, all the memories

of him being shamed by his family members in public, come flooding into his mind and makes him feel depressed. Having benefited immensely from counselling and sexuality education, he now feels that awareness about gender diversity and fluidity should take place at all levels such as educational institutions, religious institutions and within the wider general community too.

Questions for Reflection and Discussion

1. Do you think Bantei's suicide attempt during adolescence could have been linked to society's response to his sexual orientation?
2. Could his suicide ideation/attempt have been prevented? If yes, how?
3. Is homosexuality a crime in India?
4. What are the religious beliefs around sexual orientation in your own community? What are your own thoughts and feelings about this as a public health professional? How would you engage with ethical dilemmas you may face when your own religious beliefs conflict with professional work and practice, particularly in the area of sexual orientation?

Suggested Activities

Activity 1:

Work in groups and prepare a draft curriculum for an awareness programs on diverse identities of sexual orientation, gender and gender expression (including core messages, video resources, names of resource persons who could come in person or online, etc), for the following:

a. School students of different age groups;
b. Health care providers;
c. A religious group from your own religious community

Activity 2:

Request students to access the website of the Social Psychology Network and spend some time to read and do the activity on Understanding Prejudice - The Complexity of Sexual Orientation, available at https://secure.understandingprejudice.org/teach/activity/orient.htm

Annexure 4: Additional Core Messages for Case 1: Jagdeesh

1. In our society, many persons (cisgender men and women, persons of diverse gender and sex identities, sexual orientation) are pressured into getting married for various reasons. One common reason that is cited is that "they are at, or past the age of marriage". Often marriage is seen as a 'treatment' for homosexuality, asexuality, non-conforming gender expression, diverse gender identities, etc. Resisting such pressure can be extremely difficult for many people.
2. In this scenario, despite being an educated, 30 year old, employed cis-gender, Jagdeesh

is not able to live according to his wish. Even though he made it clear to Maya and his family that he was not interested in getting married to her, he felt compelled to listen to his parents. Being forced to live in an intimate relationship with someone is not conducive for a good, healthy relationship. However, many in our society believe that once people start living together, then they would automatically start forming a liking towards each other over time and form a relationship. In this scenario, maybe Maya also believed the same. But when it did not materialise, she felt cheated. Was it Jagdeesh's fault, even though he had initially told Maya that he was not interested in marrying her, as Maya also suffered the consequences? Unfortunately, many in our society go through the fate of Jagdeesh and Maya.

3. Did you think Jagdeesh and Ameen were gay? Remember that we cannot assume a person's identity. Jagdeesh and Ameen may also be asexual or bisexual. Just because a person does feel attracted to women, does not mean they will be attracted to every woman. Jagdeesh might have been attracted to women but might not have been attracted to Maya as a person, and being forced to marry her might have caused him to resent her. As professionals, we need to keep our minds open to all possibilities and remember to not get mired in stereotyping.

Additional Core messages for Case 2: Bantei

1. This case points to the intersectionality of different identities. Bantei comes from a tribal community, is gay, has non-conforming gender expression and has a practicing religious identity as well. Use this opportunity to discuss on topics such as intersectionality, religious beliefs on sexual orientation in various religious communities, discrimination against people of diverse identities, the lack of discourse on tribal people of diverse identities, and other such issues.
2. Discuss the importance of ethics and professionalism, including the need for oversight and supervision from seniors/ experts when faced with ethical dilemmas. If systems for supervision are not in place, discuss how these may be created. Emphasise how even practitioners who have been in the field for some time could benefit from peer-support, meeting regularly to discuss their work and seeking guidance from experts in the field.
3. Discuss how Public Health Administration could be enhanced by ensuring peer-discussion, oversight and supervision are embedded in job descriptions and in performance appraisals too.

CHAPTER 5
Gender Bias

A preference for one gender over the other is known as a gender bias. Explicit and implicit gender bias is commonplace. This preference is typically founded on stereotypes that portray one gender as superior to or inferior to others. Girls, women, transgender people, and people with gender non-conforming identities are more frequently impacted by broad gender bias since most societies place a premium on masculinity (Villines, 2021). Boys and men who experience pressure to adhere to strict gender stereotypes may also be stigmatised and face violence. Patients, physicians, researchers, and administrators can all exhibit gender prejudice in the field of health care. These beliefs about healthcare personnel have a negative impact on how the healthcare system functions and the quality of health outcomes.

GENDER BIAS' EFFECTS ON HEALTHCARE

Impact of Gender Bias on Healthcare (Villines, 2021):

Knowledge gaps: There are information gaps as a result of the exclusion of female, intersex, and trans persons from medical study. The majority of healthcare professionals are ill-equipped to treat transgender people (Santon et al., 2021).

Lack of women in leadership: Many stakeholders in the medical field believe men make better leaders than women. This could be the reason for the disproportionately low representation of women in leadership roles. In these environments, trans people hardly ever find work and have little chance to take on leadership positions.

Delayed or low quality care: In the medical field, if a patient is not treated seriously, the diagnosis and treatment are postponed, and the patient's condition could get worse. Lack of trust and restricted access to medical care might result from gender bias experience. In essence, due to the attitudes of organisations, healthcare professionals, especially public health professionals and patients, gender prejudice can result in inadequate quality of care.

CASE 1: KEERTHI

Keerthi, 25 years of age, is married, with two young children, aged five and three years, respectively. Keerthi has registered for employment under the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGA), whereby one can get employment for 100 days. One of the guidelines of the scheme is equal pay for both men and women. However, Keerthi was not being paid on par with the men. You are a public health worker, working in an NGO that deals with labour issues in that community. When speaking with Keerthi, you ask her what she felt about this. In response Keerthi says, "We are women so we are okay with not being paid equally with men, as we cannot work like men. If we are being paid equally, then men will not want to register, as they will feel inferior. Then they will stay at home and not go to work."

Questions for Reflection and Discussion

1. What points would you bring up in order to enable Keerthi to understand the concept of gender equity?
2. Is there something you could do to sensitise the stakeholders, men, women, boys, girls and transgenders too?

CASE 2: RAJA

Raja is a 16 year-old boy, studying in the 9th grade. He has three older sisters. Their parents don't want the girls to go out and work, as they expect them to get married and be home makers, like most of the women in the village. They also expect Raja to work and to support the family along with his father, and to contribute to the dowry that will have to be paid for the wedding of his sisters. However, Raja wants to study further. He is beaten repeatedly by his parents and forced to take up small jobs, which he does not wish to do. Soon he gets into drug addiction and becomes detached from his family. His childhood friend brings him to you for help and advice.

Questions for Reflection and Discussion

1. In your opinion, what life skills do you think Raja could learn to help him navigate through his current situation and move forward?
2. How can Raja overcome his drug addiction? How can you as a public health professional support him and his family in this situation, including sensitising them about gender and social norms and how these have affected the family relationships?

Suggested Activities

Activity 1:

Plan a workshop or program to address the gender bias in healthcare.

Activity 2:

Do a mini research to identify de-addiction services in your District, and submit this to the District Child Protection Unit, which is responsible for maintaining such a database, as required under the JJ Act, 2015.

Activity 3:

Do a mini research to identify videos, games and activities that could be used to sensitise families about gender and translate these into the local language.

Activity 4:

Do a mini research and compile a list of Youtube videos that help to break taboos about menstruation, and organisations spreading awareness about periods in India and abroad.

Annexure 5: Additional Core Messages for Case 1: Keerthi

1. Discuss how the social conditioning of women contributes to thwe furtherance of discrimination against women - how, with

hundreds of years of patriarchal socialisation, women have been turned into vehicles and enforcers of patriarchy.

Additional Core Messages for Case 2: Raja

1. Conventionally, when we speak of gender discrimination, only oppression or discrimination of women is highlighted. Discrimination against transgender people might also be spoken about. But discussion on bias against people of other diverse gender identities or even awareness about other identities is very less. Another aspect of gender discrimination that is often overlooked is the discrimination faced by cisgender men because of their gender. In this scenario, Raja has to give up his dream of higher education and start working, despite being the youngest child - only because he is male. There are many other ways in which they are discriminated against. For example, in most heterosexual marriages, it is taken for granted that the man should be taller than the girl. Many doctors have advised parents of intersex children with a particular endocrinological intersex variation, to bring the child up as a girl, since people with that variation will have somewhat limited vertical growth and a short man will not be able to find a partner easily. This is how deeply gender stereotyping and discrimination works in our society. However, in patriarchal societies, the extent and the nature of gender discrimination faced by cisgender men is much less in comparison with any other gender. Thus, equating a particular gender's discrimination to the discrimination against cisgender men is not appropriate. While discrimination against cisgender men should not be dismissed, it is not, in most cases, comparable.

CHAPTER 6

Body image and Self-esteem - their influence on sexuality and well-being

CASE 1: IBA AND RUMI

Iba is 20 years old, and has a poor self-image. She has not fared well in academics or extracurricular activities in school or college. Her classmates used to tease her about being overweight, and this only pushed her further into stress eating. She is in a romantic relationship with Rumi, and they have been seeing each other for about a year. Iba thinks Rumi is a nice person and is also considering marrying him. There are, however, some red flags that concern her. A couple of times, Rumi got very upset with her when she spoke to two of her male college mates. He became suspicious and got into an argument with her and even slapped her. The next day, he was apologetic and asked her to forgive him. He said that he loved her and wanted to take care of her and assured her that he would never do it again, ever! However, the same thing happened again just after a week, and this time, he said that he did it because he loved her and did not want her to get into the wrong company, or for anything bad to happen to her. Iba was desperate to hold onto the relationship, as she was very lonely and didn't think that anyone else would show any interest in her. So though she was extremely upset with his behaviour, she remained silent. The very next day, Rumi again proclaimed his undying love for her and even asked her to marry him.

Questions for Reflection and Discussion

1. If Iba discusses the situation with you, what are the issues you could bring up with her, to help her better understand her situation and help herself?

Suggested Activities

Activity 1

Divide the class into three groups. Tell them to prepare a script and enact role plays involving a conversation between Iba and Rumi in the following scenarios. The scenes could involve, but not necessarily be limited to the following:

a. A public health worker works with Iba and supports her in developing self-esteem and assertive behaviour, finally resulting in her being empowered to challenge Rumi and demand respect from him as her partner.
b. Scenarios where Rumi dismisses Iba's concern and Iba's assertive reaction towards it as being 'oversensitive' and alarmist - after all he had 'only' slapped her - and had promised never to do it again.
c. Scenarios where despite Iba's assertiveness, Rumi justifies his actions as the norm and Iba's reaction as ultra-feminist, telling her to 'get real' as no one would marry her because of her obesity, and how she responds to this.

Facilitate a discussion on self-esteem and body image based on the role plays.

Activity 2

How would you help Iba build her sense of self-worth, and empower her to make a good decision in terms of her relationship with Rumi and the future that lies ahead of her?

Annexure 6: Additional Core Messages for Case 1: Iba and Rumi

1. Iba is in a relationship that is beginning to be abusive. From the given information, Rumi seems to be over possessive and suspicious of Iba's friendship with other men. Unlike many people in her position, she has already identified cause for concern and doesn't seem to be making excuses for the abusive behaviour of her partner. But she still likes the person and desperately wants their relationship to work, because of her poor body image and low self-esteem.
2. Many times, people feel that their partner's behaviour will change after marriage! Moreover, Iba has a belief that her body and mind, both, do not meet the social norms of beauty and intelligence. Her low self-esteem, and erroneous notion that marriage would help her feel more secure, is pushing her into making life decisions that may be putting her at risk. Counselling and therapies such as Neurolinguistic Programming could be considered to enable her to alter limiting beliefs she is harbouring about herself. She could also learn assertive behaviour and decision making skills.
3. The most important point to be addressed here would be for Iba to recognise that she should be respected, and that no one has a right to abuse her. She needs to be supported to hold Rumi accountable for his abusive behaviour and to see whether or not Rumi takes corrective action before contemplating the future course of their relationship. The idea is not to get personal assurance or promises of change, but to see if the person takes concrete steps towards a change in behaviour - for example, joining Life Skills programs can help learn how to express one's emotions appropriately, how to express anger in nonviolent ways, how to discuss one's apprehensions respectfully, etc.

CHAPTER 7

Attitude towards Sexual Health and issues with Reproductive Health

The need for a holistic approach is not well reflected in the training of healthcare providers, organisation of healthcare systems and healthcare delivery. The need for sexual and reproductive health services are different at the various life stages and has individual variations based on environmental, social and physical factors. Public health professionals have to be sensitive to differential needs of groups of individuals based on their age, gender identity and environment. In public health, the "life course approach" is used for the provision of comprehensive sexual and reproductive healthcare for individuals (Pan American Health Organization, 2021).

CASE 1: ANJALI, ARUN AND ASHWINI

Anjali is a lecturer, aged around 52 years of age. Her husband Arun, aged 55, had a good corporate job, but has been laid off due to COVID-19. This has made him lose confidence in himself. Since he is diabetic and obese with other underlying health conditions, he took extra precautions and diligently followed the COVID-19 protocols, not going out of the house at all. He used this as an excuse and politely refused to even go and meet his friends. Though Anjali was permitted to take lectures online due to the pandemic, recently, she had to go to work in person, commuting to work at least one hour each way. They had decided not to permit their domestic help to come and work inside the home, for fear of her carrying the virus. Anjali and Arun's sex life had deteriorated significantly over the past year, and this is leading to conflict between them too. They have a little girl, Ashwini. Though they had built a loving relationship over the years, they were now confused and irritable with each other, and their daughter, who often felt lonely and sad. One day Arun lost his temper and started yelling at Anjali, telling her that she was useless, as she couldn't cook properly, and was neither a good wife to him, nor a caring mother to their daughter.

Questions for Reflection and Discussion

1. From your analysis, what are the various challenges that this family is facing?
2. What is menopause? Do you think women can have a fulfilling sexual life during this time?
3. What is androgen deficiency? How could Arun be supported to enhance his sense of well-being?

Suggested Activities

Activity 1

Spend some time alone and map out your own assumptions, thoughts and beliefs about sex during one's senior years.

Activity 2

Whatever your age or gender identity, based on your comfort level, identify a few men/women/trans persons in your own family and circle of

friends who are in the age group 46 - 52 years of age, with whom you share a close connection. Ask them about their experience of menopause/ androgen decline, to better understand this phase of the life cycle. For those who are comfortable, ask them about their sex life during this time.

Activity 3:

Design a short survey tool (using google survey tools if accessible), and find out more about the sexual life of people going through menopause and androgen decline.

Activity 4:

Design an awareness campaign to promote awareness of how one can take care of one's physical and mental health and also enjoy sexual fulfilment during menopause and androgen decline.

CASE 2: AARTHI

A 22 year-old single girl, Aarthi, found that she was suffering from a vaginal infection and approached her college residential doctor for medical assistance to address the same. The doctor asked her whether she had sex recently, or if she uses sex toys. The manner in which the doctor spoke to her made her very uncomfortable. She replied that she had not, and left the clinic feeling judged, without waiting for any prescription. Her friend suggests she meet you, a public health professional attached to an NGO.

Questions for Reflection and Discussion

1. What will you say to Aarthi? Do you have a list of sensitive medical professionals or para-professionals to whom you could refer people like Aarthi for appropriate medical advice?
2. How can doctors' judgemental attitudes on premarital sexual relationships be addressed?
3. Discuss how a network of sensitive medical practitioners, law enforcement personnel, government officials, NGO workers, counsellors and teachers can support people who feel judged or discriminated against, based on their sexual practices and preferences.

CASE 3: MARY

Mary is a public health professional working in an NGO. She does not believe in abortion. The management of the NGO is also pro-life, and therefore does not advise or permit abortions. Sunita is a 20 year-old woman who approaches Mary, with suicidal symptoms, seeking support for an abortion, as she has just found out that she is 14 weeks pregnant.

Questions for Reflection and Discussion

1. Does Sunita have a right to terminate her pregnancy?
2. If you were in Mary's position, how

would you respond to Sunita? How will you navigate the conflict between your personal beliefs, the policy of the NGO and your duty as a public health professional to respect the human rights of Mary?

Annexure 7: Additional Core Messages for Case 1: Anjali, Arun and Ashwini

1. Refer to the sections on Menopause and Androgen decline in Chapter 7 of the Book. Discuss family strengthening as an intentional process that enables family members to improve their interpersonal and communication skills, as well as provide them with the support they may need to discuss sexual and reproductive health with family members and health care providers.

Additional Core Messages for Case 2: Mary

1. The law in India permits abortion upto the age of 20 weeks, and so yes, Sunita does have a right to terminate her pregnancy. Abortion may also be permitted beyond 20 weeks in certain situations. Refer to the section on Law and Medical Termination of Pregnancy in the Book for accurate information on this.
2. As a professional, the code of ethics requires respect for human rights. Further, the principles of right to self-determination and the non-judgemental approach requires that Mary should respect Sunita's decision and support her to access the services she is entitled to under the law. Since Mary's organisation has a policy that is pro-life, she may respectfully inform Sunita that she will not be able to advise or support her with regard to the termination of her pregnancy because of the organisational policy that she is committed to adhere to. She must however provide her with the immediate mental health care support that Sunita needs, given her suicidal ideation, and ensure she gets timely care. Mary must then make a sincere effort to connect Sunita to another hospital or NGO who can provide her the assistance she needs. In situations like this, where there is a conflict between professional and personal values (and in this case, organisational values too), this becomes an ethical issue and a matter of conscience. Professional workers must consult with their seniors and with experts in ethics, if necessary. They must act in accordance with their professional training, rather than allow their personal beliefs or organisational policies to come in the way of clients being able to enjoy their human rights. If the organisation itself does not permit such referrals, Mary would have to make a choice as to whether she should continue working in the organisation in order to ensure she adheres to the obligations arising from her professional training.

CHAPTER 8

Sexual Development in Children and Adolescents

Talking about sexual development and sexuality is considered to be a taboo in India. A majority of parents and health care providers do not know how to discuss the topic with their children, especially young children and adolescents. Although public health does not directly deal with education of sexuality, understanding of the same in the future generation helps improve health and sexual wellbeing. Some of the important aspects of discussion with children include using clear, unambiguous names for the genitals. For very young children - say under five years of age, it could be 'susu-potty place' and once children are older and understand the social etiquette around talking about genitals, accurate words like penis, scrotum, vulva, vagina or their equivalent words in the language spoken at home could be taught. In many Indian households, it would be unacceptable if a two or three year old talked loudly about the penis or vagina. The important point here is to avoid using euphemisms like *flower/parrot/chhi-chhi*, etc. that are confusing, ambiguous or attach shame or dirt to the genitals. Avoid words that make them feel ashamed of their body parts. It is of utmost importance to converse positively and demonstrate for all parts of the body and its functions.

The discussion with adolescents should gradually expand to include gender identity and its expression, sexual orientation, romantic and sexual relationships, information about potential risks and dangers of sexually transmitted diseases and unwanted pregnancy, etc., if precautions are not taken. Parents can refrain from talking negatively about sexuality while talking to their children. These early life conversations often leave impressions that may last a lifetime. A positive message will go a long way in forming a respectful approach to sexuality.

CASE 1: JOHNNY

In a co-educational school in the outskirts of the city, a teacher put up a poster on anatomy. A little boy named Johnny, who is studying in the 1st standard, is observed touching the genital area of that picture every day, before and after school. The class teacher noticed this on several occasions and scolded the boy, telling him that what he is doing is wrong and that he should be ashamed of himself. She then contacted his parents, who also did not like what they heard. They told the teacher that they "never talk about such things at home". They went on to explain that whenever they watch programmes on television, they always make it a point to change their channel when there are sex scenes, and so they were wondering as to where their child learnt "such things". The teacher informs them that the school does not encourage teachers to talk about "such things" with the students either.

The teacher spoke to the boy separately and he said that he used to touch his 'pee pee' every now and then and that it "feels good".

He said that his parents have found him doing it so many times and they never scold him or tell him it is right or wrong, they just go about their way, ignoring him every time he touches himself. So he thought that touching the private part in the picture which has the same 'pee pee' as him would make the person in the picture also feel good! Parents have found the child touching himself many times, but both of them have ignored it. They said that talking about one's private parts is not a part of the family's conversation and thought that the child would learn such things by himself, as time passed, just like they did during their growing years. They explained that they do not know how to teach a child about such things. They also said that there are no specific names for private parts in the local language and even if they have to talk about such things, they will not know how to.

Questions for Reflection and Discussion

1. Who could talk to the child to explore the situation further, and to rule out the possibility of the child being sexually abused?
2. What would you like the child to understand about this behaviour? How would you support the child in learning about sexual development in an age appropriate manner?
3. How will you sensitise and educate the parents about this topic?

Suggested Activities

Activity 1

Reflect on your own childhood and adolescence and identify experiences you had related to conversations about sex and sexuality. As a public health professional, how comfortable are you talking about these aspects of human life with other people? If you are comfortable, share these in the class and discuss the reasons why most people do not talk about sex and sexuality openly.

Activity 2

Reflect on what aspects of reproductive health that you yourself need to grow in - (knowledge, attitudes and skills), in order to become more self-aware and to also provide more effective services to communities you may be working with.

Activity 3:

Work in groups and discuss and plan a session on sex and sexuality for children of different developmental ages and different genders. Similarly, develop a plan on personal safety and sexuality for adults of different genders.

CASE 2: SAJIDA AND SALIM

Roy, a young male public health professional, is staying as a guest with a family in a village, while doing a field survey for his research. The owner of the house is Ahmed, who is a close childhood friend of Roy's uncle in the nearby

city. Ahmed's daughter Sajida - a single parent who has completed her graduation, lives in the house along with her three children, the oldest being a 10 year-old boy, Salim. Sajida also works as an accountant in the NGO that has accepted Roy as an intern. On many occasions, Roy noticed Salim touching his genitals, sometimes even in front of guests. The mother had also noticed this and had scolded her son on several occasions, telling him to stop doing this.

Over a period of time, Roy built a good rapport with Sajida. He casually picked up a conversation about this with Sajida, and though initially she was awkward to talk about this topic, she explained to him that she cannot supervise all her children all the time, since her father is aged and ailing, and she is the only breadwinner for the family. She shared that she did not know what to make of her child's behaviour, and so she thinks that the best thing is to scold and beat the child. None of her close relatives live nearby, so she is not able to discuss these awkward things with anyone in person, even when she is free.

Questions for Reflection and Discussion

1. Is it developmentally appropriate for a ten-year-old child to be touching their genitals in public?
2. If you were Roy, would you pick up a conversation about sexuality with the mother? If yes, why, if no, why not? What else could you do to enable the mother to gain the understanding and skills she needs to resolve this?
3. As a public health professional, what types of programs/interventions can you have in the NGO that can help parents and children to discuss sexuality?

Annexure 8: Additional Core Messages for Case 1: Johnny

1. The hesitance to name or talk about genitals or to discuss sexuality with children is seen throughout India. A majority of parents and teachers react to children's curiosity or exploration of sexuality, by communicating messages to children that it is wrong. As in this scenario above, most parents simply ignore it. Telling children that sexuality or curiosity about their bodies or others' bodies is 'wrong' or 'dirty' or 'shameful' can possibly cause a lot of emotional and psychological harm. Sexual predators are known to avoid grooming children who know the names of their private parts, as it indicates that the child is aware of body parts and is likely to report any unsafe touch or behaviour to trusted adults.
2. Encouraging everyone, including children, the families, teachers and others to talk openly and respectfully about all parts of the body, including the genitalia parts, as well as about safe and unsafe touch, will enable them to respect all parts of the human body and shed the sense of awkwardness or shame that most people experience when talking about genitalia.
3. Please consider referring to the video on 'How to talk with a child when there is suspicion of sexual abuse' by Dr Shaibya Saldanha in Enfold's video series that accompanies this learning package. This resource is helpful in enabling children and adults to talk about and also report any unsafe or harmful sexual behaviour they encounter.

Additional Core Messages for Case 2: Sajida and Salim

1. Please refer to the sections on Sexual development from 9 - 12 years in the Book for core messages.

CHAPTER 9

Attitude towards Sexuality

Knowledge provides a foundation for action and this is a central concept in many psychological theories and is used as the basis for effective education programs. Knowledge changes behaviour indirectly by influencing values, attitudes, perceptions of norms and self-efficacy. Along with knowledge, attitudes are one of the important theoretical constructs for behaviour change. Attitudes are formed through life experiences and are learned from the behaviours of others. Attitudes are defined as complex, multidimensional constructs comprising cognitive, affective, and behaviour components. The three components reinforce each other to form a joint structure that tends to remain stable (Santosa et al., 2016).

As a public health professional, you need to examine your personal beliefs/attitudes towards sexuality in order to support others in a non-judgemental, professional manner. Acknowledging your own attitudes will help carry out your work without the influence of personal beliefs and with respect for human rights.

CASE 1: IBRAHIM

Ibrahim has been invited by his friends to go on a drive. After driving around for a while, some of his friends say, "Let's show Ibrahim some interesting sites every young man should know." Ibrahim realises that they intend to take him to an area known as the hub for commercial sex workers. He is uncomfortable and does not want to go. Some of his companions say, "Come on, be a man!" and "Don't be a baby!" The teasing and bullying continue over months.

Suggested Activities

Activity 1:

Request students to work in groups and do a role play to demonstrate assertive behaviour using this case scenario.

Activity 2:

Plan a workshop for children or young people of different ages and genders on assertive behaviour, preferably using similar case scenarios that also help generate deeper awareness and ability in dealing with situations relating to sex and sexuality.

Activity 3:

Request students to do internet searches to identify academic articles or videos prepared by organisations working to promote healthy attitudes towards sexuality, that help build a better understanding of the way adults with disability, older adults, sexual minorities, or sex workers experience their sexuality. Request the students to critique these articles/videos and facilitate a classroom discussion on the same. Create safe spaces using Restorative Circle elements to enable sharing of the shift in perspectives and attitudes on these topics.

CASE 2: ADHILA AND AADITI

Adhila and Aaditi, both just over 18 years of age, are talking to some of their close friends. Most of them have had sex and are therefore teasing Adhila and Aaditi about them waiting for the 'right' time. A few of them make remarks like "you are both so goody goody!" One friend taunts the girl saying - "I'm sure you are frigid!"

Questions for Reflection and Discussion

1. If Adhila and Aaditi came to your organisation for help in handling this situation, what would you do to assist them?
2. What is the influence of media on young people, especially given the absence of open discussion on sexuality with adolescents in most cultures in India?

CASE 3: SHWETA

Shweta was brought up in a family where sex is not a topic of discussion. However, over time, she received comprehensive sexuality education while studying in a college where such workshops were organised. She is grateful for such workshops and wishes such topics had been introduced earlier during her school days. At one such workshop the participants were asked to go to a pharmacy and purchase a packet of condoms. She was a little awkward about it, but at the same time, she was also curious to see what would happen in the shop.

She went to a well-known pharmacy and asked for a condom in a very matter of fact tone of voice. The people around her started staring at her. The pharmacist, on the other hand did not say a word, and did not look at her, pretending to be busy. What the pharmacist did was a surprise. He brought a roll of cotton instead and gave it to her. Shweta corrected him on what she wanted, but he suddenly declared that the pharmacy did not have any more condoms, even though she could see them on the upper shelf. She was surprised at the reaction and left without saying anything more.

Questions for Reflection and Discussion

1. Was it right on the pharmacist's part to refuse to sell her a condom? Would the pharmacist have behaved in the same way if the buyer was a male of the same age?
2. As a public health professional, how would you ensure that sexuality education is available to adolescents and young adults?

Suggested Activities

Activity 1:

Design a poster or an advertisement on access to reproductive health, which could be pasted on the walls of pharmacies.

Activity 2:

Do a mini-research to identify organisations (Government and Non-Government) that conduct comprehensive sexuality education in India, and share this with your co-workers, NGO networks

and the District Child Protection Unit, requesting them to publicise this information. Consider co-organising workshops for women and girls in partnership with them.

Activity 3:

Do a mini research to understand the policy and legal framework pertaining to reproductive health for women and girls in India.

CASE 4: PIYA

Piya is a 30 year-old sex worker who had run away from a violent husband, who hailed from another community. Her family had disowned her. She chose to migrate to Kolkata, and over time, decided to engage in sex work in order to survive. She has two children. She shared "I am regularly beaten up by the pimp who runs the brothel. I have lost contact with my relatives as they always judge me for the work I do. They don't realise that without any education or other skills, I have no choice but to do this work. I am poor and I have to support my children. Society also looks down on women working in this profession - they don't realise that it is women like us who are the first responders against child trafficking and human trafficking."

Questions for Reflection and Discussion

1. What are your own thoughts, beliefs and attitudes towards sex work? Do you think it is a dignified profession?
2. How would you deal with challenges that you may face, if your personal beliefs contradict professional work values and principles, and the human rights approach?
3. Do you think that there is a violation of women's rights in this case? If yes, how can you intervene?
4. What public health programs would you plan for protecting women like Piya?
5. How do you think this attitude will affect Piya and her children in the long run? How can you equip her to manage this?
6. What are the structural root causes that may drive women into situations of vulnerability, wherein they may choose to become sex workers?
7. What would be your beliefs and attitudes if a woman chose sex work, not from a position of vulnerability, but as a profession without any other compulsions?
8. What has been the effect of the COVID-19 pandemic on vulnerable groups of women like Piya?

Suggested Activities

Activity 1

Do a mini research on the National Network of Sex Workers (NNSW) in India to better understand the situation of women sex workers and the activities that the network is undertaking to promote awareness and responsiveness to their needs and rights - see http://nnswindia.org/

Activity 2

Study the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organised Crime, that has been adopted and opened for signature, ratification and accession by General Assembly resolution 55/25 of 15 November, 2000 (OHCHR, 2011).

Annexure 9: Additional Core Messages for Case 1: Ibrahim

1. In this scenario, Ibrahim will have to make a

decision and take a stance on his own rather than succumbing to peer pressure. It means he could be aware of how to stand up to peer pressure and be assertive. People like Ibrahim could be supported to make independent decisions based on their own beliefs and value systems, and taught to gain affirmation from within, rather than depending on it from peers or the wider society even at the cost of one's mental peace.

2. Consider assisting Ibrahim to reflect on his personal values and religious beliefs while also explaining the law relating to sex work in India, drawing from the sections on Law on Sex Work, and Sex for Money in Chapter 9 of the Book. Enable Ibrahim to gain clarity on how he chooses to lead his life, and to gain the confidence he needs to stand by his own beliefs and choices, whatever they may be, as long as he is not violating the rights of other people. Enable Ibrahim to gain a better understanding of sex and sexuality, and how he may choose to respond to these sexual urges. Help him gain the confidence he needs to stand by his own beliefs and choices, whatever they may be, as long as he is not violating the rights of other people.

Additional Core Messages for Case 2: Aadhila and Aaditi

1. Engaging in sexual activities should always be one's personal choice, and undertaken with both partners articulating their wish and informed consent. Yet, many young adults feel pressured to enter into sexual relationships. Phrases such as "you are just afraid," "why not, everyone is doing it," "do it, or goodbye," etc., are some ways in which this peer pressure manifests. It is important to impart the understanding that one can build one's self-esteem and practice assertive behaviour to counter such pressure.
2. Sometimes this pressure is replaced by threats of violence such as "I can hurt you and post pictures of you naked online, if you don't", "You owe me because I helped you when you were in trouble" etc. Creating awareness of how to protect oneself against such violence or threats of violence, and how to take action against people who try to force themselves on someone is crucial.

Additional Core Messages for Case 3: Piya

1. Sex work is legal in India. Some associated activities such as solicitation in public places, running a brothel, an adult profiting off another adult's sex work, etc., is illegal. However, sex work is predominantly considered a sin or shameful profession in India. Interestingly, it is usually only sex workers with whom this tag is associated with, and not their clients, who are predominantly cisgender men. Moreover, it is not recognised as a profession, despite it being the sole source of income for lakhs of people in India. As social workers, we need to reflect on our own beliefs, values and attitudes and work on our ability to apply the principle of non-judgement, with all our clients. We also need to proactively seek supervision and guidance when faced with challenging situations such as when we are unable to work with a client who holds beliefs that may be very different from the ones we hold.
2. "The 7th Report of the Panel on Sex Work, constituted by the Supreme Court in the Budhadev Karmaskar v. State of West Bengal, Criminal Appeal No. 135 of 2010 included recommendations such as adopting community-based rehabilitation, i.e. alternatives that are not contingent on

trafficked women staying in state-run 'homes' and also revising laws like the ITPA so as to distinguish between those coerced into sex work and those who engage in it voluntarily, so that interventions are tailored to those who need them." (NNSW, n.d.). Despite not being illegal, people engaged in sex work have no specific schemes that provide them with additional protection or welfare.

3. As per the National Network of Sex Workers, in India, "Anti-trafficking laws and policies must be under-girded by an understanding of structural issues like poverty, lack of equal opportunities and skewed development policies. The aspiration to move and access better living conditions forces persons to move in an unsafe manner and accept work in a criminalised environment for instance in sex work..." (NNSW, n.d.).
4. Based on this and any additional information on sex work and sex workers is India, discuss this topic and issues faced by sex workers and their children further.

CHAPTER 10
Sexuality and Disability

About 10% of the world's population – 650 million people – live with a disability. Persons with disabilities have similar sexual and reproductive health (SRH) needs. Yet, they face barriers to information and services customised to their needs. The ignorance and attitudes of society and individuals, including health-care providers, are responsible for most of these barriers – not the disabilities themselves. Existing services should be accessible to persons with disabilities. Increasing awareness among stakeholders is the first and biggest step. A lot can be accomplished by involving persons with disabilities in program design and monitoring.

Governments at all levels should pay attention to the reproductive needs and rights of persons with disabilities and to eliminate discrimination. Governments should ensure community participation in health policy planning.

The WHO recommends the following actions to avoid discrimination against people with disabilities (WHO, 2009).

1. Establish partnerships with organisations of persons with disabilities. Policies and programmers do consistently better when persons with disabilities take part in their development.
2. Raise awareness and increase accessibility in-house. Attention to the needs of persons with disabilities should be an integral part of current work. Separate or parallel programs usually are not needed.
3. Ensure that all SRH programs reach and serve persons with disabilities. Most persons with disabilities can benefit from inclusion by SRH programs designed to reach the general community.
4. Address disability in national SRH policy, laws, and budgets. UNFPA, WHO and other reproductive health partner organisations' staff should work with organisations of persons with disabilities to make sure that all legislation and regulations affecting SRH reflect the needs of persons with disabilities.
5. Promote research on the SRH of persons with disabilities. A stronger evidence base will help improve SRH programs for persons with disabilities.

CASE 1: SUSHEELA

While conducting a survey in a rural community, one of your respondents tells you that one of her neighbours, Susheela, a 30 year-old woman with intellectual disability, lives with her aged father who suffers from paralysis of the left arm and who runs a petty shop. Susheela is a sweeper in the local government school and is pregnant with her second child. She is in the first trimester. The first child also has an intellectual disability. Nobody in the neighbourhood knows who the father of the first child or the second baby is. Concerned about her well-being, you send a message requesting Susheela to drop in at your office, and she willingly comes to meet you.

Questions for Reflection and Discussion

1. What are the issues that you would need to explore while speaking with Susheela?
2. Are there any legal provisions that are applicable in this case?
3. How as a public health professional, would you be able to make a difference?

Suggested Activities

Activity 1

Reflect on your own thoughts, feelings, and challenges related to the sexuality of persons with disabilities. Do you feel the need to work on yourself and build the skills to work on this topic? If so, you could contact organisations such as TARSHI, based in New Delhi who have brought out useful resources on the same (TARSHI, 2018) and request their support in this endeavour.

Activity 2

Do a mini research and identify short videos, film clips, stories and case studies that could be used for promoting awareness about the rights of persons with disability, including aspects relating to sexuality, including in the vernacular.

Annexure 10: Additional Core Messages for Case 1: Susheela

At the outset, we need to remember that having a mild mental impairment does not inherently mean a person is fully incapacitated. Thus, many persons with mental impairment are able to lead a fulfilling life. On the same note, being intellectually dsiabled does not sever a person's sexuality from them - they have every right to a fulfilling sexual life.

In this scenario, someone or some people may have abused the woman in question. On the other hand, she may be having a fulfilling sexual relationship with another person. However, if you are able discern that someone or some people have taken advantage of her intellectual disability, and sexually abused her, you may need to offer her support to access legal assistance. You may also need to offer her advice about her pregnancy and that she has a choice whether to continue with it or not. You may also need to familiarise yourself with the provisions of the RPD Act, 2017, and help her to access medical assistance to determine whether there are any genetic issues that she may need to get assessed for, to inform the choices that she could make about her pregnancy. Additionally, you may want to also think about how you would like to support Susheela through family strengthening. This could include accessing government or private schemes for persons with disability available in your State which her father could access, as he is likely to fulfil the legal norms to avail of such schemes. You could also explore the possibility of Susheela's first child availing of special education through some local agency.

CHAPTER 11
Sexual Relationships

Almost every culture considers certain sexual relationships and romantic behaviours appropriate, while looking down on other forms of expression. We develop our ability to have psychological and physical intimacy with others through romantic relationships. Culture has an impact on the kind of relationships and connections we form and develop. Romantic bonding is often closely associated with sexual activities and aspects of sexuality (such as sexual desire and sexual fulfillment). The healthcare system must offer assistance with mental health issues as well as advice on safe practices and contraception. No matter their age, gender, or sexual orientation, anyone can be subjected to abuse and violence in a relationship. The warning signals of an abusive relationship can differ from person to person. All abusive actions aim to keep control over and maintain power over their victim. Sometimes abusive actions start in an innocuous manner, and become overt over time. Young people can be made aware that they have the right to seek support if they feel undervalued, intimidated, or controlled. Everyone has a right to safety and dignity and deserves to be in a relationship where they are respected, trusted and loved, in addition to feeling protected.

CASE 1: KONGDENG AND BAHDUH

Kongdeng, a 21 year-old woman, has been in a relationship with Bahduh, a 23 year-old man, for two years. Both of them are still pursuing their higher studies. Kongdeng is very determined to complete her studies so that she can be financially independent and also support her family. Kongdeng and Bahduh are deeply in love. They even refer to each other as 'happiness'. One day, Bahduh asked Kongdeng if they could get intimate with each other. Kongdeng is taken aback by the question, as she believes in having sex only after marriage. She loves Bahduh, but the thought of having sex with him before marriage is against her values.

Questions for Reflection and Discussion

1. If Kongdeng came to you for help, how would you support her in responding to Bahduh request for sexual intimacy?
2. Do you think Bahduh was being indecent when he asked Kongdeng if he could have sex with her? If yes, why, and if no, why not?

Suggested Activities

Activity 1

Plan an activity with adolescents and youth from the community in which you work to help them navigate similar instances in their romantic relationships? What information would you need to give them about the POCSO Act, 2012?

CASE 2: SUNIL

Sunil, a 26 year old man, is brought to the Health and Wellness Centre as he is suffering from depression. He shares that he was in love with a girl as a teenager, and unexpectedly became a father while he was still in his teens. He was

unable to financially support the girl (now 25 years of age), or his child. The girl's parents despised him and ordered her to never see him again. The girl is from a well-to-do family. Though he has managed to acquire a small job and hopes to see his son again, the girl's family are reluctant to permit him to meet them. The girl, who is still fond of him, secretly contacts him occasionally out of sympathy and takes her son out to meet his father for a few hours, far away from where she stays. It has come to his knowledge recently that she will soon be engaged to another man, and will move cities to live with her husband. He begins to lose hope of ever seeing his son again.

Questions for Reflection and Discussion

1. How are public health workers equipped to deal with such cases?
2. What type of mental health services should be available to adolescents and young adults to navigate relationships and have healthy sexual relationship with their partner?

Annexure 11: Additional Core Messages for Case 1: Kongdeng and Bahduh

Human beings are social animals and hence, forming social relationships is inevitable. Romantic and sexual relationships are also commonplace. Consent is an important and essential aspect of healthy sexual relationships. It is advisable that one is well informed about Sexually Transmitted Infections (STIs), contraception, etc., before participating in sexual activities with another person. It is also important to understand the law in our country regarding what is legally considered consent and age of consent for sexual activity in India. The POCSO Act, 2012 puts down the age of consent as 18 years. This means that even if two people under the age of 18 years engage in sex, it will be considered as statutory rape of both minors. Similarly, in a consensual relationship, if one partner is above 18 years, and the other is below 18 years, then also, it is considered statutory rape.

CHAPTER 12

Sexual Preferences and Practices

CASE 1: HISHA

Hisha is a 25 year-old working woman who is staying in a working women's hostel. She has a roommate who confided in her that she has been sexually active since she was 19 years old. Hisha tells her that she was in serious relationship until a few months ago and has been celibate since then. Hisha also says that while she does want to be in a relationship, she is also thinking of engaging in causal sex with someone she knows at her office.

Questions for Reflection and Discussion

1. What are your own views relating to sex, live in relationships, casual sex and marriage?
2. What can be done to increase awareness about precautions to be taken while having multiple sexual partners, risk of transmitting STIs etc.

CHAPTER 13
Paedophilia

Paedophilic disorder is defined as a "persistent sexual interest in prepubescent children, which manifests itself in thoughts, fantasies, urges, sexual arousal, or sexual behaviour, and is accompanied by either acting on or experiencing distress because of this interest". Paedophilia is not synonymous with sexual offending against children. Paedophilia was first formally recognised and named in the late 19th century. A significant amount of research in the area has taken place since the 1980s. Although mostly documented in men, there are also women who exhibit the disorder. Most adults who sexually abuse children are not paedophiles, nor do all paedophiles sexually abuse children. Among child sexual abusers, a subgroup of between 20 and 50% can be classified as paedophilic (Harper et al., 2021).

CASE 1: 'X'

A final year engineering student 'X', aged 21 years, goes to the college appointed counsellor, and tells him that he needs to talk to someone or else he is afraid he will do something terrible. He goes on to say that he would "rather die than do that". The college counsellor manages to calm him down and create a situation where he is able to speak freely. He starts by saying that he has always been a popular guy, and that after puberty, he had no dearth of female admirers from his age group. In school, he gradually realised that he was always attracted to younger girls than to his classmates or peers. At first it didn't bother him much, as they were all in school. But after joining college he was confused when he realised that he was still sexually attracted to younger girls, especially those around 10 years of age. Recently, he had gone to his hometown to attend a festival and there he met his older cousin's daughter, a nine year old girl. To his dismay, he started having intense emotions for this girl and found himself sexually aroused whenever he thought of her. He was horrified with what he was thinking and feeling and hurriedly left his hometown and came back to his college hostel. He tried to engage in a sexual relationship with a girl from his college who had demonstrated some affection for him, but he could not get that young girl out of his mind. He tells the school counsellor that he is thoroughly ashamed and afraid that he would hurt the girl. He also reveals that he has started having thoughts about wanting to kill himself.

Questions for Reflection and Discussion

1. Is Paedophilia a mental disorder?
2. If you were the public health personnel or person who was approached by this person 'X', how would you handle the situation?

CHAPTER 14
Intersectionality

CASE 1: ANJANA AND BINDU

Two girls, Anjana and Bindu, are school classmates. Their school is located in a city. Anjana is from a small village far from the city (lacking even in basic facilities), and therefore stays in the school hostel. Anjana's family is economically backward, her father is a daily wage labourer and the sole breadwinner of the family. Her studies and hostel are covered by a government scholarship for girl students. Bindu is from a well-to-do family and lives near the school. Due to the COVID-19 pandemic, all hostellers were sent home and online classes were started.

Questions for Reflection and Discussion

1. From the perspective of intersectionality and positionality, discuss, how the situation of online classes, lockdown and the pandemic could have been experienced differently by Anjana and Bindu.

CASE 2: HEERA

Heera is a trans woman with disability who is a wheelchair user from an economically backward family in a tribal community.

Questions for Reflection and Discussion

1. Through an intersectional framework, discuss how Heera's experiences might be different from a trans woman from upper class, upper caste, and a non-tribal background.

Suggested Activities

Activity 1

Request students to think of any one person with whom they have engaged with as part of their Case Work, and request them to write a short note on how they initially perceived this person. Then request them to reflect on the person from the lens of intersectionality and share how this exercise helped them to become more sensitive and empathetic towards them, given the challenges that the client is working through as part of the Case Work.

Activity 2

Request the students to analyse the institution/school/hospital/community or other setting in which they have been placed for field work from the angle of intersectionality. Request a few students to share what they have learnt from this exercise and what they could do in terms of social work interventions to change the way people engage with each other in that setting.

CHAPTER 15

Sexual Violence against Adults

Sexual violence is reported almost daily in the news. Yet, most of the more than 200 Indian languages and several hundred dialects do not have words that could be used to describe or talk about sexuality, let alone sexual violence. Even if there are words, people are generally not aware of them. Further, even if people are aware of the words, they are by and large, not comfortable using them given the socio-cultural norm that sex and related matters are not to be discussed in public or in families. Patricia Mukhim in her article "Create a Language to Portray the Trauma" (The Statesman, March 25 2012), suggests that the lack of a proper word for rape in the Khasi tribal language somehow fails to convey the horror of the crime. This silence around sexuality potentially contributes to the persistence of myths and misconceptions among the youth as well as adults. People, especially children and youth, receive very little age-appropriate, scientific information on sexuality and sexual health from parents, school, religious institutions, peers or the media. The little information they do receive seems steeped in notions of morality. Ignorance about sexual and reproductive health, stigmatisation of people with non-cis-het gender identities and sexual orientations, not holding the perpetrator accountable and responsible, and blaming the rape victims are probably some of the consequences of the prevailing silence and lack of comprehensive values and rights based education on the subject of sexuality and sexual violence: See: www.mlcuniv.in

CASE 1: RITA AND JAI

Rita, an 18 year-old student, has recently lost her mother to cancer, leaving her 9 year-old brother in her care. Her father is addicted to alcohol and is unavailable to the children. Her 75 year-old grandmother is the only person she can turn to. She dreams of doing well in her studies so that she can get a good job as a nurse in the future.

Her 19 year-old neighbour, Jai, was very helpful during this stressful time. She increasingly relied on him, not only for household chores, but to also discuss her problems. One day, while she was alone, Jai forced himself on Rita and threatened to harm her and her brother if she resisted, or told anyone about it.

Rita felt ashamed, depressed and kept quiet about it. She was very adamant that no one should know about how Jai had treated her. When she missed her period, she thought it was because of all the stress that she had been through. But some weeks later, she was really scared and did all kinds of things that she thought would help to make her periods come, such as eating raw papayas, etc. Finally, she told her classmate, Jenny, who suggested she do a pregnancy test. The test was positive. Rita approaches her local health worker in the hopes that they will be able to help her deal with this crisis, as she does not want the baby.

Questions for Reflection and Discussion

1. What according to you are the various options that Rita could consider as regards

the pregnancy? Discuss what the law (such as MTP Act) has to say about these options.
2. What are the responsibilities of a health worker in cases of domestic violence?
3. What are the possible health implications for Rita?

Annexure 14: Additional Core Messages for Case 1: Rita and Jai

1. Jai sexually assaulted Rita, resulting in a physical, emotional and psychological trauma that has various implications that would have to be understood and dealt with at several levels - in terms of Rita's health needs (including mental health), her unwanted pregnancy and related legal issues, family issues, etc. There are no easy answers in these kinds of situations, particularly because Rita is currently depressed. The health worker would have to work with her at her pace, and enable her to make informed choices. Rita's wishes need to be in focus so that all interventions are planned in a manner that she feels supported and all her rights are protected. She may be referred to organisations that work with survivors of violence who can support her with additional information about the legal procedures, the support systems available, etc., to enable her to consider other options.
2. Explain what the MTP Act says.

CHAPTER 16

Sexual violence against Children

Child sexual abuse (CSA) is among the major risk factors identified by the WHO that significantly affects the burden of disease and contributes to 9 million years of healthy life lost (Letourneau et al., 2014). Prevention of child sexual abuse requires comprehensive multi-agency approaches that include criminal justice and public health. Public health approaches for prevention of child sexual abuse draw on the expertise and knowledge of multiple disciplines such as medicine, education, psychology, economics and sociology. Public health models target each socio-ecological level in an inclusive and comprehensive manner (Kewley et al., 2021). Before dealing with CSA, it is important to understand the risk factors for CSA. The figure shown on the following page shows a lifecourse approach to understanding CSA and its risk factors.

Enfold believes that no single measure or intervention with a single stakeholder is going to make a dent in the prevalence of sexual abuse of children as several socio-economic, cultural, familial and individual factors influence the actions of a perpetrator. We need a multipronged, holistic approach - what Enfold calls a 360 degree approach - targeting children, parents and caregivers, teachers, general public, stakeholders involved in redressal of sexual violence, police, medical and judicial personnel, social workers, counsellors, government functionaries, policy makers in the areas of school and college level education, professional education, health and family welfare departments, child protection departments and law makers. In all of these interventions, the focus has to be on the perpetrator - how to spot unsafe behaviour, how to intervene in unsafe situations, how to manage persons demonstrating unsafe behaviour, how to be a safe person, how to support each other to be safe persons.

Interventions aimed only at supporting children in recognising and reporting unsafe behaviour to their safe adults are still probably effective to some extent. Most abusers are known to the child (according to National Crime Records Bureau, Crime in India 2020 report Table 4A.10, out of all in cases registered under POCSO, in 96% of cases, the offender was known to the child), and don't want to be caught out. So they don't assault the child outright. They put children through a grooming process where they first build trust with the child and then slowly sexualise the relationship. This grooming period offers a window of opportunity for prevention, if the child and the adults the child is likely to reach out to have been through holistic prevention programs.

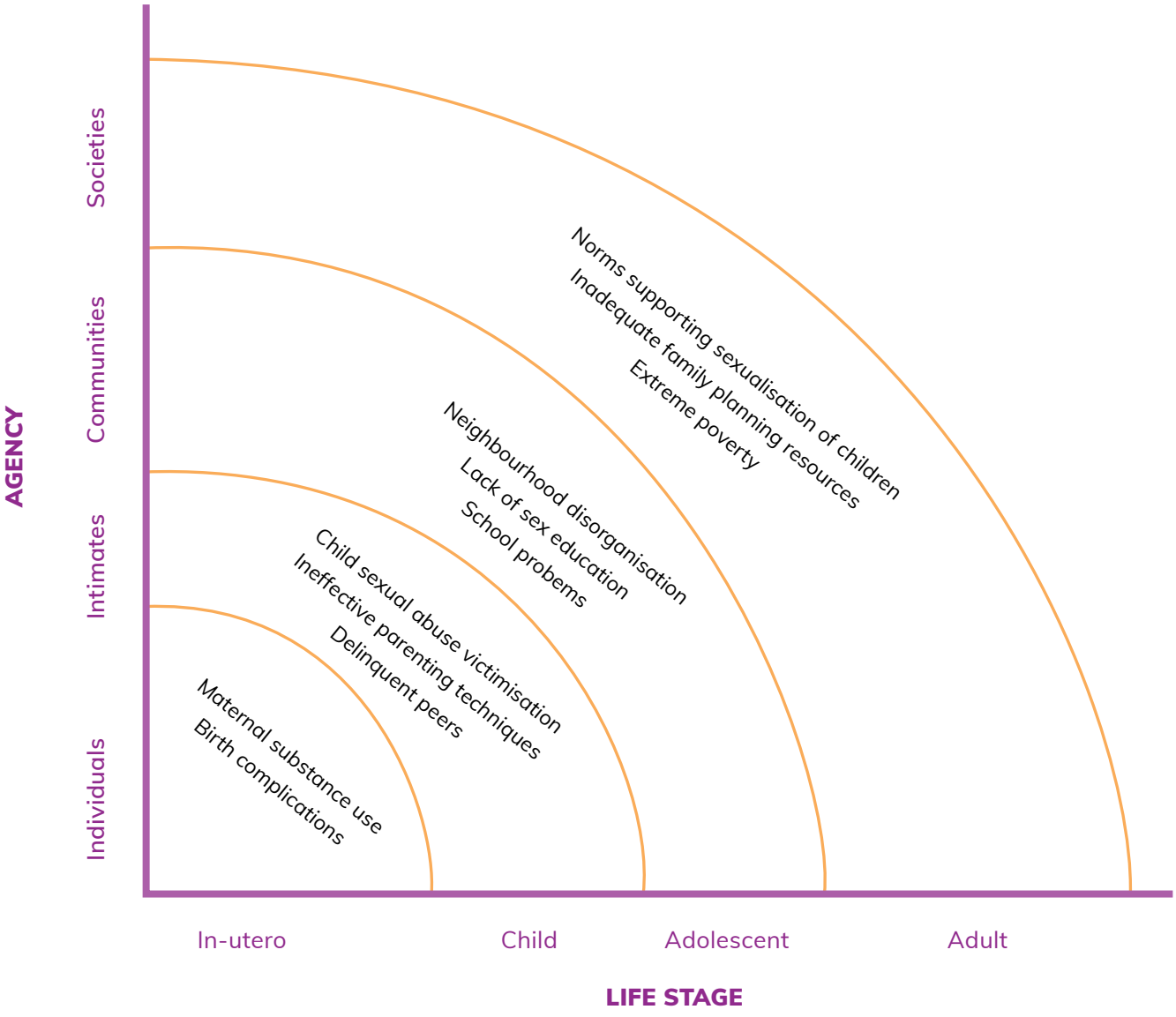


Figure: Risk factors for child sexual abuse victimisation and perpetration (Letourneau et al., 2014)

CASE 1: MONA AND RATI

Mona is a young ASHA worker. One day, a 14 year-old girl, Rati, who was very close to her, came to her and said her stepfather had been 'bad' to her. On talking a bit more to the child, Mona quickly realises that Rati's stepfather had been sexually abusing her, repeatedly. Mona is shocked and disturbed. The child says when she tried telling her mother, her mother hit her saying "don't say stupid things." The child is really scared and also shows Mona some physical signs of injury on her body.

Questions for Reflection and Discussion

1. What are Mona's options?
2. What can Mona do to support the child in dealing with the trauma of this incident? What role do local health workers play in recognising and reporting cases of violence?

Suggested Activities

Activity 1:

If there is no module on Trauma Informed Practice (TIP) in your curriculum, identify experts who are competent and invite them to conduct an orientation on TIP, so that you will better understand its importance. You may then consider doing a full course on this, to help you to prevent burnout and vicarious trauma, while working with challenging populations or cases involving abuse or any form of violence.

Activity 2:

Do a mini research to find out the organisations that work on issues related to personal safety and sexuality, competent to provide quality services to women and children like Rati in your State.

CASE 2: 'B'

In a rural community, a child 'B', aged 4 years of age, has a stepfather who is a teacher in the village school. He sexually abused 'B'. An ASHA worker comes to know about this and informs a member of the Panchayat in the village. However, the family of the child and the village Panchayat want to settle it quietly. They threaten the ASHA worker, and tell her not to reveal this to anyone.

Questions for Reflection and Discussion

1. What do you think the ASHA worker can do? How would she handle the concerns of the family and the Panchayat?
2. Using health communication tools, how can the community be sensitised about the need to prioritise the needs and rights of the child over everything else, including the family's honour?

CASE 3: 'P'

Ms. P who is 22 years old, comes to you with emotional disturbances. She tells you that her neighbour, who was also a close friend of her father's, had sexually abused her when she was 10 years old. She also tells you that this event during her childhood is taking a toll on her relationship with her partner now.

Questions for Reflection and Discussion

1. How would you help Ms. P to help herself?
2. Try to recognise the various kinds of challenges that Ms. P faces? What health and allied services could be made available to her?

CASE 4: SHEMBOR AND JARGIT

Shembor, aged 14 years, goes to tuition early morning around 5 a.m. thrice a week, not far from

his home. The streets are always quite deserted at this time. One morning, he came across Bantu, aged 40 years of age, a local fish seller who is acquainted with his father. Shembor greeted him. Bantu, realising that no one was around, came close to him and offered him a cup of tea, sitting very close to him. Soon, he started feeling Shembor's genitalia, telling him that he had grown so handsome as a young man. Shembor was shocked and speechless and ran away as fast as possible. At school, unable to hold himself together, and still shocked by what had happened, he shared this incident with his friend and classmate Jargit. Jargit burst out laughing, and when the other students asked what was going on, Jargit made fun of him in front of them about what had happened. Soon, the whole class got to know about it. During the lunch break, Shembor picked up courage and attacked Jargit for humiliating him in front of the class, and soon the other classmates too started taunting Shembor that he looked like a girl, that's why this had happened to him.

Questions for Reflection and Discussion

1. Reflect on how you feel about Bantu's actions.
2. Using health communication tools, what steps can be taken to help the class to understand sexual abuse of boys?
3. According to the law, how can Bantu be held accountable for his actions?

Suggested Activities

Activity 1:

Prepare an awareness campaign, about sexual abuse of boys, including core messages and data from the Study on Child Abuse conducted by the Ministry of Women and Child Development, Government of India, 2007, for school students aged 13-18 years of age. As part of this campaign, design a poster that could help boys report sexual abuse.

CASE 5: NANCY

Nancy, aged 14 years of age, attends Sunday school classes every Sunday from 5-7 pm, at a church located about half an hour's walking distance from her home in a rural area. The route to the school is a quiet lane with very few houses, especially on a Sunday. One day, while passing one of the houses, Avery, a man aged around 30-35 years, who is a stranger to Nancy, was standing on the pavement, masturbating. He saw Nancy walking alone, and started passing lewd comments, whistling, and flashed his penis at her, inviting her to come with him. She ran past the house, towards the church where the classes are conducted. On returning home she burst out crying and related the incident to her mother. She is terrified, and says she never wants to go to Sunday school again.

Questions for Reflection and Discussion

1. What is 'flashing'? Can you raise awareness about what to do in such cases among students and in the community?
2. Do you think this man should be arrested, or be approached and spoken to?
3. What steps can the community take to create safer public places? How could you facilitate this?

Suggested Activities

Activity 1:

Research and discuss some community initiatives undertaken in different parts of the country/ world to promote awareness about child sexual abuse, and how to help build safer communities for children.

Annexure 16: Additional Core Messages for Case 1: Mona and Rati

1. If Mona came to you for assistance, you need to help her to understand the provisions related to mandatory reporting under the POCSO Act, 2012. Though she has an obligation to either report the abuse to the police, or call the Child Help Line (1098), she may seek the support of her parents to do so. If Mona expresses fear about reporting, it then becomes your obligation to report. Keeping quiet about the abuser puts all children in the extended family, neighbourhood and at the place of work of the abuser (if any), at risk. There are government and non-government organisations where one can seek shelter and protection. You could explain to her that there are ways to also hold the perpetrator accountable and responsible and take appropriate steps to prevent reoffending. You must advise Mona to be prudent about how she handles this information and support her in ensuring that she protects herself from reprisal, since it is possible that the perpetrator might want to attack in some way.
2. Though Rati may have experienced pleasure during the sexual act, she cannot and must not be accused of enticing her stepfather. There is a clear power differential, wide age gap and a relationship of trust that has been violated, which makes this an aggravated crime.

Additional Core Messages for Case 2: 'B'

1. According to the POCSO Act, 2012, it is the legal duty of any person with knowledge of any sexual offence against a child to report it to the nearest police station, mandatorily. Moreover, aside from 'B', many other children may also be at risk, given that the stepfather is a teacher, who is well respected in the village - and so this is therefore considered as an aggravated offence with a higher penalty. As a health worker, you have an obligation to report it. At the same time, you must cater to the immediate needs and well-being of the child as well as follow-up with the procedures after an FIR has been filed.
2. If you do not have the skills and training to handle such a case, you must bring this to the notice of your supervisor and refer the case to someone who does have the expertise to do so.

Additional Core Messages for Case 4: Shembor and Jargit

1. Sexual abuse of boys is common in India. Though many feel traumatised, most keep quiet and never tell anyone, due to fear of being mocked or because the matter may be trivialised. Many boys do not realise that they can also be targets of sexual abuse as sexual abuse is mostly talked about in relation to girls.

Additional Core Messages for Case 5: Nancy

1. Exhibitionism is a crime under the POCSO Act, 2012, and since Nancy is a child, this needs to be reported to the police. However, Nancy and her mother need to be first provided the psycho-social support they may need to recover from the trauma of this event, and so the reporting need not be undertaken immediately. Reporting is a process that needs to be undertaken preferably with the active involvement and consent of the family, as this would also result in a greater chance of gaining a conviction in court. However, given the reality that children are often not

believed, and there is no physical evidence related to this crime, the mother may need to be supported in bringing up this matter to trusted village elders, who may then become more vigilant about Avery's behaviour, by perhaps initiating a neighbourhood watch, and nabbing him red-handed. Elders in the village who are sensitive and have appropriate understanding of sexuality, could be approached and requested to initiate a conversation with Avery about his behaviour, how he can manage his sexual needs and desires while being respectful of others, and how he could acknowledge and repair the harm done to Nancy.

CHAPTER 17

Restorative Practices

The philosophy and principles of Restorative Practices resonate very closely with that of professional social work. In particular, Restorative Circles provide an opportunity for social workers to co-create safe spaces and co-equalise power with others so as to enable authentic conversations drawn from one's own life experience and wisdom, engaging with the professional use of self and applying all the social work principles, especially the purposeful expression of feelings and non-judgemental attitude.

Rather than Case Scenarios, here are a few samples of a Restorative Circles that you may consider facilitating, either among yourselves as Faculty of Social Work, or with the students in the classroom, who may also facilitate Circles on their own, with a little guidance. You may consider customising Circles, bearing in mind the need for sensitivity to age and culture, and following up the Circle process by having a discussion on how the values and principles in Restorative Practice are similar to those of professional social work, taking into account the specific conversations/ processes emerging in the Circles or in other case scenarios. Aside from the content in the Book on Demystifying Sexuality, for more information about Restorative Circles please see the following additional resource - Life Skills through Restorative Circles in a school setting -

http://enfoldindia.org/wp-content/uploads/2020/11/Life-Skills-Through-Restorative-Circles.pdf

http://enfoldindia.org/reports/guidelines-publications-research-papers-articles/

SAMPLE RESTORATIVE CIRCLE 1: BODY IMAGE AND REPRODUCTIVE HEALTH

(Level 1, for girls aged 15 - 18 years of age)
Life skill: Self Esteem

Purpose: Growing up, Body Image, Respect for Body and introduction to Reproductive System

Centre: Create a simple centre, placing elements from nature, and Talking Pieces that have some symbolic or personal value to one or all of the participants.

Opening: Facilitate a mindfulness moment of approximately two minutes, while playing some meditative, culturally appropriate, secular music.

Check-in: How are you feeling today?

Guidelines: Read out the Guidelines (Speak from the Heart, Listen from the Heart, without feeling rushed - say just enough, and no need to rehearse - trust you will know what to say). Encourage participants to adhere to them.

Values: Explain the purpose of values in a Restorative Circle, explaining how they serve as a foundation for creating a safe respectful space that enables authentic deeper conversations. Facilitate a process of participants identifying values by asking them, "What do you need to be practised in this Circle, that would enable you to feel safe to share authentically from the heart?" Pass the Talking Piece around and provide every participant an opportunity to share a value.

Now facilitate a process of gaining consensus on the values, writing each one down on an A4 size paper/paper plate so that it is visible to every participant, and place them around the Centre. In subsequent Circles with the same participants, ask participants if they would like to add any new values. If there are any new values that are offered, follow the process of gaining understanding, consensus, and commitment. Then write it on a similar paper/paper plate and place it around the Centre.

In today's session, we might come across words such as body, growing up, gender, sex, menstruation, periods, reproductive functions, reproductive system, reproductive organs and a few more that seem taboo in our normal day to day conversations. We wish to take you through a safe, scientific, respectful way (respect for our bodies as well as others) to know about our bodies. We have many organs in our body and each organ plays a very important role and has a function to perform in the body. For example, when we eat, digestion begins in the mouth, and continues in the stomach and the large and small intestines. The waste produced in the body as a result of digestion is then eliminated in the form of stools. We can't think of not having a digestive system, nervous system, circulatory system, etc.

Round 1:

How comfortable are you on a scale of 1 to 10 (1 being not comfortable at all, 10 being very comfortable) about learning about Reproductive Systems sitting together here today?

Round 2:

What are the changes that you are experiencing growing up?

Round 3:

How do you feel about your body? Are there parts of your body you strongly like/dislike?

Round 4:

What are the comments or messages you may have received about your body from people around you?

Content for Popcorn input session by Facilitator

You may have studied in 9th or 10th grade science about Reproduction of organisms from amoeba to human reproduction. Here is a definition of Human Reproductive System from Wikipedia "A reproductive system is the part of an organism that makes them able to sexually reproduce. Humans and other animals use their reproductive systems to have sexual intercourse as well as reproduce."

Let's also understand what is human sexuality, and how people experience and express themselves as sexual beings.

That is, how they experience and express their sexual desires, sexual orientation and gender identity personally, socially, culturally and in intimate relationships.

[According to WHO], "sex" refers to the biological and physiological characteristics that define men and women. "Gender" refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. To put it another way: "male" and "female" are sex categories, while "masculine" and "feminine" are gender categories.

Gender Identity is an inner sense of being of a particular gender or agender. It is one's self-identification as male or female or any other. Although the dominant approach in psychology for many years has been to regard gender identity as residing in individuals, the important influence of societal structures, cultural expectations, and personal interactions in its development is now recognised as well. Significant evidence now exists to support the conceptualisation of gender identity as influenced by both environmental and biological factors (American Psychological Association, 2015).

Apart from 'girl' and 'boy', is there any other gender? While responding to this question, you need to convey that there is a wider and more flexible range of gender expressions, with a range of interests and behaviours. Gender is not a binary, but a continuum; and that many children and adults express their gender in multiple ways. We express our gender through our clothes, hairstyle, mannerisms, speech patterns, body language, social interactions, or choice of activities. Sexuality is diverse. Gender identity and sexual orientation (a person towards whom one feels sexually attracted) is largely inborn (due to genetic and epigenetic factors).

Transgender: At times, gender identity does not match the anatomical sex of the person. The gender of such people is referred to as transgender.

Every person is equally human. LGBTQIA+ {Lesbian (female with same sex attraction), Gay (male with same sex attraction), Bisexual (sexual attraction not exclusively to people of one particular gender), Transgender, Queer (an umbrella term for sexual and gender minorities), Intersex (people are born with physical or biological sex characteristics that do not fit the typical definitions for male or female bodies) Asexual (sexual attraction is not experienced)} community members are as intelligent as any other person. We need to look beyond the body at the personhood, the humanity of each individual. We can respect people for their intelligence, qualities, skills and behaviour, and not for the way their bodies are made.

Developing human traits - qualities have no gender: All humans are born with all human traits, whether labelled masculine or feminine. Like muscles and bones and heart and liver - all of us have them, though the size and amount differs among the sexes and within the members of each sex. Similarly, all of us have all human qualities and intelligences - nurturing, cooperation, empathy, competitiveness, aggression etc. To categorise these traits as masculine or feminine is discriminatory and restrictive. It prevents people - adults or children, from exploring and developing their complete humanity.

Gendering our society was a big mistake! Each person needs to be encouraged to develop all their traits. No trait is better, superior or more desirable than the other. We need all the traits for us and the society to survive and prosper.

Check-out:

How are you feeling after the session and what did you learn from today's session?

Closing:

Stretching exercises, standing and sitting ones. Alternatively, consider showing one of the videos that have been suggested in the PowerPoint Presentation on Diversity

SAMPLE RESTORATIVE CIRCLE 2: GENDER

This plan for a Restorative Circle was prepared by **Arlene Manoharan**, Co-Head, Restorative Practices Team, Enfold and **Preethi Sunallini R**, Facilitator, Enfold. The Restorative Circle was facilitated with children in a Child Care Institution on November 25th, 2020.

Theme: Gender - To explore what according to people around us tells us about being a male or a female, and the pressure of those societal messages on one's own sense of self.

Life Skills: Interpersonal and Intrapersonal Relationships, Decision Making, Gender Roles

Preparation: Print out the table below, and cut it into strips and place the half-sentences in Column A in a box named A, and the half-sentences in Column B, in another box named B.

Opening: mindfulness moment instrumental music Mindfulness music on share screen: https://www.youtube.com/watch?v=WUXEeAXywCY

Check-in: How are you feeling today?
[Facilitators must keenly observe the feelings here, if there is somebody that is not feeling ok, at the end of this round ask another question.]

Talking Piece: Ask a child to share a Talking Piece and tell a story about it.

Guidelines and Values: Share the Guidelines (refer to page 69). Facilitate a process by which children share the values they need the participants to respect, in order to enable them to share freely.

Write these down and place them in the centre. Request the children to show a visible sign that they will respect all the values.

Instructions: Divide children into two groups - 'A' and 'B'. They are now asked to try and match the half-sentences in order to make complete sense. Each group could be invited to do a small fun body movement to say they are ready with one complete sentence.

Round 1:

Share one story from your life, when you felt compelled to do something only because of your gender? How did that make you feel?

Round 2:

Share a story about something you can do, but society doesn't approve of, because of your gender? How does that make you feel?

Popcorn Round: Reflective questions, children can share or just reflect

- Are the messages that society, media and people give around, true?
- Other than male and female, are there any other genders?

Check-Out:

- Share in one word how you are feeling right now, and
- What do you wish to take away from today's Circle?

[The Facilitator should open the white board/word/ppt and share and make a list of sharing by the group as co-created core messages.]

Closing: Show these two videos

https://www.youtube.com/watch?v=4Ct2bCfPpD8&feature=emb_logo - 2.43 seconds

https://www.youtube.com/watch?v=QCR24jyhfZk&feature=youtu.be - Gillette advertisement

Video on female barbers (Hindi) 2.23 minutes

Guidelines and Values

First half of sentence (for Group A)	Second half of sentence (for Group B)
Men can take care of children	as well as women
Technical skills can place men and	women on an equal level
Women can work	as hard as men
It is believed that if we educate a girl	we educate a nation
Boys can play with dolls and	girls can play with cars
Pink and blue colour need not be	associated with girls and boys
Boys and men should share domestic work	with girls and women
Both man and woman should	get equal pay for equal work
A girl child	is not a burden
Don't neglect me	because I am a girl
"Boys should not	cry" is an accepted norm
It is believed that boys have to go out for work	while the girls can take care of the home
Homosexuality is often considered to be an	unspoken subject
Division of labour on the basis of	gender needs to be changed
Gender bias can lead to	violence against women

Source: Gender Sensitivity: A Training Manual for Sensitising Education Manager, Curriculum and Material Developers and Media Professional to Gender Concerns.

http://unesdoc.unesco.org/images/0013/001376/137604eo.pdf

REFERENCES

1. American Psychological Association. (2015). APA Dictionary of Psychology. Dictionary.apa.org. Retrieved 30 June 2022, from https://dictionary.apa.org/gender-identity
2. Committee against Torture. (2011). Consideration of reports submitted by States parties under article 19 of the Convention.
3. Harper, C. A., Lievesley, R., Blagden, N. J., & Hocken, K. (2021). Humanizing Paedophilia as Stigma Reduction: A Large-Scale Intervention Study. Archives of Sexual Behaviour, 51(2), 945–960. https://doi.org/10.1007/s10508-021-02057-x
4. Kewley, S., Mhlanga-Gunda, R., & Van Hout, M. (2021). Preventing child sexual abuse before it occurs: examining the scale and nature of secondary public health prevention approaches. Journal Of Sexual Aggression, 1-33. https://doi.org/10.1080/13552600.2021.2000651
5. Letourneau, E., Eaton, W., Bass, J., Berlin, F., & Moore, S. (2014). The Need for a Comprehensive Public Health Approach to Preventing Child Sexual Abuse. Public Health Reports, 129(3), 222-228. https://doi.org/10.1177/003335491412900303
6. Mitchell, K., Lewis, R., O'Sullivan, L., & Fortenberry, J. (2021). What is sexual wellbeing and why does it matter for public health?. The Lancet Public Health, 6(8), e608-e613. https://doi.org/10.1016/s2468-2667(21)00099-2
7. NNSW. (n.d.). Sex work is dignified work. Retrieved 25 June 2022, from http://nnswindia.org/upload/Sex-Workers-Against-Traffickers.pdf http://nnswindia.org/upload/Sex-Workers-Against-Traffickers.pdf
8. OHCHR. (2011). Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity. Retrieved 30 June 2022, from https://www.ohchr.org/en/documents/thematic-reports/ahrc1941-discriminatory-laws-and-practices-and-acts-violence-against
9. Pan American Health Organisation. (2021). Building Health Throughout the Life Course. Concepts, Implications, and Application in Public Health. Washington, D.C., Pan American Health Organisation.
10. Santosa, MJ., Ferreirab, E., Ferreirac, M. (2016). Knowledge of and attitudes toward sexual and reproductive health among college students. Aten Primaria. 2016;48(Espec Cong 1):188-194
11. Stanton, A. M., Batchelder, A. W., Kirakosian, N., Scholl, J., King, D., Grasso, C., Potter, J., Mayer, K. H., & O'Cleirigh, C. (2021). Differences in mental health symptom severity and care engagement among transgender and gender diverse individuals: Findings from a large community health center. PLOS ONE, 16(1), e0245872. https://doi.org/10.1371/journal.pone.0245872
12. TARSHI. (2018). Sexuality and Disability in the Indian Context.
13. WHO. (2022). Defining sexual health. Retrieved 25 June 2022, from https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health
14. WHO. (2009). Promoting sexual and reproductive health for persons with disabilities. WHO/UNFPA guidance note.
15. WHO. (2022). Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime Retrieved 25 June 2022, from https://www.ohchr.org/en/instruments-mechanisms/instruments/protocol-prevent-suppress-and-punish-trafficking-persons
16. WHO. (2022). Reproductive health. Who.int. Retrieved 25 June 2022, from https://www.who.int/westernpacific/health-topics/reproductive-health
17. WHO. (2017). Sexual health and its linkages to reproductive health: an operational approach. WHO.ISBN 978-92-4-151288-6.
18. Villines, Z. (2021). Gender bias in healthcare: Examples and consequences. Medicalnewstoday.com. Retrieved 25 June 2022, from https://www.medicalnewstoday.com/articles/gender-bias-in-healthcare

This Demystifying Sexuality Handbook is an accompanying document to the Demystifying Sexuality Reference Book. It has been developed by Enfold Proactive Health Trust for teachers and students of graduate, post graduate and special education courses, with the objective of reflecting on the real-life manifestations and applications of the concepts and ideas discussed in the Demystifying Sexuality program.

The handbook is a compilation of scenarios that aid the understanding of these concepts through Case Studies, discussions, role plays or reflection.

The handbook may be used as a guide by any teacher or facilitator trained in conducting the Demystifying Sexuality program, who may choose to use it as is, use parts of it or modify it to the specific needs of their learners. Teachers and students may also use it to reflect on how they are applying these concepts in their interactions with people while in training, or in their professional capacity.

enfold

Enfold Proactive Health Trust
No. 22, 3rd Main Road, Ashwini Layout, Ejipura,
Inner Ring Road, Koramangala,
Bengaluru, 560047, India
T: +91 99000 94251
www.enfoldindia.org