ENFOLD PROACTIVE HEALTH TRUST

DEMYSTIFYING SEXUALITY HANDBOOK

–

FOR STUDENTS OF NURSING AND NURSING PROFESSIONALS



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

enfold

Demystifying Sexuality Handbook for Students of Nursing and Nursing Professionals

For use in conjunction with

Demystifying Sexuality Reference Book[1]

– Looking at sexuality from a

Rights-based, Restorative and Gender Transformative Lens

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Acknowledgement 4

Introduction: 6

1. Intersectionality 7

2. Diversity in Sex 11

3. Structure and Function of Human Sexual and Reproductive Systems 11

4. Diversity in Gender Identity and Sexual Orientation 14

5. Gender Bias 19

Rights and laws in the context of discrimination and violence 22

6. Self-esteem and body image 24

7. Attitude towards sexual health and issues with reproductive health 26

8. Sexual Development in Children and Adolescents 27

9. Attitudes towards Sexuality 33

10. Sexuality and Disability 36

11. Sexual relationships 39

12. Sexual Preferences and Practices 41

13. Pedophilia 43

14. Sexual Violence against Adults 44

15. Sexual Violence against Children 48

16. Medical Ethics and Restorative Practice 52

References 54

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First and foremost, we thank the patients - children and adults - who sought medical care for their ailment, and in the process helped build the experience of the medical professionals involved in their care. The case studies in this Handbook are loosely based on the lives of patients that the authors of this Handbook have either supported directly, or have heard their colleagues speak about. We acknowledge and honour all children, young people, and the older adults who endured physical, emotional and psychological hardship, and reached out to medical professionals - nurses and doctors - sometimes despite personal, familial and social barriers. We thank them for coming forward to seek support and healing, and in the process create opportunities for the medical professionals to apply their learning in practice and enhance their own learning while doing so. Through this Handbook we aim to support medical professionals who are in training or in practice, to learn from the experience of others and refine their skills.

We acknowledge with much appreciation the crucial role of **Dr Bhavani V, Dr Nikhil Saldanha** and **Dr Sangeeta Saksena** in conceptualizing the handbook, creating case studies and elaborating the discussion for each of the case studies.

Dr Bhavani V holds an MBBS degree from Meenakshi Medical college, Kanchipuram and a postgraduate diploma in family medicine from Christian Medical College, Vellore. She has clinical work experience from a multitude of sectors, starting with Public Health for TANSACS(NACO), Occupational Health for Ford India and Capgemini Technologies, Neurorehabilitation services in NIMHANS, followed by private practice. These experiences have aided her in gaining a wider vision of holistic healthcare practices. Her interests encompass gender equity and sexuality, mental health and well being and lifestyle medicine. She has been associated with Enfold as a facilitator since 2017 - conducting life skills-based gender equity, personal safety and sexuality education for school students. She is also trained in Restorative Practices in Education from Enfold and Life Skills from Parivarthan Institute of Counselling and Training.

Dr Nikhil Saldanha graduated from St. Johns Medical College, Bangalore, with an MBBS degree. Following this he continued his work with Enfold Proactive Health Trust and Fortis Healthcare in Bangalore before completing his MSc in Health Psychology at the University of Stirling, UK. He has been involved in Enfold and its Rights-based approach to sexuality from the age of 15 when he attended his first Demystifying Sexuality course. He later went on to train as a Facilitator of Gender Equity, Sexuality and Personal Safety Education with Enfold and conduct sessions for school and college students. In this handbook, he attempted to bring this Rights-based approach towards sexuality to the Indian healthcare system starting with the individuals who have the most intimate relationships with patients, nurses.

Dr Bhavani and Dr Nikhil brainstormed, reached out to the nursing students, practicing nurses and other healthcare professionals in their network, and referred to textbooks of nursing to develop the framework for this Handbook. They are the principal authors of this handbook and jointly came up with the case studies described here. Dr Bhavani took on the work of elaborating each case study and the

discussion under each case. We are grateful to them for creating this handbook.

Dr Sangeeta Saksena has an MBBS degree from Lady Hardinge Medical College, New Delhi, and completed her MD in Obstetrics and Gynecology from Kasturba Medical College, Mangalore in 1988. She worked in St Marthas Hospital, Bangalore for 3.5 years, and later served at St John's Medical College Hospital for 8 years, leaving that institute as Associate Professor to start Enfold Proactive Health Trust in 2001 along with her colleague, Dr Shaibya Saldanha. Dr Sangeeta Saksena is also an author, counsellor and activist; working in the field of life skills, gender equity, sexuality and personal safety for over 25 years. We are thankful to Dr Sangeeta Saksena for discussing the case studies with Dr Bhavani, fine-tuning and reviewing the Handbook.

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This Handbook is part of a project aimed at preventing gender-based violence by developing and implementing a formal curriculum for teachers and students of undergraduate and graduate studies from nursing, social work, 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 the Ford Foundation for supporting this project.

Introduction:

Sexual health is fundamental to the physical, emotional health and well-being of individuals. Sexual health is not only being free of diseases or disorders of reproductive organs. It encompasses the rights of individuals to express their sexuality in a safe and healthy way, have access to accurate and complete information on sexuality, knowledge about the risks and the vulnerabilities faced, their access to good-quality sexual health care, and an environment that affirms their sexuality.

Sexuality is diverse and unique to each individual. This handbook aims to bring out the influence of sexuality and its expression on health care provision and maintenance. It aims to highlight the various biological, psychological and sociocultural factors that can influence an individual's sexuality and health. It invites the health care provider to understand and deepen their knowledge on the diversity of sexuality and its expression, so that one can be aware of the explicit and implicit biases that could come in the way of providing holistic, non judgemental and affirming health care services - a right of every person. It aims to destigmatize sexuality and sexual health concerns, so that comprehensive health care is available to everyone.

Health care providers have a unique position and authority in the society because of which their acceptance and affirmation of a patient's sexuality could be lifesaving and life changing for the person and their family.

This handbook is designed for the nursing professionals - those in practice and in training. It is to be read in conjunction with Enfold's Demystifying Sexulity Reference Book.

Structure

Each chapter starts with a description of a **case study**. This is followed by a **general discussion** of the main theme and then an **intervention plan specific to the case (wherever applicable)**. This is followed by a few **reflective questions** to look into one's own beliefs, values and any biases around the main theme of discussion. Few additional case studies have been added at the end of each chapter for the reader to work on and develop a comprehensive health care plan on their own.

Two case studies pertaining to intersectionality have been discussed first, and elaborated at the beginning of this Handbook for the benefit of students of Nursing. Thereafter the chapters follow the flow of the Demystifying Sexuality Reference Book.

1. Intersectionality

Case 1:

A 30-year-old male patient, who is an engineer by occupation, belonging to a high socioeconomic strata (Brahmin), with h/o diabetes, presents to the OPD with burning micturition and itchy genitalia for 3 weeks.

Collecting and analysing data:
A man, aged 30, employed as an engineer, has presented to the OPD with itching in the genital region for 3 weeks. This was also accompanied by burning sensation while urinating, also of the same duration and increased frequency of micturition. The colour of the urine is pale yellow. There was no history of any discharge or fever.

The patient has Type II diabetes for two years, and is on regular treatment. He is not following a typical diet pattern as his work schedule is hectic. Sleep is normal. Bowel movements- normal. Not a smoker and there is no history of alcohol consumption.

The patient is single. Sexual history: He was reluctant to talk about it. When probed, he said his last sexual contact was 2 days ago. He says that he wore a condom during the recent sexual encounter and always does.

Assessment :

- Patient's general health condition is fair.
- Genital exam reveals no ulcer, lesion or discharge.
- Symptoms of pain while urination and genital itching point towards possible urinary tract infection with sexually transmitted infection.
- Patient is a diabetic which can predispose him to infections.

Health Plan:

- Patient needs to undergo investigations as prescribed by the doctor.
- To explain the dosage and timing of the antibiotic medication prescribed by the doctor. To explain the importance of completing the course of antibiotics. Possible side effects of the medicines to be explained
- Educate the patient on importance of good hydration and use of urinary alkalinizing agent in treatment of UTI
- Give information on genital hygiene and use of topical agents to reduce itching
- Management of diabetes mellitus- To review the medicines that he is currently taking, check for his glycemic status from his old investigations and plan accordingly.
- Flyers on diabetes education and nutrition to be provided.

- Plan for review and follow up.

Discussion:
The above care plan seems comprehensive in treating the symptomatology of the patient. The psychosocial, psychosexual, interpersonal and intrapersonal factors that can contribute to the disease and its complications, treatment are often overlooked and need to be explored further.

The patient seeks medical help for his complaint of genital itch 3 weeks after the onset. Although he enjoys the privilege of being a man belonging to an upper socioeconomic strata (financial and caste) with good education and respectable job, who has access to good health care, he waited for 3 weeks before seeking medical care. It is important to explore the ideas, concerns and expectations (ICE) of the patient towards the symptoms and the disease. This is an important part of gathering information which is often overlooked. This would give us an understanding of the patient's concern in delaying medical care. If this is not addressed, it could affect future healthcare seeking behaviour. The privileges that he enjoys in society are being masked by the disadvantages of lack of sexual education and the stigmatisation of sexual illness/disease.
It would be an ideal practice to explore the fears and stigma that the person carries and to address that in the health plan.

The patient was reluctant to talk about his sexual relationships and opened up about it only on probing. Why is that? Was he ashamed or guilty of talking about it? It is necessary to explore the feelings and emotions attached to the perception of the disease as it plays a significant role in compliance to treatment and seeking medical care or attention at the earliest. Providing an empathetic safe space which is free of judgements, would help the patient to be open in communication.

The patient says that he always wears a condom and was sure that he wore one during his last sexual encounter. Use this opportunity to discuss safe sex practices, explore and make sure that the patient follows safe sex practices. To find out if there is a gap in understanding and fill that with relevant information. Sexual history is incomplete without partner history and sexual practices followed. To give complete information on testing for sexually transmitted infections and to encourage him to undergo appropriate tests based on his sexual history.

Patient gave h/o symptoms for 3 weeks and his last sexual encounter was 2 days back. This suggests that the partner might be exposed to the infection as well. So collecting the partner's history, their health conditions and encouraging the patient to bring the partner(s) for examination or to guide the partner(s) to get medical attention is needed.
While assessing the patient, with suspicion of sexually transmitted illness it is important to include oral and anal examination - to look out for any lesion, ulcer or discharge.
A detailed family history has to be recorded. The history says that he is from a brahmin community which might be conservative. To explore the perception of his family members on his sexual lifestyle as their support or disregard impacts the maintenance of his health status, risk behaviour and health seeking behaviour.

He was diagnosed to be diabetic at the age of 28. Most of the non-communicable diseases are perceived as diseases of late adulthood. To explore the stigma associated with it and to address that helps in maintaining health. To check for compliance of medications when he is with his sexual partner(s) as people might choose to keep away or hide their medication history and hence skip doses.

Additional history taking and analyzing patient**'s problems:**
His diet is high in carbohydrate and fat and says that he is sedentary most of the day as his work timings are not conducive to going to gym or work out. High stress work environment.
Exploration of safe sex practices reveal a sexual encounter a month back when he used a condom which had a small snip or cut. He saw that only later. Since his partner didn't complain about anything later, he just dismissed it.
Sexual partner history - Has been sexually active since 20 years of age, has had 2 sexual partners. Active with a single partner for the last six months.
He delayed medical attention as he was afraid that it could be something shameful and kept postponing medical attention. His family being conservative, he was afraid that his family doctor might reveal this to his parents and he didn't want that. He is sure that his family would look down on him if they come to know about his sexual relationships before marriage. He is not willing to go to a STI clinic for fear of disclosure.

Additional points in assessment:

- Examination of the anal and oral cavity
- Testing - important to ask for history of testing for HIV, Hep B and other sexually transmitted illnesses - and to recommend testing now and after appropriately.

Additional points in health plan:

- Explain the importance of partner treatment.
- Plan a health encounter with the partner, test and treat the partner as needed
- Education on safe sex practices
- Counselling on STIs
- To refer appropriately to a counsellor, nutritionist/dietician and diabetes educator

Alternate case study - applying the gender lense: 40-years-old female presents with the same complaints as the gentleman above discussed - burning micturition and genital itch for 3 weeks. The woman belongs to a lower socioeconomic strata and is a dalit. She is a sweeper by occupation . She is married but not living with her husband. She has 2 children - who are studying 12th STD and 8th STD respectively. She is the earning member of the family. She is diabetic for 2 years but is not taking medications regularly. On further questioning she says that she has to take a day off (LOP) to visit the nearest ESI hospital to stock up on medication supplies which she can't afford. Sexual history: She says that she has an on and off relationship with a partner from work and she is okay with it as long as the children are unaware of it. Her extended family knows about it. She has no idea about contraception.

She is now seeking help for her symptoms, as an ASHA worker who is her friend insisted that she seek medical attention and the ASHA worker has accompanied her to the clinic.

Questions for reflection

1. How does the experience of a middle aged woman vary from that of a young man?
2. What role does the economic and social status play in health care seeking behaviour, health maintenance, disease modification and compliance in both these cases?
3. What is the role played by family dynamics on the sexual health of the individuals?
4. What is the approach of both these individuals to diabetes and its management? How do the sociocultural and economic privileges or disadvantages/ restrictions that each individual experiences affect their respective health status?
5. As a healthcare provider, are we mindful of all these intersections and its effect while planning and implementing health care?

Case 2:

You are posted in the OBG OPD - Antenatal clinic in a metro city.
First patient is a 28 yr old woman, 32 weeks pregnant, from a upper class, South Indian Muslim. She is paraplegic. She was working as a marketing executive in a Multi National Company but currently she has taken a break from work. She has come for a routine antenatal check up.

Your second patient is a 28 yr old woman, 32 weeks pregnant. She is a native of Meghalaya, migrated to the city for her work, and belongs to a middle class family. She is working as a marketing executive for a MNC. When you are chatting with her you get to know that she belongs to a tribal community, and is a practicing catholic.

Expand this case study with the following in consideration: the advantages and disadvantages, privileges and discriminations that both the women have felt/experienced due to the different social and political identities and the impact of these intersections on their health.

2. Diversity in Sex

3. Structure and Function of Human Sexual and Reproductive Systems

Case 1.

You are working in the labour ward. The woman you supported during childbirth, gives birth to a child with ambiguous genitalia. The doctor remarks that it's a disorder. You approach the parents and grandparents to inform them of the birth. They are asking you if it is a boy or girl baby.

1. What will you say?

Discussion

While the medical and allied professionals learn about intersex variation under the name 'Disorders of Sex Development', people with intersex variations and activists around the world are opposing the use of the term 'disorder'. The demand is to recognize that biological sex is not a strict binary - with typical male and female characteristics, but is more like a spectrum, and intersex variations are a part of the spectrum. People are born with variations in sex characteristics that cannot be classified as typical of male or female sex and this does not make it a disease or a disorder that has to be medically 'corrected'. A more acceptable term is 'Differences in Sex Development'.

While this is still an ongoing debate between medical professionals and activists, it cannot be denied that the current medical approach and practice towards intersex people is causing trauma and harm, which can last a person's entire life. The impact of such harm is traumatic that medically unnecessary surgeries carried out on intersex children for sex assignment purposes has been deemed a gross violation of human rights and torture by the United Nations. As mentioned in the Demystifying Sexuality Reference Book, in April 2019 the Madras High Court, recognised the harm caused by the common practice of intersex children undergoing 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.

It is the duty of the medical and allied professionals to develop guidelines that balance the medical, social and identity needs of intersex people by working along with intersex people themselves.

A possible approach plan

- You can inform the parents that their child is born with variations in the genitalia that are atypical of male and female sex. The sex assigned to this baby is intersex. Intersex variations occur frequently and there are many people with such differences in their sex development.
- You can explain that it is not by and in itself a disease or a disorder. Investigations would be done to determine the overall health of the baby and rule out any serious issues that may require immediate medical intervention. However, no 'treatment' to 'correct' the sex of the baby would be either done or advised.
- You could also recommend that the family reach out to organizations that support persons with intersex variations, sensitive and expert counsellors who could help them navigate the emotions and questions they are facing. For this, you need to ensure you are aware of the individuals or organizations that can help with this in that particular geographic location, or access online.

Questions for reflection

1. Is it okay to assign a sex and gender to an intersex child without knowing the child's self-identify?
2. How can a child be brought up in a gender-neutral way?
3. How can you support the child in their journey to forming their identity?
4. How can you start a conversation in your hospital about the rights of intersex people and how to reconcile that with medical practice?
5. How is the language being used harmful or helpful? (Use of pronouns, use of derogatory or medicalizing terms etc.)
6. Is it possible for medical and allied professionals to offer medical assistance to intersex people without pathologizing the intersex variation?

Case 2- A man approaches the hospital in severe pain and states that he has been diagnosed with kidney stones. The man is directed to the urologist and there the doctor determines that the man is intersex (which is unrelated to the medical need and treatment). The man is sent off to a gynecologist who admits him to the hospital. He is still in pain. When he asks the nurses to help him change clothes, no one responds. In fact, no one approaches him at any point - resulting in him asking to be discharged immediately.

Discussion

The individual had approached the hospital for immediate medical treatment and was in acute pain. Even if the doctor had not started any specific treatment, an analgesic for some relief from pain should have been offered. Moreover, keeping away from a patient because of them being an intersex person is against everything the medical profession stands for. Not only is it not helping, it is the exact opposite of 'do no harm'. No one should be denied assistance for being different from what the society dictates a person should be like whether it be in terms of sex, gender, sexual orientation or gender expression, or any other aspect of life.

Questions for reflection

1) How would you feel if you were involved in the care of an intersex child or adult? Would you feel apprehensive? If so, what may give rise to this apprehension? Is it because of anything the person has done or because of something you have heard or experienced?
2) Can you think of intersex variations from a non-pathologising perspective -as a part of nature and variations in nature?
3) How can you support intersex persons when they approach your healthcare setting?

Case 3:

Parents of a 8 year old child with intersex variation and hypospadias want surgery to be done to make their child into a male.

1. What will you say to the parents?
2. What will you say to the child?

4. Diversity in Gender Identity and Sexual Orientation

Case 1:

A transgender person reaches the Casualty department with a severe asthmatic attack. They are 19 years old. You couldn't elicit any history from them as they have severe wheezing. The accompanying adults are transpersons from the community that the patient has joined recently, after they were made to leave their hometown due to persecution by their family members.

How will you address the patient?

Would you have any apprehensions when caring for this patient?

Discussion:

Lived experiences and research data points out that trans people face stigma and discrimination even from medical professionals. Many transgender individuals postpone seeking medical care and attention because of fears of discrimination and/or cost, are refused care, are harassed in health care settings, and encounter health care providers who lack knowledge of their health issue.

Transgender patients may access care for medical or surgical treatments related to transition, but are much more likely to need care for any of the myriad acute or chronic illnesses or injuries that anyone in the population may experience/present with, from sprained ankles to stroke, from childbirth to cancer. Thus, nurses in any setting may encounter trans-gender patients. Providing equal, unbiased health care with an open, non-judgemental attitude is of paramount importance. In order to provide high quality equitable healthcare, nurses have to firmly believe that a transgender patient is an individual with a health concern and a nursing professional's job is to provide equitable care.

Caring for LGBTQIA+ (Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersexed, Agender, Asexual, and Ally community) patients:

- **Use gender affirming language**

  Asking the patient how they would like to be addressed or what is the name and the pronouns they use is a sign of respect and implies that you are aware that not all individuals identify with she/he pronouns, or that their 'official' name may be different from the name they go by. By asking the patient about their name and pronouns in a dignified and respectful way, nurses and health care providers can be affirming the gender identity of trans persons.

- **Create a supportive environment**

Non verbal cues and body language play an important role in creating an affirmative environment. Some practices that can make the healthcare environment a safe and supportive place are:

- Using intake /registration forms that are inclusive with sections for the person's name, pronoun, sexual orientation, gender identity and partner information.
- Displaying LGBTQIA+ sensitive and informed education materials like posters, flyers,etc
- Asking open ended questions:

  Example:

  "*Is there anything else that would make you feel comfortable?*"

  "Would you like to discuss anything else that might help me in providing complete care for you?"

- In an inpatient setting, care should be taken to meet the person's needs for privacy and dignity.
- Patient placement in the wards should take into consideration the patient's preference, and their gender presentation.
- Having a gender neutral or unisex bathrooms if possible; if not to create a policy that transgender patients can use the bathroom that matches their gender identity.

- **Be respectful**

  Cultivate genuine respect for people of all genders, sexes, socio-economic, religious, caste or ethnic identities. It is highly unprofessional to exoticize, joke or gossip about trans persons or any other person for that matter.

- **Enquire, not assume**

  Don't assume what it means when someone identifies as transgender. The transgender experience is diverse. Not every trans person has undergone a medical or surgical intervention that affirms their identity. It is better to sensitively ask the patient about how they define their identity and about their needs/goals regarding affirming the same, rather than assuming it.

- **Build trust for preventive screening and high risk interventions**

  Being empathetic, sensitive and providing sufficient time for the provider- patient relationship to build, and brings in trust and safety. Once that is established, the health care provider can bring in preventive screening and high risk intervention appropriate to the patient's needs.

- **Mental health and queer affirmative counseling**

  As with any other patient, to provide holistic health care involving physical and mental health is the aim. Appropriate referral can be made to mental health professionals who have experience in queer affirmative counseling. Have a list of such counselors in your database.

Questions to reflect on:

1. Are there any inherent biases and stereotypes that you have, that may come in the way of caring for this patient?
2. If yes, how can you work on your judgments, biases and belief systems that may affect the quality of care you are required to provide?

Case 2:

You are serving in a Primary Health Care center in a village. A 45-year-old male, married, Hindu, farmer by occupation, comes with bleeding per rectum. He says that he suddenly had this bleeding. He gives no history of constipation, mass per rectum or any other complaints in the past or present. He was a little hesitant to give further information. On examination, his vital signs are stable and local examination reveals minor abrasions around the anus. Some whitish jelly-like fluid (semen?) is also found around the anal orifice with bleeding from the abrasions. Per rectal examination reveals a minor anal tear. On further probing, he says that he is gay and had anal intercourse following which he had the bleeding.

How would you approach this case?

Discussion:

While collecting data and information, it is important to look at the signs and symptoms with an open mind and ask questions that could help determine the possible cause for the presenting symptoms. In this case scenario, the patient's hesitation about disclosing his sexual orientation to a healthcare provider isn't uncommon for LGBTQIA+ individuals and is often due to past negative experiences.They have experienced negative reactions from doctors and nurses which include obvious embarrassment, nervousness, hostility, distancing, rejection and inappropriate psychiatric referrals that negate the autonomy of the patient. Here are some points to keep in mind:

- **Avoiding inaccurate diagnosis and inappropriate treatment** - The fear of disclosure of one's sexual orientation to a health care provider (HCP) may lead to inappropriate treatment. In this case scenario, the symptoms might have been treated as fissure in ano due instead, rather than a more accurate and appropriate treatment plan.
- **Maintaining confidentiality** - Many individuals may avoid 'coming out' to a health care worker, fearing a breach in confidentiality. It is the responsibility of the HCP to maintain confidentiality and privacy of the patient and protect their interests; while also motivating the person to provide preventive health education to their sexual partner(s).

- **Respecting an individual's rights and needs** is as important as providing medical care and support.
- **Avoiding stereotypes, homophobia** - Even if individual nurses and doctors are not prejudiced and seek to provide non-judgemental care regardless of the sexual orientation of a patient, they may inadvertently be affected by commonly held beliefs and stereotypes- for example, that LGBTQIA+ individuals do not have and do not want to have children, the idea that family life and relationships in the community are somehow less serious and less important than heterosexual attachments, etc. These kinds of stereotyping and labelling, which are defined in terms of supposed sexual acts leads to lack of recognising and understanding the needs of the individual. This narrow focus takes no account of the differences within the stereotyped group, and the fact that sexual relationships are part of, rather than all of, a person's lives, whatever their sexual orientation may be. It is this labelling, together with negative value judgements, which can lead to nurses, doctors and support staff making inappropriate remarks to patients. The person's illness or distress is further distorted when viewed through homophobic beliefs.

- **Avoiding medicalizing/ pathologizing sexuality; being aware of unique life stressors** - During most of the health care encounters , lesbian, gay, bisexual,pansexual and asexual individuals are at the risk of having their sexuality pathologised, and are vulnerable to inappropriate psychiatric treatment, such as unwanted and ineffective 'cures'. Equally, when they do have mental health problems, the way these interact with the stress of being homosexual in a homophobic society may not be addressed at all.

- **Educating oneself about specific medical needs of the community** - In addition to the disparity in accessing healthcare, there are other health indicators and diseases that can disproportionately affect the LGBTQIA+ community. For eg: Gay and bisexual men are at increased risk of HIV infection, lesbian and bisexual women are at increased risk of breast cancer (increased risk as a result of " cluster of risk factors" behaviors that are a result of the stress and stigma of living with homophobia and discrimination), increased incidence of physical, emotional and sexual abuse and increased risk of mental health issues like anxiety and depression, substance abuse, addiction, and suicide. Awareness among health care providers about these existing disparities could result in a shift towards providing a more comprehensive, evidence-based, and humane medical care to the community.
- **Obtaining required training** - It is the responsibility of the medical profession to obtain the required training, and allay the fears of LGBTQIA+ community so they are not deterred from seeking health care and can have their specific health care needs identified and attended to, with safety and dignity, while maintaining confidentiality.

The wholistic health plan in this case scenario is to discuss with the patient the risks associated with anal sex, and to provide information on safe sex practices including condom use and HIV transmission

prevention along with the medical help required to treat his presenting symptoms. It is also important to explore if the sexual encounter was consensual. This would help to identify any abuse and to provide appropriate care.

Questions to reflect on

1. What are your perceptions and beliefs on sexual minorities? Are your beliefs scientifically true? Do beliefs honour the rights of individuals? Are any beliefs prejudiced assumptions arising out of cultural and religious affiliations?
2. Identify the knowledge gaps in providing high quality unbiased non judgemental health care to LGBTQIA+ community. How can you fill this gap?

Case 3:

You are posted as a resident nurse in a reputed college. Two students aged 19 years, who identify themselves as gender fluid and enjoy each other's company, have been spending a lot of time with each other. They come to you asking about the feelings they have for each other.

How would you respond to this situation?

Case 4:

A patient who self-identified as intersex, heterosexual man approaches you with a question. He has been asked to go through with gonadectomy and his counsellor has told him it will be better if he goes through necessary steps to live as a woman as it will ensure continued support from his family. He is asking you whether having the gonadectomy will make him feel like a woman and if he will automatically get attracted to men.

What will you say to this person?

5. Gender Bias

Case 1: A 55-year-old lady brings her 19-year-old daughter for a virginity test (hymen check) before her wedding. She is getting her daughter married to a 32-year-old man who is living in another country. The mother says that the girl is of "bad character", always playing with boys and not listening to anyone. On testing, the hymen is found to be ruptured.

How will you proceed in this case?

Who should give consent for an examination?

What questions will you ask the girl?

What will you say to the mother?

Discussion:

"Virginity" testing refers to the practice of evaluating through a physical examination (inspection and palpation)of the hymen and the vaginal opening, to 'determine' whether the female has ever engaged in vaginal intercourse, with or without consent. Also referred to as hymen check, hymen examination or two-finger test, the purpose of this test is to determine if the female is a virgin or not.

Ironically "virginity" is not a medical term and there is no standard definition of it in medical literature. Virginity is not a medical condition requiring a diagnosis or treatment. Virginity is a social norm that links sexual purity with the honour of an individual woman (a notion specific to girls and women only), and by extension an idea of 'property' and 'ownership' is linked to the honour of her family and community, and even the country. It has assumed social significance because of traditions, customs and religious beliefs. Virginity is celebrated as a virtue, and women are expected to be 'virgins' prior to marriage. Virginity is a social construct that is being effectively used by a patriarchal society to control female sexuality. Most of the time women are forced to take the test and even if the woman consents to it , it's because of the pressure exerted on her to prove her chastity.

When we look at virginity testing as a clinical tool, it lacks reliability and has a very low predictive value. The hymen could remain intact after intercourse and it could show signs of tear without the act of intercourse. Activities like sports, cycling, horse riding, accidents and even the use of tampons can cause tears in the hymen. Depending on the elasticity of the hymen, its vascularity and the size of the opening in the hymen, the hymen may not tear during sexual intercourse.

It is unscientific for a health care provider to use a test which is prone to many false positives and false negatives.The moral obligation of a nurse/ health care provider is to inform and educate the patient and the family that it is simply impossible to do what is being asked. Since there is no scientific basis upon which a health care provider can certify that a particular woman is a virgin or not, it would be unethical for a health care provider to concede to such a request.

Non- maleficence which means “do no harm” to the patient is one of the ethical principles on which medical practice is grounded. Virginity testing has proven to be physically, psychologically and socially disastrous to the person. Those who are subjected to a virginity test are susceptible to anxiety and emotional trauma. Many women have reported feelings of fear and emotional distress related to the invasion of their privacy and violation of their bodily integrity. WHO describes forced virginity tests as a form of sexual violence against women. Where the test is performed as a mandate of a legal process (as in assessing non-consummation of marriage in divorce suits), it can traumatise the individual further and can lead to deleterious long-term effects. The Supreme Court of India, in Lillu Alias Rajesh & Others vs State Of Haryana (2013), 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*[2] issued by the Ministry of Health and Family Welfare, “per vaginum examination, commonly referred to by laypersons as 'two-finger test', must not be conducted for establishing an incident of sexual violence and no comment on the size of vaginal introitus, the 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.”

It is also important to remember that a child above 12 years is deemed capable of giving consent for a medical examination. No medical examination should be carried out on children between 12-18 years of age without their consent.

In most cases a virginity test is asked for precisely because someone or some group of persons, other than the individual tested, has an interest in knowing the result. Being put in a situation to have to ‘prove’ to others that one is a virgin, may result in experiencing a sense of powerlessness, fear, humiliation, worthlessness and lack of the right to self-determination. Harm can be caused by nurse/ physician participation in an act that is humiliating and degrading, the purpose of which is to intimidate, control and oppress women.

Virginity testing is a form of gender based oppression and discrimination, as well as a violation of fundamental human rights. A health care provider by performing the testing gives legitimacy to it and inadvertently becomes a part of moral policing. Health care providers should resist pressure from any source to use medical skills in ways that attempt to legitimise violations of human rights.

A gap exists between current medical evidence of virginity testing and medical education and training. As a precedent to the nation, the Maharashtra University of Health Sciences (MUHS) has approved the removal of the topic ‘signs of virginity’ from the Forensic Medicine and Toxicology textbook for second-year medical students from the academic year 2020 (Mathew, 2019). Revision of syllabus of nursing and

[2] http://www.mati.gov.in/docs/GG%20cell%20materials/womens%20rights/Guidelines%20and%20Protocols_MOHFW%20(1).pdf

other health care providers to eliminate any recommendations of virginity testing and educate on the lack of scientific evidence for and possible harms of its use is required.

As part of the global call to eliminate violence against women and girls everywhere, on 17 October 2018, The UN Human Rights Office, UN Women and WHO (2018) issued a statement stressing that 'virginity' testing was unscientific and a violation of human rights and that 'this medically unnecessary , and ofttimes painful, humiliating and traumatic practice must end.

In this case scenario, rather than refusing outright to conduct such an examination, the opportunity could be used to educate the mother and the daughter on female anatomy, sexual rights of a person, gender bias and moral issues associated with such a test, as well as the scientific reason behind not doing such an examination. The health care provider could encourage further visits to discuss this further. The practice is culturally and socially deep-rooted and it is important to keep that in mind while talking about it. Many discussions with the patient, family, or community members might be required to convince them about the brutality of such testing.

Case 2: Your neighbour, a 17-year-old who is entering 12th grade comes to you for advice. The teenager wants to take up a B.Sc degree in nursing and pursue a career in nursing. They approach you by asking questions about career paths and job options. They also say that their family is not very supportive of the decision and think that nursing is not the right path for them to choose. Their father is totally against the decision saying that the person will be looked down on in the family and friends circle, if they choose to do nursing. Many of their friends are also saying that nursing is not a profession for their gender. So the teenager is confused and seeks your advice to help him out.

What will you say?

What points/ aspects would you like to discuss?

Case 3 : You're meeting a male colleague who graduated along with you and is working/practising as a nurse in a hospital. After spending some time with him, you realise that something is bothering him and he looks dejected. When you ask what it's about , he says that he is not happy being a nurse and is thinking of shifting his career. He says that he is constantly stressed. Some patients prefer /ask for a female nurse and say that he is not caring enough. Recently he has applied for a nursing position and in the interview, he was told that the preference is for a female nurse and if the post is not filled up then they would give him a call. He feels dispirited.

What will you say?

What points/ aspects would you like to discuss?

Case 4: A colleague of yours, a 25-year-old female nurse wants to pursue her M.Sc in nursing and specialise further. She has secured admission in one of the reputed institutions. But her family is against her doing higher studies. They want her to settle down, have children, stay at home and look after them.

She has been married for 2 years and is 6 weeks pregnant now. She doesn't feel ready to carry the pregnancy and is contemplating an abortion. She hasn't informed her husband or any other family members about the pregnancy as she knows that they will definitely not allow her to take up further education at this juncture.

What will you say?

What points/ aspects would you like to discuss?

Questions to reflect on:

1. Has gender bias affected you as a student/ practicing nurse?
2. Does gender play a huge role in nurses fulfilling their responsibilities? Is it the same for doctors?
3. How can you be more gender equitable and sensitive to the gender related issues that nurses face?

Rights and laws in the context of discrimination and violence

Case 1: 26-year-old female patient, presents to the casualty with swelling in her right forearm and abrasions. X-ray shows fracture in both bones in the forearm. She gives a history of accidentally falling and injuring herself. But her medical records show repeated fractures . When you persuade her to talk, she says that her husband and mother-in-law beat her up almost everyday. She had an intercaste love marriage 3 years ago. Initially it was the husband's parents who insisted that dowry be given. The husband is participating in the harassment in order to get a house in the new city to which they have moved. She says that she doesn't know what to do.

How can you support her?

Case 2:23 year old migrant working as a daily labourer has three girl children aged 5, 3.5 and 2. She is pregnant and has come to you with an ultrasound image asking you if you can tell her the sex of the child. When you tell her that it is illegal to tell her, she breaks down and says that her family will kill her if she gives birth to another female child.

How can you support her?

Case 3: - You are posted in the labour ward. As per hospital practice, a paediatrician is present for all deliveries. A particular paediatrician frequently requests one specific nurse/ANM to assist him in neonatal care. He uses sexually explicit language towards the nurses and frequently verbally abuses other nurses. He is asking specifically for a nurse to come with him to take the child to the Neonatal ward. You notice that the nurse he asks is very uncomfortable. The doctor puts his hand on her back as he guides her out of the labour room. The nurse wants to complain about it to the POSH committee but her colleagues, especially seniors, are saying that she shouldn't complain otherwise it will affect both parties and their careers. And nothing very bad has happened. Also, the paediatrician's parent is a member of the hospital management committee and nothing good will come out of complaining.

How do you think you could support your colleague in this situation?

Discussion:

Nurses constitute the largest group of health care professionals, providing care from ICU to PHCs and from neonatal to geriatric care. With such a diverse breadth and depth of work that they do with people, nurses and health care providers hold a huge social responsibility. Many of the social and cultural issues have a direct impact on the health and well being of the individual and, in a circular fashion, affect society. By advocating for social change, health care professionals can influence the well-being of not just individuals, but society as a whole.

Assuming social responsibility:

- Understanding basic human rights
- Being aware of the laws pertaining to the protection of vulnerable populations. For example, knowing about the Prohibition of Dowry Act and Domestic Violence Act can place a nurse in a better position to help the female patient in the first case scenario described above. Similarly knowing Prevention of Sexual Harassment at Workplace (POSH Act) can help one understand and use the redressal mechanism in place in their work environment.
- Networking with other social systems- government and non-governmental organisations working at the field level, so that the victim can be referred for appropriate support. Eg: Having a directory of contact details of empathetic police, lawyers, social workers, counsellors, mental health professionals, NGOs in the locality who could provide support.

6. Self-esteem and body image

Case study 1:

A 30-year-old male patient belonging to the upper-middle class presents frequently to the OPD with different symptomatology. During this visit he was presented with complaints of persistent tiredness. He has been evaluated completely and no organic reasons for his complaint could be found. When you sit down with him and explore his history further, you understand that he has been feeling stressed and anxious for the last few months.

Exploring his psychosocial life in the last few months reveals that he was diagnosed to have vitiligo a few months back. It started as small patches of discoloration on his arms and feet. Initially, he used long sleeve shirts and socks to cover up the patches, later it spread around his mouth, cheeks and scalp and he felt helpless about it. He is under the care of a dermatologist.

You understand that he is concerned about the patches, he fears that his friends and colleagues might avoid him because of that. Hence he has been avoiding meetings and social gatherings. His relationship status is single and his parents are using his old photograph in the matrimony site to search for a bride. He avoids meeting his parents too.

Discussion:

Vitiligo is a common skin condition that presents with depigmented skin patches. It is a benign condition and it alters the physical appearance of the person. Any condition that changes the appearance of a person can cause an immense psychological impact.

Even though the disease process is benign and causes no biological impairment, it can directly affect the self-esteem of the individual. Society and culture that gives significant noteworthiness to the appearance and colour of the skin can put tremendous psychological pressure and add to a patient's suffering. Patients with vitiligo may suffer from anxiety, depression, frustration,and social phobia. They often experience fear and embarrassment when meeting people. Their interpersonal relations and sexual relationships may be affected as well.

In this case scenario, it is evident that the patient is distressed about the discoloration. His attitudes and beliefs about the disease, fear of stigmatization, negatively affected self esteem, lack of support and loss of coping strategies lead to his stress and anxiety. This might often present as somatic symptoms for which he has been seeking medical help on and off. All these issues have to be addressed in the treatment plan. His low self-esteem and hence lower self-confidence and fear of stigma affect his quality of life - personal, career and social life.

Treatment plan:

- Discuss with the patient the pathology and progress of the condition. It is important to help him understand what it is, how it affects physical and mental health and the treatment options.

- Discuss treatment options and coping strategies (viz cosmetic camouflage) that might be of help.
- Discuss with the patient how negative self esteem and body image can affect one's mental health and overall quality of life. Support the patient in identifying the negative beliefs and thoughts he has about the disease. Support him in identifying positive beliefs and thoughts about himself.
- Refer the patient to counsellors / cognitive behaviour therapists.
- Screen the patient for depression and anxiety. Refer to a mental health professional if required.

Questions for reflection

1. How would you rate/score your self esteem?
2. What is it that you love the most about yourself?(can be a quality, skill, behaviour or appearance) Introspect how the particular trait that you love the most makes you feel.
3. What are your strengths and weaknesses?
4. How can you increase your self confidence?
5. What life skills do you think are important for your professional success?

Case 2: A 20-year-old girl comes to you for treatment with acne. She informs you that she is being teased at college for her acne. She has found someone she likes and wants them to be interested in her. She is going drinking and smoking with her friends and her crush. She is very concerned about being rejected because she feels she is too fat (she is 5 feet tall and her weight is 52 kgs). Her crush has also commented several times how he likes very thin girls. She has reduced her food intake and can't concentrate on her studies.

What will you say?
What aspects of this situation would you like to discuss with the girl?

Case 3:

You have been recently posted under a senior staff nurse in the Operation Theater (OT). The senior staff is kind, caring and empathetic and teaches you all the basics. You feel comfortable working with her. As days go by, you notice that the senior staff becomes tense and stressed out on particular days of a week. She becomes irritable and unapproachable. She also keeps changing the OT schedule. You are worried and ask her about it. Reluctantly she says that a particular surgeon always speaks harshly to her and finds fault for no reason. He doesn't behave the same way with other OT technicians. She feels that she has done something wrong to receive that treatment from the surgeon. She really finds it difficult to work with him and avoids his OT schedule. When the situation demands that they work together, she feels frightened and dismayed which is further reducing her productivity.

7. Attitude towards sexual health and issues with reproductive health

Case 1: You are the nurse posted in a fertility and assisted reproduction center. A couple is under investigation for failure to conceive. The husband approaches you separately to know the results. After knowing that his results suggest that his sperm count is low and that could lead to infertility, he requests you not to disclose this to his wife and his family. He also cites that since his wife already has polycystic ovaries and is being treated for the same, it makes no difference if his condition is not disclosed.

How will you respond?

Questions to reflect on:

1. Do the social implications of infertility affect the husband and the wife in the same manner?
2. Why does the male partner want to hide his condition that could be contributing to infertility?
3. As a healthcare provider, what is your role? Will you concede to his request?
4. What could you do to take care of the mental health of the couple?

Case 2:

A 55- year-old woman came to the casualty with pain in her upper back since the morning. She was sent home from another hospital with antacids earlier in the day, but the pain didn't improve. She has a sense of impending doom. She has a family history of coronary artery disease. The ECG taken in the casualty showed evidence of Myocardial Infarction. She was shifted to the ICU immediately for further care.

Question to reflect on:

1. Why do you think she was not evaluated further in the first hospital she went to?
2. Does the gender of the patient play any role in providing emergency care /health care in general?
3. In which other health care settings does intrinsic gender bias play out?

Case 3:

A 35-year-old woman has come to the OPD to get a prescription for her antidepressants because she is travelling abroad to attend a conference. She is HIV positive and was divorced by her husband after she tested positive. She says that she has undergone two abortions because her husband did not want a child. During the second abortion, she had complications that required blood transfusions. She tested HIV positive after that. She has no history of risk factors besides this. Her ex-Husband's status is said to be negative.

How will you support the patient?

How has gender bias affected the sexual, reproductive and mental health of this patient?

8. Sexual Development in Children and Adolescents

Case 1:

You are in the paediatric OPD - vaccination clinic. A father, who is a lawyer by occupation brings his 6 year old male child for vaccination. While you are assessing the child, his father starts conversing with you. He complains that his son touches his genitals all the time. When you ask what he means by " all the time" he answers that the son touches his genitals while watching TV, sometimes while eating and once even his teacher complained about it. He has observed that his son holds his genitals sometimes while sleeping too. The father is clearly worried about this behaviour of his son and seeks your help.

1. Is this normative behaviour or a concerning behaviour as the parent perceives it?
2. What questions do you want to ask to distinguish between normative and concerning behaviour?
3. How would you address this concern of the father?

Discussion:

Sexual behaviors exhibited by children can be a source of anxiety to parents as most of the time parents are unaware of normal sexual development. Often the Primary Health Care Providers (HCP), including nurses, maybe the first professionals that parents approach with their concerns. It is imperative that primary care providers understand childhood sexuality and normative sexual behaviours of children and respond appropriately when sexual behaviours of children are brought to their notice.

Normal Sexual behaviours Vs Concerning Behaviours:,

It is important to distinguish between the normal and concerning/alerting behaviours that could point towards child sexual abuse.

A detailed behavioral history of the child has to be obtained, including the sexual behaviors. It is also important to explore the frequency of the behavior, whether the child can be redirected from the behavior to another activity, whether the child can limit the behavior to appropriate places and times, and whether the sexual behavior is causing a disruption in the child's life.

A psychosocial history of the family should be obtained to look for potential sources of stress. Any history of sudden or significant change in a child's behavior should be asked for. This would provide adequate information to ascertain if the expressed behaviour is normal/ appropriate for age.

It is important to educate parents regarding sexual development in childhood, and how it constitutes a normal part of a child's development. Reassuring the parent, providing information with normal sexual developmental milestones and equipping them with a vocabulary to communicate openly with their children is required. If the behaviour exhibited by the child is concerning for the age, further evaluation to rule out sexual abuse needs to be done and appropriate referral for the same is advised.

Nurses as Educators:

In a paediatric OPD/ vaccination clinic where the nursing staff has access to children and their parents, they can utilize that time and opportunity to impart personal safety education to the child to recognise and report abuse, and empower the parents and caregivers to respond to abuse. Nurses can double up as personal safety educators as they have access to the child all along with their growing up years.

Introducing unambiguous, clear vocabulary to name the body parts - as in vulva/penis, genitals or susu place and potty place would be the first step. This can be done by displaying a chart depicting all body parts (including the genitals, buttocks and chest) in the waiting room and playing a "call out the body parts" game with the child. As the nurse utters the words genitals/susu place, potty place or vulva/penis with ease, the child might pick up on that. Involve the accompanying adult(s) in this.

A nurse could ask a child's permission before checking a child's vital signs or taking anthropometric measurements. Following this, they can discuss how the child is the 'boss' of their own body and that is why the nurse asked for their permission to check their vital signs. By doing so, the child is introduced to the concept of body autonomy and personal space.

As the child comes back for a review, the nurse could use that moment to talk about body safety rules. This could be given in a simple language, just other safety rules (e.g. road safety rules) with children. The personal safety rule can be introduced to a child in the following way:

Our body is our own and we can care for it.
We can follow personal safety rules about clothing , touching and talking..

A. **Clothing -**

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."

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".

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:

1. We don't:
    1.1. Speak about others' or our own bodies in a way that makes others feel uncomfortable/ sad/ confused/ scared.
    1.2. Talk or joke about genitals casually with others.

2. Nobody should:
    2.1. Speak about our bodies, in a way that makes us feel uncomfortable/ sad/ confused/ scared.
    2.2. 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. 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.

The child can then be introduced to the **personal safety guide: No-Go-Tell**

We follow body safety rules – for ourselves and others. If someone breaks your body safety rules, touches, looks at or talks about your private body parts, or makes you feel uncomfortable, you can say NO to that person and runway/ GO away from that person. You can TELL this to an adult you trust. Remember that you can always come and talk to me as well about anything that is discomforting or confusing.

Empowering the parents

Nurses can support the parents in understanding the normal sexual development of a child by discussing it with them, providing pamphlets that have normal and concerning behaviours for the age and displaying posters of the same in the waiting area .

Discussing with the parents the importance of answering children's questions on sexuality by stating the scientific facts in simple age appropriate language that the child can understand will go a long way in breaking the silence around sexuality. Words like mama's baby cell, daddy's baby cell, baby house, baby birth passage, susu place etc can be used with young children. Bala Sauraksha and Surakshith App ,which is available for free download on Android devices, gives an overview of how to approach such questions asked by children.

Talking to the parents about personal safety rules and safety guides and encouraging them to reiterate these rules with the children in day-to-day discussions can help normalize discussions around personal safety, consent and respect for each other's bodies and social rules. Distributing pamphlets containing personal safety rules and safety guides can also be done.

Questions for reflection

1. Would your approach be different if the child is a female and the parent reports such behaviour?
2. Would your approach change based on the literacy status of the parent?

Case Study 2:

You are a School Health Nurse placed in a CBSE high school. You are asked by the school to conduct a class/session on adolescent health, during which 9th standard students ask the following questions:

“What are flavoured condoms? What is a morning after pill? How is HIV transmitted? What is the meaning of STD?”

1. Is this normative behaviour?
2. How would you handle this situation?
3. What is the difference between sex education and sexuality education?

Discussion:

In this case scenario, adolescents asking questions about contraception and STI is normal behaviour. Teens are curious to know more about sexuality and related topics and most of the time the information that they get is from peers or from media and magazines, or the internet. This information is often skewed and incorrect. It becomes imperative that they have access to comprehensive sexuality education from a trusted adult to negotiate the changes and manage the emotions that adolescence brings, in a healthy way.

School nurses are well placed to promote high-quality comprehensive sex education to children and young people. Parents and teachers are often seen as authority figures whereas the nurse is an independent health professional. This might give comfort to the teens and young adults to approach a nurse to seek accurate information on sexuality. This opportunity can be used to deliver unbiased, scientific information in an age-appropriate vocabulary. It is the right of an adolescent to access health education encompassing sexual and reproductive health . It is the responsibility of a healthcare provider to respect their rights and be non-judgemental in delivering the information while emphasizing the need to respect each other's bodies, each person's rights and their wishes.

Providing sexuality education:

1. Talk about the structure and function of reproductive organs bringing in the aspect of respect for all parts of one’s body and its functions, and safety.
2. Provide information on the biological basis of physical, mental and emotional changes happening in adolescence. Providing them with information to handle the same.
3. Discuss diversity in sexual orientation and gender identity
4. Discuss romantic and sexual attraction, relationships, bullying and teasing and high-risk behaviours.
5. Discuss contraception and STIs
6. Discuss pornography and its effects
7. Provide a safety net by keeping the communication channel open

Questions to reflect on:

1. Would the gender of the student who asked the question affect/ change your approach in handling the situation?

2. Would the religious affinity of the school (Hindu /Muslim/ Christian- Catholic/Protestant) change or affect the way that you deliver sexuality education? Would you withhold certain information considering the religious affiliation of the school?
3. How different your perception, understanding and expression of sexuality would be, if you have had comprehensive sexuality education right from the beginning?
4. At what age should sexuality education begin?
5. Who, in your opinion, should be the primary educator of sexuality?

Case study 3:

A 62-year-old female patient, who is otherwise healthy with no significant medical or surgical history presents to the OPD with complaints of itching in the vagina for 2 days. There is no history of vaginal discharge. She attained menopause 9 years ago and has been managing well. She is on oral calcium supplementation. As a routine , you ask about her sexual history and with much hesitation, she says that she had intercourse 2 days back, and that is when the itching started.

Questions to reflect on:

1. While collecting data,would you have asked for her sexual history? If not, reflect on why?
2. Why do you think she hesitated when describing her sexual encounter?
3. How do you feel knowing that a woman of 62 years old has had intercourse recently? How would you feel if she was 72?
4. How would you provide health care in a non judgmental manner, keeping aside your biases, if any?
5. Would holistic health care be possible if the health care provider carries and perpetuates stigma?

9. Attitudes towards Sexuality

Case 1: You are the community health nurse under the National Rural Health Mission, and placed in a block PHC. On one of your field visits to a village, you see the village head nurse (VHN) giving some medicines to a 52-year-old woman for fever. When you ask for the history of the patient, you understand that the patient has been having a fever on and off for the last 15 days. She has been reluctant to seek care and is managing with home remedies and drugs purchased off the counter from pharmacies. When you point to the VHN that the patient needs further evaluation, the VHN warns you that the patient is a sex worker and the villagers don't want to see her being treated here. She also starts speaking in a derogatory manner about the patient.

As a Community Health Nurse what is your role in providing care to this patient? Why do you think there is a delay in seeking care for an ailment that can most probably be easily diagnosed and treated?

Discussion:

(Reflecting on their bodies, their sexuality, sexual language, gender)

In this scenario, the VHN, rather than taking a complete history of the patient and creating a health plan for her, does not take her seriously and disregards her complaints. The patient was also hesitant to seek medical help, managing her symptoms on her own for the last 15 days. Both these attitudes stem from the fact that she is a commercial sex worker (CSW).

Access to healthcare is often prevented by the general repressive moral attitudes towards sexuality and sexual well-being. Commercial sex workers often experience or anticipate experiencing discrimination and negative reactions from providers in healthcare settings. Generalized social stigma leads to considering CSW as outcasts, perpetuating discriminatory attitudes and behaviours by healthcare providers, resulting in refusal of treatment or delay in providing the required care. The biased attitudes of healthcare providers, humiliating experiences, receipt of unequal treatment, longer waiting times, breaches of confidentiality, and even sexual harassment deter sex workers from seeking health care, leaving their health needs unmet.

Sex workers have more acute primary care, sexual, reproductive, and mental health needs as a direct consequence of their marginalisation and social exclusion and risks of being a sex worker. CSWs form a marginalised and vulnerable population in the community, who need unbiased support from health care professionals.

By the nature of the work, the patient in this case scenario is also prone to occupational hazards. As a public health worker, the nurse needs to minimise such harm to the patient and others involved. Thus it's important to enrol the patient in appropriate preventive programmes under the National AIDS control program and offer support by connecting her social work professionals and organisations working in the field.

Reflecting on one's attitudes and beliefs: Our attitudes produce different levels of cognitive and emotional influences which then impact our behaviour. Social, cultural and religious environments shape an individual's attitude towards sexuality (of the self and that of others). In a society that views sex as an act of procreation only and looks down at varied/diverse sexual behaviours and expressions, and growing up with no exposure to comprehensive sexuality education, it is not unusual for a person to have a negative attitude towards sexuality. In order to provide a non judgemental, equitable and high quality health care to the vulnerable population, it becomes imperative that the health care provider reflect on their attitude and factors affecting it. It is the attitudes, ideas and beliefs that shape the nurses' approach to job duties. In this case scenario, it is the attitude of the VHN that restrained her from giving what is needed to the patient.

Strong attitudes can also interfere with the acquisition of knowledge and nursing skills. Thus it becomes mandatory for the nursing professionals to be aware of their attitudes, beliefs and values and align those to exhibit professional behaviour.

Upholding patients' rights and principles of medical care: Increased knowledge is said to produce more liberal attitudes and increased comfort when dealing with sexuality in different situations, including nursing. This is not to suggest that nurses should be liberal or neutral in their opinions about sexuailty, but in order to provide a non-judgemental environment they must be able to acknowledge their prejudices and personal biases and be able to separate them from professional judgement. Awareness about the interest of the patient rather than the personal interests can give rise to a high degree of self-control and objectivity in one's professional behavior. In this case scenario, the VHN talking about the patient in a derogatory manner negates the confidentiality and respect for patients that are supposed to be held high by the health care professionals.

To provide dignified, empathetic and quality healthcare to all patients, free of any discrimination is what the health care provider should strive for.

Questions to reflect on:

1. What is your attitude on sex and sexuality? How are your beliefs and values affecting or contributing to your attitude towards sexuality?
2. Are your attitudes on sex and sexuality favourable or unfavourable to provide an unbiased, non judgemental health care environment?
3. What could be done to prevent any unfavorable attitudes colouring/masking the professional behaviour in the nurse-patient relationship?
4. Do you think that your attitude and behaviour affects the nurse-patient relationship? Would the patient trust you, if they feel that they are being judged by you?
5. What attitudes and behaviours would help in building and maintaining a healthy nurse-patient relationship?

Case 2:18-year-old boy has come for regular health checkup during summer vacation before his summer retreat/camp. You have seen him every year for the last 15 years. He tells you that he is excited to go to the camp with his secret girlfriend. He is persuading her to have sex (she is 18). He asks you how he can get condoms, and how can he ally her fears around sex.

What will you say?
What aspects of this situation would you like to discuss with the boy?

10. Sexuality and Disability

Case 1: You are the nurse in a family clinic and have been the health care provider for this family of three - parents and their 11 year old daughter. The mother approaches you asking for ways to prevent menstruation in her daughter who has Down's syndrome with moderate intellectual disability. The child hasn't attained menarche yet. She attends school and is in 4th grade. You see that the mother is anxious and convinced that the child will not be able to manage menses and will suffer because of it.

How will you address her concerns?

Discussion: The parents who are the primary caregiver approach the healthcare provider asking if menstruation can be prevented. The parents perceive it as another hurdle in caregiving and believe that the daughter who has intellectual impairment will not be able to manage her menses.

Need for information about puberty: All adolescents benefit from information regarding puberty, to understand what is happening in their body, what to anticipate and how to manage these changes. This applies equally to adolescents with intellectual disabilities. Information should be provided in ways that are accessible and appropriate to the level of intellectual development. Adolescents with intellectual disabilities require clear, direct information, and opportunities to practise new skills.

Proactive counselling and education can be initiated with the onset of puberty, even before the start of menses.The nurse can assist with providing guidance and resources to normalise menstruation as an expected part of life and support the adolescent and the caregiver in understanding different options available to manage menses. The adolescent can practice using the same much before menstruation actually begins.

Discussing menstrual management with adolescents with disabilities: The health care provider can address the menstrual cycles including the regularity and the flow, biology of menses and associated symptoms like dysmenorrhea, behavioral and mood changes. Strategies used for menstrual management depend on the degree and type of the impairment of the individual, functional capabilities of the individual, the level of dependence on the caregiver and life skills achieved by the adolescent.

- Introducing various menstrual products like sanitary pads, period proof panties, tampons and menstrual cups and helping the individual choose a product that suits them (depending on the type and severity of the impairment) is a significant step.
- Tactile books and menstruation kits (Thukral, 2012) could be used to facilitate individuals with visual disability to understand menstrual management.
- Positioning of the product in such a way that it causes least discomfort, minimises leaks and provides maximum absorbency has to be discussed.
- Adolescents with intellectual impairments benefit from having "period practice days" or "pad practice" wherein the adolescent is taught to wear the menstrual hygiene

product for a specific amount of time for a few days even before menstruation starts. This helps the adolescent get used to the product before experiencing actual menstruation.

General Principles for Approaching Menstruation in Adolescents With Disabilities (Quint & O'Brien, 2016)

1. Initiate anticipatory guidance before the start of menses

2. Discuss concerns around sexual education and expression

3. Help families with guidance on safety and abuse prevention

4. Start menstrual management on the basis of issues related to interference with the teenager's activities, taking into consideration patient medical needs and mobility concerns

5. Help families understand menstrual management options and the benefits and limitations of the different methods

Table reproduced from: American Academy of Pediatrics guidance for the clinician.

Supporting adolescents with intellectual disabilities manage menstruation: If repetitive, accessible menstrual management information and training is provided regularly to the persons with intellectual impairments, they may get a deeper understanding of cultural and social norms and be better able to manage their menstruation more independently (Wilbur et al., 2019)

- Adolescents with sensory and intellectual impairments may find it difficult to communicate the location and severity of pain associated with dysmenorrhea. This might reflect in their behaviour as temper tantrums, crying spells, moodiness, etc.
- Premenstrual syndrome (PMS) is also found to be high in prevalence among individuals with autism spectrum disorder (Obaydi & Puri, 2008) .
- Changes in behaviour that occur cyclically with the menstrual cycle, may indicate dysmenorrhoea or premenstrual syndrome. Charting behaviour changes or maintaining a symptom calendar can help identify this.
- Discussing pain and PMS beforehand and providing tools to manage the discomforts (like warm packs, analgesics) can reduce negative reactions to menstruation

Menstrual suppression, surgical interventions:

Menstrual suppression may be an option when the management of menstruation becomes difficult and significantly impairs the quality of life of the individual. Hormonal methods like oral contraceptives, progesterone implants and IUDs are some of the options available. The risk benefit ratio of these methods with respect to the impairments and health conditions of the individual has to be assessed. Appropriate referral to experts can be made to discuss this further. Similar to the use of suppressive

hormonal treatment in the population without disability, the decision to suppress menses in persons with physical disabilities is based on whether the patient believes this will help them better manage their life. In contrast, when families of persons with severe intellectual disabilities ask for menstrual suppression, the issues are more complicated if there is no clear medical indication, such as heavy bleeding.

Parents may ask the health care provider about surgical interventions, especially endometrial ablation or hysterectomy, especially if the person they are caring for has severe intellectual disabilities. Surgical interventions in these cases have clear ethical and legal implications because many patients with intellectual disabilities may not be able to give informed consent.

Addressing the concerns of the parents/ caregivers: Concerns of the caregivers/parents have to be explored. Menarche signals sexual maturity and many times concerns about menses and its management could be entangled with complexity of sexuality, fertility and vulnerability to abuse. These are separate issues. It is important to explore, understand and address the presenting problem, as well as the underlying and related concerns. Menstrual management training should be given to the caregivers as well.

Education around sexual behaviours and expressions, intimate relationships, sexual health, safe sex practices and contraception should be given to the adolescents with disability as well as their parents and caregivers. This is important to break the myth that disabled persons are asexual and help them make favourable and healthy choices while exploring their sexuality and also prevent abuse and exploitation. Issues of vulnerability to abuse can be addressed by initiating personal safety education at an early age - as with children without disability. Aids like the Suvidha kit developed by Enfold can be used to teach personal safety, basics of reproductive health and sexuality etiquette to children and adolescents with disabilities.

Case 2:

A 19 year old male patient , who has suffered traumatic brain injury resulting in locomotor disability has come for his review. After the routine examinations and physical therapy, he requests to talk with you in private. He requests for education about sex and contraception.

What is your attitude and belief about disability and sexuality?

How would you approach his requests?

11. Sexual relationships

Case 1: 32 year old female patient presents to the OPD with 6 weeks of amenorrhea. She is accompanied by her partner. She says that her urine pregnancy test is positive and she wants an abortion as she is not intending to continue the pregnancy. She is otherwise healthy and has no comorbidities/ risk factors. The partner is also keen that the pregnancy is terminated.

As you start taking the history, you come to know that they are not married and have been living together for 5 years. They have approached another health care provider seeking abortion and have been denied services citing that they are not married and that abortion require spousal/parent's consent. The patient was also looked down on and shamed for premarital sexual activity. The woman's parents want them to get married and see this as an opportunity to get them to do so. The partner's parents want them to end this relationship if they aren't planning to enter into matrimony. The couple is not interested in getting married and are happy with their living arrangement.

What would you say to the couple?

The couple has been denied medical services because of their marital status. Is this acceptable?

Discussion:. In this case scenario, the couple has been denied abortion services citing their living arrangements, which is a social factor. It is a denial of their rights to basic health care. Marriage is considered a sacrosanct union and societal norms almost always endorse this. However, relationships are as diverse as humans. When two adults enter into a mutually consenting relationship which might or might not be suitable to societal norms, it is their personal choice. It should be respected. But health care providers who are also products of the same society, often frown upon any sexual relationship outside wedlock. This makes reproductive and sexual healthcare literally inaccessible to single women.

Avoid invasive, insensitive questions: The health care providers often use their personal moral lens and end up being judgemental of the patient's lifestyle. This reductive attitude also makes them ask unrelated, invasive and insensitive questions about patients' relationships like "Are you married?" or "Do you have any contact history?" instead of simply asking " Are you sexually active?". This is arising from the moralistic assumption that for a woman to be sexually active she has to be married. Also they often assume that the woman is unmarried if there are no visible signs of matrimony on her like a mangalsutra or sindoor.

Avoid being judgmental: When a single woman gives a history of being sexually active or asks for contraceptive advice, the health care providers often express shock, dismay, look down on her and may even reprimand her for her life choices. Many may provide unsolicited advice on the benefits of

marriage and child bearing and highlight these as a panacea for reproductive and sexual health issues, or exaggerate the complications and long term effects of termination of pregnancy in the first trimester.

Be aware of the current laws, respect sexual and reproductive rights of people: Another issue is denying abortions citing lack of spousal consent or parental consent when the patient is an adult, of sound mind, who can consent for herself. Many healthcare providers continue to carry implicit biases due to the prevailing social morals, and hence avoid vaginal examination or transvaginal ultrasound (when warranted for diagnosis) in single women. There is also a significant breach of personal autonomy when the health care providers assume a paternalistic and patronising attitude.

Women often choose to lie to their healthcare provider to avoid such embarrassment. They may feel compelled to hide information for the fear of judgements and shaming. The moralistic attitude of health care providers discourages them from having medical check ups which could be crucial for their health.

Responsibilities of health care providers: Providing unbiased non judgemental healthcare, meeting the patients needs and respecting their autonomy and integrity is the job of a healthcare professional, not moral policing. Health care providers can be sensitive in dealing with issues related to the sexuality of their patients and be mindful of the influence they can have on the way a patient cares for their sexual health. The HCP should be aware of the changing social norms and understand the risks/ill effects of citing moral reasons to deny medical care for sexuality-related issues which are the rights of the person as per our laws. This helps in providing better care tailored to the needs of the patients. Health care providers can acknowledge the important people in the patient's life, even if they fall outside of the expected conventional relationship structures.

To provide care that is best for the patient and help them make informed decisions on reproductive and sexual health is what is required of a healthcare provider. Health care provider's unique professional status and authority gives them a vantage position in society. By breaking stereotypes, destigmatising sexuality and spreading information on safe sex practices, they can be an agent of positive social change.

Case 2: You are posted in an emergency ward. A 35 year old female patient presents with a foreign body in the rectum. From the history you understand that she is married and she is exploring sexual relationships with other partners. Her husband is comfortable with the wife's relationships.

What is your attitude towards polyamory?

How would you create a nursing care plan for this patient?

Case 3: A couple in their 40s, in a heterosexual marriage since 15 years approaches you. They have a 10 year old child. The wife says that she recently discovered that her husband is homosexual. She wants him to undergo treatment to convert him back into heterosexuality.

How will you respond?

12. Sexual Preferences and Practices

Case 1: 28 year old female has come with her child for vaccination, accompanied by her husband. When she is in the doctor's room, the husband approaches you asking for advice. Husband says that they both were enjoying some 'rough' sex before the child was born. But now after the child is born, he doesn't want to participate in rough sex but his wife wants to. They are unable to decide if it is healthy to do so. He is thinking of taking his wife to a psychiatrist. When you explore what he means by rough sex, you understand that they practice bondage. He was ok with it but his sister-in-law has seen the marks of bondage on his wife's wrist and thinks he is abusing his wife. She is telling everyone that he is a bad husband. That is another reason he doesn't want to practice 'rough' sex anymore.

How will you respond to the husband?

Discussion :

Bondage and discipline, Dominance and submission, Sadism and Masochism (BDSM) (also referred loosely as 'Kinky sex') is a non-traditional form of sexual practice. It occurs between consenting individuals and is considered a healthy variant of many human sexual practices. Some may try BDSM for fun or experimentation occasionally. For some it may be the primary form of sexual expression and be an integral aspect of their sexuality. People of all genders or sexual orientations, of any socioeconomic status may practice BDSM.

BDSM activities and practices which are often designed to create intense experiences can pose a health risk. The social stigma associated with non-normative, alternative sexual practices often prevents people from seeking health care when needed. The fear of judgement and shaming prevents disclosure of their sexual practices to the health care providers.

Even if BDSM or kink practices don't fit into the health care provider's personal moral boundary, it is important that they support and help their patients to express their sexuality in healthy and safe ways. Creating a safe and non judgemental environment can encourage the patient to voice their concerns and questions. It is not necessary that the healthcare provider has to know everything about a particular practice. Just acknowledging that BDSM is a variant of healthy sexual practices and is normal between consenting individuals goes a long way in supporting the health and well-being of persons who are practicing these. Using inclusive language during conversation and asking broad open-ended questions like *"What else would you like me to know about your sexuality and sexual practices so I can take best possible care of you?"* when eliciting sexual history provides a safe environment for patients to open up (Waldura et al., 2016). This creates opportunities for sharing information with the patients while addressing their concerns. Asking the patient in a sensitive way about the cause of the injuries and paying attention to the language used to describe the situation can help uncover any unspoken concerns.

Discuss:

- If everyone involved in the practice has given enthusiastic voluntary consent to all the activities.
- Prevention of accidental/unintended injuries
- Harm reduction options to help the person explore activity modifications to accommodate for any medical conditions
- Testing for STI and blood borne infections
- Immediate care for any accidental injury

In this case, the husband initially consented to the sexual practice (bondage) but later he has become hesitant to the practice. At any point of time, consent of all the participating individuals is important. Encouraging the husband to convey clearly to his wife about his consent or lack of it and to talk to her about his fear of family being judgemental could help.

Case 2 : A 34 year old well educated business executive presents to the family clinic for a regular STI check up. He has a few sexual partners. He likes to keep it casual with his partners - frequently transpeople and/or sex workers. Parents are insisting that he get married. But he does not want to get married to any one person.

How would you care for this patient's health needs?

13. Pedophilia

Case : You are in a psychiatric OPD. A 50 year old professor has come for a regular counselling consultation. The doctor and the patient are speaking about his paedophilic interests. He watches digitally produced child pornography, and is managing with that. He avoids stress and manages his life in a more relaxed manner. His children are 17 and 20 years old now. He never sexually abused any child. He started seeing a psychiatrist when he felt sexually aroused by young children, several years ago, when he was working in a school. He stopped working at the school and moved to a university instead.

What are your thoughts and feelings regarding this man?

Discussion:

In this case, the patient has had sexual desires towards prepubescent children, which has caused him personal distress. The patient didn't choose whom he is attracted to sexually. It is also important to understand that not everyone who is sexually attracted to children acts on it. Not all pedophiles are sexual abusers. And not all child sexual abusers are pedophiles.

The behaviour/impulse to act on one's sexual urges can be managed and controlled with support, thereby preventing sexual abuse of a child. Individualised treatment and support has proven effective in preventing abusive behaviour. The goal of the treatment is to prevent the person from acting on pedophilic urges- either by decreasing the sexual arousal or by providing skills to manage that arousal. Psychotherapy (Cognitive Behavioural Therapy, other modalities) and at times pharmacological treatment have been found to be effective, if the person is motivated and committed to controlling their behaviour.

In this case, the patient was motivated. He has changed his work environment so that he has no access to children, minimising the stimulus. He is well aware of his sexual interests and urges and has sought out and adopted the right tools and skills to handle them.

Although personal informations disclosed by the patient to the health care professional has to be kept confidential, the Protection of Child from Sexual Offences (POCSO) Act 2012 makes it mandatory for adults to report to the local police station or Special Juvenile Police Unit if they have information regarding child sexual abuse. If in the course of treatment, a person with a pedophilic disorder discloses perpetrator behaviour, it is mandatory to report that. This is not considered a breach of confidentiality as it is mandated by law, and is done in the interest of protecting an intended child victim and harm reduction.

14. Sexual Violence against Adults

Case 1: A 21 year old female patient presents to the casualty with bleeding per vagina and multiple abrasions on the face and body. She is in pain and visibly distressed. On eliciting the history, it is understood that she attended her friend's party last night and her friend approached her and made some sexual advances. When she refused and clearly articulated that she was not interested, he forced himself on her. He raped her twice the same night, threatening to hurt her if she screamed. She fell asleep next to him exhausted and terrified of moving. She narrates the whole incident in detail with a detached demeanor.

Discussion:

Acute health needs of the sexual offence victim should be given priority in an emergency set up. Grievous life threatening injuries need acute medical and/or surgical care and under these situations the safety and well being of the victim takes precedence over all other considerations.

Be aware that people of any sex and gender identity and sexual orientation can be violated sexually. This understanding is very important in preventing retraumatization.

Please refer to the GUIDELINES & PROTOCOLS Medico-legal care for survivors/victims of sexual violence by the Ministry of Health and Family Welfare, Government of India, 19 March, 2014 http://www.mati.gov.in/docs/GG%20cell%20materials/womens%20rights/Guidelines%20and%20Protocols_MOHFW%20(1).pdf

A comprehensive kit, like Enfold's SAFE Kit can be used to collect all samples and materials in a scientific manner. The SAFE Kit - a Sexual Assault Medical Management & Forensic Examination Guide - also contains a ready reckoner for immediate medical support - the Sexual-Assault-Quick-Guide-Book – based on Guidelines and Protocols Medico-legal care for Survivor/Victims of Sexual Violence by MoHFW. (link http://enfoldindia.org/wp-content/uploads/2021/08/Sexual-Assault-Quick-Guide-Book-SAFE-Kit.pdf)

Nursing professional conduct:

- Need to believe and support the victim's description of the assault.
- Respect the victim as a person.
- Make eye contact with the patient.
- Establish trust and rapport
- Maintain confidentiality, dignity and privacy.
- Maintain non judgemental mannerism, gestures and facial expressions - avoid showing shock, horror, disgust or distrust when disclosure happens. Be calm and composed.

- Giving options to have standby attenders/caregivers while waiting or while being examined. Ensure that the victim feels safe in the environment.
- Engage in active, empathetic and reflective listening. Do not rush the patient. Use non judgemental language.
- Don't expect a victim to express one specific anticipated emotion like crying or outbursts of anger to trauma. Each individual is unique and different and may express emotions differently.
- Converse about the wide variety of emotional responses that can be experienced following a traumatic event and reassure that all such emotions are normal
- Ask questions out of concern, and not curiosity.
- Ask questions to establish facts that would be relevant to the health and safety of the patient.
- Explaining the medical screening examinations and medico legal procedures carefully before performing them - giving a detailed account of the procedure and why it is needed.
- Obtain informed consent before examining the patient.
- Provide information about Post exposure prophylaxis (PeP) , emergency contraception and STI testing
- Be aware of the long term consequences of sexual violence and explain the signs and symptoms to the patient. Encourage them to seek medical care if they experience any of those symptoms in the long term.
- Establish a follow up plan
- Provide information on how to access sensitive mental health professionals, preferably experienced in counselling in sexual trauma. The patient could opt for it now or later. Offering this service opens another avenue of support to the patient.

Supporting victims of sexual violence to deal with their emotions

(Table reproduced from: Guidelines for medico-legal care for victims of sexual violence: World Health Organization 2003)

Feeling	**Some ways to respond**
Hopelessness	Bring attention to what they may consider important in their lives. Focus on positive outcomes/ anecdotes. Help generate alternatives where they can't see them easily.
Despair	Focus on the strategies and resourcefulness that the person used to survive; on how far they have come, their achievements.

Feeling	**Some ways to respond**
Powerlessness and loss of control	Focus on choices and options one may have that is not readily visible to them. Make space for them, encourage them to make their decisions and choose how they want to be supported.
Flashbacks	Empathise with the pain, reassure that the episodes will likely subside, help with strategies to manage when they feel the flashbacks getting triggered.
Disturbed sleep	Empathise. Help with sleep time rituals that may take focus away from painful memories to more uplifting ones, and body relaxing methods.
Denial	Do not insist that one may be in denial. Respect how they feel about the situation at that time and be willing to wait and offer support when they may need it.
Guilt and self-blame	Emphasise that they are not to blame for what happened to them, that the person who assaulted them is responsible for the violence. Explain that such experiences can be confusing, may take away our ability to assess the situation and act to protect ourselves - so anything that we may have or have not done under these circumstances is not our fault.
Mood swings	Explain that these are common and will subside over time. Help with strategies to take care of themselves when they feel down or feel like behaving in a risky manner. Invite them to speak to a mental health professional if they feel unable to cope with the mood swings.
Numbness	Stay with the person in that state - do not force them to acknowledge emotions or try to evoke them. Explain numbness as a way of self-protection - and that one may be

Feeling	**Some ways to respond**
	able to let oneself feel again when they feel safe and confident in time.
Fear	Acknowledge the fear - let them know that it is a valid emotion given the circumstances. Reassure them of their safety in the current situation and your intent to support them and keep them safe. Be patient as they journey from fear to a sense of security and confidence.
Shame	Explain that one may probably feel ashamed if they had done something wrong. However, given that they were the target of assault, they have nothing to be ashamed of. Besides, shame does not reside in the body and nothing that happens to the body is a cause for shame.
Anger	A legitimate feeling and avenues can be found for its safe expression. Assist the patient in experiencing and expressing those feelings.
Anxiety	Reassure them of safety and support. Explain that such feelings are normal and are an outcome of having had such a difficult/ traumatic experience. Help them feel confident about themselves, feel less judged, feel okay about themselves and their bodies.

Case 2:

22 year old male, single, is interning in an architecture firm. He has been "dating" his boss for a couple of months. They have already "had sex". Since the last two months, she has been demanding that he come over after work. She has been verbally abusing him if he doesn't oblige to her demands. She has been threatening him with a bad letter of recommendation should he say anything about this in the workspace. He has made a suicide attempt. He has a history of child sexual abuse by a member of his family. He has approached you for support.

How will you develop a care plan for this patient?

Case 3:

38 year old female patient from an upper socioeconomic strata, who works as a creative director in a Multinational company, presents to the casualty with history of a slip and fall from a ladder chair (3 feet high) while she was trying to clean her house. She is married. On examination you see that the injuries are inconsistent with her history. When you speak to her her in private, she discloses that her husband had beaten her up and kicked her in the abdomen following a disagreement. She also gives a history of forced sexual intercourse following this. You learn that he often beats her up and forces her to have sex.

How will you provide care and support to this patient?

How do you view marital rape? Can the woman seek legal recourse in this scenario?

15. Sexual Violence against Children

Case 1: You are in the pediatric OPD. 7 year old female child has been brought to the OPD by the mother with complaints of incessant crying and increased temper tantrums for 2 weeks. When you elicit the history you understand that the child is irritable more so in the mornings and avoids going to school. The child is also avoiding food and when fed, retches and vomits the food. The child appears healthy otherwise.

When enquiring if the grandparents are the primary caregiver for the child, you come to know of the recent stressful event in the family. The child's father met with a road traffic accident a month back and has been hospitalised. The mother takes care of him in the hospital and is away from home for a long period of time and overnight. Hence the child has been under the care of the grandparents since then. Her elder cousin who lives across the road helps out by dropping and picking up the child from school.

What could be the causative factors for the child's behaviour?

Are the child's symptoms and beahviour suggestive of sexual abuse? If yes, which of the behaviours could they be?

Discussion:

Child sexual abuse (CSA) is rampant in our society, yet it often goes unnoticed and unreported. The health care provider should remain vigilant to rule out CSA and be aware of all the presenting symptoms and signs of CSA. It is important to elicit a detailed history from non-offending parents or caregivers regarding the psychosocial and environmental factors which can render a child vulnerable.

It is also important to remember that a child above 12 years is deemed capable of giving consent for a medical examination or an interview. No medical examination or interview should be done with children between 12-18 years of age without their consent.

Approaching a child presenting with symptoms or signs suggestive of CSA:

1. Develop a rapport with the child before asking any questions related to the incident/suspicion.
2. Ask the child who can be present during the interview-as the abuser may be one of the caregivers who have brought the child to the medical center. Also, the child may not speak about the abuse if the abuser is related to the child/caregiver. Parents and caregivers can be asked to wait outside, beyond earshot, but in sight of the child.
3. Be gentle and aware of the body language and non verbal cues, like fear around certain person/s, inability to speak in their presence, signs of anxiety, signs of self harm like cuts, nail biting. Ask questions in a simple language that is easily understandable by the child.
4. Encourage the child to only state what they are sure of and to let you know if they don't remember/don't know the answer.
5. Ask open ended questions and wait for the response. If there is no response, try posing the question in other ways. Don't force the child to answer any question.
6. Questions related to personal safety can be asked gradually, beginning with general questions, as indicated below.

   Asking questions about personal safety, discussing unsafe behaviour:
   - Has anyone ever embarrassed you and you did not talk about it to anyone?
   - Has anyone ever touched you in a way you didn't like?
   - Has anyone ever done anything that makes you feel uncomfortable or you feel confused?
   - Has anyone related or unrelated to you, known person or stranger, ever touched you in a way that made you feel uncomfortable/shy/yucky?
   - I am asking you this because if this happens, you can come and tell me about it.
   - Things that trouble you need not be kept bottled up inside you.
   - Yucky things are best let out
   - The person may tell you that it's alright, that there is no need to tell anyone, may try to give you gifts or things you like and ask you to keep it a secret or even scare you
   - But for your safety, it will be best to tell an adult you trust about it. You can also call Childline on 1098 to help you. You can tell me.
   - When an adult or older person troubles (abuses) a child, it is never the child's fault.

Suggestions on how to respond to the child, if the child talks about abuse:

- **Tell the child you believe them.**
- Praise the child's courage in telling you about it. Acknowledge the child's feelings.
- Tell the child it was not their fault. The perpetrator was at fault. The perpetrator is solely responsible for what they did.

- It does not matter if the child did not tell when the abuse first started; the child is not responsible for the abuse.
- Do not question or blame the child- “why did you not shout for help?” “You should have told someone earlier” “Why did you not fight?” Remember it is a child and the abuser is most likely a person known, loved and trusted by the child.
- Tell the child that you would like to take the help of other adults (family members, institutions staff members) to support the child to be safe and heal from the abuse, with the child’s permission.
- Do not make false promises like “I will send the abuser to jail. I will beat up that person etc.”
- Do not ask the child to “forgive” “forget” or “adjust”.

Assess if the child needs immediate medical care and make appropriate referrals.

If immediate medical care is not required, inform relevant authorities to assess the safety of the child.

- Is it safe to send the child back home?
- Will the abuser or their associates have access to the child if sent home? Could the child be coerced or threatened to withdraw the case? The aim here is to minimise the harm by preventing any further abuse.

If the home is a safe place, talk about the abuse to the parents/ primary caregivers. Family is the first to be involved. Family has to provide a safe environment for the child. Provide support to the family members - discuss with them how to take care of the child. The family might require psychological support. Refer them to well-informed competent counsellors/therapists. Connect the family to child protection systems like the Child Welfare Committee (CWC).

If the home is an unsafe place, take the help of the family member whom the child trusts or a friend of the family or CHILDLINE:1098. Government agencies like CWC have to be involved if home is not a safe place for the child.

It would also be helpful to network with organisations/ NGOs working in the field of CSA to provide necessary support.

Under the POCSO Act 2012, any adult who has information or apprehension about any instance of child sexual abuse, is mandatorily required to report it to the local police station/Special Juvenile Police Unit.

Case 2:

A 16 years old transgirl has come to the OPD. She has come for a medical examination with another trans-person with whom she is living. She is asking the doctor about details of surgery and says that she has been saving money for surgery. Doctor asked her to be examined. After the examination she comes to you (nurse posted in the OPD) and says that the doctor was touching her penis and rubbing it. And he made her touch his penis.

How will you respond?

What are your legal responsibilities?

What is your social responsibility?

Case 3:

A 17 year old boy presents to the clinic with penile abrasions. He is having penile abrasions from vigorous rubbing. On detailed history taking, he says that he is engaged in a relationship with a 34 year old woman, a friend from the neighbourhood. He is excited to have a relationship. He is considering eloping once he turns 18. This relationship has been going on for one year. Their first sexual experience was at a wedding they attended together a few months back.

Would this be considered as sexual abuse?

Should this case be reported to the police?

Case 4:

A 17 year old female patient presents with 4 months of amenorrhoea. The girl is in a relationship with a 21 year old male and they are planning to get married as soon as she turns 18.The girl's parents don't approve of this relationship and are against this. They have forced her to come to the OPD and are also threatening to register a case against her boyfriend. She is refusing a medical examination.

What would you do?

Can an examination be done without the consent of the girl who is 17 years of age?

16.

Nursing professionalism includes cognitive, attitudinal and psychomotor components (Ghadirian et al., 2014). To grow as a professional, developing the core values based on human dignity, respect, integrity, autonomy and social justice is as important as acquiring theoretical knowledge and developing clinical skills. The ethos of restorative practices mirror the core values of medical ethics.

Restorative practices can be proactive or responsive. It can be used to establish simple connections as well as to solve complex problems. Proactive practices involve relationship and community building. In the health care setting, restorative practices can be used:

- **To strengthen mutual trust in the nurse- patient relationship.**
- **To strengthen health care plans, support patients in managing chronic diseases.**
  Patients suffering from chronic illnesses and lifestyle diseases could benefit from the circle process.
  For eg: The nurse who is trained in restorative practices can hold a circle for patients who have diabetes. Questions can be framed to bring in a dialogue on the experiences of living with diabetes, challenges faced by the patients in maintaining glycemic control, best practices in diet and exercise and how as a community they can support each other. It can be used to promote goal setting to achieve a healthy lifestyle. With goal setting, the patients take ownership of areas they'd like to improve and they set realistic and actionable steps to work toward their goal. Similar circles can be held for patients with migraine, stroke patients under rehabilitation, patients with substance abuse, persons with disability, parents/ caregivers of persons with disability, etc. Other ways of implementing restorative practices in provision of health care are focused group discussions and motivational interviewing.
- **To address harm caused by the health care system**: Although most of the healthcare harms are unintended, these harms can leave a lasting, permanent and painful scar for the patient and their loved ones. Implementing restorative practices to resolve the conflict arising out of health care harms has been efficacious in meeting the needs of the patient and their family (Wailling et al., 2019; Todres, 2006). The restorative framework helps in repairing the harm, regaining the trust and refocusing on the health needs .
- **To create a safe, positive and healthy work environment** - by encouraging authentic and supportive communication between staff holding different positions.
- **To address workplace harm**
- **To establish partnership with the community** - to take responsibility and participate in building healthy, proactive, supportive communities.

Resonance between medical ethics and values of Restorative Practices:

Restorative practices emphasize exercise of power with, rather than power over people. These practices rely heavily on values that are mutually agreed to when two or more people interact. Commonly agreed values are trust, confidentiality, acceptance, respect, empathetic listening, authentic speaking, being non-judgemental, and care among others.

These resonate well with medical ethics listed below:

1. **Autonomy:**

- Respecting the dignity and rights of the patient.
- Respecting the self determination of the patient- Patient has freedom of thought, intention and action when making decisions regarding the health care
- Understanding informed consent- For a patient to make a complete informed decision, they need to understand the benefits and risks of the procedures with clear information on the success rates and likely complications. This includes the need to present information with truth (veracity) and be faithful to one's commitments (fidelity) on the health care provider's part.

  Examples:

  Asking for permission : " May I take your BP?"

  Explaining the procedures: "I am going to give you a sponge bath. Is that okay with you?"

  "The catheter needs to be changed as it is kinked. Is it okay if I do it now?"

- Maintaining confidentiality of all personal and medical information

2. **Beneficence:**

- Moral obligation to work for the benefit of the patients.
- Well being of the patient takes precedence over everything

3. **Non maleficence :**

- Do no harm to the patient
- Mindful of the bedside manners and practices- using respectful verbal and non- verbal communication.

4. **Justice** : Fair and equal distribution of the health care resources

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