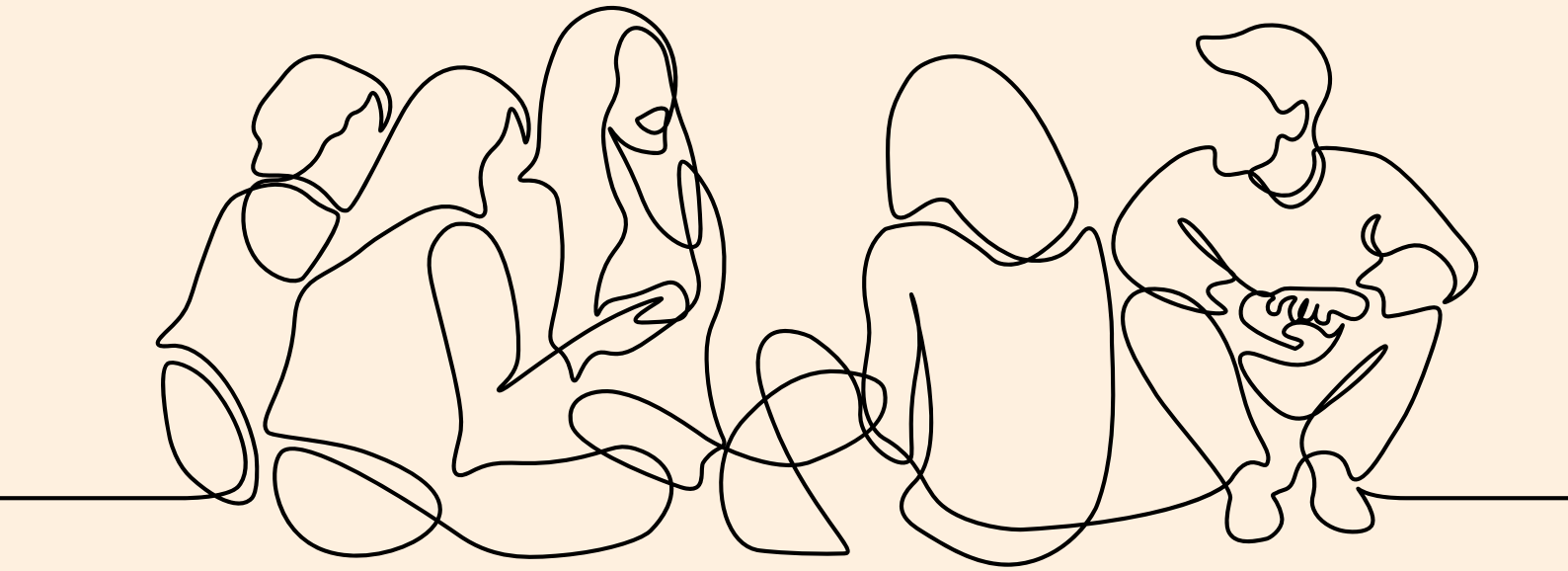
ENFOLD PROACTIVE HEALTH TRUST

DEMYSTIFYING SEXUALITY REFERENCE BOOK



Looking at sexuality with a rights-based, restorative and gender transformative lens

enfold

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Demystifying Sexuality Reference Book

- accompanies Enfold's Comprehensive Sexuality and Personal Safety Educator Program

May 2026

Note to the reader: The content in this document is aimed at increasing awareness and providing information around different aspects of sexuality - highlighting the diversity in its development, experience and expression and the need to respect this while being mindful of each other's rights. Gender bias, gender based sexual violence and child sexual abuse are discussed with a focus on overcoming or minimising their impact, and an emphasis on healing, while holding perpetrators accountable and responsible. Some readers may find the content distressing. We suggest reading the chapter descriptions provided below to know what is covered and plan how you would want to proceed with studying the content.

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This Reference Book 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 from nursing, social studies, psychology, education, special education 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 gratefully thank Ford Foundation for supporting this project.

Introduction

Dear Reader,

This book contains information on a range of topics that Enfold discusses in its flagship course, Demystifying Sexuality. But why demystify sexuality, you might ask. Isn't it supposed to be discovered as one goes through life? Yes, but for various reasons, and especially in the Indian context, sexuality is cloaked in secrecy, suspicion, silence and shame, despite it being an integral part of our lives from birth. In our eagerness to fit people into neat categories of 'sex', the first question everyone asks when a baby is born is, "Is it a boy or a girl?". And so begins the process of socialising them according to the gender we assume they are - setting the stage for further confusion, discrimination, violence and invisibilisation based on one's gender identity and sexual expression.

Secrecy and silence have made it harder for us to understand our bodies. This has led to several myths and misconceptions about sexuality, gender and relationships, particularly those that go against social norms. In this book, we aim to provide a simpler understanding of the biological and cultural factors that have moulded our bodies and psyche in relation to sexuality. It provides up-to-date and scientific information about sex, gender, sexuality, and related information. These perspectives can further our understanding of sexuality and debunk some related myths. It additionally provides practical inputs, informing the reader of ways to use this information in their daily lives.

The 'Demystifying Sexuality' course is the first step in Enfold's multi-level Comprehensive Sexuality and Personal Safety Educator training programme. This course gains more significance in the context of the unabating menace of sexual violence against women, children including those from marginalised backgrounds. This book highlights the probable causes of some of these issues and how to address them.

Our ultimate aim is to prevent violence and discrimination that people are subjected to based on their gender and sexual identity - and create safer spaces where people are not marginalised based on their gender, class, caste, sexual orientation, disability, ethnicity or social origin, or any other identity.

We aim to empower adults, especially teachers and college students, to recognise and speak against gender-based violence; provide support to survivors; and hold people responsible and accountable for their actions that caused harm. This cannot be done without a deeper understanding and acceptance of various aspects of sexuality. Pleasure and sex positivity go hand-in-hand with the application of a rights-based, intersectional, restorative and gender transformative approach. To meet these goals, we have developed a curriculum and content for B.Ed., Nursing, Social Work, Counselling Psychology, and Disability courses. This book forms the basic reading material for all disciplines, complementing the first step of the 'Demystifying Sexuality'course mentioned earlier.

We aim to work with teachers of these disciplines, and through them, equip their students with skills to impart life skills-based gender equity, comprehensive sexuality and personal safety education with a rights-based and restorative perspective. These students would then be able to

bring in this knowledge and empowering attitude in their interactions with children and adult community members during their course, and, thereafter, in their professional and personal life.

We believe that feeling empowered i.e., feeling confident of oneself and accepting and feeling good about who we are helps us experience and express our sexuality in ways that are joyful and respectful of ourselves and others. It could also help in recogising and taking action to stop and prevent abusive behaviours, and creating safer spaces for everyone to live a life full of dignity and liberty.

How we wrote this book:

The World Health Organization defines sexuality as "…a central aspect of being human throughout life - (it) 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, behaviour, 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, legal, historical, religious and spiritual factors" (WHO, 2006a). Sexuality is, therefore, a complex subject to write about. Our understanding of the topics in this Reference Book is constantly evolving with emerging research and continued dialogue and discourse with stakeholders who are impacted or actively engaged in these fields.

In writing this Reference Book, Enfold has drawn on 20 years of experience of working directly with children (from grade 1 to college students), parents, teachers and support staff of educational institutions. Since 2010, the team has directly worked with medical professionals, police, judicial office holders, media professionals, social workers, counsellors and government functionaries involved in the care and protection of children affected by sexual violence. Since 2018, the team also had opportunities to work with children and functionaries in the Juvenile Justice System.

Since its inception in 2001, Enfold developed its own content and methodology to facilitate learning in the area of sexuality and personal safety, basing it on life skills like self-awareness and empathy. The team kept its content culturally relevant, age-appropriate, scientific, and values and rights-based, and also developed a curriculum on Life Skills based Gender Equity, Sexuality and Personal Safety education for grade 1 through 12. This was translated into Kannada with support from UNICEF.

To take the work forward, Enfold has trained over 500 facilitators drawn from Bengaluru, Coimbatore, Chennai, Delhi, Hyderabad, Cochin, Kanpur, Pune, Shillong, Vellore, Yadgir and other cities and towns across India to conduct its curriculum. This includes B.Ed. students of Christ University, students of PG Diploma in Life Skills, Sexuality and Reproductive Health from Christ University, faculty of Martin Luther Christian University, teachers of schools affiliated to Pearson India in different cities, and government teachers from Telangana. Since 2018, we have been reaching caregivers and teachers of children with disabilities, equipping them to teach personal safety and sexuality education to children in their care by using the Suvidha Kit developed in-house by Enfold in consultation with external experts. As of March 2021, we have worked with 5,180 adults under our Suvidha project for persons with disability.

Based on their experience with children in schools, Dr Sangeeta Saksena and Dr Shaibya Saldanha (founders of Enfold), along with Dr Shekhar Seshadri (psychiatrist and professor of the Department of Child and Adolescent Psychiatry in NIMHANS, Bangalore) co-authored 'On Track' - a workbook series on Life Skills and Personal Safety education for students of grades 3 to 9, published by Macmillan Publishers India Ltd in 2008. Since then, the team has designed and developed a series of materials on Life Skills, prevention of sexual harassment at the workplace, thematic support for videos on abuse and trafficking of adolescents and developed information apps on child safety and women safety.

The Support and Rehabilitation team of Enfold has over 10 years of experience in providing medico-legal and psycho-social support to children and families affected by sexual violence. Team members are recognised 'Support Persons' by the Child Welfare Committee as per the guidelines of the Protection of Children from Sexual Offences (POCSO) Act, 2012. The team provides training to adult stakeholders, supports states in setting up Child-Friendly Courts and systems, and has undertaken studies on the implementation of the POCSO Act, the Juvenile Justice Act, 2015, and Model Rules, 2016 in government run Child Care Institutions in Karnataka. The team has also contributed to the development of the Standard Operating Procedures for the POCSO Act.

Based on their 15 years of experience in the field of personal safety and sexuality education, the Enfold team developed the Suvidha Kit for children and adolescents with intellectual disability to learn personal safety and sexuality education.

Various team members began receiving training in restorative practices and restorative justice from international experts like sujatha baliga and Sonya Shah, from 2016 onwards. Since 2018, the team began work with children and adults in this area and has developed and adapted content to suit the needs of the particular community it is serving.

Enfold team members also worked with the Government of Madhya Pradesh and UNICEF, to develop the Madhya Pradesh State Child Protection Policy and Operational Guidelines for State Departments and Child Care Institutions.

While writing this Reference Book, the team reached out to its trained facilitators, network of counsellors and experts in diverse fields to contribute or review the content to keep it as much in tune with the current research and scientific understanding of sexuality as possible. This collaborative effort, thus, brought together the knowledge and expertise of different professionals including practitioners, researchers, social workers, community members and mental health workers. To that extent, there are variations in the style of writing which have been retained so that the key messages are conveyed effectively and not diluted or misrepresented by editorial liberties.

Also, we would like to draw attention to the positionality of the various writers who helped develop this Reference Book as well as the external reviewers - all of whom came from different backgrounds and levels of expertise on these topics. Most belonged to urban, middle and upper-middle class, English-speaking backgrounds, across age-groups, gender identities,

and from different geographic locations (mostly in India - some resided in the US and Australia). They were approached based on their research backgrounds or if they were members of particular communities that were mentioned in the Reference Book.

Frameworks we have used

Intersectional approach

An intersectional lens takes into account how different social identities, like class, caste, gender, disability, etc., are interrelated. These identities interact and shape an individual's lived experience of power and marginality. This approach has been used throughout the Demystifying Sexuality course, as well as this book. We believe that intersectional framing is both important and urgent, especially in understanding various aspects of violence perpetrated on those marginalised by gender, sexuality, caste, class, disability, ethnicity and other identities.

Rights-based approach

We've used a rights-based lens in order to recognise, affirm and respect the human rights of all persons, including sexual health and reproductive rights, especially of communities that continue to be marginalised by gender and sexuality. We recognise gender-based violence and discrimination against people of different gender identities and sexual orientations as a human rights violation.

Restorative approach

We have looked at most of these topics through a restorative lens which encourages us to move away from shame-based and blame-based responses, common in the context of gender-based and sexual violence. It helps us look at situations and incidents as outcomes of structural inadequacies which need to be resolved, to enable people to live a life of dignity and fulfillment. There is a focus on assigning responsibility and building accountability where it belongs (the harm doer) so that a safe space can be created to address the needs of all concerned, especially the target of such violence. This is achieved through conscious efforts at building relationships and facilitating healing at an individual and community level.

Gender transformative approach

Throughout the programme, we encourage readers to question age-old norms and beliefs pertaining to gender, gender roles and stereotypes, and power inequities among people of different genders. We highlight the many ways in which we may be perpetuating gender stereotypes and oppression. The self-reflective exercises at the end of every chapter invite the reader to introspect and apply these learnings in their own lives. 17 videos on topics covered in this Reference Book offer practitioner's perspectives on how greater gender equity could be achieved in one's life.

Limitation of the work

The positionality of the writers and reviewers, as well as the limited field of work that Enfold Team members have been engaged in, are major drawbacks of this work. Though we attempted

to bridge this gap by inviting reviewers from diverse fields with different domain knowledge, the work would likely fall short on several counts given that the topic of sexuality is vast and the knowledge and experience of people in this field is constantly expanding.

Approach: We have presented evolutionary compulsions, scientific theories and modern beliefs in an easy-to-understand and practical manner. We have adopted a non-judgmental approach. We believe that the reader is fully capable of forming their own opinions.

Language: We have consciously tried to use a gender neutral, non-binary language as much as possible. For example, instead of girl/boy we have used 'child' and instead of her/him, we have used the pronouns 'they/them'. We have avoided the use of words like 'opposite' and 'both' in the context of gender and sex, except when quoting or referring to studies that have used such terms.

Terminology used by different groups to describe their experiences and identities is varied and changes over time. We remain committed to reflecting this diversity but recognise that terms used in this factsheet may vary in their usage or become outdated. Readers might therefore notice that the tone of the content is rarely in absolute or conclusive terms. We have tried to present what is the current thinking around these topics, with the acknowledgement that there may be multiple other perspectives, which may not have been represented. We are happy to receive observations from the readers as we believe these would help us in our future works.

Reference to laws: Our laws reflect existing socio-cultural beliefs held by most people at different points in history when they were framed. Gender bias, cultural beliefs and attitudes to sexuality continue to colour these. Moreover, an individual's rights are seldom mentioned or highlighted anywhere explicitly, nor are they consciously recognised by individuals themselves. Recognising these rights provides agency to individuals to ask, insist or demand the safety, respect, dignity and equality they deserve.. We have included some of the relevant laws under different topics throughout this Reference Book.

How to use this book

The content in this book follows the flow of the Demystifying Sexuality course. The chapters are best read as the course progresses. Extra reading material is provided for topics that we feel are important, but haven't been covered in detail during the course due to time constraints.

Reflective exercises and questions have been included where appropriate to encourage the reader to relate the concepts being discussed with their own life experiences, beliefs and attitudes. Some exercises may be triggering for some readers. Please do these only if you feel comfortable.

Supporting videos: We have captured practitioner perspectives in a series of 17 videos to supplement the written content in this Reference Book. These videos have been created by professionals and experts in the field who share their learning, their points of view and their recommendations. We hope these videos generate further discussion with peers, family members and teachers, encourage curiosity and seed further research ideas in these domains.

This Reference Book is divided into the following chapters. A brief overview of each chapter is given here

Chapter 1. Diversity in Sex
Speaking of sex in only binary terms is quite common, but is it really so? In this chapter we provide a clear understanding of the development of the human sexual and reproductive systems - each sex diverging from a basic common foundation. We show how the sexes are more similar than one might think or wish to acknowledge! We aim to develop an appreciation for diversity in nature, which is reflected so well in our bodies.

Chapter 2: Structure and Function of Sexual and Reproductive System
While the structure of the reproductive system is often covered in our school curriculum, the function of the sexual system is rarely discussed - more myths surround this than facts! This chapter discusses the function of sexual and reproductive organs and how pubertal changes proceed in humans. It highlights the homologous organs in our bodies and the similarities among the sexes.

Chapter 3. **Diversity in Gender and Sexuality**
Discussions on sexual orientation, behaviour and gender identity are often influenced by biases stemming from prejudices and an incomplete understanding of its nuances. This leads to myths and misinformation. We provide a simpler understanding of these topics, inviting the reader to form their own opinions.

Chapter 4: **Development of Gender Identity and Sexual Orientation**
Research and theories regarding the development of diverse gender identities and sexual orientations are lacking due to hundreds of years of taboo against talking about them and personal biases of researchers themselves. Studies in the last couple of decades are uncovering how gender identity and sexual orientation develop in individuals. The same is presented here.
Chapter 5: **Gender Bias**
We explain what gender bias is, its origins and how it affects all of us. We explore how we can learn to value ourselves and others irrespective of their gender identity, sexual orientation or assigned sex. This could create equality among different genders at home and in our society.

Chapter 6: Self-steem and Body Image in the Context of Gender and Sexuality
This chapter explores how our self-image is linked to our self-worth, self-respect and self-confidence. It delves into how these factors shape our sexual identity, expression and experience of gender and sexuality.

Chapter 7: Attitude towards Reproductive Health (including Common Issues)
We often delay or ignore reproductive-health investigation and intervention due to shame and prevalent myths and misconceptions surrounding it. At times, such issues are also addressed in silence without professional guidance. This, sadly, makes the situation worse over time. We outline what would support a person in understanding their reproductive health and preventive action where possible.

Chapter 8: Sexual Development in Children and Adolescents
We trace the physical and sexual development from the embryonic stage all the way to adolescence and early adulthood. Years of taboo and disdain have bred a sense of discomfort,

guilt and shame towards something that is natural and integral to our bodies. Adults pass on the same to children, perpetuating a vicious cycle. We aim to build a sense of acceptance, comfort and respect towards our bodies, emotions and instincts, regardless of our chronological age. We elaborate on age related considerations, developmental guidance and teaching-learning opportunities that can be used by parents and other adults to support healthy sexual development in children and adolescents.

Chapter 9: **Attitudes toward Sexuality**
How did sexuality, despite being an important and essential aspect of our lives, come to have such negative connotations? Can we cultivate attitudes that reinstate joy, autonomy, respect and accountability in our day-to-day experience of living as sexual beings? Can feelings of guilt or sinfulness give way to empathy and understanding, without judging ourselves for our sexuality, sexual characteristics and orientations which we had no part in determining? Can we accept that we are sexual beings right from birth and remain so until the end of our days - and therefore, make space for sexual expression among the elderly as well?

Chapter 10: Sexuality and Disability
The intersection of sexuality and disability is rarely talked about. This chapter moves towards building awareness of the historical, cultural and medical aspects that play a role in invisiblising this intersection and how we could move forward in a more empathetic and empowering manner.

Chapter 11: Sexual Relationships
This chapter explores the physiological and psychological dynamics of attraction, romance and a variety of sexual relationships and arrangements. The objective is to enable each other's right to sexual dignity, pleasure and relationship that can be enjoyed along with enthusiastic consent and safety.

Chapter 12: Sexual Preferences and Practices
Sometimes, it can be difficult to talk about sexuality with confidence, even with our partner(s). Sex often becomes the source of much pleasure and/or pain. We aim to support people in establishing physical, emotional and psychological boundaries related to their sexuality with confidence..

Chapter 13: Paedophilia
A term used commonly in the context of child sexual abuse, but poorly understood. A lack of clarity exists within the scientific community in understanding paedophilia as an orientation or psychological disorder. We take a look at the current emerging research and interventions available to support paedophilic individuals to manage their urges and prevent offences against children.

Chapter 14: Intersectionality
How do different socio-economic cultural and biological factors affect our experience and expression of gender and sexuality? How can we be mindful of someone else's experience of marginality if they don't enjoy the same privileges as us? In this chapter, we reflect on the many

identities we inhabit through the lens of intersectionality and familiarise ourselves of how the identities of others may play a role in their experience of oppression in this discriminatory world.

Chapter 15: Sexual Violence against Adults and Preventing It
We discuss the social, familial and gender based dynamics that perpetuate sexual violence against adults and ways to support survivors in recovering from such abuse. Can the survivor heal, let go of shame and build trust again? How can survivors be supported to take action, where possible, against this form of violence? We look at empowering strategies for the adult survivor of sexual violence that can be adopted by individuals, families and communities. We delve into the attitudes that encourage people to commit such crimes. How can perpetrators be held accountable and responsible for their actions? Can we learn to experience and express our sexuality and associated power without insulting, devaluing or subjugating the other?

Chapter 16: Sexual Violence against Children and Preventing It
Various factors have contributed to recurrent sexual violence against children by the very people they know and trust. We present ways in which adult caregivers can fulfil their responsibility and support children in learning how to recognize abuse, and tell their safe adults about the perpetrator. The effects of child sexual abuse and myths and facts around it are also discussed. How to take effective action with regard to the perpetrator, in compliance with existing laws is discussed. A note on child marriage and commercial sexual exploitation of children is also included.

Chapter 17: Restorative Practices
Patriarchal beliefs have negatively affected the experience of sex, sexuality and gender. This has also led to a punishment-focused approach to crime and justice, which does little to address the structural imbalances that perpetuate such crimes.There is the perception that inflicting pain on the offender is somehow supposed to reform them and heal the pain of the ones harmed. World-over, data tells us that this approach has not been successful. Restorative Practices offer a more humane, trusting, accountable and healing approach to building relationships and addressing conflicts, and even crime. This chapter presents a brief overview of Restorative Practices and describes the Restorative Circle process in some detail.

Additional reading: Life Skills
Here we give a brief introduction to some key life skills that may be useful as one navigates through life and develops the confidence and resourcefulness to manage oneself, one's relationships and keep oneself safe - in the context of sexuality and gender bias.

Chapter 1. Diversity in Sex
- evolution, diversity and common origins of sexual and reproductive systems

For a long time, due to various socio-political and cultural factors, we have been boxed into neat categories of sex and gender. This has resulted in rigid gender roles, gender stereotypes and justifications for perpetrating violence against those who don't conform to these societal expectations. We feel that awareness and understanding lays the foundation for acceptance, respect and appreciation. Hence, we begin with a deep dive into how our sexual and reproductive systems develop from the embryonic stage onwards. Understanding the common origins of these systems is the first step towards accepting the fact that the sexes are not inherently 'different' or 'separate' and have not evolved from some unique 'source'. This helps build appreciation and respect for our differences - our diversity.

How diversity ensures survival

Eons ago, life on Earth originated in an already existing environment. The environment changes constantly, and life forms must adapt to survive. Life, by its very nature, comes to an end for any individual organism. Reproduction ensures continuity of life forms.

Simple organisms (single-celled organisms like some bacteria, fungi, etc.) reproduce asexually. Asexual reproduction refers to reproduction that occurs through a single parent. It does not involve the fusion of female or male cells. The drawback is that the genetic variation in each progeny (baby) is not guaranteed as there is no mixing of genes between two organisms. Genetic variation is limited to spontaneous mutations (variations) in the genome (genetic material). This translates to restricted adaptability as genes carry the information for the formation and functioning of the organism. Different genes would result in diversity among the organisms, increasing their odds of survival.

Asexual reproduction works for simple organisms with less specific requirements that can survive in a wide range of temperature, gases, humidity, etc. Most complex organisms, on the other hand, have sexual reproduction. They have specific requirements and function within a narrow range of variables. Separate female and male systems developed allowing greater mixing of genes and increasing adaptability. Earthworms and flatworms have both female and male systems in the same body. Such organisms are called hermaphrodites (after Hermaphroditus, the child of the Greek god, Hermes and goddess, Aphrodite).

Various organs and systems in our bodies are therefore geared towards survival (finding food, safety, ability to protect from danger) and reproduction (finding a mate, having a baby and helping it grow to maturity). These organs are arranged longitudinally in many organisms. The brain is located at the 'head' end. The brain interprets signals from all the sense organs. The other end is responsible for the elimination of waste (urine and faeces) and provides a passage for the release of other materials like sperm and menstrual fluid and delivery of the baby.

By convention, the body that has the capacity to give birth has been called female. The human female reproductive system has evolved to produce mature eggs that can be fertilised This results in the formation of an embryo, housed and nourished in a safe environment (the uterus) until delivery. The breasts are secondary sexual organs. Breast feeding the newborn is part of

the reproductive process in mammals. It can also be fulfilled by another lactating female if the mother is not able to do so. The male reproductive system in mammals is usually designed to produce sperms that can then be deposited as close to the egg as possible - and this is usually within the body of the female.

Instructions to make our bodies are carried by chromosomes. Humans usually have 46 chromosomes, arranged in 23 pairs. A set of 23 chromosomes are obtained from each parent.

Chromosome pairs are numbered 1 to 23. The first 22 pairs code for the general body organs and are called autosomal (soma = body). They carry instructions to form the various systems and organs in the body in general. The 23rd pair codes for the reproductive system and are called the sex chromosomes. These are believed to have evolved from an ancestral autosomal pair of chromosomes (Ross et al., 2005). Each chromosome is made up of DNA which carries our genetic code and tells the cell which protein to make and how it will function.

Chromosomes are made up of a double helix structure called the DNA (Deoxyribonucleic Acid). The arrangement of bases (chemicals) in the DNA forms a code (called a gene) that tells the cell which protein to make and how it will function. The genes are in turn influenced by the environment through epigenetic factors – like temperature, food, drugs, radiation, chemicals that can turn a gene on or off. These can produce immediate as well as long term imprints on the genome that can be inherited. Epigenetic factors do not alter the genetic code but alter its expression.

In females, the sex chromosomes are X and X (one X from the egg, one X from the sperm). In males these are X and Y (one X from the egg and one Y from the sperm). The Y chromosome is very small and has one-tenth the genes than the X chromosome (Wilson Sayres & Makova, 2012). The X chromosome is a must for all cells to survive.

Development of the sexual and reproductive systems - common origins:

Human embryos develop in the same fashion until seven weeks of gestation (time period inside the womb). The embryo contains the yolk sac, in which resides the germ cells. These germ cells give rise to primitive gonads, which eventually develop into the reproductive organs (testes in males and ovaries in females). Until seven weeks of the existence of the embryo, these primitive gonads develop in the same manner.

After seven weeks, if the embryo has an Y chromosome, the gonads develop into the testes. A part of the Y chromosome, called the **SRY section**, appears to be important in this process. However, SRY is not the only factor that contributes to the development of the testes. This is because the testes can sometimes develop in the absence of Y chromosomes, as well.

Once the testes have formed, they begin to get signals from two hormones - the luteinising hormone (LH) from the foetal pituitary gland and the human chorionic gonadotropin (hCG) from the placenta. These hormones signal the cells in the testes to produce testosterone. This represents the male foetus, denoted as 46,XY.

If the embryo does not have a Y chromosome, the gonads develop into the ovaries. Two X chromosomes are required for the complete formation of ovaries. This represents the female

foetus, denoted as 46,XX. Ovarian tissue can develop in the presence of a single X chromosome. This is represented as 45,X0. This is seen in Turner's Syndrome. In such cases the ovaries may not form or function as well.

The cells in the ovaries divide to form millions of oocytes. These are surrounded by cells that secrete oestrogen, a hormone important for female development. Together, these cells form the primordial follicle. At the time of birth, each female has an average of 2,95,000 primordial follicles within the ovaries (Wallace & Kelsey, 2010). These follicles receive signals from the follicle stimulating hormone (FSH), which is released by the foetal pituitary gland. Following this, the primordial follicles develop in the primary follicles. The oocyte further grows and matures within it to form the ovum, the female sex cell.

Development of the genital ducts

At four weeks of gestation in males, in the presence of testosterone, the Wolffian ducts begin to develop into the epididymis, vas deferens and the seminal vesicle. High local levels of testosterone is a must for this. Cells in the testes produce Anti Mullerian Hormone (AMH) which suppresses the development of the Mullerian duct. In females, the Wolffian duct disappears and the Mullerian ducts develop into the vagina, uterus and fallopian tube. Presence of androgens (hormones that produce masculine effects) does not affect this development, neither does the presence or absence of the ovaries

Development of the genitalia

The external genitalia of males and females are identical in the first seven weeks of gestation. In males, after seven weeks, the presence of testosterone and its conversion to di-hydro-testosterone by an enzyme present in the cells of external genitalia, results in formation of the penis and scrotum. The genital tubercle becomes the glans, the urethral folds and urethral groove fuse to form the shaft of the penis, the labioscrotal swellings fuse and enlarge to form the scrotum.

In females, the genital tubercle forms the clitoris, the labioscrotal swelling forms the labia majora, the urethral folds form the labia minora and the urogenital sinus forms the lower two thirds of the vagina. Thus, the organs of the external genitalia are homologous i.e., they are of similar evolutionary origin, position and structure, though their function may differ. The clitoris is homologous to the glans penis, the labia minora to the skin on the shaft of the penis and the labia majora to the scrotum. It is believed that the prostate is homologous to Skene's glands (small glands located around the urethra in the female) (Zaviačič et al., 2000) and the Cowper's gland in the male to Bartholin's glands in the female (Knight, 2016). These are further explained later on.

Evolution of the secondary sexual characteristics and traits:

The basic instincts of life are survival and reproduction. Once basic survival capacity is reached, reproductive function begins. In humans this basic capacity is reached by 12 - 14 years of age. Secondary sexual characteristics develop around puberty and have to do with reproduction.

In the human male sex, , as in many other animals, the bodies evolved to establish dominance over sexual competitors. The strongest one got to mate with several females. Hence most human males evolved to develop extra height, muscle, hair and a deeper voice (Puts, 2010). They would generally compete for reproduction, and cooperate for survival of the group.

In the human female sex, the bodies evolved to develop mammary glands, a wider pelvis and extra fat under the skin (fat is stored food in case the foetus needs it) for child birth and subsequent feeding of the baby. They develop enough height and muscles to survive.

Females also need the cooperation of group members for successful reproduction and survival. Though when individual survival is at stake, they will compete and fight for resources (Stockley & Campbell, 2013).

As described in the development of the human sexual and reproductive systems, all embryos pass through a developmental stage that is common to all sexes. Similarly, pubertal changes are also similar across sexes - and vary only in degree. The hormones driving these changes - mainly oestrogen and testosterone, are usually present in all sexes, to varying degrees. Everybody - whether they reproduce or not contributes to the diversity within the group and thereby supports the continued survival of the species.

More similarities than differences among the sexes:

We share 45 out of the usual 46 genes. Our reproductive system has homologous structures like the clitoris and the glans penis. In the embryo, at around seven weeks, the genitals of all sexes look alike. All sexes have the sex hormones. Testosterone is the most abundant steroid hormone in adult females. However, its levels in females - 150-700 pg/m - are much lower than those found in males - 3000 - 10,000 pg/ml. Estrogen levels in females are much higher than the levels found in males. Estradiol (most common estrogen) levels in females range from 30–400 pg/ml while these levels in males range from 10–40 pg/ml.

Since we have evolved from animals that have female and male systems in the same body, we too have remnants of other sexes in our bodies. In the male body, nipples on the chest are the most obvious. Several remnants of the male system are found especially near the uterus. And so, we can say that we're more similar than different.

Reflection:

1. *How do you feel about the similarities between the sexes?*
2. *What were you told about the similarities or differences between the sexes?*
3. *How did these messages affect how you related to different sexes?*
4. *Notice your language - is it reinforcing the notion that there are just two sexes among humans? How can you change it to indicate the diversity in sexes?*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality -How Well Do We Know Our Bodies and the Mechanics of Sex and Reproduction? (link will be inserted).

Way forward

Our differences are more about degree rather than quality. We need not use our bodily differences to create hierarchies, privileges or biases. Respect for the body, its diversity and resilience can build a more equitable society.

We can begin by avoiding the binary language when talking about the sexes - avoid using words like ‘the opposite sex’ which implies that there are just two sexes. Instead, we can say ‘different sexes’ or ‘all sexes’.

Chapter 2. Structure and Function of Sexual and Reproductive Systems
- building understanding and respect

We carry a number of myths and misconceptions about our sexual and reproductive systems, thanks to the centuries old silence around sex, sexual organs and their functions and the association of shame with these. While we may know a little more about our own body, many are often completely confused by the structure and functions of other sexes. To begin to speak about sex and sexuality in an empowering manner, it is imperative that we have a basic, factual understanding of these systems. In this chapter we attempt to bridge this gap.

Sex 'spectrum'

Sex has been conceptualised in binary terms as female and male. It is spoken of in binary terms, and continues to be assigned to babies in this manner. Any variations in the development of sexual organs are often referred to as disorders (as in Diagnostic and Statistical Manual of Mental Disorders-5), requiring 'correction' to conform to and fit into neat medical categories.

Most societies have organised themselves around this binary notion. People confuse one's assigned sex with one's gender identity, and this negates the variations that exist on the sex spectrum and poses several challenges for individuals who do not 'fit' into an assigned category. In this chapter we aim to provide an understanding of this complex topic as simply as possible. To begin with, though we are using the term spectrum to draw attention to the variations in sexual development, it is not made up of distinct categories distributed equally, nor is it a linear, one-dimensional spectrum. Being a sexually reproducing species, a majority of expressions fall within the assigned categories of female sex and male sex.

The word sex is derived from Latin root word 'sec', meaning cut or division - and in that way, sex has the same root as the word section, and hence, the neat categorization of human bodies into the female or male sex. The word intersex came into usage much later. Now, the understanding of sex as binary is changing due to its exclusion and rejection of intersex variations. Sex is now beginning to be understood as a spectrum and the world is still learning more about intersex variations.

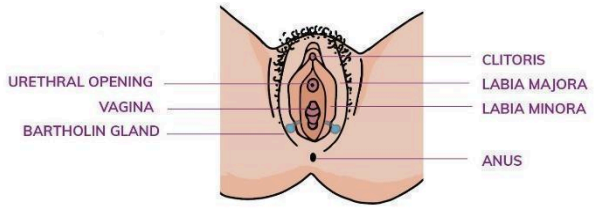
To understand the sex spectrum first we need to learn about and understand the male and female sex which are considered the two ends of the sex spectrum.

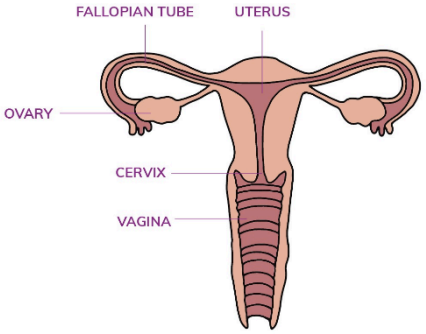
But before we begin, how well do you know your body, and the bodies of other sexes?

1. *Draw your body in as much detail as you can -especially the sexual and reproductive organs*
2. *Where in the body would one find - seminal vesicles, cervix, fallopian tubes, epididymis?*
3. *Draw sexual anatomy of different sexes - label the parts you know of. Are these the proper names of these parts?*

Female sex on the sex spectrum:
normative female sexual and reproductive system and function

These organs serve a sexual function from birth, with reproductive functions becoming active with the onset of puberty.





External genitals:
The word 'genitals' has a Latin root, meaning to 'beget'. The external genitals, also called vulva, consist of:

- **Clitoris**: A pea sized structure, covered by soft folds of skin in front of the urethra. It has an abundant supply of nerves and blood vessels, and provides sexual pleasure.
- **Urethra**: Below the clitoris is the opening of the urethra, which is the passageway for urine from the bladder to the outside of the body. The opening is a few millimetres wide.
- **Vaginal opening**: This is located behind the urethra, in the area referred to as the vulvar vestibule. This is the opening into the vagina.
- **Hymen**: This is a thin membrane that stretches across the entrance of the vagina. It has a perforation to allow menstrual blood to flow out of the vagina. The elasticity and blood supply to the hymen varies. The shape and size of the opening in the membrane also varies from person to person, as does its elasticity or stretchability. The hymen may hardly exist in some individuals, in others it is very easily stretched.
- **Labia**: The clitoris, the urethral opening and the vagina are surrounded by folds of soft skin - the labia minora (inner lips) and the labia majora (outer lips). Labia minora protects the vagina and urethral opening. Labia majora have hair and glands which release pheromones.
- **Bartholin's glands**: are two pea-sized glands located on either side of the vaginal opening. Their ducts open in the space between the labia minora and the vagina. During sexual excitement, mucus secretions from these glands help in lubrication of this area and the vagina.

Internal sexual and reproductive organs
These consist of:

- **Vagina**: the vagina is a hollow organ with elastic walls that leads up to the womb. Its walls are collapsed normally, but can stretch to accommodate a tampon, a penis or a full-term baby. It receives the penis during peno-vaginal intercourse and allows sperm to be deposited close to the mouth of the womb. It is also the birth canal. It is where tampons are inserted to absorb menstrual discharge. In a typical delivery, the baby passes from the womb to the outside through the vagina.

- **Uterus**: The uterus, also known as the womb, is a pear-shaped muscular organ in which the fertilized egg grows and develops into a foetus. Normally, the uterus is about three-inches long and two-inches wide. During pregnancy, it stretches and grows with the foetus. In a pregnant woman, the lining of the uterus, called the endometrium, nourishes the foetus.

- **Cervix**: The uterus narrows down to form the cervix - the neck - which protrudes into the upper part of the vagina. Cervix is the entrance to the uterus proper. It has mucus producing glands which respond to the influence of estrogen and progesterone hormones. At the time of ovulation (release of ovum from the ovary), it produces fertile mucus which helps sperms travel easily through the cervical opening and into the uterus. At other times the cervix produces thick mesh like mucus which makes it hard for the sperms to travel into the womb.

- **Fallopian tubes**: about 10cm long, narrow soft tubes stretch from the sides of the uterus to the ovary on either side. These tubes help pick up the ovum after ovulation and propel it towards the uterus. Sperms travel up from the vagina, through the cervix and uterus, to the tubes where fertilization occurs. The fertilized egg is propelled towards the uterus by the movements of the muscles and cilia (fine hair like structures) in the wall of the tube.

- **Ovaries**: One almond shaped ovary measuring 1cm x 2cm x 3cm is present on either side of the uterus. Each ovary contains lakhs of immature ova at the time of birth. With the onset of puberty, the ovaries begin to develop the immature ova and make estrogen and progesterone hormones under the influence of the master gland – the pituitary and hypothalamus in the brain. Beginning with puberty till menopause, usually one ovum (carrying half the genetic material of the individual) is released every month from the ovary. This is called ovulation.

Menstruation

In the absence of pregnancy, the lining of the uterus is shed about once a month. This shedding is called menstruation. Menstruation, often referred to as a ‘period’, happens about once a month. Normal range is 21-35 days. In the beginning when a child begins to menstruate, periods may be irregular – once every three, four, five or six months. Gradually the body develops its own pattern of regularity. Menstrual flow lasts for two to seven days in most individuals.

Regularity of the cycle can be affected by emotional stress or changes in diet or illness since any of these can affect the various hormones that control the cycle. There may be discomfort in the first or second day of the period, including abdominal pain, bloating, constipation or breast

heaviness and pain. Premenstrual tension (PMS) may occur in some, due to monthly changes in hormone levels during the ten days before menstruation. Fatigue, anxiety, irritability, headache, a feeling of fullness in the pelvic region, craving for sweets, breast tenderness and depression are some symptoms of PMS. Exercise and a balanced diet are thought to help reduce PMS. Depending on a person's gender identity, for example a transman, they may experience gender dysphoria in the form of distress during menstruation - as it may be contrary to their idea of themselves or their bodies. Besides the symptoms commonly associated with menstruation, there can be psychological distress at a personal level, compounded by awkwardness and safety concerns when accessing and purchasing menstrual care products that are often kept in the 'women's' section. Lack of gender sensitive health care providers could keep the person from accessing support.

Genital hygiene and managing menstruation

- While bathing or after passing urine or stools, genitals should be cleaned from the front to the back. This direction of cleaning avoids contamination of urethra and vagina by faecal matter.
- There is no medical or health reason to remove pubic or axillary hair.
- Sanitary pads or cloths used during menstruation should be changed at least every 6-8 hrs. Washable, eco-friendly sanitary napkins are now available.
- Tampons (made of cotton – look like a piece of chalk) can be used instead of sanitary napkins. One can swim while wearing these. Tampons need to be changed every 6 hours. If a tampon is not removed at regular intervals, there is the risk of toxic shock syndrome occurring
- Menstrual cups - or intra-vaginal soft plastic cups can be removed, washed and reinserted. Menstrual cups are placed inside the vagina and also need to be emptied and washed every 8 - 12 hours. The same cup can be used for several years. They are eco-friendly and durable.
- People with queer identities, who experience gender dysphoria or are otherwise uncomfortable, use menstrual hygiene products to help them manage menstruation with as much ease as possible – some may prefer to use menstrual cups (so that bleeding is not 'visible', while others may prefer pads as these don't require insertion. Some may use reusable pads to avoid shopping for the products or access them online.
- Use of comfortable, breathable (for example, cotton) undergarments is advisable, especially for people living in warm climatic conditions. People with queer identities – for example a transman may use customized undergarments to allow for 'padding' (to give the appearance of the bulge of a penis while also using a sanitary pad.

White discharge

Secretions from the reproductive tract come out as white discharge. The function is to keep the vagina clean, moist and lubricated. It is usually not foul smelling or irritating and is normal and natural. It does not cause any health problems or weakness, like some might believe. This discharge is acidic in nature and tends to leave a stain on the undergarment.

Infection is denoted by any foul smell or change in colour of the discharge - from whitish or greyish to yellow, green or red, and an itching and burning sensation around the vagina.

G Spot, female prostate and female ejaculation

G Spot, short for Gräfenberg Spot (named after German gynecologist Ernst Gräfenberg) is an erogenous area in the vaginal wall, commonly said to be bean-shaped, about one to three inches up the front vaginal wall, though the erogenous area may extend along the entire anterior wall of the vagina and sometimes include parts of the posterior wall as well. It may be part of the female prostate or an extension of the clitoris. Studies support the existence of an anatomical G spot structure in the front lower part of the vagina which shows transient engorgement with blood on stimulation (Ostrzenski, 2019). discussion on the G spot and its possible role in enhancing sexual pleasure has resulted in some women feeling under pressure to 'discover' their G spot if they can't find it or achieve G spot orgasm, also called G-Pressure. Some have even asked for G spot amplification surgery.

Female Prostate (Rubio-Casillas & Rodrıguez-Quintero, 2010) - formally referred to as Skene's glands, it has a variable anatomy and could rarely be absent. Located in the general area of the vulva, along the urethra, it is considered homologous with the prostate gland (Lentz et al., 2012). A large amount of lubricating fluid can be secreted from this gland when the vagina is stimulated. The fluid - called female ejaculate - is similar to the semen in some ways. Since these glands can be absent in women, it may explain the absence of female ejaculation (referred to as squirting) in some individuals.

Fertilization and pregnancy

Fertilization is the union of a human egg and sperm, which usually occurs in the fallopian tube. The fertilized egg travels to the womb (uterus) where it implants in the inner lining of the uterus and begins to develop into a baby (foetus). For the nourishment of the foetus, the placenta is formed from both the tissues of the foetus and mother's uterine lining.

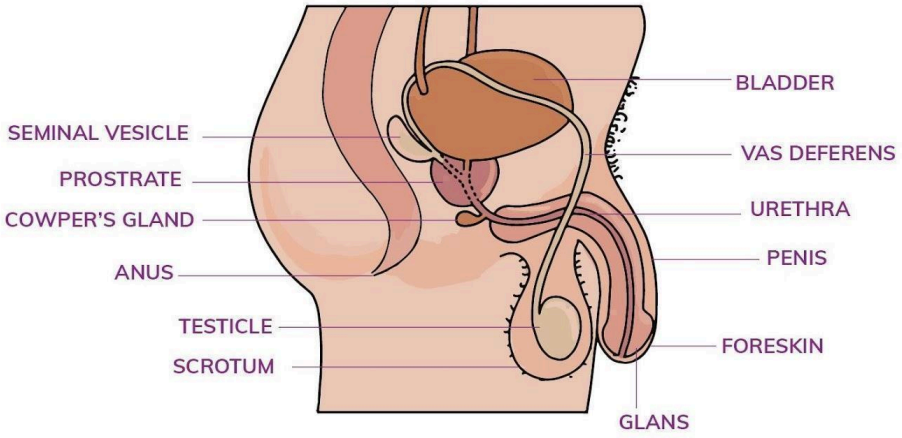
Pregnancy normally lasts for 40 weeks (counting from the first day of the last menstrual period) after which labour pains normally begin. The uterine muscle contracts rhythmically and intermittently. The mouth of the uterus (cervix) opens out and the baby slowly descends down the vagina to be born. The placenta is expelled within the next 15 minutes. The labour process normally takes around 16 - 20 hours.

Breastfeeding

It is advisable to begin breastfeeding immediately after the birth of the baby. It can be continued for several years, but is essential for the first 6 months of the baby's life. Putting the baby to the breast in the first 30 minutes after birth (and repeatedly after that) helps milk production and ensures maximum benefit to the baby. The yellow colostrum produced in the first three days after delivery is essential for the baby's health.

Male sex on the sex spectrum
Normative male sexual and reproductive system and function

These organs serve a sexual function from birth, with reproductive functions becoming active with onset of puberty.



External genitals
These consist of:

- **Penis**: The penis is made up of spongy erectile tissue and has the urethra passing through it. It serves the dual function of sperm deposition as close to the egg as possible - that is the upper vagina - and to pass urine. When erect, the penis fills up with blood and can reach a size of 5-7 inches in length and an inch-and-a-half in diameter, irrespective of its size in the resting (flaccid) state. Though the entire penis is sensitive to touch, the glans (head of the penis) is richly supplied with nerves and plays an important role in sexual pleasure. Foreskin is the loose fold of skin around the glans.
- **Testicles:** The testicles, which produce sperm and the hormone, testosterone, are located in a wrinkled-looking pouch called the scrotum, which hangs behind the penis. There are two testicles and they contain hundreds of thousands of chambers where sperms are produced from puberty onwards. Pubertal changes in boys begin about two years later than in girls.
- **Scrotum**: The scrotum controls the temperature of the testicles. Scrotal temperature is about 1-2 degrees centigrade below body temperature. This is ideal for producing sperm. In warm temperatures, the scrotum becomes somewhat looser and more expansive and limper to expose and cool a larger skin area. In cold weather, the scrotum contracts to conserve heat. Placing laptops on the lap while working for longer periods in very hot conditions can raise scrotal temperature.

Internal organs
These consist of:

- **Vas Deferens**: As sperms are produced, they pass through two fine tubes, each called a vas deferens. They carry the sperms to the urethra. The vas deferens is cut during vasectomy operation.

- **Seminal vesicles**: These are located behind the urinary bladder and produce seminal fluid that form a large part of the semen. Their ducts open into the vas deferens.
- **Semen**: It is the whitish fluid that carries the sperm. This fluid comes out during ejaculation. There are usually about 100 million to 600 million sperm in about a teaspoon of semen.
- **Prostate Gland**: This gland is present below the urinary bladder. After passing through the seminal vesicles, the vas deferens goes through the prostate gland where additional fluid is added to nourish the sperm. Then the vas deferens joins with the urethra. Prostate has been referred to as the 'male G spot' or the 'P spot' as it is an erogenous area.
- **Cowper's Gland:** Also called Bulbourethral glands, these are two pea-shaped glands located beneath the prostate gland at the beginning of the internal portion of the penis. They produce a clear, mucus-like slightly alkaline fluid that helps to lubricate the urethra and neutralize the acidic urine prior to ejaculation. This secretion can form up to 5% of the ejaculate and is referred to as pre-ejaculate or pre-cum. In some, sperms may leak into this fluid.
- **Urethra**: Extends from the urinary bladder to the tip of the penis. Besides being the passage for urine, it allows passage of sperms through the penis to outside the body.

Sperms

These are the microscopic male reproductive cells. They make up less than two percent of the total ejaculated semen. They are much smaller than the egg. Each sperm has a head, a middle piece and a tail like a tadpole, and carries either an X or a Y chromosome. If a sperm carrying an X chromosome fertilizes the ovum (which always has an X chromosome), usually a female baby develops. If a sperm carrying a Y chromosome fertilizes the ovum, usually a male baby develops. In intersex children, there could be variations in these chromosomes.

When ejaculated during peno-vaginal sexual intercourse, the sperms swim through the vagina, through the cervical opening into the uterus and on up into the fallopian tubes. Sperms can live for six to eight hours in the vagina. Once they get up into the cervix, uterus or tubes, they can live for three to five days. Of the several hundred million sperm ejaculated, only about 2,000 reach the tubes. Even though the egg is totally surrounded by sperm in order to be fertilised, only one sperm is actually able to penetrate it. The rest disintegrates.

Genital hygiene

The foreskin should be pulled back a little and glans (tip of the penis) cleaned well. Discharge from the glans collects under this loose skin. This is called smegma and can produce a strong smell. Transmen who have undergone some degree of pharmaceutical or surgical procedures would need to follow the recommended methods to care for their genitals.

After ejaculation, the semen can be wiped away with a cloth/ towel or tissue paper. Clothes can be washed to remove any smell or stains. Semen does not leave any easily visible stains. Use of comfortable, breathable (for example, cotton) undergarments is advisable, especially for people living in warm climatic conditions.

Intersex on the sex spectrum

Intersex /diversity in sex development (also referred to as differences in sex development, diverse sexual development or variations in sex characteristics) is an umbrella term used to describe a wide range of natural bodily variations in reproductive anatomy and sex characteristics.

People with intersex variations are born with physical sex characteristics (including genitals, gonads, hormone pattens and chromosome patterns) that do not fit the typical binary notions of male or female bodies (UNFE Fact Sheet, 2015).

Some variations of human development are:

- External genitals that cannot be easily classified as male or female at birth.
- Incomplete or unusual development of the internal reproductive organs.
- Inconsistency between the external genitals and the internal reproductive organs.
- Variations of the sex chromosomes: 45XO (Turner's syndrome), 47XXY (Klinefelter syndrome), X Trisomy (47XXX), 48 XXXY, 49 XXXXY. 49 XXXYY and other variations. Presence of extra sex chromosomes or absence of one may affect physical development, muscle tone, motor skills, learning, speech and language ability, muscle tone, kidney development, development of sexual organs and fertility to varying degrees.
- Incomplete or unusual development of the testes or ovaries,
- Over or underproduction of sex-related hormones (example Congenital Adreneal Hyperplasia)
- Inability of the body to respond normally to sex related hormones (example Androgen Insensitivity Syndrome)

Some of these variations are visible at birth, some evident during puberty and some not evident at all until a medical intervention is done for some other reasons. People with intersex variations have diversity of bodies and identities and every person is unique and different. Being intersex has no correlation with one's sexual orientation or gender identity. A person with intersex variance may have heterosexual, homosexual, bisexual, asexual, pan sexual, questioning, queer or any other orientation, and may identify as female, male, intersex or any of the various identities.

Scarce data is available on the incidence and prevalence of the variability. It is estimated that 1.7% babies in the US are born intersex (Fausto-Sterling, 1993). A study in Turkey estimates the intersex births to be 1.3 in 1000 live births (Aydin et al., 2019). Although no statistical data is available currently in India, diversity in sexual development is more common than it was thought to be. According to an intersex activist, there may be around 10,000 intersex babies being born in India every year and the number could be much higher because these babies aren't registered as intersex by parents usually, and there also may be a high rate of infanticide, abandonment and genital mutilation (Banerji, 2019), due to which the exact figure of intersex

births in India may be difficult to ascertain.

Pubertal changes

The term adolescence and puberty are used interchangeably although puberty is just a part of the adolescence period. The World Health Organization considers 10 to 19-year-olds as Adolescents. Puberty, on the other hand, is defined as the stage of physical maturation in which an individual's body undergoes growth and development, especially of the sexual and reproductive system, which changes are required to become physiologically capable of sexual reproduction. Puberty may start in the pre-adolescence age and the changes continue to happen throughout adolescence.

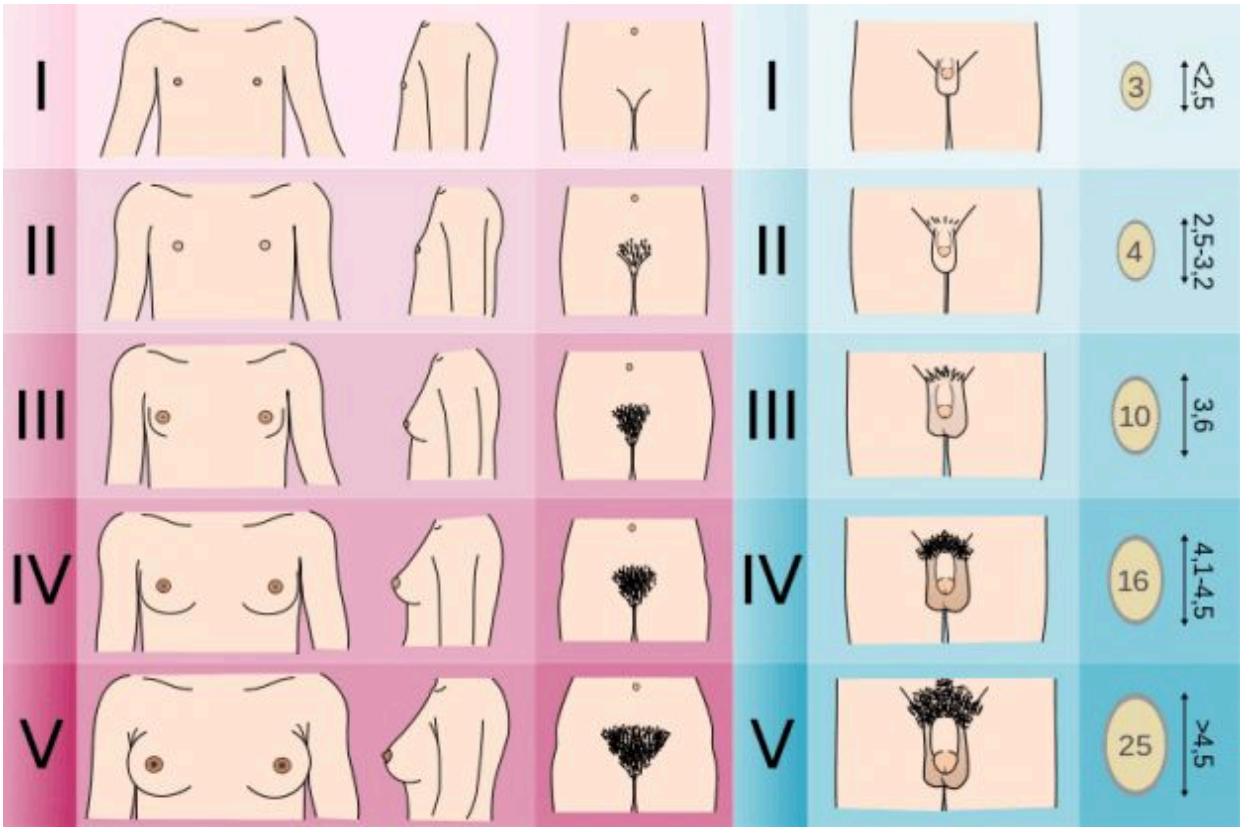
It is important to note that similar changes occur in female, male and intersex children - for example, increased height, increased weight, increased muscle mass, voice change, body and facial hair development, breast development, pelvic enlargement, and growth of genitals - but the degree of the change varies between the sexes. These are called secondary sexual characteristics. Genetic and epigenetic factors, sex hormones along with growth hormones and thyroid hormones and nutrition play a major role in bringing about pubertal changes.

Intersex variation may become evident for the first-time during puberty if the 'expected' changes do not happen in a child assigned a certain sex at birth. Some secondary sexual characteristics may seem to be exaggerated, and some may not appear at all depending on the underlying factors.

Transgender adolescents would experience the changes as per their bodily characteristics and this can often cause extreme distress. Adolescents would require support from the family, peers, teachers, and at times professionals, to navigate puberty in a safe and healthy manner.

Secondary sexual characteristics

The onset and progression of changes in secondary sexual characteristics usually occur in a sequence. The sequence was first explained by Marshall and Tanner and is commonly referred to as the Tanner staging or sexual maturity rating. Intersex variations are caused by several underlying factors (as detailed in the section on intersex variations) and the bodily changes would depend on the interplay of the factors unique to the individual.



Tanner Scale women and men.
By M Komorniczak. License CC BY-SA 3.0

- **Breast development:** As puberty progresses, the glandular tissue of the breast increases in size and elevates the contour. The areola enlarges and nipple protrudes. Menarche, the onset of menses, starts on average at age 12 years (10-15 years) (Khadgawat et al., 2016), following breast bud development on average by 12.5 years. By 14-16 years of age, the breast reaches the adult contour.
- **External genitalia growth:** The first sign of puberty in male children is an increase in testicular size. As age progresses the testicles increase in size, the scrotal bag enlarges to accommodate the growing testis.The penis enlarges in length and width. Spermarche, the counterpart of menarche, is the development of sperm in males occurring at an average age of 13 (11-16). In females, the labia grows and attains the adult contour.
- **Body hair:** Hair grows in the pubic and axillary (arm pit) region. Male pattern distribution of hair on the body viz the facial hair, limbs, chest and abdominal happens under the influence of testosterone.
- **Voice change:** Voice change is one of the secondary sexual characteristics that happens in males and females. It is more dramatic and noticeable in males (12-16 years of age) and subtle in females (10-14 years of age). During the adolescence growth spurt, the voice box (larynx) grows and enlarges too with thickening of the vocal cord. This is responsible for the typical changes like lowering of the average speaking/talking pitch, voice cracking and breaking and hoarseness or huskiness.
- **Adam's apple:** Adam's apple is a projection in the font of the neck, formed by the cartilage protrusion around the larynx. It is a secondary sexual characteristic developing

around puberty in both the sexes. It is more prominent in males as the larynx grows faster and along with it the encasing cartilage grows too. Adam's apple serves no other function in the body.

Acne:

Acne(pimple) is a common skin condition that starts in the pubertal age. It usually clears up with age but around 12 percent of women and 3 percent of men may still have acne even in their 40s. The high level of circulating sex hormones at puberty affects the oil glands (sebaceous glands) in the skin and makes them produce more oil (sebum). These glands are present near the hair follicle in the skin. The oil travels along the hair follicle and reaches the surface of the skin and helps in maintaining the suppleness of the skin and protects the skin. This oil has a 'human' odour.

During puberty, the excess of oil produced and dead cells of the skin may block the hair follicle thereby preventing the oil from reaching the surface of the skin. This accumulated oil and dead cells form a bump on the skin which is called acne. It can get infected with bacteria present on the skin surface and turn red and painful. Acne is also more common in the face, neck, upper chest and back as these regions have concentrated sebaceous glands.

Washing the face and neck with water frequently and keeping the face clean reduces acne formation. Eating nutritious healthy food and being physically active also proved to be helpful. Severe forms of acne may require medical treatment.

Acne is a trivial health condition but the psychosocial impact it has on the adolescents can be tremendous. Research shows that acne results in negative body image, low self-esteem and decreased quality of life among adolescents (Vilar et al., 2015). Acne can scar the psyche more than the physique.

Body odour:

As puberty starts, some adolescents may start sweating profusely. Sweat per se is an odourless secretion. The sweat glands in the axillary (arm pit) and genital region along with sweat produces an oily secretion which has a mild smell. The bacteria normally present in the skin act on the oily secretion and that causes a strong body odour. This is a normal change and not of any medical concern.

Changing clothes frequently, wiping or washing the armpit are better options than use of antiperspirants (usually aluminium based) that block the secretions from coming out of the pores, causing them to accumulate inside the gland ducts.

Growth spurt:

The adolescent growth spurt refers to the rapid increase in height and weight that begins with puberty, lasts throughout adolescence, and stops with the cessation of linear growth. Significant changes also occur in body composition and proportions. Some intersex variations - like Turner's syndrome, are associated with short stature, while children with Androgen Insensitivity Syndrome grow taller than expected for their assigned sex.

Height:
The growth spurt starts 2 years earlier in females, averaging a peak height of 9 cm/year at age 12. Males attain a peak height growth of 10.3 cm/year. The total gain in height is 25 cm on average in females and 28 cm on average in males. The growth need not occur proportionately. In early adolescence, the feet and hands grow faster when compared to other parts of the body. This disproportionate growth might cause a concern in adolescents.
Genetics control the adult height that can be attained by an individual with usually minimal control by environmental factors, assuming that adequate nutrition is available.

Weight:
Puberty is also the phase when significant weight gain occurs. 50% of adult body weight is gained during adolescence. In males, increase in height and weight happens almost at the same time whereas in females weight gain lags behind by 6 months. Average weight gain during adolescence is 9 kg/year for males and 8.3 kgs/year for females.

Body composition:
Females begin gaining significantly more fat mass than males and by the end of puberty have about 5–6 kg more absolute fat mass. This is attributed to the effects of estrogen on fat metabolism. The body fat is mainly centred around hips and deposited subcutaneously. The pelvis also widens in females as skeletal maturity happens. This gives the female a wide hips and decreased waist to hip ratio.

In male, under the influence of testosterone there is a significant increase in the growth of bone and muscle with a simultaneous loss of fat in the limbs broadening the shoulder and chest. The fat gets deposited around the abdomen and the internal organs.
Sexual response
The sexual response cycle refers to the sequence of physical and emotional changes that occur as a person becomes sexually aroused and participates in sexually stimulating activities. Although there is a wide variability in each individual's expression of sexuality, the phases of physiological response to sexual stimuli remain almost similar. It is postulated that the sexual response cycle has four phases: desire, excitement, orgasm and resolution. In reality, it may be hard to pinpoint exactly when one phase ends and another begins and considerable overlap happens. Thus, these phases are labelled to help simplify and explain the numerous processes that occur in the body during sexual activity.

1. **Desire**: This phase is the first, and earliest to occur - much before any physical signs of sexual stimulation become apparent. It is marked by a wish for sex. Any of the senses, or a memory or fantasizing may ignite this lust. This phase can lead to arousal and vice versa. However, both arousal and desire can happen independently. Desire may persist for long periods.
2. **Arousal**: During the arousal or excitement phase, the heart rate and pace of breathing increases and muscles tense up. The brain releases chemicals which cause more blood to flow into the genitals. The labia swells and the clitoris becomes more prominent and sensitive. Glands present in the vulva secrete fluids that help in lubrication. The vagina

expands and the colour of the vaginal wall darkens. The cervix and uterus move upwards. Nipples become erect and breast size increases modestly. The blood vessels in the penis dilate and more blood flows into the penis. It becomes wider, longer and stiff and begins to point upwards. This is called erection. In this state the penis can penetrate. The testis swells and the scrotum is drawn closer to the body.

3. **Orgasm:** Orgasm is a feeling of intense pleasure that happens during sexual activity. It is characterized by a feeling of euphoria, along with a series of rhythmic contractions of the muscles in the genital region. Blood pressure, respiratory rate and heart rate peak during this experience. Brain areas related to reward are activated, while the amygdala, the seat of fear and rage, shuts down (Holstege et al., 2003). There is an increase in secretion of the hormones prolactin, oxytocin, vasopressin and endorphins which are responsible for the feeling of well-being and pleasure, usually felt with orgasm. Oxytocin also promotes bonding.

   Orgasm may or may not occur during penetrative sex. Stimulation of the clitoris or vagina or cervix can lead to orgasm, during which muscles of the pelvic area contract rapidly and rhythmically. Ejaculation (squirting) can happen in a few cases. Contrary to common beliefs, female sexual pleasure does not depend on the depth of penetration inside the vagina.

   The clitoris, homologous in structure and function to the penis, plays an important role in the experience of sexual pleasure. Other areas like the G spot (aka the anterior vaginal wall), the cervix, anal sex and nipples can also provide orgasmic sexual pleasure. Research suggests that nipple, vaginal and cervical stimulations appear to stimulate the same sensory cortex as the clitoris does, indicating that all of these are erogenous zones (Komisaruk et al., 2011).

   With further stimulation, the muscles in the pelvic area and other parts of the body contract rapidly and rhythmically, resulting in ejaculation of semen from the penis. After ejaculation, the release of chemicals from the brain reduces blood flow to the penis. Slowly the penis returns to its normal, flaccid state.

   Orgasm in females is slower to achieve and lasts longer as compared to orgasm in males. Some females can experience multiple orgasms in the same sexual cycle. For a variable time after ejaculation, the male usually cannot experience another orgasm or erection.

   Orgasm can also be experienced by anal stimulation, with or without penetration. Penetration of the anal canal can indirectly stimulate the prostate gland (also called the P spot) or the anterior fornix of the vagina, which are erogenous zones. Oral stimulation and manual stimulation of the genitals (with or without a partner) can also lead to an orgasm.

   An individual can experience orgasm without genital stimulation too (Komisaruk & Whipple, 2011). Stimulation of secondary sexual organs and other parts of the body are found to produce orgasmic pleasure. Imagery stimulation has also been documented to produce orgasms. Few individuals might experience orgasms spontaneously without any stimulation.

Wet dreams, also known as nocturnal emissions, are erotic dreams that cause sexual excitement during sleep and lead to an orgasm. Wet or erotic dreams are common for all sexes at all ages and are a normal and natural part of our body's sexual expressions. It is also common not to have wet or erotic dreams.

4. **Resolution:** Orgasm is associated with an intense feeling of pleasure and satisfaction. After ejaculation the release of chemicals from the brain stops and blood flow to the genitals and their sensitivity reduces. Slowly the organs return to their resting state. There is a general feeling of well-being and calmness, even fatigue. For some time after ejaculation - which varies from individual to individual and with age, the male cannot experience another erection. Orgasm in females is slower to achieve and generally lasts longer as compared to orgasm in males. Females may experience multiple orgasms. The duration of the refractory period varies and changes with age.

Reflection*:*

The activities could be triggering for some. Please do these only if you feel comfortable.

1. *Do you know the proper names of the sexual organs in vernacular languages? Find out as many proper words as you can.*
2. *When did you first learn how sex happens? What, according to you, is the 'correct' age for a person to learn about this? What would be the pros and cons of this at that age?*
3. *What misconceptions about sexual organs and sexual activity did you harbour as a child? As an adolescent? How did that affect you?*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - How Well Do We Know Our Bodies and the Mechanics of Sex and Reproduction? (link will be inserted).

Way forward
The way forward is to normalize references to sexual and reproductive organs and functions in a respectful manner, maintaining the privacy that we accord to these systems. Breaking the silence, talking about these systems and functions, referring to the organs by their proper words, and being appropriate in the context we are in, can help us overcome our own hesitation and embarrassment and make space for others in our friends and family circles to develop greater comfort with their bodies.

Chapter 3. Diversity in Sex, Gender and Sexuality
- what hampers its expression, belonging & visibility?

Diversity in sex, gender and sexuality has existed since the very beginning of humanity. However, it has been silenced, negated and actively discriminated against in many cultures and societies at different periods in time. Discrimination has led to atrocities against the LGBTQIA+ individuals and communities. In this chapter, we will attempt to understand
(1) what are the diversities in sex, gender and sexuality,
(2) what have been some of the key factors in maintaining biases against queer people,
(3) the oppression that people, especially in India, face and
(4) how we can move forward to a more equitable world for everyone.

People on the margins of sex, gender and sexuality have very rarely enjoyed equality. There have been brief periods of acceptance and celebration, as seen in Greek History (in the story of Hercules and Patroclus), Roman civilization and in Indic mythology and history - there are evidences of periods of tolerance, reluctant acceptance and maybe even celebration in temple sculptural art as seen in Khajuraho, Konark and many other places and later even in early Mughal times. We also see periods of acceptance in Native American and other cultures.

For the large part, though, people who aren't cisgender and heterosexual have been the target of much contempt , systemic oppression and even attempts at annihilation. The largest example of such purging of queer populations was in Nazi Germany during the Holocaust, where Nazis exterminated more than a quarter of a million (more than two hundred fifty thousand) queer folks through the notorious Paragraph 175 (as beautifully depicted in the 2000 documentary film of the same name), along with millions of Jews, gypsies, people with hereditary conditions and others.

Despite attempts at different times to streamline sex, gender and sexuality through endogamy (marrying within a specific social group), eugenics, oppression of diversity, or other means, there has never been a time or space when there has been a perfectly binary world, where everyone is only cisgender and heterosexual.

The shift in understanding of diversity

The diversity in sex, gender and sexuality has been an increasingly well-documented aspect of our lives, and a subject of much study across different sciences, including genetics, anthropology, sociology and others. In the last three to four decades, various universities have also established specific schools for gender and sexuality studies that focus on affirmative understanding of human diversity, rather than studying it as a mere scientific curiosity as in the years prior, or worse, where it was studied with an objective of finding root causes that can be used to eliminate such differences.

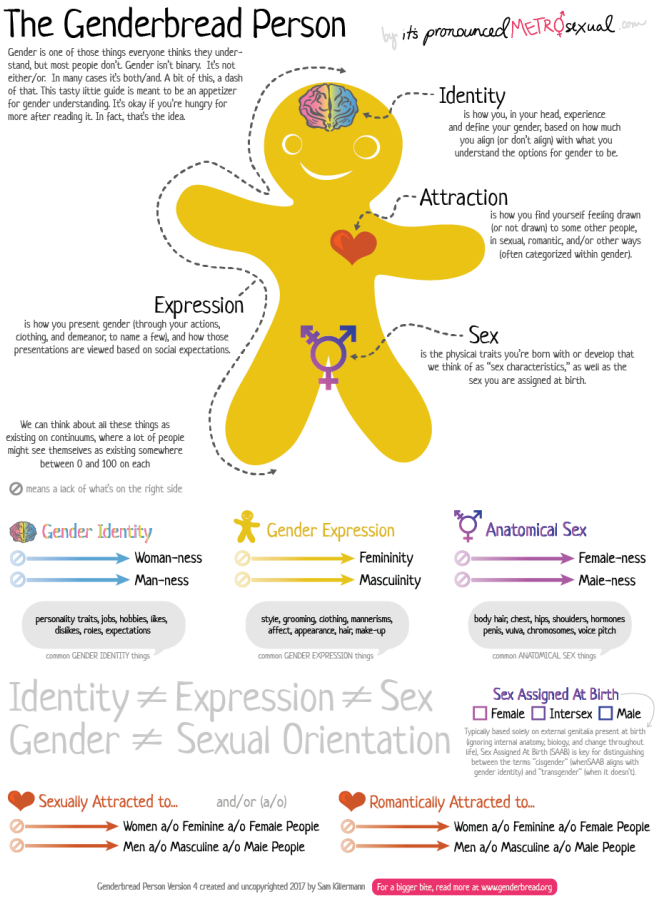
The shift from finding causality (with a view to eradicate) to understanding diversity as a way of nature that is to be respected, affirmed and validated is largely due to the labour of queer scientists themselves. This started with people like Evelyn Hooker, who, in the 1970s, was one of the first to demonstrate - through a study of sexuality and mental illness using standard tools like the Rorschach Test - that people on the margins of gender and sexuality were not mentally

ill. It was only in the 1990s that queer theory was established following Michel Foucault's works through thinkers like Judith Butler.

Despite all the advances in science towards developing a deeper understanding of diversity, people across all sexes, genders and sexualities aren't able to live openly and access the same rights and privileges as cisgender, heterosexual people (Vanita, 2008). Even as different parts of the world become accepting of diversity (such as the Scandinavian nations, much of Europe, Canada, Australia, New Zealand, South Africa and, to an increasing degree, countries in South America and East Asia), we find the world getting polarized with countries like Russia, much of the Middle East, Africa and even the USA, pushing back on the advances of queer rights to further the oppression and suppression of human diversity.

Understanding Diversity: Western conceptualisations and Indian contexts

The large umbrella term SOGIESC (Sexual Orientation, Gender Identity, Expression and Sex Characteristics) is often used as a collective way of describing all non-heterosexual, non-cisgender identities that represent the full diversity possible across these dimensions. In popular culture, the term LGBTQIA+ or a shorter form LGBT+ is used to describe the collection of specific identities.



A popular representation of the SOGIESC diversity is the Genderbread person (www.genderbread.org) that illustrates how sex, gender, gender expression, sexual orientation and romantic attraction are not equivalent and can be very different and distinct from each other (the genderbread person visual may have been appropriated by Killermann's as some have pointed out). They are, in fact, each a separate identity in their own right (a summary of some of the terms is listed in the glossary).

In the popular short-form, LGBT, L, G and B stand for Lesbian, Gay and Bisexual, which are sexual/romantic orientations, and T stands for Transgender which is a gender identity. In the slightly larger acronym LGBTQIA+, I stands for Intersex and A is for Asexual, and Q for Queer (which acts as an umbrella term) or Questioning. The '+' is typically used to include a multitude of other

identities such as gender identities like agender, non-binary/enby or gender-queer, gender expressions such as femme or androgynous, and romantic attractions such as homoromantic, panromantic etc.

While the LGBTQIA+/ SOGIESC terminologies have gained almost universal traction, different cultures across the globe have their own ways of understanding diversity. Native American communities have long held identities such as two-spirit, muxes etc. (Tikuna, 2019), and Indian heritage has long recognized a variety of different diversities such as hijras/aravanis, kothis, jogappas, jogathis, Nupi-Sabi etc. across our diverse land from the Hindi heartland, to Tamil Nadu, Karnataka and the North-East. While many of these terms might find a loose fit in the western umbrella label of trans* identities, they do not really fit into the strict categorization of western thought. Many times, in the Indian context, these identities do not preclude the individual from also having a heterosexual identity as well, especially in highly patriarchal communities where they might also lead a heterosexual life, or on the other hand, as with the hijras and aravanis, have a very distinct social and cultural identity that is different from the western trans* identities. They cannot be equated at all. For example, the annual koovagam temple festival near Villupuram in Tamil Nadu is a very unique and yet hugely significant and culturally sustained way of life for the aravanis in South India, and does not really have anything of any equivalent significance in western ideas of trans* identities (just as India did not have the Pride parade for a long time).

Our gender or other identity is an innate self-concept and we choose labels based on what we have access to in the culture we are in. As India integrates with other global cultures, we find ourselves with access to LGBTQIA+ terms, and we see more Indians adapt to this way of thinking and adopt labels for themselves such as ‘gay’. A few decades ago, the same person might have used very different terms for themselves. The diversity in sex, gender and sexuality is not only a way of categorizing humans, but a celebration of a huge cultural and social diversity as well. For the purposes of this chapter in this book, we use LGBTQIA+ as a way of referencing the diversity, while in no way diminishing the locally evolved and celebrated identities and culture. (For bias and discrimination against LGBTQIA+ people, and unique life stressors that such attitudes and practices cause for sexual and gender minorities, please see the Gender Bias chapter)

Some of the **common myths** that need to be rooted out are:

- ‘Sex, gender and sexuality diversity is not natural’: Diversity in sex and sexuality have been well-documented in hundreds of species. While gender as a social construct might be a uniquely human cognitive phenomenon, the diversity people experience in their gender has been extensively researched and documented.
- ‘Sex, gender and sexuality are deviant behaviour and not a form of any identity’: Every person is intuitively aware of their sex, gender and sexuality and this is integral to one’s identity. We all have different preferences and privileges in terms of how we live, what identities we use for ourselves and how we express our identities. Gender and sexual identities are not an obsession with sexual acts or body parts. Sexual expression is diverse and the ideas of what is normal and what is deviant comes from holding cisgender reproductive sex as ideal, against which everything else is compared.
- ‘Transgender people are not part of society’: Transgender people are across all classes and communities. Hijra communities neither kidnap babies, nor are they criminals (the

British Era Criminal Tribes Act being an egregious example of such biases and myths,) and do not have any special abilities to bless or curse anyone.

- ‘All Transgender people will transition’: Gender identity is an assertion of oneself. While some might choose gender affirmative treatment and/or surgeries, others may not choose to do so, and that doesn’t take away from one’s gender.
- ‘LGBTQIA+ people do not have their own families’: LGBTQIA+ people can and do make their own relationships and families, despite lack of legal recognition and social constraints. Some families include children, biological or otherwise, and others might be chosen families with other adults.
- ‘Intersex people must be raised as a boy/girl’: Forceful gendering and mutilation in the same of corrective surgeries takes away the right to self-determination. (For more details, refer to Intersex Health Care in Additional Reading)

Unique life stressors within the queer community

Biases arise from power differences, privilege, and social or religious beliefs. Religious texts may be interpreted against LGBTQIA+ individuals, and personal biases of preachers, prophets, gurus and others might get generalized and passed on. Added to this are unverified assumptions, misinformation and irrational fears, creating a hotbed for various biases and prejudices.

Biases against gender and sexual minorities arise from pervasive heterosexism and cissexism in societies that recognise only two genders and one form of sexuality. This perception fosters negative biases against LGBTQIA+ individuals, denies their existence, and fuels homophobia, which is defined as "the fear, hatred, discomfort with, or mistrust of people who are lesbian, gay, or bisexual."[1] Queer individuals in such societies may also internalise these attitudes.

Biases tend to get generalized and entrenched in all aspects of social life, and become prejudices, which in turn may get written in law especially when lawmaking is a majoritarian exercise with little regard for minority rights. Morality of few is imposed upon all. This was the case in India with Section 377 of the Indian Penal Code. This provision criminalised persons who "voluntarily have carnal intercourse against the order of nature with any man, woman or animal,” which was interpreted to include certain non-procreative sexual acts. Although it theoretically applied to all individuals, it disproportionately targeted LGBTQIA+ individuals, effectively criminalising consensual same-sex relationships and reinforcing heteronormativity.

Homophobia, discrimination and violence against queer persons continues despite the ruling in *Navtej Singh Johar vs. Union Of Indi*a that struck down Section 377 of the Indian Penal Code in 2018. The Court observed that Section 377 itself has been a site of violence - State, societal and familial - for queer persons, in addition to adding to the social stigma faced by the queer community, acknowledging that much remains to be done. Further, the Mental Healthcare Act, 2017 prohibits discrimination of persons with mental illness or those accessing mental health care and treatment based on sexual orientation. The Indian Psychiatric Society has also unequivocally condemned the practice of conversion therapy in 2018 and again in 2020, categorically stated that homosexuality is not a disease (IPS Secretariat, Position Statement, 2020). Across the world, conversion therapy has been denounced and discredited as a medical

[1] ‘What is Homophobia?’ (*Planned Parenthood*), <https://www.plannedparenthood.org/learn/sexual-orientation/sexual-orientation/what-homophobia>.

practice. Despite this, the suicide of a 21-year-old queer person who had been subjected to conversion therapy by her family in May 2020 shone a light on how rampant the practice of conversion therapy remains (Theresa, 2020; Chakravorty, 2018).

Difference in Punishment for Sexual Violence aginst Transgender Persons

Section 18(d), Transgender Persons (Protection of Rights) Act, 2019 provides that anyone who harms, injures, or endangers the life, safety, health, or well-being (whether mental or physical) of a transgender person, or commits physical abuse, sexual abuse, verbal and emotional abuse, or economic abuse, shall be punished with imprisonment for a minimum term of six months, which may extend to two years, and with fine. However, experts and activists have criticized the disparities and discrimination in punishment for sexual violence against transgender persons in comparison to the punishment prescribed under general penal law for rape and other sexual offences against women.[2] A writ petition challenging the constitutional validity of Section 18, Transgender Persons (Protection of Rights) Act, 2019 and seeking directions to provide stringent and severe punishment for offences against transgender persons is pending in the Supreme Court.[3]

It is important to note that the Supreme Court in *Navtej Singh Johar and Ors. v Union of India*,[4] declared Section 377, IPC unconstitutional "insofar as" it "criminalises consensual sexual acts of adults". The Section remained in the Code as it offered a legal protection against sexual violence to male and transgender victims.[5] The Bhartiya Nyaya Sanhita removed Section 377 in entirety and failed to provide any dedicated provisions to address sexual violence against men and transgender persons.[6] The BNS provides only a single

[2] Jigyasa Mishra, Raped, Mocked By Police For Seeking Justice: India's Rape Laws Do Not Cover Transwomen (Article 14, 7 July, 2022), https://article-14.com/post/raped-mocked-by-police-for-seeking-justice-india-s-rape-laws-do-not-cover-transwomen--62c65919a04a3; Pallavi Pundir Transgender People Tell Us Why India's Newly Proposed Rape Laws are Discriminatory (Vice, 11 September, 2019), https://www.vice.com/en/article/transgender-queer-people-tell-us-why-indias-newly-proposed-rape-laws-lgbt-are-discriminatory/.

[3] Kajal Mangal Mukhi v. Union of India & Anr |W.P.(C) No. 985/2021 [Supreme Court of India]. See, Srishti Ojha, Supreme Court Issues Notice On Plea Challenging Lesser Punishments For Offences Against Transgender Persons (LiveLaw, 21 January 2022), https://www.livelaw.in/top-stories/supreme-court-issues-notice-on-plea-challenging-lesser-punishments-for-offences-against-transgender-persons-190021?from-login=909275&token=RDWEBYWW3UIKMNKRU2BELAC7UCPDDKEZV9NZU.

[4] (2018) 10 SCC 1.

[5] Trans persons in India fear sexual violence under Bharatiya Nyaya Sanhita (The Hindu, 6 September, 2024), https://frontline.thehindu.com/news/trans-persons-india-fear-sexual-violence-bharatiya-nyaya-sanhita-lgbtqia-section-377-indian-penal-code/article68613348.ece; Saumya Uma, Why the Bharatiya Nyay Sanhita Is a Missed Opportunity for Gender Justice (The Wire, 1 July, 2024), https://thewire.in/law/bharatiya-nyay-sanhita-women-gender-trans-queer-justice.

[6] Trans persons in India fear sexual violence under Bharatiya Nyaya Sanhita (The Hindu, 6 September, 2024), https://frontline.thehindu.com/news/trans-persons-india-fear-sexual-violence-bharatiya-nyaya-sanhita-lgbtqia-section-377-indian-penal-code/article68613348.ece; Saumya Uma, Why the Bharatiya Nyay Sanhita Is a Missed Opportunity for Gender Justice (The Wire, 1 July, 2024), https://thewire.in/law/bharatiya-nyay-sanhita-women-gender-trans-queer-justice.

reference to transgender persons. Section 2(10), BNS provides the definition of "gender" stating that "the pronoun "he" and its derivatives are used of any person, whether male, female or transgender" and provides an explanation that the term "transgender" shall have the meaning assigned to it in Section 2(k), Transgender Persons (Protection of Rights) Act, 2019. Since the provisions pertaining to sexual violence under the Act are framed in binary terms with men as perpetrators and women as victims, the inclusion of this definition will not address the lack of legal protection against sexual violence for transgender persons.[7]

However, given the lack of sensitivity and weak protections in the current justice system and the limitations in meeting the multiple justice needs of survivors, parity in punishment may not necessarily advance justice for transgenders who face sexual violence.

Impact of biases and prejudices felt deep in the everyday life of queer people:

1. Microaggressions: Microaggression is "an indirect or subtle action or statement regarded as denigrating (belittling) a minority group."(MICROAGGRESSION definition and meaning, Collins English Dictionary (2025), https://www.collinsdictionary.com/dictionary/english/microaggression (last visited Jan 30, 2025)). Every day, queer people are subjected to name-calling, bullying and other forms of microaggressions. Their pronouns are frequently disregarded, leading to misgendering. Other forms of microaggression against queer people include gawking, insensitive jokes, and rude remarks.
2. Access to education/ employment: Systems often create entry barriers for queer people into schools, colleges and places of employment. It could start with small things like forcing a binary choice in entry forms for sex/ gender, to denial of gender-neutral washrooms, to denial of promotions etc. Lack of safe educational & work spaces often leads to many dropping out of school and work, and into informal sectors.
3. Access to Housing: Societies often refuse to sell or rent housing to queer people, leaving them vulnerable to exorbitantly priced and unsafe housing. In some spaces, this leads to ghettoization of queer people, especially of hijras and other highly visible groups, and on the other hand, it tends to keep queer people invisiblize themselves in their areas of residence to avoid any possible violence.
4. Access to Health: Very little of the health care available, both for physical health and mental health, is queer informed, let alone queer affirmative. Lack of queer affirmative healthcare also means that queer individuals do not seek medical help as easily as others do for even ordinary ailments for fear of benign misgendered at the least to, at its worst, being humiliated and denied treatment.
5. Violence in the name of healthcare: There is much violence that the LGBTQIA+ community suffers at the hand of medical professionals, including sex imposition on intersex infants and children through surgeries that are not really necessary for their physical health, but done at the behest of parents or others. For adults too, "treatment" in the name of "conversion," as if there was something wrong about being LGBTQIA+

[7] In *Anamika v Union of India*, W.P.(CRL) 2537/2018, the Delhi High Court affirmed registration of an FIR by a transwoman under Section 75, BNS/Section 354-A, IPC (sexual harassment), by relying upon the *NALSA* judgment.

when there is nothing to fix continues to be the norm, with LGBTQIA+ people forced into such treatment by parents and families unwilling to accept them, and uninformed or unscrupulous medical professionals who subject people to unscientific, useless and traumatizing procedures in the name of trying to "heterosexualize" them.

Another example of bias is layered acceptance, where social legal recognition of rights is slower than social acceptance. Even though Section 377 was decriminalized, it does not mean that queer people are now equal citizens. The right to marry, to inherit property,[8] to adopt,[9] to have babies through surrogacy,[10] , are yet to be adequately recognised.

Because LGBTQIA+ Individuals are exposed to hostile environments, it is no surprise that they experience Unique Life Stressors (ULS). Some of them are:

1. Coming out to oneself, and accepting oneself: There is constant pressure on them from family, peers and society to fit in, and persistent messaging that being queer or trans is a phase or a disorder. This makes it enormously difficult for them to accept their own difference. In the absence of supportive spaces within family and in society, many queer or trans people experience a lot of personal shame and guilt, and in the extreme, this might lead them to hate themselves to such a degree that it may lead to suicide.
2. Coming out to others: In as much queer people come out to themselves, the task of letting others know they are different, and experiencing that difference as respected, accepted and validated is a whole another process, which starts but doesn't really stop. Coming out is a process that repeats over and over again every time they are in new places and among new people. Many times, queer people may choose to let the assumption ride where it doesn't matter to them, rather than go through the process, or choose to tell some but not others and so on.
3. Isolation, rejection and conditional acceptance: Coming out isn't always met with open acceptance. Sometimes, rejection and pressures to conform can be particularly difficult, and at other times, the acceptance is conditional where the knowledge of one's identity is treated as a bargaining chip. In the absence of role models, social visibility and community organization, many individuals experience extreme isolation.
4. Systemic oppression & discrimination: There are very few places where queer and trans people are treated fully as equal citizens. For most, it is a space somewhere between being actively persecuted minorities to being tolerated, to having separate-but-equal

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[8] TG Act, 2019, s 3: Prohibition against discrimination.—No person or establishment shall discriminate against a transgender person on any of the following grounds, namely:—(g) the denial or discontinuation of, or unfair treatment with regard to the right to reside, purchase, rent, or otherwise occupy any property; Also see https://clpr.org.in/blog/realizing-trans-rights-in-india-property-ownership-and-inclusion/; https://www.outlookindia.com/national/adoption-inheritance-rights-of-transgender-persons-in-india-an-uphill-battle-magazine-314664.

[9] A single woman can adopt a child of any gender but a single male cannot adopt a girl child, regardless of their sexual orientation (Para 5(2)(b) and 5(2)(c), Adoption Regulations, 2022). However, the Adoption Regulations place two restrictions on a couple who wish to adopt: first, the couple must be married, and second, the couple must have been in a stable marital relationship. Given that LGBTQIA+ couples cannot get legally married in the country, these restrictions act as a barrier for such couples to jointly adopt (Para 5(2)(a) and 5(3), Adoption Regulations, 2022).

[10] https://www.thehindu.com/news/national/same-sex-couples-live-in-partners-not-included-in-surrogacy-and-assisted-reproduction-laws-says-govt-in-supreme-court/article66831323.ece; https://www.barandbench.com/columns/the-surrogacy-law-in-india-a-teasing-illusion.

arrangements (such as countries which reserve marriage for cis-het relationships, and a secondary civil union for queer people) Discrimination, both in law and in society, is a very real part of queer lives.

5. Challenges across Life-stages: Even after coming out and establishing somewhat of a secure adult life, queer and trans people go through unique life stressors throughout their lives, including having their relationships never treated as fully valid, their chosen families (such as a hijra jamaat, for example) consistently treated as secondary to natal families, and in later stages in life, their identities invisibilized again both in hospital/ hospice care, and in death.

Understanding Allyship

Some might often say that they do not know of any LGBTQIA+ people in their lives, or may think of diversity in sex, gender and sexuality as a 'foreign concept' or something that happens in far-away cities to other people. The reality is that LGBTQIA+ people are everywhere and in all sorts of families, but do not necessarily come out to the familial and social circles that they are in because it is not safe for them to do so. When queer people take the risk of coming out to their families, they are often met with resistance and violence, instead of understanding, acceptance and love.

The onus of being more visible is therefore not on the queer community, but on the larger society to create a safe and welcoming place for them. This is where the concept of "allyship" comes from. Allies are people who participate in active advocacy of the rights of people from the community, but may not themselves be part of the queer community. They recognize that queer voices need to be centred, validated and amplified so that the discrimination and stigma they face can be reduced, and there can be a true movement towards equality.

Being an ally is a commitment to social justice and a call to action, rather than a performative role intended to raise one's own social capital by association with the "right" causes or through tokenism, such as the occasional queer-related social media post. Rising above tokenism and being a true ally to the LGBTQIA+ community means:

- Educating oneself, learning about the nuances of the terms used by the LGBTQIA+ community and using them appropriately, for instance cross-dressing, Questioning, Transmasculine etc., and avoiding outdated terms like transsexual, FTM etc.
- Learning about the diversity of identities and lived experiences of people from the community. Participate in local events including film festivals, pride walks, cultural events and other spaces that are organized by queer groups for general public interaction, to engage in dialogues with the communities and broaden understanding.
- Recognize that queer people often make their own families outside of natal or marital families. Interact with your queer friends and their made families as respectfully as one might with birth/marital families.
- Be conscious of any microaggressions that you might have picked up and, if told about any such act, reflect on them and correct yourself. These could include staring, misgendering, deadnaming, assumptions on lifestyle, avoiding eye contact, intrusive questions etc.
- Use LGBTQIA+ inclusive language. Use 'partner', for example. Talk about your pronouns, don't assume anyone's gender or sexuality, and label yourself as needed. Do this at work calls and elsewhere.

- Hold zero tolerance for any non-inclusive behaviour from anyone, including family and at the workplace. Your ability to do so will show that your allyship is not only in intent but also in action.
- Be visible in your support. Wear a Pride Allyship lanyard or other visible signs of your allyship. Speak about the community even when there is no particular occasion to do so. Demonstrate your allyship to friends and family, neighbours, customers, community members and others. No spaces need really be a place where LGBTQIA+ people cannot be themselves or be spoken of.
- Be available for any LGBTQIA+ persons who might want help with any challenges. Listen to queer voices, and amplify their voices through your support without taking over their spaces.

These allyship practices are especially important where communities may be particularly antagonistic towards sex, gender and sexuality diversity, such as Russia, India, much of the Middle East and other places, where visible allyship by people who enjoy cis-het privilege, which can help people who are more vulnerable feel safer.

Within the family as well, the role of parents and caregivers is not only to face up to anyone coming out to them with love and understanding, but to create in the first place an environment where there is no shame or fear in talking about sex, gender or sexuality. By allowing kids to know about all possible identities and normalizing diversity, parents and caregivers of young children will help children learn to be allies from an early age and not internalize any negativity.

Whether it is someone in one's family or elsewhere coming out, it is helpful to remember:

- There is no particular cause or reason for anyone's gender or sexuality. Looking for any such reasons, or to see if there is any person or incident to "blame", does not help. Nor is it particularly helpful to explore their life before in detail for any "signs" or to make it about others or yourself.
- Coming out is an act of trust, and maintaining the trust requires that we respect privacy, do not out them to others without permission, respect names and pronouns, and respect the pace at which anyone might want to explore their identity and make choices regarding their life.
- Seek to understand the identity and the life by doing your own research, and being warmly curious and listening to what is shared while also being honest about one's ignorance and biases with intent to overcome them. Seek help for yourself from professional counsellors and others should you want to learn more.

With greater allyship, both in families and in general society, we will be able to demolish many of the myths around sex, gender and sexuality, many of which are rooted in ignorance, and yet all of which contribute to the "othering" that LGBTQIA+ people face all the time.
The Law and LGBTQIA+ individuals

The Law and LGBTQIA+ individuals

The decisions of the Supreme Court of India in *National Legal Services Authority* (*NALSA) v. Union of India,* 2014 and *Navtej Singh Johar* v. *Union of India*, 2018 have laid the foundation for non-discrimination of queer persons in India.

Right to Self-identification:

Section 2(k), Transgender Persons (Protection of Rights) Act, 2019, defines "transgender person" as follows:

> "a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), person with intersex variations, genderqueer and person having such socio-cultural identities as kinner, hijra, aravani and jogta."

The Supreme Court in *National Legal Services Authority of India (NALSA) v Union of India*,[11] discussed a range of transgender related identities while discussing the historical background of transgenders in India and the domestic and international legal framework on rights of transgender persons. Some of the identities discussed include:

a. hijras ("can be considered as the western equivalent of transgender/transsexual (male-to female) persons"),
b. eunuchs ("refers to an emasculated male and intersexed to a person whose genitals are ambiguously male-like at birth, but this is discovered the child previously assigned to the male sex, would be recategorized as intersexed – as a Hijra"),
c. Aravanis and Thirunangi ("biological males who self-identify themselves as a woman trapped in a male's body"), kothis (" biological males who show varying degrees of 'femininity' – which may be situational. Some proportion of Hijra-identified people may also identify themselves as 'Kothis'. But not all Kothi identified people identify themselves as transgender or Hijras."),
d. Jogtas/Jogappas ("'Jogti Hijras' is used to denote those male-to-female transgender persons who are devotees/servants of Goddess Renukha Devi and who are also in the Hijra communities. This term is used to differentiate them from 'Jogtas' who are heterosexuals and who may or may not dress in woman's attire when they worship the Goddess. Also, that term differentiates them from 'Jogtis' who are biological females dedicated to the Goddess. However, 'Jogti Hijras' may refer to themselves as 'Jogti' (female pronoun) or Hijras, and even sometimes as 'Jogtas'") and Shiv-Shakthis ("males who are possessed by or particularly close to a goddess and who have feminine gender expression").

The SC specifically recognised that transgender persons face "extreme discrimination in all spheres of society" and are unable to realise their full fundamental rights. It recognised that transgender persons are entitled to all fundamental rights, under the Constitution of India and as established by international law. The Supreme Court lastly issued several directions aimed at upholding the rights of the transgender persons including:

1. Hijras, Eunuchs, apart from binary gender, must be treated as "third gender"[12] for the purpose of safeguarding their rights under Part III of our Constitution and the laws made by the Parliament and the State Legislature.
2. The Central Government and State Governments were directed to:

[11] AIR 2014 SC 1863.

[12] Note: Legally the term 'third gender' includes transgender and intersex individuals. Even though they are not the same community and intersex people are trying to get separate legal recognition.

a. Grant legal recognition of gender identity such as male, female or as third gender.
b. Take steps to treat them as socially and educationally backward classes of citizens and extend all kinds of reservation in cases of admission in educational institutions and for public appointments.
c. Operate separate HIV Sero-curveillance for Transgender persons.
d. Address the problems being faced by Transgender persons such as fear, shame, gender dysphoria, social pressure, depression, suicidal tendencies, social stigma, etc. and any insistence for SRS for declaring one's gender is immoral and illegal.
e. Take proper measures to provide medical care to Transgender Persons in the hospitals and also provide them with separate public toilets and other facilities.
f. Take steps for framing various social welfare schemes for their betterment.
g. Take steps to create public awareness so that Transgender Persons feel that they are also part and parcel of the social life and be not treated as untouchables.
h. Take measures to regain their respect and place in society.

In *Nangai v Superintendent of Police,*[13] the Madras High Court relied on the *NALSA* judgment and held that forcing a person who has been socially recognized as female, as was the case with the petitioner, to undergo a medical examination to prove their gender identity violates their right to privacy and dignity under Article 21 of the Constitution.

Registration of Marriage:

In *Arunkumar v. The Inspector General of Registration and Ors*,[14] the Madras High Court upheld the validity of a marriage between a man and a transwoman. It held the registrar's refusal to register the marriage violated the couple's right to equality, right to freedom of expression of identity, and their right to dignity. The Court affirmed that the term 'bride' under the Hindu Marriage Act, 1955, includes transgender and intersex persons who identify as women.

In *Supriyo @ Supriya Chakraborty & Anr. v Union of India*,[15] a Constitution Bench of the Supreme Court comprising five judges unanimously ruled that there is no fundamental right to marry under the Constitution, and that the court cannot extend the Special Marriage Act, 1954 to recognize same-sex marriages. In January 2025, the Supreme Court rejected petitions requesting a review of the *Supriyo* decision, as it found no error apparent on the face of the record of the majority view.[16]

Welfare of Transgender Persons:

The Transgender Persons (Protection of Rights) Act ('TG Act') was passed in 2019, pursuant to the directions of the Supreme Court to the government to take steps for the welfare of

[13] W.P. No. 587 of 2014 and M.P. Nos. 1 and 2 of 2014 decided by the Madras High Court on 17.04.2014.
[14] W.P. (MD) No. 4125 of 2019 and W.M.P. (MD) No. 3220 of 2019, decided by the Madras High Court on 22.04.2019.
[15] 2023 SCC OnLine SC 1348.
[16] Ananthakrishnan G, SC closes door on same-sex marriage again, rejects review plea, says 'no interference is warranted' (The Indian Express, 10 January, 2025), https://indianexpress.com/article/india/same-sex-marriage-legal-recognition-sc-dismisses-review-petition-says-no-interference-is-warranted-9770183/.

transgender persons. The Act outlines the procedures for change of gender in legal documents, involving an application to be made to the concerned District Magistrate for issuing a certificate of identity as a transgender person. The Transgender Persons (Protection of Rights) Rules, 2020 ('TG Rules'), notified under the Trans Act, state that the District Magistrate should process an application for a Certificate of Identity solely on the basis of the person's affidavit, and not through any physical or medical examination.[17] After the issue of identity certificate, if a person undergoes surgery to change their gender to male or female, they can apply for a revised certificate. To do this, they must submit an application to the District Magistrate along with a certificate from the Medical Superintendent or Chief Medical Officer of the hospital where the surgery took place. Once the District Magistrate is satisfied with the medical certificate, they will issue a new certificate showing the change in gender. After receiving this revised certificate, the person has the right to change their first name in their birth certificate and all other official identity documents. This requirement has been criticised as being violative of the right to self-identification without the need for medical or biological proof, as affirmed by the *NALSA* judgement.[18]

Other provisions have also been criticized, including the narrow definition of 'transgender', tedious procedure of self-identification, difference in punishments for sexual violence under the Act compared to laws for women (Refer to the Section on Unique Life Stressors within the queer community for a detailed discussion).[19]

A National Council for Transgender Persons has been constituted under the Act, which has been tasked with advising the Central Government on policies, laws, and programmes related to transgender persons, monitoring and evaluating the impact of these initiatives, coordinating activities of various government and non-government bodies working on transgender issues, addressing grievances of transgender persons, and performing other functions as prescribed by the Central Government. The TG Rules, 2020 provide for setting up of a welfare board for transgender persons to protect their rights and interests, and to help them access government schemes and welfare programs more easily. An RTI investigation of these boards have revealed various operational and other challenges including non-constitution of the boards in majority of the states and the UTs, possibility of political influence in appointment of the board and its working and inadequate sittings.[20]

Sexual Relationships:

In September 2018, the Supreme Court of India read down Section 377 of the Indian Penal Code, 1860 as unconstitutional in *Navtej Singh Johar* v. *Union of India,* to the extent that it

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[17] Rule 4(1), Trans Rules, 2020, <https://transgender.dosje.gov.in/docs/TG%20RULES,%202020.pdf>.

[18] Kyle Knight, India's Transgender Rights Law Isn't Worth Celebrating (Human Rights Watch, 5 December 2019), <https://www.hrw.org/news/2019/12/05/indias-transgender-rights-law-isnt-worth-celebrating>, Shruti Jain, Pride Month 2020: Evaluating the Transgender Persons Act, 2019 (ORF Online, 2 July 2020) <https://www.orfonline.org/expert-speak/pride-month-2020-68965> and Kanmani Ray LR, 'Transgender Act : Not Just Unconstitutional!' (Live Law, 16 July 2020) <https://www.livelaw.in/columns/trasgender-act-not-just-unconstitutional-159966>.

[19] Ibid; Transgender Bill 2019 is About Disciplining Minorities and Upholding a Patriarchal Family Structure, https://www.epw.in/engage/article/transgender-bill-2019-about-patriarchy-family-disciplining.

[20] https://thewire.in/rights/the-reality-of-indias-transgender-welfare-boards-what-an-rti-investigation-reveals.

applies to consensual sexual relationships between two adults, irrespective of gender. The Supreme Court recognized the historic oppression faced by queer persons in India, with Justice Indu Malhotra stating in her judgment, "*History owes an apology to the members of this community and their families"*; a monumental acknowledgement, coming from the highest court of law in India. The Court unanimously held that Section 377 violated various fundamental rights of queer persons, including the right to equality before the law and equal protection of the law (Article 14); the right to non-discrimination (Article 15); the right to freedom of expression (Article 19); the right to privacy and dignity; the right to health (Article 21). (Refer to the Section on Unique Life Stressors within the queer community for understanding the removal of Section 377, IPC and its consequences).

The Yogyakarta Principles:

The Yogyakarta Principles, 2006 are a touchstone on the rights of queer persons in international law and policy. They were first published in November 2006 as the culmination of a meeting of human rights experts in the areas of gender identity and sexual orientation in Yogyakarta, Indonesia. The Principles recognise that gender identity and sexual orientation are inalienable from human dignity, and must necessarily be a part of any assertion of any understanding of fundamental rights. The Principles lay out specific rights over a variety of areas such as family life, privacy and safety, life and liberty, speech and expression, among others (Centre for Law & Policy Research, 2019a). An additional set of nine principles and 111 state obligations were added to the Yogyakarta Principles in November 2017, which include important rights such as the right to legal recognition, the right to bodily integrity and the right to freedom from criminalisation on the basis of sexual orientation/gender identity, among others (Centre for Law & Policy Research, 2019b). Importantly, it expanded the term SOGI (Sexual Orientation, Gender Identity) to SOGIESC (Sexual Orientation, Gender Identity and Expression, Sex Characteristics) to include diverse identities of gender expression and sex characteristics.

Law and Persons with Intersex Variations

In India, the term 'intersex' is often conflated with the term transgender, in legal and political discourse, despite intersex and transgender persons making clear the distinction between the two terms and identities.

Identification documents do not currently recognise intersex persons as possibly having a separate gender identity from transgender persons, with forms for government IDs typically offering 'male,' 'female,' and 'transgender'/ 'other' as options for gender identity. Forms do not include 'intersex' as a sex or gender category, forcing intersex persons to identify with terms that they may not identify with.

The ruling of the Supreme Court of India in *National Legal Services Authority (NALSA)* v. *Union of India,* applies equally to intersex persons with respect to the principle of self-determination of gender identity.

In September 2019, the *UN Committee on the Rights of Persons with Disabilities (CRPD)* included several recommendations on the policy measures that could be implemented by India to further the rights of intersex persons in their concluding observations. These included implementing comprehensive awareness-raising programmes for all stakeholders, addressing the use of derogatory language towards persons with disabilities and tackling multiple and intersecting forms of discrimination against intersex persons, including on the grounds of sexual orientation and gender identity. CRPD also recommended adopting measures to protect intersex children from threats to their lives and other harmful practices, preventing sex-assignment or "sex-normalizing" surgeries and addressing stigmatization and bullying of intersex children. Further recommendations included preventing the rejection, stigmatization, and bullying of children with disabilities, particularly those affected by leprosy and intersex children, reviewing regulations to ensure access to education, conducting campaigns to combat disability-related stereotypes, and establishing complaint mechanisms and sanctions in cases of discrimination.

While acknowledging the importance of legal recognition for intersex identities, it is crucial to ensure that intersex persons' rights are not narrowly framed around gender identity. This approach risks reinforcing the association between biological markers and identity. The focus should instead be on ensuring that gender does not affect individuals' access to their rights.

Living in oppressive spaces takes immense strength and courage. Many people from the LGBT+ community do live highly successful lives while being quite open about themselves, such as Wendell Rodericks, a noted Indian fashion designer, who even in his death was fully celebrated in his identity and in his relationship. For some, being able to see such stories allows for some degree of hope and aspiration. By being active allies, breaking these myths and working on making spaces safer for all, we could forge a way forward to a more equitable society.

Reflection:

1. *Imagine you are not cisgender-heterosexual. Imagine it is Valentine's day, or any other day when people celebrate their spouse/partner. Imagine going through the day in a way that people don't discover your gender identity or your sexual orientation. What hurdles would you face?*
2. *If you woke up to find yourself with the body and gender identity other than what you have now, what would change for you? What would you be able to do/not do? How would you be treated by your family/friends/teachers/the public at large?*
3. *You have to parent a child who is born with intersex variation.*
   What challenges would you face? When, where, from whom? How would you make space for your baby? What would you tell people? What will you say to the child as the child grows up and asks questions about their sex?

Practitioner's Perspective:

Watch Enfold's video series on Demystifying Sexuality - How to be Inclusive and Affirming of Sexual and Gender Diversity? (link will be inserted)

Way Forward

So, what can we collectively do moving forward, to work together to become aware of the experiences of people from across the LGBTQIA+ communities and help be more inclusive?

- We can be mindful that sex, gender and sexuality are not binary and that various identities may overlap. Individuals may or may not fit into the labels LGBTQIA, or any other identity that better fits their sense of self. We need to understand that being LGBTQIA+ would be one of the various identities and to be open to how these identities intersect and influence any individual.
- Be aware of and acknowledge systemic issues (including ones that we might be a part of and from which we derive a lot of meaning, such as religion and religious institutions) that have been part of the discrimination LGBTQIA+ people have faced, and take accountability for change.
- Understand the unique challenges of LGBTQIA+ communities even if we might not be aware of specific people from these groups, in order to become sensitive to each person's struggle. We can respect each other, stand for each other's rights and consciously avoid using words and actions that violate them.
- Value different voices and make space for individuals and groups who have been historically marginalised to tell their own story. We can work towards amplifying those voices that have been historically invisibilized or silenced by ensuring they get more representation in different socio-political and legal spaces.
- Hold space for people most impacted by an issue; talk and speak about it in different groups like our family, friends, colleagues etc., and expand our circles so that no one group is speaking on behalf of another or speaking over another.
- Lobby for changes to legislation, institutions etc.

We can keep in mind that, at least in the current social milieu, cisgender heterosexual people have more power than others and one can use that privilege to create a platform to bring awareness about issues affecting marginalised LGBTQIA+ communities. People who hold power and have privilege (due to various historical socio-cultural factors and accidents of birth) have a responsibility to use their privilege to speak up, act and work with those with less or no privilege to realize everyone's rights and have people experience respect, belonging and worthiness.

Chapter 4. Development of Gender Identity and Sexual Orientation - *understanding and respecting diversity and fluidity.*

If the structure and function of sexual and reproductive organs is not well known or understood by people, then the development of gender identity and sexual orientation is even lesser known or understood. Scientific understanding is expanding rapidly as newer, more reliable ways of studying the plethora of factors that contribute to this development are being explored among diverse communities, debated and documented. Here we present the current understanding of this complex topic, with the intention that understanding will deepen empathy for each other, preventing the violence that is perpetrated by families and societies on non-conforming individuals, thereby creating safer spaces for the true diversity among us to flourish.

The World Health Organization defined sexuality as, "A central aspect of being human throughout life that 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, legal, historical, religious and spiritual factors" (2006).

Sexuality is more than just an individual's inclination or desire for sexual acts, or the expression of one's sexual needs. It is the experience of one's sexual identity, which may also include an indifference towards sexual acts, but an attraction to other aspects of people like their intellect, conversational skills, emotional groundedness etc.. Such an orientation may be called romantic but asexual. There are also people who identify as "aromantic but not asexual" in that they don't experience romantic attraction but do experience sexual attraction.

As with any other development, development of sexuality too varies vastly from person to person, influenced as it is by several biological, psycho-social, historical and temporal factors. Below is a description of our current understanding of the concept and development of gender identity and sexual orientation. These identities and orientations are increasingly being seen as being part of a spectrum - varying and dynamic - rather than something linear and rigidly defined or enforced.

Development of Gender Identity:

Factors influencing the development of gender identity

Gender identity is the gender that one associates oneself most closely with or the self-conception one has of one's own gender. It is believed to develop under the influence of several factors, including prenatal hormones, genetic factors (Heylens et al., 2012), socialization and other environmental factors. Though different scientists have studied psychological and environmental factors and others have studied biological ones, all of these have not been integrated into a single theory that can explain all the variations seen in the gender identity of children, adolescents and adults (Steensma et al., 2013). Both nature and nurture - including the multitude of factors at play during puberty and adolescence, seem to play a role and no one factor can be said to single handedly determine one's gender identity.

Development of gender identity during childhood

Gender identity begins to develop in early childhood. Children observe the roles and behaviour of people around them and begin to associate these with gender. Language too may also influence gender identity attainment (Guiora et al., 1982). Children usually begin to identify themselves with a particular gender around 2-3 years of age, often coaxed by adults around them who are quick to assign a gender based on the sex assigned at birth. They also learn to announce their gender once they begin to talk. In early childhood, this awareness is predominantly binary, mostly because they are largely exposed only to binary possibilities.

Older children begin to respond to the prevailing social cues about dressing, hair style, and behaviour. They begin to choose toys and demonstrate differences in the kind of play they engage in. Gender identity forms as the child identifies themselves, often as ‘a boy’, ‘a girl’ and at times, as neither or as both. Gender roles are practiced and reinforced by day-to-day interactions, for e.g., children may often be seen imitating a same-sex parent and play-acting the tasks that they have seen that parent do. Children imitate and play imaginary games of ‘house-house’, marriage, or being a parent.

While cementing their self-concept of gender, children often show a strong preference for gender-typed clothing, toys, and activities (Martin & Ruble, 2004). According to Bussey and Bandura (1984), around the age of 6, children begin to behave in a way that is consistent with the gender they identify with. Children between 6-9 years of age are seen to engage more with same-sex and similar-aged playmates, friends and school groups. This may pose a challenge for children with gender non-conforming identities. They may also tease each other about having boyfriends and girlfriends or being “in love” (Chrisman and Couchenour, 2002). Gender variant development is an umbrella term to indicate development of gender non-conforming identities where one’s gender identity does not conform with the sex characteristics or the assigned gender at birth.

Development of gender identity during adolescence

Studies indicate that for most adolescents the gender identity they developed during childhood is in accordance with their assigned sex and gender and persists into adulthood (Diamond & Butterworth, 2008). There is a dearth of studies on gender identity development during adolescence. Among children who demonstrate gender non-conforming behaviour from early childhood and continue to do so into adolescence, the consolidation of their gender identity was influenced by (1) the onset of puberty with its associated physical and psychological changes, (2) sexual activity and exploration with others, and (3) peer and family and other social interactions.

Early adolescence, 10-13 years, was found to be particularly formative in a prospective, qualitative follow up study of 25 adolescents (Steensma et al., 2011). These adolescents felt that their gender related behaviour, level of discomfort and gender identity formation were affected by (1) how others perceived them, (2) their own sexual feelings, (3) experience of falling in love, and (4) degree of feminization or masculinization of their bodies. It was also found that

gender identity is more malleable in early adolescence (before puberty) than in late adolescence or adulthood (Byne et al., 2012).

Brain studies are difficult to control for every factor that could be influencing the process - like how one is being treated by the family and peers, the level of stress experienced by the individual, their body image or even administration of puberty blocking hormones. Pubertal hormones could also be an influencer. Researchers concluded that, perhaps all these factors - pubertal changes, interactions with others, sexual feelings and exploration of sexuality - have to be experienced and explored by adolescents with gender non-conforming identities before their gender identity is consolidated (Steensma et al., 2013).

There aren't a lot of studies exploring gender identity formation among intersex children, adolescents or even adults. Prenatal androgen exposure may affect gender role behaviour, but does not seem to have a definite, direct role to play in gender identity formation (Dessens et al., 2005). Once again, pubertal changes, hormonal exposure, psychological factors, exploration of sexuality and other environmental factors could play a role. In a review of studies across regions, it was noted that gender dysphoria in Intersex children has been underestimated and gender and sexual counselling by a multidisciplinary team could support the intersex individual (Warne, 2008).

Support to the child and adolescent

Parents, family members and teachers can be sensitive, accepting and respectful of a child's gender identity and expression as it develops. Gender identity is the gender that one associates oneself most closely with or the self-conception one has of one's own gender. We can avoid restricting the child's gender expression and not impose rigid social norms on clothing or accessories that the child chooses. Reprimanding, ridiculing, punishing or physically restraining children from exhibiting gender non-conforming behaviour or forcing a certain gender expression on them is considered harmful to their developing sense of self. It does not alter their gender identity but instead, it could cause confusion, anguish and anxiety for the child. Sensing a lack of support, the child could withdraw and become socially and emotionally distanced from the family and other support systems that children generally have. Refer to the '**Diversity in Sex, Gender and Sexuality**' chapter for more details.

Gender fluidity

Gender fluidity is the change in a person's gender identity or its expression over time. There may be a change in one's identity but not in one's gender expression and vice versa (Katz-Wise, 2020). Presence of gender fluidity in some individuals should not be construed to mean that every one experiences it or that a transgender person can or should work at being gender fluid and 'change' their gender identity. Also, not every individual who experiences gender fluidity identifies themselves as gender-fluid.

Sexual Orientation:

The concept of sexual orientation

The discussion below is based on ideas put forth by modern western researchers, who have conceptualised sexual orientation as being based on one's gender and sex identity, and one's sexual desires and acts - such as heterosexual, homosexual, bisexual, asexual, pansexual, queer and questioning. This conceptualisation may vary in other cultures. In some communities, sexual orientation is defined not by the sex of one's partner, but by the role one plays in the sexual activity. In other cultures, it may be defined by one's role within the family, however different it may be from one's sexual activity outside the family (Mustanski et al., 2014). Some cultures combine aspects of sexual activity with one's gender expression - for instance some terms used by Native Americans encompass gender roles and sexual behaviour. (L. B. Brown, 1997). Colonialism resulted in adoption of the western model in many countries, including India. The same is presented below, drawing heavily from research done in western countries who have built a substantial and nuanced body of work, more so over the last fifty years.

The following sections are based on Chapter 19 - Development of Sexual Orientation and Identity by Brian Mustanski, Laura Kuper, and George J. Greene in APA Handbook of Sexuality and Psychology Vol 1.

Researchers have identified four aspects - self-identification, sexual behaviour, romantic attraction, and sexual attractions as components of one's sexual orientation. Self-identification is how the person prefers to describe themselves using labels like heterosexual, gay, bisexual, pansexual, asexual, queer and questioning among several other evolving labels. Sexual behaviour is related to the gender of the person/s with whom one has sexual activity. Romantic attraction is related to the gender of persons one 'falls in love with' or would like to form a romantic relation with. Sexual Attraction focuses on the gender(s) of persons that produce sexual arousal, though for some individuals, the gender of their partner is not a consideration.

The development of sexual orientation

Researchers have devised tools to measure each of the 4 components mentioned above, in order to study the development of sexual orientation. How these 4 components influence each other and which one is more important in giving the person a sense of their overall sexual orientation seem to vary among sexes. In males, sexual attraction and arousal seems to drive sexual behaviour and both ultimately lead to self-identification. The relevance of romantic orientation has not been studied much in males (Bailey, 2009).

Females appear to have greater variability among these components. They may experience sexual attraction towards people of a particular gender but this may not necessarily reflect in their sexual behaviour or romantic attraction. The relative importance of these 4 factors - self-identification, sexual behaviour, romantic attraction, and sexual attractions - in constructing one's sexual orientation also varies. No one component seems to be the leading factor. An identity-centred development sequence (rather than sex-centred sequence seen commonly in males) may be more important (Dube, 2000) and occur before sexual activity in females

(Diamond & Savin-Williams, 2000). Sexual orientation also seems to be more fluid and more likely to change in one's life span among females as compared to males (Diamond, 2012).

Among transgender and gender non-conforming persons, development of sexual orientation may follow different trajectories due to several unique factors including medical and surgical interventions (Meier et al., 2013). Gender identity and sexual orientation seem to be entwined to some degree in all people, and more so among sexual minorities. Describing one's sexual orientation may be more complex, especially if one identifies as a transgender person and more so if one has or is undergoing transition or one has gender non-conforming identities and expressions that differ from one's assigned sex at birth, according to another study conducted in the US (Katz-Wise et al., 2016).

Development of sexual orientation in intersex individuals has not been studied much. The study design and tools would need to capture the diversity that exists in the underlying factors, presentation, personal and social construct of sexual orientation in the context of intersexuality. Some suggest that, as in the case of gender identity, self-identification with a particular sexual orientation may not occur until adolescence or early adulthood (Schober, 2001).

Factors influencing the development of sexual orientation:

Here is the current understanding of the factors and processes that are involved in the development of sexual orientation. The authors point out that it is incorrect to look at purely biological or purely socio-psychological factors. It is better to look at how differences in biological factors could interact with different social and psychological factors to produce variations in sexual orientation for and among individuals. Most studies have been conducted in adult white gay males, fewer in lesbians and other groups.

- Biological factors studied are: genetic, biochemical, hormonal, neuroanatomical differences, age of onset of puberty and fraternal birth order, prenatal stress, cerebral asymmetry, among others. Though studies in families and twins show consistent evidence of genetic influence, no specific gene or mechanism has been established. Similarly, having an older brother increases the chances of homosexuality in males, but the mechanism is not fully understood (Mustanski et al., 2002). Biological factors seem to serve as predisposing factors, "to respond affectively and intimately to members of the same sex" (Hammack, 2005, p. 277). According to Hammack, affectional bonding and sexual desire are separate and independent experiences that can occur concurrently. The degree of this distinction and its effect varies across genders and cultures. The fusion of the two, for members of one's own sex might create a sense of homosexual subjectivity. Biological models often ignore social and contextual factors in the search for an etiology - a cause - for one's sexual orientation. This can lead to a debatable construct of sexual orientation as stable - solid - and unchanging rather than a concept that may change over time for a person, given their unique experiences and socio-temporal contexts.

- Socio-cultural and developmental factors - Adolescence is recognized as the period of heightened social and cognitive development when one constructs a sense of self and develops one's identity. Several factors are thought to impact this. Factors studied are

gender non-conforming behaviour (consistent association has been found, more so among males than females, though several methodological issues exist), child sexual abuse (inconclusive evidence), historical, cultural and temporal factors affecting social acceptance of LGBTQ individuals, race, gender, religion, socio-economic factors and disability among others.

Life-course approach and the development of sexual orientation:

Hammack's (2005) life-course approach uses a bio-social, historical framework to understand the development of human sexual orientation, expanding on work by Diamond (2003). It emphasizes that an individual is located in a wide social structure and their experiences are affected by the characteristics of multiple, dynamic contexts like family, school etc. Individuals internalize the socio-cultural system that they grow up in and try to align their sexual orientation and identity with this system. Hammack (2005) emphasizes the role of individual agency in interpreting and responding to socio-cultural influences.

Developmental and social factors are difficult to separate and study. Models that define sexual orientation as a universal, linear, staged development, are now being challenged.

Earlier, sexual orientation was believed to form early in one's life and remain stable throughout the lifespan (Bailey, 1995; Swaab, 2007). However longitudinal studies spanning a range of diversities and age are leading to a more nuanced understanding of the construct of sexual orientation through a person's life span.

Models for development of sexual orientation among the LGB population

These models have been developed in the US and Australia. One such model that is widely referred to is the 'Identity Development Stages' by Vivienne C. Cass (1979):

5. Identity Confusion
6. Identity Comparison
7. Identity Tolerance
8. Identity Acceptance
9. Identity Pride
10. Identity Synthesis

In these stages, the adolescent begins to acknowledge and accept themselves. They begin to seek out information and persons with similar orientations/persons from the LGB community. This helps them compare their feelings and experiences with others, have relationships that confirm their identity and become more accepting of their orientation. This sexual identity then gets incorporated into one's larger sense of self. According to Cass (1979) this self-acceptance may be associated with identity pride. However, strong negative reactions from influential others may result in foreclosure of the identity.

Bisexual identity

For some persons this identity is 'temporary' before they identify as gay or lesbian. For some, it is a stable identity. Some arrive at it after having identified themselves as heterosexual or homosexual (Fox, 2000). Persons with bisexual identity may face unique challenges - biases and prejudices from people within the LGB community as well as those outside the community. They may experience confusion, as the attraction they experience may fluctuate, making them question the legitimacy of this identity. Lack of social support and opportunities to act on the attraction may produce 'continued uncertainty' rather than attainment and maintenance of a definite bisexual identity.

A study (Martos et al., 2015) among 396 LGB New Yorkers found sexual identity milestones were reached earlier by men than women, but they took longer between milestones. On the other hand, bisexual people took longer than lesbian or gay people to reach these milestones. Large scale longitudinal studies among LGBTQIA+ individuals would elucidate this complex development better.

The differential development trajectories **(**DDT) model emphasizes the uniqueness of the experiences of LGBT individuals arising from biological, social, temporal and historical factors influencing the development of their sexual orientation. This model points out that mathematical averages and general descriptions of groups should not be applied to, forced upon, or used to understand individuals.

Earlier attainment of milestones:

Researchers (Dank, 1971; Drasinet al., 2008; de St. Aubin & Skerven, 2008) studying generational cohorts are finding that individuals from recent cohorts are attaining some psychosexual milestones, such as awareness of one's sexual attraction and self-identification, at an earlier age than individuals belonging to older cohorts.

Homosexuality and same sex marriages have been recognized and legalized in various countries. Movies, TV serials and social media are increasingly providing information and narratives of LGB persons. Availability of information, greater access to narratives and role models (Boxer et al., 1993), and reduced stigma (Grov et al., 2006) may have a role to play here. Greater openness and acceptance from family, peers and society as a whole would further affect the developmental experiences of LGB individuals over their life span, and would need further studies. LGB individuals may experience less secrecy, stigma, isolation, distress, fear or anxiety than those coming out some decades earlier. However, LGB related discrimination and violence continue to be commonplace. One report in the US by the FBI in its 2018 Hate Crime statistics listed 1404 offences accounting for nearly 19% of hate crimes in the year (Hate Crime Statistics, 2018). This kind of environment and prevailing hostility towards gender and sexual minorities would then continue to influence their developmental trajectories.

Fluidity and variability in sexual orientation

Sexual fluidity can be defined as change over time in one or more components of sexual orientation in an individual (Diamond, 2008; Katz-Wise, 2015). As per studies done primarily in the US, sexual fluidity is believed to be a part of every person's sexuality (Diamond, 2015) -

whatever be their sex or sexual orientation, though, to varying degrees. Research suggests it might be more prevalent among people with transgender and queer identities and among women.

In a longitudinal study of 89 young adult women, Diamond (1998, 2000, 2003b, 2005b, 2008) tracked changes in the sexual attractions, identity labels, and behaviours over a period of 10 years. While sexual attraction remained relatively consistent, more fluidity was found in identity labels and sexual behavior. Several researchers have found that sexual orientation labels can change in adulthood. This is more likely in women and in bisexuals. (Dickson, Paul, & Herbison, 2003; Pattatucci & Hamer,1995; Stokes, Damon, & McKirnan, 1997; Stokes, McKirnan, & Burzette, 1993; Weinberg et al., 1994). In a community-based study of 452 Gender Minority Individuals in Massachusetts, the authors found that sexual fluidity in the dimension of sexual attraction is often the norm. Transition also seemed to be correlated with this, with 64.6% of 205 respondents who had transitioned reporting a change in attractions post-transition (Katz-wise, 2016). Meier et al. (2013) analysed data from 503 self-identified transmasculine individuals in an international study and found that 40% of those who had transitioned reported experiencing a change in sexual attraction. Any association with testosterone use needs further study, as does any influence of gender affirmation surgery. Auer et al (2014), in their study involving 70 transmasculine and 45 transfeminine persons found a significant number of persons reporting a change in sexual orientation and for a large number of them, this happened before having undergone any sex affirmation surgery. The authors concluded that several factors, like an individual's sexual arousal patterns, their own construct of sexual orientation, self and social acceptance, and confusion preceding or after surgery may have a role to play in this change.

According to Diamond (Diamond, L M 2015), when individuals experience a shift in an aspect of their sexual orientation like erotic attraction, the change comes across as 'unexpected and beyond their control'. This is consistent with the current scientific understanding that it is not possible to change a person's orientation through any 'therapy' or mode of 'treatment'. The presence of sexual fluidity should not be construed to mean that a change in sexual orientation is a voluntary process that an individual controls and can produce if they 'choose' to, through medical or therapeutic interventions. Such interventions could be potentially harmful to the person's wellbeing (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Thus, sexual orientation develops with a complex interaction between several biological and sociocultural factors and processes. It is not a stable goal-oriented process and is better understood as a lifelong process with the possibility of changes in sexual and romantic attractions, behaviours, and the labels one identifies with.

Reflection:

5. *When did you first become aware of your gender identity?*
6. *When did you first become aware of your sexual orientation? How comfortable were you with it? Who was in your support network during this time?*

7. *How comfortable would you be if a close family member or friend has a gender identity or sexual orientation different from what is 'expected' of them? What would you be worried about?*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - How does sexual identity develop in children? (link will be inserted)

Way forward
We can move towards a society where the etiology and presentation of sexual orientation or one's gender identity has no moral, legal or social consequences. Whatever may be a person's sexual orientation or gender presentation at any point in time, whether it be biologically influenced or not, be stable or fluid, be clearly labelled or not, the variability and diversity in sexual orientation and gender identity is natural and needs to be protected and respected. We can, as individuals, do our part in creating such a society in our sphere of influence.

Chapter 5: Gender Bias – ***its effect on different genders, working towards gender equity***

Ideas and perceptions around gender permeate all aspects of our everyday lives. Right from the time we are born, the fixation around determining our sex as either 'male' or 'female' sets the stage for a life-long process of gendering, in which we are taught and coerced into acting in 'gender-correct' ways through a set of norms, roles and guides. People are made to conform to conventional binary notions of femininity and masculinity, where femininity is viewed as less than, or only in relation to, masculinity. People who identify differently, beyond the binary, are viewed as even less worthy. Even though the cultural associations and meanings of these terms may be historically fluctuating and shifting, it has contributed to bringing about unequal relations of power between people of different genders in a patriarchal society. Gender biases, or the tendency to differentiate against people based on their gender and favouring one gender over others, are so thoroughly embedded in our institutions, social interactions, beliefs and actions that they have become normalized in every sphere of our lives. These can manifest in harmful ways with powerful social consequences for all genders.

In a patriarchal and heteronormative society, heterosexuality is viewed as the ideal to the point where it is romanticized and institutionalized. Through a system of rewards and punishments, anyone who doesn't conform to the norm of heterosexuality is penalised in the form of harassment, violence and criminalisation and those who adhere to its norms are rewarded through a set of social privileges. Women have been socially, economically and politically oppressed and discriminated against by cis men in positions of power and continue to be routinely subjected to stereotypical and prejudicial attitudes. For instance, men in a patriarchal society have enjoyed certain privileges by assigning all care work to women, thereby relegating them to the private realm and limiting their opportunity to live life on their own terms. All domestic and care work-related responsibilities including child-rearing are seen as 'women's work', and stereotypical statements such as "a woman's place is in the kitchen" etc. further reinforce such beliefs.

Gender biases perpetuate and enable gender-based discrimination in society, which is the unfair or unjust treatment of an individual based on their gender. This occurs in various aspects of one's life, such as in access to nutrition, healthcare, education, employment,, opportunities, remuneration, legal rights and services and many other areas. It ranks genders in a hierarchical fashion, placing those identities at the bottom that fall outside cis heteronormative standards, like transgender people, who are commonly referred to as the "third gender" - suggesting there is a 'first' and 'second' gender in this hierarchy.

Gender-based discrimination creates socially constructed barriers that deny certain individuals rights and opportunities that those who are at the top of the gender hierarchy freely exercise. Power relations are inherent in family structures and practices, where due to social and economic conditions, the preference for sons is more prevalent. As a result, this is the lived experience of many, where families save the most nutritious food for their male children and male adults, spend money disproportionately on male children or more resources are poured in for the health, nutrition, education, clothes etc., and in creating opportunities for the male child, often at the expense of female children. Trans or intersex children may only be allowed to exist in the margins of society, and are discriminated against and often made homeless.

Biases are often learnt at home by observing the everyday roles adults perform. For instance, in some households, the mother is usually seen in her role as the caregiver and as the housewife, managing household chores, taking care of the needs of the family etc. while the father is seen as the breadwinner and provider of the family, and it is socially acceptable for him to have minimal involvement in child-rearing and household responsibilities. This is in contrast to rural women, who regularly travel outside their house for work along with the men, but this has had little effect in changing the dominant perception of division of labour based on gender. Rural women are also simultaneously expected to take care of domestic duties of fetching water, cooking and cleaning, among others.

In India, gender biases aren't experienced in similar degrees across the country but are dependent on local gender norms in relation to factors like poverty, colonial past, history of local women's rights movements, caste-based norms, gender division of labour, purdah practices and labour-intensive agriculture among others (Evans, 2020). There are also some communities in India that are matrilineal (transference of surname, property, rights etc. from the mother), for instance, the Khasi, Garo and Pnar/Jaintia communities in Meghalaya, or the Nairs in Kerala (that practiced matriliny until April 1925 when it was abolished by law) and Bunts in the coastal districts of Karnataka. However, women in these communities didn't necessarily enjoy more social power than men, as one would think.

Biases based on gender - where did it all start?

What could have led to biases based on gender in society? The ‘women’s question’ has preoccupied many theorists who’ve attempted to explain the origin of the subjugation of women in society - known to be historically oppressed and relegated to the domestic realm and continue to be so. However, there is no single explanation of the origin of this oppression. One of the theories was put forth by German philosopher and historian Friedrich Engels in his 1884 historical materialist treatise, “The Origin of the Family, Private Property and the State”, in which he provides a historical account of the origins and development of the family (Engels, 2007). His views on the oppression and subordination of women have been widely cited as a key text explaining the Marxist position in this regard.

In this text, Engels claims that in prehistoric or primitive societies, when the survival of the community depended on an individual's labour of gathering and hunting to sustain only one person i.e., themselves, there was no room or motivation for exploitation or oppression. He calls this period one of "primitive communism", which was a period where men and women enjoyed an equal status, were interdependent on each other in a way that wasn't antagonistic, and lived in harmony in a matrilineal family structure. The oppression of women, according to him, began with the shift in the nature of economy from 'hunting and gathering' to 'agriculture and herding' (Ursel, 1977). The rise in the development of agriculture and the domestication of animals created a 'surplus', which enabled an individual to provide not only for themselves but for others as well. This disrupted the harmonious and egalitarian nature of social relations in those societies and led to the development of private property, and eventually, of inheritance followed by monogamy, after which men began viewing women and children as ‘possessions’ or ‘property’. Therefore, Marxists understood the origin of women’s oppression as a product of the invention of “private property, class distinctions, commodity production, the economic isolation of the family and patrilineal kinship” (Heitlinger, 1979).

Another position on explaining the cause of women's oppression has been the early Feminist position, developed by earlier feminists like Shulamith Firestone (1980), who believed that the answer lay in biology, which made it "natural" for men to oppress women and made women economically dependent on them. It was understood that through a feminist revolution (i.e., putting an end to the sexual and reproductive oppression of women), one would be able to put an end to this domination. Much like Firestone, Simone de Beauvior (2010) also believed that the origin of this oppression lies in the biological differences between women and men, because women are seen as 'physically weaker' in comparison to men due to their childbearing capabilities, menstruation, menopause and other such "ills" etc., and so these became the cause for their oppression.

Gayle Rubin (1975) in her work, "The Traffic in Women: Notes on the 'Political Economy' of Sex" proposes a theory that situates the cause of women's oppression in kinship systems and challenges common explanations of the cause proposed by other theorists like Engels, who claimed that prehistoric human society was matriarchal (a family structure where woman is the head of the family). She analyses the theories of Marx and Engels (as explained above), Jacques Lacan, Freud and Levi-Strauss and says that while they provide us with the conceptual tools to understand oppression of women and sexual minorities, they still don't explain what causes it in the first place. For instance, she criticizes Marxist theory by saying that women's oppression cannot be simply explained as a product of capitalism because economic oppression is a by-product of this oppression and not the cause of it. Moreover, if capitalism was the reason for women's subjugation, Rubin states that then we would be able to put an end to this oppression with a socialist revolution, but that is not the case.

For Rubin, it is kinship systems (which she takes from Levi-Strauss' work) that produce gender division i.e., assigns distinct gender roles to women and men in which desire is directed towards the 'opposite sex', and the preferred female sexuality is "one which responded to the desire of others, rather than one which actively desired and sought a response." (p. 182). According to her, women's subordination is "a product of the relationships by which sex and gender are organized and produced." (p. 47). The "exchange" of women within these system i.e., women are exchanged as "gifts" in marriage in order for men to hold social power, oppress women and normalize compulsory heterosexuality, simultaneously othering those who transgress heteronormative norms, like queer or trans people for instance (Bethie, 2018).

The women's question in India

In India, patriarchy, the caste system and a number of other social and religious practices and ideas have historically impacted women's position in society, the effects of which persist till today. The impact of these, however, hasn't been the same for all women in its manner and extent due to structures of caste, class, family, rights over property etc. which has varied across different categories of women. It has often been claimed that historically, women enjoyed a 'high status' in early India during the Vedic period (2000-500 BCE) and were as free as men in all respects until the Mughal invasion (Zainab, 2018). These claims have been challenged as unfounded stating that the control and domination of women in India has persisted at all points in history, albeit in varying degrees, and has been reflected in texts that talk about code of behaviour of men and women in those times.

For instance, Manusmiriti, an ancient religious text of Hindu brahmins (not all communities in India subscribe to its tenets), gives precise instructions for the conduct of upper caste men and women. Its content upholds patriarchal structures of authority, enforces caste hierarchies and conservative ideas of gender roles and legitimizes the inferior status of women. One of the translated excerpts from it reads, "Even in her own home, a female – whether she is a child, a young woman or an old lady – should never carry out any task independently. As a child, she must remain under her father's control, as a young woman, under her husband's; and when her husband is dead, under her sons" (Ali, 2020, para. 18). It is also important to note that most of the claims made about women's equal status in ancient India have been made using historical sources that refer to only a specific category of women i.e., the elite class and upper caste, leaving out a range of experiences of women from labouring castes and class and those from tribal backgrounds.

In India in the 19th century, colonial rule was a period of dominant control and influence of colonial ideology, which sought to 'civilise' Indian men and women for their 'backward' practices. Women were especially seen as being in a 'degraded condition' by colonial officials due to oppressive practices like sati, child marriage, purdah, prohibition of widow remarriage etc. (Pande, 2018). According to them, women's abysmally low position could be improved with the introduction of modernity, and rule by an advanced country such as theirs. This colonial intervention and the influence of western ideas of modernity, liberalism, civilized society and rationalism etc., permeated through Indian society, but also brought with it its Victorian morality and the ideal of "true womanhood" deeply tied to notions of virginity, respectability, piety and unattainable standards of beauty, morality and ethics. This also changed the notion of family itself, where while different communities in India practiced different kinds of family structures other than monogamy, the colonial impact erased these practices and enforced only one idea of family - heterosexual and monogamous.

An analysis of 264 judgments[21] from 2019-2021 from Assam, Maharashtra and West Bengal concerning sexual offences that attract the death penalty found a large-scale reference to the status of the survivors' hymen in the medical examination reports referred to in the judgments. The relevant excerpts from the report are as follows:

"Observations on the hymen and the "two-finger" test are typically associated with the virginity of the survivor. In cases of rape, these findings are used to comment on the victim's sexual history and perpetuate myths about false allegations and victim resistance for the offence to have taken place. They bear no relevance to establish the lack of consent or extent of penetration, and are irrelevant in POCSO cases, as consent of the minor is immaterial. The Ministry of Health and Family Welfare Guidelines (MOHFW Guidelines) includes injury and infection involving the hymen as a part of examination of the vulva in case of a female survivor. However, the Guidelines also make it clear that:

> ...the status of hymen is irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. An intact hymen does not rule out sexual violence, and a torn hymen does not prove previous sexual

[21] Enfold Proactive Health Trust and Project 39A, 'Verdict and Beyond: Judicial trends and Survivor Narratives in Child Sexual Abuse Cases' <https://enfoldindia.org/wp-content/uploads/2024/11/The-Verdict-and-Beyond-Digital.pdf>.

intercourse. Hymen should therefore be treated like any other part of the genitals while documenting examination findings in cases of sexual violence. Only those that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema etc.) are to be documented.

Exposed to western ideas and values, though male Indian reformers agreed that women's overall status needed to be improved, they only picked up issues that the Britishers pointed to. This meant that despite women's active political participation during the Nationalist Movement against colonialism and despite social reforms to improve their status, already existing patriarchal structures and gender relations were barely challenged and rather gender biases were further reinforced, which persisted even after independence.

Reflection:

- *What is your idea of an ideal man and ideal woman?*
- *Here are some common things people say - Do you agree, somewhat agree, are neutral, disagree, strongly disagree? Note your responses and discuss with your friends and colleagues.*
    - *Girls have more sexual urges but they pretend as if they don't.*
    - *When a girl says "no" to sex, it means "yes".*
    - *In some cases, if a girl is raped it is her fault.*
    - *Dowry is a woman's fair share in her father's property.*
    - *Boys will be boys.*
    - *Employing women is a liability.*
    - *If you love a person unconditionally, it means that….*
    - *The man should pay the bill when he goes out with his girlfriend.*
    - *Movie dialogues like 'Aap apni jaan aur laaj bacha kar vapas aa jaana' or 'Izzat lut gayi'.*
    - *Men have to be strong.*
    - *Men must protect the honour of their women.*

3. Do you think you may be perpetuating gender bias through the following?

    - *Your body language, posture, behaviour and habits (example expecting to be served, not cleaning up after oneself)*
    - *The words you use?*
    - *Jokes you tell/ forward?*
    - *Rituals you observe?*

Gender bias and its impact

Within the institution of marriage, sexuality continues to be seen as only procreative i.e., meant for the sole purpose of reproduction and not as something one can derive pleasure from. There exists a patriarchal desire to have sons owing to their apparently better economic position and control over family inheritance (Bhalotra et al., 2020). This understanding of sexuality has also

become the basis for many who refuse to recognise same-sex unions and view them as 'unnatural'. Despite Section 377 of the Indian Penal Code being struck down, there is a lot more to be done to foster social acceptance for the LGBTQ+ community.

In a patriarchal society like ours, sexuality is routinely regulated by controlling who one falls in love with or who one marries or has sexual relations with. For instance, in some parts of India, caste endogamy, which is the practice of marrying within one's caste, is quite prevalent among upper caste Hindus and has led to numerous killings in the name of 'honour'. Marriage outside of one's religion, region, ethnicity etc. or with someone of the same assigned sex are also discouraged. Add to that, the idea of pre-marital sex and sex for pleasure being taboo.

This social control of one's sexuality has resulted in violence perpetrated towards cis women, queer and transgender individuals including other sexual minorities in the form of physical, sexual, emotional, verbal, mental or even spiritual abuse, mostly by cis heterosexual men. This violence is perpetrated largely by intimate partners or people the survivors have known rather than strangers. It also disproportionately affects women and other gender and sexual minorities, especially when in a relationship with cishet men.

Gender bias at home

In most households, only girls are taught domestic chores and care work from an early age, and their movement outside the house is restricted, while boys enjoy a considerable amount of freedom and privileges. For instance, they're fed better and more nutritious diets, while girl children are neglected or not sufficiently breast-fed in comparison to boys. A study conducted in two states in India found that by the time children turn 15, there is a noticeable gender gap in diet, where "adolescent girls are less likely than boys to consume those costlier foods that are rich in proteins, vitamins and micronutrients necessary for their healthy development" (Mukherjee, 2016, para. 2). Pregnant women in India also experience malnutrition and are known to be underweight.

Rigid gender roles and norms force individuals, especially women and girls, to conform to these norms, regulating their mobility. Culturally stereotypical ideas of manhood are forced on boys, which have harmful effects on them in adulthood and encourages them to perpetuate cycles of harm and abuse onto others, especially women. Queer kids or children who may be experiencing gender dysphoria, for instance, are pressurised even more to adhere to these gender norms so they don't transgress them and bring 'shame' to the family.

Sex selective abortions

In a hegemonic, patrilineal (transference of surname, property, rights etc. from the father) and patrilocal (when a married couple settles in the residence of the husband's family) society, bearing a son is almost like a status symbol. Sex selective abortion & female/intersex infanticide are a common practice in India. According to the Sample Registration System (SRS) Statistical Report (2018), the sex ratio at birth (no. of females per 1,000 males) declined from 906 in 2011 to 899 in 2018 in India. According to the Economic Survey 2017-2018, as of 2014, there were "nearly 63 million and more than 2 million women" who went "missing" every year in India across age groups due to "sex selective abortion, disease, neglect, or inadequate nutrition".

The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994 (which was amended in 2003 to the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition Of Sex Selection) Act) was passed to prevent and stop the practice of prenatal sex-selective abortions in India. The Act applies to all medical establishments engaging in prenatal counselling, diagnostics or testing. It aims to prevent the misuse of prenatal diagnostic techniques for the purpose of sex-selective abortions, as well as processes of sex selection before conception. It does this by regulating the use of pre-natal diagnostic techniques, such as ultrasound, and banning medical establishments from using any diagnostic technique to determine, or provide information about, the sex of a foetus. Under the law, informing the pregnant person regarding the sex of their foetus, whether through speech, words or even symbols, is illegal. Advertising pre-natal sex determination diagnostic facilities is a crime, with a punishment of fine and up to three years imprisonment. The law and its attendant Rules and other notifications released by the government from time to time also include several provisions regulating the setting up, registration and practices of prenatal diagnostic centres.How effective has the implementation of this Act been is unclear.[22]

Female infanticide in India continues to exist due to multiple underlying factors. “Between 2013 and 2017, about 460,000 girls in India were missing at birth each year. According to one analysis, gender-biased sex selection accounts for about two-thirds of the total missing girls, and post-birth female mortality accounts for about one-third. (The State of World Population 2020)”. [23] A key reason is the long-standing cultural preference for male children, who are often regarded as the ones who will carry forward the family name and provide financial security in their parents' old age.

In many communities, daughters are still viewed as an economic liability because of the prevailing, though illegal, practice of dowry during marriage, as prohibited by the Dowry Prohibition Act of 1961. This discriminatory practice persists in certain regions. Furthermore, limited access to education, healthcare, and opportunities for girls in some areas reinforces these biased attitudes. Poverty also contributes to this issue, with economically struggling families mistakenly believing that having a son will improve their financial stability in the long run.

Gender bias in education

Gender bias in education manifests in different forms - parents might allocate more funds for the education of male children, there is a gap in educational attainment which has become worse over time, and parents tend to send their male child to private schools and their female child to a free government school. According to the Annual Status of Education Report (ASER) 2019, only 39% of girls between the ages of 6 and 8 are enrolled in private schools as compared to 48% boys.

It is also a common practice among parents belonging to certain classes to support their daughter’s education just so that it increases her prospects to get married. Whether she gets to

[22] Center for Reproductive Rights and Centre for Constitutional Law, Policy, and Governance, National Law University, Delhi, ‘Securing Reproductive Justice In India - A Casbook’ (2019), <https://reproductiverights.org/wp-content/uploads/2020/12/SecuringReproductiveJusticeIndia-Full.pdf>.
[23] https://socialwelfare.vikaspedia.in/viewcontent/social-welfare/social-awareness/female-infanticide?lgn=en

work after school or not will then depend on her husband or in-laws. Gender norms and stereotypes affect the learning opportunities of girls, who are also discriminated against within the classroom by teachers who might subject them to differential treatment as compared to boys and discourage them by having lower expectations from them.

Gender-based Violence

Gender-based violence disproportionately affects women, transgender people and other minorities in both public and private spaces, and is directed at an individual based on their assigned sex or gender identity. It includes physical, sexual, verbal, psychological and emotional abuse as well as controlling behaviours by an intimate partner, usually a cisgender man, like verbal sexual degradation, refusal to use condoms, or refusal to use contraception.

Oppressive cultural norms have made it socially acceptable for male partners to subject violence on women for a number of reasons such as dowry, 'disobeying' the husband, for not bearing a son etc. In India, married women experience domestic violence at a frightening rate. Even though the dowry system was abolished in 1961, the practice of giving money or gifts as dowry to the groom's family still persists in India. Violence against women perpetrated by the husband and in-laws for refusing their demand for dowry or for asking for more dowry once marriage has taken place is still a ,common practice. As many as 13,479 cases were registered in 2022 under the Dowry Prohibition Act, 1961, according to the National Crime Records Bureau (NCRB). At the same time, 6,450 dowry deaths were registered in 2022.[24] However, it is important to note that NCRB stats are not really indicative of actual prevalence as NCRB follows the principal offence rule - a lesser offence is subsumed under a major one. So, a case will not be reported as dowry death if murder provisions are also used.

Section 63, BNS/Section 375, IPC defines rape and provides an exception which states that "sexual intercourse or sexual acts by a man with his own wife, the wife not being under eighteen years of age, is not rape," often referred to as the marital rape exception. This exception was challenged before the Karnataka High Court and the Delhi High Court. In *Hrishikesh Sahoo v. State of Karnataka*,[25] the Karnataka HC noted that Exception 2 to Section 375, IPC creates inequality by exempting husbands from being prosecuted under the provisions and thereby violates Article 14 of the Constitution. It urged the lawmakers to consider the inequalities in the law and "hear the voices of silence." In May 2022, the petitioner filed a Special Leave Petition and challenged the verdict before the Supreme Court of India.[26] A 3-judge bench of the Supreme Court ordered an interim stay on the Karnataka HC order.[27]

In *RIT Foundation v. Union of India*,[28] the Delhi HC gave a split verdict on the constitutionality of the provision. Justice Shakdher held the provision unconstitutional as it violates a woman's right to bodily autonomy and expression and Justice Shankar held the provision constitutional as consensual or non-consensual relations are legitimate expectations in the institution of

[24] https://www.thenewsminute.com/news/more-than-6000-dowry-death-cases-registered-in-2022-ncrb-data
[25] 2022 SCC OnLine Kar 371.
[26] https://www.scobserver.in/cases/challenge-to-the-marital-rape-exception/.
[27] https://www.scobserver.in/cases/challenge-to-the-marital-rape-exception/.
[28] 2022 SCC OnLine Del 1404.

marriage. In 2022, a fresh petition challenging the constitutionality of the marital rape exception was filed before the Supreme Court. The matter is still pending.

With regard to the application of the exception to wives below the age of 18 years, in *Independent Thought v Union of India*,[29] the Supreme Court held that sexual intercourse between a man and his wife below 18 years of age will constitute rape under the IPC. This change is also reflected in Exception 2 to Section 63, BNS, 2023.

Intimate partner violence (IPV) is not only prevalent in heterosexual relationships, but persists in **LGBTQIA+ relationships** as well. It is in fact much harder for individuals from the community to seek help if faced with violence because they doubt that anyone would believe them and due to lack of appropriate legal remedies and legal biases that prevent them from seeking help. IPV leads to various mental health issues including depression and post-traumatic stress disorder (PTSD), which have substantial comorbidity, and are the most prevalent mental-health consequences of intimate partner violence.

The Law and Domestic Violence Against LGBTQIA+ individuals

The Protection of Women from Domestic Violence Act, 2005 ("DV Act") permits only women to file complaints. As per Section 2(a) of the Act, an aggrieved person means "any woman who is, or has been, in a domestic relationship with the respondent and who alleges to have been subjected to any act of domestic violence by the respondent". against family members for domestic violence. However, the term 'woman' is not defined in the Act. A case on the issue of whether a transwoman can be considered as a 'woman' under Section 2(a), DV Act, is pending before the Supreme Court of India.[30] In some cases, the courts have held the inclusion of transwomen as women under other legislations. For instance, in Vishwanathan Krishna Murthy v. State of Andhra Pradesh,[31] the Andhra Pradesh High Court held that a trans woman in a heterosexual marriage is entitled to file a complaint under Section 85, BNS/Section 498-A, IPC for cruelty against her husband and in-laws. The Court further affirmed that a transgender person's identity does not depend on undergoing any medical or surgical intervention.[32]

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[29] [2017] 10 SCC 800.

[30] *Vithal Manik Khatri v Sagar Sanjay Kamble @ Sakshi Vithal Khatri & Anr.*, Special Leave Petition (Criminal) Diary No(S). 34425/2023, <https://www.livelaw.in/pdf_upload/344252023112047845order30-oct-2023-501427.pdf>; Also see https://clpr.org.in/blog/reimagining-protection-making-the-pwdva-work-for-trans-women-facing-intimate-partner-violence/.

[31] Criminal Petition Nos. 6783, 7064 and 6830 of 2022, decided by the Andhra Pradesh High Court on 16.06.2025.

[32] *Vishwanathan Krishna Murthy v. State of Andhra Pradesh,* Criminal Petition Nos. 6783, 7064 and 6830 of 2022, decided by the Andhra Pradesh High Court on 16.06.2025.

> "21. The argument of the learned counsel for the Petitioner that the Respondent No.2, being a trans woman, **cannot be regarded as a 'woman' merely because she is incapable of biological reproduction, is deeply flawed and legally impermissible.** Such a narrow view of womanhood with reproduction undermines the very spirit of the Constitution, which upholds dignity, identity, and equality for all individuals, irrespective of gender identity. The Hon"ble Supreme Court in National Legal Services Authority (referred supra) has unequivocally recognized the rights of transgender persons, including their right to self-identify their gender. **To deny a trans woman the status of a 'woman' for the purpose of legal protection under** Sections 85 and 86, BNS/**Section 498-A IPC solely on the ground of her**

Secondly, as noted above, the presence of a domestic relationship is a prerequisite to file a complaint under the DV Act. A non-heterosexual relationship will not qualify as a 'domestic relationship' as per its definition in Section 2(f), DV Act. This provision states "domestic relationship means a relationship between two persons who live or have, at any point of time, lived together in a shared household, when they are related by consanguinity, marriage, or through a relationship in the nature of marriage, adoption or are family members living together as a joint family". Since the Supreme Court refused to accord legal recognition to non-hetersexual unions, it will also be difficult to bring these relationships under the "relationships in the nature of marriage" as provided in the Act and interpreted by the Courts.[33]

Gender bias in religion

Menstrual flow consists of blood, mucus and fragments of lining tissue. This flow gradually comes out of the uterus through the vagina. The blood in the uterine lining nourishes the baby during pregnancy. In the absence of a pregnancy, the blood is shed along with the lining. It is not 'bad' 'dirty' 'unclean' or 'sinful' in any way, however, some cultures view menstruation as unclean or embarrassing and put restrictions on menstruating women from praying or visiting a religious place. Cultural norms and religious taboos on menstruation are often compounded by traditional associations with evil spirits, shame and embarrassment surrounding sexual reproduction. But carrying disempowering beliefs about ourselves is restrictive and gives the idea that periods are dirty and must not be discussed. Women are also often at the receiving end of benevolent sexism when it comes to menstruation, where the tendency is to talk about menstruation in relation to "womanhood" and "femininity" and restricting women from doing certain activities when on their period because they're "fragile".

There are also practices like Female Genital Mutilation or FGM which involves cutting or removal of some or all of the external female genitals in an attempt to control women's sexual urges, sensations of sexual pleasure and their sexuality. It is a predominant practice within the Bohra Muslim community in India and in several other parts of the world. Attempts at reform are resisted in the name of 'tradition'.

Gender bias in the workplace

Gender biases also extend to workplaces in the form of differential treatment towards certain genders, and often there is a difference in the amount of remuneration paid, with women and other marginalised identities being paid much less as compared to cis men (or may not even get hired in the first place), which is what we call the gender pay gap and it is often justified by citing differences in capabilities between men and women, social stigma etc. The pay gap may not always be a conscious choice by employers and only becomes apparent when we look at

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reproductive capacity is to perpetuate discrimination and to violate Articles 14, 15, and 21 of the Constitution. Such a contention, therefore, deserves to be rejected at the outset."

[33] See, Priyanka Sunjay, 'Reimagining Protection: Making the PWDVA Work for Trans Women Facing Intimate Partner Violence' (CLPR, 8 July 2025), <https://clpr.org.in/blog/reimagining-protection-making-the-pwdva-work-for-trans-women-facing-intimate-partner-violence/>.

data that reflects pay practices, but is prevalent in most organised as well as unorganised sectors.

Bias in the workplace also manifests in our behaviour and interaction with others. Sexism in the workplace, which is discrimination meted out disproportionately towards cis women because of prejudicial attitude towards their gender or sex, is common knowledge. What this looks like in action is that women are paid lower wages in comparison to cis men, there is a decline in women's labour force, there are discriminatory attitudes and behaviours towards women including sexual harassment that can take verbal and physical forms, or sexist jokes that objectify women etc.

Women are also expected to work as well as take care of responsibilities at home including child care. Because child rearing is seen as predominantly women's responsibility, most employers provide maternity leaves but not paternity leaves, or will provide shorter paternity leaves in comparison. For women, there are also gendered expectations around one's appearance at the workplace, where they tend to face a lot more pressure and scrutiny around how they look and present themselves at work, the clothes they wear including the make-up they apply etc. Gender biases in the workplace also affect all genders, not just cis women. This includes cis men.

Because men are less likely to share their experiences of everyday stress, discrimination or even sexual harassment due to masculine norms that discourage them to do so, they are more likely to suffer in silence/feel incompetent, which can then manifest in harmful ways like perpetrating acts of violence or discrimination towards others and also resulting in mental health issues and stress. Transgender individuals experience significant hardships in getting employment, and if they do, face harassment and discrimination due to their gender identity. Gay men specially face taunts and harassment - more so from cis-het male colleagues.

Gender bias in the media and shifting beauty ideals

Media perpetuates gender biases and creates stereotypical and unrealistic images that influence our views on gender. The most common form of bias is the underrepresentation or misrepresentation of women, trans, queer and other gender and sexual minorities in cinema, advertisement or print. The portrayal of characters in films is also usually done in a gendered and stereotypical fashion. Most cis men are typically portrayed as powerful, strong, sexually aggressive and emotionally aloof or unavailable while cis women are portrayed as young, fit, emotionally dependent and enmeshed in relationships and household work.

Majority of public perception of gender and sexual minority communities is shaped through representations in visual media. These representations can reinforce negative stereotypes that already exist around these communities. The portrayal of a gay character is usually shown to be flashy, flamboyant or overtly sexual, and is almost never assigned a lead role. Indian cinema also routinely misrepresents and caricatures the Hijra community by ridiculing trans characters and using them mostly to bring in elements of humour or comedy to the story. These roles are also mostly played by cis men, thereby denying trans actors paid opportunities in the film industry.

Media is also responsible for perpetuating unrealistic standards of beauty, and social media platforms have contributed to and encouraged the disciplining of bodies to conform to those unrealistic ideals. The beauty standards that women are expected to adhere to today, like wearing make-up, maintaining a certain body type and “looking the part” in a workplace setting for instance, have a historical relevance and have been influenced by changing representations in the media, visual art as well as recently, technological developments. Our perception of beauty has undergone several modifications throughout history with shifting societal ideas of what a woman's body should look like. Art has played a crucial role in shaping this perception and in the standardization of beauty types. For instance, in the West, corset/tight lacing became a popular practice during the Renaissance until the 20th century, which women wore to accentuate a certain body type - plump and curvy - after it was depicted by the 17th century painter Peter Paul Rubens in his artworks.

From prehistory to contemporary times, gender has shaped women's artistic representation and the expression of 'feminine beauty'. Not only has there been an erasure of women's contribution to art history, they have also been represented primarily through the male gaze and through traditional, patriarchial conceptions of femininity symbolised by fertility. Neoclassical art in the 18th and 19th century, for instance, depicted women in an idealized and sensualized form (especially female nudes), sometimes manipulating her figure to accentuate her 'aesthetic beauty'.

Historically, there have also existed gender-specific practices that have been harmful to women. For instance, foot-binding in China, which re-shaped the feet of millions of women, or the practice of wearing neck rings among the women of the Kayan Lahwi tribe. There are several factors that have played a role in the persistence of such practices. For instance, marriage prospects, women's labour values, and social and economic incentives had a role in making women adhere to the practice of foot-binding in China (Fan, & Wu, 2016). We know that the process of choosing a mate in females in other species is quite straightforward, depending on different traits such as "good genes", "best foraging abilities", "pheromone cues" (Low, 2015). However, in human societies, women don't exercise the same degree of autonomy in choosing their partner.

Gender bias in language

The language we use for everyday communication also plays a crucial role in perpetuating gender bias and discrimination. It can reinforce imbalances in power and privilege in our society through "grammatical and syntactical rules" that give preference to the masculine terms over the feminine (Menegatti & Rubini, 2017). For instance, the pronoun 'he' is often used to refer to both men and women, or 'mankind' to all human beings etc. but not the other way round. Bias is also seen in the ordering of words or pronouns with the masculine pronoun always appearing first - ‘men and women’ or ‘his and her’. Even when we refer to objects in many languages, they are gendered and people tend to attribute ‘masculine’ and ‘feminine’ qualities to these objects. Words like “leader”, “head” or “chief” are automatically assumed to be masculine terms.

In the 1960s during the civil rights movement in the US, questions began to be raised about the way people from different social groups were represented linguistically. For instance, derogatory terms in English such as ‘bitch’ for women and ‘boy’ to address a man of colour

began to be associated with particular groups (Luck, 2020). The bias in language and the representation of men and women belonging to different communities began to take centre stage. We will find this bias in representation evident in many Indian languages and the use of sexist and casteist slurs directed at marginalised communities.

Gender bias is also evident in humour, where one might crack jokes that stereotype and ridicule others by using humour that is sexist, transphobic or homophobic in a way that justifies prejudicial attitudes against those individuals. For instance, sexist humour that may also be sexually coloured is often shared in workplaces by cis men and is a part of a culture of sexual harassment which women are made to tolerate.

Bias towards queer communities

Regardless of geographic location, all queer communities have consistently and persistently experienced bias. In India, even as hijra communities are noted to have co-existed with mainstream society for centuries, it has hardly been one of social integration. Other than specific ritualistic spaces made for hijras, there has been bias towards the community in education, employment, inheritance, family and religion. Same goes for other marginalized identities as well.

Bias that we experience is not necessarily a factor of ignorance or an active act of malfeasance alone. Rather, biases emerge from how societies interact around power and privilege. Bias dont exist in a vacuum, outside the structures of how certain aspects of our diversity are seen as more preferred than others.

Gayle Rubin in her 1984 work, “Thinking sex: Notes for a radical theory of the politics of sexuality” talks about a ‘charmed circle’ in which certain types of sex are privileged over others, creating a sex hierarchy. The types of sex that are within the circle and are privileged and seen as “good” or “natural” include heterosexual, procreative (with the intention to reproduce), married, monogamous etc. The types of sex seen as “bad” and “unnatural” include ‘homosexual’, non-procreative, unmarried, non-monogamous etc. People on the margins of this charmed circle are almost always deprived of power and privilege in society, and often legally and systematically.



An illustration of this concept as seen here, helps to show how a young, cis-gendered, fit, fair, rich, able-bodied, English-speaking, upper-class or, in the Indian context, upper-caste and Hindi-speaking, heterosexual man might enjoy a lot more power and privilege in society, and be able to exercise rights guaranteed by law.

On the other hand, a transgender, dark, poor, disabled, vernacular speaking, Dalit/ Bahujan, non-Hindu or queer female-identifying person might not only struggle, but have their rights actively curtailed. In the Indian context, a western-educated, able-bodied, cisgender gay man would very likely enjoy greater power and privilege, than say, a jogappa in interior North Karnataka, or an aravani in Tuticorin, Tamil Nadu, who would also experience biases based on their region, language, caste, class and other aspects.

Law and Gender Bias

Article 15 of the Constitution of India prohibits the State from discriminating against Indian citizens on the grounds only of religion, race, caste, sex, or place of birth or any of them. Several decisions of the courts have helped evolve the jurisprudence on Article 15 and have furthered an understanding of gender-based discrimination. It has strengthened women's rights across areas such as employment, property, marriage, reproductive choice, equal access to public spaces (such as temples as was seen in the *Sabarimala* case[34]).

Courts have examined how legal frameworks perceive women's bodies and personhood. In *Joseph Shine v. Union of India,*[35] the Supreme Court struck down Sections 497 [removed in BNS] and Section 84, BNS/498, IPC, which criminalised adultery for men. It observed that such a provision views women only as victims with no agency in matters of infidelity.

In *Navtej Singh Johar v. Union of India,*[36] the Supreme Court held that Section 377, IPC violated Article 15 of the Constitution, among others, on the ground that it discriminated against individuals on the basis of sexual orientation and sexual identity. The Court also observed that "discrimination on the ground of sex under Article 15 and 16, includes discrimination on the ground of gender identity".

Article 15(3) empowers the State to enact laws that provide "special provision for women and children." This has been the basis for various legislations that acknowledge and provide redressal specifically to women such as the Protection of Women from Domestic Violence Act, 2005 and the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 ('POSH Act'). The POSH Act recognises the inherent power dynamic that exists between men and women at workspaces and how they function differently for different gendered groups.

While a significant body of work has been developed through judgments on gender bias in different settings, legal scholars argue that a less restrictive view of Article 15 and the term 'only of' could lead to the development of a more intersectional discrimination jurisprudence (Bhatia, 2015a; Bhatia, 2015b).

Reflection:

- *How do you feel about your gender? How can you think about it in ways that make you feel better and empowered, and at the same time make space for the same feeling for people of different genders?*
- *How can you bring about greater gender equity in your interactions with people?*
- *What makes you feel optimistic about sexuality and gender when you think about it from a wider, social perspective?*

Practitioner's perspective:

[34] [2018] 9 SCR 561.
[35] (2018) 2 SCC 189.
[36] AIR 2018 SC 4321.

Watch Enfold's video series on
Demystifying Sexuality - Gender Bias - how it began and how it could end (link will be inserted)

Demystifying Sexuality -How Toxic Masculinity And Femininity Invade Our Lives - And What We Can Do About It? (link will be inserted)

Way forward

If we are to unlearn gender biases that we have internalised, we can make a conscious effort to question some of our actions or words that may be objectifying, dehumanizing or stereotyping others, or encouraging cycles of harm and violence against marginalised identities, thereby reinforcing societal norms and roles based on gender.

We must question the bias against boys and men as well that puts pressure on them to dismiss a large part of their emotions, enforces the role of 'protector' and 'provider' for the entire family and humiliates those who don't conform. Similarly, the negation and invisibilization of people who do not fit into the gender binary system needs to be actively replaced with acknowledgement, appreciation and affirmation of each person as an equal human being.

Gender inclusive parenting and interactions

We have seen how the seeds of gender bias are sown right from birth itself - by what the child experiences - through the actions and verbal and non-verbal communication of others and as the child grows, how the systems set up by society over generations impact them. However, no society, no system, no person is static and set in an iron cast mould. We know that each of these changes. Recorded history of civilizations is proof of this, as is our own experience. We see our policies change, our laws get amended or new ones are made, traditional customs change in how they are practiced - and some are discarded, and each person's beliefs, behaviour and attitude also change as they become aware, gather new information, and have fresh experiences. Different cultures interact with each other and learn and affect each other as well. Electronic media is creating space for this exchange and its effect at a speed like never experienced before in human history. Each individual - especially from adolescence onwards begins to question, challenge existing beliefs and explore new ones.

A shift in the way people and systems relate to and respond to the gender of a person is happening as we speak - and we could be active agents in this process - create positive, respectful experiences for each other, irrespective of one's gender. This does not mean negating gender, or enforcing some gender neutrality or uniformity - rather the opposite - acknowledging, accepting, respecting each form of gender experience and expression - and not discriminating or being biased towards any particular gender. It's about acknowledging, respecting and possibly celebrating diversity - which is the norm in nature, as well as a part of us. This would be in tune with the practice of universal human rights as well.

Enfold believes we can practice gender inclusive, gender equitable interactions individually, in our sphere of influence. We can also work collectively to create safe spaces for all genders. We could keep the following in mind, and give children and the adults we interact with an experience of the same.

4. I can be aware of how I feel about myself and my gender - what label, if any, I want for myself, and how others' actions affect my conception and feeling about my gender, and people of other gender identities.
5. Different beliefs and expectations can influence how I feel and my self-esteem - I can examine these, challenge beliefs that bring down my self-worth and adopt ones that I find empowering without impinging on the rights of others.
6. Human qualities, intelligence, skills are not limited to people of particular genders. I can identify what makes me feel good about myself to build my self-esteem - whatever be the gender I feel or the label I carry. While doing this, I can be mindful of and respect the rights of others.
7. All people, irrespective of their gender, are worthy. I can build awareness about gender and gender identities and encourage respect towards people of all genders.
8. Respect is not constant or given - it is dynamic and can be lost by behaviours that infringe on the rights of others. While all of us deserve respect, it has to be maintained through our actions and words. It is not 'obtained' by virtue of one's class, caste, gender etc.

In my interactions with children and adults, I could create space for:

1. them to respect their body and use respectful words to refer to their body and body parts. Invite them to be mindful and develop an independent positive regard for oneself and one's body
2. discussion on gender - its experience and expression. How it is a human right to be free to express oneself - as long as it does not impinge on another person's rights. How to be mindful and respectful of all forms of these expressions.
3. considering each other as complete human beings - and not limit each other by imposing different codes of behaviour, activities, jobs etc. for different genders.
4. diversity and differences, and use that to create opportunities for each other to express themselves, and not biases. Our bodies are all very different. That does not determine or limit what we can do and achieve - except biological functions. People of all genders deserve equal opportunities to live, learn and develop.

Chapter 6: Self-Esteem and Body Image - their influence on sexuality and well-being

Self-Esteemand body image are factors that influence how we express our sexuality and gender, how confident we feel in asserting our sexual and reproductive rights and whether we speak out and demand justice in the face of sexual or gender based violence. Sexual or gender based violence could negatively impact one's self esteem - and often one would need to actively work on rebuilding one's sense of self worth. In this chapter we explore factors that influence our self esteem and body image and how we could strengthen our sense of self and a positive body image.

Self-Esteem

The concept of self-esteem is a person's overall sense of their value or worth and how it impacts their confidence, their perceived sense of agency in a situation and their ability to take care of themselves. It can be understood as a measure of how much a person "values, approves of, appreciates, prizes, or likes him or herself" (Blascovich & Tomaka, 1991).

A person's self-esteem is impacted by many factors - mostly related to the standards set by society or a community and the need to meet those standards. Very often, people experience self-doubt, feel inadequate and incapable and struggle with notions of not being good enough and this impacts their ability to grow, to take care of themselves and to protect themselves from harm or unwanted advances. In this chapter, we will look at the dynamics of how self-esteem can be built to help people feel agency in their lives

Self-esteem, though, is not fixed, nor based solely on one aspect of our identity. It can be understood as the sum of our judgements on specific domains of our lives. Domain-specific self-esteem (judgements about our academic ability, physical appearance, closeness to peers, etc.) help form a global self-esteem, which is generally conceptualized as the individual's general attitude towards or evaluation of the self, and it reflects people's beliefs about how worthy they are as persons and if they merit respect (Blascovich & Tomaka, 1991).

Influences on self-esteem

How an individual perceives themselves may change as they age. Studies indicate that our self-esteem varies as we grow, with a drop in our self-evaluations especially during adolescence. It also changes depending on how we 'match up' to what we see and compare ourselves to. Cultural factors have a significant impact on our self-esteem. For example, while some cultures lay great importance in family ties, maintaining traditional cultural practices and obedience, other cultures value individual achievement and freedom, creativity and exploration. Depending on where one spends one's formative years, whether one perceives themselves as matching these expectations and benchmarks can impact one's self-esteem.

Children and adolescents whose parents are warm, accepting and hold reasonable expectations as well as engage in positive problem solving with the child, feel especially good about themselves. Warm, positive parenting lets young people know that they are valuable and

worthy. Firm but realistic expectations backed with explanations help them make sensible choices and evaluate themselves against achievable standards.

On the other hand, if a parent is too controlling, it may communicate to the child that they are not capable of making their own decisions or performing tasks independently. Constant insulting and disapproving is also linked to low self-esteem (Goldman & Kernis, 2002). Such children tend to seek reassurances and external validation relying heavily on peers to affirm their self-worth, which makes them vulnerable to adjustment difficulties, aggression, antisocial behaviours and delinquency (criminal behavior) (Donnellan et al., 2005).

In contrast, overly indulgent and tolerant parents are linked to unrealistically high self-esteem in children, which also undermines their development. Indulgent parenting style may lead to children having an inflated sense of superiority with obsessive worry about what others think of them. This may result in children growing up anxious, underconfident etc. As a result, they are vulnerable to sharp drops in self-esteem when the overblown self-images are challenged (Berk, 2012).

Impact of Self-esteem:

Low self esteem

Individuals with low self-esteem tend to be more cautious, conservative, restrained, and modest (Josephs et al., 1992, p. 31). According to Morris Rosenberg and Timothy J. Owens (2001), people with low self-esteem are hypersensitive with a fragile sense of self which is easily wounded by others. They are hyper alert to any signs of rejection and sense of inadequacy. Often, they tend to perceive rejection and disapproval even when it's not intended. It is thought that negative experiences are particularly aversive for individuals with low self-esteem because of the uncertainty that typically surrounds their self-concepts (Campbell et al., 1996) and their tendency to make internal attributions for negative outcomes (Tennen et al., 1987).

Some may mask their low self-esteem by putting on a brave face but at the same time be terrified of failure and of getting 'found out' - referred to as the imposter syndrome. They may work too hard to cover up a personal sense of inadequacy, procrastinate to avoid facing reality and not acknowledge that they need help. Those struggling with low self-esteem may also present as people-pleasers, giving in to other's demands and foregoing one's own thoughts and beliefs, thus, also becoming vulnerable to abuse and exploitation. Low self-esteem also presents itself as feeling helpless and using self-pity as a shield against taking responsibility.

People with low self-esteem may have opinions about their bodies and their sexuality, that suggest that they are not okay, that they are less than desirable, that their needs and preferences are not important or that their sexual identities are not 'normal' or 'natural'.

High self-esteem

People with high self-esteem tend to focus on growth, be creative, realistic and focus on problem solving. They are reflective and take responsibility for both their failures and successes. They are assertive and have a better locus of control leading them to feel competent to deal with life's circumstances. They can also be good team members and can think expansively. As Morris Rosenberg (1965) put it, individuals with high self-esteem are content to be on an equal plane with others. They rarely try to bolster their feelings of worth by discounting others, pleasing them or disregarding them because their feelings of self-worth are not easily challenged.

People with high self-esteem are confident about themselves, are usually comfortable in their skin, are accepting and respectful of their bodies and their sexuality. They rely less on the opinions of others to feel okay or good about themselves. They acknowledge their feelings about themselves, their needs and preferences and work on ways to meet those needs in respectful ways that keep their own and others' rights in mind.

Attaining a healthier self-esteem

Adequate self-esteem is central to an individual's mental health and adaptive functioning (Chan & Lee, 1993). Self-esteem can be thought of as a buffer and often is associated with coping mechanisms we learn and use to manage or defend ourselves against the ups and downs of life. An individual with a stable and positive self-esteem is one who is open to both positive and negative experiences, working through difficult emotions and is able to be creative and present in the moment. The integrated, healthy self is when one is able to experience non-defensively all thoughts and feelings in its organism, a way of being that Rogers has termed 'congruence' (Kahn & Rachman, 2000).

Given that we live in a world that is mostly caring, holding, all embracing, and at the same time can also be prejudiced, biased and exclusionary, it is helpful to see ourselves in this backdrop and recognize that it may not be us but the world that needs changing. And since we are also the ones who make up this world, there may be many areas of our behaviour and ways of thinking that could be worked upon - but still, in the present moment, just as we are, we are all deserving of love, value, respect and dignity.

Self-esteem, self-confidence, self-respect, self-worth are ultimately an inner sense about oneself. How we perceive what others say about us has a huge impact on what we come to believe about ourselves. However, there are some aspects of us that are inherent. No matter what the nature of their social and personal circumstances, infants are born with an innate sense of self-worth that is bolstered or impeded by the care they receive, and the importance they are made to feel. We also know that we are born with neuronal structures that have the potential to develop different qualities (like kindness, fairness empathy, courage, aggression, self-centeredness, selflessness etc.) and multiple intelligences (as described by Howard Gardner (2000), these include linguistic, logical-mathematical, bodily kinesthetics, interpersonal, intrapersonal, naturalistic, spiritual/existential intelligences) that are important survival mechanisms.

The capacity to be empathetic is embedded in our neural network (Fan et al., 2011). Empathetic in this context does not mean a mindful empathy/quality like we usually talk of – it means the firing of mirror neurons that make us feel what the other feels. It is inborn, because if the neurons don't fire, we won't feel, we won't act. The sense of music - a sense of rhythm - consonance and tone appears to be active as early as 1-3 days of age! Research using fMRI found that the neural architecture underlying music processing in new-borns is sensitive to changes in tonal key as well as to differences in consonance and dissonance (Perani et al., 2010). Similarly, the capacity to distinguish various units of different intelligences - be it quantity, phonemes, or distance - is inbuilt in our brain as these help in our survival as individuals and as group members.

One becomes aware that they struggle with self-esteem issues when they have experiences that make them doubt themselves and their abilities, and prevent them from actively pursuing their goals. They may feel inadequate when with family, friends and colleagues and feel like they have no agency to think, feel or act independently.

Reflection:

1. How people see you:

- *List 3 things which you heard about yourself as a child from the adults around you.*
- *List 3 things different people say about you now - your parents/grandparents, your siblings/cousins, your friends, your coach etc.*
- *Do you think these are accurate descriptions of you? Which ones do you agree with and why?*

2. How you see yourself:

- *List three things about yourself according to you. How different are these from the ones listed in 1.a and 1.b?*
- *Which beliefs about yourself make you feel good? How did these form?*
- *Which beliefs about yourself make you feel bad? How did these form? Are these still true? How can these be worked on so they feel more empowering?*

NOTE: It may be challenging to be objective and this experience may precipitate feelings of inadequacy in you. You may choose to seek assistance from others in building, sustaining or regaining your self-worth and self-esteem. It is important to note here that a low sense of self-esteem develops in the context of a punitively demanding society that holds one up to certain standards that are normalized (intelligence levels, body shape and size, oratory skills etc) that tend to discount those who do not meet these criteria or exclude those with certain identities (based on caste, disability, gender).

Given this, it is still possible to acknowledge these dimensions, learn to set aside unhelpful messages and develop a healthy sense of oneself. Some ways to do it are to

- Identify negative thought patterns and reflect on whether they are from the present or carried over from past experiences. E.g., I will mess up this presentation so I shouldn't do it – is it something one told oneself after a particularly awkward situation in the long gone past? Or is it a reaction to something that happened recently?
- Identify if this is a pattern of thinking that is activated automatically, or is it a logical

conclusion from a consideration of realities? E.g., Of the latter – I am in an emotionally stressed situation and might be distracted while presenting. So, I should let someone else do this

- Give yourself permission to try and fail – as a learning experience
- Give equal attention to positive and negative strokes that one receives – appreciation as well as critiques – and not get hooked to just the latter
- Be congruent in thoughts/ beliefs and action, and to experience conviction and pride in taking that position
- Actively seek opportunities and experiences where one's strengths are brought to play and to experience the confidence/ satisfaction/ joy of that moment and the appreciation received for it
- Avoid unhealthy comparison with others whose circumstances, values, ambitions and drivers may be very different than one's own. To develop, grow and achieve a specific goal, compare self with one's own previous performance or how one behaved in a similar situation in the past or with qualities/ capabilities of others that one respects. Consider the current reality and chart plans on what next goals to aim for.
- Be mindful and reject inputs/ suggestions/ advice/ instructions that may be detrimental to one's sense of okay-ness about oneself. E.g., When you feel strongly about pursuing an opportunity and a close friend tells you that it is going to be too hard/ impossible for you to achieve it. Rejecting this perspective is possible when one considers the reality of the situation, one is aware of own motivations and strengths that are aligned to the opportunity and when one recognizes the friend's advice as a product of possibly their reality and not one's own.
- Avoid situations and experiences that are consistently negative and uninspiring or demotivating.

- A lot of times, one may be in a socio-cultural context that is structurally disempowering for those who do not conform, and are 'different'. In such situations it is the society and its structures as players that need change. Such structures impact a person's sense of self and often impede the development of an empowering sense of one's identity, through no fault of the individual.

- **Activities** like the worksheets on multiple intelligences, qualities and values given in the annexure could support a person in becoming aware of these aspects of themselves. This could bolster one's sense of self-worth.

Self-compassion

Some of us may have a tendency to be kind and compassionate to others, but harsh and uncaring towards ourselves. We might find ourselves saying things like, "Why can't I be like other people?" or "I should be quiet. Every time I talk, I make a fool of myself." The inner critic develops over years of being put down for our perceived inadequacies, receiving scarce appreciation for who we are, being told that having pride in oneself is not right and so on from our parental figures. In summary, the inner critic develops from having experienced a lack of compassion which we then internalize and act out for ourselves. In order to stop the inner critic, one could practice self-compassion. Self-compassion is a way of understanding and relating to the self when considering personal inadequacies or difficult life circumstances. This thinking process can be developed into a practice, when we notice ourselves getting into a spiral of

self-blame, guilt, shame and self-criticism.

One way to do this would be to write negative and self-defeating statements on one side of a paper, and realistic and more gentle statements on the other. For example, in place of writing "I am stupid," one can write, "I may struggle at times, but I am smart and competent in many ways." According to Dr. Kristen Neff, self-compassion is not based on any evaluation or judgement of ourselves; rather it is a steady attitude of kindness towards the self. Self-kindness can create a non-judgemental acceptance of present experiences (Bishop et al., 2006, p. 238). Research states that treating ourselves with compassion and kindness acts as a buffer against anxiety and leads to better psychological well-being and emotional maturity. Self-compassion can be followed using the following three steps:

1. Acknowledging and noticing our suffering
2. Being kind and caring in response to suffering
3. Understanding that imperfection is a part of human experience and nothing to be ashamed of.

Learning to be compassionate towards ourselves takes time and patience. By setting the intention to be kind towards ourselves, we may, in small ways, shape our mind over time to begin noticing our self-worth.

Social connectedness

In situations where a significant aspect of our identity is negated, an increased risk of negative outcomes and maladaptive behaviours can occur. For instance, members of sexual and gender minority groups experience chronic stress resulting in part from prejudicial encounters, which in turn contribute to a higher prevalence of mental health and behavioural issues (Meyer, 2003). In such a scenario, the source of strength can be people's connection with other individuals who are also stigmatized for the same characteristic. Individuals having closer and deeper social relationships tend to have high self-esteem. The kind of people one surrounds oneself with tends to have a major impact on their self-esteem. Individuals practicing compassion towards themselves regularly have reported developing deeper and more meaningful relationships.

Working on low self-esteem would require working on one's self-awareness as well as restructuring the environment. It would also require practicing self-nurturance and investing in one's strengths and weaknesses as well as getting help from others.

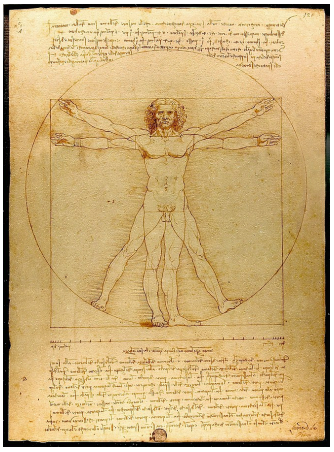
The Law and emotional harassment of children in schools:

Section 17, Right of Children to Free and Compulsory Education Act, 2009 prohibits physical punishment and mental harassment to a child and it attracts disciplinary action under the service rules applicable to the person. The United Nations Convention on the Rights of the Child, 1989 (UNCRC), which India acceded to in 1992,[37] also provides protection of children from all forms of physical or mental violence and maltreatment under Articles 19, 28(2) and 37.

[37] National Human Rights Commission, 'The United Nations Convention on the Rights of the Child (UNCRC) & Indian Legislations, Judgements & Schemes' (2019) 9, <https://nhrc.nic.in/sites/default/files/UNCRC_2020.pdf>.

Body Image

Body image is defined as attitudes, feelings and perceptions about one's physical appearance. These perceptions are shaped by the social and cultural norms of a society. What is perceived as beauty can impact one's body image. The Merriam Webster dictionary defines beauty as "the quality or group of qualities in a person or thing that gives pleasure to the senses or the mind" Besides social norms, the perception of beauty is also linked to our inherent sense of symmetry as symmetry and the proportion of body parts are one of the markers of health. Because of this, one feels attracted to symmetrical and proportionate bodies and faces and calls them 'beautiful'. Most people don't have extremely symmetrical or proportionate bodies, but are healthy. Each person looks, thinks and behaves differently. One can focus on one's values, behaviour and skills and appreciate the same in others, rather than focussing on how the body looks.



The *Vitruvian Man*, by Leonardo da Vinci
(Source: Wikipedia)

Body image issues evolve with changing economic and social circumstances, which include migrations, economic liberalization, colonisation and globalisation. Different factors such as cultural and religious values, access to media, whether urban or rural communities, family values, teachers/ caregivers - influence the formation of one's body image among adolescents and adults (NB Research Ltd, 2013). Body dissatisfaction has been a rising concern in India and has been examined by researchers all across the country. In samples across various backgrounds, 40-78% adolescents in India report body dissatisfaction (Ganesan S et al., 2018; Suresh AG et al., 2018).

Body dissatisfaction is even more heightened amongst vulnerable populations and minority groups such as people with disabilities and people from the LGBTQIA+ communities.

Body image impacts how we experience our sexuality and how comfortable we feel in expressing it

Why are body image concerns important to address?

Body image dissatisfaction leads individuals to adopt behaviours that may be harmful. Dieting, skipping meals, using laxatives for weight control etc. are examples of unhealthy weight control behaviours one may adopt when dissatisfied with their weight or body size. When practiced in extremes, these behaviours cause harm to the individuals' physical and mental health. Research studies in India have reported girls are more likely to engage in behaviours such as skipping meals and using fairness products than boys (Stigler et al., 2011). Appearance related concerns are also closely related to self-esteem. With low self-esteem, individuals may find it challenging to participate confidently in society or meet the demands of their personal relationships.

The American Psychological Association (2008) examined the presence and impact of sexualising girls through the media and other cultural messages. They highlighted several instances of sexualising of females in popular culture such as music videos, dressing of dolls in sexualised clothing such as fishnet stocking, or broadcasting of fashion shows in which women dressed in lingerie are graded. APA reported such sexualising of the female body affects the mental and physical health of women, and has cognitive and emotional consequences. For example, researchers found that comparing one's own body to the cultural ideals leads to shame, anxiety and self-disgust among women.

Body image and mental health

Body image has been correlated to self-esteem, depression and disordered eating behaviours. In Khammam, South India, researchers examined the relationship between psychological distress, social anxiety and body shape concerns (Kornapalli et al., 2017). They found a positive correlation between body shape concerns, social anxiety and psychological distress among undergraduates (Dixit & Luqman, 2018). Another researcher found that appearance shaped body image concerns in Indian women much like in women globally. The Dove Girls and Body Confidence report. 2017, (5,165 girls, 10-17 years) found that most girls in India have medium body esteem which was calculated on the basis of a face-to-face questionnaire. The study also found girls with medium and high self-esteem were resilient to beauty pressures and did not succumb to the pressure to meet beauty standards. Thus, building self-esteem can help cultivate resistance to pressures of society to conform to body size standards.

Body fitness and health related goals such as losing excessive weight and building muscle encourages one to diet or moderate eating habits from a young age. Disordered eating patterns among adolescents, spurred by the aspiration to meet prevailing beauty standards, can predispose them to developing eating disorders. In fact, the prevalence of eating disorders such as bulimia nervosa, binge eating disorder and anorexia nervosa have increased in India in the past decade. In a study, 45 of 66 psychiatrists in Bangalore had seen patients with dietary concerns and had made a total of 72 diagnoses pointing to eating disorders (Chandra et al., 2011).

Queer identities and body image dissatisfaction

Due to non-conformance to gender expression norms or not identifying with the norms of body expression, the queer community faces increasing body image concerns. Mannerisms, dressing styles or body expression - such as colourful clothes for men or short hair for women etc.- that are outside the gender norms, often lead to bullying. Surveys have shown that body image dissatisfaction causing shame affects almost 40% of LGBTQIA+ adults in the US (Tabaac et al., 2017). Half of them feel that their body image has affected their self-esteem. Furthermore, feeling at unease with your own body is an overwhelming experience for trans people and body dysphoria is a lived experience for them. Transitioning, for those who choose to, can lead to alleviation of experienced discomfort that may be stronger or weaker at different time periods. Subcultures of the queer community show preferences for certain body types including features such as body hair, body build, lean or muscular, mannerisms etc. Fitting into these categories also creates pressures and fetishizes gays and lesbians. Examples of these categories are twinks, bears and otters for gays, and femmes, butch for lesbians.

Within the queer community drag culture has become a powerful source of disrupting existing norms of gender expression. Drag as a performance originated both within specific queer communities and African-American communities - drag queens were typically gay men, and drag kings were typically lesbian women. Over the last few years this has changed and more individuals from across the sexuality and gender spectrum are now known for their drag performances.

Drag creates a space to alleviate body image concerns, assert self-love and expression. Drag shows provide a space that fosters body positivity and a platform to express their sexuality, for example, many drag queens are males performing their feminine side using dresses, make-up and other forms of gender expression.

Body image standards - trends and determinants

Societal expectations stemming from the existing norms of patriarchy and the myth of body perfection suggest that bodies should look a certain way to be thought of as desirable. These are binary standards, only considering bodies as being male or female and anybody that does not meet these standards as being less than worthy. It is important to note how none of these societal expectations have remained the same and how much they have evolved since ancient times. Since the presence of Aryans (as far back as 1500 BCE) in India, the colour of the skin has signified caste divisions. A lighter skin tone was associated with high skill labour of the upper castes, while dark skin was associated with manual labour performed by the lower castes (Devakishen, 2019). Colonial rule involved cultural, social and economic imposition of the coloniser's culture on the colony. Perpetuating racial division, those belonging to upper castes were employed by the British in positions of power.

While heavy, curvy bodies were valued in ancient times as signs of prosperity and well-being of the community, Britishers with white skin, blue eyes and petite bodies came to represent power and authority which led to the idealisation of their bodies among the native population of the colony including India (Regmi, 2020). With economic power consolidated in them, the colonists deepened the racial and cultural divides among the populations. For example, Bharatanatyam, a dance form practiced by devadasis (a woman considered given in marriage to God) in temples and courts was not considered a respectable expression of body and art. However, when upper

caste artists removed many body postures that involved waist movement and others that were considered vulgar, and revised the art, it became a popular and prevalent art form.

Another qualitative study examined how standards of beauty have changed due to globalisation (Phadke, 2017). One of the impacts of western influence in India was the acceptance of western ideals of beauty and valuing thin bodies, fair complexions, and western clothing. However, this change in cultural and societal opinions increased the pursuit of an ideal body type that is not suitable for the Indian bodies. In fact, a qualitative study reported that the fear of not fitting into western clothes available at commercial malls causes body anxiety in women (Dhillon & Dhawan, 2011). Western brands often manufacture clothes in limited sizes that are often smaller than typical local body sizes. This exclusivity suggests that those with bodies that do not fit into their catalogues need to be altered in order to be acceptable. "Tall, muscular, and lean" are adjectives commonly used to describe an ideal male body type (Chander, 2018). Sources such as superhero movies, content from gyms, sports brands seeking to sell their "fitness" products on social media platforms reinforce pursuit of this perceived ideal.

Body image concerns often come to the forefront when one is appearing for a job interview or searching for romantic or marital partners. The myth of having a fair skin and thin body to fit into these roles discounts the individuals' qualities, self-worth, capabilities, and lowers their self-esteem. Unilever introduced "Fair and Lovely", a skin fairness product in the Indian markets in 1975. The advertisements for this product depicted primarily women who were unable to find success while seeking jobs or marriage until they started using the cream and became fairer versions of themselves in just one and a half months. Recently, the company faced a lot of media opposition and pressure against the racist and Eurocentric notion that white skin is the standard for beauty. Following the outrage, the brand changed the names of its products to, "Glow and Lovely" and "Glow and Handsome" for women and men respectively. This is reflective of the power media and the community holds in changing perceptions of the ideal of beauty and holding others accountable.

People belonging to the LGBTQIA+ community may face further marginalisation for not conforming to traditional gender norms when appearing for job interviews. Their appearance and gender expression is conflated with the requirements of the job and it is often concluded that they might not 'fit in', or be able to do the job well, and might attract unwanted attention or be a distraction to other team members.

A meta-analysis reviewed different interventions for body image delivered to international university students (Yager & O'Dea, 2008). One of the major biases with the interventions was that they targeted females and only one of the 27 delivered the intervention to males as well. Additionally, none of the interventions specifically targeted the LGBTQIA+ community. In fact, surveys have shown that 40% of adults 'who identified as gay, lesbian, bisexual or other' experienced shame due to body image dissatisfaction as opposed to 18% heterosexual adults (Mental Health Foundation, 2019). Research has also revealed gay and bisexual boys used dieting pills, fasting, vomiting, and laxative use to control their weight (National Eating Disorders Association, 2018).

Peers, family and region

The social environment plays a crucial role in the development of one's body image. This environment consists of our peers, educational institutions, parents, society and the region we grow up in. These influencers play a crucial role in moulding our body image in both positive and negative ways. For example, schools impose rigid rules about dressing, appearance and acceptable expressions of behaviour. By restricting and reprimanding different uniform types and lengths, hair growth, expressions of culture etc., schools glorify certain cultural traits while dismissing local cultural practices, standards of beauty and appearance. Policing of students' bodies leads to an increase in negative perception of them. Furthermore, bullying, name-calling, and comparisons made with peers when not pursuing the standardised body types leads to increase in body image concerns. Additionally, educational institutions often reinforce gender stereotypes through dressing styles, extracurricular activities including sports and art, and subjects of study.

Parents and the community one lives in, are a part of the social environment that influences the development of one's body image. A qualitative study interviewed ten adolescent girls from New Delhi and inferred that parents play a dual role in body image perception (Dhillon & Dhawan, 2011). On the one hand, they encourage children to be active and make them feel loved, which helps promote positive body image. On the other, to ensure socio-economic benefits when their children appear for jobs or marriage prospects, parents add pressure to conform to perceived ideal body type thus increasing body dissatisfaction in their children. Furthermore, research studies claim the education level of parents, specifically the primary caregiver, also affects body image concerns among adolescents (Sihag & Joshi, 2017).

Researchers have also made comparisons between students from rural communities and urban communities, and poor and well-off families (Dixit & Luqman, 2018). While the research has not examined why urban communities show larger percentages of body dissatisfaction, some suggest that it is due to easy access to media and digital resources that perpetuate the myth of a perfect body.

Body image and media

With technological developments, forms of media have been evolving drastically. Visual media including those that are live streamed, computer games and advertisements have enabled quick and vast dissemination of messages. The ease of communication has allowed us to consume media from across the globe and has led to widespread viewership of a variety of content by younger audiences. Messages received through such media have thus created an idea of homogenised ideal body types. Cosmetic surgery, weight loss regimes, fairness creams and other such products and medical interventions are offered to individuals who are in the pursuit of these 'ideal' beauty standards.

In recent years, social media platforms such as Instagram have also seen the emergence of body positive activism. BIPOC (Black, Indegenous and People of Color) people, the Korean cosmetics industry, plus-size models, dalit artists, members of the queer community and allies are creating spaces for individuals to acknowledge and appreciate the diversity and uniqueness of bodies which defy any kind of attempt to homogenize. There is an increasing presence of individuals of various shapes and sizes that use their own experiences and scientific literature to debunk myths inculcated through the media and society.

Consumers of media, however, do experience frustration, anxiety and develop negative attitudes towards their body when they are unable to achieve the perceived ideal body type. In Delhi, two researchers developed an intervention to improve media literacy among adolescents (Dhillon & Deepak, 2017). They discussed editing or duplicity of media images and the negative impacts of pursuing idealised body type in a 4-component module with the experimental group. They found that adolescents in the experimental group were more aware of the ills of the media and saw a mean difference in their body satisfaction levels post the intervention. This suggests that media literacy can help promote body positivity and break down myths of the perfect body.

A meta-analysis reviewed different interventions for body image concerns (Alleva et al., 2015). They found psycho-educational interventions that included media literacy were effective in reducing body image concerns. Psycho-education was useful in giving information about the key features of a healthy lifestyle rather than focussing on physical appearance. Furthermore, interventions based on reducing the cognitive dissonance related to their bodies helped reduce body image dissatisfaction. Identification and appreciation of individual differences, strengths (e.g., sense of humour, intelligence), and talents, and building skills that are necessary for healthy coping and development (e.g., interpersonal skills) were useful in building self-esteem and positive body image.

Reflection:

Here are some self-reflective exercises. Please do these only if you feel comfortable.

1. *What messages about your body did you receive as a child, adolescent and as an adult? Whose words had the biggest impact on how you feel about your body?*
2. *What would it be like to live in a world where people did not comment on how a person looks, and instead spoke about their behaviour?*
3. *Mirror activity- Hold a mirror to different parts of your body one by one and note how you feel about them. How many of these feelings are because of what people have said about your body and how much is your own internal sense? If you had lived on a deserted island, how many of these feelings would still arise? Would it still matter?*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - How does our self-esteem and body image affect our sexual self-esteem? (link will be inserted)

Way forward

Like any other skill, the more we practice self awareness and self compassion, the better we would become at it as our 'default' mode. There are many things about us that are admirable and worthy. We can take the effort to discover and hone them - for example our intelligences, capabilities, strengths and values we like to uphold. These help us adapt and respond to situations and also make each one of us unique. We can become aware of all our qualities and

learn to use them in ways that support us in reaching our goals - be it in relationships, academic or other areas - while keeping the rights and well-being of others in mind.

We can develop a realistic perspective on body image and develop an appreciation for one's body - the way it functions, heals and grows by itself. What we do with our capabilities is more valuable than how we look. We get different messages from others about our body. We can accept those that help us love and care for the body and reject those that don't. We can keep in mind that our bodies are all very different, and each one of us is worthy of respect, safety and dignity.

We can mindfully build the belief that one is good as one is, and develop an independent positive regard for oneself and one's body. We can accept all parts of ourselves and our lives; neither ignoring nor ruminating on them excessively. We can simply accept these and be kind to ourselves for it. We can choose to work on changing those ideals which do not help us grow or live a full life. We can remember that all of us fail, make mistakes, and feel inadequate in some way. It is human and natural. This makes us similar to others, and is also a space for connection with others.

We can remind ourselves that different beliefs and expectations and messages can influence how we feel, our self-esteem and body image - we can critically examine these, challenge beliefs that bring down one's self worth and adopt ones that one finds empowering without impinging on the rights of others. And last, but not the least, we can keep in mind that each one of us is worthy of love, just as we are.

Chapter 7 Attitude towards sexual health and issues with reproductive health
- discussing stigma, seeking support early

Myths, misconceptions, and shame create a deadly silence around sexual health and issues associated with the reproductive system. People of all ages and sexes hesitate to talk about the problems they are facing with their family, spouse or sexual partners and delay seeking professional advice, sometimes with extremely serious consequences on their health. Much violence is perpetrated on women as they are blamed for being infertile, or for having 'brought HIV into the house' or even male erectile dysfunction. In this chapter we discuss the facts around common reproductive health issues and their social implications with the aim of creating a better informed society that is proactive - at least about its reproductive health, if not sexual health!

Sexual health

According to the current working definition, sexual health is, "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006a).

The determinants of sexual health are multifactorial - social, cultural, economic, psychological and biological. Though sexual health is considered an important contributor to overall health and well-being, it has been largely ignored, both at the individual and public health level in our country. The silence in the Indian context on issues related to sexuality, compounded with the social stigma and discrimination and the lack of confidential, non-discriminatory and non-judgemental health care providers makes appropriate, affordable and accessible high quality sexual health care unfeasible (Rao et al., 2012).

Stigma and sexual health (Evans, 2001):

Sex, sexuality and sexual health are an integral part of an individual's life, and yet, the idea that sex for pleasure, or outside marriage or heteronormative norms is shameful, disgusting or sinful has been cultivated for centuries in our society. That people can also be asexual and have little to no desire for sexual interaction is also looked upon as 'abnormal'.

Healthcare providers, too, contribute in perpetuating this stigma and as they're also members of the same society that discriminates. Sexuality and sexual diversity are not a part of the undergraduate medical curriculum and it provides only that knowledge that support and reinforces heteronormative attitudes. Heterosexism and patriarchal notions are so prevalent that the terminologies and practices used assumes that everyone is heterosexual and provision of care is directed towards heterosexual (reproductive) needs only, rendering others invisible.

Sexual diversities are often pathologized as perversions. This leads to shaming the individual for their sexual identity and affects the care provided to them. Unless these stereotypical representations of sexual health within the medical community is challenged, the stigma around sexual health will persist. The basic right of an individual to the highest attainable standard of health (including sexual health) can be attained if the health care provider is provided with adequate knowledge and skills to challenge their own beliefs and values first.

In the section below we discuss attitudes towards reproductive health - which is a small component of sexual health - and some common issues associated with it. According to the World Health Organization (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."

Contraception

Contraception - meaning 'against' conception - is defined as the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures (Jain & Muralidhar, 2011). Though invented for this purpose, some barrier contraceptives, especially condoms, are also used for the specific purpose of preventing sexually transmitted infections or STIs. Effective contraception enables people to enjoy a physical relationship without fear of an unwanted pregnancy and freedom to have children when desired. An individual's choice of contraception includes factors such as safety, effectiveness, availability (including accessibility and affordability), and acceptability.

For attitude towards use of contraceptives, see **attitudes towards contraception and safer sex practices in the chapter on Attitudes towards Sexuality**

The various contraceptive methods listed below are to be adopted by a person after discussion of the advantages and disadvantages, indications and contraindications of each method with a healthcare provider. The failure rates of each contraceptive method discussed below is based on typical use and involves both method related and user related failure (Bradley et al., 2019).

Continuous abstinence:

This means not having sex at any time. It is the only sure way to prevent pregnancy and protect against sexually transmitted infections and infestations.

Natural family planning/rhythm method:

This method is when a woman does not have peno-vaginal sex on the days she is most fertile (most likely to become pregnant). In a 28-day cycle, the fertile period lasts from day 8 to almost day 21 – almost two weeks. They are unlikely to conceive for the first 7 days of the cycle the days that they are menstruating) and the last 7 days before menstruation begins. However, this method has a high failure rate of 19 pregnancies per 100 women in one year

Barrier methods:

Phallic condom (commonly called male condom, but using the word phallic makes it more gender-inclusive) is a thin sheath of latex or polyurethane placed over an erect penis. It can be used either to keep sperms from entering a female body or to avoid contracting STIs through other forms of sexual activities. In peno-vaginal sex, condoms work best when used with a vaginal spermicide, which kills the sperm. A new condom should be used for each sexual act. If used to prevent pregnancy, failure rate is about 8.6 pregnancies per 100 women in a year. Other barrier methods are (widely available in the West) vaginal condoms (commonly known as female condoms), diaphragm and contraceptive sponges which are placed in the vagina.

Hormonal methods:

Combined oral contraceptives pill or “the pill" contains the hormones estrogen and progestin. It is taken daily for 21 days in a month with 7 days off, during which time menstruation occurs. Next pack should be started on day 29 to keep the ovaries from releasing an egg. The pill also produces changes in the quality of the mucus produced by the cervix, and in the lining of the uterus, and, to make these inhospitable to the sperms and fertilized egg if any. Failure rate in typical use is 6.3 pregnancies per 100 women in a year.

Shot/injection:

A high dose of the hormone progestin is injected in the buttocks or arm every 3 months. A new type is injected under the skin. Due to the negative effect on bone density, it is advisable not to use these for more than 2 years at a time. Failure rate is 2 pregnancies per 100 women in a year.

Implantable devices:

This is a matchstick-sized, flexible rod that is put under the skin of the upper arm. The rod releases a progestin, which causes changes in the lining of the uterus and the cervical mucus to keep the sperm from joining an egg. Less often, it stops the ovaries from releasing eggs. It is effective for up to 3 years. Failure rate is 0.03 per 100 women in a year

Intrauterine devices:

4. **Copper IUD** —This T-shaped device is inserted into the uterus. It releases a small amount of copper continuously, which prevents the sperm from reaching and fertilizing the egg. If fertilization does occur, the IUD keeps the fertilized egg from implanting in the lining of the uterus. A doctor needs to put in the copper IUD. It can stay in the uterus for 5 to 10 years. Failure rate is 1.2 per 100 women in a year.
5. **Hormonal IUD** —This intrauterine device releases progestin into the uterus, which keeps the ovaries from releasing an egg and causes the cervical mucus to thicken, so that the sperm can't reach the egg. It also affects the ability of a fertilized egg to successfully implant in the uterus. A doctor needs to put in a hormonal IUD. It can stay in the uterus for up to 5 years. Failure rate is 0.2% per year.

Permanent birth control methods (Surgical sterilization):

- For women, surgical sterilization blocks the fallopian tubes by cutting, tying, sealing or scarring them. It stops the egg and sperm from meeting in the tube. It is a major surgery and requires hospitalization. Sometimes, a woman giving Caesarean birth has the procedure done at the same time so as to avoid having additional surgery later.

6. For men, having a vasectomy keeps sperms from reaching the penis so that the ejaculate never has any sperm in it. A small cut is made in the upper part of the scrotum and the vas deferens is cut. It is an outpatient procedure, quick and safe. Sperms stay in the remaining portion of the vas after surgery for about 3 months. During that time, a backup form of birth control should be used to prevent pregnancy. After three months semen analysis is done to check if all the sperms are gone. Failure rates are 0.5% for female sterilization and 0.15% for male sterilization.

Emergency contraception:

Emergency contraception can be taken as a single pill treatment or in two doses 12 hours apart. The pills contain a high dose of hormones. It works by stopping the ovaries from releasing an egg or keeping the sperm from joining with the egg or preventing implantation of the fertilized egg. The pill should be taken as soon as possible after unprotected sex, or within 72 hours after having unprotected sex. Failure rate is around 6-10%.

Common Sexual Health Issues

Sexually transmitted infections (STI):

STIs are spread predominantly by sexual contact, including vaginal, anal and oral sex. The most common STIs are syphilis, gonorrhoea, trichomoniasis, chlamydia, HIV, Hepatitis B, Herpes simplex virus (HSV) and Human papilloma virus (HPV). The first four are caused by bacteria and curable whereas the last four caused by viruses are treatable but not curable.

Common symptoms include abnormal vaginal discharge, urethral discharge, genital ulcers and pelvic pain. But most of the time a person can have an STI and have no symptoms at all. Hence it is important to get tested.

Who should get tested?

Center for Disease Control and prevention (CDC) suggests the following guidelines for STI testing:

- All adults and adolescents from ages 13 to 64 should be tested at least once for HIV.
- All sexually active women younger than 25 years should be tested for gonorrhoea and chlamydia every year. Women 25 years and older with risk factors such as new or multiple sex partners or a sex partner who has an STD should also be tested for gonorrhoea and chlamydia every year.
- All pregnant women should be tested for syphilis, HIV, and hepatitis B starting early in pregnancy. At-risk pregnant women should also be tested for chlamydia and gonorrhoea starting early in pregnancy. Testing should be repeated as needed to protect the health of mothers and their infants.

- All sexually active gay and bisexual men should be tested at least once a year for syphilis, chlamydia, and gonorrhoea. Those who have multiple or anonymous partners should be tested more frequently for STDs (i.e., at 3- to 6-month intervals).
- Sexually active gay and bisexual men may benefit from more frequent HIV testing (e.g., every 3 to 6 months).
- Anyone who has unsafe sex or shares injection drug equipment should get tested for HIV at least once a year.

In India, STI screening is done tailored to individual patients' needs based on symptomatic presentation.

Prevention (Sexually Transmitted Infections (STIs), 2019):
WHO states that counselling and behavioural interventions offer primary prevention against STIs (including HIV), as well as against unintended pregnancies. These include:

3. comprehensive sexuality education, STI and HIV pre- and post-test counselling;
4. safer sex/risk-reduction counselling, condom promotion- when used correctly and consistently condoms offer one of the most effective methods of preventing STIs.
5. STI prevention education and counselling tailored to the needs of adolescents.

Vaccines are available for two of the STIs - Hepatitis B and HPV. Hepatitis B vaccine is covered in the Universal immunization programme and given at birth followed by three doses at 6,10 and 14 weeks of age.

In India, HPV is given to all female children between the age of 10-12 years followed by a second dose in 6 months (Choudhury, 2009). However, vaccination can be administered to women up to 26 years of age. Ideally the vaccine has to be given before the female becomes sexually active. By preventing HPV infection, the vaccine offers protection against cervical cancer in women.

HIV and AIDS

HIV stands for Human Immunodeficiency Virus. It is a virus which attacks the human immune system. For many years, this virus can live in the body without the person becoming ill or showing any symptoms. During this time however, the virus remains in the body damaging the immune system and the person is infectious; is able to spread the infection to others if precautions are not followed.

Over a period of time, the HIV can damage the immune system to such an extent that various infections can start to occur. When this happens, it is called AIDS or Acquired Immune Deficiency Syndrome. The person’s immune system is unable to fight off infections and other diseases.

HIV is found in the genital fluids, blood, and breast milk. Infection will occur when body fluids from an infected person enter the body and reach the bloodstream of another person.
The most common methods of transmission of HIV are: unprotected sex with infected partner and sharing of needles with infected person.

HIV does **not** get transmitted by: coughing, hugging, sneezing, spitting, shaking hands, crying, sharing clothes or plates, spoons, vessels, sharing bathrooms or toilets or by mosquitoes.
In fact, with proper use of condoms, pre-exposure prophylaxis (Starting and Stopping PrEP, 2020), post exposure prophylaxis, HIV transmission can be brought down significantly. Pre exposure prophylaxis (PrEP) refers to use of antiretroviral medicines in high-risk individuals to prevent acquiring HIV infection. WHO recommends that people who are at high risk should be offered PrEP as an added choice, as a part of comprehensive prevention? In India, as of now it is available through private healthcare providers and non-governmental organisations working in the field of HIV prevention. With consistent and proper use of ART (antiretroviral therapy), medical supervision and proper nutrition a person can manage HIV infection efficiently.

Rights of Persons with HIV:

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 ('HIV and AIDS Act') aims to protect the human rights of HIV-positive persons in India. Under Section 2(s) of the Act, protected persons are defined as individuals who are HIV-positive and those who currently reside or have previously resided with HIV-positive individuals. Section 2(d) defines discrimination, and Section 3 explicitly prohibits such discrimination against protected persons. This includes unfair treatment in workplaces, hospitals, educational institutions, and other settings, as well as imposing restrictions on their freedom of movement or access to public or private spaces.
To safeguard the autonomy and privacy of HIV-positive individuals and their families, section 5 of the Act mandates that informed consent be taken before administering any HIV test, treatment or other medical intervention. HIV patients are also entitled to receive Antiretroviral Therapy (ART) at government medical facilities.
The HIV and AIDS Act also protects HIV-positive persons from forced disclosure of their HIV diagnosis, both by themselves and by anyone who has received this information from them in a relationship based on trust and confidentiality, subject to certain exceptions, such as that a doctor or counsellor may disclose a person's HIV-positive status to their partner if they believe that their partner might be at significant risk of contracting HIV (Section 8 & 9; Mr. X v. Hospital Z, 1999). An exception is carved out in favour of women in the Act - healthcare providers are not to inform a woman's partner of her HIV-positive status if there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health or safety of such woman, her children, her relatives or someone who is close to her (Section 9). Medical establishments are obligated, under Chapter V of the Act, to protect the identity of their HIV-positive patients and also implement adequate data protection measures for this purpose.

Sexual Dysfunction

Vaginismus:

Vaginismus is a condition where the muscles around the opening of vagina goes in for involuntary contraction and tighten around the vagina making penovaginal sex, inserting a tampon or gynaecological examination extremely painful, difficult and impossible. It is like a protective guarding response to prevent getting hurt.

This might be due to negative attitude towards sex, values attached to virginity, misinformation regarding first sexual encounter, lack of sex education and sexual techniques in both the partners and sometimes a sudden change of status from being single and virgin to married and sexually open. Most couples might seek help for infertility or unconsummated marriages.

Erectile dysfunction:

Erectile dysfunction (ED) commonly called as impotence, is the inability to achieve and sustain an erection suitable for sexual intercourse. According to Kessler et al. (2019), the overall global prevalence was 13.1–71.2% (Kessler et al., 2019).

Many men do experience occasional failure to achieve erection, which can occur for a variety of reasons, such as drinking excessive alcohol, stress, relationship issues, performance anxiety or extreme tiredness. It is recommended to seek medical advice if erection can't be reached more than 75% of the sexual occasions and lasting for more than 6 months of duration (Segraves, 2010). It can be due to vascular (blood vessel) diseases, nerve damage, hormonal issues, psychological factors or drug induced.

ED does not have to be a part of getting older. Treating ED is based on identifying the underlying condition causing it and treatment options include oral medications, sex therapy, penile injections, vacuum devices, intra urethral medications and surgery. However primary treatment includes exercise, counselling for performance anxiety, low self-esteem and loss of sexual arousal; behavioural therapies like the squeeze-pause technique.

Law and Impotence:

In India, impotence is recognised by law as one of the possible grounds for divorce or annulment of marriage. Different codes of personal laws such as the Hindu Marriage Act (HMA) 1955, Special Marriage Act (SMA), 1954, Parsi Marriage and Divorce Act (PMDA), 1936, Indian Divorce Act (IDA), 1869 and Dissolution of Muslim Marriage Act (DMMA), 1939 contain provisions regarding the same. As was held in Rangaswami v. Aravindammal, the burden of proof lies on the petitioner who "alleges that the respondent is incapable of consummating the marriage to give particulars of the nature of the incapacity alleged" [3 AIR 1957 Mad 243].

Use of Viagra for erectile dysfunction

Viagra aka Sildenafil citrate, is a drug used for erectile dysfunction (a form of male impotence) though now being used to enhance regular sexual performance. Some of the side effects of the drug include priapism (i.e., an erection that will not go away), sudden loss of vision in one or both eyes (NAION), sudden decrease in hearing or hearing loss. Other side effects include: feeling uncomfortable about eating food, headache, flushing, back pain, nasal congestion, myalgia, visual disturbance and dizziness (Erectile Dysfunction: AUA Guideline).

The biggest issue with Sildenafil is the linking of male sexual prowess to the duration of the erection which is quite toxic. The performative nature of this form of masculinity leaves many men deeply disturbed, insecure and can lead to very low self-esteem (and use of Viagra to staunch the bleeding of their self-esteem). Moreover, while the publicity surrounding Viagra may lead to a positive approach to sexuality among elderly, it might also perpetuate the stereotypical expectation that normative sexual expression of elderly requires the youthful dynamic sex lives with penetrative intercourse as the focus (Potts et al., 2003).

Circumcision

Male circumcision is the surgical removal of the foreskin/prepuce, which is a fold of skin that drapes the tip/head of the penis. It is commonly practiced as a religious custom even when not medically indicated. It doesn't affect the act of sex or the sexual pleasure derived for the male or their partners.

Female Genital Mutilation (FGM) - please see additional reading section

Postponing menstruation:

Many times women may choose to delay the menstruation to participate in religious ceremonies, weddings, pilgrimages, sports and gaming, holidays, travel, examinations or to meet deadlines at work , etc. Medical practitioners often prescribe a synthetic progesterone to be taken at least 3 days prior to the onset of the cycle for a period till one wants to postpone the bleeding. Withdrawal bleeding (menstruation) happens a day or two after one stops the medicine. Some of the side effects are heavy bleeding, breast tenderness, bloating, headaches/ migraines and fluid retention (WHO, 2011). It is important that an individual is making an informed choice/decision of taking the medicine with all the adverse effects of it being clearly explained and understood.

Challenging one's belief about menstruation, adequate counselling and support to manage stress and anxiety, access to supportive therapy to alleviate pain, use of menstrual cups in place of napkins/pads are some of the alternatives that can be explored and encouraged.

Abortions in India:

The World Health Organization defines abortion as pregnancy termination before 20 weeks' gestation or with a foetus born weighing < 500 g. The Ministry of health and family welfare data places the total number of induced abortions at 2.71 abortions per 1000 women whereas a research study (Singh et al., 2018) published in The Lancet places the number at 47 abortions per 1000 women aged 15-49 years, of which around 73% are done in the private sector and 5% (0.8 million) are done outside a medical facility. Almost half of the abortions performed in India are unsafe and are the third leading cause of maternal mortality (9-13% of MMR) (Partners for Law in development, 2018). Often women resort to unsafe practices or seek help from untrained professionals when abortion is denied by the trained professionals or when they face stigma in their eyes.

The most common reason that is being cited by the trained professionals for denying abortion is lack of spousal or parental consent. Although there is no legal requirement for spousal consent or authorization for an abortion to take place, the insistence of it stems from the patriarchal notion that women can't decide for themselves and the decisions are to be made by the husband or a parental figure and moral policing of the unmarried sexually active women. Only in case of a minor (less than 18 years old) consent of the parents or an adult is required. This is a critical issue for a woman who is a victim/survivor of marital rape or any gender-based violence, woman legally separated from the husband and single women. The stigma, shaming and discrimination faced by single women seeking abortion is double fold.

Other barriers that women face are access to health care facilities, forced sterilisation on grounds of providing abortion, lack of post abortion care, health care providers denying medical abortions and promoting surgical (D & C) methods by giving incorrect information and abortion denied in case if it is a first pregnancy citing secondary infertility as an adverse effect (Bhate-Deosthali & Rege, 2019). Often, abortion is a measure forced on women by the husbands who refuse to use contraception. Most of the time the health care provider assumes a paternalistic attitude and cajoles or coerces the woman to continue the pregnancy rather than support her in the decision to terminate it (Wyatt, 2001).

Law and Medical Termination of Pregnancy

The Medical Termination of Pregnancy Act, 1971 (MTP Act) specifies when pregnancies can be lawfully terminated by registered medical practitioners. According to Section 3(2), pregnancies below 20 weeks can be terminated if the continuation of the pregnancy "involve(s) a risk to the life of the pregnant woman or of grave injury to her physical or mental health" or if, "there is substantial risk that if the child were born, it would suffer from such physical or mental abnormalities to be seriously handicapped." Termination can be carried out based on the evaluation of risks and opinion of at least one medical practitioner when the pregnancy does not exceed 20 weeks, and by two medical practitioners when it exceeds 20 weeks, but is below 24 weeks.

No pregnancy can be terminated without the consent of the pregnant woman (Section 3(4)(b)). The written consent of the guardian is required to terminate a pregnancy if the woman is below 18 years of age or is above 18 years but is a mentally ill person. Although the MTP Act does not expressly recognise the agency of minor girls or women with disabilities, courts have held that such decisions cannot be made against their wishes. In *Marimuthu v. Inspector of Police*,[38] the Madras High Court relied on the Convention on Rights of Child, the object of MTP Act and women's right to autonomy and bodily integrity to state that "Section 3(4) cannot be read as to dispense with the consent of the minor where she wishes to continue her pregnancy." In *Suchita Srivastava v. Chandigarh Administration*,[39] the Supreme Court upheld the right of a woman with mild mental retardation to decide about the continuation of her pregnancy and held that her pregnancy could not have been terminated without her consent and to do so would not serve her best interest.

[38] WP (MD) No. 12212 of 2016, decided by the Madras High Court on 19.09.2016.
[39] (2009) 9 SCC 1.

Medical Termination of Pregnancy Act, 1971[40] Note: If the pregnancy is under 24 weeks, no CWC or Court order is required for the termination of pregnancy.			
Gestation Period	**Requirement of medical opinion**	**Conditions**	**Applicable category of pregnant woman**
Upto 20 weeks [Section 3(2)(a)]	One medical practitioner	6. Risk of life to the pregnant woman 7. Risk of grave injury to her physical/mental health 8. Substantial risk of serious physical or mental abnormality in the child **" where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by the pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman."** [Explanation 2, Section 3(2)]	**All pregnant women**
20 to 24 weeks [Section 3(2)(b)]	Two medical practitioners		**e. survivors of sexual assault/rape/incest** **f. minors** g. change of marital status during pregnancy h. women with major physical disabilities/mental illness i. foetal malformation - substantial risk to life of child/ substantial abnormalities j. pregnant women in emergency/disaster/crisis [Rule 3B, MTP Rules, 2003]

[40] The table has been taken from an upcoming publication by Enfold. Enfold Proactive Health Trust with support from UNICEF-India, 'Application of the Principle of Best Interests of the Child by Child Welfare Committees: A Handbook', P. 70-71.

Beyond 24 weeks [Section 3(2B)]	Diagnosis of a Medical Board[41] (unless in emergency where one RMP is enough)	Termination is **necessary** to save the life of the pregnant woman, or **termination is necessitated by the diagnosis of any of the substantial foetal abnormalities.** [s.5(1) & s.2B]	**All pregnant women**

Infertility

Infertility is defined as not being able to get pregnant (conceive) after one year (or longer) of unprotected sex by the Center for Disease Control and Prevention. Pregnancy happens when the sperm fertilizes the ovum and the ovum gets implanted inside the uterus. Infertility may result from problems with any of the steps mentioned.

The overall prevalence of infertility in India is between 3.9% to 16.8% (National Health Portal Of India, 2016). Infertility is often perceived as a woman's problem. This is false, as it was reported that 40% of infertility cases were related to men, 40% of women and 20% of both sexes (Sarkhel, 2009). While many women experience considerable shame and perceive infertility as a devastating role failure spoiling their ability to live normal lives, men perceive infertility as disappointing but not devastating, so long as it is assumed that the cause of the problem is the female partner (Greil, Leitko, and Porter, 1988: 181). Biological determinism makes it socially accepted that women are responsible for increasing the infertility rates in the country by their "poor, untimely, and problematic prioritization of life choices viz education and career". Seldom do we talk about the paternal age and its effects on fertility. Studies also show that the quality and motility of the sperm are affected with certain lifestyle choices (smoking, alcoholism, stresses) and increasing paternal age negatively affects the sperm quality (Brandt et al., 2019).

Assisted reproductive technologies (ART) which include intrauterine insemination (IUI) and in vitro fertilization (IVF) are considered as a boon to a childless couple. Many a times the options and choices available for a childless couple, the risks involved, the actual success rate of the procedure, the adverse effects of the treatment (short and long term) are not explained clearly to the couple in order for them to make an informed decision. ART also reinforces motherhood as a necessary status for 'normal' women. Even if women choose to opt for the ART consciously, it is worthwhile to note how much of an agency the women have in the decision making without subjecting themselves to the coercion of family and institutions. The psychological support, a woman undergoing ART could get from the partner, family or the medical institutions is highly neglected.

[41] Medical Boards comprising (i) a gynaecologist, (ii) a paediatrician, (iii) a radiologist or sonologist, and (iv) other members, as may be specified.

Adoption is often not discussed openly as an alternative in Indian families. People are under psychological, familial and societal pressure to have their own biological child (Singh and Dhaliwal, 1993; Widge, 2001). The system of patriarchal descent, patrilocal residence, property inheritance, lineage and caste in India effectively discourages people from seeing adoption as a possibility, hence a very low rate of adoption in the country. Central Adoption Resource Authority (CARA), an autonomous statutory body of Ministry of Women and Child Development, Govt. of India, is the nodal body monitoring and regulating the adoptions- in country and inter country.

Laws Regarding Adoption

A single woman can adopt a child of any gender but a single male cannot adopt a girl child, regardless of their sexual orientation (Para 5(2)(b) and 5(2)(c), Adoption Regulations, 2022). However, the Adoption Regulations place two restrictions on a couple who wish to adopt: first, the couple must be married, and second, the couple must have been in a stable marital relationship. Given that LGBTQIA+ couples cannot get legally married in the country, these restrictions act as a barrier for such couples to jointly adopt (Para 5(2)(a) and 5(3), Adoption Regulations, 2022).

LGBTQIA+ couples should be allowed to adopt[42]

In the context of adoption, the United Nations Convention on the Rights of the Child, 1989 requires the best interest of the child to be the primary consideration. The JJ Act defines the "best interest of the child" to mean the basis for any decision concerning children to ensure their "basic rights and needs, identity, social well-being and physical, emotional and intellectual development." The Adoption Regulations stipulate that the "child's best interests shall be of paramount consideration while processing any adoption placement." Indian courts have applied the principle of "the welfare of the child" in the context of adoption, custody, and guardianship cases and arrived at decisions on a case-to-case basis.

The best interest of the child cannot, however, operate in exclusion of other human rights. In *Suzanne Du Toit Anna-Marié De Vos v. Minister for Welfare and Population Development and Others*, (2002), the Constitutional Court of South Africa held that the exclusion of unmarried same-sex couples who are otherwise suitable to adopt, from jointly adopting children violated the principle of the paramountcy of the best interest of the child, as well as the right to dignity of the parents.

Sexual orientation or marital status cannot be the sole basis for the exclusion of same sex couples from jointly adopting as long as they meet the suitability criteria and can ensure the best interest of the child. The lack of legal recognition of marriage among same-sex couples also cannot be a reason to exclude them, as Central Adoption Resource Authority (CARA) permits applications from adoptive parents in live-in relationships, which it examines on a

[42] Swagata Raha, Sreedevi Nair and Ranu Tiwari, Why LGBTQIA+ couples should be allowed to adopt (*The Indian Express*, April 20, 2023), https://indianexpress.com/article/opinion/columns/why-lgbtqia-couples-should-be-allowed-to-adopt-8565664/.

case-to-case basis. Several countries around the world, including Argentina, Brazil, Cuba, South Africa, the UK and the US have legal provisions to allow unmarried same-sex couples to adopt. More importantly, an adopted child being raised by a same-sex couple through single parent adoption should not be discriminated against and deprived of the rights available to an adopted child raised by a heterosexual married couple. Both the Parliament and the Supreme Court should consider the best interest of children, as well as the fundamental right to equality and non-discrimination of children and couples identifying as LGBTQI while examining the matter.

There is lack of clarity on the adoption procedure for intersex children and how they are listed for adoption. The CARA eligibility criteria for adoption also only recognizes children as either 'male' or 'female.' (CARA, n.d.). Per a parent's experience, their adopted intersex child was listed for adoption as a 'transgender' 'special needs child.' (Bose, 2019). In the past, adoption authorities have also struggled with listing intersex children for adoption, due to a lacunae in existing legal frameworks to list children who cannot be assigned as 'male' or 'female' at birth for adoption (Ashwini, 2016).

In a consultation paper on *Reform of Family Law* published in 2018, the Law Commission of India recommended that adoption laws should make use of the term "parents" in place of "mother" and/or "father", enabling persons of all gender identities to adopt children. The Law Commission also recommended the use of the term "child" in lieu of "son" or "daughter," which would be a term inclusive of intersex children and facilitate their adoption with more ease. Pertinently, the Law Commission recommended that single parents should be allowed to adopt children irrespective of their or the child's gender identity (Emmanuel, 2018). These recommendations are yet to see fruition.

Chronic pelvic pain

Chronic pelvic pain is a common diagnosis among women with a prevalence of 3.8% to 14.7% (Mathias et al., 1996). It can be quite debilitating resulting in lower scores for reported general health. Some of the causes of chronic pelvic pain are endometriosis, post-operative adhesions, pelvic congestion syndrome, ovarian retention syndrome, adenomyosis, fibroids, interstitial cystitis, pelvic floor tension myalgia, abdominal myofascial pain syndrome and irritable bowel syndrome (Vercellini et al., 2009; Benjamin-Pratt & Howard, 2010). Non-cyclical pelvic pain was associated with numerous general, gynaecological, and obstetrical factors; abuse and psychological morbidity - notably, childhood physical or sexual abuse, lifetime sexual abuse or any abuse, anxiety, depression, hysteria and somatization.

PCOS/PCOD

Polycystic Ovarian Syndrome (PCOS) has no known cause or cure and research shows the prevalence of PCOS to be as high as 15-20% (Sirmans & Pate, 2014) indicating that it is

extremely common. The reason for this is simple: the diagnostic criteria for PCOS is the presence of two of the following - irregular periods, polycystic ovaries and excess androgen.

The incidence of cysts in the ovary is as high as 14% with new cysts developing in 8% every year - half of which remain for at least a year (Greenlee et al., 2011). The prevalence of irregular menstruation can be as high as 35% (Kwak et al., 2019); or more due to underreporting. This indicates that the wide diagnostic criteria for PCOS allows many people to be diagnosed with this condition.

This is still not a large issue if PCOS was considered, like ageing or obesity, to be a natural development in some people and something to be dealt with by improving exercise and dietary behaviours (which have numerous other health benefits). While PCOS is usually expected to be treated with only symptomatic care and health behavioural changes, the pathologizing of a very common characteristic makes many people feel like they have a very serious disorder that cannot be cured - rendering them permanently "sick."

Pelvic floor dysfunction (aka Prolapse): please see the additional reading section

Breast cancer

Breast Cancer has become the most common cancer in Indian women, especially those living in urban areas. Breast self-examination can help to detect problems early.

Breast self-examination:

A Breast self-examination is a check-up that a person conducts at home to check for problems or changes in their breast. The ideal time for a breast self - examination is 3 to 5 days after the period as breasts will not be too lumpy or tender during this time of the cycle. Ideally it is done every month. After menopause it can be done on the same day every month.

How to do breast self-examination:

4. Begin by lying on your back
5. Place your right hand behind your head
6. With the middle fingers of your left hand, softly but firmly press down on your right breast in small motions. Begin from the outside and make circular motions to cover the entire breast and reach the nipple.
7. Next, sit up or stand and gently feel your armpit (because breast tissue extends to this region as well)
8. While sitting or standing, softly squeeze the nipple to check for discharge
9. Repeat the above steps for your left breast.
10. Next, stand in front of the mirror with your hands on your hips and check for dimples/irregularities in skin surface/puckering/indentations etc.
11. Note the overall shape of your breasts and check to see if your nipples are concave – curving inwards.
12. Repeat steps 7 and 8 with your arms raised
    Note: most women find breasts lumpy, so that, in itself, is not cause for alarm. If you see

any changes from your previous Breast examination, consult your doctor as soon as possible.

Cervical cancer

Cervical cancer is the second leading cause of cancer deaths among Indian women aged 15-44 years, accounting for more than 60,000 deaths per year (Bruno et al., 2019). Ironically cervical cancer is preventable and curable. Sexually transmitted Human papillomavirus (HPV- strain 16 and 18) is responsible for almost all the cases of cervical cancer and is strongly linked with cancers of anus, vulva, vagina, penis and oral cavity.

Prophylactic HPV vaccination

This can reduce the burden of cervical cancer in India by more than 75% (Basu *et al). Gardasil* and *Cervarix* are the two vaccines available in the market. The violations of ethical clinical trial rules and human rights in the trial phase deterred the inclusion of HPV vaccine in the Universal Immunization programme (Sharma, 2013), making the vaccine accessible only to a particular socioeconomic stratum and restricted to only private clinics and hospitals. Most of the time the parents are unwilling to get their daughters vaccinated due to lack of knowledge of HPV vaccine, its safety and efficacy, including the socio-cultural, economic and religious issues. Many are of the opinion that HPV vaccines would make sex safe, leading to promiscuity and high-risk sexual behaviour in younger generation, which would cause social stigma, and may tarnish family prestige.

Research shows that only 47% of the health care provider recommends HPV vaccine to girls and young women (Chawla et al., 2016). Hence the coverage of the vaccine is negligible in India where the burden of the disease is high. With HPV 16 and 18 associated with 31% of penile cancer, desexualisation of the vaccine is of paramount importance. HPV vaccine uptake rate among women is very low to confer herd immunity to heterosexual males and female only programs do not offer protection to men with other sexual orientations.

Pap's smear done in a doctor's clinic is an easy way to screen for cervical cancer. This screening should begin with onset of sexual activity and repeated once in three years.

Undescended testis:

- Absence of one or both testis in the scrotal position at birth.
- Most common in premature babies and testis usually descends into its position inside the scrotum by 6 months of age.
- If undescended until 6 months of age, treatment options include surgery and hormone therapy with HCG.
- Men with undescended testis have higher risk of developing testicular cancer. It is important for men and teenage boys who have had this condition to examine their testicles each month to feel for lumps or other signs of tumours or problems.

Prostate - enlargement and cancer

Benign (non-cancerous) enlargement of the prostate is a common issue among older men, causing blockage in urine flow, resulting in difficulty in emptying the bladder and kidney problems. It often requires surgical intervention.

Prostatic cancer is fairly common - it is one of the top ten most common cancers in males in India, and the risk increases as the age of the person increases, especially beyond 65 years. Other risk factors are family history, genetic factors, race (African males have higher incidence) and to some extent, diet rich in animal fats and low in vegetables (Mayo Clinic, 2020). Screening in the form of rectal examination and PSA test (Prostate Specific Antigen) are recommended for high-risk individuals.

Transgender Health Care

- Please see the section on additional reading

Intersex Health Care

- Please see the section on additional reading

Mental Health Disparities

Please see the section on additional reading

Reflection:

- *How comfortable do you feel discussing reproductive health issues with your doctor? Your sexual partner? Would you discuss this with your close family member or friend? With whom would you like to increase your level of comfort in talking about such issues?*
- *How comfortable do you feel discussing sexual health issues with your doctor? Your sexual partner? Would you discuss this with your close family member or friend? With whom would you like to increase your level of comfort in talking about such issues?*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality -What Are Some Common Issues in Reproductive Health? How Can One Manage Them? Part 1 and part 2 (links will be inserted)

Way Forward:

We can work towards developing respect for the body and its functions - and not stigmatizing any of them. Seeking timely investigation and interventions would be beneficial when one feels that something is amiss. Having a fulfilling sex life, practicing safer sex, and preventing

sexually transmitted infections (STIs) are also important for the health and well-being of sexually active persons.

Chapter 8. Sexual Development in Children and Adolescents
- accepting, respecting and supporting

Why study sexual development in children and adolescents, and why support it? Because we feel the foundation of how we relate to our sexual self is laid in childhood and adolescence - when sexuality first emerges and develops. If shame, guilt, or a sense of 'dirtiness' is inculcated in a child or adolescent's mind about their sexual and reproductive organs, then it becomes difficult for them to experience their sexuality with dignity, pleasure and joy. As adults we should be careful not to influence their experience of their sexuality in such negative ways! Also, the rise in toxic messages about masculinity and femininity, making it all the more important that we counter such sexual expressions and discuss with our adolescents how sexuality can be experienced in a responsible, respectful manner, mindful of the feelings, bodies and rights of the other(s). Having age appropriate conversations with our children about the sexual and reproductive organs would normalise these, making it easier for the child or adolescent to report perpetrators of inappropriate sexual behaviour. In this chapter we trace sexual development from birth to adolescence and suggest some appropriate developmental guidance and teaching moments.

"Many people cannot imagine that everyone - babies, children, teens, adults, and the elderly - are sexual beings. Some believe that sexual activity is reserved for early and middle adulthood. Teens often feel that adults are too old for sexual intercourse. Sexuality, though, is much more than sexual intercourse and humans are, and remain, sexual beings throughout life." (Apgar, 2017).

According to the theorists, the first critical period for development of sexuality and intimacy is early childhood. Much before puberty, young children can experience protosexual (a primitive sexual process or stage preceding sexual maturity). feelings with undertones of passion, love and even sexual excitement (Doidge, 2007). Childhood sexuality was ignored and denied for a long time due to Freud's concept of latency (1965). This was disproved by R. Goldman and J. Goldman (1982). It is believed that sexual 'maps' aka sociosexual scripts (Simon & Gagnon, 1986) to help children navigate their sexual life begin to form in early childhood. These help them navigate their sexual life later in life. However, societies continue to view children as innocent (confusing ignorance about sexual matters as 'innocence') and asexual, lacking any sexual desires, thoughts or erotic interests (Heiman et al., 1998).
The illustrations below depict the development of sexual behaviours in apes, monkeys and human children.

As with any other development, sexual development too varies from individual to individual, influenced as it is by several biological, nutritional and psycho-social factors. The sexual development of children has been described here by drawing heavily from the work of Wurtele (2011).

(Note: for sexual development in children and adolescents with disability, please see Chapter 10 on Sexuality and Disability)

Sexual development from 0-3 years:

The foundation of an individual's sexuality is laid at conception. Within a few weeks, the gonads have differentiated into a testis or an ovary and started secreting hormones which have a role to play in anatomical, neurological and sexual development. The foundation for development of gender identity and orientation is also believed to be laid during foetal life in the brain (Zhou et al., 1995; Kruijver et al., 2000).

Caring, consistent and sensitive touch from adult caregivers is believed to help children develop a sense of trust as well as autonomy. Harlow's (1973) research confirmed that children, from a very early age, learn to receive and express love by experiencing nurturing touch and body contact. According to Frayser (1994), the caregiver's verbal and non-verbal communication with the child influences their feelings about their body, including their gender identity and sexuality.

Touching one's genitals feels pleasurable and as a normal developmental process. Toddlers may rub and explore their genitals, more so after 18 months of age, as a self-soothing mechanism during sleep or when tensed, afraid or excited. Children may have penile erections, especially when the urinary bladder is full or during sleep and vaginal lubrication is thought to happen just as often (Haffner,2004).

Toddlers do not associate 'shame' or 'dirtiness' with their genitals. There is a curiosity regarding the passage of urine and stools. They develop curiosity about their own bodies and other people's (especially parents) genitals (Schuhrke, 2000). They soon realise that children of different genders urinate differently and have many questions they seek answers for. This pleasure or curiosity shouldn't be shamed or discouraged in an attempt to help children learn society's sexuality related etiquettes. Whenever possible, their questions and observations about gender, reproduction, sex and sexuality should be answered in simple, easy-to-understand ways so they develop a healthy attitude and respect towards themselves and others.

Developmental guidance and teaching opportunities:

Teaching children the correct name for their genitals from an early age helps children develop a healthy, more positive body image and the same has been recommended as a practice for parents by several experts (American Academy of Pediatrics, 2011; Honig, 2000; Wurtele, 2010). Some sexual offenders avoid children who know the correct names for their genitals, because this suggests that the children have been educated about body safety and sexuality and are therefore likely to recognise and report the abuse (Elliot, Browne, & Kilcoyne, 1995).

- Begin by naming all body parts and their function in simple words. While helping the child bathe you can say, "Wash your face, chest, susu and potty place, legs and feet". If you are comfortable, use anatomical words in the language you speak with the child - example 'genitals, penis, scrotum, vulva, anus, buttocks'. It shows that you are willing to talk about these parts of the body and that you do not think of them as shameful or embarrassing. When these parts are not named, the child senses that you do not wish to talk about these and will carry their increasing curiosity about these matters to other sources where they can find more information (the internet, seniors at school, unsafe adults). Avoid calling the genitals "Chhi Chhi" or "shame shame" - sounds that mean

dirty or shameful. Such associations come in the way of children respecting their body and fully accepting their sexuality as they grow up. Avoid using euphemisms like 'flower' or 'parrot'. This makes it difficult for people to understand that the child is telling them about sexual abuse.

- Provide ample socioemotional space for the child to explore their own bodies
- Provide ample warmth, affection, touching and love as this builds stable attachment for future intimate relationships.
- Provide opportunities to play with all kinds of toys, do all types of activities. Avoid gendering any activity, colour, clothing or role or behaviour.

Sexual development from 3-6 years:

Children continue exploration of their own genital areas, rubbing and touching, and are curious about other's bodies. They often question their parents and siblings regarding the differences in the bodies especially the genitals, breast and pregnancy.

Preschool children may be found imitating adult social and sexual behaviour like holding hands, kissing and sometimes 'lying on top of each other'. This is part of their learning by observation and imitation of real-life situations or on television. They enjoy 'you show me yours; I'll show you mine' and 'doctor-doctor' games. These games are common in this age group (Rutter, 1971; Sandnabba, Santtila, Wannas, & Krook, 2003), and are usually played with a sense of curiosity and exploration, and occur with children of similar age (Lamb & Coakley, 1993), size, and developmental level. It is usually voluntary and children actively agree to play these games with their friends. Adult caregivers could choose to ignore these games unless there is any distress or discomfort that any child feels in participating in these games. On occasion when it is forced or a child feels excessively cajoled by others, caregivers can intervene and ask children to stop and children can be easily diverted to other activities. Normative sexual play is usually spontaneous. Children do it playfully, with much laughter, fun, and embarrassment, and varying levels of inhibition and disinhibition (Shaw, Lewis, Loeb, Rosado, & Rodriguez, 2000).

Since parents usually do not use the correct names while speaking about the genital organs, children of this age pick up a lot of slang words which they often don't understand. 'Susu-potty' jokes fill them with mirth because these are considered taboo topics and ones that can potentially cause embarrassment to people!

By 5 – 6 years of age children become more modest and prefer to bathe and dress in private. Caregivers can respect their wishes without disregarding or making fun of them. They have numerous questions on reproduction, especially if they see a pregnant woman, or see mating behaviour of animals. If parents and caregivers fail to respectfully and honestly answer their questions, the children may turn to their peers, or older children, for information. They usually accept whatever answers they get as they are pretty ignorant about this area. This unattended curiosity can also make them vulnerable to abuse.

Developmental guidance and teaching opportunities:

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- **Support children in learning Personal Safety -** A primary goal for this age group relates to teaching personal boundaries, personal space, and body ownership. It is recommended that children be educated and given names for their genitals, their questions answered and curiosity satisfied in an age-appropriate manner; and taught about personal safety. Children who do not know about these two topics—sexuality and body safety— are more vulnerable to sexual abuse (Wurtele & Berkower, 2010). Not considering the positive impact of encouraging healthy sexual development, the prevention of sexual abuse alone is sufficient reason to provide education on these topics to children.

  Help children understand that their body belongs to them and no one has the right to touch them in any way that makes them feel uncomfortable or unsafe. This is an important concept to convey to children (Wurtele, 2007).

- **Answer questions on reproduction and sexuality**: Respond to questions regarding pregnancy and sexuality, as and when asked, factually, in an age-appropriate manner, using simple words that the child can understand. Use a normal and comfortable tone. If caregivers answer their questions as and when asked, the child will learn about personal safety and their curiosity about pregnancy and delivery will also be satisfied in a safe manner. They will begin to trust the caregiver and will not hesitate to come and ask them their doubts. Refer to **Bal Suraksha App,** available in 10 languages on Playstore for suggestions on how to answer some of these questions.

- **Practice gender inclusiveness and equity**: Avoid gendering roles, activities, qualities or behaviours while helping the child explore and express their own gender. Avoid derogatory, discriminatory words, phrases and body language towards people of different genders.

  If children ask a trans person about their gender, it can be explained in this manner (this is an anecdote shared by a colleague at Enfold): a person's 4-year-old niece asked them if they were a boy or a girl. The person responded "my body is that of a boy, but in my heart and my brain I am a girl". The child then proceeded to declare that in that case, they were a girl!

Sexual development from 6-9 years:
Curiosity about physical differences continues during this phase. Children try to peek and catch a glimpse of family members bathing or undressing. Socio-sexual play among peers may continue. Though children show greater initiative and autonomy at this age, they need physical closeness, hugs and kisses from their caregivers. (Rademakers, Laan, & Straver, 2000).

Interest in sexual activity and masturbation increases, but as the sense of modesty develops, children take better care to ensure they won't be seen by others while exploring their own bodies or bathing or dressing. Questions about sex, pregnancy and childbirth increase. When parents hesitate to respond to these questions accurately, children sense the discomfort and eventually learn not to bring up these conversations with their safe adults. They often turn to

peers and media or the internet to get their answers. Chances are that the information they receive is incomplete, inaccurate and not values or rights based.

Children giggle nervously about "private parts" and feel thrilled telling "dirty" jokes which adults around them disapprove of, and may use sexual or obscene language, often to test parental reaction. They begin to understand more complex ideas with regard to sexuality and begin to comprehend intercourse as an activity apart from making a baby. The idea that adults, specifically parents, have sexual intercourse is, however, unpleasant to most children of this age.

The process of gender role socialisation is heightened during this period. Refer to the section on development of gender identity above.

Developmental guidance/teaching opportunities:

- As listed in the previous section on sexual development of 3-6 year olds, discuss **Personal Safety, safe and unsafe behaviour, accountability, responsibility and the No- Go - Tell guide**.

- **Provide values-based discussion on healthy sexuality** even if children don't ask for it – as they may have questions that they feel awkward to ask. Use day-to-day opportunities to talk about sexuality - e.g., watching a show on television, which may have the occasional intimate scene. Explain that sexual activities are adult behaviours that are usually conducted in private. Deconstruct any media messages that promote moral policing on someone's dress sense or body shape or relationship status and provide them more healthy perspectives. Give them actual biological terms or commonly used terms in the language spoken by the child, and explain how slang words and jokes are inappropriate.
- Reinforce the concept of **privacy and respect** the need for privacy by children as they grow. Ask more open-ended questions to explore the sexual behaviours of children rather than condemning a behaviour.
- Help children get in touch with their **emotions** and express challenging emotions like embarrassment and shame in healthy ways.
- **Practice gender inclusiveness and equity**: Role model respect and appreciation of sexual and gender diversity for the child to pick up these attitudes. By 6 -7 years, begin using the words female, male instead of girl/ boy/ woman/ man to refer to the assigned sex of a person. Explain that when babies are born, doctors look at their genitals (use appropriate words in the language the child speaks) and give the baby a sex - usually female or male which is what we have to fill in official documents and certificates that ask for it
- Explain that we also have a sense of our gender - of whether we feel like a girl or a boy or neither or many different genders. Sometimes this inner sense may not match our assigned sex and that is okay too.

  Explain how our gender or sex does not limit what interests we can have, aptitudes or skills we develop, or activities and jobs we can do.

Reflection:

1. *What questions have children asked you about pregnancy/ delivery/ sex? How did you respond to them?*
2. *What questions did you ask as a child? What answers did you receive?*
3. *How comfortable do you feel naming the genitals for children 6 to 9-year-olds?*
4. *How comfortable do you feel answering their questions around sex and reproduction? How can you increase your level of comfort and ease in this area?*

Sexual development from 9 - 12 years:

Puberty is the period in life during which a child develops into an adult, capable of survival in the group and environment they live in. They also develop adult sexual and reproductive capacities.

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Puberty typically begins by 8-10 years in females and by 9-11 years in males. Among intersex children, the onset of puberty varies depending on several underlying factors. Besides sex, the timing of puberty is influenced by genetic and environmental factors. Adrenal glands are the first to become active, causing the prepubertal growth spurt. Height and weight increase and children become more bodily conscious. Soon thereafter, growth and development of primary sex organs happens. The ovaries and testes start secreting sex hormones. These physical changes may also be accompanied by a range of intense emotional experiences for the child.

The extent and speed of pubertal changes vary considerably from person to person, while the sequence of these changes remains fairly consistent. In the early adolescence period, breast buds start appearing under the areola and this is often the first sign of puberty in female children. In male children, the testes grow in size, the scrotum enlarges, the scrotal skin darkens and its texture changes. Pubic hair begins to appear. Nocturnal emissions (wet dreams) can happen. White discharge in female children is also seen. These changes may contribute to psychosocial stress in early developing females and late maturing males because of the social norms that persist around these changes (Copeland et al, 2010). Often the ‘expected changes’ may not occur among children who have an undetected underlying intersex variation. This may still go unnoticed due to the variability in the beginning of puberty itself.

The onset of pubertal changes can cause a lot of distress for transgender children, including a feeling of ‘loss of control’ over one’s own body and the feeling that all is ‘lost’ and they will be trapped forever with these unwanted changes in their body. Bullying and social ostracism adds to their stress.

The surge of sex hormones in early adolescence can generate sexual and romantic interests and attractions. Adolescents may engage in some forms of physical intimacy like holding hands with romantic partners, kissing or fondling. Mutual exploration between same sex and other sexes is common and is not indicative of sexual orientation of the adolescent. Children (of all sexes) may begin to masturbate for sexual pleasure (Haffner, 2004).

The nature of social interactions changes, with adolescents preferring the company of their friends and peers over their family members. Their sense of modesty and their desire for privacy heightens. As curiosity about sexual behaviour increases, children begin seeking out sexual content in media (television, movies, games, music, magazines, internet). Adolescents use the internet to ask questions about sexual topics, exchange information with peers about sexuality, and explore their emerging sexuality (Subrahmanyam, Greenfield, & Tynes, 2004; Suzuki & Calzo, 2004). Unfortunately, the internet can be an unhealthy, and even dangerous, sex educator.

Developmental guidance/teaching opportunities:

- Continue to build on personal safety education, No - Go - Tell guide, safe adults, unsafe behaviour, accountability and responsibility (elaborated in previous sections).
- Provide values - based discussion on **healthy sexuality -** encourage them to be mindful of boundaries, consent, rights, feelings and needs. The media and other sources of information have exposed children of this age to sexual relationships that exist in our society. They have questions about these. Discuss these and provide value and rights based answers to their questions.
- Create awareness of puberty, the physical and psychological changes to expect and how physical and emotional changes are part of the growing up process that prepares one to become an adult.

  Discuss how our bodies are all very different and that it is the norm in nature to be different. Reassure children about differing growth and maturation rates from person to person and also convey that different parts of their bodies will grow at different rates. Invite children to be mindful and support them in developing an independent positive regard for oneself and one's body and care for it. Discuss that it is natural to have fears and anxieties and other negative emotions, as well as positive emotions towards growing up and puberty. Discomfort about growing up can stem from beliefs and images we have of growing up and adults and what is expected of them. Use guided/critical questioning to help them challenge beliefs that bring down their self-esteem (self-worth), body image and feelings around their gender.
- Build awareness about gender and gender identities and encourage respect towards people of all genders. Support the adolescent in being who they are - to express their gender identity in accordance with what they feel and not what society expects or how their body looks. Explain that what people of different genders do is often determined by society but one need not necessarily follow these norms and should not make fun of people for not following them.
- One's gender or sex does not determine or limit what we can do and achieve - except biological functions. One can feel differently about their gender than the sex they were labelled as and that is okay.
- Discuss how they could identify peer pressure, taunting and bullying. Discuss what actions could be taken in such situations, such that every person's right to safety and dignity is maintained.
- Develop media literacy skills to critically think about and interpret messages in advertisements, songs, movies and other media - especially those messages around body image, gender roles and other aspects of sexuality.

- Discuss establishing safe connections and boundaries in both the real and virtual world. Talk about internet safety and establish rules on usage of electronic devices.
- Discuss pornography – how they may come across it accidentally or out of curiosity. How some adults watch it for a variety of reasons. How it can give a skewed notion of people's bodies, sex and how to relate with each other. This can be disturbing for children to watch and may affect them in different ways. It would be good if they could ask their safe adults their doubts and questions about sexual activity.

Reflection:

The activities could be triggering for some people. Please do these only if you feel comfortable.

- *When did you first learn the proper names of the sexual and reproductive organs?*
- *What misconceptions about sexual organs and sexual activity did you harbour as a child?*
- *How comfortable do you feel answering questions or engaging 9 to 12-year-olds in conversations based on romantic content with sexual innuendos that they may have watched or sexual words they may have heard about? How can you increase your level of comfort?*

Sexual development from 12 -18 years:

The process of puberty continues and over the next decade or so the child will become an adult. The body will mature earlier than the brain, which matures by 22-24 yrs.

Refer to the chapter on **Structure and Function of Sexual and Reproductive Systems** for details of physical changes during puberty

Brain development in adolescence:

The brain grows rapidly in the first few years of life, attaining 80% of the adult volume by 2 years of age (Knickmeyer et al., 2008). Different parts of the brain grow at various tempo and brain growth and development happens well into adulthood. During adolescence, dynamic reorganisation of the brain architecture happens. The gray matter volume increases and peaks in early adolescence (Arian, 2013). The neural connections seldom used are destroyed (synaptic pruning) and those neural circuits frequently used are strengthened. This synaptic pruning helps in transition from open potential in childhood to specialisations in adulthood. By late adolescence the gray matter volume declines.

The prefrontal cortex (PFC), which is bigger in humans than in any other mammals, is still developing in adolescence and matures at the age of 22-24 years (Arian M, 2013). PFC is responsible for higher cognitive functions like reasoning, decision making, planning, inhibiting inappropriate behaviours and social interactions.

The adolescent brain functions from the limbic system (amygdala- hippocampus), the seat of emotions and reward processing which is fully developed in adolescents. The neurotransmitter (serotonin) mediated behavioural inhibition (impulse control) is immature in adolescent brains. Both these factors contribute to the characteristic adolescent behaviours such as quickness to anger, intense mood swings, risk taking and making decisions on the basis of "gut" feelings (Casey et al., 2008).
Social brain which directs the ability to take into account someone else's perspective in order to guide ongoing behaviour is still developing in mid to late adolescence (Blakemore, 2008). The adolescent brain is adaptable and malleable and the environment can and does shape the developing brain.

Sleep:
Puberty also delays the biological clock or the circadian rhythm in an individual. The shift in the secretion of hormone melatonin (late as in 2 hours to adults/children) makes the adolescent active late into midnight and sleepy in the morning. Sleep deprivation in adolescence has become quite common, not even the 8 hours of minimum sleep (Carskadon, 2002).

Chronic sleep irritation can lead to moodiness, irritability, laziness, depression, concentration and attention issues. Sleep is the resting time when memory consolidation and emotional processing. With sleep deprivation, the brain, body and behaviour suffer.

Self -consciousness
The adolescents' fascination with the body and its looks, clothing, and grooming increases as does their interest in sexual activities. The onset of puberty with its changes often causes distress and aggravates gender dysphoria in transgender adolescents. As a child, the individual may have made peace with their body, but with the onset of puberty and the appearance of obvious secondary sexual characteristics, the adolescent may feel that they are no longer in control and have to endure this body and related bullying.

Peer relationships
Relationships with peers play a major role in adolescents' emerging individuality and may cause emotional separation from parents. Peer and social influences may expose adolescents to values that differ significantly from their family's values. They try to gain autonomy and this may be perceived by the parents/adults as challenging and critical behaviour. However, it is really a way for them to separate their identity from their parents and is crucial for the development of their individual identity. Vocalising sexual thoughts with peers in the form of sexual jokes, sexual innuendos, hinting about their own sexual activity to gauge the feelings of others are commonly observed.

Adolescents rate media as the leading source of information about sex. Pornography may also be alluring. Thrill seeking experimentations may lead to high-risk sexual behaviours. Peer-to-peer sharing of sexual content via electronic media is observed. When the pubertal and social transitions of adolescents are not supported and guided positively, it may result in teens perpetrating sexual harassments in the form of sexual bullying (Fredland, 2008). Sexual bullying includes touching, grabbing, pinching in a sexual way; brushing up against someone in a sexual

way on purpose; giving someone sexual pictures, messages or notes; name calling such as ‘slut’, ‘gay’, or “lesbo”; writing sexual messages/graffiti in school restrooms; spreading sexual rumors; and forcing someone to do something sexual such as kissing or oral sex. Sexual bullying is also perpetrated through electronic technology. This aspect of adolescent development is neither healthy nor necessary - and is better prevented or dealt with immediately. Interventions at the earliest have to be made as sexual bullying appears to be antecedent to more severe forms of relationship/partner violence.

Romantic and/or sexual attraction towards another takes the form of crushes and infatuation. Romance, sexual activity, jealousy and break ups are common. Romantic partners provide acceptance, companionships, and emotional comfort to weather the storm of adolescence. It helps to explore their sexual identity and prepare them for adult relationships.

Sexual orientation

This emerges between mid to late adolescence and adolescents may feel uncertain or ambivalent about their orientation. With further sexual development, youths begin to identify themselves anywhere in the spectrum (example heterosexual, homosexual, bisexual, asexual, pansexual, queer, questioning). It is an internal, psycho-emotional experience of an individual. Thus, no rigid norms, labels or judgements should be applied to how a person expresses their orientation as long as it is not impinging on the rights of other people. Parents, family members and teachers can attempt to be sensitive, accepting and respectful of an adolescent’s sexual orientation. For more details refer to the chapter on **Development of Gender Identity and Sexual Orientation**

Developmental guidance/ teaching opportunities:

- Continue to talk about bodily changes and its individual variability in time of onset and progress and other points as in the section of 9-12 years of age. Parental supervision need not clash with the developing autonomy of the adolescent. Support them through this process rather than fault them for it.
- Puberty could be blocked in transgender children, to allow the adolescent to grow older, and then decide whether they want to undergo any irreversible hormonal or surgical intervention. However, this option is not readily available in most cases, resulting in the pubertal changes producing several permanent changes in the body. Trans persons may then undergo procedures or find ways to downplay these changes - like voice training to change the pitch of their voice to suit their gender. Use of puberty blockers is still being studied and clear, non-controversial guidelines on their usage are awaited. Support the adolescent to manage these changes according to their wishes and in an affirmative manner. Proactively take steps to sensitise their teachers and peers.
- For an intersex child, the variation may first become apparent during puberty. The intersex adolescent would require socio-emotional and psychological support to understand their body and develop their identity. Support the adolescent and proactively take steps to sensitize their teachers and peers.
- Listen to the teen, to understand their point of view. Understanding is not the same as agreement!

- Continue to build on personal safety education, No - Go - Tell guide, safe adults, unsafe behaviour, accountability and responsibility (elaborated in previous sections).
- Provide values - based discussion on **healthy positive attitudes towards sexuality:**
    - Discuss sexual feelings, masturbation, safe sex practices, contraception and STIs and address their concerns. Discuss tools to manage sexual pressures.
    - Affirm sexuality and discuss how it could be experienced without guilt and expressed responsibly.
    - Discuss romantic relationships in the context of values and rights, and how these may be different from what is portrayed in the media. Extend the talk on boundaries to consent (informed and enthusiastic). Encourage them to set their boundaries, and be mindful of others' boundaries, consent, rights, feelings and needs. Explain how we can accept another person's "No" by acknowledging them and saying "Thank you for letting me know and expressing your true feelings!"
    - Discuss sexual relationships that exist in our society. Engage them in value and rights based discussions on these topics.
- Discuss cyber safety and how to establish safe connections virtually.
- Ask the adolescent to identify their safe adults and their safety circle - people whom they can reach out to if required. Strive to be a safe adult for the adolescent.
- Role model respect for diversity in gender and sexual expression.
- Teach the adolescent about the current laws that govern us - not from a moralistic perspective, but more as a way for them to understand how to safeguard themselves from possible legal complications

Laws impacting adolescent sexuality in India:
Indian laws operate on the assumption that persons below the age of 18 years are incapable of giving consent for sexual activities. The Protection of Children from Sexual Offences Act, 2012 (POCSO Act) criminalises different forms of sexual activities with children and does not create any exception for non-exploitative consensual sexual activity among adolescents. In *Independent Thought v. Union of India, (2017),* the Supreme Court read down the exception to marital rape and held that sexual intercourse by a man with his wife below 18 years would constitute rape. The Supreme Court also observed that a "child" cannot give consent to sex. Under the POCSO Act, the minimum punishment for repeated penetrative sex, sex with a spouse, or pregnancy that results from sex with a minor is 20 years rigorous imprisonment, which can be extended to life imprisonment till the remainder of a person's natural life, or even death.

Multiple empirical studies analyzing judicial data have found that a significant number of cases registered under the POCSO Act and relevant sections of the BNS ~~IPC~~ for sexual offences against minors involve consensual relationships.[43]

[43] Ibid. Shruthi Ramakrishnan & Swagata Raha, "Romantic" Cases under the POCSO Act (Enfold Proactive Health Trust, 2022) 5. In this study 1715 out of 7064 cases (24.3%) of POCSO cases decided between 2016-2020 by Special Courts in Assam, Maharashtra, and West Bengal were "romantic" cases; ; Vidhi Centre for Legal Policy, A Decade of POCSO: Developments, Challenges and Insights from Judicial Data (2022) 95 - In their analysis of 138 random POCSO judgments revealed that there was a prior romantic relation between the victim and the accused in 18% of the cases; Implementation of the POCSO Act: Goals, Gaps and Challenges - Study of cases in Special Courts in Delhi & Mumbai 2012 - 2015 (2017) 100 - In 83 out of 231 (35.9%) POCSO cases from Mumbai and Delhi were of romantic relationships; Centre for Child and the Law, National Law School of India University, Implementation of the POCSO Act, 2012 by Special Courts: Challenges and Issues (2018)- Studies based on 2788

The law plays out in a gendered and protectionist manner, in that, girls involved are invariably treated as victims and the boys as offenders (Chaudhary, 2018). This is because the criminal justice system is predominantly set into motion by the girl's parents who lodge a complaint alleging she has been kidnapped and raped. The girls are usually detained in Child Care Institutions if they wish to live with their husband or partner and refuse to return to their parents. Although most cases end in acquittal,[44] scores of adolescents are subjected to the criminal or juvenile justice systems and their dignity, privacy, best interest, and evolving autonomy is undermined in the process.

The mandatory reporting obligation under Sections 19(1), 20 and 21 of the POCSO Act and Section 397 of the BNSS (previously, Section 357C of CrPC) can complicate the access of adolescents to sexual and reproductive health services and information. For instance, a gynaecologist will have to inform the police if a pregnant 16-year-old girl in a consensual relationship seeks an abortion. This could push adolescent girls to resort to unsafe means of termination of pregnancy.

Recognizing the impact of the law on adolescents, the Madras High Court in *Sabari v. Inspector of Police*,[45] the Madras High Court urged the government to reconsider criminalization of children above 16 years involved in consensual sexual activity. More recently, the Law Commission of India, in its report on Age of Consent under the POCSO Act in 2023 acknowledged that the "blanket criminalisation of sexual activity amongst and with a child, though intended to safeguard children, is leading to incarceration of young boys and girls who engage in such activities as a consequence of sexual curiosity and need for exploration that may to some extent be normative for an adolescent."[46] It recommended that judicial discretion be introduced in sentencing to deal with such cases instead of imposing high minimum mandatory sentences.[47]At an international level, the UN Committee on the Rights of the Child has also advised countries to strike a balance between protection and evolving autonomy, and has cautioned countries against criminalization of adolescents involved in non-exploitative consensual sexual activity. (UN Committee on the Rights of the Child CRC, 2016)

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cases decided by Special Courts under POCSO Act across five states in India by the Centre for Child and the Law at National Law School of India University (CCL-NLSIU), revealed that romantic cases constituted 21.2% cases in Andhra Pradesh (108 out of 509 cases), 15.6% in Assam (27 out of 172 cases), 21.5% in Delhi (144 out of 667 cases), 5.45% in Karnataka (6 out of 110 cases) [in 3 districts], and 20.5 % in Maharashtra (273 out of 1330 cases)..

[44] According to a study of 1,715 "romantic" cases, 93.8% resulted in an acquittal, with the "victim" herself stating that she was in a romantic relationship with the accused in 87.9% of the cases. *See*, Shruthi Ramakrishnan & Swagata Raha, '"Romantic" Cases under the POCSO Act: A Study of 1715 Judgments of Special Courts in Assam, Maharashtra & West Bengal' (Enfold Proactive Health Trust, 2022) P. 28 available at <https://enfoldindia.org/wp-content/uploads/2022/12/Romantic-cases-under-the-POCSO-Act.pdf>.

[45] [2019] Criminal Appeal No.490 of 2018 [Madras High Court].

[46] Government of India, Law Commission of India, Age of Consent under the Protection of Children from Sexual Offences Act, 2012, Report No. 283 (September 2023) https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2023/09/20230929466194485.pdf accessed 20 January 2025, para 18.2, 101.

[47] The Law Commission of India suggested Law Commission of India, 283rd Report on Age of Consent under the Protection of Children from Sexual Offences Act, 2012 (2023) 116-118 <https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2023/09/20230929466194485.pdf> accessed 20 January 2025.

Reflection:

These exercises may be triggering for some. Please do these only if you feel comfortable.

1. *What messages about your sexual body did you receive from people when you were growing up, and later in life? What messages would you like to give yourself now?*
2. *Think of parts of the body you find "shameful" - in your body, in other people's body. Where, when and how did these feelings arise?*
3. *List parts of the body in order of your respect for them. Take the part you have listed at the bottom - what if this part was missing? Not working well? How would your life change?*
4. *Create a time-line from birth to your present age. Mark all the points at which you underwent/heard messages which changed something in your sense of yourself, particularly self-worth, body image and sexuality.*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - How to talk with children about personal safety?

To learn more about how as a safe adult one can have value-based conversations around sex and other aspects of sexuality with adolescents, refer to Enfold's video series on Demystifying Sexuality - How to Discuss Sexuality with Adolescents? (link will be inserted).

Way Forward
As adults we can accept the fact that children are sexual beings from birth. We can treat them with respect, and support their emerging sexuality right through adolescence into adulthood - such that they can experience their sexuality with pleasure and positivity, and not shame or guilt. We can have conversations with children and adolescents in ways that build respect for each other's bodies, and all body organs and functions. We can support them in expressing their sexuality with responsibility, mindful of the rights of all concerned.

Chapter 9: Attitudes towards Sexuality
– building a positive, respectful and rights-based perspective

Healthy sexuality, which contributes significantly to the well-being of every individual, refers to the multiple aspects of sexual health and well-being - physical, psychological and social - related to one's sexuality. This is impacted by several variables as listed below and could vary across one's life span:

- One's sense of acceptance about their gender identity, sexual orientation and preferences etc., which is devoid of shame, guilt or fear
- Autonomy over one's sexual experiences, along with the responsible expression of it. To be free of coercion or use of power and force in the experience of it.
- Experience of fulfilment in one's sexual experience and expression, especially of pleasure which is often denied to some individuals, labelled as 'immoral' or 'characterless'.
- To have the choice of engaging with people or practices of one's preference, provided that the other people involved consent to these practices, demonstrate an active enthusiasm and willingness for them and do not violate anyone's rights.

Individuals engaging in a healthy sexual interaction would:

13. View sexual interactions as something individuals share with one another instead of do to one another (demonstrate a genuine respect for each other's wishes and stay connected to the heightened intimacy rather than "turning off" and treating the interaction as more of a transaction);
14. Value honest, proactive communication about each other's likes, dislikes, expectations, and respect them
15. Value positive sexual expression and respect sexual diversity
16. Promote physical sexual health by proactively taking necessary precautions.

The objective of examining sexual attitudes is to:

- examine the relevance of the socio-economic, political and cultural factors that influence our view of our own and others' sexuality.
- develop an understanding of the diversity of sexual experience and expression that exist and to welcome even those expressions that one might not agree with.
- minimise abusive, discriminatory, judgemental and exploitative behaviours towards oppressed sexual minorities
- reduce self-harming behaviours that members of sexual minority groups may suffer from, as a result of the discriminatory, oppressive experiences they are subjected to.
- create space for people of all sexual identities to live a fulfilling life

Sex positivity

Before we explore the attitudes towards sex, sexuality and how they impact one's experience of their own sexuality, we need to understand the idea of 'sex positivity'. Sex positivity is the idea that all forms of sexual experience and expression are positive as long as they are healthy, explicitly consensual and do not violate the rights of others. It assumes that there is nothing

shameful or 'bad' about one's orientations and desires, even if some of these may be frowned upon by society owing to heteronormative ideals.

Sex positivity is the attitude of valuing sex and sexual pleasure for its own sake and not just from a reproductive lens or against morally constraining, unforgiving religious/ faith-based value systems which are often reflected in our laws. At the same time, it is an acknowledgement that one's attitude towards sex and sexual expression may not be shared by all and to believe that is okay as well.

Bullough (1976) described societies as being sex-positive or sex-negative. "Sex-negative societies encourage sexual asceticism, and sex is largely constructed as being particularly risky, problematic, or perhaps adversarial. Sex negativity is linked not only to prejudices associated with various sexual practices, but also to sexism, racism, homophobia, and ageism (Glickman, 2000)".[48]

Charles Glickman (2000) describes the language of sex positivity as being an important way to understand how sex-negativity permeates our atmosphere. Derogatory slurs are made of words related to sex like 'fuck', 'slut', 'screw', etc. These often denote sexual violence as a way of taking revenge or insulting someone. This can also be seen in various Indian languages, where words considered "obscene" are often related to body parts (usually female ones) and/or to sexual practices. Glickman (2000) also mentions that the advantages of sex-positivity are numerous. They include:

- It allows us to stop questioning our own normality - something that people always do in the context of sexuality. But it would have no meaning in a sex-positive world, because it would be normal for us! And trying to find out someone else's sexuality is only important if we want to do something specific with them or learn from them.
- Secondly, sex-positivity lets us relax and experience our natural sexuality without guilt or fear. In some ways, sex-negativity is like an injury. We are always walking around with a limp, restricting our movements. Learning to heal, stretching our muscles and physical therapy all hurt. However, when we are done, the freedom of movement amazes and delights us.
- Especially for polyamorous people (having a relationship with multiple partners with explicit consent of all involved), a sex-positive world would be poly-positive. A person's gender, sexual preferences or number of partners matter very little, as long as everyone's rights and preferences are respected and maintained.
- Finally, sex-positivity permits us to explore and access a greater range of choices which may be key to our sexual fulfilment across different times in our lifespan. This becomes especially important with different kinds of bodies and as our own bodies change. Sex-negative sexuality gives no leeway for aging, disability, the effects of medication, changing health, etc.

[48] Williams, D. J., Wegner, J., & Prior, E. (2013). Resolving Social Problems Associated with Sexuality: Can a "Sex-Positive" Approach Help? *Social Work, 58*(3), 273-276.

Lawyer Margo Kaplan (2014) describes how sex-negativity has permeated law especially in the conception of obscenity laws, the criminalisation of BDSM practices and the restraints on sexual freedom. She adds that sex-positive lawyering can also improve areas like family law, sex work and prostitution, and rape law.

The purpose of examining our attitudes towards sexuality is to reflect on how to instill a sense of sex positivity in our thinking about the topic and to be able to acknowledge and embrace its significance in our lives

Attitudes towards sex

Sexual activity is thought to have the primary purpose of reproduction. In order to facilitate that, the sexual act itself has to be experienced as pleasurable so that members of a species are motivated enough to engage in it. Copulation (sex) had to be rewarding enough for individuals (of any species) to risk the vulnerability of engaging so intimately with other individuals – the risk of injury or being harmed when unprepared.

As societies began to organise themselves, reproductive and sexual activities began to be controlled. Religious beliefsinsisted that sex for pleasure was immoral. Other beliefs created different rules for men and women: sexual activity and fulfilment of sexual desires were more permissible in men, while restricted in women. In such cases, women were bound by their role as the nurturing parent who was designed not to be sexually driven. Women who demonstrated or defied these norms were/ continue to be viewed as characterless or immoral. The concept also evolved of women as "goddesses" or "witches", which of course, turned on their sexuality too. Patriarchy also had another reason to "restrict" women's sexuality: the fact that they were (and still are, in many cultures) seen as the property of the man (father in her childhood, husband when she got married, and her son in case her husband dies). At each stage, these men would be expected to control her sexuality (among other aspects of her life).

Indian history has a lot to contribute towards the understanding of sex and its practices and shows us the many seemingly contradictory attitudes and mindsets that we have towards sex. In ancient India, there existed literature like the Kamasutra and temples, most famously the Khajuraho complex built around the 9th-12th century, with vivid depictions of erotic sexual activities of a diverse nature. The art and literature of the time often had themes of love and romance and celebrated sexual intimacy, sometimes even elevating it to divine proportions.

"As in all societies, there was a difference in sexual practices in India between common people and powerful rulers. People in power often indulged in hedonistic (pleasure-seeking) lifestyles that were not representative of common moral attitudes. India is a multi-ethnic and multilingual society with wide variations in demographic situations and socioeconomic conditions" (Chakraborty & Thakurata, 2013, para. 1). It was common for the ruling classes for instance, to follow polygamy and even polyandry as a way of ensuring dynastic succession.

With the advent of British Raj, came the imposition of Victorian values and moralities. Many Indian practices and mindsets were judged as being immoral and barbaric. Thus began the systematic 'reform' of the public and private lives of our people, through laws (many of them exist to this day in the BNS). While we continue to follow the values set by a foreign culture, our own structures of marriage and expression of sexuality evolved to become more

conservative and controlling, ridden by patriarchal values (handed down as Manu Smriti). Physical love making outside of the structure of a marriage or sex for pleasure, with one's own spouse, was seen as immoral (Chakraborty & Thakurata, 2013).

Recent conversations, however, have challenged these norms and promote more open conversations around sex for pleasure. Rye and Meaney (2007) discuss that, among many others, one of the motivations for people to engage in sexual activities is pleasure. They advocate a continuing dialogue around sexual pleasure to 'change the script' about what is considered acceptable or not.

Another interesting development in the 20th century is the decoupling of sexual activity from reproductive activity. Today, with the advancement of medical sciences and assisted reproductive technology, the two can be considered separate and even independent. Recreational sex or sex for pleasure is therefore not frowned on. In some cultures, it is considered a necessary aspect of one's complete well-being and health (Benagiano et al., 2009).

Reflection*:*

1. *Write down all the swear words you know (especially the really bad ones). If you have less than 20 call a friend to help you out! How many of these swear words revolve around sexuality - sex, who is having sex with whom, parents are not married, having sex with family, etc. etc.*
2. *What do you feel about this negativity in sex? Why is sex not spoken about in pleasant, happy and respectful ways?*

Attitude towards virginity

Virginity is a social construct that has been commonly understood as the abstinence from sex prior to marriage or the state of not having had any partnered sexual experience, especially for women. Premarital virginity of women is held at a premium in many cultures and by most religions.

Kanyadan in Hinduism is a marriage ritual, where the father of the bride presents his daughter to the groom. It literally translates as, 'donation of a maiden/virgin/unmarried girl' and is considered the highest form of charity one can do to earn significant spiritual merit. Early Christians associated sex with 'sin'. The New Testament equated spirituality with abstinence and celibacy. Chastity and virginity were considered holy and divine - Mary is referred to as the 'Blessed mother' or the 'Virgin mother'. Jesus is thought to have been conceived without sexual intercourse, and that Mary continued to be a virgin even after Jesus' birth.

In Roman times, there are examples like the Vestal Virgins - girls dedicated as virgin priestesses to the service of goddess Vesta and sworn to 30 years of being celibate. They enjoyed great power and privilege that was not allowed to other women, but were also required to be celibate under the threat of death. Islam also looks down upon premarital sex as sinful and requires both men and women to be chaste and moral (League, 1995).

In most cultures, an intact hymen is considered a sign of sexual purity among women. Some cultures and societies even permitted and endorsed various kinds of 'tests' of virginity which included two-finger tests (inserting two fingers into the vagina to ascertain whether hymen was intact/ laxity of the hymen) or having to show 'proof of blood' (showing signs of bleeding/ blood stains on consummation of marriage). These tests while mostly deemed illegal or inappropriate, continue to be used to establish virginity as a pre-requisite for marriage or to establish the character of a woman by inferring her familiarity with sexual practices.

The two-finger test is also commonly used by medical practitioners to determine the status of the hymen of a survivor or victim of sexual violence. The defence often use the absence of a hymen, or claimed the the victim was 'used to sex', even though such references are prohibited (BSA, 2023). It is important to note that medical practitioners cannot make any observations on whether rape took place or not - "Rape is a legal term and not a diagnosis to be made by the medical officer treating the victim. The only statement that can be made by the medical officer is that there is evidence of recent sexual activity. Whether the rape has occurred or not is a legal conclusion, not a medical one" (Madan Gopal Kakkad v. Naval Dubey, 1992). Further, in Lillu Alias Rajesh & Others vs State Of Haryana (2013), the apex court held that the two-finger test, commonly used by medical practitioners while examining survivors of rape, violates the "privacy, physical and mental integrity and dignity."

Further, according to the *Guidelines and protocols on medico-legal care for survivors/victims of sexual violence* issued by the Ministry of Health and Family Welfare, "per vaginum examination, commonly referred to by lay persons as 'two-finger test', must not be conducted for establishing an incident of sexual violence and no comment on the size of vaginal introitus, elasticity of the vagina or hymen or about past sexual experience or habituation to sexual intercourse should be made as it has no bearing on a case of sexual violence. No comment on shape, size, and/or elasticity of the anal opening or about previous sexual experience or habituation to anal intercourse should be made."

In some cases, women even resort to surgical procedures like hymenorrhaphy or hymenoplasty to restore a broken hymen so they can pass the virginity test. "The practice of clitoridectomy of young unmarried girls in several tribes predates even the origin of religion and it was believed to protect a woman against her own temptations, hence preserving her chastity. There was a strong association of clitoral mutilation with premarital chastity in Nigeria and Egypt usually performed by an old woman in the village with assistance from female relatives of the girl." The study further elaborates on this practice in urban Mumbai, and lists several reasons including 'religion, tradition, hygiene with the actual intent of controlling the women's sexuality" (Nagpal & Rao, 2016, p. 2)

Virginity as a morality-based concept adds no value to the healthy experience of sexuality and is increasingly being discounted as an outdated idea. It is, however, still spoken of as a milestone in one's sexual experiences, with many discussions and deliberations on how to make it a 'memorable' or 'fulfilling' experience, etc. In queer circles, losing one's virginity is often equated to one's 'coming out' (since the loss of virginity is defined as the first peno-veginal intercourse in heteronormative contexts) or to any of the numerous other sexual acts that may be practiced by queer people.

Reflection:

- *Is virginity gender-specific?*
- *What do you think about virginity? How would you define it? What does it mean to you?*

Attitudes towards contraception and safer sex practices:

Efforts to control the fertility of women, the number of children one had, and consequently, improve the quality of life and life span of mother and offspring, were well in place before proven methods of contraception were invented. With the push for equality among men and women, this was accelerated as more women chose to go beyond their prescribed roles as mother and homemaker.

Traditional and religious figures resisted this development, stating that recreational sex is against the will of nature or god. The Catholic Church promotes natural methods of contraception (Rocca, 2018) and to this day, it remains opposed to any artificial forms of contraception (unless under specific conditions of failing health). This significantly influences the birth control practices and policies of Christian societies. For instance, the Church's disapproval of condom use during the HIV crisis left people without the most effective way of protecting themselves. This meant that they were at a greater risk of getting the virus (Clayton, 2009).

At first, Protestant churches had a critical attitude towards contraception. Over time, different groups have begun to support natural family planning methods; 'prudent use' of contraceptives; or the option to choose a method that fits within their beliefs. Hinduism has held no overt ban on the use of contraception. Some Hindu scriptures and early practitioners of Ayurveda like Rishi Charaka have, in fact, advised on how to use contraceptive methods to prevent pregnancies. Other scriptures go on to refer to killing of embryos as a sin. However, the prominent attitude towards sex was its acceptance as a natural way of life. Use of contraception was usually avoided till the birth of a male child who could ensure continuation of the patrilineage.

Since there is no direct guidance from the Quran on contraception and family planning, Muslims rely on Islamic scholars to provide them direction on this matter. Except for the most conservative groups, most schools of Islam permit some form of family planning, especially if it is to the benefit of the woman's health, the family's welfare and with the consensus of both husband and wife. What is frowned upon, are contraception methods used after conception or without the knowledge of the spouse. Some verses of the Quran are interpreted to mean that Allah will take care of his worshippers' and followers' needs and that one should not hesitate from bringing new life into the world 'out of 'fear' or 'for selfish reasons' (Huda, 2019).

In our current times, attitudes towards sexuality have significantly evolved. Programs and advice that instil fear around the negative consequences of sexual activities restrictimportant conversations about sexual health, sexual rights and sexual pleasure. These are merely aimed at controlling the expression of sexual desire and using the fear of god, health or morality. Abstinence-focused sexuality education promotes the beliefs of what is virtuous or not. For example, abstinence is a virtue that only evolved persons can demonstrate, premarital sex/ extra

marital sex is "immoral," or that it is unacceptable for women to express sexuality or sexual pleasure. These are mostly ineffective in curbing the participation in or the early initiation into sexual activities and may, on the other hand, increase the curiosity about and tendency to experiment with such actions.

Higgins and Hirsch (2007) discuss how programs for HIV prevention and contraception are not sensitive to the impact of pleasure on the effectiveness of such programs. Specifically, they describe that men do not like using condoms as they reduce sexual pleasure. However, women were also found to dislike male condoms because they worsened vaginal dryness. Furthermore, women perceive sex that is intimate, loving and monogamous to be incompatible with condom use. Thus, women face barriers to using condoms from social, emotional and financial dependence on men and their conceptions of romantic relationships.

In a study done with a group of MSMs (men having sex with men) from Kolkata, it was found that, "48 (44.4%) felt that they will perform the sexual act without a condom if their sexual partner is extremely attractive, 96 (88.9%) felt that using a condom is not necessary if the partner is clean and hygienic, 75 (69.4%) felt that anal sex is for fun, so no condom is required, 47 (43.5%) felt getting HIV was a matter of bad luck" (Deb et al., 2009, p. 206).

Reflection*:*

- *What would you think of an adolescent who was seeking information on contraception?*
- *What would be your advice as a professional working in the field of Sexual and Reproductive Health to a person seeking abortion?*
- *How would you treat a friend who develops a sexually transmitted infection/ HIV?*

Attitudes towards sexuality of people with disabilities:

People with disabilities are often infantilised or thought of as asexual or in some cases hypersexual (Addlakha et al., 2017). Their desire for pleasure is usually overlooked or overtaken by their assigned identity as a disabled person. On occasion when their needs and desires are expressed, they are received with surprise and judged for wanting anything more than overcoming their disability or for seeking pleasure despite their disability.

This is also upheld by social ideas of who is considered attractive and who should feel deserving of love and attraction. As a result, people with disabilities may sometimes feel unworthy of love or sexual experiences, often resigning to a life devoid of such experiences (for more on sexuality and disability, read the chapter on Sexuality and Disability).

Attitudes towards age and sexuality

Popular culture has ensured that sexual drive and vigour is considered appropriate and normal only within the reproductive ages of an individual. According to existing laws and policies related to child protection and welfare, adulthood (above 18 years of age) is when a person is capable of making informed decisions. Anyone below that age is incapable of providing consent for sexual activities or initiating such actions. For most adults, childhood is an age of sexual innocence with no sexual urges or needs, until they become adults or are ready for marriage.

With an increased focus on building careers, pursuing professional success and ensuring livelihoods, it is often thought that children should only focus on academic or skill development pursuits during their foundational years.

Despite the push to recognise children as sexual beings, they are still not regarded as such and there are now, more than ever, a plethora of rules and regulations that define sex as the exclusive realm of adults. When children engage in consensual sexual acts or are subject to abusive sexual acts, they are seen as having been "robbed of their childhood" (Piper, 2000). Because of this denial of children's sexual awareness, any early interest they show in sexual acts is seen as an early warning sign of promiscuity or sexual abuse.

Likewise, people over 50 years of age are thought of as declining in vigor and health. They are expected to slow down, focus more on aspects of health, retirement and sorting out their 'worldly affairs'. Individuals who defy that expectation and pursue an active sexual life or partnerships are ridiculed, looked upon, and more so if they are women. Older persons seeking to get married may also be actively discouraged by their children, who find the new family structure either inconvenient or embarrassing.

This view of age-related sexuality is also endorsed by major religions. For example, the 4 stages or 'Ashrams' of Vedic life according to Hinduism where the early years were for the practice of
(1) brahmacharya (till 24 years of age) – life away from home as a student, in pursuit of knowledge and spirituality. The important practice in this stage was celibacy, austerity and building qualities.
(2) grihasta (24-48 years of age) – life as a married man, taking responsibility for a family, to teach children values, to do charity.
(3) vanaprastha (48-72 years of age) – retirement from family responsibilities, focus on spiritual matters and abstinence from all sexual activities.
(4) sanyasa (72 years till death) – a life of detachment and pursuit of self-realisation and oneness with god.

Reflection*:*

These exercises may be triggering for some. Please do these only if you feel comfortable.

- *How do you view sexuality among the elderly?*
- *How would you respond if an elder in your family circle decided to get married/ move into a live-in relationship?*

Attitudes towards sexual minorities

In many societies including in India, conversations around sex are considered taboo. When this is the case, it severely limits the acknowledgment and expression of a range of human sexual diversity and contributes to marginalising and othering. The majority of members of such societies hold strong opinions about what is okay and what's not. They consider any other form or expression of sexuality as abnormal, inappropriate and deserving of scorn or exclusion.

Prejudice against sexual minorities also comes from an irrational underlying fear that such people could lead members of a society 'astray' or corrupt an entire culture. Despite a growing awareness and acceptance of diversity in sexuality, studies have shown that many mental health professionals hold biases against clients with such alternative erotic preferences (Hoff & Sprott, 2009).

Criminalisation of certain behaviours and identities (e.g., LGBTQIA+ populations) has greatly limited the ways in which sexual pleasure has found expression in policy and programmes. Social and cultural taboos in relation to sexuality are often embedded in laws and policies. For example, some societies have laws that penalise and criminalise sexual health related matters, such as same-sex sexual acts and behaviours, transgender expression, sex work, HIV transmission, possession of a condom as evidence of crime, and penalisation of the advertisement of contraception or abortion. The burden of unjustified use of criminal and punitive laws is significant: certain population groups, such as gay, lesbian and transgender people, women, adolescents, people engaged in sex work, and those living with HIV, can experience difficulties in accessing relevant services, let alone engaging in positive sexual experiences, with direct impacts on health and pleasure (Amnesty International, 2018). Until recently, this was true in India under Section 377 of the Indian Penal Code (IPC) that had criminalised same sex relationships. This Section was read down by the Supreme Court of India in 2018, and it excluded adult, consensual, same sex sexual relationships (Navtej Singh Johar v Union of India, 2018).

For a more detailed reading on this, please refer to the chapter on 'Diversity in Sex, Gender and Sexuality'

Reflection:

1. *List A – Z of sexuality - including reproduction. For example, A for asexuality (add other words with A that relate to sexuality, B for bondage, …, till Z for Zygote – which of these words do you not understand? Find out about these words.*
2. *How do you feel about what the words mean?*

Sex for money

Sex work is legal in India under the Immoral Traffic Prevention Act (ITPA), 1956. However, asking for clients in a public place, kerb crawling, owning or managing a brothel, sex work in a hotel, child prostitution, pimping and pandering are illegal. Sex workers are often trafficked or coerced into the trade, but they are not always without agency. Stigmatisation and discrimination of sex workers prevent them from participating in community activities and decision making. The COVID-19 pandemic and the subsequent (unplanned) lockdown in India, also brought into sharp focus that sex workers, of all gender identities, had no access to basic rights and entitlements like health services and food. This brought them dangerously close to starvation and deprivation.

The representation of sex workers as women who are always marginalised and oppressed takes away their choice to engage in this work out of their free will and not being coerced into doing it (Azhar et al., 2020). Devine et al. (2010) uncovered another reason for entering into sex work in India, called the "pleasure pathway." This is not a reference to sexual pleasure, but to the lifestyle that sex work can afford, the economic independence and "freedom from reliance on a male partner, and the ability to reinvent the system of property ownership and inheritance (Chattopadhyay et al. 1994).

"Through a process that McClintock (1991) called "whorearchy," sex work provides women the opportunity to effectively cut men out of the possession of the wages they have independently earned from their sexual labour. By being able to leave their wealth and possessions to their children or other cisgender female sex workers within their networks, whorearchy allows women to reinvent patriarchal inheritance schemes that had traditionally left them out of the equation of property ownership. Regardless of their initial reasons for entry into the profession, sex worker respondents in our four studies chose to remain in the sex work field because of the increased pay and flexibility that the profession affords them over other forms of labor" (Azhar et al., 2020).

Some myths about sex workers are that they do not have families, they are mostly cis women, and that they do not operate independently, but only under a brothel owner or a pimp. Sex workers have typical families that include mothers, sisters, children. They may also be cis-men, trans-men, trans-women or any identity that they may identify as and many sex workers operate independently - some with families who are aware of what they do, and others who prefer to keep this knowledge away from their family.

Law and sex work:

While sex work is not illegal under the Immoral Traffic (Prevention) Act, 1956 ('ITPA'), soliciting sex work, particularly in public, running or owning a brothel, is illegal. Sex work within 200 metres of any public place is criminalised under the Act, including hotels. The Act also criminalises anyone above the age of 18 who is supported by income arising from sex work, as well as anyone who knowingly permits sex work to take place in their premises. The Act criminalizes running or being part of a brothel, which is defined as any set up in which two or more persons work together as sex workers, meaning that anyone who wants to engage in sex work has to do it as an individual, and cannot be seen soliciting for work in public.

ITPA is the only legislation in India governing sex work, and as the name of the Act implies, conflates sex work with trafficking, leaving little room for sex workers to define themselves and their work outside the binaries of trafficked/not. With sex workers necessarily being identified as victims of trafficking, their needs are often left unaddressed if they are not to do with trafficking, or they claim means to legitimize their work and continue to engage in sex work in safe, autonomous environments. Given the stigma surrounding sex work, and the limits of the law in terms of where and how one can engage in sex work, sex workers often struggle to legitimately access STD testing services, contraception and other medical services provided by the government, from fear of being penalised for engaging in sex work.

Sex workers, while protected by the ITPA, are often harassed for "public indecency", or for being a "public nuisance". They experience a lot of police violence and abuse of power,

including arbitrary arrest, bribery and extortion, physical and sexual violence, lack of access to justice and forced HIV testing. This treatment also prevents them from organizing themselves to demand and lobby for their rights.

While sex workers are looked upon with derision and contempt for what they do, persons who use the services of sex workers mostly avoid such scrutiny and judgement. Clients of sex workers, especially if they are cis men, do not attract any humiliation or contempt since it is thought to be natural for men to seek sexual pleasure and pay for it if they wish. Even in an interaction deemed immoral, patriarchal values persist. It is the commercial sex worker (often from the minority and oppressed genders and castes) offering their service who is shamed and criminalized, while the client (often the cis man) is let go with a warning if caught.

Reflection:

1. *Do you consider sex work a legitimate form of labour?*
2. *Should sex work be considered a profession?*

Pornography

The publishing or transmitting of pornographic material in any form is a criminal offence in India under Sec 294 of the BNS (previously, Section 292 of the IPC), with Section 67 of the Information Technology Act, 2000 ('IT Act') criminalising the publication or transmission of 'obscene' material, including pornography, online, specifically. An exception is made for the publication of material for the 'public good' (in the interest of science, literature, art, learning), as well as for representations in temples and other religious purposes, and in monuments classified as such under the Archaeological Sites and Remains Act, 1958. The distribution, sale or circulation of "obscene" materials, including pornographic material, to any person under the age of 20 years was a criminal offence, with a greater term of imprisonment as punishment, under Section 293 of the IPC. Now Section 295 BNS replaces “person under the age of twenty years” by “child”, thereby restricting the scope of this provision to children. Section 67A of the IT Act criminalises the publication or transmission of sexually explicit content on the internet.

Child pornography is a criminal offence under Section 67B of the IT Act. Section 13 of the POCSO Act, 2012 criminalises the use of a child for pornographic purposes, which it defines as the use of a child in any form of media for sexual gratification purposes, including "representation of the sexual organs of a child"; "usage of a child engaged in real or simulated sexual acts"; "the indecent or obscene representation of a child." Section 14 prescribes the punishment for using a child for pornographic purposes. Under Section 15 of the POCSO Act, storage of pornographic material involving children is also a punishable criminal offence, again even if it is for personal consumption. It is now referred to as Child Sexual Abuse Material (CSAM), globally, as this recognizes the sexual abuse of children in the production of child pornography.

Chandra and Ramachandran (2011) in their article about the right to pornography in India found that the laws that ban pornography because of its obscenity also violate rights to freedom of speech and expression, and/or right to privacy under the Indian constitution. The primary concern that leads to the ban against pornography, in their view, is the safeguarding of public

morality and decency. They find that a large part of the issue is the definition of pornography as sexually explicit material designed to produce sexual arousal in viewers. This is considered obscene.

Why do people watch pornography?

Human beings perform sex in private for a variety of reasons, safety being one of them. At the time when humans lived in the jungles, performing sex in private (behind a bush for example) enhanced the safety of the couple as a quick get -away is difficult in the jungle. Moreover, peno-vaginal sex, or penetrative sex, is not instinctive - it has to be seen or told about. Children and adolescents are therefore naturally curious about body parts and how sex actually happens. This curiosity becomes more urgent and persistent during puberty as the body prepares for reproduction. Hence, most young people watch pornography out of curiosity, to learn about sex or succumbing to peer pressure to prove themselves as grown up or adult enough.

Diamond et al. (2010) argue that pornography provides an outlet for sexual desires - especially paedophilia, without actually harming a child. It is considered enjoyable, educative and harmless fun by some people. There are pornography viewers who are also particular about the kind of porn they watch – ensuring that it is not exploitative (ethical pornography) and of adult participants indulging in consenting sexual actions. People who have non-heteronormative sexual desires often look for pornography as a way to find sexual information and pleasure. It is also one of the safest forms of sexual self-gratification.

There are recent disturbing trends for video recordings of real-life sexual assaults going viral as pornographic content, sometimes also involving minors. While this violates multiple legal lines. It is also a reflection of how individual liberties and freedoms can be infringed upon when digital platforms are misused or exploited by people.

Reflection:

6. *When did you first learn about pornography? What useful role did it play? Did it have any harmful effects on you/ someone you know?*

Practitioner's perspective

Watch Enfold's video series on Demystifying Sexuality - Attitudes Towards Sex and Sexuality - How Do These Form and Impact Us? (link will be inserted).

Way Forward

People have different ways of expressing, experiencing and communicating their sexuality and sexual preferences. We could strive to understand sexuality and sexual expressions with an open mindset rather than from the lens of the charmed circle - of certain acts and behaviors as more permissible than others. As long as any sexual behaviour and preference is conducted with a rights - based approach, keeping active consent in mind, it should be no one else's business

except those engaged in it. Viewing our own sexuality and sexual needs with a positive attitude (rather than blaming oneself/ being critical of oneself or being ashamed of one's sexuality) may be the first step towards sex positivity and the acknowledgment and acceptance of others'.

Chapter 10. Sexuality and Disability
- accepting, acknowledging and affirming

Our society's discomfort with sexuality combined with ableism has resulted in invalidating the sexual and reproductive rights of persons with disabilities - especially those with intellectual disabilities. Persons with disabilities are denied sexual experiences and shamed and ridiculed for expressing such needs. Comprehensive personal safety and sexuality education is withheld, while sexual and reproductive violence against them continues. We present a rights based perspective on sexuality in the context of disability, with discussions on common myths and a brief note on how individuals with disabilities could be supported with comprehensive sexuality education.

The Rights of Persons with Disabilities Act (2016) defines a person with a disability as, "A person with long term physical, mental, intellectual or sensory impairments which, in interaction with barriers, hinders their full and effective participation in society equally with others." 2.21% of India's population has one or more disabilities and 1.67% of 0 to 19-year-olds have a disability (Census 2011).

The RPD Act 2016 includes the following disabilities:

- Locomotor Disability
    - Leprosy Cured Person
    - Cerebral Palsy
    - Dwarfism
    - Muscular Dystrophy
    - Acid Attack Victims

- Visual Impairment
    - Blindness
    - Low Vision

- Hearing Impairment
    - Deaf
    - Hard of Hearing

- Speech and Language Disability
    - Intellectual Disability
        1. Specific Learning Disabilities
        2. Autism Spectrum Disorder
    - Mental Behaviour (Mental Illness)
    - Disability caused due to-
        1. Chronic Neurological Conditions such as
            - Multiple Sclerosis
            - Parkinson's Disease
        2. Blood Disorder
            - Haemophilia

        - Thalassemia
        - Sickle Cell Disease
    - Multiple Disabilities

How is disability perceived? What frames our attitude towards disability?

Reflection:

- *How do you perceive disability?*
- *What beliefs do you hold regarding this - in terms of what causes it, why some people are born with disability, some acquire it later?*
- *What degree of participation in decision making, economic activity, reproduction, sexual rights and other such areas a person with disability could be involved in? Who and what would determine this?*

Models of Disability

Models of disability provide significant insight into the attitudes towards disability (Petasis, 2019; Disabled World, 2019). These models show the ways in which our society contributes towards or restricts access to gainful employment, provision of goods and services along with economic and political participation of people with disabilities. They assist us in understanding various perspectives and prejudices of society towards persons with disabilities and how these have changed over time

Moral/Religious Model

This is the oldest model of disability. Various religious traditions view disability as a punishment given by God for sins committed by the person with disability or their family at some point in time. An individual with a disability is held responsible for their condition. Disability, illness and 'suffering' are justified as punishment for ill deeds. This can result in their mistreatment and abandonment by society.

Medical Model

The Medical Model of Disability appeared around the 19th century. It was during the time when modern medicine began to develop. Since many disabilities have medical reasons, it was thought that medical interventions would benefit persons with disabilities. This model considered that complications in the body impairs a person. If the individual is "cured", then problems would go away. The focus remains only on the individual and society neither has any underlying responsibility nor is bound to provide access and a friendly infrastructure for persons with disabilities. The medical perspective of disability resulted in the creation of institutions that were developed for people with disabilities where they could be trained and skilled. It focused on supporting,skilling and seeing them as productive members of the community, rather than a burden, dependent or helpless.

Rehabilitation Model

This model is quite similar to the Medical Model. A person with a disability is taken to be in need of rehabilitation services who can impart training, therapy, counselling or other associated services to lessen the limitations caused by the disability. This model gained importance after WWII when many disabled individuals needed to be integrated into society. The framework of the present day Vocational Rehabilitation system is based on this model.

Tragedy/Charity Model

This model portrays people with disabilities as sufferers who are deserving of our pity. This and the Medical Model are used by non-disabled people to define and explain disability. Because of their circumstances, persons with disabilities are seen as dependent, in need care and unable to manage their own affairs. They need charity in order to survive. This perspective has an adverse impact on the self-esteem of people with disabilities.

The Social Model

This regards disability as a consequence of environmental, social and attitudinal barriers that prevent people with impairments from maximum participation in society. It says that there is a lack of equal opportunities due to physical or social barriers. If cities, structures and built environments were set up in a way that was accessible for people with disabilities, they would not be excluded or restricted. It also recognises that harmful attitudes towards disabled people create unnecessary barriers to inclusion and requires people to take proactive action to remove them. The social model distinguishes between impairment and disability. While disability is to do with activities (see below), impairment is described as a characteristic or long-term trait which may or may not result from an injury or health condition that may affect a person's appearance or functioning of their mind or body. For example, an individual is prevented from accessing information in a print magazine, not because of blindness, but because of the absence of alternative formats.

Bio-psycho-social Model

This model forms a non-discriminatory and all inclusive concept around disability. It encompasses elements from both the social and the medical model. This model proposes that disabilities are the result of physiological or biological problems that need treatment and intervention by medical professionals. This Model also holds society responsible to take measures to include persons with disabilities in social, economic and political activities by supporting and providing them equal opportunities. This model is the foundation of the World Health Organization's (WHO) International Classification of Functioning, Disability, and Health (ICF). In the ICF, functioning and disability are multifaceted. Here 'functioning' refers to "all body functions, activities and participation" and disability is used as an umbrella term for "impairments, activity limitations and participation restrictions" (WHO, n.d.). The following terms are used in this model:

- **Impairment**: These are "problems in body function or structure such as a significant deviation or loss' - for example leprosy.

- **Activity limitation**: to do with the activities of people (functioning at the level of the individual) and the activity limitations they experience; - for example loss of sensation due to leprosy making it difficult to grasp objects.
- **Participation restriction**: to do with the participation or involvement of people in all areas of life, and the participation restrictions they experience in life situations (functioning of a person as a member of society); - for example, stigma associated with leprosy leads to unemployment or participation in social gatherings.
- **Inhibitors or enhancers**: to do with the environmental factors and personal factors which affect these experiences (and whether these factors are facilitators or barriers) - for example, availability of prosthesis, reconstructive surgeries and the resources to avail these.

In this way, the ICF conceives a person's level of functioning as an effective interplay between their health conditions, environmental factors, and personal factors.

Rights-based Model:

According to this approach, people with disabilities are rights holders and the state needs to undertake positive measures to ensure their rights. Social structures and policies that limit or ignore the rights often result in discrimination and exclusion. A human rights point of view necessitates the government and its agencies, as well as private establishments to take steps to respect, protect and fulfil human rights. Sizeable structural and procedural modifications would ensure the equal exercising of rights. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2008) aimed to achieve equity for people with disabilities around the world. It outlines the duties that governments around the world must perform to sustain, promote and protect the rights of persons with disabilities.

In India there has been a significant paradigm shift in the way disability is seen i.e. from a charity-based model to a rights-based perspective (Nagaraja & Aleya, 2018). Whereas the rights-based model is of the opinion that all human beings have rights that may not be compromised. This model promotes dignity, confidence and agency of the individual as a human being, as a holder of rights, not only the recipient of any resources, services and aid.

Attitudes towards disability, sexuality and rights

The United Nations Convention on the Rights of the Child (UNCRC) that India acceded to in 1992, states that all children - irrespective of their abilities or disabilities - have needs and the right to have their needs met. It states that all children have the right to education, information, guidance, support and play opportunities. Article 8(1)(b), UNCRPD, obligates state parties to take immediate, effective, and appropriate measures to “combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life”.

However, these rights are hardly being met for children in India. Children with disabilities are further isolated, ignored, invisibilized and denied their rights (Sharma & Sivakami, 2019). This is especially true for children with intellectual disabilities. UNCRC also emphasises children’s right to dignity, safety and protection from abuse and exploitation. In this area too, the silence around the sexual, physical and emotional abuse of children with disabilities is alarming.

Parents and teachers in India continue to shy away from discussing sexuality or personal safety with adolescents and children, or do not think of it as necessary (Saksena & Singh, 2018). 61% of disabled children attend educational institutions (Census 2011), but their teachers are not trained to address sexuality and abuse related issues. 54% of children with multiple disabilities and 50% of the children with mental illness never attended educational institutions. Thus, most adults with disabilities have grown up without access to sexuality education.

Discussion on sexuality is largely considered a taboo in India. People with disabilities are often scolded and ridiculed by their caregivers for expressing their sexuality and even special educators treat young people's sexual desire negatively (Nagaraja & Aleya, 2018). People with disability are considered asexual beings and most discussions around sexuality and disability focus on medical health, abuse, violence and consequences of unsafe sex. The full scope of sexuality as being vast and connecting deeply to human life and human rights at multiple points, such as intimacy, pleasure and eroticism, self-expression, self-worth, relationships, etc. is barely explored.

The United Nations Committee on Rights of Persons with Disabilities has explained stereotypes that are detrimental to women with disabilities such as, "being burdensome to others (i.e., they must be cared for, are a cause of hardship, an affliction and a responsibility, or require protection); being vulnerable (i.e., they are considered defenceless, dependent, reliant or unsafe); being victims (i.e., they are considered to be suffering, passive or helpless) or inferior (i.e., they are considered unable, inadequate, weak or worthless); having a sexual abnormality (e.g., they are stereotyped as asexual, inactive, overactive, incapable or sexually perverse); or being mystical or sinister (stereotyped as cursed, possessed by spirits, practitioners of witchcraft, harmful or bring either good or bad luck)" (Committee on the Rights of Persons with Disabilities, 2016).

Partly due to dearth of research and quality comprehensive education, the information gap around comprehensive pleasure and rights-based sexuality education has not been bridged appropriately or adequately (Sharma & Sivakami, 2019). Adolescents with disabilities are not taught sexuality etiquettes or reproductive health, and later, are blamed for being 'oversexed'. They may express themselves in 'socially inappropriate' ways, as their rights to dignity and education have not been addressed. People with disabilities from marginalised backgrounds find it difficult to access sexual and reproductive health information, care or services due to various factors - lack of information in an accessible format, infrastructural inaccessibility, dismissive or judgemental attitudes of service provider including medical personnel, lack of disability domain knowledge, lack of support from family members, lack of privacy and individual factors like personal inhibitions, sense of stigma and financial constraints (Sharma & Sivakami, 2019).

Another area of concern is how silence and stigma around sexuality makes children and adolescents vulnerable to sexual abuse. Many caregivers are unaware of the extent of child sexual abuse in India or that boys are equally, if not more, vulnerable to it. 53% of the 12,000 child respondents in a 2007 study by the Ministry of Women and Child Development (2007) reported sexual abuse. Children with disabilities have been found to be at much greater risk in several studies and how they often have no means to recognise or report it.

In India, due to various socio-economic and cultural factors, most parents find it challenging to bring up a child with disability. Many caregivers, parents, and other adult stakeholders often

assume that there are larger concerns looming in their lives, than puberty or sexuality. Therefore, it becomes important that this topic is discussed with respect and empathy for families, caregivers as well as for children and adults with disabilities themselves, since the majority of the stakeholders are in a state of unaddressed anxiety and fear due to widespread myths and limited access to knowledge around these subjects.

Through dissemination of information and training in accessible ways, people with disability, their family members, caregivers, teachers and trainers etc. can develop a deeper understanding of sexuality and life skills. This would result in enhanced self-esteem, a positive body image, more nuanced regulation of feelings, knowledge of personal safety rules, how to recognise and report abuse and to whom, a basic understanding of reproductive health and sexuality etiquette and the development of a positive attitude towards sexuality. This would enhance the quality of life of persons with disability and would be a huge step towards realisation of the rights of children and adults with disability.

Time frames, scripts and disability

There are ableist norms of how people should grow from childhood to adolescence, in terms of their physical and sexual development. A person goes through their stages of development through phases bound by time. For example, everyone must complete schooling by a certain age, obtain higher education, vocational or professional training by a certain age, get a job, get married, have children, etc. However, adulthood is often questioned in persons with disabilities - they are seen as 'unfinished adults' (Kafer, 2013).

What is required is to reconsider our ideas of what can and should happen in time, in what sequence, and if these should happen at all. Rather than trying to mould disabled bodies and minds to meet the clock, there is a need to bend the clock to meet disabled bodies and minds (Kafer, 2013).

Reflection:

1. *Is your home, the place of your work or study accessible to a person with disability?*
2. *Do you make your presentations, word documents, videos accessible for people with visual or hearing impairments?*

In the section below, we discuss some aspects of sexuality and sexual and reproductive systems in the context of disability.

Sexual development in children and adolescents with disability:

Physical changes:

In most children with sensory impairments and locomotor disability, puberty begins and progresses the same as in children without disability. Some disabilities like developmental disabilities, including cerebral palsy and spina-bifida, can affect the onset and rate of pubertal changes and menarche differently. In white children with Cerebral Palsy, it was found that pubertal changes began earlier but ended later in comparison to other white children (Worley et

al., 2002). However, it delayed the median age for onset of menarche in white females by almost a year from 12 years 10 months to 14 years, while spina bifida often caused puberty to begin early, and menarche also occurred almost 2 years earlier at 10 years 2 months (Murphy & Young, 2005). 20% of female children with spina bifida may experience precocious (early onsent) puberty, though the same has not been observed in male children with spina-bifida.

Children with developmental disabilities are 20 times more likely to experience early onset of puberty (Siddiqi et al., 1999). This is attributed to changes in the hypothalamus-pituitary axis in the brain that controls the timing of puberty and release of hormones that regulate the gonads - testes and ovaries. Presence of tumours, variations in the structure of the brain, injuries in the brain and genetic factors also have a role to play. At the same time, children with developmental disorders often have gastrointestinal issues that interfere with absorption of nutrients leading to them being underweight, thereby delaying the onset of puberty.

Personal care and hygiene:

Sometimes parents and caregivers may not focus on self-care aspects like toileting, bathing, changing clothes when the child with disability is young. This leads to lost learning opportunities. They, however, become increasingly uncomfortable in providing this support as the child enters puberty, especially if the parent or caregiver is not of the same sex. Early intervention and skill building is a far better option. With time, each family develops its own best practice to support the adolescent who is unable to manage such care on their own.

Emotional changes:

Adolescents with disability experience the same range of emotions as any other adolescent - they feel attracted to people, fall in love, may want to get married/ live with a partner, have children - they too want to follow the social scripts that they see around them. They also express themselves in similar ways based on what they see or hear in their homes, in the media or how they see their peers behaving.

A study conducted on examining the difference in aspects of sexual behaviour between adolescents with and without disability in the US found that although pubertal changes were delayed and were more isolated in the case of adolescents with disability, they were as sexually experienced as the adolescents without disability (Cheng & Udry, 2002).

Children and adolescents with developmental disability may not pick-up social cues as quickly or as easily as their developmentally typical peers. They also tend to have fewer social interactions and fewer intimate relationships. Precocious puberty or a delay in onset of puberty can negatively affect the body image and self-esteem of the child, further affecting their social interactions (Murphy & Young, 2005).

Social development:

Children learn by observation, imitation and then by practicing/modelling through trial and error and play. Playing games, going out with friends, interactions at home and outside afford opportunities for communication, emotional regulation, empathy, problem solving, creative and critical thinking, discovering oneself and developing one's identity. Friendships and relationships develop naturally in such interactions. All of this could be lacking to varying degrees for children and adolescents with disability depending upon the socio-economic factors, cultural milieu and the type and extent of disability. They are generally provided less opportunities for social interactions within or outside their homes due to society's attitude towards disability, and/or the unique features of sensory- motor and/or intellectual disability. This may interfere with intake and uptake of social cues and self-regulation. Interventions and surgeries that the child may require can further hinder the psycho-social development of the child.

Erik H. Erikson (1994) described eight stages of psychosocial development through the lifespan - trust vs mistrust (during infancy), autonomy vs shame and doubt (early childhood), initiative vs guilt (preschool), industry vs inferiority (school age), identity vs role confusion (adolescence), intimacy vs isolation (young adulthood), generativity vs stagnation (middle adulthood) and ego integration vs despair (maturity). Each of these stages may be hindered in children and adults with disability as psychosocial development requires opportunities for interpersonal interaction, feedback, introspection. Social skills training would require all these as well as rationale, modelling, rehearsal and reinforcement.

To enhance self-care and social competency, children and adolescents with disability often require focused intentional training, opportunities to practice the skills and reinforcement of positive behaviours. Parents and caregivers may feel apprehensive about letting their children be on their own out of concern for the child's safety. They may step in and 'help' - not only in personal care situations, but also in social interactions - as it also saves time. However, letting the person attempt again and again, eventually builds competency that is a huge boost to their self-esteem (and self-efficacy) and also promotes independence. The earlier in life this is promoted, the better would be the skill development.

Sexual development:

Children are born with sexual organs and are capable of experiencing pleasure by touching the genitals (see the Development of sexuality through the Lifespan chapter). As they grow older and begin to walk and interact with other children, they begin to explore each other's genitals. They are curious about the primary and secondary sexual organs of adults and attempt to touch, see or ask questions about these.

Pubertal changes are associated with heightened sexual desires and masturbation, and these generally bring about a romantic and erotic interest in other persons which persists to varying degrees into the later years. However, all these channels of learning and opportunities for exploration, experience and expression of sexuality are limited for individuals with disability. For example, persons with Autism may experience challenges in establishing and maintaining emotional relationships. Further, unique features of disability may be perceived by people as barriers in forming and developing relationships with the individual with disability. All of these factors come in the way of forming intimate and/or sexual relationships. The most significant

barrier is society's attitude towards disability, sexuality and sexual and reproductive rights of persons with disability.

Sexuality education for children with disabilities:

Sexuality education is often withheld from children with disabilities, including those with physical disability (Bermal et al., 1999; Stevens et al. 1996) This them of their right to information, to enjoy and satisfy their sexuality in safe and healthy ways, and exposing them to the risks of unprotected sex and sexual abuse. Parents often feel that talking about sex would increase sexual experimentation while the opposite is actually true - having open discussions, and explaining sexual behaviours can reduce the likelihood of abuse (Committee on Child Abuse and Neglect, & Committee on Children with Disabilities, 2001).

Lack of sexuality education from parents, teachers or the medical practitioners limits an adolescent's learning sources to the media, the internet and the experience of their peers. The silence and stigma around sexuality and the sexual and reproductive system also make children vulnerable to sexual abuse. Many children with disability can learn to recognsze and report sexual abuse.

Principles of sexuality education

The following section is customised for children with intellectual disability. Parents, teachers and caregivers can customize the same for the child in their care.

- Have frequent values and rule-based conversation with ease and comfort.
- Emphasise and demonstrate boundaries and respect for the other.
- Understand that the adolescent with disability has the same range of sexual thoughts, desires, fantasies, etc. as anyone else, but has fewer opportunities to engage in age-appropriate sexual activity, while keeping their social context in mind.
- Adolescents may see public displays of affection by people who are around them, on television or online. Young viewers tend to imitate and play out what they have seen. Movies and serials can create unrealistic expectations. The caregivers can provide education and training in appropriate expressions of sexuality.

People with intellectual disability (ID) can be vulnerable to abuse because they don't always recognise when something isn't right. So, you might need to explicitly teach your child the difference between safe touch and unsafe touch. For example, one person might like to be tickled (this is a safe touch), whereas someone else might not enjoy being tickled (this is an unsafe touch). Or it may be okay to kiss a close friend or family member on the cheek, but it's not okay to kiss a stranger. Visual materials showing appropriate and inappropriate touching can be used. Social Stories© (developed in 1991 by Carol Gray) might also be useful. Here are some examples of unsafe touch:

8. Touching of private areas (other than safe adults touching the private areas for assistance in cleaning, dressing up and doctors examining in the presence of a safe adult)
9. Hitting
10. Unwanted kissing on the cheek

The child/adolescent might come across pornography on the internet or might be exposed to it through their peers. Discuss pornography with the adolescent. Pornography is not sexuality education and sexual acts depicted in pornography are exaggerated and often exploitative. It does not build care and respect for intimate relationships, sexual acts or even for oneself (Perry, 2015). For a person watching pornography, risk of cyber harassment and bullying increases and they might also act out what they have seen.

Sexual development in adolescents with autism spectrum disorder (ASD) usually occurs in the same way as in other adolescents, but they might need extra support and guidance to build social skills and to manage their developing sexuality. Since sexuality education for children with disability, especially children with ID (Intellectual Disability) is rarely made available, they may lack the basic understanding of safety, concepts of private and public spaces and privacy. Because of disability, some people may face challenges with communication; understanding others' perspectives; keeping personal boundaries; or picking up non-verbal cues. Such behaviour may come across as inappropriate. Behaviours like touching others' private parts, pulling at others' clothes, talking about sex or private parts in public, using or showing pornographic content, etc. can put children/adolescents with disabilities at risk of sexual exploitation. They could inadvertently break personal boundaries which may lead to them being in conflict with the law and being accused of committing sexual offences.

The World Health Organization defines comprehensive sexuality education (CSE) as "a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives" (UNICEF & UN Women, 2018, pp. 1–3). Comprehensive sexuality education needs to include how to build a positive self-esteem and body image as well - besides focusing on positive attitude to sexuality, basics of human sexual and reproductive system and pubertal changes, personal care and hygiene, how to manage sexual desires, masturbation, pornography, how to manage romantic feelings and relationships, contraception, STIs, sexual and reproductive rights and responsibilities, consent, respect for boundaries, and medical examinations.

Moreover, educational materials need to be customised to the person's specific learning abilities. Material used needs to be clear, have anatomically correct representations and done in a setting that is equitable for the person with disability. Role plays, frequent review, repetition and reinforcement can help in retention and behavioural change. One-to-one teaching and learning may be required.

Reflection*:*

- *What would your response be if a person with a disability, whom you have known for a while as a friend, expressed their romantic and sexual interest in you?*

Sexuality and the adult with disabilities

Sexual identity and sexual self-image:

Society's negative attitude towards disability and sexuality affects the sexual identity and self-image of adolescents and adults with disability. Interference with stages of psycho-social development affects the success of forming and retaining sexual and/or romantic relationships. Experiencing sexual abuse further negatively affects sexual relationships and one's sexual self-image (Basson, 1998).

Sexual pleasure and satisfaction:

Sexual desires and feelings arise naturally, irrespective of the nature of one's ability or disability. The brain has been considered the most important sexual organ (Dennis, 2004) and studies have shown that sometimes thoughts alone can lead to orgasm (Komisaruk et al., 2006). Different disabilities have different effects on a person's capacity to express their sexuality and participate in sexual activities. Neurological impairment can result in loss of sensations in genitals or limit one's movements. Sexual pleasure can also be derived from erogenous zones other than the genitals like the mouth, lips, ear lobes, neck, breast, nipples, area between the genitals and anus (perineum), back of the knee and feet. A person could explore and determine which parts of the body are more erogenous for them. Similarly, all senses - and not just touch - could be explored to see if these lead to sexual excitement. Visual, auditory, olfactory (smell) and gustatory (taste) senses could be explored by the sexual partners through creative use of clothing, accessories, sexual conversations, visualisation (thoughts), scents and taste. Different types of penetrative sex (engaging different orifices in the body) could be explored - using body parts or sex toys.

The majority of males with spina bifida (75%) can have an erection with direct stimulation of the penis, however they may have difficulty in sustaining the erection for penetrative sex (Liptak, 2003). Locomotor disability may interfere with one's ability to adopt certain postures and positions. Accessories, supports, sex toys, creative positions could be used to obtain and provide sexual pleasure. A physician or a sex therapist could be consulted in case of pain or anxiety about faecal or urinary incontinence or other concerns.

Reproductive health and the adult with disabilities:

Menstrual management:

This can be taught to almost all girls with disabilities. In case of menstrual disorders, gynaecological examination and appropriate treatment should be sought.

Gynaecological examination and treatment:

This can be particularly challenging for persons with certain locomotor disabilities. With proper and patient explanation, allaying any fears, explanation of the procedure, modification and use of appropriate implements, internal examination can be done, if required.

Fertility

Retrograde ejaculation (ejaculation into the bladder rather than out of the penis) and reduced sperm motility may happen in people with spinal injuries or spina bifida, reducing their fertility. Most neuromuscular disorders (except myotonic muscular dystrophy and X-linked spinal bulbar muscular atrophy) do not affect fertility. Most women with disabilities may be fertile but conception, pregnancy, delivery and care of the baby may pose challenges that would be best addressed by a multidisciplinary team and social support.

Use of contraceptives:

Decisions regarding use of contraceptives are best made in consultation with a health care provider, the person with disability and their partner and parents or caregivers, when and if appropriate. Certain medications can interfere with and reduce the effectiveness of oral contraceptives. Condoms made of polyurethane are more likely to tear and break than those made of latex. People with spina bifida tend to have more latex allergies.

Parents or caregivers sometimes request for sterilisation of the person with disability. Many such procedures are performed, often without the consent of the disabled individual. It is important that such decisions are made keeping in mind the person's rights, needs, desire for children, ability to care for them,decision-making abilities, available support from the family or state and the existing laws.

Reproductive rights of women with Disabilities

The following is an excerpt from Swagata Raha & Shampa Sengupta, "Rights of Women with Disabilities under Indian Legislations", Socio-Legal Review, Vol14, pp.191-211 at pp.208-210.

Reproductive rights intersect with the right to exercise legal capacity and the protection from violence, especially in the context of bearing and raising children. Article 23(1)(c), UNCRPD emphasizes that PWDs, including children, "retain their fertility on an equal basis with others", but does not make any reference to forced sterilizations. The Committee on the Rights of Persons with Disabilities in General Comment No.3 (2016) on women and girls with disabilities, made observations about the pervasive violation of the right to legal capacity of women with psychosocial or intellectual disabilities. It stated:

> *Forced contraception and sterilization can also result in sexual violence without the consequence of pregnancy, especially for women with psychosocial or intellectual disabilities, women in psychiatric or other institutions and women in custody. Therefore, it is particularly important to reaffirm that the legal capacity of women with disabilities*

should be recognized on an equal basis with that of others and that women with disabilities have the right to found a family and be provided with appropriate assistance to raise their children.

Section 10(2), RPD Act protects PWDs from being subjected to medical procedures which lead to infertility without their informed consent... Under the MH Act (Section 95(1)(c)), sterilization of men or women is prohibited if it "is intended as a treatment for mental illness". ...This is a restrictive provision as it is possible that sterilization may be carried out for convenience and non-medical reasons (Raha S, 2009; Abreu R, 2013).

The Supreme Court in Suchita Srivastava v. Chandigarh Administration (2009), a case predating the RPD Act, where the woman had become pregnant because of rape while living in a government-run welfare institution; emphasized "that persons who are found to be in a condition of borderline, mild or moderate mental retardation are capable of being good parents." It regarded forced sterilisations and abortions of persons with mental retardation as being "anti-democratic and violative of the guarantee of 'equal protection before the law' as laid down in Article 14 of the Constitution." Further, it opined that "the language of the MTP Act clearly respects the personal autonomy of mentally retarded persons who are above the age of majority." A trust filed an affidavit signifying its willingness to "look after the interests of the woman in question which will include assistance with childcare".

Unlike the Suchita Srivastava case, at the ground level, we find several disabled women coming from lower economic backgrounds, mostly from rural areas, who become pregnant as consequence of rape, for whom bearing and raising a child is difficult without any State support.[49] However, the RPD Act does not obligate the State Government to provide any assistance to disabled women who become mothers.

Sexuality, myths and the person with disability

Several myths surround the sexuality of persons with disabilities, especially those with intellectual disability. Most are harmful and deprive the individual of natural, normal experiences that others enjoy as their right. Our physical, emotional and psychological spaces are shaped by non-disabled majority - also called the ableist or "normate" world - therefore some of it may come across as ignorance, negative attitude and hostility. Some common myths are discussed below:

- **Myth: People with disabilities do not have sexual feelings, or are not sexual, lack desire for sex**
    - **Fact:** Children and adults with disabilities experience bodily changes and feelings like any other person (Saksena & Saldanha, 2003). People with disabilities come across as being asexual because of the way society views disability - as needing constant care, as making an individual broken, weak or helpless. When providing sex and sexuality education to children and youth with disabilities, one would need to keep their unique needs in mind. For example,

[49] This is based on Shampa Sengupta's direct experience of working with women with intellectual disabilities and their families through Sruti Disability Rights Centre, Kolkata.

children with developmental disabilities may learn at a slower rate than peers yet physical maturation usually occurs at the same rate. They would need comprehensive sexuality education that builds skills for managing sexuality in fulfilling and healthy ways, and appropriate language and behaviour in public.

- **Myth**: **People with disabilities are innocent like young children with little or no knowledge of sex.**
    - **Fact:** Many adults mistakenly view young children - with or without disability - as asexual. They consider knowledge of the body's sexual functions as undesirable and 'corrupting' for young children - and prefer to label such ignorance as *innocence*. They tend not to answer young children's questions around genitals or how babies are made and born. This is rooted in the larger societal discomfort with sexuality. When people think of someone with a disability, they often think of someone who is in need of care as weak or helpless and find it convenient to label persons with disabilities as 'children'. Compounded by society's general discomfort with sexuality, it becomes convenient to view a person with disability as an 'innocent, asexual child' whatever be their age. This is called infantilisation. By doing so, they also automatically ignore or deny their sexuality, rather than accept and acknowledge it and support the individual in managing it. This view may also be the foundation for the denial of many rights that an adult may fully expect to experience - e.g., bodily integrity, freedom of expression, freedom of association, etc. Their feelings may be trivialised in this manner and their rights not respected. Because of their disability, they may find it difficult to seek restitution of their rights.

9. **Myth: People with disabilities have uncontrollable and unmanageable sexual urges (oversexed)**
    a. **Fact:** Belief in this myth can result in reluctance to provide sex education, as any input given may be viewed as furthering inappropriate, uncontrolled sexual behaviour. Some people with disabilities may take more time to pick up social cues. However, early and consistent inputs, scientific information, value-based discussions, teaching appropriate public and private behaviours and empowering socialisation that are provided in a way that is sensitive to their disability are key to ensuring healthy, empathetic and dignified sexual behaviour regardless of one's capabilities.
7. **Myth: People with disabilities can't have sex**
    a. **Fact:** A vast majority of persons with disability experience physical sensations just like persons without disability do. There are a few people that might have issues like pain, or paralysis which may obstruct feeling sexually aroused. People with physical impairments (including paraplegia) which make movement difficult may find certain positions and movements quite difficult. But through clever and comfortable positioning, they too find ways to derive sexual pleasure. There is a very small number of people with disabilities who have issues around the way their bodies work. They may feel their body but might not have much movement or sensation in their genitals. Even then, they can still enjoy a sex life as there are ways of creating and finding erogenous orgasmic zones in different parts of one's body that aren't centred exclusively around the genitals. That allows one to enjoy sexual activities and reach orgasm.

8. **Myth: People with disabilities only have sex with each other**
    a. **Fact:** Sexual partner(s) are a matter of choice and personal liking. Some people with disabilities may prefer to have sex with other people with disabilities as they may share similar experiences and an understanding of each other. Others may actively choose not to go out with them. The majority do not care if the other person is abled or disabled. However, they may find it difficult to find a partner who is willing to look beyond their disability and perceive them as potential sexual partners. The harm this does is that it makes people with disabilities unable to access sexual pleasure with a partner, unless the partner is similarly disabled. And at that time, they may feel a sense of disrespect towards their partner, or lowe confidence in themselves a partners.
9. **Myth: People with disabilities aren't sexy or desirable**
    a. **Fact:** This stems from the way that our ableist and neurotypical society thinks about disability and persons with disability, as unattractive and undesirable. A person's attractiveness or desirability does not rest on the way they look - their qualities, behaviour and other attributes are often considered more desirable by many people. Physical attractiveness is a biological mechanism that increases a person's desirability in the eyes of others. However, the stigma of disability means that people with disability are not seen as people who are different, so much as people who have something fundamentally 'wrong' with them. They are considered sexually undesirable as they do not "look desirable" because of their physical disability or they cannot behave in a way that makes them desirable because they have an intellectual/neurological disability. However, people with disabilities can be seen as sexy and desirable as long as we stop perceiving them as flawed; instead, we can see them as being different.
10. **Myth: People with disabilities can't have kids.**
    a. **Fact:** Most disabled people are fertile and can have children just like everybody else. There are a very small number of disabilities that impact fertility, but even then, with the help of modern science one can conceive or adopt children or have children through surrogacy. Once the sociological imperative to have children with your own DNA is not essential, the perceived ability of people with disability to have and raise kids is markedly improved. There will be challenges that a person with disability may face in the process of adopting a child and raising them, but these should not be equated to impossibility. Again, it is the mindset of an ableist society that makes these decisions on behalf of disabled people, thereby infantilising them.
11. **Myth: People with disabilities will pass on their disability to their kids**
    a. **Fact:** A majority of disabilities are not inherited, so they won't be passed on. But even for those that could be passed on, there is nothing wrong about being disabled. Support systems are required - not only by people with disability, but by all people, at some time or the other, to some extent or the other. Once the importance of support systems to individuals of all types is acknowledged, the fear of disability may be diminished. Living with a disability is just the same as living with another identity.
12. **Myth: If I have sex with a person with disabilities, I will catch what they've got**
    a. **Fact:** Disabilities are not contagious; they're not sexually transmitted.
13. **Myth: People with disabilities do not require sexuality education**

a. **Fact:** Ignorance makes people vulnerable to harm. A child, adolescent or adult with disabilities would benefit from scientific, value-based sexuality education just like any other person without disability. The tools and teaching methods would have to be individualised to meet the unique requirements of the individual. Some children with disabilities may experience physical development much earlier than intellectual or emotional development. Sexuality and personal safety education started early and provided in a structured, developmentally appropriate manner would enable the child/adolescent to build social and emotional skills and integrate into social environments more easily. It is also their right to have comprehensive sexuality education, as the right to education is a fundamental right. The same is true for an adult with disabilities.

14. **Myth: It is difficult to handle menstrual hygiene in women with disabilities.**
    a. **Fact:** Nearly all women with intellectual disability can learn menstrual hygiene just as they can learn about general hygiene. However, the level of independence in this task depends on their level of disability, associated problems and early opportunities for learning. Because of her intellectual disability or 'difficulty' in managing menstruation, the menstrual cycle of a woman may be suppressed (e.g., through hormonal treatment or non-consensual hysterectomies) However, this is not respectful of her right to bodily integrity, and reproductive rights.
15. **Myth: People with disabilities cannot form meaningful relationships, are not fit for marriage or committed relationships as they are dependent and cannot make decisions. They are a burden on their partners.**
    a. **Fact:** The level of support a person requires depends on the type and extent of disability and other environmental/ economic and social factors. The majority of people with disabilities do not need much, or any, care at all. They are independent, earn to make a living and are able to reciprocate and participate in intimate relationships. Some people with disabilities overtly appear to be unable to fully participate in an intimate relationship. They might require a high level of support and care, more so than others, from family and society. For a fact, every individual in society is dependent on others. The position at which we draw the line that separates people with disability from others is quite arbitrary and is a form of ableism. It is also how the dependency of individuals is defined that allows us to make conclusions about their suitability and capacity for intimate, meaningful or committed relationships like marriage.
    b. In fact, Article 16 of The Universal Declaration of Human Rights states that (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution. (2) Marriage shall be entered into only with the free and full consent of the intending spouses. (3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.
16. **Myth: Consent doesn't matter for a person with disability**
    a. **Fact:** Consent is crucial for any healthy relationship. It becomes extremely important, and no doubt, complex in the context of disability. This myth arises from society's misplaced conceptualisation of persons with disability as 'innocent children' and an extension of the misconception that 'if disabled in one way, disabled in every way' including cognitive disability. People feel that a person with disability cannot distinguish right from wrong or that consent -

especially sexual consent, does not hold any meaning for them. Because of these myths, people with disability do not receive adequate information on various topics including sex and consent, in an accessible format. In instances of intellectual disabilities, even if there is consensual sex, it may be difficult to determine if the person understands the consequences of sex and is giving informed consent. The risk of sexual violence against people with disabilities is 3.4 times higher than those without disabilities (Sullivan & Knutson, 2000). The nature of disability may make it difficult for the victim to recognise, resist or report abuse. The perpetrator of abuse often takes advantage of this. The person with disability may also be dependent on the abuser (if it is a known person, a caregiver, for example.) for various types of support - making it that much harder to report the offence.

17. **Myth: People with disability can't use/ don't need contraception**
    a. **Fact**: Most men with disabilities can impregnate someone and most women with disabilities can get pregnant. They are also equally susceptible to sexually transmitted infections (STIs). They have an equal right to information and support in using and choosing the contraceptive methods most suitable for them. With education and awareness, we can guard against making inaccurate assumptions regarding sexuality of persons with disability.

Vulnerability, sexual abuse and the person with disabilities:

According to Government of India Study on Child Abuse (2007), 53% of the children said that they had faced some form of sexual abuse. The majority of perpetrators were known to the child. Disabilities, especially intellectual disability, multiply the likelihood of sexual abuse. Studies have found that children, adolescents, and adults with intellectual disabilities (ID) are particularly vulnerable to sexual abuse and exploitation and are in need of intervention services (Dion et al., 2013). Children with intellectual disabilities were found to be at a slightly greater risk of sexual abuse than children with disabilities in general, who in turn were at a 3.14 times greater risk of experiencing sexual abuse than children without disabilities (Peterson et al., 2014). Some disabilities like spina bifida, or some developmental disabilities make a person prone to precocious puberty. Precocious puberty is the condition where pubertal changes begin before 8 years of age in females (including breast development and onset of menstruation) and 9 years in males (including enlarged testicles and penis, facial hair and deepening of voice). This can heighten the risk of sexual abuse, especially in environments where awareness is lacking.

Children with disabilities are also denied the right to privacy, right to set boundaries from touch and any information around sexuality and safety. Indian parents and teachers, who by and large avoid discussing sexuality with neuro-typical children/adolescents may label children/adolescents with ID as 'hypersexual' and punish them for failing to deduce and conform to social norms. This (understanding and conforming to social norms) is, ironically, exactly the issue people with intellectual disability find most challenging.

Children and adolescents with intellectual disability may be vulnerable due several factors:

- Dependency on others for personal care
- Multiple caregivers in different settings
- Adults generally playing a role of authority

- Seeking affection due to lack of socialization
- Difficulties in understanding or drawing boundaries
- Inadequate access to personal safety and sexuality education
- Difficulty in communicating about abuse
- Lack of learning opportunities - parents and caregivers may be over-protective and not leave the child or adolescent unsupervised, thereby taking away opportunities for the child to establish their personal space and boundaries.

Communicating with a person with disabilities about abuse

Parents, caregivers and medical practitioners can be alert to signs of sexual abuse, especially if the person with disability is not able to communicate. Signs such as change in bladder or bowel movement, sudden onset of bed wetting, change in eating pattern, sleep disturbance or change in behaviours including suddenly avoiding people or a certain person etc. need to be explored further, keeping in mind the possibility of sexual abuse.

Talking to children with disability when there is a suspicion of sexual abuse can be challenging. A person skilled in communication and rapport building with the persons with that particular type of disability would be best suited to communicate with the child or adult, The same can be communicated to the counsellor/ primary interviewer. Patience, commitment and adequate time would be required. A multi-disciplinary team would be most helpful to have especially in the context of disability, sexuality and abuse. (Refer to the chapter on Sexual Violence against Children for more details.)

Adults with disability (especially Intellectual Disabilities) and allegations of sexual harassment:

Persons with intellectual disabilities (ID) need special attention to their overall safety. There can be occasions when they unintentionally do some acts which are considered inappropriate, harmful or abusive in common parlance. Persons with ID do such acts without understanding the impact of their actions. For example, after puberty begins, hormonal change triggers sexual developments in the body of every individual, including a person with ID. This leads to increased feelings and curiosity, increased experimentation, adult-like behaviours and also acts that are sexual in nature such as masturbating in public, body rubbing, fondling or trying to have forced oral/genital contact (Stop It Now, 2007). In such cases, the persons with ID do not carry any harmful intent, but their actions may result in causing harm to their own self or to the other. Most of them do not also understand that the behaviour is harmful/abusive.

The question arises: what immunity does the criminal legal system in the country provide to persons with ID if their act ends up being abusive and thereby unlawful? Do they have any immunity from criminal liability?

According to Section 20, BNS/section 82 of the Indian Penal Code (IPC) a child below 7 years of age gets a complete defence from any kind of criminal liability. It means that a child under the age of 7 cannot be said to have committed an offence. While the Protection of Children from Sexual Offences Act (POCSO) does not include such a provision, the BNS ~~IPC~~ immunity would apply for any POCSO offences as well. The law imposes an iron-clad presumption that children below the age of 7 years are *doliincapax* (A Latin phrase refers to the presumption in

law that a child is incapable of forming the criminal intent to commit an offence). Children between the ages of 7-12 are also presumed to be incapable of committing crimes, but this is a rebuttable presumption. This means that a child between 7-12 years can be subjected to an inquiry under the juvenile justice system unless it is established that the child lacks sufficient maturity to understand the nature and consequences of the act.

The only immunity that the criminal law structure in the country provides to any individual with ID is the defence of insanity under Section 22, BNS/section 84 of the IPC. It is based on the assumption that at the time of the crime, the defendant was suffering from severe mental illness and therefore, was incapable of appreciating the nature of the crime and differentiating right from wrong behaviour, hence making them not legally accountable for the crime (Math et al., 2015).

Section 22, BNS/Section 84 IPC can be divided into two broad categories of, major criteria (medical requirement of mental illness) and minor criteria (loss of reasoning requirement). Both major (mental illness) and minor (loss of reasoning) criteria constitute legal insanity. Researchers have pointed out that there is no definition of "unsoundness of mind" in the IPC [The BNS retains this provision, except that it replaces the term 'unsound mind' with 'mental illness']. The courts have, however, mainly treated this expression as equivalent to insanity. But the term "insanity" itself has no precise definition, carries different meaning in different contexts and describes varying degrees of mental disorders (Math et al., 2015). Moreover, insanity defence is a legal concept, not a clinical one (medical one). This means that just suffering from a mental disorder is not sufficient to prove insanity. The defendant (the person charged with the act of violation) has the burden of proving the defence of insanity (State of Rajasthan v. Shera Ram @ Vishnu Dutta, 2012). It is hard to determine legal insanity, and even harder to successfully defend it in court.

Hence, according to most researchers working in this field, with the broader understanding of disability, there arises the need for reform in the way people with IDD charged with sexual offences, particularly adolescents, are treated under the criminal justice or juvenile justice system.

Also, the criminal justice system must include Psychiatrists to assist the court in determining psychological disorders. At present, no such system is in place in the Indian Criminal Justice System. Researchers in this field have urged that there is an urgent need to initiate formal training and sensitisation of the judiciary, setup Forensic Psychiatric Training and Clinical Services Providing Centres across the country to increase the necessary human resources to the criminal justice system who would be capable of clarifying psychiatric issues, provide honest and objective opinions based on factual data and sound reasoning. Psychiatrists should also look into behaviours of the defendant before, during, and after the commission of the act that is considered to be an offense, which can give clues toward a person's complete mental status. A standard evaluation procedure of all persons who plead insanity defence is absolutely necessary. It is unfortunate that till date, no such standardized procedure exists in our country. To provide a fair and speedy trial, forensic psychiatry needs to be given utmost importance. The IPC could make such provisions mandatory when a person with disability is accused of a crime.

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - How To Mitigate The Effect Of Disability On Sexuality? (link will be inserted)

Way forward

We can develop an accepting, empowering and empathetic attitude towards all people. Language is a significant and powerful tool of empowerment. It can create a sense of inclusion and pride. When we address someone or talk about someone, or think of ourselves, words become important in forming a sense of identity and self-esteem. This especially holds true for persons with disabilities.

Language used to refer to people with disabilities may either be what we now call the 'Identity-first' language or what we have mostly used in this reference book which is the 'Person-first' language.

People who use the Person-first Language believe that people with disabilities are, first and foremost, people and that their entire identity should not be reduced to their disability. Some people may find it disrespectful and dehumanising to be labelled by the disability they have. According to this school of thought, a person isn't a disability, condition or diagnosis; a person has a disability, condition or diagnosis.

However, some people with disabilities believe that just by changing words, their reality does not change - much more needs to be done to make a real difference and be truly inclusive. They also prefer to claim their disability as their identity instead of obscuring it and they prefer to use the 'Identity-first Language' in references to themselves (Mackelprang, 2010). Identity-first language was born of the disability pride movement (which took root in the 1990s in the US) which pushed for the idea that a disability is nothing to be ashamed of (compared to the Person-first language which some thought tried to distance them from their disability, to be respected and treated as equal)

To determine what might be the most appropriate language to use, it is best to ask the particular individual or members of the particular community rather than assume that what one believes in holds true for others too. Language that may be empowering to some may be traumatising for others.

Some examples of Person -first and Identity -first language are:

Person First Language	**Identity First Language**
Person with a disability, people with disabilities	Disabled person; the disabled[50]

[50] Some persons with disabilities prefer the term 'disabled person' to be used to refer to them

Person with paraplegia	Paraplegic; paraplegic person
A person of short stature	Dwarf, midget
A person with autism	Autistic person
A person who cannot see/ who is blind	A blind person

Other recommendations are that we could avoid using language that portrays the person as passive or suggests a lack of something: victim, invalid, defective.

Use	**Avoid**
Person who has had a stroke	Stroke victim
Congenital disability	Birth defect
Person with epilepsy	Person afflicted with epilepsy, epileptic
Person with a brain injury	Brain damaged, brain injury sufferer
Burn survivor	Burn victim

(Source: https://adata.org/factsheet/ADANN-writing)

Chapter 11. Sexual Relationships
-understanding how attraction works, respecting diversity in sexual and living arrangements

We're social beings and seek out other people to build connections and relationships with and these relationships can also be sexual in nature. We may engage in sexual activities due to attraction towards another person, to express ourselves sexually and experience sexual pleasure, to enhance the bond in an existing relationship, for the purpose of reproduction or may be simply fulfilling societal expectations to sustain social structures and institutions like marriage, family etc. Society tends to define, formalize and even legalize certain forms of relationships as desirable, and exclude others as 'immoral' or 'inappropriate', in an attempt to control (primarily) women's sexuality and maintain power structures within the community. Sexual attraction, however, can't be regulated and many have resisted and pushed back against these strictures to establish multiple other ways of being in relationships with each other that also involve sexual pleasure.

Sexual autonomy is an important and core component of sexual freedom and rights. This refers to the right to determine and decide who one will have sexual relationships with, in what forms and to be able to insist on one's sexual rights being respected. Many individuals don't get to exercise this right and are coerced by institutions and cultures (religious or otherwise) to give up their right to choose. This prevents them from developing healthy sexual relationships and also allows the prevalent patriarchal attitudes to continue. Those most impacted are sexual and gender minorities, women, children and people with disabilities.

In this chapter we will look at the dynamics of attraction and multiple forms of sexual relationships through the lens of romance, love, pleasure and commitment – all as different as well as valid preferences of individuals in consensual relationships.

Attraction

Research studies have identified various aspects of a person that make them sexually attractive. Conventionally, it is thought that being 'good looking' is an important aspect to be thought of as sexually attractive. However, the standard of 'good looks' is a variable that changes according to culture, region, era and politics of the time. These standards are then reinforced by popular figures of the time and the media, and shape our idea of attractiveness accordingly.

We use our senses to find potential sexual or romantic mates and are also drawn to other bodily characteristics like -

k. Voice: indicates a sense of vigour, health and confidence. Multiple studies have shown that instinctively, individuals tend to use a lower pitch when they are trying to woo or attract another person and that in laboratory settings, subjects have often shown a preference for lower pitched voices irrespective of gender (Woznicki, 2010; Bering, 2014; Oguchi & Kikuchi, 1997).
l. Smell - axillary and pubic hair traps pheromones, which are released once puberty begins. Each of us also has a unique "odorprint" (Hadhazy, 2012).

m. Feel of the skin – certain kinds of consensual, caring touch stimulate the production of oxytocin and the reward pathway in the brain. Hugging and stroking are therefore useful indicators of whom one may find sexually attractive.
n. Taste (from kissing) – saliva has MHC (Major Histocompatibility Complex) antigens that indicate the level of compatibility between people. Saliva is also thought to trigger release of oxytocin and dopamine, increasing the levels of bonding and pleasure among partners.

There's more to sexual relationships than these basic instincts. We also have the ability to weigh our options, to acknowledge our preferences and to choose our way of life, however sometimes, only within the boundaries defined by our family, community and social structures and the access we may have to the opportunities we seek.

When we are thought to get 'infatuated' by someone, usually said to occur in the early stages of a romantic or sexual relationship, our cortisol levels increase, serotonin levels decrease and we may experience intrusive and preoccupying thoughts. During this phase, the neural pathway, responsible for emotions like fear and critical evaluation, is deactivated by this cocktail of chemicals in the body. The neural system that helps make critical assessments shuts down. Serotonin provides a sense of being in control and this reduces during infatuation or the feeling of losing control.

According to research, romantic love lasts for about a year (similar to infatuation/ limerence) before being replaced by a more stable, non-passionate "companionate love." Companionate love, also known as affectionate love, is a slow-to-develop affectionate love or attachment, where the mad passion of the infatuation stage gives way to more durable intimacy and commitment.

Factors that impact attraction

Role of hormones and pheromones in enabling attraction

While a lot of what happens hormonally is not very clear, many studies have tried to isolate how and what hormones work and to what extent, during and for what period. Some of the findings are listed below and they are by no means comprehensive or conclusive, but just an indicator of the many variables and combinations of hormonal factors that determine sexual attraction in humans.

9. Attraction involves the reward centre of the brain. When we enjoy an experience, like being with someone, doing something with them, high levels of dopamine and norepinephrine/ noradrenaline are released causing the feeling of 'attraction'. This is experienced as an elevated sense of excitement, energy and euphoria. This is accompanied by a reduction of a hormone called serotonin, leading to a loss of appetite and mood – often considered signs of being 'madly in love'.
10. Oxytocin and vasopressin interact with the dopaminergic reward system and can stimulate dopamine release by the hypothalamus.
11. Pheromones are chemicals that act like hormones but external to the body, with their intended effect on the potential sexual partner. Pheromones are thought to release a

certain odour, through glands located on the body surface (esp. in six areas - the axillae, the nipples, the pubic area, the lips, the eyelids and the outer ear) that is found attractive to another individual of the species (Mostafa et al., 2012).

12. Studying how ovulation affects sexual attraction in women, Steve Gangestad, distinguished professor of psychology at the University of New Mexico, in a study of 238 college women in 2007 found that "in mid-cycle, women tended to prefer flings with "caddish" men. On average, fertile women were more interested in short-term relationships with men who came across as confident, or even cocky, on videotape. In comparison, at other points in their cycle, they gravitated toward longer-term relationships with kinder, more conscientious, deferential types — good father material" (Law, 2011)

External factors that impact attraction:

- Physical familiarity – researches have shown that people are regularly attracted to others who are physically similar to their opposite sex parent – especially the hair and eye colour of the other. This is understood as an outcome of imprinting processes during infancy (Little, 2003).
- Similarity or dissimilarity of the attitudes - The proportion of shared similar attitudes or opinions between a subject and their target has been found to positively and linearly predict attraction (i.e., more similarity = more attraction). Research published in the journal 'Proceedings of the National Academy of Sciences' found that spouses tend to be more genetically similar than two individuals chosen at random (Domingue et al., 2013). Opposites also attract, like the old cliché goes, but in a smaller percentage of cases. The biological advantage of attraction between people who are very different from each other, is perhaps to ensure diversity in gene expression and improve survival rates and healthy genes.
- Social standing - Higher the prestige/status of the individual, greater was found to be the attraction. However, knowing more about the attitude of the person decreased the effect of social status/prestige. (15) (34).
- Academic and intellectual competence - has been found to increase attraction in some studies. (63,125). Persons who are attracted by these qualities are called sapiosexuals

Reflection*:*

- *Do you think there is a difference between infatuation and long-lasting love? What comes to mind when you think of these forms of attraction - what values, opinions and judgements do you hold around these?*
- *How do you feel when you are attracted to someone? Physical experiences? Thoughts and feelings?*
- *Is it normal to be attracted to multiple people at the same time?*

Romantic Relationships

Physiology of romantic relationships

One of the major biological systems that may play an important role in the formation of romantic attachments is the stress response system. Research suggests that the activation or inhibition of the stress response system regulates experiences of attraction, mate preference, and emotional connectedness. New findings suggest that as the romantic relationship progresses, partners' physiological patterns reinforce the pair bond and affect overall well‑being.

In 2005, the first fMRI study of people experiencing romantic love was conducted (Fisher et al., 2005). Seeing photos of people, they were romantically attracted to, activated the dopamine-rich areas of their brain. These parts of the brain were also associated with reward-detection and expectation; and with pleasure, focused attention and motivation to pursue and acquire rewards – which in this case was to ensure that they sustained the attention of their partners and did what it took to keep them in committed relationships.

Long-term intense romantic love was also studied (Acevedo et al., 2012) and it was found that for intensely loved, long-term partners, the following parts of the brain were activated i.e.

- Areas of the dopamine-rich reward systems consistent with results from studies of early-stage romantic couples
- several regions implicated in maternal attachment

Correlations of neural activity in regions of interest with widely used questionnaires showed:

11. Responses from dopamine-rich parts of the brain correlated well with romantic love scores and inclusion of other in the self;
12. Maternal attachment parts of the brain correlated with friendship-based love scores;
13. Some parts of the brain (like the hypothalamus) correlated with sexual frequency; and
14. a number of other regions of the brain responded in correlation with obsession.

“Overall, results suggest that for some individuals the reward-value associated with a long-term partner may be sustained, similar to new love, but also involves brain systems implicated in attachment and pair-bonding” (Acevedo et al., 2012).

The reward circuit utilizing dopamine is what makes love addictive (Wu, 2017) making it impossible to think of anything else, and to be constantly obsessed with our partners. This is the infatuation stage that was explained earlier. The next is the attachment stage which is characterized by high levels of oxytocin and vasopressin that lead to a high level of well-being and security that is conducive to a lasting relationship (Parvez, 2018).

Similar to the study previously stated, researchers used pictures and fMRI imaging to see brain activity when pictures were shown. However, the difference was that they showed a variety of pictures. Participants were shown pictures of someone they love, a stranger, people they know but are not in love with, and pornographic photos. The conclusion of this study was that “both stimuli activate the brain’s pleasure centre (nucleus accumbens), but only love activates the region that assigns value (insula)” (Weiss, R. 2015).

Psychology of romantic relationships

In a research in Utah, it was proposed that sexual desire and romantic love are very separate, and that romantic love can occur in both same-gender or other-gender partners (Diamond, 2003). Romantic relationship suggests a long-term commitment between partners involving all or a combination of physical, emotional and social intimacy.

We discussed the physiological bases that might support such pairing and bonding earlier. However, a committed relationship – and we will look at cis-heterosexual relationships to start with – is not just an outcome of physiological or chemical machinations. Studies show us that many other survival compulsions may also have shaped the need for humans to pursue mostly monogamous relationships unlike other primates in our mammalian group, who still tend to be polygamous.

The theories that have found some support are related to

- Preserving wealth and power through committed relationships like marriage
- Ensuring the containment of sexually transmitted diseases that threatened to annihilate communities if they practiced promiscuity and increasing the chances of survival and reproduction
- Protection of one's offspring and increasing chances of its survival (which otherwise could be killed by other males so they could mate with the same female when she comes back to heat early)
- The two-parent advantage – where it is hypothesized that a child raised by 2 parents has a psychosocial advantage over the ones raised by single parents
- Ensuring social support and benefits that arise from legally recognized committed relationships

Among members of the LGBTQia+ community, monogamy has been an evolving matter. Given the pressures to conform to a heteronormative world, the pride movement in the early days seemed to reject any form of imposed structures of commitment and monogamy. Same-sex relationships for instance, while they are modelled initially along heterosexual lines (attraction, bonding, deepen commitment, deteriorate and end – Levinger's ABCDE model (1980) find that it is limited and does not address their unique circumstances like having to 'come out' about one's identity or orientation, having to negotiate preferences or even discover them along the way, social/ legal constraints that one has to be concerned about etc. Being queer is often associated with sexual freedom and experimentation. This idea has positive and not-so-positive connotations – while it has given the LGBTQia+ community the space to break out of the strict heteronormative sexual mores and feel more liberated in their preferences and choices, it is also often associated with promiscuity and immorality by society.

The other influencing factor that determines the quality and health of adult relationships are the attachment styles of individuals. Attachment styles are related to the bonds that develop during the course of interactions between a child and its primary caretaker – the emotional, psychological and social connections that a child experiences that shape how this child will learn to connect with others as an adult. The different attachment styles are thought to be secure, anxious-ambivalent, anxious/ fearful - avoidant, dismissive-avoidant and disoriented.

Secure attachment styles are associated with healthy and trusting relationships (Ainsworth, 1979; Simpson, 1990). Research has found that secure adult attachment, leading to the ability for intimacy and confidence in relationship stability, is characterized by low attachment-related anxiety and avoidance, while the fearful style is high on both dimensions.

Diverse living and relationship arrangements:

Monogamy

Monogamy is a dyadic living arrangement where an individual has only one partner during a lifetime or one partner at any given time (serial monogamy). To get a sense of how prevalent this living arrangement may be, data from the Ethnographic Atlas Codebook by George P Murdock is useful. It recorded the marital composition of 1231 societies from across the world, between 1960 and 1980 and found that 186 were monogamous; 453 had occasional polygyny; 588 had more frequent polygyny; and 4 had polyandry.

Monogamy is usually institutionalized within society through legal, social and religious structures that encourage marriage between heterosexual partners, which is commonly considered as a life stage, an organic progression in life (which it is not, in fact), as decreed by the Gods as the right and virtuous thing to do, celebrated and revered in communities. It is also recognized and protected by law and other institutionalized policies, which assures marital partners of certain benefits and security (property claims, protection from 'infidelity', 'conjugal rights', work/ residence permits based on partner's employment and such). It is important to note here that monogamous marriage systems are not necessarily monogamous mating systems – marriage in some cultures may be considered a social obligation that one fulfils while seeking sexual relationships outside of it (an arrangement that is usually condoned in public, but permitted covertly)

Mammalian monogamy is a puzzle because, theoretically, males could have more offspring if they mated with many females instead of being committed to one. In humans, male parental investment (human offspring are dependent for a long period and care is expensive but important to ensure the survival of the offspring and the passing on of the male gene) and mate guarding may have been the reasons.

Polygamy (Polyandry and Polygyny)

Polygamy is the practice of an individual marrying multiple partners. The commonly acknowledged forms of polygamy are (1) polyandry, where one woman marries multiple male sexual partners, and (2) polygyny, where one man marries multiple women. In some societies, these are approved practices. For e.g. – Tibetans in Nepal, some parts of China and northern parts of India practice fraternal polyandry, where brothers are married to the same wife. Paharis in the Jaunsarbawar region and some tribes in Himachal also follow fraternal polyandry as a way of carrying on the tradition of the pandavas who were husbands to the same wife, Draupadi.

Polygamy lies outside the traditional heterosexual monogamous relationship structure and there can be a number of polygamous living arrangements possible as might be preferred by consenting adults – involving people with any gender identity or sexual orientation. Polygamy

became illegal in India in 1965 for all citizens except Muslim men who are allowed to have four wives through Islamic law courts and Hindus in Goa who can practice bigamy.

Mixed orientation relationships

In mixed orientation relationships one partner experiences same-sex attraction and the other does not. This may be an unfortunate outcome of pretending to be a heterosexual person in a marriage and disclosing oneself as being bisexual or pansexual. This may also be a matter of discovering the various aspects of one's own sexuality while being in a committed relationship. It may also be that individuals enter into such relationships as a matter of choice.

Sexless/ celibate marriages

Celibate marriages are those in which the partners choose not to have sex with each other. One or more partners in these marriages may be asexual and not interested in having sex and the couple/ partners may mutually decide to refrain from having sex with each other.

Polyamory

Polyamory is the practice of engaging in multiple romantic and/or sexual relationships with the consent of all involved. Individuals in such relationships may be members of a closed group where sexual activity is restricted to only members of the group (also referred to as 'polyfidelity') or they may engage in non-exclusive sexual relationships with other individuals and manage the insecurities and jealousies that may come with it. It is often argued that polyamorous relationships are more value-based than exclusive romantic/ sexual relationships because they are based on open communication, faith that the promises and agreements will be maintained, non-possessiveness, trust, honesty, dignity and respect.

Commitment remains a salient feature of polyamorous relationships and polyamorists do not condone violations of relationships. Polyamorous relationships emphasize emotional along with sexual intimacy and rely upon acute self-knowledge and choice exercised through the ability to express needs and boundaries (Wosick-Correa, 2010).

Law and Relationships

All adults above the age of 18 have a right to union under Article 21 of the Constitution of India, i.e., the right to have any kind of physical, sexual, mental and emotional relationship/companionship. All adults also have the right to reside with whoever they want, wherever they want. In Shafin Jahan v. Asokan K.M., the Supreme Court of India unequivocally upheld the right of an adult woman to choose her partner, recognising that the right to choose is a constitutionally guaranteed right available to all adults; one which will always take precedence over social morality, family values. The Court also held that the right to choose a partner is a core part of an individual's privacy, which cannot be violated.

In the Navtej Singh Johar case, the Supreme Court upheld the right to intimacy of all queer persons, which includes the right to choose of partner and the nature of relationship. Following this, many High Courts across the country have upheld the right of adult queer persons to be in a consensual relationship (Mann @ Manjusha Yadav v. State, 2018; Sadhana Sinsinwar v. State, 2018; Shampa Singha v. State, 2019; Sreeja S. v. Commissioner of Police, 2018).

A live-in relationship between two consenting adults is considered a 'domestic relationship' under the Prevention of Domestic Violence Act, 2005. An adult woman who is in a live-in relationship with her male partner can claim maintenance from him under the Act, in addition to reporting any incidence of intimate partner violence. She would also be entitled to maintenance under Section 144 of the BNSS (previously, Section 125 of the CrPC). However, only married couples can adopt a child in India if they both want to be identified as the child's parent.

Reflection:

- *How do you view marriage and live-in relationships?*
- *How do you view cheating in a relationship vs. polyamory?*
- *Do you think it is important to regulate relationships and living arrangements? Why or why not and what are your concerns?*
- *What do you think of people in non-typical romantic or sexual relationships? What might be your response if you knew someone like that?*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - Attitudes Towards Sex and Sexuality - How Do These Form and Impact Us? (link will be inserted)

Way forward

There are many different relationships that are possible. There are people who prefer to be single without engaging in sexual or romantic relationships at all, people who prefer to be single and engage in many different sexual relationships with different partners, people who like to live together (cohabitation) without getting married and relationships that may be consensually non-monogamous. There are also relationships like friends with benefits - individuals who are friends and decide to be sexually involved but without any commitment or even strong feelings of sexual attraction. And there are groups of people who will get into a single sexual community.

The point is that whatever works for you, is valid. Relationships are as unique as the people in the relationship and follow no set pattern. Each one of us is free to create what we wish in a relationship, for oneself and the other. There may be a lot of moral policing in our society that may affect one's relationship. As individuals we can be mindful of our own rights and the rights of others and choose to be in relationships/ arrangements that best meet our needs of sexual pleasure, companionship and emotional connection.

Chapter 12. Sexual Preferences and Practices
- sex and pleasure, understanding various sexual acts

Aman is in the final year of his college and is considered charming, articulate and attractive. He has recently gotten into a relationship with his batchmate, Ruhi, and things seem to be getting serious as they quickly progressed from kissing and fondling to having sex. In some time, Aman began to suggest that they should spice things up a bit and Ruhi, while unsure, agreed enthusiastically. She thought he was probably referring to different sex positions, using sexy lingerie or using some of the new fancy condoms and lubricants. She coyly asked him what he had in mind and he was suddenly reticent and brushed it off as nothing. After a couple of occasions of such banter, Ruhi was quite perplexed at what Aman was getting to and asked him to just tell her in a straightforward way, what he was referring to.

Unable to put it off any further, Aman shared that he had recently got interested in some kinky sexual acts that he had read about and seen in movies and on the internet, and he was very keen on experimenting with sexual acts which involved bondage and dominance. Ruhi had no clue about any of this but continued to listen, read and learn more about BDSM. The idea did not appeal to her though and she was frank with Aman about this. She admitted that she liked him a lot but was not willing to experiment along the lines he had suggested. While she was a little startled with the new knowledge she had about sexual acts, she understood that it was a preference and only done with consenting partners. She was open with Aman and told him that he was free to find other partners who might have similar preferences. She believed that there had to be some compatibility between sexual partners and it might not be a healthy relationship if one continued to remain dissatisfied in the relationship.

Aman was quite heartbroken and disappointed. He mentioned that a previous relationship had also ended the same way and he was beginning to wonder if he was wrong/ if he was abnormal in expecting a partner to enjoy these kinds of different sexual acts like he did. At that time, his girlfriend had been rather shocked at his admission and seemed disgusted at him, and they had to split on acrimonious terms. He respected Ruhi's wishes though and wished her well. They decided to part ways and remain friends from then.

Aman's story represents one of the sexual activities that raises questions about what is considered okay in sexual relations/ intercourse: Who decides what is okay or not and whose standards are these? Why are some sexual acts socially approved and others considered abnormal or weird or unpalatable by a majority of people? What are the prejudices society harbours about sex, and celebrates sex only within a narrow band (between a man and a woman, of a certain age, in a legal marriage, and only for procreation)? The narrow inner circle of privileged sex acts and actors question and belittle others who engage in other types of sex and sexual practices. They question kinks and fetishes, sex between adolescents, sex between unmarried adults and older adults, same-sex acts, sex without commitment, sex work, sexual imagery etc. This puts people on a defensive and they usually are not forthcoming about their sexual preferences to those who do not share these or have prejudices about it.

The list continues when couples are married: people may have adulterous relationships, open relationships, swap spouses, or have more than one spouse. Some married couples have

polyamorous relationships, that is, have more than one sexual partner at a time with the knowledge and consent of everyone. These are all activities well within the spectrum of known and accepted activities, so long as they are done between consenting adults and no one is harmed or exploited. However, since in our society, only those in heteronormative relationships enjoy more privilege than others, they are in a position to impose shame and guilt on those who do not conform to their preferred ways. In these circumstances, many people with sexual desires that do not fall under traditional sexual behaviours and fantasies may feel ashamed and guilty about their desires or feel afraid to express them, and end up suppressing them. Many then exploit this shame, guilt and fear created by society to make money by offering "cures" that do not really work for "disorders" that do not really exist.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has been slowly evolving over the years in its understanding of sexual diversity as evidenced in its treatment of LGBTQIA+ concerns. What used to be listed as disorders of the mind, with regard to sexual preferences and practices, have now been acknowledged as normative behaviors and delisted from the manual – for eg. homosexuality. For the purposes of this Reference Book, we are avoiding categorization as disorders/ illnesses, and only looking at a variety of sexual practices with a view to understand what is pleasure, what is abuse, when can some sexual practice be harmful to its practitioners, and how they can be safer in its practice.

According to a survey that covered 4042 people in 19 cities in urban India, 41.8% of respondents said they practiced some form of domination, submission or role-playing. One-third of the respondents fantasized about orgies with women, and group sex was popular with 57% of men respondents saying they can love more than one person (Chowdhury, 2016). More interesting trends surfaced: “Trends across cities reveal a wide variety of interests, 31 per cent of people in Bhubaneshwar are open to sex in public, followed by 24 per cent in Patna... A quarter of Patna residents prefer group sex. 55 per cent of respondents there (Chandigarh) said they had sex any time of the day. At 64 percent, Chennai masturbates the most, followed by Pune at 56 per cent” (para. 6).

In the section below we have considered some sexual acts that appear to be fairly common, listed what each one is, how people engage in it and what probable consequences or effects one can be aware of.

Masturbation:

This is an act by which a person stimulates themselves by touching the genitals to derive sexual pleasure. It may be done till the person reaches orgasm or a person may delay or even deny themselves an orgasm depending on their context and choice. People of all sexes and genders can masturbate. The clitoris is especially sensitive to touch, as is the glans penis. A person may use their hand. objects or specially designed instruments called sex toys and/or fantasize about sexually pleasurable things during this process. Masturbation is a common, normal and natural practice and has been observed in many animals as well.

Sexual feelings arise as secondary sexual characteristics begin to develop in a person with the onset of puberty. Since we delay sexual activity for several years after the onset of puberty, many people manage their normal and natural sexual feelings by masturbating. Young children

also rub their genitals as it is pleasurable. The body has other pleasure points that can be explored to derive sexual pleasure. Gentle rubbing/caressing of the back of the ear, the sole of the feet, behind the knee, the neck and the lips, aid in deriving sexual pleasure.

Since no other person is involved in self-stimulation, there is no risk of HIV/STI or pregnancy. It does not result in weakness, infertility, pimples etc. Semen is a natural body fluid like saliva or tears - just with a different function. Contrary to common misconceptions, semen is not the equivalent to any amount of blood and ejaculating semen does not amount to any loss of blood.

Different people have different sexual needs. Different people masturbate to different extents, and some may not masturbate at all. Mutual masturbation is also commonly practised. Individuals touch each other's genitals and other body parts using their hands, mouth, other body parts or sex toys. As with all sexual acts, the first and paramount step in any sexual activity that involves another person, is **consent**.

Penetrative and non-penetrative sex

Penetrative sex and sexual intercourse:

People derive pleasure through various types of penetrative sex. Penetration can be done using the penis or any other part of the body (examples fingers) or an object. Peno-vaginal penetration is commonly referred to as intercourse. It can lead to pregnancy, and sometimes sexually transmitted diseases as well, including HIV. Peno-anal sex is associated with a higher risk of bleeding and can be harmful to the anus. Unprotected sex could raise the risk of HIV transmission and this is higher with anal sex. Anal sex does not lead to pregnancy. Penetrative oro-genital sex does not carry the risk of pregnancy and risk of HIV transmission is also extremely low. Sexually transmitted diseases can be passed on from an infected partner to the sexual partner in all forms of sex.

Sexual outercourse or non-penetrative sex:

Outercourse refers to a range of sexual expressions and activities that are pleasurable, that does not include penetration. Also called non-penetrative or non-coital acts, it includes a myriad of sexual acts like hugging, kissing, holding hands, love letters and sexting, mutual masturbation, petting above or below the waist, body to body rubbing (dry humping), oro-genital or oro-anal sex, erotic bathing and massaging, role playing, use of sex toys, communicating sexual fantasies to the partner, touching, caressing, massaging or stimulating other erogenous zones of the body like nipples, ear lobes, inner thighs, legs, buttocks, nape of the neck, lips, scalp, etc.

Outercourse is different from foreplay. Foreplay almost always leads to an act of penetration, which is stereotypically considered as the real or ultimate act of orgasmic pleasure. Outercourse is sexual stimulation to orgasm without penetration. It is relatively safer with less risk of STIs and pregnancy. It also increases the bonding between partners, allowing them to communicate and explore their sexual expressions to derive utmost pleasure.

Kissing:

Romantic kissing in sexual relationships plays a role in mate selection. Kissing involves a complex and intricate exchange of information through various senses - olfactory (smell), gustatory (taste) and tactile (feeling through skin). This helps in subconscious, subjective interpretation of a potential suitability of a mate. The pheromones are found to play a role here. Kissing helps to assess genetic compatibility, general health status and genetic fitness of a suitable mate. Evidence suggests that kissing brings about feelings of attachment, bonding and satisfaction in romantic relationships (Wlodarski & Dunbar, 2013, p. 1418). "Kissing may even reveal the extent to which a partner is willing to commit to raising children, a central issue in long-term relationships and crucial to the survival of the species," writes Chip Walter (2012) in an article for the Scientific American.

Sensual touch

The sense of touch is one of the first senses to develop in the womb and remains significant throughout life (Montagu, 1986). It not only helps in survival but also plays a role in mate selection, and hence, reproduction. Touching and intimacy go hand in hand. People touch to express affection, understanding, compassion, sexual interest, pleasure and love. Research shows that during interpersonal touch, oxytocin is released that promotes a feeling of calmness, pleasantness and mild euphoria (Floyd, 2006). Indulging in sensual touching - caressing, cuddling, hugging and holding hands - in both roles, as receiver and as giver, often leads to deeper levels of connection and pleasure.

The cultural, social and religious milieu that we grow up in, might create touch taboos, resulting in intimate touch being equated and restricted to genital stimulation with the goal of achieving orgasm. Focussing only on achieving an orgasm can deprive sexual partners the pleasure of sensual touch, create performance anxiety and can paradoxically result in disinterest and a lack of arousal.

Casual sex

Casual sex refers to the practice of having sex without a promise of emotional commitment to the partner or outside of a committed relationship, and sex for the purpose of pleasure from the act itself. This has often been frowned upon in the Indian context and people who engage in casual sex are considered 'promiscuous', 'characterless', 'sexually depraved' or even as 'sex addicts'.

Some sections of our society continue to frown upon the 'hook-up' culture and 'one-night stands'. In trying to raise children to be 'morally upright' citizens who are discreet and of 'chaste' character, we make sex seem like an act of transgression unless sanctioned by societal structures of marriage. The changing demographics of our population, the increased access to technology and networking sites, and the changing attitudes towards committed relationships like marriage have now provided a space for alternate attitudes towards sex. With a burgeoning number of networking and dating apps, individuals are now able to explore in more open ways,

sexual relationships with an increasing number of people, with people who share their preferences and to the extent of commitment they are willing to make.

Casual sex may be preferred with a total stranger - someone one has met recently and does not know with any degree of detail, with a friend in arrangements often referred to as 'friends with benefits' or 'booty call' – sex with someone who one can call a friend or an acquaintance, that one does not have any exclusive commitment to or as a 'swinging' arrangement where people in committed relationships swap partners for recreational purposes or because they believe that it improves the quality of their sex lives or their committed relationships.

In India, hook-up culture is becoming more normalized in specific circles like the middle class, upper middle class, urban population and this is aided by the number of dating apps like Tinder, Bumble, Grindr, OKCupid and others. Subscribers of these platforms have many safety features built in to ensure they feel confident of using these services. They also have options to choose from that inform them of the preferences and desires of the partners seeking relationships online.

While sex prior to marriage is still considered taboo, it may be one of the social norms that is changing slowly. Apart from the burgeoning number of platforms to enable meet ups for sexual relationships, our movies and other media have also begun to portray unconventional relationship arrangements and to acknowledge the reality of people of all ages seeking to fulfil their sexual desires. As the character of the father in the movie 'Piku' shows, he has no qualms about acknowledging that his daughter is not a virgin and that marriage is not the threshold for a young woman to explore her sexual needs.

Reflection*:*

1. When you have watched movies or heard of people enjoying casual sex, what are the thoughts that immediately come to you?
2. What might you say to someone who was in a casual relationship and found out that one of the partners expects a commitment after a couple of hook-ups?

Use of sex toys

Sex toys are objects or aids that are used to enhance the sexual experience between partners or for masturbation. It is a personal decision whether one uses these or not and what types of toys one may use and how/ with whom. Sex toys also are aids for non-binary persons to affirm their gender identity and to have fulfilling sexual experiences. They may also be used for medical purposes for e.g., to help correct sexual dysfunctions or to help persons with disabilities engage in a greater variety of sexual acts and experiences.

Some commonly used sex toys are vibrators that help simulate the sexual organs' vibrating action, dildos which are objects shaped like the penis that can be inserted into the vagina, anus or the mouth to simulate the feel of the penis, Anal toys like butt plugs, anal beads, prostrate massagers and sleeves or strokers that the penis can be inserted into.

Sex toys are available in stores where one may also find more information on how to use them and newer products with increased, improved features. In India, the law around selling of sex

toys is a little ambiguous. While there is no explicit law prohibiting the sale of sex toys, there are sections in the law that ban the sale of 'obscene' items. With the increasing demand for sex toys in India now, manufacturers are taking care to ensure that the packaging and display of these items is not explicit or seen as 'obscene'. According to a study of trends and usage patterns of sex products in India, "44 per cent of the demand comes from people in the age group of 25-34 years. They are not only the highest transactors, but also the biggest repeat users. However, customers over the age of 45, who constitute 16 per cent of the demand, are the ones demanding luxury products, some of which can cost as much as Rs 30,000. This age group also has more female customers. Overall, women are responsible for nearly 40 per cent of the demand. In fact, there are more female customers in cities like Baroda, Pune and Thiruvananthapuram. The average basket size of orders placed by female customers also tends to be 18 per cent larger than that of male customers" (Grey, 2017, para. 4)

Reflection:

6. *How would you view use of sex toys by a couple in a committed relationship?*

Fetishes/ Kinks

A fetish is an intense sexual attraction to an inanimate object or a body part that is not traditionally considered sexually attractive. The word is derived from the Portuguese word feitiço which means "charm, sorcery, allurement". Many people have a fascination for and may get aroused by different non-genital body parts of their partners. Almost any body part or object can be a fetish - hair, ears, hands, underclothing, shoes, perfume and others. For some, it might be the shape of the nose or the feet, the smell and feel of certain body parts and so on.

According to a study, the most common fetishes involve body parts, such as feet, or body features such as obesity, piercings or tattoos. This is followed by fetishes around body fluid, body size, and hair (Wiederman, 2003). There are indications that fetishism existed in different forms from ancient times - between 1780s and the start of Queen Victoria's reign in 1837 (Darwin, 1872), especially flagellation which combined the rituals of punishment with the pleasures of pain and is practiced commonly today (Rosen, n.d.).

Suspicion of any non-reproductive sex outside of a legal marriage has often caused fetishes to be viewed as a perversion or a fixation. Krafft-Ebing's (1998) was the first to link the fetish to immoral and illegal practices. His most famous work, Psychopathia Sexualis, has described fetish as an "encyclopedia of perversions." It is a chronicle of 237 case studies of sexual practices that he identified as "abnormality". He defined fetishes as something that: "invests imaginary presentations of separate parts of the body or portions of raiment of the opposite sex, or even simply pieces of clothing material, with voluptuous sensations."

Havelock Ellis (1911), an English physician and eugenicist and a social reformer who studied human sexuality, re-conceptualized fetishism as an expression of "individual taste in beauty." He noted that the fetish was so universal and mysterious that "even a mere shadow may become a fetish." Magnus Hirschfeld, a German physician, gay rights activist and sexologist noted in his work, Sexual Pathology that "the number of fetishes is unlimited. From head to foot there is no tiny spot on the body, and from head-covering to foot-wrapping there is no little fold of attire from a fetishistic attraction cannot arise" (Hirschfeld & Gibbs, 1940).

Some forms of fetishes include the pearl necklace (ejaculation on or around the neck or chest of the sexual partner), pegging (woman penetrates a man anally using a dildo), queening (sitting on someone's face as part of the sexual encounter) and nasolingus (where sexual pleasure comes from sucking one's partner's nose).

The words 'fetish' and 'kink' are often used interchangeably, because they both refer to 'alternative' sexual acts and preferences. Sexologists use them with slightly different connotations though: A fetish is an umbrella term for a variety of non-normative sexual acts where sexual arousal or fulfilment can only be achieved through a particular kind of act or use of a specific object. A kink, on the other hand, is a desire for similar acts without the dependence on it for sexual fulfilment. One may indulge in kinky sexual acts as a way of breaking monotony and having a novel sexual experience or fulfilling a fantasy.

Despite all these movements and efforts to understand fetishism as an alternate form of sexuality, there is stigma that continues to be attached to fetishistic desires. People with such desires are often pathologized as not normal or weird. Fetishistic disorder has been listed in the DSM-5 as a form of dependence on the object of desire to the extent that sexual arousal and gratification can only be achieved with the particular body part in focus or the object of desire. People with such desires sometimes experience self-doubt and a distaste for themselves for having such desires. This confusion, guilt and shame may often be the reason they fail to experience sexual fulfilment rather than the dependence on the object of their fetish itself.

BDSM

This is an umbrella term for sexual acts of three categories - Bondage/Discipline, Dominance/Submission, and Sadism/Masochism. BDSM is a less understood preference in the larger population and evokes images predominantly of pain and torture rather than pleasure and playfulness, which is the primary reason people engage in such acts. It refers to (sexual) experiences where, in mutual consent, physical restraint, intense sensorial feeling and/or fantasy about dominance and submission play a key role, often experienced in role play involving power exchange between consensual participants (Holvoet et al., 2017). It is often used as a catch-all phrase for a wide variety of non-normative sexual acts and people self-identify as being part of the BDSM community. It does not necessarily need to involve penetrative sex, though some sessions may include it. Common acts are animal roleplays, flogging, spanking/ impact play, flagellation, suspension and tickle torture among others.

Sexual acts of these kinds have been referred to in various ancient texts and literature. Some of these can be found in:

- Art and texts from ancient Greece and Rome show physical pain being used as an erotic stimulus (Cooper, 1900).
- The *Kama Sutra*, a comprehensive guide on sexuality and relationships, written in India about 2,000 years ago, describes six appropriate places to strike a person with passion and four ways to do it. It also has chapters titled "Scratching," "Biting," and "Reversing Roles" (Vatsyayana, 2009).

- The Marquis de Sade, a French aristocrat who lived from 1740 to 1814, wrote a variety of erotic novels and short stories involving being beaten and beating others. Eventually the author's name gave rise to the term "sadism."
- The term "masochism" is derived from the name of Austrian nobleman and author Leopold von Sacher-Masoch, whose 1870 novel *Venus in Furs* describes a dominant-submissive relationship.
- In 1953, a Kinsey Institute study found that 55 percent of women and 50 percent of men were aroused by being bitten (Alberts & Young, 2019).

While many people may not subscribe to such practices, studies have shown that people do engage in sexual acts that could be categorized as BDSM though they may not identify it as such. Many others have admitted to having fantasies of indulging in such acts though they may have never experienced it. An indication of the popularity of such practices may be the subscriber base of sites like FetLife India, a site completely dedicated to kinksters. "FetLife India has a network of almost 53,000 registered kinksters across the country, with around 9000 users from Maharashtra alone. These conversations also transform offline through Munches (social gathering of kinksters/BDSM practitioners. No sex involved), events and private dates that FetLife members organise at their own discretion. Not just metros but even tier 2 and tier 3 cities have active BDSM and kink groups that meet behind closed doors" (Nighoskar, 2018, para. 6).

According to members of this community, consent plays the most important role in the practice of BDSM. Informed consent is complete only when the participants understand all the conditions and risks associated with the activity, each partner's limits and safety requirements, and acceptable activities and safe words to use to indicate when to stop or withdraw from the activity. BDSM communities are guided by the motto of SSC – that sexual acts have to be Safe, Sane and Consensual – or a code of behaviour called RACK – Risk-Aware Consensual Kink, where each participant is responsible for their own well-being. After any BDSM activity, participants then go through sexual aftercare so they can calm down and heal and recover from the intensity of the act they participated in.

Historically, these practices and interests have been pathologized and were previously considered immoral, unethical or illegal behaviour. And a lot of studies also backed these beliefs. A study showed that the prevalence of self-reported sexual childhood abuse was higher among BDSM practitioners (8% men, 23% women), as compared to the general population (3% men, 8% women). But some scientists started having a different opinion towards BDSM. Graham and his colleagues (2016) showed that participating in accepting environments where BDSM is stimulated and celebrated has a positive impact toward stigma management and helped in busting myths around BDSM. BDSM, when performed keeping all the safety measures in place and with proper communication and consent, has been known to be sexually arousing and fulfilling experience. It has been suggested that BDSM activities are associated with reductions in psychological stress and negative affect, and increases in sexual arousal Ambler et al., 2017). One landmark study published in 2008 in the *Journal of Sexual Medicine* found that people who engaged in BDSM were more likely to be open to exploring their sexuality, and have a more positive attitude towards sex (Richters et al., 2008).

Healthy BDSM relationships demonstrate trust, caring and an ongoing commitment to mutual growth - all valid indicators of any positive mainstream relationship. "While mainstream sexual

encounters also stress the importance of consent, consent often takes the form of an unstated, implicit assumption based on perceived behavioural displays of interest or willingness. The BDSM community takes consent further, demanding explicit rather than tacit consent" (Dunkley & Brotto, 2020).

Public sexual behaviour

Public sex, as the name suggests, is a sexual activity that takes place in a public place. It refers to one or more people having sex in a public place, or in a private place which can be viewed publicly. Such places may be a garden, the balcony or one's bedroom with the curtains open. Public and semi-public places may be shopping malls, in a car, on a beach, in a forest, theatre, bus, aeroplane, street, or toilet cubicle among other locations.

People typically regard their sexual activities as private for a variety of reasons. Given that most other primates do not necessarily seek privacy for sex acts, human concepts of sex in private as acceptable and those in public as condemnable or shameful can only be theorized from the point of view of social constructs and learnt emotions like shame. However, Darwin (1872) stated that our sense of shame was a concealment of a more primitive feeling of wanting and seeking cover for safety. According to MacCurdy (1930), humans preferred private sex as opposed to public sex for safety purposes as postures during sexual intercourse prevent people from rapid self-defence. Malinowski (1927) stated that sexual intercourse in public could invite jealousy among rivals and could lead them to seize what is being enjoyed. However, there have been historical accounts of sex being performed in public places as well, which means that preferences for both public and private sex have existed for a long time.

In ancient Egypt and Crete, sexuality was fluid and people had a more open perspective about sex as it was incorporated in everyday life and rituals like religion, festivals and even funerals which involved dance performances that had erotic undertones as they were believed to sexually rejuvenate the dead in after-life (Joyce, 2008). These instances prove that ideas about sexuality have varied across time and culture.

While public sex might seem scary or unfathomable to some people, it is desired by some. People with such inclinations may be turned on by the thrill of taking risk - by breaking rules, breaking the routine and doing something different, being watched by others or by the act of exposing oneself to others to watch. 'Dogging' is increasingly becoming a popular practice in some parts of the world, in which people organize to meet in public places where they can practice public sex safely. They can either choose to participate or observe these acts to the extent they wish to. Engaging in sexual acts that is livestreamed on the internet using a webcam is also an act of public sex. Several checks are used to ensure the safety and confidentiality of such acts and its participants while also allowing them the experience of engaging in public sex

Clinical psychologist Dr. Carl Hindy explains the reason behind public sex or public display of affection, which could be two-fold.

"People feel that PDA validates their relationship as it's a public display of their love and a public validation of their status as a couple. If, however, you consider that one person is uncomfortable with PDA and their partner does it anyway, this is accomplishing the very opposite of a show of affection. That person is making it about them rather than about them as a

couple. That person might be wanting others to see it because they want to mark their territory, for example, or assertion dominance, or put on a 'show' for some personal reasons, but that might say more about problems in the relationship" (Travel Insurance Direct, 2020).

However, in a lot of places, people showing any kind of physical intimacy towards each other are met with disapproval and they can be charged under indulging in obscene acts in public. Section 296, BNS/Section 294 ~~Section 294(a)~~ of the Indian Penal Code, 1860 deals with the offence of "obscene acts," prescribing a punishment of imprisonment up to three months, fine or both for "obscene acts" done in public "to the annoyance of others." The test that Courts in India generally apply to determine whether something is obscene or not is the Community Standards Test, which depends on contemporary community standards. Although no judgment has gone into whether public sex itself would be considered 'obscene' or not substantially, public displays of affection, such as kissing, and actor-model Milind Soman running naked on the beach to celebrate his birthday, have been viewed as a crime by law enforcement agencies (ET Bureau, 2012; Press Trust of India, 2020).

Group sex

Group sex is sexual activity involving more than two participants. Participants in group sex can be of any sexual orientation or gender, and this form of sexual activity can involve any kind of sexual preferences and practices. While fantasies of group sex are extremely common among both men and women, group sex sometimes poses a moral dilemma in a heteronormative patriarchal society and the fear of HIV/ STI is often used as a way of controlling group sexual practices.

Group sex may take different forms some of which may include threesomes (where a couple may admit another person into their sexual experiences), swinging (where people in open relationships choose to have sex with other couples or individuals), orgies (where multiple participants engage in free and unrestrained sexual activities with any consenting member of a group), circle jerks (where a group of men masturbate themselves or each other) and bukkake (a sex act where one participant is ejaculated on by two or more participants).

Reflection*:*

- *How do you view fetishes?*
- *What would you think if a friend told you that they practice BDSM?*
- *Sex in animals is uncomplicated and also unregulated. Do humans tend to experiment more when it comes to sexual activities? What makes having sex a more complex issue when it comes to human beings?*
- *Why is monogamy so institutionalized in our society? Do you think it should be so or not?*

Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - Attitudes towards Sexuality (link will be inserted)

Demystifying Sexuality - Consent - what, why, when, by whom and how? (link will be inserted)

Way Forward

Given the stigma or wariness around any form of sexual activity that deviates from conventional norms, we have long learnt not to actively explore our sexuality and often feel shame and guilt when we become aware of our sexual desires and fantasies. Exploring our sexual desires keeping in mind mutual consent and safety of all, embracing the diversity of experiences and possibilities, learning to have conversations about our sexual preferences, fantasies and needs with intimate partners, in authentic and respectful ways may help improve our sexual experiences.

We can actively question the basis of some of our long-held beliefs around sex and morality to determine if they are still relevant in the world and society we live in. We can reflect on how prepared and ready we feel to let go of beliefs and values that seem to be rooted in moralities that infringe on the rights of people. We can also mindfully choose to be non-judgemental about the diversity of preferences and practices that exist, that we may be unfamiliar with or personally uncomfortable with.

Chapter 13. Paedophilia
- what is it?

Paedophilia is a term that has entered common parlance, especially in the context of child sexual abuse, but isn't understood well by most people. Most sexual abusers are not paedophilic and not all paedophilic persons sexually abuse a child. We feel that it is important to understand this difference so that more and more persons with paedophilia can receive interventions that would support them in managing their sexual urges in ways such that sexual offences against children are entirely avoided.

Defining paedophilia

Paedophilia (from Greek 'paidós, meaning "child"+ philos "loving") is a primary or exclusive sexual interest in prepubescent children. It is listed in the DSM-5 (2013) and ICD -11 under 'paraphilias', which is a term derived from Greek para meaning "beside, aside" and philos meaning "loving". The etymology of the word indicates that these sexual interests are not 'mainstream' and are therefore 'aside'. The term paraphilia is used when the preferred sexual interest(s) of the person are greater than sexual interests that are considered more 'conventional' in the current cultural context. (For more details on the different sexual practices, preferences and fetishes, see the 'Sexual Preferences and Practices' chapter.)

DSM-5 (APA 2013) distinguishes between the terms 'paraphilia' and 'paraphilic disorder'. A person may have a paraphilia, but may not have a paraphilic disorder. To consider a diagnosis of paraphilic disorder, it requires that the person:

10. feel personal distress about their interest, not merely distress resulting from society's disapproval; or
11. have a sexual desire or behaviour that involves another person's psychological distress, injury, death, or
12. a desire for sexual behaviours involving unwilling persons or persons unable to give legal consent

DSM-5 includes paedophilic disorder under paraphilic disorders. The current scientific understanding is that paraphilias, including paedophilia, do not require or justify psychiatric treatment in themselves. It names and includes eight disorders - exhibitionistic disorder, fetishistic disorder, frotteuristic disorder, paedophilic disorder, sexual masochism disorder, sexual sadism disorder, transvestic disorder and voyeuristic disorder.

According to DSM V (APA 2013), the following criteria have to be met:

Paedophilia (criteria A only) and Paedophilic disorder (where criteria A **and** B is required to be fulfilled)

A. An adult, for at least 6 months has recurrent, intense sexual urges or fantasies about sexual activity with a pre-pubescent (less than 14 years old) child(ren). (acting on these desires is not necessary for the diagnosis)
B. B. The individual has acted on the sexual urges or the fantasies or urges cause marked distress or interpersonal difficulties

Paedophilia can be exclusive (attracted to children alone) or non-exclusive (attracted to children and adults). Paedophilia can be attraction to females, or males or both.

According to ICD-11 for Mortality and Morbidity Statistics (Version: 09/2020), "Paraphilic disorders are characterised by persistent and intense patterns of atypical sexual arousal, manifested by sexual thoughts, fantasies, urges or behaviours, the focus of which involves others whose age or status renders them unwilling or unable to consent and on which the person has acted or by which he or she is markedly distressed. Paraphilic disorders may include arousal patterns involving solitary behaviours or consenting individuals only when these are associated with marked distress that is not simply a result of rejection or feared rejection of the arousal pattern by others or with significant risk of injury or death" (ICD-11 - Mortality and Morbidity Statistics, n.d.).

The ICD-11 defines paedophilic disorder as a "paedophilic disorder is characterised by a sustained, focused, and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges, or behaviours—involving pre-pubertal children. In addition, in order for paedophilic disorder to be diagnosed, the individual must have acted on these thoughts, fantasies or urges or be markedly distressed by them. **This diagnosis does not apply to sexual behaviours among pre- or post-pubertal children with peers who are close in age**" (ICD-11 - Mortality and Morbidity Statistics, n.d.).

Paedophilic disorder involves fondling or manipulation of the child's genitals or penetration. Injuries may result from the sexual act - and are usually a by-product rather than the goal.

The prevalence rate of paraphilias, especially paedophilia is difficult to estimate. In one study in Germany from a community sample of 1,915 men aged 40-79 years on paraphilia-associated sexual arousal patterns found that in 1.7% of cases, these were causing distress (Ahlers et al., 2011, p. 1363). Self-reporting studies seem to suggest that the upper limit for the prevalence of sexual interest in children may be around 5%, though only some of them would meet the diagnostic criteria for paedophilia as questions regarding the intensity or persistence of sexual fantasies or behaviour were not asked. Paedophilia appears to be much more common among males than among females (Seto, 2009, p. 398).

Paedophilia is defined by the **body maturity** of the preferred partner. Tanner's stages 1 to 5, also known as Sexual Maturity Rating, referred to in the chapter on **Structure and Function of Sexual and Reproductive System**, is used to determine the stage of maturity.

Various terms are in use to differentiate the body type:

- **Paedophilia** - primary or exclusive sexual interest in prepubescent children - Tanner stage 1 (the DSM-5 extends the prepubescent age to 13)
- **Hebephilia** is the strong, persistent sexual interest by adults in pubescent children who are in early adolescence, showing Tanner stages 2 to 3 of physical development. Typically ages 11–14 years
- **Pedohebephilia** - attracted to both above
- **Ephebophilia is** the primary sexual interest in mid-to-late adolescents, generally ages 15 to 19. Partly
- **Teleiophilia** (from Greek téleios, "full grown") is a sexual preference for adults (Tanner

stage 5)

Because puberty varies, some definitions show overlap between paedophilia, hebephilia and ephebophilia. For example, the DSM-5 extends the prepubescent age to 13, the ICD-10 includes early pubertal age in its definition of paedophilia and some definitions of ephebophilia include age 14.

The nature of paedophilia

According to Dr James Cantor, of the Centre for Addiction and Mental Health in Toronto, Canada, paedophilia could be considered a sexual orientation "Paedophilia is something that we are essentially born with, does not appear to change over time and it's as core to our being as any other sexual orientation is" (BBC News, 2015).

Researchers studied brain MRI scans of paedophiles and non-paedophiles (Cornwell et al., 2006) and found that

- There were differences in the neural networks of paedophilic individuals as compared to non-paedophiles.
- There seemed to be "cross-wiring" in the brain.

"It's as if, in these people, when they perceive a child, it's triggering the sexual instincts instead of triggering the nurturing instincts," says Dr Cantor.

It is known that human faces depict age cues including cues to sexual maturity (Cornwell et al., 2006). This stimulates the appropriate reproductive behaviour: either caretaking (nurturing) or mating (sexual behaviour) when adults see a child or an adult face, respectively. Human face processing is tuned to sexual age preferences. Brain networks that normally are tuned to mature faces of the preferred gender show a tuning to sexually immature faces in paedophilia (Ponseti et al., 2014). The researchers used (fMRI) to test for the existence of a network which is tuned to face cues of sexual maturity. During fMRI, participants sexually attracted to either adults or children were exposed to various face images. In individuals attracted to adults, adult faces activated several brain regions significantly more than child faces. These brain regions comprised areas known to be implicated in face processing, and sexual processing. The same regions were activated in paedophiles, but with a reversed preferential response pattern.

At present the exact causes of paedophilia are not known. However, what is known is that many persons with paedophilia find it difficult to manage their attraction in ways that are safe and do not involve harm to children.

Paedophilia and issues faced by the individual

- often feels guilty about their sexual urges and fantasies
- faces the possibility of social rejection
- carries the burden of disclosing/ seeking help.
- their orientation affects their personal, social and occupational life and relationships (Cantor & McPhail, 2016, p. 126).

Differences in the neurological functioning among offending and non-offending paedophiles

has been studied. The researchers studied brain regions involved in attentional control of behavior and perception of salient stimuli in 13 paedophilic sex offenders and 13 matched controls (Ristow et al., 2018, p. 339). In a region related to cognitive control and salience mapping, paedophilic sex offenders showed reduction of the inhibitory neurotransmitter GABA which may be seen as a neuronal correlate of inhibition and behavioral control. Such research informs management options for paedophiles.

"People, they think 'why should we help the paedophile? We should be prosecuting them, throwing them in jail, having them castrated'. But if we offer help to paedophiles we might save children who might have been abused." - the Father of the child who was abducted and murdered by a person with paedophilic disorder in October 2012 (BBC News, 2015, para. 1).

Paedophilia - how it differs from child sexual abuse

A paedophilic disorder is characterised by strong sexual urges towards prepubescent children. Child abusive behaviour is frequently a result of lack of behavioural inhibition. It is linked with sexual offending against children. However, some persons with paedophilia do not make any sexual contact with children. According to Seto (2009a, p. 396), "perhaps half of sex offenders against children would not meet diagnostic criteria for paedophilia.". The review concludes that "there is no evidence to suggest that paedophilia can be changed" and further recommends that paedophilic sex offenders receive different interventions like increasing voluntary control over sexual arousal, reducing sex drive, and teaching self-management skills.

Paedophilia	**Child sexual abuse**
Some researchers consider it to be an orientation - Paedophilia describes the **primary or exclusive** sexual interest in prepubescent children	Child sexual abuse is an opportunistic act to demonstrate power over or to use the child as a substitute to fulfil sexual needs.
Many have feelings of guilt about their sexual urges and fantasies.	It is illegal and harmful - involves physical or psychological coercion or at least one individual who cannot reasonably consent to the act.
Distress often extends to and affects their personal, social and occupational life and relationships	The perpetrator usually does not feel guilty or expresses distress because of their behaviour. The person usually maintains personal, social, occupational relationships.
Many persons with paedophilia never act out on their impulses and abstain from abusing a child,	Perpetrators groom children Includes actions performed by people with paedophilic disorder.
Defined by body maturity, not the age, of the preferred partner. eg. Sexual activity with a person in late adolescence may not concern a person with paedophilic disorder.	Defined by age of the child, not body maturity.

Way forward:

People with paedophilic impulses and desires can seek interventions that will help them manage their sexual attraction. For example, the KEM Hospital Research Centre (KEMHRC) offers 'Programme for Primary Prevention of Sexual Violence (PPPSV)'. It provides treatment for individuals sexually attracted towards children. The programme has been culturally and socio-legally adapted from 'Prevention Project Dunkelfeld' (PPD) introduced in 2005 by Klaus Beier, Charité University Clinic, Germany (Beier, 2016). The goal of the therapy is to overcome problems in dealing with one's sexual urges and strengthen the ability to control one's behaviour in such a way that sexual offences against children are entirely avoided. Some components of the therapy include:

- Having an appropriate perception and evaluation of sexual desires and needs
- Developing the ability to identify and cope with risky situations
- Improving interpersonal relationships
- Improving quality of life

Support is also available on TROUBLED DESIRE which offers completely anonymous and free of cost online self-assessment and self-management.

Paedophilia is a sexual condition that is still not understood completely except to know that, acting on such urges violates legal provisions owing to the harm it causes children. For individuals who are aware of their paedophilic sexual urges, people around them (in the know) can offer supportive spaces for them to talk about their dilemmas and needs, in ways that help them manage these urges without harming any child.

Chapter 14. Intersectionality
- looking at the intersection of gender & sexuality with other social identity structures

Our experiences of living in this world can't be simply understood by focusing on a single axis of our identity. Contrary to commonly held ideas, we don't exist simply as men or women. There are various other identities that we inhabit, which intersect with social identity structures such as gender, sexuality, economic status, religion, caste, ethnicity or disability, and all of these identities play a role in how we experience the world through a set of advantages and disadvantages. A helpful way to explore what these multiple identities are or how all of them overlap or interact with each other is by adopting the lens of 'intersectionality'. But how does one acquire such a lens and why is it important that we do?

To answer this question, let's begin with the genealogy of the term. In 1989, an American lawyer and civil rights activist, Kimberlé Crenshaw, introduced the term 'intersectionality' to bring our attention to the very unique experiences of living as an African-American woman in the United States (Crenshaw, 1989). According to her, a black woman's experiences of discrimination were different from those of white women as well as black men because they faced discrimination not only on the basis of their gender, but race as well. Therefore, their unique experience of marginality was a product of "intersecting patterns" of both racism and sexism (Crenshaw, 1989). By using the analogy to an intersection, Crenshaw was able to demonstrate how race and gender interacted in shaping the experiences of women of colour as though they were two roads that met at an intersection.

Since then, the term 'Intersectionality' has been utilised by activists, academics and organisations all over the world, including in India, as an analytical framework to understand how multiple overlapping identities like the religion of a person, their language, their gender, the caste they belong to or their sexual orientation have an impact on their or a group's experience of marginality. These markers of identity don't exist separately, but overlap or interconnect in unique ways. Intersection allows us to look at more than one aspect of our identity at one time and stops us from universalizing experiences that are felt by different people in different social settings. By recognizing the intersectionality of gender for instance, i.e., how it's intertwined and co-constituted by different and multiple identities like caste, religion, sexuality etc., we understand the role these identities play in our everyday experience of gender.

The concept of intersectionality originated in the United States specifically in the context of gender and race, and especially through the work done by black feminists. In the 1980s and 1990s, black feminists challenged the exclusionary aspects of the women's movement in the West, which was dominated by white, middle class feminists who were mostly silent about how the experiences of black women were different from theirs. Black women's continued political interrogation in this regard demonstrated how talking about racism had become the sole responsibility of black women only.

Intersectionality as a framework, then, helps all of us analyse the multiple levels of discrimination and the unique structures of domination that black women are subjected to because of both their gender and race, taking the burden off of them for having to educate others about their unique experiences. One can draw parallels between the experiences of black

women in the US and Dalit women in India, where the category of caste is much more relevant to understand power relations as opposed to race. This is because the caste system is an overarching system of discrimination and oppression in India and is intrinsic not only to Hinduism but persists in other religions as well, despite them having opposed such a system.

In this chapter, we will attempt to understand how gender and sexuality intersect with other identities such as caste, class, religion, disability, ethnicity and citizenship in India and how these impact our life experiences. The theory of intersectionality isn't only restricted to the identities mentioned so far, however, in this chapter, we will focus on providing an overview to only some of them.

Gender, Sexuality & Class

In a society where, who we are, how much money we make, what kind of family we belong to etc. matters, our identities become important markers of our experience. Let's say you're planning to go eat at an expensive restaurant. If you're well-to-do, you wouldn't think twice before entering. Rather, you'd be met with a welcoming and hospitable staff, who would ensure that all your needs are met. However, a similar situation might not end up in the same manner for those who don't have the financial means to be able to afford such a restaurant. They will be judged based on their looks, attire or even ability to speak English fluently, and so, their access to the restaurant will be decided based on their outwardly appearance. This is the defining experience of one's class, which is deeply tied to the notion of respectability. What would it look like when one's class intersected with one's gender?

Although women are disproportionately harmed by gender-based violence, not all women experience it in the same manner or extent. The experience of a woman belonging to a low socio-economic background with violence and discrimination is very different from that of a woman who has the financial means and resources to pursue a legal case against her perpetrator/s. She might even be subjected to violence *due* to her lower-class status. Let's say she musters up the courage to file a report against her abuser. Not only would she lack financial and other resources to pursue her case legally, she also wouldn't have access to qualified professionals, for example, or other networks that could help her with her case. And so, she would face great difficulty in getting access to justice and holding her abuser accountable.

> Under the Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redressal) Act, 2013, domestic workers and informal workers can only approach the Local Complaints Committee ('LCC'), while women who work in more formal settings can approach their employer's Internal Committee to report sexual harassment. This disproportionately impacts working class women, who are more likely to be employed in informal workplaces, often as ad-hoc/contract workers. This remains so despite the fact that the Act was drafted as a consequence of the directions given by the Supreme Court in *Vishaka* v. *State of Rajasthan, 1997*, which came out of a case of rape of an informal Dalit woman worker. (https://thewire.in/gender/bhanwari-devi-sexual-harassment-at-the-workplace-law) Sexual harassment at the workplace is difficult for women to redress, due to the pre-existing imbalance of power between men and women at the workplace, and more so for women combating sexual harassment by a superior as opposed to a colleague. Raising grievances under the Act therefore becomes all the more difficult for women who are twice, or thrice, discriminated against, on account of gender, class and caste.

For a transgender person, navigating social spaces is characterized by experiences of discrimination, vulnerability and violence. The commonly held belief that there are only two genders and the resulting transphobia conspires to deprive trans people of work opportunities and the freedom to openly live as themselves without fear of violence and oppression. This perception and conflation of sex and gender has given rise to prejudice against all those individuals who don't fit into the gender binary or don't identify with the gender assigned to them at birth. Their experiences are different, and one can say more severe, than cisgender men or women (those who identify with the gender assigned to them at birth and therefore, enjoy cis privilege).

Now, let's say a transwoman has been subjected to sexual violence. If she decides to report her abuser, chances are that her experience of violence itself may get invalidated, her testimony may be dismissed, and she may not have access to supportive networks to seek redress. She would face difficulty not only in accessing legal help, but also face harassment by the police or even be physically or sexually assaulted by them in custody, as is common.

> Sexual assault of a transgender person entails a maximum punishment of imprisonment for a term of two years (Sec. 18 - Transgender Persons (Protection of Rights) Act, 2019), whereas the minimum punishment for the sexual assault of a woman under the Indian Penal Code, 1860 is seven years, which can extend to life imprisonment. The law, itself, is unequal in its understanding of sexual violence redressal, meaning that a transgender woman is placed at a greater disadvantage in redressing her sexual assault than a cis-gendered woman, despite being more marginalised. When law and policymakers understand the intersectional nature of the identities that people hold and the social locations they come from, rights get framed through an intersectional framework, as well.

An intersectionality framework would help us understand the interplay of gender, sexuality and class as explained above, and how these are intrinsically linked in a society like ours. This framework tells us how uniquely these categories of identity shape the social realities of different individuals or communities and how the nature of discrimination experienced by someone who exists at the intersection of such multiple identities becomes much more layered and severe.

Gender, Sexuality & Caste

In a society where individuals are discriminated merely for being born into a lower caste family and their basic rights are denied to them as a result, being from a lower caste or a Dalit community means being subjected to an additional violence based on one's caste identity. Forms of discrimination, prejudice and violence directed at a woman in our society for instance, are felt more severely when the woman also belongs to a Dalit community.

Dalit women face extreme forms of oppression and violence and are 'doubly' discriminated against due to their gender and caste. When a Dalit woman is sexually assaulted by upper caste men, the intention is to bring dishonour and shame to her community, and violence is used as a means of punishment and show of power. It isn't only an instance of gender-based violence but primarily a caste-based atrocity. It is through the bodies of Dalit Bahujan women that upper caste men reinstate the boundaries between them and lower caste communities. For a Dalit

woman who has been sexually violated, there are roadblocks in accessing justice. Apart from lack of socio-legal resources, she might also be prevented from seeking any redress from the upper caste members of her community, including the police. By acknowledging this form of violence as caste-based, we understand the role intersecting patterns of sexism and casteism play in a Dalit woman's lived experiences.

> The violence faced by Dalit women deserves particular attention as it sits at the intersection of caste and gender categories. By categorizing crimes against persons belonging to Scheduled Castes and Scheduled Tribes as 'atrocities,' the Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989 acknowledges, and writes into history, caste-based violence as a specific phenomenon. It attempts to 'infuse criminal law with constitutional ideals of substantive equality by re-signifying previously stigmatised bodies as bearers of rights.'(Sonavane N, 2017) Section 3 of the Act specifically recognizes sexual violence against a woman belonging to a Scheduled Caste or Scheduled tribe as a caste-based crime, as the perpetrator must necessarily belong to an oppressor caste (he cannot be a SC/ST man), implying that the sexual violence must have taken place because of the offender's position of dominance. Importantly, the law acknowledges the intersectional nature of caste-based crimes, as the Act can be applied in addition to crimes listed under general laws, such as the Indian Penal Code, 1860.

The experience of being a queer or a trans person is defined by the constant fight for survival and fear of public violence and abuse at the hands of the state (custodial violence perpetrated by someone employed by the state, for e.g., police officer, prison staff, public servant or hospital staff) and society (verbal harassment, physical assault etc. for being 'different' than 'us'), with not enough redress mechanisms or social support offered to them. During the lockdown imposed after the spread of the COVID-19 pandemic, the trans community found itself to be completely unprepared and devoid of support from the state to be able to sustain itself in the face of loss of livelihood, homelessness, inaccessibility to healthcare and also experienced an increase in instances of violence (Sahai et al., 2020).

When that queer or a trans person also belongs to a Dalit community, they face discrimination based on their gender and sexual identity as well as caste identity. For trans individuals, this discrimination is not only limited to outside the trans community but within the community as well. A Dalit trans person might be discriminated against by an upper caste trans individual. In this way, the lens of intersectionality helps us become conscious of those forms of prejudice and oppression that are invisibilized, not too evident or not spoken about openly. All three of these social identities i.e. gender, sexuality and caste play a huge role in how public spaces are defined and accessed, who is more likely to be believed and who is more likely to be harassed, humiliated or assaulted by those who enjoy caste privilege.

Gender, Sexuality & Tribal identity

While caste is an overarching system of oppression in India, there are communities that exist independent of the caste system or outside the hierarchical structure of Hindu society, like tribal communities (Xaxa, 1999). Over 400 groups in India belonging to different geographic locations are officially designated as 'tribes' by the Constitution of India. For the tribal

communities inhabiting the North-eastern parts of India and many tribal-dominated states in Central India, tribal realities play a much more defining role than caste realities.

There exists a lack of information in the Indian mainstream about the ground realities of people from tribal communities as these aren't authentically understood or talked about. While 'Northeast India' refers to the states of Meghalaya, Assam, Mizoram, Nagaland, Manipur, Arunachal Pradesh, Tripura and Sikkim, there has been a tendency to lump together these very disparate states into a single identity with the use of this label, and also as one that's separate from the rest of the country, thereby erasing the diversity of its languages, cultural practices and traditions. Its history and cultural practices are also missing from our school textbooks. There are several dominant stereotypes about this region, mostly known for its insurgency and related violence as only these are picked up by the media (Misri, 2011).

Due to poor infrastructure, high unemployment rates and political turmoil, a lot of North easterners migrate to cities like Delhi, Mumbai etc. to seek better opportunities. However, in these metropolitan cities, they are socially and emotionally ghettoised and racially stigmatised for having distinctive cultural practices, religious affiliations and physical features. They are regularly subjected to derogatory ethnic slurs that are used to alienate them from the mainland.

A common assumption made about women from India's Northeast region is that they enjoy an equal position in a society understood to be egalitarian and progressive owing to its tribal traditions and cultures. It is also assumed that because this region has communities that follow the matrilineal system, the Khasi community for instance, the women there are supposed to be much more liberated and not bound by patriarchal rules and norms as are those in the rest of the country (Gill, 2014). Although women from matrilineal communities do tend to exercise more decision-making power and everyday freedoms, they do so largely from within the private realm. Public spaces are still occupied mostly by men, with them enjoying far greater representation in areas such as politics etc. For the Khasis, ‘ethics and respectability’ hold a lot of significance, and as a result, discussions on sexuality, family planning etc. are seen as ‘embarrassing’ subjects. (Mukhim, 2017). Furthermore, in the entire Northeast region, only Meghalaya has a matrilineal community, and yet the crime against women and children continues to be on the rise. These assumptions, therefore, do misinform the public and may also interfere in the counselling process.

Women from marginalised-ethnic communities suffer day-to-day social, physical and emotional persecution in cities like Delhi (Reena, 2020). There are routine instances of them being subjected to racial slurs and gaze, being addressed by derogatory words and perceived as sexually promiscuous with men asking for “their price”. This perception of them is made worse by representation in Hindi cinema of women from North-eastern states as mostly sex workers or of men from this region as criminals etc., which has contributed to their regional identity being perceived as that of secessionists and prone to violence. An intersectional lens helps us confront this form of everyday violence and discrimination that people from tribal communities face due to their ethnicity and how they're represented in the mainstream, which contributes to dominant stereotypes about them.

Gender, Sexuality & Disability

According to the 2011 Census of India, persons with disability make nearly 2.1% of the population in India. Yet, the marginalization and discrimination faced by disabled individuals receives very little attention. People with mental and physical disabilities have been condemned, alienated, even feared – their disability explained away, overtly or subconsciously, as a punishment from God, as 'inferior genetics' or 'bad karma', as bringing dishonour to the family and other such beliefs.

The biggest hurdle that a person with disability faces is accessing public spaces, education and employment among many other challenges. During the COVID-19 pandemic, a lot of disabled individuals spoke out about how the shift to working from home was carried out with ease only because able-bodied individuals were in need of such a facility. Workplaces were suddenly understanding of the needs of all people as the fear of the virus loomed over, while disability rights activists had been vocal for years demanding easy access to employment and work-from-home services. However, those had not been met thus far. The world that we live in has been infrastructurally designed and conceived for able-bodied individuals which can be inaccessible to people with different disabilities.

To understand the intersection of gender, sexuality and disability, we can look at the experience of a queer disabled woman. A woman with disabilities is more vulnerable to sexual violence, sometimes by her own care-givers, and faces severe challenges in accessing public services. Within the family, her identity as a care-receiver comes into direct conflict with her identity as a woman, and therefore, a care-giver. People also refuse to view women with disabilities as sexual beings – as having sexual needs, needing sexual and reproductive health services etc. which hugely impacts their mental and physical well-being. This perception also makes it harder to accept them and their sexual identity - for instance, a queer or non-binary disabled woman would experience stigma not only for expressing her sexual desires but also for transgressing gender norms due to her gender identity.

Gender, Sexuality & Religion

For a woman in a patriarchal society, accessing the public realm can be full of difficulties. Gender norms and stereotypes ensure that women are restricted to the private realm, where it is expected of them to take care of the needs of their husband, children and in-laws, while simultaneously being responsible for chores like cooking, cleaning and other everyday household management. While their mobility in the public sphere is already limited, if a woman belongs to a low socio-economic background or lower caste, this accessibility gets further restricted, as we have seen so far. One of the few public spaces she might be able to access freely are places of worship (that too only if she belongs to an upper caste community). However, a woman's position within religion hasn't been particularly an empowering one either.

Religion lays down behaviours and values that are essentially cultural, but seem to derive their power from the idea of a divine source. These include cultural mores such as modesty or the emphasis on virginity or chastity in women. So, when we wonder why the purity of women is emphasized so much in many cultures, we can reflect on the stories and ideas that we grew up hearing. For instance, a menstruating woman is considered 'impure' and is therefore told not to enter religious places so as not to 'pollute' them. These ideas often set a standard for how an individual, in this case a woman, is supposed to behave - by following what is considered 'pure'

and acceptable and avoiding a life that is considered ‘dirty’ or ‘immoral’. These perceptions of purity/pollution within religion are intrinsically linked to gender and in some religions, to caste as well.

For instance, individuals from the LGBTQ+ community are constantly made to question their place within the religious realm due to their gender and sexual identity. Their lived experience is marked by fear of coming out to their families with religious beliefs that do not accept their sexual orientation and gender identity as ‘natural’. Religious scriptures have been used as a weapon to ostracise them from society with no one to fall back on. Religions have rarely considered queer lives, and therefore, do not have much by way of how they might participate in a religious life, places of worship, or even the everyday lived realities of life such as marriage and death.

Intersectionality can help us quash stereotypes perpetuated by society by becoming aware of the different cultural and religious practices of people belonging to different religions and faiths. For instance, the popular perception of a Muslim woman is that they're ‘vulnerable’ and always in need of rescue from their ‘really oppressive’ religion. In doing so, we reduce Muslim women to a monolith category and view them as hapless victims with no agency. This ignores the many ways in which a Muslim woman or a queer Muslim woman resists, subverts and negotiates patriarchal control and oppression in her life.

Gender, Sexuality & Citizenship

A common understanding of citizenship is one based on the status of being a legal citizen of a country. However, if we expand the definition of citizenship beyond the relationship between a citizen and the state to other institutions like the family, marriage and other civil society organisations, we will be able to analyse the role gender plays in who gets to be viewed as a ‘genuine’ or ‘ideal’ citizen of a country (Kangas, Haider, & Fraser, 2014). Who decides who is a ‘genuine’ citizen of a nation? Which identities would check all the boxes? Does being a citizen on paper ensure that the needs and interests of all are met? The experiences of the marginalised will tell us how that’s far from the truth.

In the nationalistic imagination, women are seen as the embodiment of a nation’s culture and honour and the bearers of tradition accompanied by certain do’s and don'ts for them to follow so as to match up to an ideal of womanhood. In this imagination, it is expected of women to continue to work from within the confines of the home, which pushes them further into the domestic realm. They may be equal citizens on paper like the rest of the population, but they may not be able to exercise their right to be in a public place freely and without the fear of violence. They are constantly reminded through street harassment and abuse that they do not belong in public spaces. It is also expected of them to dress modestly, to marry at a certain age and bear children and to take care of other domestic responsibilities. But who is an ideal woman or a man, or rather who decides what is ideal at all?

Historically, the state has given precedence to the male property-owning individual, while women’s citizenship has usually remained suspect. There is a noticeable discord between the state wanting to recognize women as workers and equal contributors to the economy on the one hand and viewing them as dependent and passive recipients on the other. If being seen as an ideal citizen is contingent upon a woman’s identity as honourable, family-oriented, chaste,

loyal, nurturing etc., we can see how those who don't conform to this ideal can be viewed as less ideal and therefore lesser citizens. And all of this, because societal norms keep alive the perception that there are only two genders i.e., male and female, who are in turn attracted only to the 'opposite sex'. A transwoman, by virtue of falling outside this normative view of gender, problematizes this perception and creates anxiety in a cis heteronormative society, which subjects her to further violence to drive across the message that she is not welcome or does not belong here. Her identity as a citizen is also made questionable.

A scene from the 2019 movie *Kumbalangi Nights* quite tellingly captures one of the many hegemonic and idealised forms of masculinity that can be observed in our society today. Shammi, the only male member in his family of four and by default the patriarch, stands in front of a mirror carefully shaping his mustache until it's perfectly symmetrical. As he admires his reflection, he proudly calls himself "the complete man" and scrapes off his wife's *bindi* from the mirror. For him, the mustache is more than just facial hair - it is representative of his masculine identity that needs to be honoured, protected and reified.



The *bindi* is like a blot on his manliness - the effeminate 'other', because of its association with femininity and subordination. Men like Shammi don't represent the entire spectrum of masculinity and its cultural manifestations in India but are an essential figure to understand the ways in which it is embodied - through something that needs to be protected/honoured and that which needs to be controlled/repressed. A man like Shammi would be the representation of an ideal citizen of our country - hyper masculinized, upper caste, upper class and a straight, Hindu male.

The nation-state with its rigid boundaries seeks to protect itself from foreign elements outside and to throw out 'anti-national' elements from inside. Who decides who is 'foreign' and who is a 'citizen' is contingent upon the dominant political doctrine of the time? If we think of the nation-state as representing a man's virility, we can link its fear of the foreign to the fear of being penetrated or 'reduced to a woman'.

How can we apply an intersectional lens to our lives?

To understand how we can apply intersectionality to our everyday lives, we can begin by examining our own identities or how we're socially situated in this world - also known as our positionality. For instance, a researcher acknowledges that they have certain values, beliefs and moral stances due to their identities that could impact how they carry out their research. And due to these, they are aware that they can't be completely objective in their research process.

Even the author of this chapter holds certain viewpoints and perspectives owing to their social location, which may have impacted how and what they have written. The task for the researcher is to reflect, introspect and delineate what their positionality is and what are the different biases owing to their identity that could be at play in relation to their work. We can apply a similar kind of introspection to our own identities to understand and become aware of what our social location tells us about our experiences.

Reflection*:*

1. My Position and Intersections

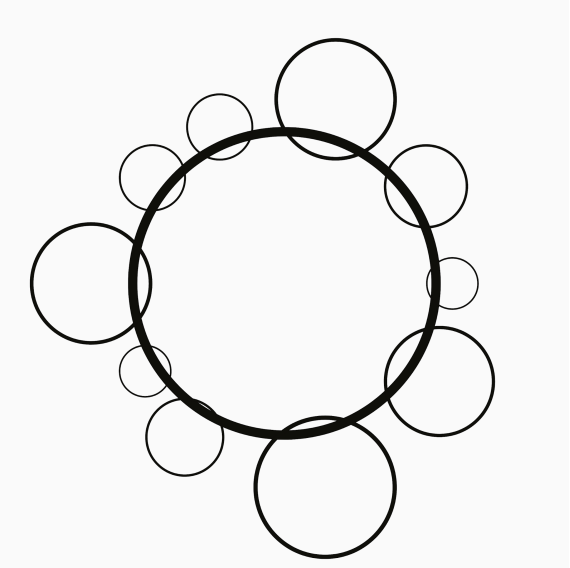
Draw / write

Draw a circle and write your name in the centre.

Around the circle, draw several intersecting circles of different sizes. Write the intersectionality that affects you the most, the ones you think more about in these in the larger circles. Which identities pose challenges? Which ones provide privileges? Write these as well in the larger circles. In the smaller circles write the intersectionality that affects you less.

Some intersectionality to consider would be - age, gender identity, cisgender or trans etc., economic class, education, caste, religion, disability, languages spoken, type of food eaten, nationality, state you belong to, position at work/ home, your birth order, profession, skills etc.

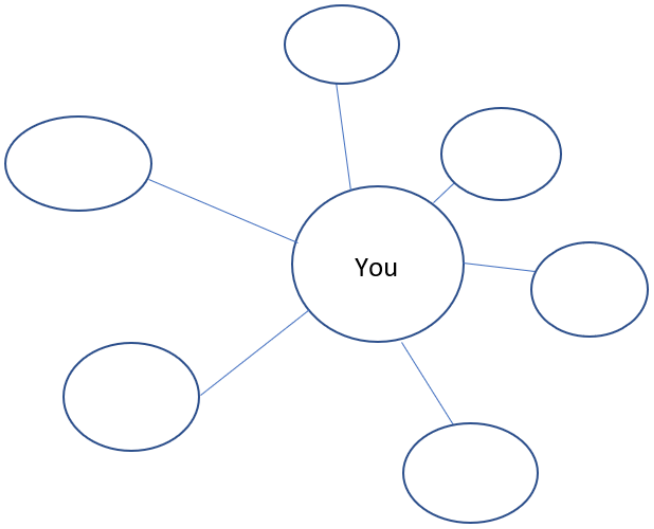
- What do you observe?
- Which are the identities that have the greatest effect on how you perceive yourself?
- Which identities have the greatest effect on how others perceive you?
- How many of these were in your control?



2. Positionality:

Draw a bubble with your name in the centre and then draw lines with the different intersectionality (or privileges or identities) that you hold to be important in your life. Radiations of different length indicate the importance of that identity to you.

Reflect on how these identities intersect and influence your experiences and expression. For e.g., if you're an Indian upper caste woman from a well-to-do family, you will enjoy access to a good education, knowledge and skills and other assets known as cultural capital.



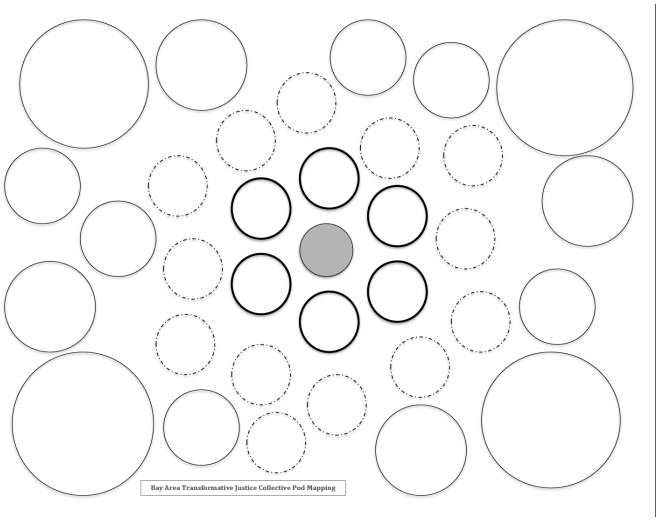
3. Other's Position and Intersections

Think of a person you know, but whom, for no obvious reason, you're not very fond of.
Draw a circle and place them in the centre.
Draw two layers of circles around this circle.
Write the intersectionality that you think most affect this person, pose challenges/ provide privileges in the first layer of circles around their circle.
Write the intersectionality that you think affects them less, in the outer circle.

Compare your position and intersections with those of this person.

- What do you notice?
- What do you feel?

Do you have any insights on why you feel a certain way about this person? What are you curious about w.r.t this person now? Do you think you might have felt differently if your position was different along any of the dimensions?



Practitioner's perspective:

Watch Enfold's video series on Demystifying Sexuality - Understanding The Intersectionality Of Our Identities And How These Impact Us (link will be inserted)

Way forward

Here we discuss some things that we can do moving forward, to draw upon intersectional frameworks in our daily lives. It's important for us to work together to become aware of the experiences of people from communities and backgrounds different to ours.

- The first step is to be mindful of and sensitive to the various identities that one may possibly hold, and be open to understand how it may have shaped us. What may seem like a non-issue to one person may be a life-defining influence on another. For example, having the privilege of a high school education.

- The next step is to become aware of and acknowledge the multiple struggles of other individuals and their intersectional identities and the impact it has on their lives. Understanding that every individual or community has their own unique challenges even if we might not be aware of what they are, could help us in becoming sensitive to another person or community's struggle. We can respect each other, stand for each other's rights and consciously avoid using words and actions that violate them.

- Another important step is to hold space for people most impacted by an issue; talk and speak about it in different groups like our family, friends, colleagues etc. and expand our circles so that no one group is speaking on behalf of another or speaking over another. Valuing different voices and making space for individuals and groups who have been historically marginalised to tell their own story as opposed to speaking on behalf of them would go a long way in demonstrating respect and sensitivity towards each other. We can work towards amplifying those voices that have been historically invisiblized or

silenced by ensuring they get more representation in different socio-political and legal spaces.

- The concept of intersectionality can be imagined as a web - an interconnected network where all the identities are interconnected in one way or another. In a power circle, people with power are at the centre. The circle has a margin, a boundary which can stand for inclusion and exclusion. An interconnected web on the other hand, does not have a single power centre. It has as many power centres as the number of people in it. It does not have a limit or a boundary that can be used to include or exclude people. Each person is connected and can form new connections to expand the network; no one is kept out and anyone who comes in contact becomes a part of the network. The thread winding and connecting people is a thread of respect, rights and worthiness. Keeping the imagery of the web in our minds in this way can help us adopt the lens of intersectionality in our lives.

- Strive to interact with people from communities different than ours and listen to what they say about the challenges they face. Awareness and respect for intersectionality encourages cross-community, cross-sector and cross-issue collaboration, and investment in each other's issues and concerns. People from different walks of life - teachers, students, social artists, social workers, medical and media personnel, cultural workers, strategists and laypeople can work with each other collaboratively. These types of collaborations encourage innovative solutions, expand networks, and encourage transformative change.

We can keep in mind that, at least in the current social milieu, some people have more power than others and one can use that privilege to create a platform to bring awareness about issues affecting marginalised communities. People who hold power and have privilege (due to various historical socio-cultural factors and accidents of birth) have a responsibility to use their privilege to speak up, act and work with those with less or no privilege to realize everyone's rights and have people experience respect, belonging and worthiness.

Chapter 15. Sexual Violence against Adults
- from stigma, shame and blame to healing and accountability

The issue of sexual violence, perpetrated overwhelmingly by cis men on women and children, cuts across caste, class, religion and region, but is especially perpetrated on those from marginalised groups and communities. It is a pervasive and systemic form of violence that is rooted in institutionalised power and patriarchy and adversely impacts survivors with long-term effects on their physical, psychological and emotional health. It includes (but is not limited to) marital rape, intimate partner violence, sexual violence by non-partners, violence used as a weapon of war, sexual harassment or sexual advances, forced or early marriage, sexual abuse of people with physical or mental disabilities, denying the right to use contraception or measures to prevent STIs, forced abortions, violent acts against the sexual integrity of women including female genital mutilation (FGM), forced sex trafficking, sexual abuse of children, among others.

Sexual violence is normalized by patriarchal and socio-economic structures like the family, state, marketing practices and structures of domination and oppression for e.g., the pornography market (McVey, Gurrieri, & Tyler, 2020) etc., and the perpetrator commits this form of violence in different situations and settings, be it in public places (streets, workplaces and transportation), at home (by intimate partners/acquaintance rape/ sexual abuse) or on digital spaces (cyber abuse).

Survivors, especially women, have resisted or opened up discussion of their experiences of sexual violence directed at them by all these structures and disrupted its normative nature by naming such acts as ‘rape’, ‘sexual harassment’, ‘domestic violence’, ‘marital rape’ etc. and by lobbying for these acts to be recognized as criminal acts, through campaigns and movements to raise awareness about human rights and dignity. However, the rising cases of brutal rape and violence and the several barriers in accessing justice goes to show that the situation continues to be quite dismal. The patriarchal understanding of sexual violence deems rape as a crime against the family’s ‘honour’ and as a ‘fate worse than death’ (Menon, 2012). This dissuades survivors from coming forward and reporting incidents of sexual violence perpetrated against them.

As cases of sexual violence against women and children continue to rise in India, 99% cases of sexual assault still go unreported, telling us just how systemic this form of violence is (Bhattacharya, 2018). Low reporting of rapes could be because a majority of sexual violence in India occurs within marriage or by intimate partners, and since marital rape isn’t criminalised in India, along with the shame and stigma attached to it, survivors aren’t able to access help easily (Raj & McDougal, 2014). There are also multiple barriers to obtain justice, more so for those who belong to marginalised communities in the country, like Dalit, Bahujan and Adivasi women. There are a large number of cases still awaiting trial, while the conviction rate remains low.

In South Asia, there are many dimensions of sexual violence. There is no clarity on the definition of ‘sexual violence’ due to its complexity - the legal, medical and forensic understanding of it varies (Geetha, 2016). There is also the patriarchal understanding of sexual violence as ‘shameful’ and bringing dishonour to the community (when it is sexual assault outside of a marriage) or as ‘unfortunate’ and being a normal ‘domestic issue’ that the spouse needs to adjust to (when it is within a married relationship). On the other hand, the feminist and

women's rights activists understand it as a 'systematic violation of women's right to bodily integrity and autonomy' (Geetha, 2016).

What we know about the persistence of sexual violence is usually limited to what is picked up and highlighted by the media. These seldom talk about how endemic sexual violence and rape is within groups marginalised by their caste, religion, region and ethnicity. Media tends to focus on individual acts of violence, instead of its systemic nature rooted in power and privilege. They also rarely talk about sexual violence perpetrated by the armed forces deployed in conflict zones or by the police themselves in the form of custodial rapes. The perpetrators are rarely held responsible or accountable, leading to more violence being inflicted with impunity. Sexual violence against women, therefore, needs to be also seen as a structural, systemic issue, focusing on the culture of normalised sexual violence within institutions, homes, public places and digital spaces etc. and not simply as an act of violence.

There is also a lack of awareness around the concept of consent. Consent is not so easy to define, nor is it easy to assume (Menon, 2012). Consent once given for a particular sexual act can be withdrawn for another act. According to Explanation 2 of Section 375:

"*Consent means an unequivocal voluntary agreement when the woman by words, gestures or any form of verbal or non-verbal communication, communicates willingness to participate in the specific sexual act: Provided that a woman who does not physically resist to the act of penetration shall not by the reason only of that fact, be regarded as consenting to the sexual activity*"

Unfortunately, in a society like ours that's rooted in male entitlement and power, the concept of consent has never been fostered and there has been little to no conversation about it in our homes, schools, colleges or academic institutions. A common source of misinformation on consent is the media, especially movies and their portrayal of romantic relationships, where a woman's 'no' is perceived as her being coy and actually meaning to say 'yes'. This results in incorrect ideas about consent. Consent can also not be assumed to be present within marriage. For consent in a sexual activity to be adequate, the consent of both individuals must be taken into account at all times.

Why does sexual violence continue to persist in India?

Women experience continued violence and intimidation in a patriarchal society that shifts the fault on survivors when an act of sexual violence is committed - they are blamed for their clothes, what they were doing, they are labelled as 'good' or 'bad' women etc. - and shames them and their family into remaining quiet and never speaking up. There is also a public denial of recognizing the continual sexual violation and degradation of Dalit women, who are seen as sexually available, and are discouraged from demanding to be treated with respect and dignity. Their sexual humiliation is used as a tool by upper caste perpetrators to affirm dominance and control over lower caste communities.

Further, when a person reports sexual abuse or assault, they are often re-victimized by the medico-legal-social systems - for e.g., law enforcers shaming the survivor, during the interrogation process - asking her about her sexual history, her values, suggesting that she was at fault; medical professionals showing great insensitivity by continuing to use the now-banned

"two finger test “practitioners of law asking the survivor to recount their story multiple times/being disbelieved etc. and pressures from law enforcement agencies to give up the case or "compromise". These systems that are often against the interests of the survivor are also responsible for the persistence of sexual violence in our societies.

Intimate partner violence in India

The most prevalent and underreported form of violence against women in India is perhaps intimate partner violence or IPV, which includes "physical, sexual, and emotional abuse and controlling behaviours by an intimate partner" (WHO, 2012, pp 1,para 1). This kind of violence can cause severe physical, psychological and sexual harm to the survivor and can take place in all kinds of socio-economic, religious and cultural contexts. (WHO, 2012, para 2). According to a National Family Health Survey (NFHS) in 2005-06, 40% women reported experiencing some form of violence from their spouse, and 55% thought the violence was justified (Priya et al. 2014). According to a recent study, there was a rise in IPV during the COVID-19 - related countrywide lockdown in India, with survivors left with little to no support or redressal mechanisms to escape the violence (Pal et al., 2021).

The perpetrators of IPV are largely male, however, this form of violence can also be perpetrated by women and isn't only restricted to heterosexual relationships. Fear of retaliation, lack of financial support, stigma, losing custody of children etc. are some of the reasons why survivors of IPV - largely women - find it difficult to leave their abusive and violent relationships or marriage (WHO, 2012).

There exists a lot of misconception around IPV in society as well as the law, with poor understanding of the socio-cultural and individual factors that lead to this form of violence. Prevalent gendered norms that associate aggression and dominance with masculinity cause men to feel entitled to a woman partner, who is usually dependent on them for survival and livelihood due to their low socio-economic status (WHO, 2012).

The silence around male rapes

When we recognise sexual violence as one of the many forms of violence that can be perpetrated on anyone - including men, and not a ‘life destroying’, shameful event for the survivor, we begin to understand its multiple dimensions. The fact that sexual violence is perpetrated on men is rarely recognised or talked about because society assumes it is only women who are at risk of being raped or penetrated. Because of the shame and ridicule associated with males being sexually violated, male survivors of abuse choose to stay quiet and suffer in silence. Men who are seen as effeminate or who are openly gay are routinely subjected to sexual and other forms of violence because of this enforced culture of silence which lets the perpetrators get away without any consequence. Trans individuals’ life experiences are defined by acts of sexual violence perpetrated on them to ‘put them in their place’. This comes at great cost to survivors - from social ostracization, loss of employment, mental health issues and even death.

How can we support survivors of sexual violence?

Sexual violence, like other forms of violence, is often a way of demonstrating power over another or an opportunistic act to satiate one’s sexual needs. Sexual violence in particular is thought to cause greater pain to the victim than other forms of violence, because of the association of sexuality with moral ideas like ‘honour’, ‘virtue’, ‘character’, ‘purity’ and such which one ‘lost’ or ‘violated’ is thought of as a greatly dehumanizing experience.

Changing this narrative in the public psyche may be key to preventing sexual violence from being used to inflict humiliation, shame or emotional trauma. It may also help survivors to think of it as violence of another form - dissociated from any morality or shame. Survivors may all have different physical, emotional and psychological reactions to the crime inflicted on them - there is no one way to respond or think about it.

Other factors that have to be considered are:

- Survivors of sexual violence who end up reporting the incident to the police are met with many hurdles in their journey to obtain justice and critical support services. They need to be provided with effective redressal mechanisms that go beyond punitive measures against the perpetrators, that focus on their voices and replace shame-based responses with those that could lead to their healing from the harm caused to them.
- Systems need to be in place that offer accessible care and support to persons who face violence. Counselling, holistic therapy and support group initiatives have been found to be helpful.
- Programmes for perpetrators that help them acknowledge the harm they caused and move towards repairing it need to be introduced.
- Focusing on educating individuals in life skills and communication have also been found to reduce violence against women in many communities.
- We also need structural changes in the legal system, and ensure effective survivor and witness protection programs, increased police accountability and ending impunity for perpetrators, especially when they are in positions of power or belong to dominant castes.
- Most importantly, we need to direct focus on building support services for survivors by ensuring that the survivor's needs are met and that they receive psychosocial care and support.
- Systems and processes that help build accountability and responsibility in the offender would go a long way in preventing reoffending, instead of focusing on ‘just punishment for the crime committed or making punishment harsher in the hope that it would deter potential offenders’.
- Involvement of the community in recognizing its role in perpetuating a culture of violence as well as the part it can play in healing the victim and supporting the offender to reform their behaviour would go a long way in protecting each person’s right to safety and dignity.
- Involvement of families and communities, schools and colleges in building and strengthening self-discipline, deterring one’s friends/ colleagues/ family members from offending, encouraging proactive behaviour like intervening and standing up for the person harmed could help reduce violence.

Listed below are some pointers to how one can support a survivor who reports that one was sexually assaulted. Some of these are simple techniques and gestures while others are demonstrations of care, concern and the intent to help and support - conveyed authentically through a combination of efforts.

- Educate yourself and manage your emotions

- Be aware that people of any sex and gender identity and sexual orientation can be violated sexually. If you believe otherwise, educate yourself and discuss with those who work in the field of supporting survivors of sexual violence. This understanding is very important in preventing retraumatization of the survivor
- Be aware of the long-term consequences of sexual violence. Encourage them to seek medical/ mental health care if they experience any of those symptoms in the long term.
- Don't expect a survivor to express stereotypical emotions like crying or outbursts of anger and fear. Each individual is unique and different and may express themselves differently. Respond to their emotional state with empathy
- Avoid showing shock, horror, disgust or distrust when disclosure happens. If you do experience any of the listed emotions in response to the disclosure, recuse yourself from engaging with the survivor, and take this to your counsellor/ therapist to discuss with
- Survivors may not all be submissive, grateful and pliant to you, your suggestions and expectations. They may also not behave as you expect just because of the incident because sexual assault does not change their personality but may cause some changes in behaviours in the short term. Manage your disappointment, annoyance and frustration and persist with providing a holding space for the survivor

- Demonstrate empathetic communication
  - Believe and support the survivor's description of the assault. If there are gross contradictions in the disclosure, ask questions to clarify (at a later time if appropriate), without appearing to doubt the narration.
  - Demonstrate respect for the survivor and convey that sexual assault does not change their worth or character and that you value them for the person they are
  - Make eye contact with the survivor in a non-judgemental, caring manner that does not convey curiosity, fatigue or any form of accusation or distrust.
  - Express any parallel emotion you may feel - pain that the survivor talks about, distress over the violence - in a manner that shows that you are tuned into the survivor's experience
  - Establish trust and rapport - this might take time because trust is built over multiple interactions where one demonstrates genuine intent, shows one's own vulnerability, and seeks to understand more than to advise or instruct.
  - Use active, empathetic and reflective listening without rushing the survivor. Use non-judgemental language.
  - Ask questions out of concern, and not curiosity. Ask questions to establish facts that would be relevant to the well-being and safety of the survivor.
  - Converse about the wide variety of emotional responses that can be experienced following a traumatic event and reassure that all such emotions are normal.

- Protocols and ethical practices
  - Maintain confidentiality, dignity and privacy.
  - Ensure the survivor does not have to re-experience the trauma by repeating their experience more than absolutely required for the socio-psycho-legal process
  - Educate yourself and provide information about emergency contraception, STI testing, legal processes

- Establish a follow up plan
- Refer to a sensitive mental health professional, preferably experienced in counselling in sexual trauma to be suggested to the survivor.

Supporting victims of sexual violence to deal with their emotions

(Table revised from: Guidelines for medico-legal care for victims of sexual violence: World Health Organization 2003)

Feeling	**Some ways to respond**
Hopelessness	Say, "You are a valuable person. What you have experienced does not change any of that. I am sure you will be able to put this behind you and focus on things that are important for you." "What would you like to see happen/ do for yourself in this? Let's think about how to enable that and what is possible." Focus on the strategies and resourcefulness that the person used to survive and come this far and remind them of it.
Despair	Explore what is the key cause for the despair - what values and beliefs may be challenged? What may be the fears and concerns? Focus on putting the experience in perspective - in terms of intensity/ timelines/ impact/ facts and data - to convey that tough times don't last forever, that time heals, that there are multiple ways in which to attend to whatever is important to the person.
Powerlessness and loss of control	Say, "You might have felt powerless in that situation because the abuser was physically stronger/ threatened to cause harm and had an upper hand. That is not what most situations in your life are going to be like. Some people choose to wield their power in harmful ways and that is very unfair and wrong. You are smart, intelligent, resourceful and you have choices and options today in how to proceed. You have chosen to talk about it / report the abuser / take action and that is appreciable. It takes a lot of courage to do that and you have it in you to move forward"

Flashbacks/ Disturbed sleep	Recommend to professionals who can guide with calming processes, visualization techniques, intrapsychic processes, body/ movement therapy, that help reframe painful memories
Denial	Say, “You look shaken and upset/ sad/ fearful <reflect emotion>. It must be difficult to talk about what happened. It is also possible that sometimes the details are unclear or you are unsure about what transpired. It is ok to feel that way. I do wish that you feel better about things and if you would like to talk about it anytime later, let me know.” I’m taking what you have told me seriously. I will be here if you need help in the future.”
Guilt and self-blame	Say, “You are not to blame for what happened to you. It may seem like you had a part to play because the abuser took advantage of the situation and manipulated you. It is difficult to make logical, right decisions and respond when you are being deliberately manipulated emotionally/psychologically. You are being too hard on yourself by holding yourself responsible. It is not your fault that you trusted someone/ believed them/ allowed them to make decisions for you. The person who assaulted you is responsible for the violence.”
Mood swings/ Numbness	Say, “It is normal to feel anger, anxiety, fear, sadness and any distressing emotions with varying degrees of intensity because of what you had to go through.” Explain that such experiences are to be expected given the shock/ trauma/distress of the violence they faced. It happens when one is trying to make sense of things and sees things differently at different times. It is also a process of venting and expressing grief and demonstrating hope/ courage. The numbness that may follow is a way of coping for the mind and body to deal with the overwhelming feelings they have. It is the defence of the mind and body by shutting out distressing thoughts and feelings. Refer to a professional who can help them make sense of these experiences, acknowledge them and learn to cope with them.

Fear	Emphasize, “You are safe now” (if the situation has improved) You can say, “That must have been very frightening for you. What you went through/ are going through was a terrible/ scary/ distressing experience and it is natural to feel fear. It is ok to take measures to protect yourself, to feel safer, to take precautions. What can I/ we do to make this feel safer? Let us look at the options”
Shame	Say, “There is no loss of honour in being sexually assaulted. The person who did this crime is wrong and has to face the consequences. You had to go through a lot of pain and fear/ anger because of what X did and you have been very brave/resilient/resourceful in getting through it so far. You have not done anything wrong to be ashamed about. You are worthy, smart, capable, intelligent and nothing changes because of this experience. Honour does not rest in our bodies or our private parts that we should be ashamed when someone abuses us”

Cultivating accountability and responsibility in the context of violence

Violence and oppression have a negative impact on our interpersonal relationships as well as on those within our neighbourhoods and communities. To create safety in our families, neighbourhoods and communities, involves building meaningful and trusting relationships with people around us and learning the necessary skills to respond to violence that could lead to accountability and responsibility for the harm caused. In our culture, perpetrators are rarely held accountable for their actions for a number of reasons - refusal to believe survivors, victim-blaming, perpetrators belonging to positions of power etc. When they are held accountable for the harm they’ve caused, it is usually conflated with putting them in jail and subjecting them to the harshest form of punishment. However, punishment does not build accountability or a sense of responsibility in the harm-doer. Instead, it often makes them vengeful. The fear of punishment on the other hand drives them in the opposite direction - to deny their role in the harm caused. Neither does it meet the needs of the person harmed.
If we are to think of strategies to address harm and conflict in our families, neighbourhoods and communities that don't resort to punishment, we need to shift our focus to thinking about individual and community accountability.

This is where practices such as restorative justice (RJ) and transformative justice (TJ) come into play. Both RJ and TJ are alternative approaches to crime that challenge punitive and retributive responses (restorative justice-based practices are discussed at length in Chapter 17). A restorative justice-based approach shifts the focus from the act of crime to the harm caused, centres the voices of survivors and recognizes the impact the harm had on the community as a

whole. This gives the perpetrator an opportunity to fully recognise the impact their actions had on multiple levels, and move towards taking accountability and responsibility for it. According to TransformHarm.org, a resource hub created by American activist and organiser Mariame Kaba, "Community Accountability (CA) strategies aim at preventing, intervening in, responding to, and healing from violence through strengthening relationships and communities, emphasizing mutual responsibility for addressing the conditions that allow violence to take place, and holding people accountable for violence and harm." Such a strategy allows us to work together with our group of friends, families, colleagues and neighbourhoods to create conditions for care and support for each other.

While RJ is largely practiced within or alongside the criminal justice system and comes in once the crime has already been committed, TJ rejects the legal system entirely and looks into intimate systems of community and civil society to create conditions that could prevent future harm from occurring. In our society, where being respectful towards elders trumps holding adults responsible for their harmful behaviour, the boundaries of children are rarely ever respected or taken seriously. For instance, if a child expresses, they don't like when their grandmother kisses them on the cheek, the parent might dismiss their discomfort by talking about how the grandmother does that out of love. The parent would rather invalidate the experience of their child, and expect the child to make room for the older person's feelings, than ask the grandmother to make space for the child's feelings! Instead, the practice of community accountability would ask us to transform those conditions and behaviours that hold the potential to reinforce oppression and violence.

Both TJ and RJ recognize that building the skills to address harm in society starts with learning how to resolve conflicts in our interpersonal relationships and elsewhere and practicing self-accountability first before we move towards holding others responsible for their actions. A lot of us are discouraged from taking responsibility for the mistakes we make or harm we cause, because we don't want to be associated with "those people" who commit crimes or do wrong. This conflation of behaviour with the personhood does not help us own up to our mistakes and harms we may have caused, and prevents us from moving forward in a good way. This perception not only stops us from building community safety and accountability processes, but also acts as an obstacle for the survivor to heal from the trauma and harm caused to them. We can instead, separate our behaviour from our selfhood, and work towards changing our behaviour so as not to cause harm in the future, and making good the harm we may have already caused.

Practitioner's perspective:

Watch Enfold's video series on
Demystifying Sexuality - Which Socio-Cultural Factors Enable Sexual Offenders? What Can We Do To Change Them? (link will be inserted)
Demystifying Sexuality - What We Need To Know About Consent (link will be inserted)

Download Enfold's App on adult safety:
Enfold UNICEF India, CDAC, Min of Electronics and Information Technology, Govt of India collaboratively launched **Stri Suraksha App. It** details how one can recognize and report

violence against women in different places - home, public places, workplace and cyberspace; learn about relevant laws and sections, resisting without aggravating, intervention and community based Restorative Justice. Emergency numbers for reporting and reintegration of Self exercises for recovery are also included. **The App is available in 10 languages, downloadable free on Android systems**.

Way Forward

Sexual violence is a symptom of the patriarchal mindsets of our society that make abusers feel entitled to exert violence on another and normalize behaviours that breach one's dignity and safety - even cheer such violent behaviours as a sign of masculinity. The way forward to limit such crimes is to change this narrative and engage in dialogues that make adults aware of their rights, to develop their agency towards asserting their rights and to hold people who abuse accountable for their actions.

Chapter 16. Sexual Violence against Children
- addressing core issues for child protection and safety

Child Sexual Abuse

Child sexual abuse is an area that has received little focus, despite it being a common crime committed all over the world. The attitude of secrecy and suppression that presides over conversations on sexual violence makes it harder to truly understand the extent of sexual abuse of children. Child sexual abuse is a form of sexual violence and a criminal offence perpetrated by an adult on a child. It includes intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing children to adult sexual activity or pornography, and the use of the child for sex trafficking or pornography. It can have complex, and often traumatic impacts for a child. Most children who do go through traumatic experiences, suffer from mental health issues in adult life. Child sexual abuse should not be looked at as a 'disorder' or a condition to be 'diagnosed' or a label.

According to the latest report on crime in the country, 4 in 10 victims of rapes are minors (Crime In India 2012-16, NCRB). In 2016, 43.3% of the total female rape victims were under 18. The Study on Child Abuse by Ministry of Women and Child Development, 2007,[51] in 13 states found that out of 12,447 children (hailing from all strata of society, and from 13 different states), more than half had faced sexual abuse and 1 in 5 had faced severe sexual abuse. 52.94% boys and 47.06% girls said they were reportedly subjected to sexual abuse. Most cases weren't even reported to the law enforcement agency. To combat sexual violence perpetrated on children, the Protection of Children from Sexual Offences Act (POCSO) was enacted in 2012. However, the conviction rate of perpetrators remains abysmally low. According to NCRB data of 2016, out of the 64,138 child rape cases that went into trial in court, only 6626 were completed, out of which 89.6% cases are still pending. The conviction rate in the cases where trial was completed was only 28.2% (Study on Child abuse: India 2007).

Factors that can put children at risk of sexual abuse

Sexual offences targeting children occur both in public places like schools and shelter homes as well as in the child's own home - the latter being the most common. Studies have found that most perpetrators of sexual abuse are known to the child or are in positions of trust, like a close relative (Study on Child abuse: India 2007). Small children are mostly unaware of personal safety, haven't been given the vocabulary to refer to genitals or other private parts of the body, and parents don't encourage or even have the tools or the vocabulary to talk to their children about sexual safety. Instead, children are often told that the private parts are somehow shameful and dirty and shouldn't be talked about. On the other hand, the adult perpetrators often occupy a position of trust and authority in the family or school or community. In many cases the child has a prior relationship of love, trust and belonging with the person who at some point in time begins to groom and then sexually abuse the child. This further discourages the child from resisting the abuse, believing that the adult they trust will never do them any harm. The perpetrators also manipulate, threaten or bribe children into silence, or appeal to their sense of

[51] Disclaimer: While this study has been cited several times in this chapter, there has been criticism regarding its methodology. See: https://saveyourchildren.in/wp-content/uploads/2017/09/Save-Your-Child-from-UNICEF.pdf

loyalty to get the child to keep the abusive conduct a secret. The abuser, therefore, rarely faces the consequences of their act.

There is nothing about a child itself that puts them at risk of being sexually abused, but the external circumstances of a child (and its impact) might increase such risks. Children who are exposed to domestic violence or alcoholism in their families, who may be exposed to pornographic content either intentionally or due to neglect, who haven't learnt the concepts of privacy and personal space because it is not observed in their homes, who may be neglected, or physically and emotionally abused in their homes are likely at higher risk of being targeted by abusers. Circumstances that cause a child to be emotionally vulnerable causes them to be less confident of themselves and seek validation and affection from any person who may offer it to them. They may also not be able to distinguish safe from unsafe contact, when sexual violence and abuse has been normalized through repeated exposure to these acts (performed on others/ family members)

A common myth is that usually only girl children are sexually abused. However, children of all genders can be vulnerable to abuse. The stigma attached to male rape and the misconception that male victims of sexual abuse will "outgrow the experience" plays a role not only in the invisiblization of the crime against them but also in and silencing of their voices (Subramaniyan et al., 2017).

Queer, transgender and intersex people have reported being sexually abused as children due in part to their gender and sexual identity and expression - as a way to "put them in their place" or to enforce their assigned identity on them. They may rely on much less social support than other children. According to a survey conducted by Swasti Health Resource Centre, "Four of 10 transgender people face sexual abuse before completing 18 years" (Chaturvedi, 2017).

A Central government committee that studied 9,589 Child Care Institutions and Homes across India, under the Juvenile Justice (Care and Protection of Children) Act. found that 1575 minors had been sexually abused and 189 were victims of pornography (PTI, 2018).

In India, underreporting of child sexual abuse is a big challenge. There are quite a few reasons as to why this is so. Fear of the perpetrator, association of shame with the victim rather than the perpetrator of sexual violence, reluctance to have a close family member incarcerated, reaction of parents or guardians etc. all play a role and act as obstacles in cases of CSA being reported by the child victim to the caregivers, and the caregiver in turn reporting it to the police (Chandran et al., 2018).

Data from the 2007 Government study in India also showed that most instances of child sexual abuse are of children between the ages of 12 to 16. However, cases have been registered of perpetrators targeting children as young as 2-3 years old. The 2007 study found that it is young children, in the 5 to 12-year group, who are most at risk of abuse and exploitation. Abuse that began in childhood can continue into adulthood given the power dynamics between the perpetrator and the child.

Children with disabilities are at a much higher risk of sexual violence. Those with physical disabilities might find it hard to escape violent situations or call for help, and those with psychosocial or intellectual disabilities might not have access to information to be able to

identify it as sexual abuse. Various studies have found that children, adolescents and adults with intellectual disabilities (ID) are particularly vulnerable to sexual abuse (more than 4 times more likely (Jones et al., 2012), sexual violence and exploitation and are in need of intervention services. Children with intellectual disabilities were found to be at a slightly greater risk of sexual abuse than children with disabilities in general, who in turn were at three times greater risk of experiencing sexual abuse than children without disabilities (Institute of Medicine (US). Committee on Child Maltreatment Research, Policy, and Practice for the Next Decade: Phase II, (2014).

Consequences and manifestation of child sexual abuse

Child survivors of sexual abuse, including their families, often experience a range of immediate and long term psychological and behavioural consequences. It can result in many wide-ranging, complex, and sometimes devastating consequences for the survivor. Some of the outcomes include "depression, anxiety, guilt, fear, sexual dysfunction, withdrawal and acting out" (Deb & Mukherjee, 2009). While the short-term effects may vary depending on the circumstances of abuse and the child's developmental stage, the long-term consequences can last for many years after the incident and into adulthood (Deb & Mukherjee, 2009). However, not all survivors of child sexual abuse experience traumatic outcomes.

1. Short term consequences of child sexual abuse

Child sexual abuse can manifest in a multitude of symptoms that are behaviourally visible. Some children though, might not show any symptoms or clues that they have been sexually abused. They learn to cope with and hide their distress and keep the matter a secret. The changes one might notice in the behaviour of the child may be emotional reactions such as fear, shame or guilt, showing aggression, being moody or having problems concentrating, having difficulty with sleeping or getting nightmares or bed wetting (Choudhary et al., 2019). The child may suddenly show signs of fear towards the abuser, try to avoid being alone with them or avoid them completely. The child might also display age-inappropriate sexual behaviours or may replay the abuse with another child.

There may be physical effects like chronic pain in the abdominal area, and soreness in the genital and anal areas. They may contract sexually transmitted infections, or may become pregnant. Some eating disorders have also been attributed to child sexual abuse.

Behavioural indicators of child sexual abuse

- A change in the social behaviour of the child – a happy child becomes introverted, silent, refuses to participate in group activities. The child may become insecure and cling to a trusted adult, or become excessively fearful. Occasionally the child may become violent, easily enraged. The child tries to avoid coming in contact with a particular person.

- Change in the personal grooming of the child – neglects personal appearance, deliberately tries to look unhygienic, shabby or unattractive. May begin to wear multiple layers of clothing, inappropriate for the weather.
- Change in academic performance, poor concentration, distracted behaviour, lack of interest.
- Sleep disturbance, nightmares, causing sleepiness at odd hours, feeling tired when one wakes up.
- Replaying the abuse with another child generally younger or the same age as them. This is known as sexualized behaviour.
- Change in eating habits: Child starts eating erratically, may eat too less or excessively and may lose or gain weight.
- Bedwetting or faecal soiling beyond the usual age, or recurrence of this after a child had gained control.

Physical indicators of child sexual abuse

- Presence of sperms
- Pregnancy
- Sexually transmitted disease
- Unexplained injury to the genitals
- Recurrent vulvovaginitis
- Vaginal or penile discharge
- Pain on urination
- Frequent urinary tract infection
- Anal complaints (fissures, pain, bleeding)

Adapted from Guidelines for medico-legal care for victims of sexual violence (World Health, 2021, pp. 1–3).

2. Long term consequences of child sexual abuse

Apart from the actual intensity of the sexual assault, parental child-rearing practices or lack of awareness on the part of the parent, their own experiences and their reactions and responses to a child survivor, play a role in the severity of the impact. Children may be blamed for the abuse, may not be believed and may be silenced in order to maintain family secrecy, to protect their reputation (a prevalent practice in many Indian families).

Children may also internalize cultural belief systems and hold themselves responsible for what happened, or may hold onto many unresolved emotions arising from the trust and respect they had in the abuser (which was broken) and how the other adults around them managed (or mismanaged) the aftermath of the abuse

Adults who were sexually abused as children have been known to experience difficulty in maintaining interpersonal relationships, have a hard time building trust and intimacy with

people, and may have difficult relationships with parents/siblings - this could be because most perpetrators are family members or people close to the survivor.

Some studies point to deleterious effects on the brain structure and functioning cause by trauma related to sexual abuse, especially the development of the hippocampus, amygdala, corpus callosum, cerebral cortex and cerebellar vermis (Rinne-Albers et al., 2013). This causes "difficulties in memory retrieval associated with the traumatic event (Tomoda et al., 2009) and dissociative symptomatology that CSA survivors tend to suffer from (Stein et al., 1997)" (Lev-Wiesel et al., 2018). In addition, PTSD and major depression have also been noticed, due to overactivation of the amygdala. Other research points to immune dysregulation across the lifespan (Fagundes et al., 2013) and lower resilience to recent stressors in adulthood (Lind et al., 2018).

Long term effects of child sexual abuse may include

•Inability to trust close family and friends
•Difficulty in maintaining relationships
•Poor body image
•Anger management issues
•Need for control
•Substance abuse
•Developing harmful sexual behaviour
•Marital issues
•Anti-social behaviour
•Dysfunctional family formation/poor parenting
•Intergenerational trauma

Understanding the dynamics of child sexual abuse and countering myths

Child sexual abuse continues to persist because of a lack of awareness about what circumstances make children vulnerable; social mores especially around power, that make it difficult to confront and resist the abuser; the inability and lack of conviction of the adult caretakers of the children to intervene and take any action; and the laxity in social and legal systems that make it easy for an abuser to get away with the crime. Some common myths about sexual abuse that hold us back from dealing with it are:

1. **Child sexual abuse is committed by strangers – False**. A majority of sexual abuse of children is committed by a person the child knows quite well, usually a person in a position of authority (Study on Child abuse: India 2007). This is the foremost reason for children being met with denial or disbelief when they finally disclose information on sexual abuse to their parents/guradians.
2. **Child sexual abuse does not happen in religious, cultured and orthodox families - False**. Child sexual abuse can occur anywhere regardless of the type of family, religious or not.

3. **All child sexual abusers are men - False - Though the overwhelming majority of perpetrators are male,** women are also likely to be perpetrators or abet a male perpetrator**.**
4. **If 50% of children report sexual abuse, it means that 50% of adults are abusers. No**. Majority of people interact with children in a safe manner. Though the statistics on CSA does not specifically call out or highlight repeat offenders, anecdotal accounts and a few studies among specific populations of offenders seem to indicate that an offender often abuses multiple children (Darkness to Light, 2017). This could mean that it is not a one-to-one ratio of abuser to victim, and people who sexually abuse children often target multiple children.
5. **24-hour surveillance of the child will prevent sexual abuse - No**. 24-hour surveillance of a child is neither possible, nor is it a guarantee of safety. It can in fact have adverse effects on a child, creating a sense of constant surveillance that prevents the child from being spontaneous and playful. A more effective way is to empower the child to be able to recognize unsafe situations and take practical actions to keep oneself safe to the extent possible.
6. **Explaining about personal safety to the child will unnecessarily frighten the child. No**. Not sharing personal safety rules with children can make them vulnerable to abuse or prevent them from talking about the abuser. In fact, telling them about personal safety at a young age makes them more aware of when their personal boundary is being violated. These rules can be taught using simple, easy to understand, non-threatening language and without instilling fear of people in the child's mind. Download and refer to Surakshith App and Bal Suraksha App (details given in the ….).
7. **Not naming the private parts of the body makes it difficult for children to report abuse - Yes.** In India, children are mostly not given any words for their private parts, or given ambiguous words like flower or parrot for their genitalia. This makes it hard for the child to talk about sexual abuse, and it makes it difficult for a third person to understand what child is saying when they do report sexual abuse. The parents themselves may forget what names they have given to these parts and may not understand a child who is using such language to report an experience of abuse.
8. **Silence around sexual parts keeps children from talking about sexual abuse. Yes.** Parents usually start naming parts of the body for their child by 1.5 -2 years. If the genitals are not named, the child feels curious about this omission. They learn slang words from their peers. They also infer that parents / adults do not talk about these parts with them, so they too cannot talk about these parts with their caregivers.
9. **Attaching shame to sexual and reproductive organs keeps children from talking about sexual abuse. Yes.** Many of us have grown up hearing 'shame, shame', '*chee*'. '*thoo* dirty - go wash your hands!' or similar such comments when we talk about these organs. Shame, stigma and silence keeps children from telling their parents and teachers about sexual abuse. It also paradoxically attributes shame to the victim rather than the perpetrator. Shame and respect come from how one behaves, one's action and words. Shame and respect are not parts of one's body. The genitals are no more 'dirty' than other parts of the body - say the mouth.
10. **If parents ignore the sexual abuse, the child will also learn to ignore it and move on - No**. Sexual abuse can have several short-term and long-term effects even in those showing no obvious signs. Ignoring a child's experience of sexual abuse may aggravate the emotional difficulties of the child. Parents and caretakers of a child survivor of

sexual abuse have to accord the incident appropriate attention and action - without catastrophizing the matter and being judgemental and fatalistic about it.

11. **Children often lie about CSA - No.** Children may not report the incident well and they may have confused memories but they hardly ever lie. When children fabricate such incidents, it is often at the behest of adult caretakers who exercise some power over the child.
12. **The abuser uses bribes, threats, secrecy, promises and manipulation to keep the child from telling anyone - Yes**. This offence thrives in silence and secrecy. The abuser ensures silence by using these tactics.
13. **Children generally don't report abuse because they feel they won't be believed or that they will be blamed for it or because they don't want the family to break up - Yes.** This is the primary reason why children do not report abuse, or retract what they have said or shared with a person they trust or an official like doctor/ counsellor/ police/ judge. These fears of children are also often proven to be legitimate when they do speak up.
14. **If the abuser is a close relative/family member, then nothing can be done about it - No**. Keeping quiet about the abuser puts all children in the extended family and neighbourhood and at the place of work of the abuser, at risk. POCSO Act 2012 has made it mandatory for all adults to report any instance of sexual abuse of a child to the nearest police station. There are government and non-government organizations where one can seek shelter and protection. Children have the right to live with dignity and safety. As adults, it is our responsibility to ensure that they enjoy this right. There are ways to hold the perpetrator accountable and responsible and take appropriate steps to prevent reoffending.

The grooming process

Abusers use several tactics to gain access to children and keep them from talking about the abuse. They groom the family or the institution and then they groom the child – get close to the child, try to appear trustworthy and caring, then slowly enter the child's personal space and test their boundaries. The abuser may target their own children, nephews, nieces, neighbour's children, students and friends' children or children in public places. Some even access children through caretaking, such as babysitting. They then target children by using bribes, gifts and games to ensure their continuing compliance. They systematically desensitize children to inappropriate sexual acts through touch, talk about sex, and persuasion.

In our experience, the perpetrators seem to use some or all of the following to gain access to and abuse a child.

1. Target the family/ caregiver/ institution
2. Be an authority figure, helpful, financial help
3. Gain trust
4. Fill a need (taking care of the child)
5. Breach boundaries of the child - publicly and in private
6. Sexualize the relationship - sexually abuse the child
7. Maintain control

The grooming process offers a window of prevention. If children are supported in learning about personal space, personal safety rules and encouraged to report behaviours that they find uncomfortable, scary or unsafe, then many abusers could be stopped in the grooming stage itself.

Sex Offenders Registry

India has a National Database of Sexual Offenders, which was launched by the Ministry of Home Affairs on 20 September 2018. The database is not public and is accessible only by law enforcement agencies. Schools, hotels, hostels, colleges, etc., can approach the police to seek character verification of employees as against the NDSO.

What can we do to prevent child sexual abuse?

Efforts towards preventing child sexual abuse have to begin with removing stigma and shame surrounding conversations on sex, building public awareness and focused action against this form of violence and its systemic nature, building socio-legal structures that penalize perpetrators who inflict such violence, educating children about sexual abuse and encouraging disclosure of abuse by child survivors.

Personal Safety Education:

Personal safety education can empower children to share any invasion of their personal space and privacy, however trivial it may appear, with adults they trust. Personal safety rules help children understand that if somebody touches them 'secretly' or breaks the personal safety rules, or if they feel discomfort or feel confused by someone's behaviour, it is ok to act to stop it if possible. Knowing these rules makes it easier for children to follow through with the next course of action, which is communicating about the person's unsafe or confusing behaviour to a safe adult. They would also be less prone to threats, bribery, manipulation or other tricks often used by abusers to keep a child from talking about the abuse.

It is important for children to understand they have agency (decision making power) over their body, that they can care for it and decide how to use their body, decide who can come close to them and who shouldn't. This also means that this needs to be reinforced through the behaviour of the caregivers who should respect a child's right to stop them or anyone else from touching them.

This is best done in a graded, age-appropriate manner, keeping in mind the developmental stage of the child. It is not a one-time conversation, but in fact, a life-long discussion with the context and the content of the discussion changing as the child grows from young childhood to adolescence and beyond.

- Principles of personal safety education and how to impart it

    - Present the world as an inherently safe place. Most adults do care for children and want to keep them safe.
    - Become aware of own emotional reactions to the topic of sexual violence, manage one's distress/ panic and be able to communicate with children about it in a grounded manner
    - Encourage children to respect and care for every part of their body**.** Avoid attaching shame or dirt to parts of the body.
    - Name the genitals, anus, chest, breast using clear unambiguous words that you are comfortable using, in the language spoken with the child.
    - Focus on giving clear instructions rather than on explaining concepts, especially with children with disability. Give clear black and white rules to children with intellectual disability as they may have difficulty with ambiguity
    - Help children comprehend the difference between public and private behaviours.
    - Explain who are Safe Adults without identifying specific individuals or role holders like parents or teachers.
    - Focus children's attention on available resources: highlight what children may be able to do/ how they may be able to communicate to keep themselves safe.
    - With older children, speak about responsibility and accountability for one's actions.
    - Educate yourself on the dynamics of child sexual abuse and the tactics perpetrators may use to manipulate the child into not talking about the abuse with anyone. Learn who could be a perpetrator and myths around this.

Here's how the concepts of personal safety rules, safe and unsafe behaviour, accountability and responsibility could be explained to children from 3-6 years of age and 6-9 year olds:

15. Personal Safety Rules

A. **Clothing** –

To 3-6 year olds You could say, "We keep certain parts of our body covered - our private parts like anus, buttocks, chest and genitals in front of others. Even when we go swimming, we keep these parts covered". If a child runs in naked into a gathering, you can say, "Please go wear your clothes/*chaddi*" instead of "shame, shame!". If the child is pulling someone's pants down, you could stop the child and say, "Remember the clothing rule? We don't pull off other people's clothes!'

With 6-9 year olds, discuss and explain how our body is our own and we can care for it, that we follow these rules when we are in the presence of others for everyone's safety, how we do not touch people in ways that make them feel uncomfortable, scared or sad or confused. Avoid saying, "Don't let anyone touch you there". This is often not in the child's hands and may only make them feel guilty for being unable to prevent it. "We don't touch others in unsafe ways. And neither should they.", would be a better way to help children start learning about agency, accountability and responsibility.
Explain:

1. We don't:
    1.1. Undress and show our own body in a way that makes others feel uncomfortable/ sad/ confused/ scared
    1.2. Show our chest, genitals, anus/buttocks in front of others
    1.3. Take off the clothes from anybody's body in a way that makes them feel uncomfortable/sad/confused/scared
2. No one should:
    2.1. Undress and show us their body in a way that makes us feel uncomfortable/ sad/ confused/ scared
    2.2. Show us their chest, genitals, anus/ buttocks
    2.3. Take off our clothes in a way that shows our chest, genitals, anus/buttocks or makes us feel uncomfortable/ sad/ confused/ scared

B. **Touching** –

To 3-6 year olds you could say, "We don't touch our private parts in front of others. No one should touch our private parts either. They may touch only if we need help or are sick." As soon as possible, ask the child to clean their genitals and anus by themselves. A touch can feel pleasurable even if it is unsafe and this can cause confusion to a child, who may blame the self for feeling so. Appropriate interactions need to be demonstrated and reinforced. For example, if the family is watching a program and the child's hand is inside the pants, you can distract the child. Later you can take the child aside and say, "You were so absorbed in watching the program that you didn't realize where your hand was" and reiterate the touching rule.

Make room for socio-sexual play: To 3 to 7-year-old children do explain that, "as children, we often play 'doctor, doctor' games with each other, where children of the same age group sometimes get together and show each other or touch each other's genitals / susu place. It's Ok to play like this when we are young but no one older should join in this game and no child should be forced to play this game!"

6-9 year olds

Explain the difference between public and private behaviours and that certain behaviours, such as picking one's nose or touching one's genitals, are best done in private. Explain:

1. We don't touch
    1.1. anyone's body in a way that makes them feel uncomfortable or sad or scared or confused.
    1.2. anybody on their mouth, chest, genitals or anus/buttocks
    1.3. ourselves in our chest, genitals or anus/buttocks in front of others.
2. No one should touch
    2.1. Our body in a way that makes us feel uncomfortable or sad or scared or confused.
    2.2. Us on our mouth, chest, genitals or anus/buttocks
    2.3. Themselves on their chest, genitals or anus/buttocks in front of others.

C. Talking:

To 3-6 year olds you could say, “We talk about private parts with adults who help us take care of ourselves. We don’t talk or draw attention to these parts in front of others”. Supposing a child calls out in public, “Daddy! Is your pant zipped up? Is your susu showing?” You can tell the child, “Go close to daddy and talk to him. We don’t draw attention to these parts in front of others”
Discuss exceptions to these rules for say health care or if they need help. Discuss accidental unsafe touch and how people generally say sorry and do not repeat it.
Explain that our mouth is private too, though we don’t cover it. This is because a lot of sexual abuse of children happens using the child’s mouth.

With 6-9 year olds discuss:

- We don't:
  - Speak about others’ or our own bodies in a way that makes others feel uncomfortable/ sad/ confused/ scared
  - Talk or joke about genitals casually with others
  -
- Nobody should:
  - Speak about our bodies, in a way that makes us feel uncomfortable/ sad/ confused/ scared.
  - Talk or joke about genitals casually with us

D. Discuss exceptions to these rules
When we face discomfort in our body or private parts, when doctors have to examine us (in presence of safe adults), when engaging in normative sexual behaviour (when we are young - say 3 to 7-year-old we often play with each other - touching and showing our private parts to each other. This is ok, but an older person should not join in this game, and we should not force a child who does not want to play this game). Discuss further, social contexts where certain behaviours may be considered harmless (hugging, sitting, kissing on the cheeks, etc), where one can take their own decision on what is ok for them or not.

2. Unsafe behaviour: Explain that unsafe behaviour is when anyone intentionally (despite knowing the personal safety rules) touches/ talks with another person in a way that makes the person feel uncomfortable or touches on the mouth, chest, genitals or buttocks, or exposes/ forces one to expose their bodies.

If someone behaves in a way that is unsafe and this is either by accident or from being unaware (accidental touch while playing, pulling down clothing when doing something else, making a joke that is age inappropriate without knowing that a child is around), they should apologize and not repeat it.

3. Safe adults: Explain that people who follow personal safety rules are safe adults and people who don't follow these rules are unsafe adults. Avoid naming safe adults for the child, because sexual abuse is done in private and those adults who we may consider as safe for the child (for e.g., parents, grandparents, cousins, uncles, other relatives and ‘close’

friends) may not actually behave so. Most individuals who abuse children are people known to the child. They exploit the familiarity and trust that the child has in them. Teaching a child to only worry about strangers and stay safe from them may give them a false sense of safety about people in their immediate circles. Help children think and arrive at who will form part of their safety network.

4. Talk about No- Go - Tell Guideline when someone behaves in an unsafe manner -

You can teach concepts of boundaries and set rules about behaviours that are acceptable and unacceptable and explain that these rules are being placed for our safety. You reinforce these by role modelling such behaviour e.g., stop tickling the child if the child says NO or ask for permission before taking a child's bag or stationery. We take it only if they say yes.

3-6 year olds:
Children as young as 2 year olds often say "No" to a lot of things, in day to day situations. Support them in understanding that if someone makes them feel unsafe or uncomfortable about anything, including their bodies, they can say "No!". Explain that it is perfectly acceptable (and not rude) to ask the person to stop such behaviour. Teach the child to say "No!" (and its equivalents) as clearly and loudly as possible in such situations. Don't insist that the child must say 'No' under all circumstances, but only when the child feels prepared and safe doing so. Saying No or stopping the abuse should not come across as the responsibility of the child or for that matter, any victim of any age. Explain that they can go away from the unsafe person as and when they can and tell a safe adult. Explain that they can come and tell you.

With 6-9 year olds discuss and explain -

Saying NO - You may find it difficult to say No to an older person, especially if the person has authority over us. However, it is perfectly Ok to say No for your safety. If someone breaks personal safety rules, say 'NO' to that person, if you can.
GO away from that person as and when you can, as safely as you can. No one should risk their lives - get hurt - to get away or prevent abuse at any cost. If online, stop talking to the person and go offline. You are not doing anything wrong - you are not breaking any rule - that person is. You are precious! Take care of yourself!
TELL a safe adult about this person because the person is doing something unsafe and has to be stopped. When you tell people about this rule breaker, they would be able to take steps to stop the abuser. Keep telling until someone listens and takes steps to help you.

5. Accountability and responsibility: Explain that the one who deliberately breaks personal safety rules has to be held responsible and answerable for it - just like in other situations. If a person purposely breaks something, we ask them why they did that and we want them to make things right and not repeat such behaviour.
Repeat that there is no shame in talking about trouble of any type – including when people break personal safety rules. Explain that it was not the fault of the child if someone did that. To older children explain that telling safe adults about it can help keep them and other children safe - when trusted adults take the effort to stop the unsafe person.

If they feel that they are not being taken seriously or not heard, they can continue telling until someone listens and takes action to support them. Explain that it is never too late to tell. They can always come and tell you, that you believe them, and won't scold them or blame them for it, and that you will do all that you can to keep them safe.

You can show the children stories on No - Go - Tell, accountability and responsibility from the Surakshith App. **You can use the stories in Surakshith App (available in 11 languages, free download on Android phones from Playstore)**

Interventions when a child is sexually abused

Child survivors of sexual abuse may be impacted in different ways that cannot always be anticipated or predicted. In helping them heal from their adverse experience, we can look at two broad goals - 1) to help them express their emotions, their pain and trauma if any, their anxieties and their current beliefs that might have been shaped by that experience 2) to enable them to move on from a sense of victimhood, to not allow their identity to be defined by such incident(s) or abuse, to learn to trust again and feel positive about themselves and what lies ahead for them

When a child reports, or is suspected to have been a victim of sexual abuse, the immediate goal will be to attend to the current and ongoing safety of the child. It will be to ascertain the risk that the child is in and whether any action might help or aggravate the conditions for the child. The action to be taken may not always seem straightforward and may require multiple consultations with all who are impacted (including the child) and with experts in the space of child safety, with those who are aware of the psycho-socio-legal aspects of such situations.

When a child reports being sexually harassed or abused, it is important that the child be trusted and that trust has to be demonstrated in word and action. Factors that have to be taken into consideration are the child's age, developmental level, intensity of alleged crime, cultural influences, emotional resilience and the interviewer's own biases. Since in CSA cases, witnesses are rare or seldom forthcoming, a child's statement is crucial to determine what may have happened and to know what evidence to pursue for the protection of this child. While the focus on justice is important, more important is that the child is provided all opportunities to heal and normalize their life and is not re-traumatized through the well intentioned, but at times inconsiderate demands of the criminal justice system.

Emotional support to a CSA survivor

Whether a child survivor of sexual abuse seems visibly impacted by the experience, it is likely that the child is processing emotions like fear, anger, confusion, shame and guilt. Some children may choose to stay silent, withdraw and be wary of other adults who interact with them. Other children may show visible signs of abuse that may be physical, behavioural or psychological, or may even try to report the abuse to an adult and get help for themselves. A social worker/ counsellor or a concerned adult can take efforts to make the child feel confident, trusted, believed and not judged. The process of rebuilding trust begins in the supportive relationship

with the safe adult, where the child feels acknowledged, experiences safety, empathy and acceptance (Kaminer, 2006).

Much has been said about what closure means and how important it is for survivors. Survivors deal with many questions (why me? Why at this time? Why in this manner? etc.) and do not always find all the answers. It is thought that getting some of these answered might help them put away feelings of shame, self-blame, inadequacy and helplessness. That may be so for some survivors and not for others. Closure is defined as the survivor becoming free from habitually thinking about the trauma in such a way that causes distress (Klempner, 2000). However, the pressure to forget or stop feeling distressed about the act of violence against them, should not be placed on the survivor. If these emotions make one feel stuck and constrained and unable to extend their energy to other meaningful pursuits of their lives, it may help to express these emotions as a cathartic process. An aspect of healing may also mean that with time and cathartic expression of one's emotions and experiences, one is able to acknowledge their experience of abuse without the feelings of intense anger, shame or guilt that they may have associated with it.

Involvement of supportive parents or caregivers in the treatment is recommended for children who have experienced sexual abuse (Lanktree and Briere 2008). When people in the child's immediate living environment demonstrate healthy, positive attitudes towards the child, when they can stay grounded and patient as they support the child to move on, the treatment outcomes for the child are vastly improved. On the other hand, any catastrophizing of the matter, a show of helplessness and despair, may aggravate the child's emotional state and keep them from returning to a sense of normalcy and wellness.

While most research findings have been focused on Trauma focused Cognitive Behavioural Therapy (TF-CBT) as an effective way of supporting children impacted by CSA, current research and evidence indicate that modalities beyond 'talk therapy', like dance therapy, movement therapy and EMDR are also efficacious in dealing with trauma.

How to speak to a child when sexual abuse is suspected
- for caregivers/ teachers/ parents and counsellors/social workers.

When we suspect that a child may be undergoing some form of abuse, esp. sexual abuse, it is important that we remain objective in our approach and ensure that we do not alarm the child or instil any shame, fear or guilt in the child when we probe them for more details. We should be careful not to impose our thoughts on the child, to lead them to a particular answer or to set any particular expectations that the child feels compelled to meet. Examples of inappropriate leading questions are

- Is x troubling you and touching you in your private parts? *(implicating x without proof and suggesting that the child should be careful of x)*
- You look scared of x - what have they done to you? *(suggesting that x is a scary person)*
- I know that you will not lie. Tell me exactly what happened and why you didn't do anything about it? *(pressurizing the child to be exact in info they share + hinting that child may also have contributed to the situation)*
- Why did you stay friendly with x if you were uncomfortable with them? (*hinting that child may also have contributed to the situation)*

We can sensitively ask questions to determine the emotional and psychological well-being of the child and to elicit what may be troubling/ disturbing them. Here is how you can probe the issue further if there is a suspicion or apprehension that child is facing some form of sexual violence but the child is not forthcoming:

Have a conversation with the child in private, in a casual setting, where the child is comfortable and at ease.

o. **About the child's feelings and emotional state**: How do you feel right now? How have you been in this last week? How are you feeling about yourself these days? What has made you feel happy? Is there anything that made you feel worried or scared or sad?

p. **About relationships with family and friends:** Who are you closest to among family members and friends? What do you like about them? Is there anyone who is making you feel uncomfortable or confused with their behaviour? Has anyone ever upset you and you did not talk about it with anyone?

q. **About places the child frequents**: How do you feel at home? Where do you feel the safest? What kind of places make you feel scared or unsafe? Where do you go for different activities like sports or tuitions or music classes?

r. **About uncomfortable other situations**: Has anyone ever touched you in a way you didn't like? Has anyone – related or unrelated to you, known person or strangers, ever touched you in a way that made you feel uncomfortable / shy / yucky? Have you felt coerced into watching something that was a private act that might have been breaking body safety rules?

s. **To make the child feel comfortable and reassured,** you could state:

   i. I am asking you this because if this happens, you can always come and tell me about it.

   ii. Things that trouble you, need not be kept bottled up inside you.

   iii. The person may tell you that it's alright, that this is how people express love, no need to tell anyone, to keep it secret, may try to bribe or even threaten you. But for your safety, it will be best to tell an adult you trust about it.

   iv. When an adult or older person (older child) troubles or abuses a child, it is never the child's fault. The adult or older person is responsible.

How to respond to a child who has faced sexual abuse:

- **Listen and reassure:** Try and provide a safe space for a child to be heard, reassured and believed. One can convey this by saying "I am sorry you had to face this. I believe you.", "None of this is your fault or doing. We will figure a way to ensure this does not repeat - I'll do all I can to ensure that"
- Ensure that their fears (of not being believed, parents will punish them, etc.) are not reinforced within the relationship they share with you i.e., **don't blame the child and do not apportion responsibility to them. Do not ask them to "forgive", "forget", "let go" or "adjust".**
- **Listen without commentary** - i.e., use active listening, do not second guess what the child may be trying to convey, do not finish sentences for the child or try to explain to the child what they may be experiencing. Listen with care, demonstrate empathy and show concern.

- Gain an understanding of their background/situation/context. Assess for support structures that could support the child in different ways - in their own social environment and the external ones that you will need to connect them with. The child may not always be aware of this off hand - ask them pointed questions about family, friends, teachers, neighbours, acquaintances and how they feel about receiving support from such people.
- Explain to the child that you are **required by law to report this to the police** (Protection of Children from Sexual Offences, 2012) but the best interest of the child is paramount and that you will want to work with them to provide them the support they need. Try to ascertain how the child may wish to proceed, what the child's concerns are, the extent of resilience the child demonstrates. For example, you could say: "People like this person trouble many children. Our laws and police are there to protect children from such people. Now that you have brought it to our notice, we can stop this person. For this, we may need to talk to a few people in detail. Is that Ok with you?"
- **Safeguard the child:** Find out what you can do to stop the abuse and ensure the overall safety of the child (i.e., there is no retributive or consequential threat to the child's life or welfare). Discuss options with the child and keep them informed of the steps you need to take, keeping in mind the developmental age of the child.
- Explore options and plan how you may **involve support persons** in the child's life and request the consent of the child before contacting others for help to support the child. This includes guardians or caregivers, extended family members as well as health professionals.
- Consider how reporting the case to the police could affect the child. **Explain investigative, legal and reintegration processes to the child and family** so that they can be prepared.
- Encourage and assist the child and caregivers in receiving **medical and mental health** care. Also consider what financial and instrumental support the child needs and signpost them to supporting organizations.
- Consider whether to **warn friends and family or institutions** that the accused individual is an alleged sexual abuser, in order to protect children that the abuser may be in contact with. Prioritize immediate needs and safety of the affected child. Ensure the first priorities are met first.
- While it might feel appropriate, **do not make tall promises** like "I will send the abuser to jail." Or "I will maintain confidentiality and never tell anyone about this." Breaking such promises can further damage the trust the child has in you.
- **Take the help of mental health professionals** – If you feel you are unable to support the child, you can always take the support of a competent, empathetic and trained counsellor. Depending on an assessment of the child's behaviour, symptoms and coping skills, mental health professionals need to be consulted. Severe symptoms, suspected or apparent self-harm behaviour warrant a prompt consultation with a mental health professional with expertise in dealing with children who have faced sexual violence.

Reporting child sexual abuse and dealing with the perpetrator

The emotional and physical health of the child is of paramount importance and must be addressed first. Placing accountability on and verifying details about the sexual abuse from the perpetrator an important next step, if the alleged abuser is accessible.

Discuss with someone who works with issues like this. Prepare yourself and speak with the abuser. You could say:

- What you have done is unacceptable.
- You do not seem to respect children or the values that this institution/ household/ we stand for.
- You are not to go near the child. You are not to contact the child.
- Do whatever you need to do to change your behaviour.
- You are not to leave the premises until the police arrive (if abuse happened in an institution).

Respect the child's confidentiality and the law. We can share information about the abuse only with those individuals who will be directly involved with supporting the child in recovery and in processes of the criminal justice system.

Reporting: The purpose of reporting is to prevent further sexual abuse of the child. Possible involvement of a parent, family friend or other close person, makes it extremely difficult for children to report sexual abuse. Refer to the section on Mandatory Reporting below to understand your responsibilities.

The Law and child sexual abuse

The Protection of Children from Sexual Offences Act 2012 was enacted because:

- There were increasing incidence of child sexual abuse and low rate of conviction in rape cases.
- Indian Penal Code failed to adequately address sexual assault, sexual harassment, pornography, as well as sexual violence against boys.
- Interests of a child victim and witness needed to be protected through child friendly procedures and a Special Court.
- Obligations under the United Nations Convention on Rights of the Child, 1989 needed to be complied with.

Some key features of the POCSO Act are:

- It is gender neutral, in that the victim and the alleged offender can be of any gender.
- Child is defined to mean any person below 18 years of age
- The POCSO Act introduces the obligation of mandatory reporting, which requires anyone having information about the commission of a sexual offence to report to the police or the Special Juvenile Police Unit. Failure to do so is a punishable offence.
- The police are under an obligation to register a report of sexual offence and their failure to do is a punishable offence. Child victims of sexual offences are entitled to emergency medical care in the nearest hospital and first aid should be provided to them free of cost.
- The police, medical practitioners, Magistrates and Special Courts have to adhere to child-friendly provisions while discharging their functions.

- A range of sexual offences have been recognised under the POCSO Act. It provides for penetrative, non-penetrative but touch based, and non-touch based offences.

Offence and Punishment under POCSO Act, 2012

Offence	**Punishment (imprisonment)**
Penetrative Sexual Assault (Sec 3)	Minimum of 10 years imprisonment to life imprisonment with a fine (Sec 4(1))
Penetrative Sexual Assault on a child below 16 years of age (Section 4(2))	Minimum of 20 years imprisonment to life imprisonment, which means imprisonment for the remainder of natural life, and fine
Aggravated Penetrative Sexual Assault: (Sec 5)	Minimum of 20 years of rigorous imprisonment to life imprisonment, which means imprisonment for the remainder of natural life, and fine, or death.
Sexual Assault (Sec 7)	3 yrs—5 yrs and fine (Sec 8)
Aggravated Sexual Assault(Sec 9)	5yrs – 7yrs and fine (Sec 10)
Sexual Harassment (Sec 11)	Upto 3 yrs and fine (Sec 12)
Using child for Pornographic purposes (Sec 13)	Minimum 5 years and fine (Sec 14) Second/subsequent conviction is punishable with a minimum of 7 years and fine.
Storage or possession of pornographic material involving child with intention to share or transmit (Sec 15)	Fine not less than Rs 5000 and for second or subsequent offence, fine not less than Rs 10000.
Storage or possession of pornographic material involving child for transmitting or propagating or displaying or distributing (Sec 15(2)	Upto 3 years or fine or both
Storage or possession of pornographic material involving child for commercial purposes (Sec 15(3))	First conviction: 3 yrs- 5 yrs and or fine or both Second or subsequent conviction: 5yrs-7yrs and fine
Abetment; Commission, Omission, Aiding (Sec 16)	Punishment provided for the offence if it is committed as a consequence of abetment (Sec 17)

Attempt to commit offence and thereof (Sec 18)	Punishment	1/2 of longest term of imprisonment prescribed for the offence of ½ of life imprisonment or fine or both punishment (Sec 18)

Offence is deemed to be aggravated on the following grounds

Aggravating Factors	Grounds
Status of the Accused	Police officer; member of the armed forces or security forces; public servant; management or staff of any custodial institution for children, hospital, educational institution, religious institution, institution providing services to the child; relative of the child through blood, adoption, marriage, guardianship, foster care, or having a domestic relationship with parent, or living in the same of shared household; person in a position of trust or authority; repeat sexual offender.
Nature of the Assault	Gang assault; use of deadly weapons, fire, heated or corrosive substance; repeated assaults; assault and attempt to murder; assault in the course of communal or sectarian violence or during any natural calamity or in similar situations; assault followed by stripping and parading the child naked in public; persuading, inducing, enticing or coercing a child to administer any drug or hormone or any chemical substance, with the intent that such child attains early sexual maturity
Impact on the Victim	Grievous hurt or bodily harm and injury; physical incapacitation, mental illness, or temporary/permanent impairments; pregnancy; HIV or any other life threatening disease or infection that impairs the child; causing death of child.
Status of the Victim	Child below 12 years of age; pregnant child (knowledge of pregnancy is necessary); child with disability (taking advantage of the disability)

Abetment and attempt to commit an offence -

- A person who instigates any sexual offence against a child or conspires with others for the commission of the crime, intentionally aids by committing such crime is said to abet an offence, Sec 16, and shall be punished with punishment provided for that offence, Sec 17.
- Punishment for attempting to commit an offence will be one half of punishment as prescribed for the offence itself, Sec 18.

Mandatory reporting

The POCSO Act 2012 places the responsibility to report not on the child but on an adult who may be in a better position to support. It requires that any adult who gets to know that a child is

being sexually abused, or suspects that such abuse may be happening is required to report this to the Special Juvenile Police Unit or the local police station. This applies to everyone including parents, doctors and school personnel, whether the information was acquired through the discharge of professional duties or within a confidential relationship. It is unrestricted by any pre-condition that the complaint be first reported within the respective departments or agencies, even if the alleged perpetrator is an employee of that institution. This means that reporting the matter to the Child Protection Office/ Head of the School/ Institution/ parent is not sufficient. The matter has to be reported to the police and a report filed. Failure to report the commission of any sexual offence against a child is punishable with imprisonment of up to 6 months or fine or both. (Sec 21(1)). Any person in charge of an institution who fails to report the commission of an offence in respect of a subordinate under his/her control shall be punished with imprisonment for a term which may extend to one year with fine (Sec 21 (2))

Penalty for false reporting:

Any person who makes a false complaint or provides false information against any person in respect to specific sexual offences mentioned under POCSO shall be punished with imprisonment between 6 months to 1 year with/without fine, Sec 22 (1).

Any person who makes a false complaint or false information against a child knowing it to be false, against a child thereby victimizing the child shall be punished with imprisonment up to one year or a fine or both, Sec 22 (2).

Secondary victimization - Though the POCSO Act provides for speedy, sensitive processes, these are rarely followed in practice. Confusing reporting mechanisms, lack of coordination between stakeholders, lack of comprehensive care plans can delay the process and cause anxiety and uncertainty for the child and family. The medico-legal process could be traumatic for the child. This can lead to secondary victimization due to factors like

13. Repeated, insensitive, and humiliating interviews
14. Frightening, insensitively done medical examination
15. Confronting the perpetrator
16. Facing a hostile family
17. Unpleasant placement experience as a child in need of care and protection
18. Treatment that the child finds unhelpful
19. Court procedures and need to give testimony
20. Not knowing what is going to happen

Refer to the Bal Suraksha App to learn more about how to prevent and manage child sexual abuse.

Child Marriage: A brief history & summary

As per the 2011 census data, 10.3 crore girls and 1.9 crore boys were married off before they reached the legal marriageable age, i.e., 18 years for girls and 21 years for boys. 78.5 lakhs of them were girls below the age of 10 years (Chowdhury, 2016). A disaggregated age-wise breakup of the number of minor girls married as per the 2011 census is given in the table below.

Age (years)	Female
Less than 10	78,49,859
10-11	34,34,492
12-13	77,17,216
14-15	2,81,24,694
16-17	5,54,89,428
Total	**10,26,15,689**

The National Family Health Survey in 2015-16 reports that 26.8% of women between the ages of 20 – 24 surveyed were married before they attained 18 years of age, down from 47.4% in 2005-06. In comparison, 20.3% of men aged 25-29 years reported to have married before they attained 21 years in 2015-16.[52] Although the rate of child marriages has reduced significantly in the past few years, India remains very far from its goal of completely eliminating the practice as enshrined in the National Plan for Children, 2016. Ending early and forced marriages by 2030 is also one of the United Nations Sustainable Development Goals.

Fear of elopement by daughters, threat of sexual abuse, patriarchy, gender and social inequality, and monetary concerns are factors that contribute to the prevalence of forced child marriages and also explain the social acceptance of the practice. Apart from these, recent trends depict an increasing number of self-initiated marriages by adolescents eloping from home which are largely triggered by refusal of family members to accept the relationship. The exact numbers of self-initiated child marriages in the country are unknown, however, studies indicate that these are the marriages that predominantly see the sanction of the law. For instance, a study conducted by Partners for Law in Development ('PLD') in 2020, analysing 83 High Court and District Court judgements from courts in various states from 2008 to 2017 found that the Prohibition of Child Marriage Act, 2006 ('PCMA') was used twice as much in cases of elopement of children than in cases of marriages arranged by parents. Another study by PLD, in 2019, looking into why minor girls elope, found that in most instances young couples ran away after their relationship was discovered at home and they faced the brunt of stigma around pre-marital sex, refusal to accept inter-caste and inter-faith relationships.

Child marriages have a grave and deleterious impact on the enjoyment of rights of children, particularly the girl child. Child marriages violate the right to bodily and decisional autonomy of children and sanction sexual and physical abuse against them. Early marriages are also directly linked to early motherhood that not only threaten the health of young girls who are physically and mentally unsuited to become mothers, but also deprive young girls of their childhood who are forced to take up household and child caring responsibilities from a very young age. Further, early marriages also interrupt the education of girl children and renders them financially dependent, as well as vulnerable to violence.

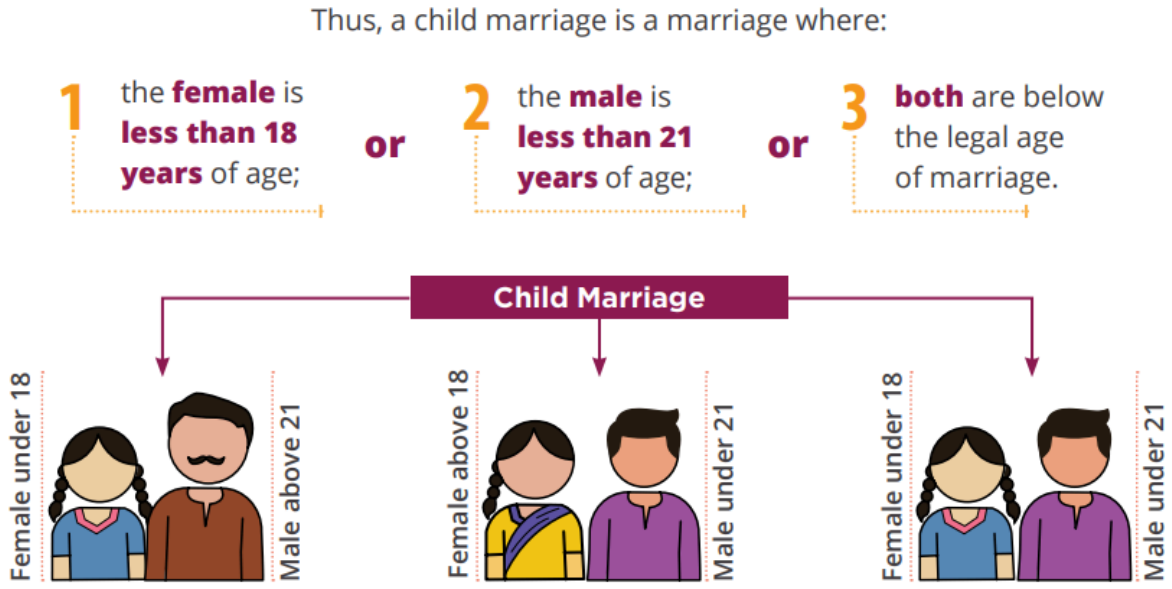
The Prohibition of Child Marriage Act [PCMA] was enacted in 2006 repealing the Child Marriage Restraint Act, 1929 [CMRA], also known as the Sharada Act after the CMRA was considered ineffective in tackling child marriages. The CMRA prohibited the marriage of girls

[52] Ibid.

below 14 years and boys below 18 years of age which was later revised to 21 years for boys and 18 years for girls.

The PCMA is a comprehensive law that not only criminalizes offences related to child marriage, but also provides for the annulment of such marriages, provisions for maintenance and residence orders in favour of women and children, and preventive strategies.

The PCMA (Section 2(a)) defines a 'child' as any male who has not completed 21 years, and any female who has not completed 18 years. A child marriage is a marriage solemnized where either or both parties to a marriage is a child (Section 2(b)).



[53]

When a child marriage occurs in violation of the PCMA, the statute does not render the marriage automatically void unless the child was taken or enticed out of the keeping of his/her lawful guardian, compelled by deceitful means to go from any place for the marriage, or sold for the purpose of marriage/ an immoral purpose (Section 12). A child marriage solemnized remains legally valid and an option is provided to the party who was a child to annul the marriage. This option may be exercised until two years after the child reaches the legal age of marriage, i.e., until 20 years for a female and as per some interpretation until 23 years for males. (Section 3).[54]

[53] Enfold Proactive Health Trust-UNFPA, *Annulment of Child Marriage under the Prohibition of Child Marriage Act: A Primer, 2006* (2024) 26, available at <https://enfoldindia.org/wp-content/uploads/2024/10/UNFPA_Enfold-Annulment-of-Child-Marriage_English_Web.pdf>.

[54] Enfold Proactive Health Trust-UNFPA, *Annulment of Child Marriage under the Prohibition of Child Marriage Act: A Primer, 2006* (2024) 57-58, available at <https://enfoldindia.org/wp-content/uploads/2024/10/UNFPA_Enfold-Annulment-of-Child-Marriage_English_Web.pdf>.

Excerpts from: Anindita Pattanayak and Swagata Raha, Substantive equality in child marriage laws (*The Hindu*, January 29, 2025), https://www.thehindu.com/opinion/op-ed/an-opportunity-to-advance-substantive-equality-in-child-marriage-laws/article69151446.ece

Artificial differentiation

While 'child' in PCMA means a girl below 18 years and a boy below 21 years of age, under the Majority Act, 1875, majority is attained on completing the age of 18 years, without any distinction between men and women. A literal reading of the provisions of the PCMA thus suggests that both male and female parties can seek annulment before they attain 20 years of age. The question that arises is whether the male party can annul the marriage at 23 years or 20 years, due to the gender-based difference in the minimum age of marriage.

In 2011, the Madras High Court in *T. Sivakumar v. The Inspector of Police* held that a literal interpretation will create an unfair disadvantage for males married at 20 who, despite being married below the legal age, would not be able to annul their marriage, and thus interpreted the age limit for annulment for males to be 23. Now, the Allahabad High Court in Sanjay Chaudhary has countered this by reasoning that male parties entering into a marriage after attaining 18 years cannot claim ignorance of law or incapacity, as a male above 18 years is criminalised under PCMA for marrying a female child. The Allahabad High Court noted that the difference in the minimum age of marriage stems from patriarchal notions that expect men to be older and financially responsible in a marriage, while women are perceived as secondary partners and child-bearers. It opined that having the same age limit, i.e., within 20 years of age, to file a nullity petition is aligned with the principle of gender equality.

Despite these observations, the Allahabad High Court felt bound by the Supreme Court's observation in *Independent Thought v. Union of India* (2017), which mentioned that men could file annulment petitions till the age of 23 years. Consequently, the Allahabad High Court annulled the child marriage, and the wife, aggrieved by this ruling, has appealed before the Supreme Court. While the Supreme Court will decide the age limit for boys and men to file nullity petitions under the PCMA, the High Court's reasoning strikes at gendered assumptions that may require re-examining the legal age for marriage.

In Independent Thought, the issue before the Supreme Court was the constitutionality of the marital rape exception in respect of wives below 18 years, and not the age limit for filing a nullity petition under the PCMA. Its observation that "a male child can get the marriage annulled before attaining the age of 23 years" was made without examining in detail annulment under the PCMA. This interpretation results in a substantive unfair disadvantage, giving males more time than females to exit a child marriage, leaving wives unprotected and disproportionately affected, which undermines the central objective of the PCMA to protect and advance the status of women.

A case for no difference

This case exemplifies the need for an uniform age of marriage in India, but raising it to 21, as was proposed in the now-lapsed Prohibition of Child Marriage (Amendment) Bill, 2021, to delay pregnancy and marriage, and advance women's education and health, will do more harm than good. Indian laws recognise 18 as the age at which all major civil and political

rights take effect such as voting, buying and selling property, and entering into contracts, among others. To delay the civil right to enter into marriage and blur the distinction between adults and children would deprive adults between 18-21 years of their right to life, liberty, decisional autonomy, privacy, and dignity. A 2024 study by Enfold Proactive Health Trust and Civic Data Lab, based on 174 PCMA judgments from three States, revealed that 49.4% of these marriages were self-initiated, with the girls' families lodging complaints in 80% of these cases as opposed to families reporting it in only 30.9% of arranged or forced marriages. Raising the age of marriage will further extend state and parental control over the agency of women to be with a partner of their choice. It will also place them at greater risk of deprivation of social protection and health services as they may fear criminal repercussions if their child marriage is reported. It will result in more arrests, detention, breakdown of families, and institutionalisation of young people, at a significant socio-economic and health cost, and overburden the criminal justice system. Gender equality and improved health maternal outcomes can be better achieved through less restrictive and more substantive alternatives such as access to free and compulsory education till 18 years, social security schemes, barrier free access to health services, and comprehensive sexuality education.

According to Section 3(4), where a child marriage has been annulled, the court may also order for the return of any money and valuables exchanged during the marriage. The court can also, where appropriate, make orders for the residence and maintenance of women and for the custody, visitation, and maintenance of children born of such marriages. All children born of child marriages are deemed to be legitimate even where the child marriages are later annulled (Section 4,5 &6).

Under Sections 9, 10 & 11, the PCMA criminalizes several acts in relation to child marriage. Firstly, it is an offence for an adult male to marry a child. The Act however does not criminalize a woman for marrying a minor boy. Secondly, the PCMA criminalizes the solemnization of a child marriage by performing, conducting, directing or abetting it. Lastly, the PCMA criminalizes the promoting, and permitting of child marriages. Under this provision, where a child contracts a child marriage, the parent or guardian of the child permitting the marriage to take place commits an offence. Additionally the provision also punished members of organisations or associations that promote a child marriage. A woman, however, may not be punished with imprisonment under the above provision.

Apart from the above, the PCMA also provides for various prevention strategies to tackle this practice. The PCMA mandates State Governments to appoint of a Child Marriage Prohibition Officer [CMPO] for the state or part of the state to aid in prevention of child marriages (Section 16). The CMPO plays a key role in ensuring that no child marriage is solemnized. The CMPO is also entrusted to collect evidence for prosecution under the Act and create community level awareness and sensitization efforts advocating against the practice. Where a child marriage has been organized and is likely to occur, a Judicial Magistrate of First Class or a Metropolitan Magistrate can issue an injunction against a person, or organisation or association of persons prohibiting the marriage from being solemnized (Section 13). Any persons who contravenes such an injunction commits an offence under the Act and such a marriage is null and void (Section 13(10) & 14).

Commercial sexual exploitation of children

Children have been sexually exploited by adults in different ways, for commercial purposes. Persons engaged in such exploitative, illegal activities usually do so in three primary and interrelated forms: forcing children into prostitution, exploiting minors to create child sexual abuse material (child pornography) and trafficking children for sexual purposes. Other forms in which they sexually exploit children are by encouraging and building a business around child sex tourism and actively negotiating child marriages with adults who demand child brides. Through this fundamental violation of human and child rights, traffickers and child sexual exploiters have built a global trade involving millions of dollars with scant regard to the risk of getting apprehended. Such trade is propped by influential and wealthy persons and organized rings who ensure that the legal repercussions of getting caught is minimal.

Child prostitution – involves the exploitation of children where they are forced to engage in sexual acts in exchange for money or other favours paid/ made to the intermediaries. Children are forced by circumstances, social structures and individual agents into situations in which adults take advantage of their vulnerability to sexually exploit them.

Child pornography (Child Sexual Abuse Material) – involves the coercion, threatening or tricking of children to participate in sexual acts to produce pornographic material. The demand for such material keeps it profitable for producers of such content to continue to exploit children repeatedly or find new targets that they can use. Though the production and viewing of child pornography is illegal in India, there continues to be a thriving market for it that incentivizes makers of such content.his problem is further compounded by the availability of the internet and other technology to produce and circulate such material. The lack of uniform and collaborative legislation across nations makes it difficult to apprehend and restrict the makers of child pornographic content.

The POCSO Act criminalizes storage or possession of child pornography,and failure to delete or destroy or report the same with an intention to share child pornography. The Supreme Court in *Just Rights for Children Alliance v S. Harish*[55] observed that the offence was not the actual sharing or transmission, but the intent to do so coupled with the failure to delete, destroy or report any child pornography.[56]

Trafficking of children - Trafficking refers to the cross-border or internal recruitment, transportation and receipt of children for sexual exploitation, forced labour or any similar purpose (www.ecpat.net). This often involves removing the child from the relatively safer and familiar support structures of the family and community systems – sometimes through coercion, threat or deception and sometimes with the express consent of the child's family, in exchange for favours or monetary considerations that temporarily help alleviate their extreme poverty.

[55] Just Rights for Children Alliance & Anr. v. Union of India & Ors., Criminal Appeal Nos. 2161-2162 OF 2024, decided by the Supreme Court of India on 23 September 2024.
[56] Just Rights for Children Alliance & Anr. v. Union of India & Ors., Criminal Appeal Nos. 2161-2162 OF 2024, decided by the Supreme Court of India on 23 September 2024, 87-89.

Children may be trafficked across national borders or state borders, through well organized trafficking rings that manage to subvert the legal system to sustain such trafficking

Child sex tourism – involves using children to attract people from other places, so they can engage in sexual acts with minors in places where such acts are claimed to be 'culturally appropriate' or where the legislations are loose enough to allow such a trade to be conducted. Often this involves travelers from richer countries to the poorer ones or less developed ones.

What makes children vulnerable?

The United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) estimate that 2 million children are exploited in prostitution or pornography every year. http://yapi.org/csec-and-child-trafficking/ . Such exploitation of children has been reported worldwide esp. in countries beset by poverty, political strife and unrest. Child sexual abusers and traffickers perpetrate these crimes usually on children who come from vulnerable situations like - conditions of extreme poverty that force families to sell or give away their children, or that encourage children to escape their homes in the hope of a better life; children who suffer physical or sexual abuse in their homes, or whose families are involved in the sex trade; children having refugee or uncertain legal status, and those who live near tourist destinations or military bases.

The National Human Rights Commission (NHRC) estimated that almost half the children trafficked in India, were between the ages of 11 and 14. These are usually children from poor families or from disaster hit areas where the traffickers find it easy to trap children. India is also the route through which children from Nepal and Bangladesh are trafficked to Pakistan and the Middle East. It is estimated that ~ 6000 girls are trafficked from Nepal to India each year. There is also an increasing number of girls who are trafficked from India to Bangladesh, presumably for the purpose of marriage but who are sexually exploited by multiple adults along the trafficking chain.

Children who are rescued from such conditions are often re-trafficked due to- non-acceptance by their families, lack of livelihood options and the inherent vulnerability of these children who are then targeted again by brothel owners. Apart from the physical and psychological impact of such exploitation of children, many also risk contracting sexually transmitted diseases but are unable to access medical services given the exploitative situation they are in.

The perpetrators of child sexual abuse under these circumstances seem to be diverse – belonging to all age groups and socio-economic strata. Any adult who is willing to pay for sex and accesses the commercial sex market may potentially end up abusing a minor. The younger the child, the greater the price that sexual abusers are willing to pay. Traffickers are often people that pose as boyfriends or girlfriends who promise a better life for the child, or adult influencers who convince the family that their child is being recruited for lucrative, safe, respectable jobs in other locations

The law

The specific legislation in India dealing with trafficking is the Immoral Trafficking Prevention Act (1986). However, this Act only refers to trafficking for prostitution and therefore does not

provide comprehensive protection for children. The substantive law in India is the Indian Penal Code (IPC) of 1860 that is now replaced by the Bhartiya Nyaaya Sanhita (BNS). It addresses issues of the buying and sale of minors, importation of girls etc.[57] Existing rape, assault and abduction laws can also be used to address the abuse of women and girls in brothels. The Goa Children's Act (2003) is the only Indian statute that provides a legal definition of trafficking and is child–specific.

Prevention

A multipronged approach would be required for prevention of CSEC, spanning strict implementation of laws, booking of cases against perpetrators at all levels in the organized crime cartel, tackling socio-economic factors that lead to poverty, education and socio-economic empowerment of people living in poverty, efforts by government and NGO sector working in this area, awareness building of the public to this issue and what to do if they suspect a child is being trafficked/ exploited, and awareness building among children on how to use CHILDLINE and other such services if in trouble.

Reflection

These exercises may be triggering for some people. Please do these only if you feel comfortable

Sexual abuse/ harassment

1. *What makes you feel angry/ upset about sexuality and gender?*
2. *Why do you think CSA is so common in India?*
3. *How would you deal with a perpetrator within the family?*
4. *What do you think of the #MeToo movement?*
5. *How would you support a friend who was sexually assaulted? How would you support them in altering feelings of guilt/ regret/ shame?*

Safety, sexuality and gender

7. *What makes you feel sexually safe?*
8. *What makes you feel unsafe?*
9. *What does consent mean to you? What does enthusiastic consent mean? How important is consent in day-to-day activities with people? How important is it in sexual activity?*
10. *How have you seen people use clothing to meet their sexual goals?*
11. *How have you seen people use clothing for their safety?*
12. *Who are the people in your life you can go to for support?*
13. *Have you been in situations where you needed help from people in a public place? What kind of support did you want?*
14. *What do you do to create safer spaces for others?*
15. *Download the Stri Suraksha App - reflect on the Bystander effect and how one can be proactive and safely intervene in certain situations of sexual violence.*

[57] Sections 141 (Importation of girl or boy from foreign country), 98 (Selling child for purposes of prostitution, etc.) and 99 (Buying child for purposes of prostitution, etc.), BNS, 2023/Sections 370, 372 and 373, IPC, 1860.

Practitioner's perspective:

Watch Enfold's video series on
Demystifying Sexuality - How To Talk With Children About Personal Safety? (link will be inserted)
Demystifying Sexuality - How To Talk With A Child When There Is Suspicion Of Sexual Abuse? (link will be inserted)

Enfold's Apps on child safety:

Enfold Proactive Health Trust, UNICEF India, CDAC, Min of Electronics and Information Technology, Govt of India collaboratively launched

a. **Surakshith App**- a Personal Safety information app for children, Surakshith, in 11 Indian languages in 2016. The information includes Personal Safety Rules, Safe and Unsafe touch, Safe Adults and has stories for 6 to 18-year olds.
b. **Bal Suraksha App -** It elaborates prevention strategies and management guidelines as per the POCSO Act 2012, for each of the adult stakeholders - namely parents, school management, police, medical, judicial and media personnel. The App is available in 10 languages, downloadable free on Android systems.

Way Forward

We can address the factors that make a person feel that they can abuse or exploit children. This requires that we hold the perpetrator of sexual violence accountable and responsible for all forms of sexual abuse and violence - including child marriage and commercial sexual exploitation of children. We can strengthen our reporting, response and reintegration mechanisms so that people and children feel safe and confident when reporting such crimes to the functionaries in the child protection system. Underlying socio-economic- cultural factors can be alleviated through a multipronged, multi disciplinary approach.

At a personal level and professional level (as family members, teachers, social workers, counsellors, medical professionals and government functionaries) we can emphasize respect for all body parts and functions, and teach children the names of their genitals, personal safety rules and highlight their right to safety and dignity. We can encourage children to exercise their agency and confidently report all forms of abuse, especially sexual abuse. We can respond effectively, efficiently and in an empowering manner to such reports at an individual and community level.

Chapter 17. Restorative Practices
- building trust in relationships and communities, restoring a sense of justice

Introduction

Restorative practices (RP) are a mechanism to build and strengthen a sense of community and humanity, strengthen social and emotional learning, address conflict and harm, and repair relationships. They serve as an effective participatory tool to engage with children, adolescents, and adults and offer a space for building and strengthening relationships, both of which are critical to responding to harm or conflict when it arises. Restorative processes can be used in different settings such as schools and other educational institutions, family, workplace, community, hostels, the Juvenile Justice system, and prisons.

Restorative Circles, a form of community-based Restorative Practice, enables the use of value-based dialogues to build relationships, celebrate, make decisions, and address conflict and harm so as to support participants to move forward in a good way by working together to set things right.

The roots of these practices are traced back to indigenous communities like the Tagish and Tlingit in Canada, Maori in New Zealand, Navajo Nation, Sioux and Great Plain Indians, among others. Restorative practices are used by different indigenous communities, as well as legal systems in different parts of the world to address harms that arise when an offence is committed by children or adults.

Contemporary restorative practices emerged as a result of social movements in the 1960s that shifted the focus from thinking of the *causes* of crime to the *impact* of the expansive use of criminalisation on society. It was felt that the penal policies of the criminal justice system did not adequately meet the needs of the victims, offenders and members of the community. It mostly re-victimized the victims and turned them into passive participants in the legal process. For decades, the adversarial criminal justice system has sought to address crime through punishment for offenders, and little effort has been made to address the harm experienced by victims or foster healing. The Restorative Justice approach offers a "different frame for crime, offenders and victims" and a space to "address needs of those affected by harm" (Raha, 2020). Although the legal or criminal justice system's approach to justice has some important strengths, there are also growing acknowledgements of the system's limitations and failures. Victims, offenders and community members often feel that justice does not adequately meet their needs. Many feel that the process of justice deepens societal wounds and conflicts rather than contributing to healing or peace. For several reasons, people may find invoking the current legal system impractical or undesirable. Yet, accountability and closure may be necessary for the parties involved to move forward.

Restorative Justice (RJ) entails a community-based approach to resolving conflict and harm. In the RJ approach, offences are seen as harms that reflect a breakdown of relationships which can be set right by involving persons harmed, the person causing harm, and the community. Professions and fields like criminal justice, social work, education, among others, have adopted different models of RJ processes including mediation, conciliation, conferencing and sentencing Circles. Restorative practices also include the use of informal and formal processes that precede wrongdoing, those that proactively build relationships and a sense of community to prevent

conflict and wrongdoing (Wachtel, 2013). Respect, voluntary participation, and accountability are at the heart of restorative justice processes.

RJ processes involve bringing together the persons harmed, the person who caused harm, and the community along with a facilitator who is equally partial to all parties involved with the objective of repairing harm, and fostering healing so as to enable parties to move forward, while ensuring accountability and addressing needs. Restorative justice processes have been used to address sexual harm as well (Baliga, 2018). Refer to *The Little Book of Restorative Justice* for a foundational understanding of the concept (Zehr, 2015). Restorative processes can help create a safe and respectful space for harm to be acknowledged and action to be taken to address the needs of affected persons; thereby restoring justice at a personal and community level. Research has shown that RJ has been "more successful in improving victim and offender satisfaction, decreasing recidivism of offenders and increasing offender compliance with restitution when compared to more traditional criminal justice programmes" (Daly, 2006). Studies have also stated that opting for an RJ process has meant more satisfaction to the victims than would have been possible through traditional justice mechanisms (Raha, 2020). RJ provides victims a respectful, empathetic space to tell their story as a first step to heal from their trauma - something that isn't usually possible in a court proceeding. In doing so, the survivor's testimony is heard, acknowledged and validated, and not discredited as is often the case. They are provided a less threatening and non-judgemental space to voice their experience - necessary prerequisites for any survivor, particularly survivors of sexual harm.

There are several normative guidelines available at an international level (United Nations, 2000) and in different countries that guide the implementation of RJ in the context of crimes.

Since its application from the 1970s onwards to respond to crimes by children, RJ processes have been applied not just in criminal justice and juvenile justice systems, but also varied spaces like system-wide offences, social justice cases, sexual abuse, prisons, handling conflicts at workplaces or schools, addressing neighbourhood disagreements and family conflicts. For instance, Restorative Justice in education is about “facilitating learning communities that nurture the capacity of people to engage with one another and their environment in a manner that supports and respects the inherent dignity and worth of all” (Evans & Vaandering, 2016). Instead of punishment and exclusion, restorative processes in school settings focus on value-based dialogues to set things right and enable healing through the repair of relationships based on consent of the parties (Clifford, 2015).

Within the RJ movement internationally, Restorative Circles have been widely integrated and have received a lot of attention as an effective approach. The Enfold team, for instance, facilitates Restorative Circles in various settings such as schools and Child Care Institutions (CCIs) established within the juvenile justice system, with children in conflict with the law and children in need of care and protection, as well as the staff of these institutions to facilitate strengthening of life skills, social and emotional learning and co-creating a restorative child friendly culture within the home. Reintegration Circles can serve as a tool to rebuild familial relationships and facilitate restoration and reintegration of children currently residing within such CCIs, with their families, provided this is in the best interest of the child.

This chapter offers a brief overview of Restorative Circles and the manner in which they can be facilitated.

Significance of "Restorative Circles"

The Restorative Circle is a tool, a space, and a process that facilitates self-awareness and helps build authentic value-based relationships. It affords us an opportunity to express and reflect on emotions, thoughts, and experiences, and learn from the life lessons and wisdom shared, irrespective of age, class or any other differentiating factor, given the sense of community and shared humanity that is fostered. We are able to connect better when we know ourselves and those with whom we share spaces at home, work, school, CCIs, or in the community. Circles enable participants to co-create and foster a welcoming and safe space that is collectively owned, for people to share authentically their feelings, life stories, how they are doing, their fears, vulnerabilities and strengths, their hurt and the harm they may have experienced and/or caused.

Restorative Circles refer to a "Way of bringing people together in which everyone is respected; everyone gets a chance to talk without interruption; participants explain themselves spiritually telling their stories; everyone is equal - no person is more important than anyone else; and emotional aspects of individual experience are welcomed" (Pranis, 2005, p. 8).

Restorative Circles are useful when concerned/ affected people (Pranis, 2005, p. 8):

- Want to work together as a team
- Have a disagreement
- Wish to share difficulties
- Want to learn from each other
- Need to make decisions
- Need to address an experience that resulted in harm to someone.

The Enfold Restorative Practices team has partnered with Innisfree House School, Bangalore since 2019 in a pioneering initiative involving the training of teachers and facilitating Restorative Circles among teachers, and by teachers with students. According to the teachers at Innisfree, the practice of Restorative Circles at Innisfree House School "enabled creation of a safe and comfortable space for students to express unpleasant feelings, build relationships, identify conflicts and learn how to resolve them in a way that made them more empathetic and respectful towards each other." The Restorative Circles became a vehicle to address difficult issues like emotions, conflict, name-calling, consent, regret and anger, and offer a space for children to learn from the experience of their peers.

In a Child Care Institution for children in conflict with the law, where Enfold facilitates Restorative Circles, adolescent boys shared that the Circle was a space where there is no judgment, one can speak from the heart, one feels heard and listened to, and everyone's opinions are equally valued and respected. It also provided them with an emotional vocabulary and helped them realize the impact of their actions on the people around them.

While Restorative Circles are not the answer to all situations, they are being increasingly recognized as a powerful way to enable deeper levels of sharing, listening, empathy, learning, expressing support and compassion, and finding ways to collectively move forward in a good way. Participants talk about the subject by sharing experiences from their life. Those listening get a better understanding of the speaker's viewpoints and life. The feeling of being listened to with empathy and without judgement supports emotional expression and even a spiritual experience for those inclined. This in turn deepens the sense of connection and belongingness, that nurtures and nourishes the recognition of a shared humanity cutting across social barriers. Participants draw strength, support and wisdom from one's own and each other's lived experience and insights.

"(Circle) is a place where you know, a safe space to share stuff, a fun way to get to know people and get things off your chest."

- Student from Class 9

" The Circle brought the class closer and it helped many people to solve their problems, understand their mistakes, become a group and stand with each other. "

- Student of Class 7

" I used to feel afraid going to the teacher with my problems. But now I feel more safe with my teacher."

- Student from Class 5

"We have become more considerate about others' feelings… and think about what we would feel if we were in their position. So before saying anything we think about it."

- Student from Class 7

STUDENTS' REFLECTIONS ON THE CHANGES THEY NOTICED IN THEMSELVES DUE TO THE RESTORATIVE CIRCLES

"I used to feel I am not special. After everyone spoke (in the Circle), I felt that each person is special." -Student from Class 4.

"I used to be selfish before. I have started sharing now." -Student from Class 4.

"It changed my attitude and ideas about certain topics. I have become more mature and accepting towards others' opinion likes and dislikes." -Student from Class 8.

"My behaviour has changed, I was very naughty before. There was a Circle done only with a few students from my class- which really helped me reflect on my actions." -Student from Class 8.

"Now I do not react to something without thinking. I think about how the other person in front of me will feel before I react." -Student from Class 8.

"I have stopped thinking that the grass is always greener on the other side... all of us have gotten our own difficulties." -Student from Class 9.

"I understood that all people are different in their own ways, in the way they think and the way in which they share their experiences." -Student from Class 9

"Before I used to think very low of myself but the Circles changed the way I thought of myself. Now I feel much better and wish to have more of these (Circles). I could recognise the qualities in me which helped me to increase my self confidence." -Student from Class 9.

" The silent kids never used to talk and speak freely, now they have totally changed - they feel heard and respected. "

- Student of Class 4

" [The Circle] is like a box of room freshener. When you open the box, the fragrance spreads everywhere. The Circle is like that. It has opened my mind to so many things."

- Student of Class 4

Quotes excerpted from Enfold Proactive Health Trust, *Life Skills through Restorative Circles - Highlights of Feedback received on the Pilot Programme May 2019 - March 2020* (November 2020).

Key Elements of Restorative Circles

Various thoughts and feelings hinder people from authentically sharing thoughts and feelings or in their listening to what others are saying. These include the fear of ridicule, misunderstanding, lack of trust leading to the potential breach of confidentiality, the lack of time, power dynamics, perceptions that other people do not really care, etc. The following are key elements of Restorative Circles that help participants to co-create a safe space:

- **Voluntary participation:** Restorative Circles are voluntary for all participants at every stage. No one should be coerced, pressured, or induced by unfair means to participate. As a corollary, no-one should be censured or punished if they decide not to participate. Participants are supported to exercise their choice and to feel free to leave the Circle at any time, if they feel upset, triggered, unwell, uncomfortable, etc.
- **Values:** Values are used as bricks to help build a strong foundation for a safe space in the Circle. Without them, the Circle will not be a safe container to hold the emotions, experiences, and stories that are shared.



Visual of Values as Jenga Blocks in a Circle with Adolescent Girls in a Children's Home in Bangalore

The values are not imposed on participants by the Circle Keepers. Participants are invited to identify values that they need in order to feel safe and share freely and authentically in the Circle. The Circle Keepers then guide the group in arriving at a shared understanding of the meaning and implication of each value, and to arrive at a consensus on the values they can collectively commit to while participating in the Circle

and it is this mutual agreement that makes the Circle a safe space. The values are revisited in every Circle even if after they have been agreed upon in the first Circle that the group has sat in. They are also re-visited during the Circle itself, in case of breach - and any participant is invited to call out the breach, in a restorative manner without blaming anyone, but rather sharing how that breach resulted in making the space unsafe for her/him/them. For instance, in a Circle on friendship in a Children's Home, an intense discussion broke out on whether "love" could be reintroduced as a value. A fight had broken out the previous week and the girls had decided that since they did not feel love towards each other, the value would have to be excluded. The girls had made up their mind and all except one wished to have it back in the Circle. This posed an interesting situation for the Keepers as the majority wanted "love" back as a value. The child who didn't want it back shared that she could only "love" her parents and siblings and no one else. The discussion then proceeded to unpack love of different kinds and intensities, with the children agreeing that friends could also be loved in a different way from family. 'Love' was then included as a value. In another Circle in a school, a child frankly admitted that she could not abide by confidentiality, an integral value, as she shared everything with her best friend who was in a different section. The Circle then agreed that confidentiality could not be included as a value and the Keeper advised the children to bear this in mind while participating in the Circle.

- **Equality:** Circles honour each participant equally and no person is more important than anyone else. This is practiced in the following ways:
    - The T**alking Piece** is a designated item passed around the Circle in a particular direction - clockwise or anticlockwise.
    - Agency of participants, irrespective of age, is recognised and encouraged and it is clarified that there is no compulsion to speak. Participants are invited to share their thoughts, feelings and stories based on their comfort. Participants are informed in the beginning itself, that if they are uncomfortable sharing, they are welcome to pass the Talking Piece.
    - The Circle Keepers steer the Circle, but are equal participants, not experts. They too share responses from their own life experience. They invite all participants to co-create the values, and to own the space by sharing the responsibility to ensure adherence to them encouraging them to call out the non-adherence of values as mentioned above without shaming anyone. The Keeper can of course facilitate the Circle participants in re-examining the space and in identifying additional values that may need to be added too.
    - While the Circles are predominantly based on oral sharing, it is recognised that there are different ways of communication, especially among children and persons with disability. For instance, many adolescent boys in CCIs found it easier to express their emotions through art. While facilitating a Circle in a Children's Home in Bangalore, a facilitator from Enfold observed that a child was hearing impaired and could not communicate orally. The child was encouraged to express her feelings and thoughts through art work and this helped enable her participation in the Circle.

Types of Circles

Based on their purpose, Circles may be:

Community Building Circles:

The purpose of a community-building Circle is to create a sense of community, and strengthen relationships and bonds among a group of people who have shared interests. These Circles are facilitated in the initial stages of Restorative Practice with any group sitting in a Circle, to help break the ice, build rapport, and foster team spirit, trust and connection among the participants, serving as a foundation for subsequently deeper sharing on sensitive topics and to even address harm and conflict. For instance, such Circles can be facilitated to celebrate occasions, festivals, farewells, birthdays, or discuss interests and experiences at the workplace or in school. Community building circles can support effective collective action and mutual responsibility.

Learning Circles:

These Circles can be around exploring a learning goal and learning something together. They help enable everyone in the Circle to avail of an equal opportunity to participate, share different perspectives from their own lived experience, and even contribute to discussions and debates on controversial topics in a safe space where everyone is encouraged to listen from the heart. Such Circles reinforce the idea that no-one is an expert on any topic, and that even those who are perceived as immature, untrained or illiterate can be sources of tremendous wisdom and insight. For e.g., Enfold has facilitated Learning Circles on sensitive topics as part of the course on Demystifying Sexuality that it offers.

Talking Circle:

In a talking circle, participants explore a particular issue or topic from many different perspectives. Talking circles do not reach consensus on the topic, rather they allow all voices to be respectfully heard and offer participants diverse perspectives to stimulate their reflection. For instance, a student from Class 8 at Innisfree House School shared, “[Circles] changed my attitude and ideas about certain topics. I have become more mature and accepting towards others’ opinion likes and dislikes.” Another student from Class 9 shared, “I understood that all people are different in their own ways, in the way they think and the way in which they share their experiences.”

Themes for Talking Circles can also foster life skills and social and emotional learning through sharing of stories and perspectives. The Enfold team routinely facilitates such Circles on emotions with children and adults that generates reflections on what a particular emotion means, how it is expressed, whether it changes with time, and what the participants have learnt from the Circle about the emotion. For instance, in a Circle on Happiness and Empathy, a group of boys alleged to be in conflict with law shared about a time they felt happy and then also reflected on a time when they felt happy, but it also caused harm or difficulty to another person. In Circles on the theme of anger, children were able to recognise emotions and unmet needs and feelings underlying anger, as well as identify strategies that could help cope with anger.

Healing Circles:

The purpose of a Healing Circle is to share in the pain of a person or persons who have experienced trauma or loss. A co-created plan for support beyond the Circle may emerge but is not required. Also, if a friend, a loved one, or a family member needs extra support, one can

facilitate a Circle to enable a coming together to offer a safe space to share and enable healing to that person.

Support Circles:
These are typically on-going Circle processes that enable a group of people to offer support to each other during difficult times at work or at home or in the community, though it can be a one-off Circle too. One Keeper from Enfold used Circle elements to facilitate the co-creation of a safe space for her daughter and her fiancé to break an impasse they had reached in their relationship, and to co-create an agreement that would enable them to move forward in a good way, with support from her other daughter.

Harm Circles:
These Circles can be facilitated to address specific instances of conflict and harm, involving the parties concerned – the person harmed, the person who is responsible for the harm and acknowledges it without any compulsion, and representatives of the community. Parties come together, share, discuss, understand the harm caused, the impact of the harm, how it can be repaired in a respectful and empathetic manner. Accountability, responsibility and healing of all participants remain the cornerstone of this process. This is an advanced form of Circles and requires suitable training to facilitate.

Circle Process:

Participants can sit in a circle on the floor or on chairs with no tables or barriers in between. The physical format of the Circle symbolizes shared leadership, equality, connection, and inclusion. It also promotes focus, accountability, and participation from all.

Circle Keeper: The 'Circle Keeper' facilitates the Circle and is at the same time an equal member. A circle keeper is the 'steward' of the circle. The Circle Keeper is not responsible for finding solutions or controlling the group. The keeper's role is to initiate a space that is respectful and safe, to engage participants in sharing responsibility for the space and for their shared values. By sharing authentically from their life, the keeper leads by example.

Steps of a Circle process are as follows (Clifford, 2015):[58]

11. **Welcome:** Participants are welcomed by the Keeper and the theme or purpose of the Circle is stated.
12. **Opening:** The opening is usually a poem, prayer, intention, quote, a piece of music, or short meditation which is chosen with care and can enable the participants to gain an insight on the Circle topic. It sets the stage for the Circle by marking the opening of a reflective process, and helps create an ambience that sets the space apart from the pace

[58] Also based on the handout created by The Ahimsa Collective which was liberally drawn from: Pranis, Kay. The Little Book of Circle Processes. Intercourse PA; Good Books, 2004. Pranis, Kay. Three Day Circle Process Training. Oakland, 2009 Roca. Circle Keepers Manual. Boston, 2004. Baliga, Sujatha. Handout: A Highly Abbreviated, Super Short Cheat-Sheet for Circle Keepers. 2009.

and stress of everyday life. The Opening helps participants to focus and centre themselves while drawing strength and energy from the universe.

13. **Center:** The Center physically marks the center of the Circle and is typically made by placing certain objects that hold meaning for the individuals in the Circle as well as some elements from nature, such as pictures, flowers, a plant, feathers, a selection of Talking Pieces, bowl of water, etc. Values that have been agreed upon by the group are placed around this Centre. Participants also tend to 'speak into the center' rather than look at the Keeper or other participants. The Center serves as a kind of imaginary receptacle for the voices, feelings, thoughts and views that each participant shares during the Circle, which gets interwoven with the sharing of other participants and collectively evolves into the wisdom generated by the Circle. Each participant draws their own insights as they reflect on their own sharing and what they have heard from other participants.
14. **Talking Piece**: The Talking Piece is an object that carries special symbolic meaning for any one of the participants, or the participants as a group. The person holding the Talking Piece has the opportunity to speak while everyone else has the opportunity to deeply listen. After speaking the object is passed around the Circle either clockwise or anti-clockwise. The Talking Piece creates helps to establish order in the dialogue, by enabling the expression of difficult emotions one at a time as per the speaking order, rather than two or more people going back and forth at each other when they disagree or are angry. It serves as a powerful equalizer as everyone in the Circle gets a chance to speak. However, participants are also given a choice not to share if they choose to remain silent. They are then requested to accept the object when it is passed to them, hold it and respectfully to honour the memory that it holds for the person it belongs to, and to pass it to the next participant without speaking. This object then becomes a way of enabling each participant to connect with all the participants in the Circle through the physical motion of weaving an imaginary connecting thread through the hands of every participant within the group.





15. **Check in Round:** The Keeper of the Circle facilitates a Check-in by providing an opportunity for each participant to express where they are at that moment in their day, and thereby share a little part of themselves with the other participants. The Keeper

poses questions such as -"How are you feeling today? Is there anything you feel is important for the group to know?" Check-ins can be made as long or as short depending on the time constraints and the theme for the Circle. It helps everyone in the Circle understand what other members of the Circle are feeling or carrying into the Circle, and provides an opportunity for participants to also respond to the needs that may be expressed during this time, during the sharing that takes place subsequently.

16. **Values:** As stated above, values are agreements each participant of a Circle makes with one another. Expressing these values establishes clear expectations and common ground to provide a safe space for people to speak. Values help articulate what each participant needs from the group to participate fully, this is important and specific to each group, and can even be specific to each Circle. For instance, while facilitating Circles with children and adults, Enfold Keepers state - "We have all come together in this Circle so that we can listen to each other's stories, and also tell stories from our own lives. For this to happen meaningfully, we all need to feel safe and comfortable to be ourselves, so as to share about what we really feel and think without fear, - expressing ourselves freely. I now invite you to list three values that will help you feel safe and speak from your heart in this Circle." Following this, participants are invited to share values, and then to ask for clarifications if they need, informing them that they are now required to commit to adhering to these values during the Circle. A discussion is facilitated by the Keeper on any particular values that seem to be difficult to understand or apply in the Circle. Finally, the Keepers facilitate a process of arriving at a consensus on the values that will be used as bricks for the foundation of a safe space that is being co-created by the participants. Some of the values that usually emerge include respect, dignity, trust, confidentiality, non-judgemental attitude, empathy, deep listening, acceptance, etc. The value of honesty triggers discussion as some participants feel that they do not trust the others in the group enough to be completely honest about everything. The Facilitator then helps the group to understand that while sharing participants are not expected to share the entire story and all the details that go into it, but to share only content that they feel comfortable to share, and that content needs to be honest.
17. **The Rounds:** This is the central element of the Circle. These are questions or reflective statements that the Keepers normally plan in advance based on the theme identified for the Circle, and ask one at a time, inviting the participants to share. Listening closely when in a Circle, the Keeper assesses whether the group needs another "round" on a specific issue, based on what is arising in the group, and could either frame a question and ask it or even invite the participants to collectively decide what question they would like to use for a round, that best meets the needs of the group.
18. **Check-out Round:** The Circle Keepers ask participants to share their how they are feeling at the end of the Circle. This helps the Keepers to get a better understanding of how each participant is doing at this time, and whether or not the Keepers need to provide additional support to anyone after the Circle. Keepers could also invite participants to share the insights they derived from the Circle, which in turn helps the participants to share and draw from the wisdom that has been co-created together.
19. **Closing:** A Closing marks the end of the group's time together in Circle. It is ideally something that is positive and uplifting - and can be affirmations, a secular prayer, a physical movement, inspirational poem or a song sung together. Closings convey a sense of hope for the future and prepare participants to return to the space of their daily lives.

In a nutshell: Restorative circles can serve as a means of:

- Creating a sense of community and interconnectedness, and strengthening, and repairing and healing relationships in case of Harm Circles.
- Supporting the acquisition of and strengthening of life skills - like self-awareness, empathy, communication, managing emotions, managing stress, decision making, problem solving, critical thinking - by children and adults alike.
- Creating a positive restorative culture within families, workplaces, communities, institutions.
- Enabling the peaceful resolution of conflicts.

Reflection

1. *What do you think about power?*
2. *What does being powerful mean to you?*
3. *How would Power "with" be different from Power "over"?*
4. *What does respect mean to you? How is it different from obedience?*
5. *Draw your Circles of relationship - who is close, who is farther away from you? What creates distance between people who may be otherwise related by blood or marriage? What can bring people together even though they are not related?*
6. *What, in your opinion, results in harm between people who are related to each other?*
7. *What values do you value? Do these differ in different relationships?*

Practitioner's perspective:

Watch Enfold's video series on
Demystifying Sexuality -What Are Restorative Practices? What Happens In A Restorative Circle? (link will be inserted)

Way Forward

If you wish to know more about restorative practices and wish to use it in different settings, you may contact Enfold Proactive Health Trust for training and resources on Restorative Circles at info@enfoldindia.org

Additional reading

Facilitation Guide

We have included a note on facilitation as part of this reference book, because we understand that the topics covered under this program are best understood and internalized when there is space provided for dialog, for reflection, for constructive conflict and sometimes an extended period and process of emotional processing before they are integrated into one's way of thinking, feeling and behavior. The instructor therefore will benefit by using this approach in the class.

The difference between facilitating and teaching

Etymology of the words often point to the fundamental difference between them. According to Oxford Languages, the word teach has its origins in Old English *tǣcan - to* 'show, present, point out', of Germanic origin. It is related to 'token', a word with an Indo-European root shared by the Greek word *deiknunai* which means to 'show', or *deigma* which means to 'sample'. The word facilitate comes from the French *faciliter*, the Italian *facilitare*, and from the Latin *facilis* which mean 'easy'.

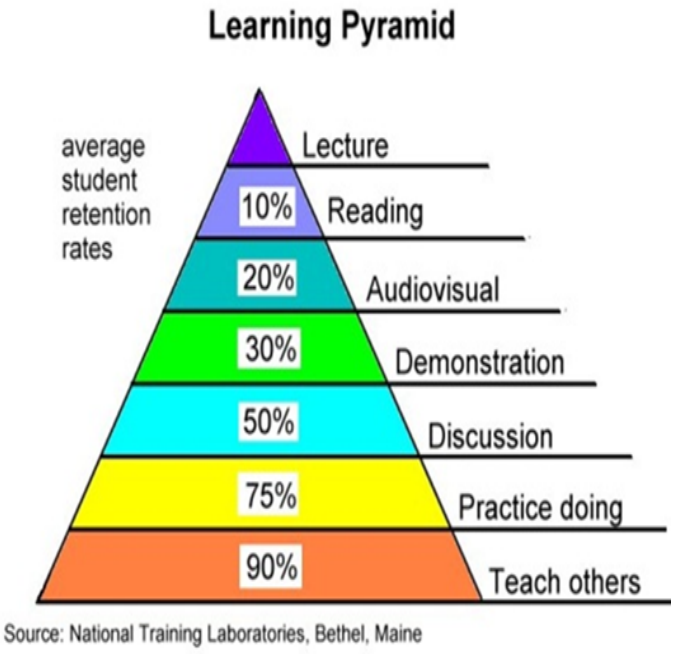
Basically one is about pointing out, showing, demonstrating, while the other is about making something easy.

Facilitators have egalitarian dialogues - where the status or position of power of the speaker is not considered when determining the validity and usefulness of the views expressed. Instead, every one is considered worthy, and encouraged to voice their opinion. Opinions are weighed by their logic and validating facts and figures. (**Sharing Words: Theory and Practice of Dialogic Learning**
By Ramón Flecha published by Rowman & Littlefield, 2000

Facilitation	**Teaching**
Facilitator may not be the subject matter expert	Teachers are expected to be subject experts
No clear cut definition of who is the 'source' of knowledge during the session.	Roles of teacher and student are clearly defined and mostly, do not interchange.
Facilitators establish existing knowledge and skill, identify gaps in knowledge and skill, and provide information, share experiences to support the participants in building on it.	Teacher takes students through an agenda designed to transmit a body of knowledge – facts and figures.
Each participant is incharge of their learning	Take a more leading role - often 'making' a student learn what is on the agenda.

For example - think of a music session – the music is being written by each participant. The facilitator helps them to see how they can bring harmony in it!	For example, think of a music class - the music teacher teaches all students a particular song already written and set to music.

What tools can I use to facilitate?
As a facilitator, encourage discussion, and share authentically from your life experiences. Encourage participants to do the same. Encourage participants to put the concepts they agree with, into practice - and share how you did the same. Encourage participants to discuss and engage with others on these topics to expand and deepen their learning. Once again, share your experience of doing the same. Keep the Learning Pyramid in mind - use the 'lecture' mode only when sharing facts and figures!



Preparation

It is good practice to spare some time for preparation before one starts facilitating a program or a session. This is so whether one is facilitating for the first time or it is a session one has facilitated multiple times. It is seldom that one can hold a session in exactly the same way as they did a previous session because the audience is different, the external contexts may have changed, the needs of the group may vary and there may be emerging, newer perspectives and research findings about the topic being facilitated. Preparation might include

- Finding and consuming information about the topic, scanning for the latest news and reports about the same, attending learning events and engaging in conversations with experts and practitioners in the space
- Reflecting on own beliefs about the topic - to be aware of one's own conviction about the topic, to acknowledge any reservations or conflicts one may have with key messages to be conveyed, to process these and feel okay about discussing the topic without judgement or prejudice is very important to the effectiveness of this program
- Planning the session - to include information relevant to the group, activities that will engage and stimulate the thinking of the audience or address questions they may have had, finding and showing digital content relevant to the topic (videos, apps, blogs) - which is beyond just what is part of the course content suggested.

What can I keep in mind when facilitating a session?

We can utilize all our multiple intelligence (as proposed by Howard Gardner) when engaging with people. We can keep in mind that each one of us has a unique mix of these intelligences AND we can develop these to some extent with practice. So, being aware of these and honing these as we take sessions would support us in being more effective facilitators. Also, each participant also has a unique mix of intelligences - so some may be linguistically inclined, while others may be more kinesthetic and so so on. So if we use all intelligences, we would be in a better position to connect with all participants. Also, the intelligences are interconnected and overlap.
I can keep in mind the following:

- Linguistic intelligence:
    - vocabulary is sensitive, relevant and easily understood by the participants,
    - words used reinforce Enfold's core values
- Logical-scientific intelligence:
    - reasons given to explain an idea/ process/belief.
    - authentic and researched information provided
    - To the point, logical responses to questions
    - content presented and discussed in a logical flow
- Spatial intelligence
    - appropriate use of gadgets, props
    - walking and utilizing available space in the classroom to connect with all participants

- use of space on the writing board
- Kinaesthetic
  - open, easy, friendly and respectful body language,
  - moves in the classroom
  - inclusion of activities that require movement
- Sense of rhythm and time (musical intelligence)
  - session started at the scheduled time (even if only a few participants were present).
  - Maintain a flow and spread out the delivery of the content throughout the session. Avoid a rush to complete the topic towards the end
  - time allocated for interaction, sharing, questions and activities during the session.
  - session completed in the allotted time
- Interpersonal Skills:
  - tone of voice, eye contact to include all participants
  - Harmonious interaction with participants and sensitive to the socio-cultural background of the participants
  - Respond to questions in ways that address the underlying assumption, biases and beliefs - in ways that the participant can connect with
  - Not force participants to agree to one's point of view immediately (even if it is supported by scientific evidence) and give them time to process the new inputs they have got.
  - Space for disagreements, invitation to participants to explore the topic further, look at it from different perspectives, speak with people with different points of view.
  - Respectful yet assertive handling of disruptions and interruptions. Use of "I - statements to describe one's feelings, describing the behaviour or the issue at hand without labelling the person.
  - Appropriate use of humour
  - Reiterates inalienable human rights of all persons
- Intrapersonal
  - Manage one's emotional state to facilitate the session well
  - The process of preparing to facilitate a session, the content itself and the sharing in the sessions can lead one to question their beliefs which they may discover to be disempowering, or violating of other's rights. The facilitator takes time to reflect on and resolve such beliefs for themselves.
  - Set boundaries regarding kind of questions one would answer and regarding personal space
- Naturalistic intelligence:
  - Content delivered has link with Nature - connecting with evolution, other life forms and the environment
- Spiritual intelligence

- Content delivered has links with values, is humane and speaks of the larger picture.

Connecting with participants:

Facilitation of topics as sensitive as the ones in this program become easier when one has established an authentic connect with the participants. It might help to think of the participants as members eager to learn from the facilitator and by listening and sharing with each other. The facilitator's role as mentioned, is to introduce topics, help learners discover new perspectives and information and create an environment conducive to learning. It is not to establish one's credentials as an expert and to 'teach' the others. Connection with participants is enhanced when one listens actively, demonstrates empathy, acknowledges the unique contexts and experiences of participants, connects topics with experiences and ideas shared by participants, admits to one's own vulnerabilities and takes the effort to bring in information that adds value to the specific group of participants.

Facilitating approach:

17. Invite participants to arrive at a common set of values they will observe during the sessions. The facilitator can offer the following if the participants don't bring it up - respect for each other, confidentiality, sensitivity, being non-judgmental, being open to others' viewpoints
18. Introduce a topic and invite points of view, opinions, sharing of information from the audience, in a respectful way. Acknowledge the relevant, appropriate parts of the sharing, reframe the less appropriate ones, fill in gaps in understanding and correct any misinformation there may be
19. Share one's own experiences where relevant and when appropriate. Invite participants to also share their experiences, perspectives and opinions. Where there are differences in opinion, invite participants to listen with an open mind - listen to understand rather than counter for the sake of it
20. Offer reflective exercises so participants can understand the relevance of the topic in their own lives, in their thoughts and beliefs and their understanding of it. Make it optional for students to share these reflections so they do not feel awkward and pressurised to share something that they are apprehensive about

Managing boundaries

- At times a participant may ask a personal question out of curiosity or in an attempt to be humorous or to put the facilitator in a spot. One is not obliged to answer questions that have been posed, esp. those that cross personal boundaries. One could respond by saying something to the effect that "I choose not to answer that question or comment on that statement because it is personal / will not add value to this discussion." or "The

particular question has no relevance to the topic we are discussing. Besides, it is a personal question that is inappropriate to ask a person you barely know."

- One could also use this opportunity to facilitate a discussion on boundaries and assertively establishing them

Class/ time management/ organizing skills

- A facilitator often has to plan carefully to cover a given topic within a specified time - or decide well in advance what might be possible to cover within a given time. This may mean working with the available content and tweaking it to include/ exclude certain parts, ensure key messages are conveyed and not compromised or rushed through and that participants are not overwhelmed by the pace or volume of the content that was shared
- Once there is a broad plan for a session, the facilitator needs to be conscious of delivering the session more or less as per plan. Common challenges to this are when
    - A topic generates discussions that run to an unexpectedly long time
    - There are interruptions that cannot be avoided (students get called away for other activities, power outage, student needs care and attention because of emotional distress, class dynamics becoming difficult to manage etc)
- This requires the facilitator to be mindful of time, take decisions on the spot about what deviations from the plan are required, prioritize between covering the topic and enabling discussions, and the ability to pace oneself so that the participants feel sufficiently engaged and reflective.

Handling a disagreement that is disrespectful

- Disagreements are normal and bound to exist in a group of individuals with diverse backgrounds and upbringing. Disagreements can surface critical points that enhance the understanding of a concept. A facilitator may do well to anticipate disagreements and not be perturbed by them - and not take them as a personal affront.
- Thank the participant for sharing a disagreeing point of view since it takes conviction and courage to do so. Ask for more details and explanations if one is unclear about what they mean.
- Offer verified information if the disagreement is about facts and information. Acknowledge and agree to let an opinion be (and not try hard to change it), if the disagreement is about an unverifiable feeling, perspective, or belief. It might be counterproductive to insist that learners/ participants should come over to one's own pov.

Sometimes, a participant or a group of people may disagree strongly with the facilitator on a topic, or on an opinion they stated. For example, the idea that paedophilia is an orientation and

people with a paedophilic orientation are not well understood may offend a section of participants, disturb them or outrage them. Facilitators may be seen as defending child sexual abusers.

In such situations, the discussion may feel like an attack on the facilitator. It will help the facilitator to stay open to the information and emotions expressed by the participants and provide them a safe space to express distress while also conveying that disrespect will not be tolerated. Convey how disagreement may be expressed assertively without attacking or insulting the other. Do not get argumentative or defensive (in tone or words) when countering any points made by the participant. If the participant insists on holding a certain point of view that is contrary to currently available and accepted information and perspectives, agree to disagree respectfully and move on in the interests of time and the needs of other participants in the session

It could help to ease the situation by stating that we are only presenting the current understanding around the topic and these are evolving concepts that change as we learn more about people, as we discover new scientific facts and information and as we listen to more and more people and their experiences. Besides, facts or information are not moral judgements about anyone. Knowledge is amoral.

Personal attacks become personal only if we start believing them to be true. We know our truth. No one else is the expert on us, except us!

To avoid getting hooked to proving our point of view as the “right’ ‘valid’ ‘scientific’ ‘reasonable’ ‘correct’ point of view, it helps to remind ourselves that there are as many opinions and beliefs as there are people. Our job is not to change or convince people to align with our beliefs. Our job is to present different perspectives, facts and figures and maybe share anecdotes and relevant experiences from our lives. It's the job of the participants to challenge their own selves, move forward to a space that is respectful of their own selves and others and every person's rights. Whether they move or not, is their choice - it's up to them. Our job is not to pull or push them - but to gently call upon them to explore and discover for their own selves. Sometimes, this journey begins right there, in the session itself. Sometimes it takes longer. We can take solace in the fact that no one can ‘unhear’ what they have heard! It may have a positive effect someday, somewhere - or not. We have done our bit!

Life Skills

Our well-being is linked to our quality of life, access to resources and means to fulfil our aspirations, our overall emotional health and sense of acceptance and belongingness in relationships and communities. In other words, well-being is the healthy functioning of mental, emotional, social and spiritual dimensions of our life, which is also referred to as psychosocial well-being. Sexual well being is also dependent on how we apply different life skills in the interpretation and expression of our sexuality and gender, and our sexual or gender based experiences..

According to the World Health Organization, life skills education is “designed to facilitate the practice and reinforcement of psychosocial skills in a culturally and developmentally appropriate way; it contributes to the promotion of personal and social development, the prevention of health and social problems, and the protection of human rights.” (Department of Mental Health, World Health Organization, Geneva, 1999)

Life skills education is an important dimension to enhance one’s sense of intrapersonal and interpersonal well-being, one’s self-esteem, conviction in oneself and asserting one’s needs and rights. WHO’s department of Mental Health has identified five basic areas of life skills that are relevant across cultures:

- self-awareness and empathy
- coping with emotions and coping with stress
- communication and interpersonal skills
- decision-making and problem-solving
- critical thinking and creative thinking

When we talk about life skills, the sexual aspects of our life aren’t often considered, but are an essential element of our experience of day-to-day living. Life skills can, in fact, enable healthy experience and expression of sexuality as well. Certain patterns of thinking prevent us from expressing our qualities, abilities and even our feelings – saying or doing what we wish to say or do. In such instances, we feel let down (sadness, low energy) and may feel regret later on. The idea is to make it easier for a person to express their qualities (strengths) and skills in their daily interactions with people, and reflect on their attitudes and behaviour objectively. It feels great to experience joy and fulfilment in our life and life skills can enable that experience.

1. Self- Awareness:

Simply put, self-awareness is the conscious knowledge of one's own personality and individuality, as evidenced by one's thoughts, actions and feelings. Daniel Goleman (2005), who coined the term in his book ‘Emotional Intelligence (EQ)’, writes that EQ is twice as important as technical skills or IQ. He identifies self-awareness as a self-management skill and writes, “Self-awareness is the first component of emotional intelligence - self-awareness means having a deep understanding of one’s emotions, strengths, weaknesses, needs, and drives. People with strong self-awareness are neither overly critical nor unrealistically hopeful. Rather, they are honest - with themselves and with others” (Goleman, 2020).

People who are highly aware of themselves know about and acknowledge both their strengths and shortcomings (and the contexts in which they are so). They understand their potential and their limitations at any point in time and put their strengths to work towards achieving their goals. They do not dwell on their shortcomings as insurmountable and instead work towards improving them without feeling discouraged or demotivated by them. Some ways to improve self-awareness are by:

- being mindful of one’s thoughts, feelings and behaviours - by paying attention to what drives one’s actions, by being watchful of others’ responses to oneself, by reflecting on what went on within oneself and how it impacted others. Journaling is a good way of keeping a record of one’s thoughts and observations to enhance this mindful practice.

Setting aside time to reflect on one's experiences, to get in touch with what thoughts and feelings are driving one's actions, is a healthy practice.

- being open to feedback and criticism and seeking it actively. Feedback is useful for our growth, to be able to receive and process it objectively.

- identifying and accepting our strengths, aptitude and flair for certain things and not being shy about demonstrating or using it when there is an opportunity. Discard the misplaced sense of humility that requires one to hide their strengths and not openly claim it.

Self-awareness is, for e.g., recognizing when one may feel inadequate or annoyed in the presence of people who are well groomed and conventionally good looking and that this is triggered by early experiences of being criticized and labelled or being compared to others, because of one's looks. Self-awareness is the understanding that this feeling is from one's own internal processes of meaning making and not just because of anything the other person did or said. It is knowing what to do that can assuage this feeling and make oneself feel better.

Self-awareness may also be, when one acknowledges that they feel discomfort with their assigned sex or their sexual orientation and does not judge oneself harshly for it, and recognizes the conflicting feelings that may be accompanying this knowledge. Self-awareness is a steady and committed process one can embark on, to gain clarity on oneself and what one wants to pursue as goals, and how.

2. Empathy:

The term "empathy" is used to describe a wide range of experiences. Goleman (2020) writes, "Of all the dimensions of emotional intelligence, empathy is the most easily recognized. We have all felt the empathy of a sensitive teacher or friend; we have all been struck by its absence in an unfeeling coach or boss."

Empathetic people can understand and are sensitive to the experiences of others and this enables them to offer support to the people around them. Empathy enables us to recognize and share others' feelings and connect with them in an authentic way. Inclusion and acceptance of diverse expressions of sexuality is fostered when one can feel empathetic towards what it means to belong to a minority group that is vilified, discriminated against and deprived of one's rights.

3. Coping with Emotions:

Emotion is a subjective response to a situation, evoked by instinctual biological processes or learned associations from past experiences. Emotions serve many survival and social purposes, conveying to the self what one may need to do to take care of themselves, and in an interpersonal context, communicating to others what one may be experiencing. For example, fear is an indicator that there may be a threat to oneself and some action may need to be taken to ensure safety. Jealousy suggests that one would like to possess what another has or maybe aspire to be like them/ have their experiences. Sadness may suggest that one needs to be taken care of and so on...

Coping with emotions is commonly understood as ‘sanitizing’ one’s emotions according to societal norms, but that is a misconception. Because limiting emotional expression hinders a person from living a whole and fulfilling life. A common example is when men are taught that crying is a sign of weakness or women are told that expression of anger is not woman-like. People trying to fit these expectations of gender expression learn to stifle their emotions, feel awkward or unable to tell others how they feel or ask for or provide emotional support, and this limits their ability to connect and engage in meaningful relationships. Anyone who freely expresses themselves may also be labelled as hysterical, sensitive, unstable or viewed from a gendered binary lens as being ‘unmanly’, ‘too masculine’, ‘girl-like’ and so on.

“Emotions can help us learn about and manage more than just ourselves. They give us hints about what keeps us in our place, how we may change places, and even what it might take to change the whole place,” explains Petriglieri (2014), an associate professor of organizational behaviour at INSEAD. Normalizing experiencing all kinds of emotions is the first step towards an inclusive and nurturing emotional health - sadness, frustration, guilt and jealousy are as much a part of our experience of emotions as are happiness, love and contentment, even though they may be more unpleasant. If one experiences the urge to cry, they should do so as it is a completely healthy way of letting out grief.

Those who are struggling to cope with emotions that are overwhelming can explore a multitude of ways to find some relief and support for their distress. Different things work for different people and there is no one-size-fits-all, quick-fix solution. It may also be very useful to reach out to people in our close circles, find support groups for people in similar circumstances or to seek professional help if one is ready for it. Some ideas to explore:

- finding support groups or special interest groups of people dealing with similar issues; exploring options collectively and finding relief from the support and possibly help from others.
- engaging in experiences that one finds enjoyable and calming. These can include physical activities, creative activities, spiritual practices or any others.
- getting some fresh air and sunshine at regular intervals.
- practicing mindfulness and mindful meditation: this requires practice and the conviction that slowing down, introspecting or just observing oneself is a powerful self-development practice
- confiding in close friends or family members, seeking their counsel and perspectives (and being selective about who can offer objective support without being judgemental or preachy)
- writing - as a way of expressing oneself, clarifying one’s thoughts, documenting one’s experiences and journeys
- self-care activities like taking a break/ day off, having a relaxing bath, body massages, listening to music

NOTE: None of these methods or approaches can be claimed to be universally helpful. We can all discover what works best for us, given the intensity of our struggles, the resources we have access to and what we relate to the most.

Emotions are as unique as the person experiencing them, and hence, any strict guideline on coping strategies is bound to fail. However, educating people on healthier ways of coping enables them to deal with it better, and grow and evolve.

4. Coping with Stress:

Stress is the experience of feeling overwhelmed and finding coping with difficult life experiences challenging, like being overworked, dealing with academic pressures, having significant health problems, having difficulty in relationships, anticipation of life events like marriage or childbirth etc. In such circumstances, the mind and body become prepared to preserve oneself by activating all the internal resources one has, and stay in a sustained state of alertness and preparedness to face the challenges.

There are two main types of stress:

- **Acute stress**: This is short-term stress that is caused by an episode of a sudden, extreme, intense or unfamiliar nature. E.g., when you trip down the stairs, have an altercation with your colleague at work or learn that you just lost some money in the stock market. Everyone experiences acute stress at one time or another. It is a response to what the brain assesses as a dangerous situation.

- **Chronic stress**: This kind of stress lasts for a longer period. This may result from circumstances that gradually add up to unbearable proportions or continued, sustained problems that do not let up and require an individual to be in a constant state of firefighting. Sometimes, one may not even realize that they are operating under such stress. Chronic stress often results in physical and mental health problems that add to already existing stress levels.

There are many potential stress factors that could affect the healthy expression of an individual's sexuality - some caused by one's internal perception of their identities and self-image and others built and sustained by an unforgiving, insensitive society which demands that one should conform to normative standards and expectations - e.g., conforming to gender roles, being a certain body size, shape and colour etc.

Creating healthy physical exercise routines, spending time with friends and loved ones, making time for fun and recreational activities, managing one's time better and eating healthy are all a few ways of building a healthy lifestyle and can be effective strategies to manage stress.

Similar to coping with emotions, coping with stress can also be unique to different individuals. However, having a good understanding of the nature of stress and how it plays out in interpersonal relationships might help in strategizing better and in learning coping mechanisms that are efficient.

5. Communication:

Communication is critical to the functioning of society and the well-being of its members, especially when societal and economic structures become more complex and demanding. Communication has verbal and non-verbal components that have to be congruent to be effective. Verbal communication relates to the use of words to convey specific meanings and non-verbal communication refers to the accompanying body language, tone of voice, gestures and expressions.

Many aspects influence our mode and style of communication including the particular circumstances that we have grown up in and been conditioned to. Eg. We are taught to dress, walk, and talk in a certain way based on the gender we are assigned. We may choose to conform to that or choose to express ourselves differently to communicate our identity. For example, the tone we use, the words we choose, our gestures and mannerisms, how we convey our attitudes, confidence, and our sense of self.

There are many ways in which we can improve the effectiveness of one's communication. Some of them are:

- Maintain eye contact
- Use a respectful, confident, assertive tone of voice
- Respect personal space and boundaries
- Practice using gestures and facial expressions that suggest that one is interested and cares about what the other is saying
- Ask questions to encourage others to communicate
- Use simpler language
- Do not interrupt when the other person is speaking
- Be an active listener

When a person takes time to nurture their communication skills, they start building better relationships, are able to identify problems if they arise and are able to resolve conflicts efficiently. The basic bricks for building better communication skills are:

- Thinking clearly about what one wants to say: be clear about what message one wants to convey and the impact one wishes to have.
- Choosing words carefully: language is a complex skill to master. Our messages gain different meanings based on the words we choose. Developing a flair in the use of any language that we use for regular communication helps build our ability to communicate accurately and effectively
- Using appropriate channels of communication, body language and technology is important to complement the messages we craft with language. Incongruence in any of these might impact the effectiveness of the messages we want to convey
- Listening actively: This helps us build relationships and improve trust and intimacy.

6. Interpersonal Relationships:

As social beings, we are constantly interacting and building connections with other people - for companionship, kinship, to feel needed and significant, to feel cared for and to care for, to do business together and so on. These relationships do not always happen spontaneously and need

effort to build and maintain. Sometimes one finds people whom they find interesting, share common interests with, are fun to be around and if the feeling is mutual, the relationship seems effortless. However, there are other relationships that need effort to sustain and it is these skills that are called interpersonal skills.

Interpersonal relationship skills provide us with the ability to interact, communicate and connect well with others. Apart from good communication skills, one has to understand other people, be cued into what their interests and preferences are, and be considerate and sensitive to their needs. It is the ability to understand other people's emotions and where they come from and to engage with them from a space of empathy.

Power: Interpersonal dynamics are not always one of equal power. People coming together from different backgrounds and circumstances may find it difficult to relate to each other and when they do so, for different reasons, they may grapple with how to relate with each other - wonder who is occupying a more powerful position, and at times, 'jockey' for power. A power play emerges that is based on the use of authority, domination, coercion and oppression and that has reflected in our perception of power as 'power over' - exercised to control and dominate others. This is where power has been most commonly understood as something we take away from someone else and use it to rob them of their agency, rendering them powerless. For instance, people in an intimate relationship might compete for power or those in a co-dependent relationship might wield power over the other. They may stop their partners from doing things that are not okay with them and not allow room for each other to grow. The power dynamic in such relationships isn't relational but one based on the perception that relationships are about possession and not freedom.

When we shift our understanding of power from 'power over' to 'power with', we focus on power that is shared, not taken away. This type of power is built on care, mutual support, respect, trust and holding space for people so they realize their power as well. 'Power with' can help promote healthier relationships not only between individuals, but also groups and communities. We can unlearn our negative associations of power by realising that power can also be used to lift each other up, to build solidarities, resolve conflicts and harm and move towards collective action.

An example of using interpersonal skills to build relationships with others, is to use a language that is respectful and inclusive. For instance, using the right pronouns (or asking everyone what pronouns they use) to address our acquaintances, connecting with people of diverse sexualities from a space of genuine interest and concern and not just to fulfil one's curiosity, respecting others' expressions of their identities and their preferences even if we don't necessarily agree with it.

Some key things to keep in mind when trying to build good interpersonal skills:

- Take the effort to understand the other person, their style of interaction, their expectations, their opinions
- Take feedback and reflect on what impact you had on the other and how you may want to change that to get the desired impact/ influence

- Connect with people from a space of curiosity and with a genuine interest to know them better. Maintain contact even when there is no specific need to ask or gain anything from being in touch with them.
- Have empathy for the limitations of the other. Understand that the same problem might look very different from another's standpoint and so, give them the space and time to deal with things at their own pace.

7. Critical Thinking:

Critical thinking enables us to think about an idea or an issue from different perspectives, ask questions about it, analyse it, and come to the best possible and informed conclusion. It allows change and transformation and helps us understand questions better - sometimes it is also about framing the right questions.
Critical thinking enables one to make better reasoned decisions, independent of fallacies and cognitive biases. The following could be used to improve your critical thinking skills (Bouygues, 2019):

- Question assumptions - For example, when registering for programs/ schemes, various personal details are asked in forms that we fill up without thinking - like father's name, sex, caste etc. Ask yourself, why are these details needed; are they relevant for the program? etc.
- Reason through logic - If filling the form is mandatory to avail certain benefits, you may choose to do so. If the details are irrelevant to the program (eg. training program) then you may choose not to and communicate why to the organizers. If the details are likely to be used to discriminate unfairly between participants, then you can raise the matter with the organizers, in protest.
- Diversify thought - use this experience to be mindful of yours and other people's privacy. Think before asking for details that others might be awkward about sharing, and also about your privacy settings on different digital platforms - how comfortable you are about sharing details about your life.

In heterosexual relationships, when two individuals go on a date, there is a standing expectation that the man will pay the bill. Though it may appear like the 'nice thing to do', it is symbolic of stereotypical gender roles which will continue to be perpetuated if we don't recognize and do something about it. If we apply critical thinking in this situation, one may begin by questioning the assumption that men should always pay the bill. It is an unfair patriarchal expectation and can also be stressful for men. This assumption also keeps the stereotype - that women can't be financially independent - alive. Expecting men to pay the bill promotes toxic masculinity, creates an unhealthy hierarchy in the relationship and an explicit expectation from men to be the 'provider' and have high financial 'value'.

8. Creative Thinking:

Creative thinking is about finding creative solutions or new solutions to problems. "Creative thinking and creativity are not quite the same thing. Creative thinking leads you to the new idea; creativity includes actually bringing it into existence. It doesn't mean conjuring up new ideas from the air. Creative thinking involves combining ideas or elements that already exist. If the

result is an unlikely but valuable combination of ideas or things that hitherto were not thought to be linked, then you will be seen as a creative thinker. You will have added value to the synthesis, for a whole is more than the sum of its parts (Adair, 2007, p. 109 & 7)."

We employ creative thinking regularly, as we face and cope with different situations in our lives. People use creative ways to express themselves and their gender identity. Social campaigns to change the beliefs and practices that are prejudicial towards gender and sexual minorities often use creative campaigns that highlight the struggles of the community, and that help develop more effective ways of dealing with the issues. e.g. - the Bell Bajao ad campaign that helped bystanders intervene when they witnessed any form of domestic violence (Ramakrishnan, 2008).

9. Decision Making:

Decision making is widely defined as a cognitive process of making a choice after a single or series of considerations. "We make thousands of decisions every day. Many are easy, but others are complex, stressful, or both. Because there are so many decisions and because they are literal forks in the road with dramatic impact on results, costs, time, feelings, and relationships, how you make decisions is extremely important." (Latham, 2015, para, 2). Effective decision making is possible when one follows these steps:

7. Utilization of the information available
8. Risk assessment
9. Evaluating the different alternatives

Imagine a scenario where Aman, who recently graduated from school, wants to join a commerce course in a top college. To make an informed decision:

- Aman could collect information on different colleges which offer the course of his interest - from the internet, from seniors who have taken such courses, from education journals and career counsellors. Aman could then shortlist the most suitable one from these for further analysis.
- Aman could then analyse the affordability of each program, the ability to pay back any loans that are taken for funding the education, the political stability in the state/ city where the university/ college is located.
- Then, Aman could compare and understand the pros and cons of each institution, the probability of finding jobs after completing the program from there, the practicality of each option given the risks assessed, and evaluate their conclusions with a focus on choosing the best option.

We're constantly making decisions for ourselves and others who are dependent on us or lean on us for support. We make personal decisions - like whether we want to talk about our gender or sexual identity with others, especially our parents and friends. There is often immense pressure on individuals to 'come out' and declare their sexual identities and orientations - it is a decision that the individual makes based on how ready they are, what the consequences could be etc.- and not be coerced into doing so by succumbing to pressure.

We are able to make sound decisions and be guided by them when our conviction in ourselves is high, when we are able to recognize and acknowledge both the logical and emotional content that influences us, and when we have access to information on the matter from different perspectives and to different experiences that people have had in similar situations.

10. Problem Solving:

A problem can usually be solved by developing a set of generic methods used in an orderly manner to arrive at the most favourable result. There are many ways to approach a problem and one of them is the IDEAL method outlined by Bransford and Stein (1993, pp. 1–3),

- **I** - Identify the problem
- **D** - Define the problem
- **E** - Examine Alternatives
- **A** - Act on a Plan
- **L** - Look at the consequences

Following a comprehensive thought process, examining the alternatives and deciding the best possible solution with clarity are efficient ways to deal with a problem. The problems may seem minor or may be complex and demand more of our mindful, grounded selves to solve them. Being disallowed from pursuing certain interests because of one's gender, not having access to resources, spaces and people that support one's sexual expressions and preferences - all are common issues people face and have to work through by evaluating their unique circumstances and variables that maintain the status quo.

Sexual and reproductive health and common issues related to it

Lactation
Lactation is the providing of breast milk to babies/children by breastfeeding. There are numerous benefits of breastfeeding. Many mothers are also moving towards using artificial feeds due to hectic work schedules, ease of use and other reasons.

Health benefits to the baby (Allen & Hector, 2005): Breastfeeding provides protection from diseases including upper and lower RTIs, gastrointestinal illnesses, and otitis media during the infant period and beyond. This is due to the immunological (Heinig, 2001; Oddy, 2001) and antibacterial (Oken & Lightdale, 2001) properties of human milk and the elimination of exposure to pathogens that may be introduced through the preparation and delivery of formula feeding (Isaacs, 2005). Breastfeeding even for short duration provides protective effects against childhood obesity. It may be protective against chronic diseases such as ischaemic heart disease and atherosclerosis and also for risk markers for diabetes and heart disease. Systematic reviews report that studies show 'probable' protection against inflammatory bowel disease (Crohn's disease and ulcerative colitis) (Klement et al., 2004) and coeliac disease (Nash et al., 2003).

Health benefits of lactation: Studies have consistently shown that hormonal changes associated with breastfeeding help recovery after childbirth and suppress fertility (Rea, 2004; Labbok, 2001). It decreases depression and improves bonding with the infant. There is evidence that breastfeeding is protective against developing breast cancer and may protect against ovarian cancer.

Although the dominant Western discourse on infant feeding emphasizes personal preference on the part of the individual, there are significant economic and employment-related factors which impinge on infant feeding options. In particular, individuals in the most disadvantaged positions in the labour market are, in general, the most constrained in terms of such choice. Breastfeeding has not received the same attention and advocacy as pregnancy and childbirth in the context of the workplace.

Law and breastfeeding

India's Maternity Benefit Act, 1961, as amended in 2017, entitles women to a maximum period of 26 weeks of maternity benefit. The obligation to provide maternity benefits extends to establishments including factories, mines, plantations, Government establishments, and establishments (industrial, commercial, agricultural, etc) that the government may notify. A woman having two or more surviving children is entitled to a maximum of 12 weeks of maternity benefit, of which not more than six weeks should precede her delivery date (Maternity Benefit Act, 1961, Section 5(3) first proviso). Women who legally adopt a child below the age of three months or commissioning mothers i.e., biological mothers who use their egg to create an embryo implanted in any other woman (Maternity Benefit Act, 1961, Section 3(ba)) are entitled to maternity benefit for a period of 12 weeks from the date the child is handed over to them (Maternity Benefit Act, 1961, Section 5(4)). Obligation is also cast on establishments having 50 or more employees to have a creche facility separately or along with other facilities (Maternity Benefit Act, 1961, Section 11A).

Further, women employees should be allowed four visits to the creche, including the rest interval (Maternity Benefit Act, 1961, Section 11A proviso). The law is silent on paternity leave or parental leave for transgender persons. The All India Services (Leave) Rules, 1955, applicable to those in government service provides for paternity leave in case of birth of a child or adoption, leave of 180 days to a female member for adoption of a child below one year, and a maximum of 730 days child care leave to female members having children below 18 years during her entire service for taking care of up to two children (All India Service Rules, 1955).

Female Genital Mutilation (FGM)

WHO defines Female Genital Mutilation (FGM) as involving "the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2020). The act of female genital mutilation involves removal of clitoral hood, damage to the clitoris, and/or vaginal opening of a woman. The process is usually carried out on girls between infancy to15 years of age and is ascribed no health benefits for girls and women whatsoever.

FGM can cause irritation, dysmenorrhea, loss of sexual pleasure and desire, pain while walking, numbness, urinary incontinence (inability to hold urine inside i.e. continuously peeing), vesicovaginal fistulas, sepsis, abscesses, painful sexual experience, uncomfortable relationships with partners, ulceration of the genitals, keloid formation etc. (WHO et al., 1997). It has a profound negative impact on a woman's psychosexual life (El-Defrawi et al., 2001, p. 472).

Female genital mutilation is recognised by WHO as a grave violation of the human rights of girls and women and their sexual rights like bodily integrity, security. It is one of the ways in which patriarchy continues by preventing women from experiencing sexual pleasure and trying to maintain their chastity and virginity before marriage and improve fidelity after marriage. Female Genital Mutilation while practiced mostly in Africa, also has some pockets of practice in Asia and in developed countries (mostly among African immigrants) (WHO et al., 1997; Black & Debelle, 1995, p. 1590). It has been likened to male circumcision and is followed for religious and cultural reasons - both among Christians and Muslims in Africa. However, the problem here cannot be compared to male circumcision which causes minimal harm from the removal of the prepuce.

FGM as it is practised in India is known as “khatna” or “khafz”. This practice has been observed amongst some members of the Bohra community, living in Gujarat, Maharashtra, Rajasthan, Madhya Pradesh and Kerala. In India the veil of secrecy around the practice has meant there is no official data on its prevalence. Emphasis on health risks of FGM hasn’t brought about much change in the incidence. The behavioural change was not stopping the practice, but shifting from traditional circumcisers to modern health practitioners.

In India, there are no specific laws providing explicitly for a ban on the process. In May 2017 a Public Interest Litigation was filed by Sunita Tiwari, a Delhi based lawyer seeking a ban on the process (Shelar, 2017). She argued that not only is the process discriminatory against women but also violates Articles 14 (Right to Equality) and 21 (Right to Life) and women’s right to privacy and responsibility. The respondents, comprising representatives of the Bohra community, in turn, argue that it is an essential religious practice and hence protected under Articles 25 and 26 of the Constitution (PTI, 2018). In April 2018, India’s Attorney General K.K. Venugopal asked a Supreme Court bench to issue directions on the case stating how FGM was already recognised as crime under the existing set of law (Hindustan Times, 2019). The bench went on to adjourn the case and issue notices to states of Kerala, Telangana, Maharashtra, Gujarat, Rajasthan and Delhi. The PIL has been referred to a 7-Judge Bench to be examined along with other women’s right issues such as the entry of women to temples (as was the case in Sabarimala). The court said it was a "seminal issue" regarding the power of the court to decide whether a practice is essential to a religion. As of now, the case is still pending before the SC and a verdict is yet to be established.
Pelvic floor dysfunction (aka Prolapse):

The pelvic floor is made up of a group of muscles and connective tissue that extends as a sling across the base of the pelvis stretching from tail bone at the back to the pubic bone in the front. Pelvic floor supports the internal organs - urinary bladder, bowels and uterus. Pelvic floor dysfunction (PFD) may lead to urinary incontinence (dribbling of urine while coughing/ sneezing), prolapse of the uterus and anal incontinence. The wider pelvis in females itself predisposes for weakness of the pelvic floor (Herschorn, 2004). Pregnancy and childbirth increase in parity, aging, heavy weight lifting, constipation, menopause and obesity can contribute to pelvic floor weakness.

Pelvic Floor Dysfunction is rarely life threatening, but it is common and undermines the quality of life (QOL) of at least one-third of adult women of all ages (Rao et al., 2014). Most of the women misinterpret PFD as a natural process of aging and don't seek medical attention.

The symptoms can be embarrassing and, if left untreated, it can lead to social isolation, sexual inhibition, restricted employment and leisure opportunities and potential loss of independence.

Pelvic floor exercises like Kegel's exercise is a simple exercise that helps to strengthen the pelvic floor muscles and hence prevent PFD. It is recommended after every pregnancy.

The first step is locating the pelvic floor muscle. Trying to stop urinating in midstream or pretending to prevent a fart helps in identifying the contracting muscle.

Technique: Empty the bladder and sit comfortably with legs apart or lie down. Try and squeeze the pelvic floor muscle as in preventing a fart or stopping urine midstream. Hold for 3 seconds and then relax. It should be noted that the muscles of the abdomen, thighs and butt are relaxed. Repeat the squeeze-relax technique for 10 times a day. The repeat sets can be increased gradually.

Urinary Tract Infection

Urinary tract infection (UTI) is one of the most common problems that women present with to their treating physician (Foxman et al., 2000). Sexually active women and post menopausal women are more at risk. Fecal E coli stick to the vaginal and urethral lining. These and other bacteria can cause UTI. Infection can travel to the kidney, especially during pregnancy. UTI in males is rare, due to the longer urethra and prostatic antibacterial substances. Sexual intercourse, use of spermicidal products, history of UTI at an early age and maternal history of UTIs are found to be risk factors for recurrent UTIs; while wiping patterns, passing urine before or after sexual intercourse, frequency of passing urine, douching do not affect the risk of getting recurrent UTIs (Hooton, 2001). If there are symptoms of UTI like burning or painful urination, a mid stream sample of urine should be given for urine culture before starting antibiotics. After a complete course of antibiotics, repeat culture should be done to make sure infection has cleared (Mabeck 1972). Use of lactobacilli containing probiotics may help by altering the bacterial flora in the gut and vagina (Gupta, 2017).

Teenage pregnancy

Though India has a large youth (15-34 year olds) population of 422 million according to the Central Statistics Office (Census 2011), the health of the youth, especially that of girls and their access to information and services for sexual and reproductive health remains a matter of concern (Banerjee et al., 2015).

Teenage pregnancy (first pregnancy between 10-19 years of age) was associated with higher undernutrition risks and their children were shorter and more likely to be stunted compared with those born to adult mothers (Nguyen, P. H, 2019). Among 60096 primiparous women aged 15–49 years who gave birth between 2010–16, the teenage mothers had married younger, were poorer, undernourished themselves, and reported lower agency, and were excluded from health services.

In a comparative analysis of 620 teenage pregnancies and 14,878 pregnant women above 19 years of age, Sagili et al., (2012) found a higher incidence of anaemia, past dates, premature rupture of membranes, normal vaginal delivery, episiotomy, low birth weight, and a significantly lower incidence of caesarean sections/perineal tears in teenage mothers compared to other mothers. They found no difference in the incidence of hypertension, intrauterine growth restriction of fetus, pre-term labour and postpartum haemorrhage in these two groups. Mukhopadhyay P et al., (2010) found that teenage mothers have a higher proportion of preterm

deliveries, stillbirths, neonatal deaths and low-birth-weight babies.when compared with adult women during their first pregnancy.

Phuong Nguyen and colleagues concluded that the health effects of teenage pregnancy in India, can be lifelong and intergenerational, and affect the lives of a large number of girls and their children (Nguyen, P. H.,2019).

Coronary heart disease in females

Post menopause, women become more at risk from cardiovascular disease and this is because the cardioprotective effect of oestrogen is no longer present and atherosclerosis, the disease process that is the biggest cause of cardiovascular disease, increases drastically (Dinu et al., 1998). Cardiovascular disease is still the major cause of death in women over 65 years though it develops 7-10 years later than it does in men (Maas & Appelman, 2010). However, it is found that when women complain of chest pain (stable angina) they are less likely to be referred for testing (i.e., functional testing for ischemia and fewer diagnostic angiograms) or interventional procedures (Towfighi et al., 2009).

Risk factors might be similar in male and female but the level of danger from these risk factors is different. Women were previously excluded from clinical case trials and thus this information was greatly overlooked. Smoking has much stronger negative effects on pre- and post-menopausal women cardiovascular health than men (Prescott et al., 1998; Grundtvig et al., 2009). Similarly, clinical presentation profiles and non-invasive testing is not as reliable in women as it is in men (Douglas & Ginsburg, 1996; Johnson et al., 2003). Thus, traditional diagnostic methods are not optimal for women and their risk factors need more aggressive management (Milner et al., 1999; Chiaramonte & Friend, 2006).

Sexuality in Adulthood:

Sexuality and its expressions, sexual behaviours and preferences are so varied and diverse. These have been discussed in detail and depth in the following chapters - Gender and sexual diversity, attitudes towards sexuality, sexual relationship and sexual preferences and practices.

Sexuality in Mid-Life:

Changes:

Menopause - Menopause is strictly defined as 1 year without menses. It occurs between 45 to 55 years of age, when ovulation stops. The ovaries start slowly reducing the amount of oestrogen they produce from the late 30s. By their mid-50s most females experience a significant decline in estrogen that results in a number of changes, notably the stop in menstruation (hence the name). While the change can be free of any symptoms, many women (85%) experience hot flashes, sweating and insomnia. These symptoms may reduce spontaneously in about 5 years though some women continue to experience these. Breasts, genitals and urinary systems slowly atrophy - that is, the size begins to shrink and lubrication and thickness of the structures reduces. Vaginal walls become thinner and less elastic, the lubrication decreases as the glands atrophy resulting in vaginal dryness and discomfort. This may result in uncomfortable experiences with penetrative sex. Urinary problems like incontinence often increase. The clitoris remains excitable all through the life of a woman.

Orgasm through clitoral stimulation is possible well into old age. Bone thinning occurs at a faster rate. Skin loses elasticity and shows wrinkles. The estrogenic protection over the cardiac system and blood vessels reduces, increasing the risk for heart diseases.

Menstrual Hormone Therapy (MHT) is used to reduce the symptoms and their effects on the quality of peoples' lives. Treatments include:

- Estrogen creams for vulvar and vaginal dryness, burning and itching;
- Estrogen tablets for hot flashes and night sweats.
- Prevention of postmenopausal osteoporosis and subsequent fractures using bisphosphonates, selective estrogen receptor modulators and estrogen.

MHT has been known to increase the risks of breast cancer, uterine cancer, cardiovascular disease, deep vein thrombosis and pulmonary thromboembolism, etc. Thus, the choice to start or stop MHT has been left for a case-by-case discretion of the consultant of the patient. This allows them to start potentially dangerous medication in the hope that it will relieve some of the (normal) debilitating symptoms that are considered to impair quality of life in menopausal women.

Androgen decline or Androgen deficiency in aging male (ADAM)
Testosterone levels begin to decline in males from 40 years of age onwards, declining on average 1% per year (Mayo Clinic, 2020). 10-25% of older men may reach levels considered to be low and are symptomatic. Symptoms of low testosterone include reduced sexual desire with or without erectile dysfunction, decreased strength, energy, or stamina, reduced motivation, increased irritability or decreased enjoyment of life; and alterations in certain components of cognitive functions; reduced height, hot flushes or sweat and changes in body hair and skin.

ADAM can lead to osteopenia/osteoporosis, loss of muscle mass, increased fat deposition around the viscera, testicular atrophy, and gynecomastia or breast discomfort.

Testosterone replacement therapy is available in the form of gels, patches, injections and tablets. Androgen replacement therapy is shown to increase the risks of prostate cancer, cardiovascular disease and sleep apnea. Hence careful patient selection and assessment of risk benefit ratio is important in choosing the treatment options.

Among intersex persons, the onset of decline in sex hormones would vary depending on underlying factors like size, differentiation and function of the gonads.

Trans persons who are on hormonal treatment would require regular screening for side effects of long-term hormone use, function of reproductive organs and other changes like osteoporosis. Any prosthesis and breast implants if used would also need regular attention. Vaginal and cervical smears and prostate examination would be required if these organs are present.

Sexuality in older adults:
The experience and expression of sexuality changes with advancing age. Ideas of beauty, emphasis on youthfulness, regarding sex as only for reproduction and conception of sexual activity from a biomedical perspective may come in the way of elderly individuals exploring their sexuality. Ageism prevents us from respecting all forms of intimacy and sexual orientation

in later life. Expressing sexuality or engaging in sexual activity in later life is considered by many in society as immoral or perverted.

Contrary to these beliefs, a majority of people aged 60 and above continue to engage in and most importantly, enjoy sexual activity (Kaplan, 1990; Diokno et al., 1990). Studies examining sexual behaviour and attitudes of older people towards their own sexuality, reported that most engage in partner or other intimate relationships and view sexuality as an important part of life (Lindau et al., 2007).

Older people are the same people who were once young, and therefore, it is unlikely that their sexual thoughts, desires, fantasies, abilities, and expressions would vanish or disappear as they age. What does change sometimes, are general health, hormones, and the availability and quality of companionship (Bauer et al., 2007). Sexuality and its expression in midlife is an interplay of a complex biophysical, psychological, and sociocultural factors

Age and the degree of sexual activity are not related in a strictly linear fashion and aren't mutually exclusive (Verwoerdt, 1969). Advancing age brings about significant changes in the sex organs and their function. Testosterone levels decline with age in men, however the impact of lower androgen levels on libido and sexual response at midlife is likely small. There are less sexual thoughts and fantasies. Men may need more time and direct stimulation to achieve a complete erection as there is a reduced blood flow to the penis and less sensitivity in the penis. Erections may become softer, the need to ejaculate is less urgent, and the rest period between ejaculations grows longer. Orgasms also happen sooner.

The decline of estrogen in perimenopause and menopause can cause vaginal dryness due to decreased vaginal lubrication, thinning and loss of elasticity of the vaginal wall. These changes may make vaginal intercourse difficult or painful. Vaginal and genital lubrication, blood flow and engorgement are slower to occur. However, women don't have to be at the mercy of their hormones. Lifestyle changes, vaginal lubricants (water based) and moisturizers, or hormone therapy may help alleviate many of these problems. The clitoral sensitivity decreases with age. Despite these physiological changes which occur with aging, several studies have reported that postmenopausal women experience little or no changes in the subjective or psychological experience of sexual arousal (Myers & Morokoff, 1986). The sexual response phase is usually prolonged and resolution happens rapidly. Women retain multi-orgasmic capacity, although the number and intensity of orgasms may decrease (Meston, 1997).

For intersex persons, the hormonal functions would change according the underlying factors. Decline in sex hormones may occur earlier depending on the structure and functioning of the gonads.

Trans persons who are using hormones would need to discuss with their health care provider regarding the duration of use, dosage and precautionary measures to be undertaken. Health check-ups and screening as recommended could be followed. Trans Persons who have not taken any pharmaceutical support and have not undergone any removal of gonads would experience menopause or decline in androgens with advancing age.

Not every person experiences a similar level of change. People who were more sexually active in their younger years continue to have a higher level of sexual activity into their elder years.

Anderson et al found that age, health, past experience and social class were related to sexual activity of elderly males, while for females, the factors were age, past experience and availability of a partner were related to their sexual activity (Anderson, 1975). Elderly people show considerable variation in frequency of sexual activity as well as in their sexual preference (Bretschneider & McCoy, 1988).

Greater experience, fewer inhibitions, and a deeper understanding of the needs of self and the partner can more than compensate for the consequences of aging, such as slower arousal, softer erections, reduced vaginal lubrication, and less intense orgasms. And these physical changes can provide an impetus for developing a new and satisfying style of sexual expression—one that's based more on extended foreplay and less on intercourse and orgasm.

Research indicates that older people can define and express their sexuality in more diffuse and varied terms and that they can be less goal-oriented in their sexual expressions, and that they can perceive the experience less in quantifying terms and more on significance and quality of the experience to them (Starr, 1981). A study on sexuality in 80 to 102-year-olds found touching and caressing to be the most common form of sexual expression beyond 80 years of age (Martin, 1981).

The most common reason cited by adults in older age for stopping sexual activity was the death of the partner (Pfeiffer, 1968). The partner gap (Pfeiffer & Davis, 1972) is a particular problem for heterosexual women, because they tend to live longer than men (on average by six to eight years) (Global Health Observatory Data) and because women marry men who are on average three years older, that can mean even more time alone. Should a woman want to remarry, her chance of finding a new mate is low. Finally, starting a new sexual relationship after the loss of a partner can present its own dilemmas. People often fear that they will not become aroused or be able to have an orgasm with a different partner. Though the clitoris remains sensitive and orgasm can occur in all sexes well into old age, many elderly individuals may have beliefs around masturbation that come in the way of exploring such options.

The other factor that can cause significant hindrance is performance anxiety. An overwhelming concern about sexual performance that obscures pleasure and leads to sexual dysfunction, performance anxiety is a particularly insidious issue affecting aging couples. Performance anxiety becomes a problem for both men and women as they move into their 50s. The natural effects of aging dictate that a male needs more time and direct penile stimulation for an erection. Medications, cardiovascular disease and diabetes may also contribute to erectile dysfunction. When a male doesn't understand the changing physiology and expects to have rigid erections (as in his 20s or 30s) it usually causes worry and fear of failure in sexual performance. After a few tries, embarrassment and feelings of defeat set in. This may result in withdrawal from all forms of physical intimacy to avoid failure or fear of not performing. In turn, his partner may feel rejected and fear that they are no longer attractive enough to sexually excite him.

Women, especially those who have had pain during sex in their younger years, may also experience performance anxiety. It manifests in different ways. They may be worried that sex will be uncomfortable again, and this anxiety can decrease lubrication or cause involuntary tightening of the vaginal muscles. In turn, this makes sex more painful, which heightens anxiety. Women may also worry about how long it will take to reach orgasm, which then interferes with

experiencing maximum pleasure during sex and makes orgasm more difficult. Ultimately, some women decide to avoid sex entirely.

Studies show that older people internalize many ageist attitudes towards sexuality in later life and become less interested in sex and less sexually active. The societal emphasis that has linked sexuality almost exclusively to young people may lead some older people to feel ashamed of their continued sexual interest and prevent action.
Internalized ageism - and social beliefs like sexuality is for the young and elderly people who desire sexual activity are perverted - can come in the way of elderly people discussing their sexual needs and difficulties with their healthcare provider. They may fear disapproval from their doctor or nurse and refrain from discussing these issues (Gott & Hinchliff, 2003).
Older women may also internalize societal norms, of beauty and ageism, and view themselves as unattractive and perceive their bodies in negative ways such as 'wilting', getting 'rolls', 'sags' and 'flabby' (Vares, 2009). This results in a negative body image and low self-esteem hampering the sexual interest and response. A recent Indian study on attitudes toward geriatric sexuality pointed out prevalence of a general sense of guilt, fear, and shame surrounding sex among elderly in anticipation of negative reactions from family members, especially children (Darshan et al., 2015).

LGBTQIA+ elderly people: Most sexual minority individuals have had to navigate through discrimination, prejudices, threats, persecution and even, violence, almost from their childhood, to reach their old age. Their challenges however do not seem to end. LGBTQIA+ elderly people face greater social isolation, lack of familial support (from children and other relatives), poor legal support as well as lack of expertise among medical personnel to address their needs, as compared to their heterosexual peers (Witten, 2012). Fearing judgmental attitudes and discriminatory practices they may not access medical services (Panich E, 2005). Elderly LGBTQIA persons may face difficulty in finding new partners and social acceptance in the place they reside – if say, it happens to be a facility for the elderly.

Though a large number of trans persons come out and may transition much earlier in life, sometimes the death of a partner, retirement, financial stability or other factors – like a desire to settle long standing internal conflicts - may motivate an elderly trans person to come out. Some may consider transition. Older people who choose to come out or transition face often face further medical and social challenges, including being accepted in the LGBTQIA community – for not being Queer enough or for long enough.

Several surgeries may be required, supported by long term hormonal use. Medical issues like pre-existing cardiovascular disease, high blood pressure, use of tobacco, or being overweight may compromise their fitness to undergo surgeries or even take hormones as required. Psychological issues that may arise would need to be considered too. Familial and peer relationships, and peer network support (which play an important role at this age) may have weakened – or worse, been withdrawn by the person's decision to transition. The need for regular follow ups, screening and management of any side effects would have to be considered too, as these are likely to be higher among the elderly. Some may opt for less arduous means. Having said that, several elderly persons have undergone surgeries for transition and are living permanently in their affirmed gender (Factsheet 16 Transgender issues and later life, 2020).

For trans people who have undergone transition several years earlier, regular check-ups and screening would have to be continued and hormones taken or discontinued as per the physician's advice (For health issues that may arise with long term hormonal use/surgery, refer to the chapter on Common issues with Sexual and Reproductive Health).

Sexual activity, sexual preference, choice of partner, and number of partners should not be assumed for any person of any age- including elderly persons belonging to sexual minority groups. Also, a person's sexual identity may differ from their sexual behaviour. This should not be assumed but enquired into as a regular practice for every patient. Medical professionals should also provide information about condom use, STIs and HIV to the elderly as well and not assume it is not required or relevant.

Lack of privacy, loss of job or social status, financial dependence, polypharmacy for various chronic illnesses, general health status, lifestyle and stress, marital satisfaction and attitude towards sex are some other factors that significantly impact the sexual functioning in elderly.

Education about the normal age-related changes in sexuality, acceptance of the range and variability of sexual expression, and attitudinal barriers are the real determinants of continuing sexual expression in elderly.
Transgender Health Care

Physical and sexual health care of trans persons who are considering, undergoing or have completed transition, requires specialized customized intervention and monitoring. There is still a dearth of medical professionals trained in providing health care to transgender persons, though expertise is now increasing in some cities because of the support from state governments and private practitioners obtaining required training and gaining experience. Some common issues are discussed below:

Suppression of puberty:

Pubertal suppression, also called puberty blocking, is a reversible medical treatment. Drugs (like GnRH analogs) are used to suspend puberty in gender non-conforming adolescents with gender dysphoria. Gender dysphoria can be intensely stressful and cause undue pain. The development of secondary sexual characteristics of the assigned natal sex, which is in discord with that of experienced or expressed gender, may add to this stress and increase psychological morbidity (Holt et al., 2016). Pubertal suppression helps in relieving the psychological stress by temporarily arresting the development of secondary sexual characteristics, reducing the dissonance between assigned sex and gender. It also provides adequate time for the adolescent to safely explore their gender expression without the trouble of developing into a body that doesn't affirm their gender, and to take a balanced decision on further gender affirming treatment options (Cohen-Kettenis & van Goozen, 1998).

The World Professional Association for Transgender Health's (WPATH) standards of care suggests that the pubertal suppression be offered as a treatment option only to the adolescents who have undergone a complete physical and psychiatric assessment, and who have reached at least Tanner stage II of puberty. Regular monitoring of bone mineral density (BMD) is advised in patients receiving treatment (Hembree et al., 2009). There is a paucity of research on the long-term benefits and risks associated with pubertal suppression treatment. However, the

available body of evidence suggests that, when clearly necessary, the treatment is reasonably safe (Mahfouda et al., 2017).

The section below is based on the information available at https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs16_transgender_issues_and_later_life_fcs.pdf

Transition:

The American Psychological Association defines transition as "the process of shifting toward a gender role different from that assigned at birth, which can include social transition - such as new names, pronouns and clothing - and medical transition, such as hormone therapy or surgery." Though not all trans persons opt for medical transition, many do. It can take several years and can involve hormonal and or surgical procedures. Set protocols exist in some countries to support the individual through this process, beginning with a detailed assessment of the psychological impact of being trans, physical health, discussion on risks and benefits of hormonal/surgeries and in-depth exploration of what life may look like post transition. Some guidelines require that the person spend one to two years, living in their preferred gender prior to undergoing surgery in order to have a range of experiences - say at home, in the community, workplace, public places, during events and ceremonies - and gauge their effect on one self and how best these could be dealt with while building one's confidence and self-esteem in the affirmed gender.

Hormone therapy is aimed at building effective levels of certain hormones and countering the effects of others, so as to produce changes in the body that are aligned with the gender identity of the person. The effect of the hormones varies from person to person and requires regular follow-up to manage the changes and any side effects.
If testosterone is taken, the expected changes in the body of the trans man (a person assigned female sex at birth, and who identifies as a man) include more body and facial hair growth, male-pattern baldness, increase in muscle mass, lowered pitch of the voice, enlargement of the clitoris, and cessation of menstruation. Breast size does not reduce. Libido increases. The person may opt for breast reduction surgery which involves removal of breast tissue, reduction in nipple size and contouring the chest wall to give it a more masculine look. Some trans men undergo phalloplasty (creating a penis) as well as scrotoplasty to create scrotal sacs with testicular implants.

Long-term healthcare for trans men would include:

Assessment of bone health (osteoporosis), the effect of long-term testosterone use, vaginal health, smears from vagina/cervix if a complete hysterectomy was not done, any need for hysterectomy now, urethral stones if genital reconstruction has been done, breast screening (even if breast tissue has been removed - as some tissue may remain), and the state of testicular implants and penile prosthetics. From a general health care perspective, screening for diabetes, high blood pressure, and the long-term effects of commonly used drugs (if any), would also be considered.

If estrogen is taken by a trans woman (a person who was assigned male at birth, and identifies as a woman), the expected changes are: more fat deposition over hips, reduced muscle mass,

reduced libido, increased time taken for erection and orgasm, a slight reduction in the size of the penis and scrotum, breast tenderness and modest increase in size, and a weaker body and facial hair. Baldness may stop or slow down but usually does not reverse. The person may use hair removal techniques to manage facial hair and body hair, and may use wigs as well. The pitch of the voice does not change. Voice therapy is often used to sound more feminine. Some trans women may undergo removal of the penis and scrotum, followed by vaginoplasty (creating a vagina) and/or breast implants.

Long-term healthcare for trans women would include:

Assessment of bone health, long-term effects of oestrogen use, checking for prostate enlargement (if it was not removed), dilation and douching advice if a vaginoplasty was done, smears and vaginal health, breast self-examination and mammograms, and the state of silicone breast implants (if any). From a general healthcare perspective, the screening for diabetes, high blood pressure, and the long-term effects of commonly used drugs (if any) would also be considered.
Trans persons may face unique mental health issues related to transitioning. While affirmative surgery can boost one's sense of well-being, other people's negative reactions, unexpected effects of surgery or hormonal treatment may be disturbing. Queer-affirmative mental health practitioners and psychologists could support a trans person in navigating through these. Trans persons not undergoing transition would be exposed to similar health risks and issues as discussed above for cis women and men.

Law and access to health care

Under the Transgender Persons (Protection of Rights) Act, 2019 (or the 'Trans Act'), the government has been directed to provide various healthcare measures to trans persons, such as setting up separate facilities for HIV surveillance, facilities for sex-reassignment surgeries and hormone therapy. The government has also been directed to review medical curriculum to better address the health of trans persons, in addition to setting up a comprehensive insurance scheme for trans persons to access medical procedures including sex reassignment surgery, hormone therapy, and laser therapy.

Article 12 of the International Covenant on Economic, Social and Cultural Rights ('ICESCR') recognizes transgender persons as a vulnerable group that require states to enact specific positive welfare measures to enable them to realise their right to health.Van Kuck v. Germany (2003), the European Court of Human Rights ('ECHR') held that it is unreasonable for countries to require an applicant to prove that a gender-affirming medical procedure is a medical necessity in order for them to access it through the public health system (free of cost), as gender identity is one of the most basic parts of self-determination. This is one of several judgements both from ECHR and other individual countries, in addition to policy and legislation, that recognise that access to gender-affirming procedures is an integral part of the right to health.

Intersex Health Care

There is a similar dearth of medical professionals trained to provide healthcare to intersex individuals. Expertise is required for caring for the intersex child at birth, managing puberty in

adolescents, managing transition if desired, and maintaining health into adulthood and elder years.

Intersex Genital Mutilation

Children assigned intersex at birth or during puberty, as well as adults, face a number of misguided attempts and pressure to 'correct' their anatomical features to conform with a binary (female or male) sex. The predominant 20th century 'treatment' of intersexuality rested on assumptions that individuals are psychosexually neutral at birth; and healthy psychosexual development is dependent on the appearance of 'normal' (meaning binary) genitals (Diamond and Sigmundson, 1997).

The result of such an ideology led to various medical interventions to create the appearance of a 'normal' child. And various cosmetic surgeries on infants and hormone therapy on adolescents were administered without proper information given to parents or children either out of ignorance or in hopes of ensuring proper gender role development. Unfortunately, a lack of information and repeated doctors' visits often left children feeling humiliated and stigmatized (Dreger, 1998; Preves, 2003).

The procedures are often justified on the basis of alleged health benefits, improving the quality of life, gender and sex role satisfaction and prevention of further complications - but there is a lack of significant scientific evidence to this assertion (Creighton et al., 2001; Thyen et al., 2005). Key decisions about gender assignment were based on technical aspects of surgery and heteronormative function rather than leaving the decision to the individual, including the idea that "you can make a hole but you can't build a pole" (Hendricks M, 1993), alluding to the current state of knowledge, skills and materials which makes it easier to fashion a vagina, rather than a functional and sensitive penis. Such surgeries can cause permanent infertility, incontinence, and loss of sexual sensation and function, causing life-long pain and severe psychological suffering, including depression and shame linked to attempts to hide and erase intersex traits (Carpenter, 2018), and hence must be postponed until the individual could make an informed decision and give unbiased consent to the procedure (Wiesemann, 2010). It also appears that medical care for intersex persons hasn't changed much in the last two decades DuBois & Ilitis, 2016).

In a momentous move, in April 2019 the Madras High Court, in Arunkumar v. The Inspector General of Registration and Ors (2019), recognised the harm caused by the common practice of intersex childrenundergoing surgery, sometimes even as infants, to 'correct' their naturally occurring bodily features to conform with societal expectations of gender. The court, noting the irreversible effects of such surgeries that are performed on children without their consent, directed the Government of Tamil Nadu to issue an Order banning intersex surgeries on minors. The judgement referred to the report of the World Health Organisation titled 'Sexual Health, Human Rights and the Law', which stated that the sex normalizing surgeries constituting intersex genital mutilation (IGM) should be deferred until the intersex persons are old enough to make the decision (Goled, 2019). Following this, in August 2019, the Government of Tamil Nadu passed on Order banning sex reassignment surgeries on intersex infants and children, except in cases where such intersex variations may pose a life-threatening risk to child. Recently, on 15 January 2021, the Chairperson of the Delhi Commission for Protection of Child Rights ('DCPCR') issued an order recommending the Government of Delhi to declare a ban on

‘corrective’ surgeries on intersex children, except in cases where such intersex variations may pose a life-threatening risk to child (Express News Service, 2021).

Mental Health Disparities

Gender is a crucial issue in mental health. Women have a higher lifetime prevalence of mood or anxiety disorders than men (Seedat et al., 2009; Wittchen et al., 2011). The incidence of these disorders can be linked to gender-based violence, domestic violence and sexual harassment although no research has been found to support the link between the two as the primary causative factor in the higher prevalence of common mental health disorders in women. Similar contributing factors that symbolize gender disadvantage include excessive partner alcohol use, sexual and physical violence by the husband, being widowed or separated, having low autonomy in decision making, and having low levels of support from one's family (Patel et al., 2006; Shidhaye & Patel, 2010; Nayak et al., 2010). Hormonal changes related to the reproductive events are found to be associated with increased vulnerability to mental health illness among women (Parry, 2000).

The focus on determinants of poor mental health of women needs to be shifted from individual and “lifestyle” risk factors to the recognition of the broader, social, economic, and legal factors that affect women's lives (Malhotra & Shah, 2015). Interventions at various levels aiming at both individual women and women as a large section of the society are essential. It is important that the primary health care providers are trained to routinely screen for symptoms of major mental health issues affecting women and to provide adequate care and support when required. Multidisciplinary approach involving the community has to be adopted. Women are increasingly joining the workforce, and there is great potential to intervene at this level too.

Statistics indicate that individuals from the LGBTQ community are three times more likely to have thought about suicide, five times more likely to have attempted it. 40% of transgender youth report having attempted it at least once (James et al., 2016). Families that reject their identity increase their risk factors by nearly 8.4 times (Family Acceptance Project, 2009). Each episode of LGBT victimization increases the likelihood of self-harming behaviour by 2.5 times on average (IMPACT, 2010).

Mental Healthcare Act, 2017

The Mental Health Care Act, 2017 (MH Act) recognises the right of all person to “access mental healthcare and treatment” which means “mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers” (Mental Healthcare Act, 2017, Section 18(2)). It is the first piece of Indian legislation to prohibit discrimination on grounds of sexual orientation. The MH Act mandates equal treatment of persons with mental illness to persons with physical illness and prohibits “discrimination on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability” (Mental Healthcare Act, 2017, Section 21(2)). It recognises their rights in any mental health establishment to dignity, privacy, and protection from cruel, inhuman or degrading treatment

and all forms of physical, verbal, emotional, and sexual abuse (Mental Healthcare Act, 2017, Section 20).

Worksheets
Multiple Intelligences Worksheet

Scientists believe that we have various kinds of intelligence. Each intelligence is important and as useful as others. These intelligences are developed naturally to different people in different levels. We can develop them further by practice but it is almost impossible for a person to develop all intelligences to their highest level.

Intelligences make us good at doing different things.
Check out your true unique mixture of intelligences. 6 statements are given under each intelligence. Tick the statements that are true for you. Count the number of ticks and write it next to the intelligence in the space provided.

Linguistic Intelligence _____

1. I like reading books
2. I enjoy word games like scrabble, crosswords.
3. I enjoy rhyming words and can easily remember the words of the songs.
4. I use unusual and difficult words in my writing / speech/ essays.
5. I like debating and extempore talks.
6. I can learn a new language easily.

Logical/ mathematical intelligence _____

1. Math and Science are my favourite subjects
2. I count numbers easily in my head.
3. I am interested in scientific discoveries.
4. I enjoy logic puzzles.
5. I like to find out reasons for various things
6. I enjoy doing research /experiments/ finding out information on topics.

Spatial Intelligence§ _____

1. I love jigsaw puzzles
2. I like to draw, paint, or doodle and make posters.
3. I am good with following and giving directions to reach a place.
4. I find it easy to read graphs, pie charts, bar diagrams.
5. I can imagine things clearly in my mind.
6. I enjoy origami (paper folding to make objects)

Bodily Kinesthetics Intelligence _____

1. I like to walk up and down while thinking.
2. I enjoy dance and dramas
3. I use my hands and body a lot while talking.
4. I enjoy taking part in sports.
5. I like activities like- model building, craft and other indoor physical activities.

6. I like playing outdoor games.

Musical Intelligence _____

- I enjoy learning poetry by singing them.
- I play a musical instrument.
- I listen to music often.
- I can tell when a song is not in tune.
- I like to make my own musical beats by tapping or humming.
- I often hum or sing while reading, working or walking

Interpersonal Intelligence _____

1. I make friends easily
2. I enjoy group games like carrom, cards, and monopoly.
3. I prefer being with my friends rather than spending an evening by myself.
4. I like to work in a group rather than work alone.
5. I prefer to talk about my problems with my friends or family instead of keeping them to myself.
6. I can easily make out when my friend is feeling sad.

Intrapersonal Intelligence _____

1. I like myself
2. I do my work/ keep deadlines by myself without being reminded.
3. I prefer to take care of my feelings and problems by myself rather than discuss it with others.
4. I have a favourite place in the house where I like to be by myself.
5. I am happy with my body
6. I follow rules even when no one is there to enforce them

Naturalistic Intelligence _____

1. I prefer being outdoors than sitting inside.
2. I know names of different plants / birds / insects.
3. I like planting, watering and taking care of plants.
4. I like nature walks and treks.
5. I would like to keep a pet.
6. I like to help animals that are hurt or sick.

Spiritual Intelligence _____

1. My energy is a part of the universal energy
2. I think everything has not been explained by science.
3. I wonder, think about God/ Soul/ Spirit
4. I wonder about consciousness
5. I feel all of us are connected, linked with each other.
6. I believe that each person faces the consequences of his/her actions in some form or the other.

You may not have got the same number of ticks for each of the intelligence. This is because in each one of us, some intelligences are naturally better developed than others. We enjoy doing work/ jobs related to these intelligences. Think of intelligences that are developed in your friends, in your family members.

Each and every intelligence is useful, and equally important for the society to progress. We can further develop those intelligences that we find difficult, by practice, but only to a certain extent. It would be almost impossible for a person to develop all intelligences to their fullest potential. We live in groups. In a group, different people are good at doing different things. In this way, there is a greater possibility that everything gets done well! No one person is required to do everything!

My Qualities/ Traits Worksheet

Each one of us has many traits or qualities. Tick the ones you think you have. Remember, being a cheerful person does not mean that you have to be cheerful all the time. If you feel that on the whole you are a cheerful person, tick 'cheerful'. Same goes for all qualities listed below. Think of more adjectives we use to describe the behaviour of people/ yourself - add these to the list below

If the worksheet is being done in a group, ask participants to not influence or discuss or look into each other's worksheets. This part of the exercise is to be done individually.

Cheerful	Impulsive	Honest
Aggressive	Self- centred	Serious
Shy	Careless	Punctual
Confident	Mean	Thoughtful
Submissive	Brave	Frank
Competitive	Arrogant Manipulative	Determined
Peaceful	Enterprising	Cooperative
Argumentative	Playful	

Count the number of traits and qualities you have ticked. Please note that

- Sometimes we are very strict with ourselves and don't want to tick a quality that we feel we aren't exhibiting all the time. We can't be showing all qualities all the time anyway, so it's okay to tick a quality even if you show it occasionally.
- Sometimes we are not aware of our own qualities and as these are demonstrated in our behaviour - others may be more aware of them. You could ask a close friend or a caring adult to point out your qualities.
- Sometimes, we don't want to tick qualities that we consider to be 'negative'.

Our qualities help us survive, solve different problems and live together in a group. Different situations, different problems require different ways of behaviour. Hence the need for so many qualities! But **are some qualities bad and some good?** We often consider some qualities to be undesirable - for instance aggression or impulsiveness, manipulativeness or even self-centeredness. In fact, in different situations, different qualities come in useful. For example, in a situation when there is threat of violence, one may use manipulation to be safe and avoid injury. Like intelligence, no quality is better than the other.

Are some qualities found only in one particular gender? We often consider some qualities to be manly and some to be feminine. This is not true! You can see it for yourself. Redo this activity in another way - write M (for masculine) or F (feminine) or N (neutral) against each quality. Next tick the qualities you think you have - even a little bit. Check if you have ticked any quality which does not match your gender. Chances are that you have.
To force people to show only some of their qualities and not others is unfair. It is restrictive, and prevents the person from fully expressing their capacities.

Do all of us have all the qualities? Yes - though it may not seem like that! We have the capacity to demonstrate all the qualities - even if just once, even if for a short period of time. For instance, you may not have ticked punctually or calm - but if you were asked to be punctual just once, or be calm for 1 minute, could you do that? Most probably yes. We have the capacity to demonstrate, behave in all the ways mentioned in the worksheet. If we think back, we have probably done this already at some point in our life.

Can we develop our qualities? Can we alter our behaviour patterns? For sure some qualities are better developed than others in each one of us, and we can also develop our qualities further by practice! While all qualities are necessary for our survival, we can learn to use them appropriately. Context matters. Aggression / being self-centred/ is not a negative quality - its use is very much required in certain situations, but using them to resolve issues with friends may not leave me with many friends!

Working on your qualities: Qualities are like our invisible tool box - like a carpenter's tool box. **Being aware** of all the tools that you have is the first step. Becoming aware of which tool you tend to use by **default** is the next step. Which tool you use as 'force of habit' often depends on what comes naturally to you, what you saw people around you use in such situations when you were growing up, tools that people in your environment

seem to use etc. Next you can learn to pick and choose the tool you want to use. You may be using that tool in some other situations anyway. Now you can be **purposeful** about it. So, becoming aware of one's behaviour is the first step - identifying which quality you are bringing out in your behaviour, then you can consciously work to alter that, bring in some other, more appropriate quality. You may be using that behaviour - say with your friends. Now, can you use it with your siblings?

We can slowly alter the way we behave, with practice and patience. None of us are 'this way only'. There isn't any set you, there isn't any set me! We can be kind to ourselves in this journey - to be better versions of ourselves :))

My Values Worksheet

Reflecting on one's values is an important aspect of self-awareness. Here is a self-reflective exercise on values

Read through the values listed below carefully. Please add any value that may not be listed here, in the space at the end of the table. Score each value between 1 and 5, 5 being the most important value for you and 1 being the least. More than one value can get the same score. Write it down under the 'Score' column.

Pick 5 values with the most score. If more than 5 values have the highest score, you have to choose and finalize 5 values which are the most important to you. Circle them.

Values	**Score**
1. Adventure	
2. Advancement in career:	
3. Affection:	
4. Being imaginative, innovative	
5. Competitiveness	
6. Creativity:	
7. Duty	
8. Economic security:	
9. Fame:	
10. Family happiness:	

11. Friendship:	
12. Freedom: independence, autonomy	
13. Helpfulness:	
14. Health:	
15. Inner harmony	
16. Integrity: honesty, sincerity,	
17. Involvement, participation, belonging	
18. Loyalty	
19. Obedience	
20. Order: Arrangement, proper placement, stability	
21. Personal development:	
22. Pleasure:	
23. Power/ influence:	
24. Privacy	
25. Recognition: acknowledgement, respect from others, status	
26. Responsibility: accountability	
27. Spirituality:	
28. Wealth:	
29. Wisdom	

Reflection:

- Why do you value these over other values? What incident in life or person instilled these in you?
- Have your values, what you consider more important, shifted over time in your life?

- Think of your close family members/ friends. What do you think are their top few values? Do you value (respect) their values?
- Are some values more valuable than others?
- What would happen to society if any one or more of the values were no longer upheld by people?

Legal Literacy Questionnaire

Indicate your answer by ticking the appropriate box.

B	Subject Related Questions	Agree	Disagree	Not Sure
1	An FIR can only be filed by the victim and not by a witness or any other third person who has come to know about it			
2	An FIR cannot be filed if 48 hours have elapsed since the incident			
3	In case of a road traffic accident where a person is injured, by law the driver does not have to stop if he perceives a threat to his life.			
4	A child who has been sexually abused need not go to the police station to lodge a complaint with the police			
5	If a person gets to know or thinks that a child is being sexually abused, he or she is required by law to report it			
6	A child above 14 years can be employed in a commercial enterprise/ household			
7	A person cannot be penalized for having complained against a colleague or senior to the organization's sexual harassment committee			
8	A woman or female child cannot be arrested and taken to the police station between 6pm- 6am			
9	If a woman is being arrested, a woman police personnel should be present			
10	A Hindu girl (daughter) has as much right to ancestral property as a boy (son) irrespective of a will			
11	Dowry is illegal. If a woman dies within 7 years of marraige of unnatural causes, the husband and his family are suspected to have caused it unless they prove otherwise			
12	Possession of child pornography is not an offence unless one plans to sell or distribute it for commercial purposes.			
13	Consensual sex among adolescents is legally recognised in			

	India.			
14	A person may be arrested for posting defamatory comments on facebook/ blogs -			
15	IT Act gives the government the right to intercept (access) and check private messages on social media sites for content that may disrupt public order			
16	Homosexual marriages are legal in India			
17	A child born in a live in relationship has the same rights as a child born in a marriage.			
18	A voter has the right to choose 'None of the above" while voting from 2014 general elections			
19	Every person has a right to know the work being done in government departments			
20	Child marriages in India are not valid under the Prohibition of Child Marriage Act, 2006.			

Do you feel you are as legally literate as you need to be?

How is a working knowledge of the law useful?

Please check your answers here:

Answer Key to Questionnaire on Legal Literacy

1. An FIR can only be filed by the victim and not by a witness or any other third person who has come to know about it - **False**. Anybody can file an FIR. It is not necessary that only the victim has to file an FIR.
2. An FIR cannot be filed if 48 hours have elapsed since the incident - **False**. An FIR can be filed even after 48 hours after the incident has occurred. But it is better to file the FIR as soon as the incident has occurred because it will be easier to collect evidence and gather witnesses.
3. In case of a road traffic accident where a person is injured, by law the driver does not have to stop if he/she perceives a threat to his/her life. **True**. The person need not stop if he/she perceives a threat to his life, but he/she must go immediately to the nearest police station and report the incident
4. A child who has been sexually abused need not go to the police station to lodge a complaint with the police - **True**. Anyone else can report it on the child's behalf. The police should come to the child at home or hospital as the case may be
5. If a person gets to know or thinks that a child is being sexually abused, he or she is required by law to report it. **True.** According to Protection of Children From Sexual Offences Act 2012, anyone suspecting or having the knowledge that a child is being sexually abused must (mandatorily) report the matter to the nearest police station or Special Juvenile Unit of Police Station. A person who knows that a child is being

sexually abused and does not report it, wil be presumed to be a party to the abuse.

6. A child above 14 years can be employed in a commercial enterprise/ household - **True**. A person above 14 years of age can be employed. But employing a person below 14 years of age is considered as child labour and is punishable under law.
7. A person cannot be penalized for having complained against a colleague or senior to the organization's sexual harassment committee - **True**. The person cannot be penalized because they are just performing their moral duty and seeking justice.
8. 8 A woman or female child cannot be arrested and taken to the police station between 6pm- 6am of the following day - **True**. It is illegal to arrest a woman or female child after 6PM and before 6AM. If it is completely necessary to arrest a woman after 6PM or before 6AM, the prior permission of a magistrate will have to be taken. The woman will also have to be given all opportunities to defend herself and have a lawyer of her choice. She will have to be produced in court within 24 hours of arrest.
9. If a woman is being arrested, a woman police personnel should be present **- True.** A woman police officer will have to be present and the arrest has to be made with all dignity after following all the procedures.
10. A Hindu girl (daughter) has as much right to ancestral property as a boy (son) irrespective of a will - **True.** A female has equal right on ancestral property as a male irrespective of whether a will is there or not.
11. Dowry is illegal. If a woman dies within 7 years of marriage of unnatural causes, the husband and his family are suspected to have caused it unless they prove otherwise - **True.**
12. Possession of child pornography is not an offence in India. **False** Under the amended Section 15, POCSO Act, " Any person, who stores or possesses pornographic material in any form involving a child, but fails to delete or destroy or report the same to the designated authority, as may be prescribed, with an intention to share or transmit child pornography, shall be liable to fine not less than five thousand rupees, and in the event of second or subsequent offence, with fine which shall not be less than ten thousand rupees." In other words, possession of child pornography is an offence, even if the person does not intend to sell or distribute..
13. Consensual sex among adolescents is legally recognised in India. **False.** The POCSO Act, 2012 does not recognise consensual sex among adolescents as it defines child to mean a person below 18 years and there are no exceptions in favour of non-exploitative and consensual sexual activities among adolesents.
14. A person may be arrested for posting defamatory comments on facebook/ blogs - **True**. According to the IT Act, if a particular post is a threat to society and may lead to chaos, he/she can be arrested.
15. IT Act gives the government the right to intercept and check private messages on social media sites for content that may disrupt public order - **True.**
16. Homosexual marriages are legal in India - **False**. Homosexuality is no longer considered illegal in India.As per the judgment of the Supreme Court in *Navtej Singh*

Johar v. Union of India,(6 September 2018) Section 377 of the IPC cannot be applied to consensual homosexual sex between adults as it is unconstitutitional, "irrational, indefensible and manifestly arbitrary". However homosexual marraiges are not yet recognized in India.

17. A child born in a live in relationship has the same rights as a child born in a marriage. - **True**
18. A voter has the right to choose 'None of the above" while voting from the 2014 general elections - **True**. This option is now available to voters. This option was introduced for the first time in the elections held in Rajasthan, Delhi, Mizoram, Madhya Pradesh and Chhattisgarh in November-December 2013.
19. Every person has a right to know the work being done in government departments - **True**. The RTI Act empowers people to know about the work being done in government departments. A citizen can file a question about the government's work with the RTI officer in the concerned department of the Government. The department is bound by law to reply expeditiously or within 30 days. Certain departments of the government are outside the preview of the RTI Act for security reasons
20. Child marriages in India are not valid - **False** Child marriages are illegal, yet valid. Child marriages are voidable at the option of the party who was a child to the marriage under Section 3, PCMA. However, under certain circumstances described in Section 12, PCMA, child marriages can be void. Karnataka has passed an amendment to declare all child marriages void ab initio.

Glossary

We have put down definitions of terms related to gender and sexuality that have been used in this Reference Book so that they are understood by the reader in the way that the authors had intended to use them. The list is in no way comprehensive and the definitions of these terms are always evolving and mean different things to different individuals. Therefore, these will vary depending on different contexts and we urge you to build on these further to develop your own understanding of these terms.

To help with defining these terms, we have drawn from the following sources:

1. Definitions Related to Sexual Orientation and Gender Diversity in APA Documents
2. Breaking the Binary, LABIA, 2013
3. Terminology Related to Gender and Sexuality, Nazariya, 2017
4. Glossary of Terms, Human Rights Commission
5. LGBTQIA Resource Center, UC Davis
6. LGBTQ+ Vocabulary Glossary of Terms - Safe Zone Project
7. Queertionary - Albany Pride

1. **Asexual**: A sexual orientation in which a person experiences little or rare to no sexual attraction, either within or outside of a relationship. It does not mean that asexual people cannot develop romantic or emotional ties, or exhibit affection and love. They may feel other types of attraction, for e.g., intellectual attraction or sensual attraction (a non-sexual desire to touch or be touched for e.g., hugging, cuddling etc.).
2. **Aromantic**: a person who experiences little to no romantic attraction towards others.
3. **Cisgender**: a cisgender (or cis) person is someone whose gender identity (their own sense of their gender) aligns with the gender assigned to them at birth. For eg. someone who was assigned male at birth and also identifies as a man. A cisgender person enjoys cisgender privilege in a society which upholds the gender binary (which a trans* person does not). + add
4. **Cross-dressing**: wearing clothing, accessories, and/or make-up, and/or adopting a gender expression not associated with a person's assigned sex at birth according to cultural and environmental standards (Bullough & Bullough, 1993). Cross-dressing is not always reflective of gender identity or sexual orientation. People who cross-dress may or may not identify with the larger TGNC community.
5. **Drag**: the act of adopting a highly exaggerated gender expression, often as part of a performance. When referring to men performing as women, they are gender called 'drag queens' and when referring to women performing as men, they are called 'drag kings'. Drag may be enacted as a political comment on gender, as parody, or as entertainment, and is not necessarily reflective of gender identity though it may form an integral part of one's whole identity.
6. **Female-to-Male (FTM)**: an outdated term which indicates both a type of trans (transgender or transsexual) identity and the direction of physical transition that a person can make either socially or with medical assistance through hormone therapy and

surgery. Other abbreviations include FTM, F-to-M, F2M, F → M, and F-M. (Green, 2014, p. 1)

7. **Gender**: refers to the attitudes, feelings, and behaviours that a given culture associates with a particular sex. For example, in a segregated, patriarchal, heteronormative society, men and women are expected to dress in attires that are typically associated as being masculine or feminine respectively; men are expected to be strong and aggressive while women are thought to be sensitive, emotional, sacrificing and nurturing. However, these attributes aren't uniform across all cultures. Behaviours that are compatible with cultural expectations are referred to as gender-normative; behaviours that are viewed as incompatible with these expectations constitute gender non-conformity.
8. **Gender Binary**: a system in which people are categorized exclusively as either girl/woman or boy/man in their gender, or feminine or masculine in their gender expression.
9. **Gender Dysphoria**: previously known as Gender Identity Disorder, gender dysphoria is a medical term referring to, the distress a person may feel due to incongruence between their gender identity and their sex assigned at birth. This may be experienced differently from person to person and also vary in intensity. Transgender or non-binary individuals and some intersex individuals may experience intense gender dysphoria.
10. **Gender Expression**: the manner in which one chooses to present their gender, often done through one's clothing, behaviour or demeanour etc. in accordance with the socio-cultural expectations of that gender. Gender expression may be aligned with one's assigned sex and gender or may differ from it.
11. **Gender Roles**: refers to the tasks and responsibilities one is expected to hold or assume based on the gender that one is assigned. For e.g., a person assigned the feminine gender at birth (based on their female sex) is expected to be a caregiver of the family, cook and clean for them and play the more nurturing role while a person assigned male at birth is expected to be the breadwinner, to protect the family and to be the one who does all the rough and tough work around the house.
12. **Gender Identity**: this is the internal perception of one's gender and how one may choose to label themselves. Gender identity need not be the same as the gender one is assigned at birth. For e.g., one may identify as trans, non-binary, queer, woman, man, gender non-conforming etc.
13. **Gender Non-Conforming (GNC):** an adjective used as an umbrella term to describe people whose gender expression or gender identity differs from gender norms associated with their assigned sex or is outside the gender binary.
14. **Questioning**: an adjective to describe people who may be questioning or exploring their gender identity and/or sexual orientation and sexual identity, and whose gender identity may not align with their sex assigned at birth.
15. **Intersex**: an umbrella term for people born with sex characteristics, including reproductive or sexual anatomy, that differ from the normative binary notions of male or female bodies. Intersex variations are congenital differences in reproductive parts and/or secondary sexual characteristics, and/or variations invisible to the eye such as chromosomal and/or hormonal differences.

16. **Male-to-Female (MTF)**: an outdated term which indicates both a type of trans (transgender or transsexual) identity and the direction of physical transition that a person can make either socially or with medical assistance through hormone therapy and surgery (See Female-to-Male).
17. **Non-binary**: an adjective describing someone who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do. Non-binary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid.
18. **Pansexual**: a term to describe someone who can have sexual, romantic or emotional attraction or desire for members of all gender identities or expressions. Gender or sex of the other person are not determining factors in this feeling of attraction.
19. **Queer**: an umbrella term that individuals may use to describe a sexual orientation, gender identity or gender expression that does not confirm to dominant societal norms. Some youth may adopt 'queer' as an identity term to avoid limiting themselves to the gender binaries of male and female or to the perceived restrictions imposed by lesbian, gay and bisexual sexual orientations.
20. **Sex**: refers to sexual activity (when used with reference to people) and also to the classification of individuals into categories of female, male or intersex based on physical and biological characteristics indicated by internal and external genitalia, gonads, hormones, chromosomes.
21. **Sexuality**: includes all forms of sexual experience and expression of a person. It includes what a person feels in relation to their sexual needs, what they find erotic, their sexual orientation, sexual acts they prefer, and behaviours related to these in the personal, private, social, cultural and spiritual domains.
22. **Sex assigned at birth**: the sex assigned to an individual when they are born (typically male or female) as it may appear on one's birth certificate. For e.g., assigned male at birth (AMAB), assigned female at birth (AFAB). This phrasing was historically used by the intersex community to talk about forced corrective surgeries carried out by medical professionals on intersex individuals. Other phrasing includes designated sex at birth (DSAB), sex coercively assigned at birth (SCAB).
23. **Sexual Identity**: a person's sexual identity would include sexual behaviour, romantic attraction and sexual attractions, and self-identification with the terms used to describe these. Often used interchangeably with sexual orientation.
24. **Sexual Orientation**: this is about who one is attracted to and who one feels drawn to sexually. In reality, this may be the same as or different from who one is attracted to romantically. E.g., One may be a homoromantic bisexual - romantically attracted to a person of one's assigned sex and sexually attracted to persons who are male or female.
25. **TGNC**: an abbreviation for Transgender and Gender Non- Conforming.
26. **Trans***: an inclusive term to refer to all persons whose own sense of their gender does not match the gender assigned to them at birth. Spelt with an asterisk in this way, trans* is an umbrella term coined within gender studies in order to refer to all non-cisgender gender identities including transsexual, transvestite, genderqueer, genderfluid,

genderless, agender, non-gendered, third gender, two-spirit, bigender, MTF (male-to-female), FTM (female-to-male), transman, transwoman, other, man-identified PAGFB (Person Assigned Gender Female at Birth), woman-identified PAGMB (Person Assigned Gender Male at Birth), and (m)any others.

27. **Transmasculine**: a broader term for a transgender person who was assigned female sex and feminine gender at birth, but identify with masculinity to a greater extent than they do with femininity. An identity in its own, transmasculine individuals may also identify in a multitude of other ways, such as being a Trans man, demiboy, multigender/polygender, genderfluid, demifluid or nonbinary.
28. **Transfeminine**: a broader term for a transgender person who was assigned male at birth, but identifies with femininity to a greater extent than they do with masculinity. An identity in its own, transfeminine individuals may also identify in a multitude of other ways, such as being a Trans woman, demigirl, multigender/polygender, genderfluid, demifluid or nonbinary.
29. **Transition**: the steps and process taken by transgender/nonbinary individuals to realise their gender identity. These may include hormone therapy, gender affirming surgeries or procedures, coming out to family, friends and colleagues, legal name change and official gender recognition, use of pronouns etc. The transitioning process varies from person to person.
30. **Transgender man**, **trans man**, or **transman**: a trans man is a person who was assigned the female sex and the feminine gender at birth, but who identifies as a man. Some transmen may choose to undergo surgical or hormonal transition (increasingly, the term being used instead of transition is gender affirming surgeries or procedures), or both, to alter their appearance in a way that aligns with their gender identity more appropriately. And some transmen may choose not to undergo surgical or hormonal transition.
31. **Transgender woman**, **trans woman**, or **transwoman**: a trans woman is a person who was assigned the gender male at birth, but who identifies as a woman. Some transwomen may choose to undergo sex or gender reassignment surgery to alter their appearance in a way that aligns with the gender identity they identify with more appropriately. And some transwomen may choose not to undergo sex or gender reassignment surgery.

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