A woman with a bindi and a nose ring, wearing a vibrant orange and pink floral sari, is smiling while operating a sewing machine. The machine is a treadle type with a blue thread spool. The background shows a factory environment with several other sewing machines.

Sexual & Reproductive Health and Rights of People Living with HIV

A Training Manual

India HIV/AIDS Alliance

Headquartered in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national programme, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations affected by the epidemic. The organisation's programmes focus on those most vulnerable to HIV, with a particular emphasis on marginalised populations including men who have sex with men (MSM), transgenders, hijras, sex workers, injection drug users (IDUs), at risk youth and women, and people living with HIV (PLHIV).

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Preface

In April 2014, India's National AIDS Control Programme completed a decade of free antiretroviral therapy (ART) for people living with HIV (PLHIV) in India. The last ten years have seen significant reductions in morbidity and improvements in longevity for PLHIV. Though many PLHIV in India still need to start ART, the progress we have seen has allowed an expansion of support for PLHIV into areas beyond treatment, addressing issues such as general health, livelihoods, and discrimination to improve their overall quality of life.

The specific sexual & reproductive health (SRH) needs of PLHIV and key populations, particularly female sex workers, men who have sex with men, transgenders, and people who inject drugs, have too often been neglected. As health systems move towards normalising care for these groups, it will become increasingly important to develop policies and interventions that are responsive to them – as PLHIV, as members of high-risk groups, and as patients deserving the same quality healthcare as anyone else.

With support from the European Union, Alliance India worked with state partners and PLHIV networks in Maharashtra, Gujarat, Andhra Pradesh, and Tamil Nadu to implement the Koshish programme to respond to this growing need. Over its three-year duration, Koshish advocated for improved SRH for PLHIV and key populations and addressed some of the important barriers that prevent access to these services. The programme built advocacy capacity in implementing partners and other civil society organisations to sustain these efforts and created a pool of community-based Technical Support Providers (TSPs) across the four states to strengthen organisations working in this important area.

Tested by Koshish TSPs in the field, this Training Manual reflects the activities and technical support processes developed under the programme. It describes key SRH advocacy priorities for PLHIV and key populations, along with participatory exercises and notes for facilitators. Though developed for India, these approaches can be adapted to contexts in other countries. We hope that this manual will be a useful resource for individuals and organisations working to improve SRH for PLHIV and key populations around the world.

James Robertson

Executive Director

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
CBO	Community-based Organisation
CSO	Civil Society Organisation
CHC	Community Health Centre
DLN	District Level Network
DNC	Dilation and Curettage
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HT	Hormone Therapy
ICPD	International Conference on Population and Development
IDU	Injecting Drug User
IPPF	International Planned Parenthood Federation
KP	Key Population
MSM	Men who have Sex with Men
MDG	Millennium Development Goal
MTP	Medical Termination of Pregnancy
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
NHM	National Health Mission
ORW	Outreach Worker

PHC	Primary Health Centre
PID	Pelvic Inflammatory Disease
PLA	Participatory Learning and Action
PLHIV	People Living With HIV
PPTCT	Preventing Parent-to-child Transmission
PWID	People Who Inject Drugs
RCH	Reproductive and Child Health
RH	Reproductive Health
RTIs	Reproductive Tract Infections
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
SLP	State Lead Partner
SLN	State Level Network
TG	Transgender
TSP	Technical Support Provider
TSO	Technical Support Officer
ToT	Training of Trainers
UDHR	Universal Declaration of Human Rights
VCTC	Voluntary Counselling and Testing Centre
WHO	World Health Organisation



Introduction

With increased access to antiretroviral therapy (ART) that increased longevity, people living with HIV (PLHIV) have regained the opportunity to live longer, fulfilling lives and to plan for their future. Their plans include decisions about sex and the possibility of starting or expanding families. Experience from India suggests that a comprehensive approach to sexual and reproductive health and rights (SRHR) for PLHIV has been lacking and that current responses are not decreasing their vulnerability and ill-health. Vulnerability to issues of SRH is further exacerbated for those whose rights are violated due to stigma, discrimination, and marginalisation. Lack of a comprehensive approach to the SRHR needs of PLHIV and stigma and discrimination limit accessibility to and availability of essential SRHR services. Among PLHIV from the marginalised groups, the health indicators show even higher rates of unmet SRH needs.

To address these issues, the European Union funded Koshish programme to effectively advocate for policies and strategies on sexual and reproductive health and rights (SRHR) for PLHIV and key population in India. India HIV/AIDS Alliance (Alliance India) implemented Koshish in partnership with CHETNA, MAMTA, PWDS and VMM, along with state-level PLHIV networks in Maharashtra, Tamil Nadu, Andhra Pradesh, and Gujarat.

Koshish aimed to achieve its goals by strengthening civil society organisations (CSOs) and networks— specifically those representing and working with PLHIV and other key populations (KPs)¹ such as men who have sex with men (MSM), transgender (TG), hijras², female sex workers (FSW) and their clients, and people who use drugs (PWUD). Through coalitions, the partner organisations developed and implemented state and district level interventions that were based on the principles of empowerment and meaningful partnerships as core elements of effective advocacy.

¹ The term 'key populations' refers to those who are most likely to be exposed to HIV or to transmit it. Their engagement is critical to successful HIV response. The key populations include PLHIV and, in many countries, also include MSM, FSW, TG, PWID, and sero-negative partners in sero-discordant couples (UNAIDS Terminology Guidelines, October 2011).

² Hijras have a long-recorded history in South Asia, and have many names in the different languages of the region. They usually are men who have feminine gender identity, adopt feminine gender roles and wear women's clothing. They can be transgender, transsexual, cross-dressers, and/or castrated. Sometimes they also identify themselves as the third gender. In South Asia, many hijras live in well-defined and organised all-hijra communities, led by a guru or a spiritual leader.

Koshish supported capacity building and advocacy to realise the rights of PLHIV and helped address barriers to accessing SRH interventions by PLHIV. Also, the programme supported development of national and state level policies by engaging important decision makers, such as government officials and state and national level parliamentarians. The implementation of these policies created an enabling environment for PLHIV rights. Moreover, the programme filled gaps at the grassroots level by building capacities of the target populations.

Overall Objectives of Koshish

- To improve sexual and reproductive health rights (SRHR) of people living with HIV/AIDS in India.
- Increase access to SRHR information, services and realisation of related rights of PLHIVs, especially from the marginalised groups in Andhra Pradesh, Gujarat, Maharashtra and Tamil Nadu.

These objectives were achieved by undertaking the following activities:

- Strengthen the evidence base by identifying needs and gaps of PLHIV with regard to SRHR.
- Identify and train technical support providers in advocacy for SRHR for PLHIV.
- Build the capacity of Alliance India partners, CSOs and networks working with and representing PLHIV and other KPs in four states of India to advocate for SRHR of PLHIV.
- Create and strengthen advocacy coalitions of these organisations for joint advocacy.
- Support advocacy with decision makers at state and national levels for improved SRHR.

Capacity Building in Koshish

Koshish followed an extensive and comprehensive approach to capacity building to strengthen capacities of the implementing partners and other stakeholders to effectively advocate for change in policy and its implementation with regard to SRHR of PLHIV and KPs. A range of capacity building activities—trainings, workshops, and onsite technical support – were organised for the programme partners. The programme created a pool of 40 community based technical support providers (TSPs) and capacitated them to provide technical support to networks and CBOs in a cascading model. To support the efforts of TSPs, the programme developed technical support tools such as job aids, technical briefs, and a training manual on SRHR of PLHIV and other KPs. The training manual was a technical document used in Koshish for providing technical support to the PLHIV networks, CBOs, and other CSOs.

Purpose of Training Manual

This training manual was first developed in 2011 for TSPs of Koshish to provide technical support and was regularly modified and expanded till December 2013 based on the experiences gained from implementing the programme and evolution of programme implementation modalities.

This training manual is aimed at trainers and TSPs working on SRHR of PLHIV and other KPs. This manual can also be used by organisations and individuals working with PLHIVs and KPs on SRHR issues. Within the NGOs, it will be useful for programme managers, counsellors, outreach workers, and other technical staff.

Within the broad capacity building framework of Koshish, this training manual aims to strengthen the technical capacities of TSPs of Koshish partners to effectively advocate for and implement policies and strategies to improve the access to SRHR for PLHIV and other KPs in India.

To this end, this training manual has sessions that address the following four clusters of issues:

- Contexts within which PLHIV and other KPs live and their risks and vulnerabilities to HIV.
- Gender relations, sexuality, and human rights, and how they influence the lives of PLHIV and other KPs by mediating their access to SRHR services and entitlements.
- SRH needs and rights of PLHIV and other KPs and the barriers they face in accessing SRHR services and entitlements.
- Using advocacy as a tool for strengthening access to SRHR services and entitlements by PLHIV and other KPs.

The training manual has nine sessions: six covering the four clusters of issues; one session on starting and one on ending the training workshop; and another on approaches and tools on how to provide technical support on the key issues covered by the manual.

Each session includes a range of participatory activities. According to the training needs of the participants and time, space, and the level of privacy available, the facilitators can select activities they want to include in a specific capacity building intervention. They can also use or adapt other programme learning and action (PLA) activities from the additional resources given at the end of the manual. All activities come with detailed facilitating guidelines, and sometimes there is a specific section in the module, preceding the description of the activities, with suggestions on preparation and facilitation.

Each session has a section with brief technical notes on the issues covered in the session. Facilitators can read these notes before facilitating the particular session, and draw information from them, to clarify issues and correct any misconceptions. The technical notes can also be shared with participants as hand-outs, after being translated into appropriate languages, if necessary.

The training approach of this manual is a participatory one. Largely based on PLA methods, the activities described in the different modules of this manual are analytical and problem-solving in nature. The methods focus on dialogue and critical reflection, helping users to identify and analyse barriers to accessing SRHR services and entitlements by PLHIV and other KPs, and plan ways to address them through advocacy.



SESSION 1



Introducing a Workshop



Objectives

- To welcome the participants to the workshop.
- To enable the participants and the facilitators to get to know each other and begin the process of creating an environment of mutual understanding and trust.
- To collectively set the ground rules for the workshop.
- To understand the expectations of the participants and match them with the objectives of the workshop.
- To introduce the workshop agenda.
- To explain the process and the participatory approaches of the workshop.
- To organise how the participants can review the workshop on a daily basis.



Material Required

- Chart papers, markers, double-sided sticky tapes, and printouts of workshop objectives and workshop agenda for all the participants. Example of the workshop agenda is given as annex 1.
- Three small rubber or plastic balls, if the option three for introductory game is used. You can also make balls from old newspapers and bits of strings or adhesive tape.



Notes for Facilitator

It is important to do all the activities when introducing a workshop. Ensure that each activity follows the previous one promptly, the facilitation style is quick and clear, and discussions are brief and to the point. This session, if done briskly and with a lot of energy from the facilitation team, will set the pace of the workshop. It is equally important to set aside time for bringing the workshop to a close, properly and not hurriedly. Facilitators owe the

participants an opportunity to provide feedback on the content and the facilitation of the workshop and to take leave from each other.

Before introducing the workshop, get a clear idea about the context of the programme or project within which the particular technical support intervention is being implemented: a training or trainers' workshop, a refresher training for field workers, or a capacity building session for key population members. Also have a clear idea about what follows the workshop in terms of next capacity building intervention planned, or the next programmatic step to follow the current intervention. This will help you to convincingly elucidate the rationale, scope, objectives of the capacity building intervention, and the next steps to the participants.

To assess the impact of the training, keep aside time during the introductory session for participants to fill in a pre-training questionnaire. Similarly, in the closing session, allow time for them to fill in a post-training questionnaire. An example of a pre and post training questionnaire is given in annex 2.

Suggested Activities

Introducing the Workshop

Activity 1: Welcome Address

Estimated time: 10 minutes

- Thank the participants for their interest in the workshop and for taking time to come to the workshop.
- Introduce the programme or project framework within which this particular capacity building intervention is being conducted.
- Introduce the facilitating team.
- Take the consent of the participants for taking their photographs.

Activity 2: Introducing Oneself

Estimated time: 10-15 minutes

Note for facilitators: *There are a number of participatory activities that can be used for introducing participants and facilitators to each other, apart from the three options given here. Selection of an appropriate activity will depend on whether the participants already know each other or whether it is the first time most of them are meeting each other. Some introductory games can help participants and facilitators learn and remember everyone's name. Others can be used to introduce the theme of the workshop right at the start.*

(For more introductory activities, please see 'Participatory Learning and Action: A Trainers' Guide' (1995), by Jules N. Pretty, Irene Guijt, John Thompson and Ian Scoones.)

Option 1: What do we have in common?

Estimated time: 10-15 minutes, depending on the number of participants

Ask the participants to stand in a circle. Call out different questions that each participant can or cannot answer in 'yes'. If they answer 'yes', they have to jump

up and quickly get into a huddle with the others who have also jumped up. Before asking the next question, ask the participants who have jumped up to go back to their original positions. When the next question is asked they can either jump up and join another huddle, or remain in their original positions, depending on whether their answer to the question is 'yes'.

Ask questions that allow the participants and the facilitating team know a bit more about each other's work life, and also include some fun questions that will help break the ice.

Possible questions:

- Lived away from your home town for more than a year?
- Slept in a cowshed?
- Worked in a government agency?
- Been in love with someone from a different state?
- Worked in an STI clinic?
- Have you ever seen a movie star in real life?
- Facilitated a training workshop?
- Accompanied a sex worker to an ICTC centre?
- Had sex without a condom?

Option 2: Nick-name game

Estimated time: 10-15 minutes, depending on the number of participants

Ask the participants to stand in a circle. Ask each participant to step into the middle of the circle and say their name and another name (a nick name or a pet name) by which they are also called and do a movement or gesture (jumping, shrugging shoulder, or giving a flying kiss) while they say their names. When they step back, it is the next person's turn. At the beginning of the game, emphasise that participants cannot say anything other than their given name and a nick name. For instance, they cannot even say 'my name is ...' or 'I am also known as...'

Option 3: Juggling ball game

Estimated time: 10-15 minutes, depending on the number of participants

Ask participants to stand in close circle. Keep three small balls ready. Start the game by throwing a ball at someone in the circle, calling out her/his name as you throw it. The person has to catch the ball and throw it to a new person calling out the name of the person who she/he throws the ball at. Continue catching and throwing the ball establishing a pattern for the group. Each person must remember who they receive the ball from and who they have thrown it to. Once everyone has received the ball and a pattern is established, introduce two more balls, so that there are always several balls being thrown at the same time, following the set pattern.

Activity 3: Ground Rules

Estimated time: 10 minutes

The activity is called 'Flowers and thorns':

- Ask participants to take turns to call one thing that they really like to happen

in workshops (things that should be done are ‘flowers’) and also the one thing that really disturbs them during workshops (things that should not be done are ‘thorns’).

- On a chart paper, draw symbols of what the participants call out, and ask everyone if these norms will be followed during the workshop.
- Put up the chart paper on a wall so that the ground rules set by participants are on display for the rest of the workshop.

Activity 4: Expectations and Contributions

Estimated time: 15 minutes

- Ask participants to pair up with the person sitting on their left and decide, in pairs, one thing they bring to the workshop and one thing they expect to take away from it.
- Ask the pairs to report back in plenary. Sum up the group’s contributions and expectations.
- Explain the objectives of the workshop, emphasising that this training workshop will focus on strengthening participants’ skills in advocating for better access to SRHR services and entitlements by KPs and PLHIV. Also, tell them the workshop will strengthen their knowledge about issues related to PLHIV and other KPs and about SRHR issues specific to them.
- Introduce the workshop agenda; discuss how far participants’ expectations can be met in this workshop and how their contributions are critical for the success of the workshop.

Activity 5: Daily Review Teams

Estimated time: 5 minutes

- Ask participants to volunteer to form two teams of two members each for each day of the workshop to do the following:
 - Team 1: Recapitulate the previous days’ main learning and critically reflect on how sessions were facilitated the previous day.
 - Team 2: Review logistics arrangements after consulting all the other participants.
- Note down the names of review team members for each day on a chart paper and put it on display for the rest of the workshop.
- Explain that each team will have to consult all the other participants to report back a collective review of the day. Other members should also take on the responsibility of giving their feedback to the review team for each day.

Note for facilitators: *Even if it is a one-day or even half-day workshop, it is good practice to have representatives of the participants review the workshop content and process. This underscores participants’ active involvement as equal partners in the workshop, helps participants to follow the workshop process more critically,*

and reinforces the key learning from the workshop sessions. The feedback from participants also enables facilitators to gauge the mood and the level of understanding of the participants, and to adapt the training programme and methodology to the participants, if necessary and feasible.



Key Learnings

Participants will be able to do the following:

- Clearly understand the objectives and the structure of the project/programme and their role in it.
- Understand the objectives and the scope of the workshop and appreciate how their need to strengthen their skills in advocating for better access to SRHR services and entitlements of PLHIV and other KPs would be addressed.
- Understand the learning process and the participatory approach of the training.
- Contribute to an enabling learning environment within and beyond the workshop.

The facilitating team will be able to do the following:

- Explain the participatory approach and the objectives of the workshop to the participants and explain what can be realistically achieved within the scope of the workshop.
- Gauge the different skills and experiences that the participants' bring to the workshop, and plan how to use these resources during the course of the workshop and in the project/programme.



SESSION 2



Beyond Labels: Understanding PLHIV and Other Key Populations



Objectives

- To strengthen the participants' understanding of the HIV epidemic dynamics in the context of their states or regions.
- To strengthen the participants' knowledge of lived realities of PLHIV and other KPs.
- To enable the participants understand HIV risks and vulnerabilities of PLHIV and other KPs.
- To strengthen the participants' understanding of the role of key populations in the HIV epidemic dynamics and to the HIV response.
- To help the participants identify realistic ways to address barriers to HIV/STI risk reduction, keeping vulnerability factors in mind.



Material Required

- Chart papers, markers, double sided adhesive tapes.
- For activity 3 decide beforehand where you will put up the 5 charts.



Notes for Facilitator

To facilitate the activities in this session effectively, you need to have accurate and up to date knowledge about how HIV epidemics play out in the states or regions the participants come from and how key populations impact and get impacted by the epidemics. However, beyond sound epidemiological understanding, you also need to have first-hand knowledge about the lived realities of different KP groups and genuine respect for their rights. You will need both the knowledge and the empathy to address misconceptions about key populations and challenge prejudices. Refer to annex 4 for more information.

Quick Reference³

- KPs are key to the HIV epidemic dynamics because they are most at risk of acquiring and therefore transmitting HIV. Structural factors make KPs particularly vulnerable to the risk of HIV. They are also key to the HIV response, as evidence shows that if they are empowered to lead HIV interventions for prevention, treatment, care, and support, the epidemic and its adverse impact can be limited, and interventions can be sustained.
- KPs vary in different places depending on the context and the nature of the local epidemic. In all countries, however, KPs include PLHIV. In most settings, MSM, TG, IDUs, FSW and their clients, and sero-negative partners in sero-discordant couples are at higher risk of exposure to HIV than other people.
- Risk is defined as the probability or the likelihood that a person may be exposed to HIV or become infected with HIV. Certain behaviours create, increase, or perpetuate risk. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV. Examples include unprotected sex and unsafe injecting practices in drug use.
- Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment, and other social, cultural, political, and economic factors that make a person more susceptible to exposure to HIV infection and to developing AIDS. Vulnerability results from a range of factors outside the control of an individual that reduce the ability of an individual and communities to avoid HIV risk. These factors may include the following: lack of access to knowledge and skills required to protect oneself and others; factors pertaining to the quality, accessibility, and coverage of services (such as inaccessibility of service due to distance, cost, stigma, discrimination, or other factors); and structural factors such as human rights violations or inequalities based on gender and other social relations. These inequalities often manifest themselves through practices, beliefs and laws that stigmatise and disempower certain populations, limiting their ability to assert their rights or to access/use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

Suggested Activities

Activity 1: Know Your Epidemic

Estimated time: 30 minutes

- Brainstorm the following question with participants in plenary and write all their responses on a flipchart: What are the main factors driving HIV in the participants' respective states or regions?
- Among the responses noted down, highlight the structural factors such as lack of access to education, health services, or justice; stigma and discrimination; criminalisation of practices and groups; violence, and so on.
- Ask participants to identify which groups of people are targeted by the HIV programmes in their states or regions? Are they the ones who are most vulnerable?

³ UNAIDS *Terminology Guidelines*, October 2011; PATH, 2005, *Interpersonal Communication for Action on HIV (InterAct IPC): A Guide to Dialogue-Based Communication Methods to Help Key Populations Put HIV Messages into Practice in India*

- Conclude the activity by clarifying that in any given context any one can take a risk that may expose them to HIV (that is, take an individual action like having unprotected sex, or share infected injecting equipment). However, only some specific groups are most likely to be vulnerable to HIV exposure because of structural factors, such as legal barriers, lack of access to health services, and so on. In most countries, such as in India, these populations are sex workers—women, men, or transgender/hijras—and their clients; MSM; TG persons; IDUs; and of course PLHIV. These populations are called key populations because they are key to the epidemic dynamics (they are most likely to be exposed to HIV infection, and as a result most likely to transmit HIV) and more importantly, because they are *key* to HIV response (experience around the world shows that wherever resources are focused on these populations and wherever they take leadership roles in HIV response, there have been greater and sustained impact on the epidemic).

Activity 2: Key Populations: Who Are We?

Estimated time: 45 minutes

- Divide participants into five small groups with an energising activity.

Suggested energiser: **Bunty and Babli (or 'A's and 'B's)**

Ask everyone to choose silently one person as Bunty (or A) and another as Babli (or B). They can choose anyone they like as one or the other. Once everyone has made their choices, tell them to get as close to their Bunty as possible, while getting as far away from their Babli as possible. People can move quickly but should not grab or hold anyone. After a few minutes ask participants to stop and reverse the process, getting close to Babli and avoiding Bunty. After a few minutes, ask participants to stop where they are, and count 1–5 aloud, one after the other. Ask those who had called one to come into one group, those who have called two to form another group and so on, till there are five groups of randomly mixed participants.

- Give each group chart paper and markers.
- Assign the following KP characters to each small group:
 - Group 1: a female street based sex worker in a big city.
 - Group 2: an adolescent living with HIV in a small town who attends high school.
 - Group 3: an unemployed transgender/hijra in a village.
 - Group 4: an urban middle-aged MSM caretaker of a primary school.
 - Group 5: a daily wage labourer who injects drugs and works in suburban town.
- Ask each group to imagine the details of the character they have been given: What is the character's name? How old is she or he? What is her or his economic status? Where does she or he live? Who else live with her? And so on. That is, from the brief description given to them, they have to build a flesh and blood character based on their knowledge and experience about KPs.
- Ask participants to draw pictures on the chart paper to depict a day in the life of the KP character they have developed. It can be anything they want to portray, from the time of their waking up to going to bed. It can be part of the characters' work, school, and/or personal lives.

- Ask each group to present their drawing in plenary.
- Ask all the participants to look at the drawings and discuss how far the portrayals represent what they know about the different KP groups, and add anything that they think is missing from the drawings presented. Correct any misconceptions and challenge any prejudices.

Activity 3: HIV Risks and Vulnerabilities

Estimated time: 30 minutes

- Put up the drawings from each group on a wall or a board. Take one drawing at a time and ask the participants to discuss the following in plenary:
 - During the day in the life of the KP character depicted, what are the risks of HIV transmission being taken by the character?
 - What aspects of the character's life might make them *vulnerable to HIV*? In other words, what make them take those risks?
- Help participants identify the difference between risk and vulnerability and how PLHIV and other KPs are made more vulnerable to HIV risks because of structural factors.
- Sum up the session by defining HIV risk and vulnerability and reiterate why certain populations are key to the HIV epidemic dynamics and to HIV response.

Activity 4: Statues

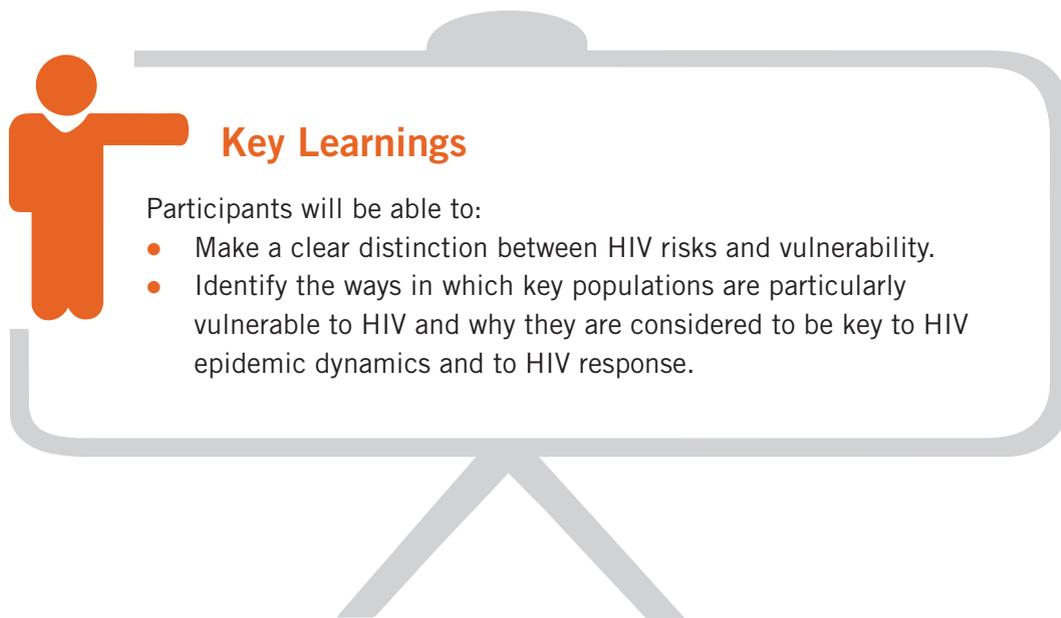
Estimated time: 30-45 minutes

- Ask the groups to brainstorm ways in which one can get HIV. Correct any misconceptions and challenge any prejudices.
- Now ask the participants to go back to their original groups and think about the character they had developed.
- Ask each group to decide on a 'freeze frame' (arranging themselves in a particular way and then stand as still as statues, not saying anything) showing one way to reduce their respective characters' risk of HIV. Remind them that the factors that make their character take the risks in the first place need to be addressed to make the HIV risk reduction strategy realistic.
- Go to the groups, if necessary, to clarify what you want them to do.
- Now ask each group in turn to show their statue arrangement in plenary. Facilitate a discussion amongst the remaining participants about the followings:
 - What does the statue arrangement show?
 - Will this reduce the risk of HIV?
 - If so, how easy their suggestion would be to put into practice in real life?
 - Are there any changes that could be made to the statue arrangement to make their risk reduction strategy more practical and effective?
- If there are suggestions for change, and if everyone agrees, let the group amend their statue arrangement accordingly.
- Conclude the activity by asking the participants to define HIV risks and vulnerabilities of the KPs.

Concluding Activity: What Did We Learn from the Session?

Estimated time: 15-30 minutes, depending on the number of participants

- Ask the participants to sit in a circle and you too join the circle.
- Keep a free space to your left, and ask a participant to come and sit in the empty space.
- Ask the participant who has moved next to you to tell the rest of the group one thing she or he has learned from the session and one thing she or he will change (do or think differently).
- As the participants moves, there will be an empty space on the left of another participant. Ask the participant who is sitting next to the empty space on her or his left to call the name of someone different to come and sit on her or his left and tell the group one thing she or he has learned and one thing she or he will change.
- Make sure participants do not call the same person twice. Continue the process until the entire group has moved once and every participant has spoken.





SESSION 3



Gender Relations and Key Populations



Objectives

- To arrive at a common understanding about gender relations by strengthening the participants' conceptual clarity about the following:
 - How gender relations are socially constructed.
 - Ways in which gender division of labour and resources create and reinforce gender inequalities.
 - How gender inequalities are mediated and reinforced by other social relations and identities, such as class, caste, religion, sexual orientation, and so on.
- To enable participants to identify how gender and other social inequalities impact the lives and the rights of PLHIV and KPs, their risks and vulnerabilities to HIV and other sexual and reproductive ill-health, and their access to appropriate and quality services.



Material Required for the Session

- Chart papers, markers, and double-sided adhesive tapes.
- Whistle
- Temporary marker to draw lines on the floor



Notes for Facilitator

Most participants are likely to have had some previous training on and basic understanding about gender. Explain to them that this Session aims to help them arrive at a common understanding about gender relations, and how gender relations impact the lives of PLHIV and other KPs. While going through this session, keep drawing participants' attention to gender and sexuality issues in relation to the lives of PLHIV and other KPs. One way of doing this would be to give, and ask for, concrete examples from the lives of PLHIV and other KPs to illustrate the point being made.

Quick Reference

Gender⁵

- Gender is not the same as biological sex.
- Biological sex refers to differences in biological and physiological characteristics between males, females, or intersex people and is determined by a person's chromosomes, hormones, internal and external reproductive organs, and genitalia. For example, only males can produce sperm. Only females can produce eggs and can become pregnant. At puberty men have growth of facial hair and women start menstruating and develop breasts. Intersex people can have intermediate or ambiguous combinations of male and female physical features. An intersex individual may have biological characteristics of both male and female sexes.
- Gender, as opposed to biological sex, refers to relations between men and women, and the social meanings given to being either a woman or a man in a given society. Transgender and hijras do not fit into either of these two categories. Transgender/hijras define their gender identity as women, men, neither, or both, not matching their 'assigned sex', whether male or female.
- Gender relations are socially constituted and not derived from biological sex. They are historically and contextually specific. As gender relations are socially constructed they can and do change in response to wider social changes. For example, what was considered to be socially appropriate for women to do in urban India fifty years earlier is very different from the acceptable behaviour for urban women now, as the social context has changed because of changes in macro-economic structures, cultural globalisation, women's movement, and so on.
- Gender relations are essentially relations of power. In all societies known to us, men and women have unequal power, and men, as a group, enjoy social and institutional power to command women's bodies, intellect, labour, and fruits of women's labour. Therefore, gender relations are relations of conflict and not necessarily harmonious or co-operative and are unlikely to be so as long as they remain unequal.
- Gender equality means equal treatment of men and women in laws and policies, and equal access to resources and services within families, communities, and other social institutions⁵. Gender equality permits women and men equal enjoyment of human rights, socially valued goods, opportunities, resources, and the benefits from development results. The fact that gender categories change over time means that development programming can have an impact on gender inequality, either increasing or decreasing it.
- Gender equity means fairness and justice in the distribution of benefits and responsibilities between women and men. To ensure fairness, measures must be available to compensate for historical and current social disadvantages that

⁴ *The Oxfam Gender Training Manual (1994); Royal Tropical Institution (KIT), Gender and rights: a resource guide (2010)*

⁵ *In social science, such as anthropology, economics, political science, or sociology, Social institutions refer to any structure or mechanism of social order governing the behaviour of a set of individuals within a given community. In this sense, some examples of social institutions are marriage and family, religion, the market, law and legal systems, education, and so on.*

prevent women and men from operating from an equal platform. It often requires women-specific programmes and policies to end existing inequalities.

- Gender identities are organised through a complex system of social relations. Men and women have multiple identities—class, race, ethnic, national, and so on - constructed by history and culture and they make sense only when seen in that context. Thus there is no essential category of ‘woman’ or ‘man’. Gender identities and experiences are mediated by other social relations of power such as class, caste, ethnicity, religion, age, education, etc.
- Gender roles relate to expectations a culture has about what one should do based on biological sex. For example, in most traditional social contexts, the given gender roles say that women should stay at home to raise children and men should go out and earn money to support the family. However, these roles may not be what all individuals want or desire or even can practice in reality. Those who move away from these gender roles may be looked down upon, and punished, by family, friends and community. This can result in stigma and discrimination. It is through social punishments and rewards normative gender roles are kept in place.
- There is no one ‘masculinity’ or ‘femininity’. The terms ‘masculinities’ or ‘femininities’ are more appropriate because, at a given time in a given place, there can be many forms of masculinities and femininities. There may, however, be one dominant form of masculinity or femininity that influences the behaviour and attitudes of men and women. This can result in pressure on them to fulfil this expectation and restrict them from moving away from this gender-role.
- Gender division of labour: In specific social contexts, particular tasks are allocated to a particular gender. Like women cook at home, men operate lathe machine at a workshop. These then become social rules—women cannot work in a factory operating machine, or men are not supposed to cook at home. These social rules refer to socially acceptable gender roles and responsibilities—women’s role is to work at home and take care of the household, while men’s role is to go out and earn and support the family. This gender division *of labour* leads to division of skills and access to resources. Thus women are trained to cook for the household and not learn how to operate a machine in a factory; so even if women want to go and operate a machine, they will not have resources invested in them to learn the skill to do so, and therefore are refused the job. In turn this becomes part of gender identity and leads to gender hierarchies because as women are expected to and are trained to only do household jobs, their work do not earn them money and are therefore undervalued compared to the work men are expected and trained to do. However, like other aspects of gender relations, gender division of labour also change in response to wider social changes. For example, in Bangladesh, after devastating flood in the 1980s, large scale relief programmes offered women employment in building roads and thousands of women were enrolled to dig earth, an activity women in Bangladesh had never been expected to undertake earlier.
- Greater equality and flexible gender roles give everyone more opportunities to develop his or her full capacity as a human being. Restrictive gender roles usually limit opportunities, especially of women, in most societies.

Sex, Gender, and Violence

- Gender-based violence, or violence against women, MSM and transgender/hijras is a major public health and human rights problem throughout the world.
- Domestic violence or intimate partner violence: One of the most common forms of gender based violence is that perpetrated by a husband or a male partner against a woman. Domestic violence or intimate partner violence is a pattern of abusive and threatening behaviours that may include physical, emotional, economic, and sexual violence as well as intimidation, isolation and coercion. Domestic violence can also include threats of violence, physical harm, attacks against property or pets, acts of intimidation, emotional abuse, isolation, and use of children as a means of control. Domestic violence is frequently invisible since it happens behind closed doors, and is effective when legal systems and cultural norms do not treat it as a crime but rather treat it as a 'private' family matter or a normal part of life. Studies show that worldwide between 25% and 50% of women have been abused by intimate partners and between forty and seventy percent of all female murder victims are killed by an intimate partner.

Domestic violence is an intentional behaviour. The purpose of domestic violence is to establish and exert power and control over another. Perpetrators' violence is carefully targeted to certain people at certain times and places. Studies show that perpetrators make choices about what they will or will not do to the victim, even when they are claiming they 'lost it' or were 'out of control'. Such decision-making indicates that they are actually in control of their abusive behaviours.⁶ Men most often use it against their intimate partners, which can include current or former spouses or partners. For example, batterers "choose not to hit their bosses or police officers, no matter how angry or 'out of control' they are."⁷ Although domestic violence and stranger violence have much in common, they are experienced differently by the perpetrator, the victim, and the community.

According to the international law, the rights violated by domestic or intimate partner violence include core fundamental rights that are protected under the international law, such as the right to life and to bodily integrity. Violence against women has been recognised as having its roots in the subordinate role of women in private and public life in most contexts. The United Nations Declaration on the Elimination of Violence Against Women describes violence against women as "a manifestation of historically unequal power relationships between men and women." At the same time, violence is one of the "crucial social mechanisms by which women are forced into subordinate positions compared with men".⁸

- Sexual violence occurs throughout the world, although in most countries there has been little research conducted on the problem. Sexual violence is perceived as a private matter and so it is difficult to estimate the extent of this kind of violence. Sexual violence is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act

⁶ Anne L. Ganley & Susan Schechter, *Domestic Violence: A National Curriculum for Family Preservation Practitioners* (1995).

⁷ Ethel Klein et al., *Ending Domestic Violence: Changing Public Perceptions/Halting the Epidemic* (1997).

⁸ *The United Nations Declaration on the Elimination of Violence Against Women*.

⁹ CDC, 2007

is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure); and 3) abusive sexual contact.⁹

Often, people who coerce their spouses into sexual acts believe their actions are legitimate because they are married. Sexual intercourse against one's consent will be called rape by any person regardless of their relationship to the victim, in any setting. But, the law has been slow to criminalise rape within marriage. Rape by a stranger can be highly traumatic but is usually a one-time event and is clearly understood as rape. Marital rape is likely to happen repeatedly.

- Violence and key populations: Key population members are frequently regarded as easy targets for harassment and violence for several reasons. They are considered immoral and deserving of punishment. Criminalisation of sex work, homosexuality, and drug use contributes to an environment in which violence against key populations is tolerated, leaving them less likely to be protected from it. Violence against sex workers, for example, from police, local criminals, boyfriends, or occasionally clients is considered to be 'normal' or 'part of the job' and sex workers do not have access to justice. As a result, key population members are often reluctant to report to the authorities the incidences of rapes, attempted (or actual) murders, beatings, molestation, or sexual assault. Even when they do report, their claims are often dismissed.

Rape may also be used to punish people for transgressing social or moral codes. Rape of women is also used as a weapon of war, as a form of attack on the enemy. Rape of MSM and transgender/hijra is a common way to punish them for their dissident gender and sexual identities. In certain parts of the world, lesbians are subjected to what is called 'corrective rape', with the intention of changing their sexual preference.

- Laws related to rape in India:
 - Section 375 and 376 of Indian Penal Code addresses rape in India.
 - The Indian Penal Code continues its restrictive recognition of sexual violence as heterosexual rape and offences against the modesty of women. As a result men or transgender/hijras are not seen likely to be raped.
 - The Indian law on rape is itself problematic in its traditional interpretation of sexual intercourse, the absence of sensitive procedures, medico-legal collection protocols, evidentiary requirements of signs of resistance to prove 'no consent', and the failure to take sexual violence seriously where a relationship exists between the survivor and the accused. Continuing social stigma associated with sexual violence, based on notions of chastity and purity that the legal system perpetuates, has led to reluctance on the part of survivors and their families to report sexual violence or even seek other support services, hindering any possible assistance to the survivor in terms reducing trauma and the risk of HIV infection.
 - The response of the state in providing for the survivor has also been limited. Indian law does not provide for post-violence medical attention or counselling of survivors. This is of particular importance in context of HIV where the survivor

faces the risk of contracting HIV through direct transmission from the assailant and requires information and counselling. Further, there is little provision of harm reduction options to survivors, in the form of post exposure prophylaxis.

- Due to the social stigma and the non supportive legal system, many victims and their families do not report rape incidents to the police.
- HIV and violence:
 - Social tolerance of violence against women prevents women from discussing the issue, from leaving or confronting an abusive situation or from seeking help. Discrimination associated with HIV heightens such tolerance.
 - Women are often the first member of a household to discover their HIV status through antenatal testing. This can result in blame, violence, and rejection from partners, in-laws, family, friends, and community.
 - Exposure to re-infection due to refusal by sexual partner, particularly husbands and regular boyfriends, to use condoms can endanger key population members life due to HIV-related complications.
 - Fear of disclosure of HIV status may prevent a key population member, particularly if they are women, from accessing available ICTC and PMTCT programmes, and prevent them from using safer infant feeding options, as a woman who does not breastfeed her child may be suspected of being HIV positive.
 - During rape, because of the force used, it is very likely that there will be tears to the lining of the vagina, something that will greatly increase the probability of transmission of STIs, including HIV. During unprotected and forced anal sex, the risk of transmission is even higher.
 - During forced sex, younger women are especially vulnerable to injury to sexual organs and infections because their genital tracts are not yet fully mature, their vaginal secretions are not so copious, and because they are more prone to lacerations or tears of the vaginal lining
 - There is an additional difficulty of negotiation of use of condoms or contraception in violent relationships.

Suggested Activities

Note for facilitators: *This session has many activities to cover the range of learning objectives. While planning a workshop you can prioritise objectives, and therefore activities, according to the training needs of the participants.*

Activity 1: Sex vs. Gender

Estimated time: 30-45 minutes

- Start the activity with an energiser.

Suggested energiser

Ask participants to stand in a circle. Ask one participant to mime a gesture they associate with women. Ask the next participant to mime a gesture they associate with men. Ask rest of the participants to mime gestures they associate with women and men alternately, till the circle is complete. Ask participants not to repeat a gesture that has already been enacted by another participant.

- Create a clear space in the middle of the room. Paste a blue chart paper on a wall and a red chart paper on the opposite wall. Ask participants to stand in a straight line at the centre of the room. Tell them that the wall with the blue chart paper represents 'biology', and the wall with the red chart paper represents 'society'. Tell them you will read out some statements one by one, and after you have read out each, participants will have to move towards 'biology' (the wall with blue chart paper) or 'society' (the wall with red chart paper), depending on whether they feel that the statement is based on social and cultural factors or has a biological basis. Explain what you mean by 'biology' and 'society' with an example.
- Read one statement aloud at a time. Ask participants to move towards one wall or the other, as you had explained. If they are undecided, they can remain in the middle.

Suggested statements

- Girls are gentle, boys are not.
- Having sex with her husband is a woman's duty.
- Women can get pregnant, men cannot.
- Men are good at logical and analytical thinking.
- Real men don't cry.
- Men have sperms.
- Women are creative and artistic.
- Women can breastfeed babies, men cannot.
- Women have maternal instincts.
- Men's voices break at puberty, women's voices don't.
- Men have a greater sex drive than women.
- Women like to dress up and wear makeup.
- Men have to take on the responsibility of earning to support their parents, wives, and children.
- A marriage works better if the husband is older than the wife.

Note for facilitators: *After all statements have been read, most people should be closer to the 'society' wall since all but four of the 14 statements have a social or cultural basis.*

- After reading out each sentence, once participants have moved, ask them to discuss their views about the statement and explain to one another why they felt a certain way about each statement. Facilitate the discussion by asking the following:
 - Is the question controversial, i.e., all participants did not agree that it was based on biology or society?
 - Why did everyone not agree?
 - Does anyone have further questions or comments?
 - Does anyone have examples that illustrate what a particular society expects a man or a woman to be and act based on their socially determined gender identities, and not just their biological sexual qualities?
 - Does anyone have any example of how gender identities can be different even within the same society?
 - Does anyone have any example of how gender identities are played out differently in different societies?

- Clarify misconceptions and discuss with examples from the exercise how gender identities are socially constructed and dynamic and not biologically given and constant across time and place.
- Conclude the activity by asking participants to reflect on how socially constructed gender identities may affect key populations.

Activity 2: Becoming ‘Gendered’

Estimated time: 45 minutes

- Divide participants into groups of two. Ask each pair to discuss the moment when they first realised that they were a girl or a boy, or a woman or a man, or that they did not fit in either role. They should think about who was involved, what actions were involved in bringing about this realisation, and how it made them feel.
- After 10 minutes bring the group together in plenary and ask volunteers to share their stories.
- Once some of the stories are told, ask participants to collectively reflect on the following:
 - Who provides the earliest messages about how different genders should behave? (Is it parents? Other family members? Neighbours? Peers? School teachers?)
 - What kinds of ideas are used to enforce ideas about gender norms? (Is it about economics? Sexuality? Roles? Physical movement? Morality? Violence?)
 - What spaces did this occur in? (At home? In a public space such as the school classroom or in the street?)
 - If a person has acted in ways that are not in line with gender norms, how is this dealt with? (For example, if a girl wants to climb trees or a boy wants to wear dresses?) What happens when a person follows the norm?
 - How do we feel about the process of ‘becoming gendered’? (Pride, fear, anger, humiliation, a sense of responsibility?)
- While participants recount their stories, note down and classify their responses on a chart paper in the following manner:

Rules	Applied to		Individuals and social institutions reinforcing the rule	Material consequences of the rules
	Women	Men		

- Conclude the session by summing up how all of us undergo a process of being ‘gendered’ that often begins at a young age, when we learn to identify ourselves as girls or boys, women, or men. Those of us who find it difficult to identify ourselves as either women or men, or feel our desired gender identity conflicts with our given biological sex, are not even acknowledged by the people around us. Our own sense of our gender identity grows and changes over time, in response to discourses around us and to our own experiences and agency¹⁰. Gender identity is usually enforced through messages about our biology or physiology, our sexuality

¹⁰ In sociology, agency refers to the ability of social actors to make independent choices and act on them.

and reproductive capacity, and expected social roles. The family (immediate and extended) is often the first context in which we learn about gender. Gender norms are often enforced through violence (emotional, psychological or physical) and/or through threats of paying penalties for non-conforming and promise of rewards for conforming.

Activity 3: Gender Roles and Gender Stereotypes

Estimated time: 30-45 minutes

- Ask the participants to stand in a circle.
- Ask each participant to mime an activity one usually performs, or a role one normally plays, that is considered to be typical of one's gender in one's given context, and one that is not typical of one's gender.
- Note down and classify the activities that the participants are miming on a chart paper in the following manner:

Women		Men	
Gender typical	Gender atypical	Gender typical	Gender atypical

- Lead a discussion on how gender stereotypes and gender division of labour are socially constructed and vary according to social contexts, time, and other social relations such as class, caste, religion, region, etc.
- During this discussion, stress that other than strictly biological functions, such as child bearing, childbirth and breastfeeding, all other gender segregation of labour is socially determined as opposed to biologically fixed. What is a typical male activity or a role in one context can be customarily performed by women in another, showing that these roles are not biologically determined. To further clarify the point, during the discussion ask participants to name what men or women in their locality and context would never have done 50 years earlier, and what they now do, to show that gender roles have evolved over time in their own contexts too.

Activity 4: Gender Division of Labour and Resources

Estimated time: 30-45 minutes

- Divide participants into two groups. Ask a volunteer from one group to come to the centre of the room to take on the role of the man of the house and ask another volunteer from the other group to assume the role of the woman of the house. Ask them to decide what kind of a household they belong to; that is, are they a sero-discordant couple, both working in a bank, or a female sex worker and her husband living in a city, or an MSM and his mother from a poor household in a small town, and so on. Ask participants to give names to the two characters.
- Give small cards of one colour to one group and small cards of another colour to the other group.
- Ask one group to draw pictures of tasks that have to be performed in this particular household. Explain that tasks or labour can be both productive and reproductive, that they can be about generating income, or about taking care of the household members.

- Ask the other group to draw pictures of resources that are there in the household. Explain resources can be those that are used to produce things and also those produced through human labour. Also, clarify resources not only refer to money but to all kinds of resources that makes human reproduction and production processes possible - human resources (labour power, health and skills); tangible resources (money, assets, commodities); and intangible resources (solidarity, contacts, information, political clout).
- Ask them to draw only one resource or one type of labour on each card. If they need more cards they can ask for them.
- Ask each group to arrange the cards on the floor in front of the woman or the man, according to who is primarily responsible for performing the task and who owns the resource.
- Once all cards are put on the floor, read out what cards the woman has got and ask participants whether they agree to it or not. Do similarly for the cards the man has got. If participants decide a particular task or resource is shared between them, tear the card and put one piece in front of each.
- Ask participants to observe how tasks and resources are distributed between the woman and the man, and facilitate a discussion on gender division of labour and resources and how gender division of labour creates and reinforces gender inequalities and inequities.

Note for facilitators: *In more unorthodox households, such as that of a breadwinning female sex worker and her dependent, unemployed husband may share some gender roles and tasks that may be different from more conventional households. However, it is likely that the adult male member of any household will have the ownership of more resources.*

Activity 6: Power Walk

Estimated time: 30 minutes

- Mark out on the floor a starting line and a finishing line. Ask all participants to stand in one straight line along the starting line you have marked out on the floor.
- Assign identities to each participant, ensuring no one else can overhear. Allow each participant to get into the identity that they have been assigned. (They have to imagine what the person does every morning from waking up until bed time). Ask them to keep their identity a secret for the time being.

Suggested identities:

- Female sex worker
- PLHIV film actor
- *Panchayat*¹¹ head of a large village
- Married MSM
- *Kothi*¹²
- *Panthi*¹³
- Widow of an industrialist
- Transgender/hijra sex worker
- Male college student

¹¹ Local self-government structure in South Asia

¹² Local name for MSM who usually plays the feminine gender role in their sexual relationship in South Asia

¹³ Local name for MSM who usually plays the masculine gender role in their sexual relationship in South Asia

- A successful fashion designer who uses drugs
 - PLHIV truck driver
 - Businessman
 - PLHIV bank officer
 - Doctor
 - Nurse
 - Rickshaw driver - male
 - Street beggar - female
 - Widow in a dalit¹⁴ sharecropping family
- Call out the situations (as suggested below) one after the other. If they feel they can answer 'yes' then ask them to take a step forward. If they feel their answer is 'no', then they take a step backwards. Remind them that they will have to answer according to the role assigned to them and not as what they really are. Some will move up and others will move down. At the end some will have moved ahead of the starting line and others behind.

Suggested situations to be read out:

- I can read newspaper every morning.
 - I have completed my school education.
 - I can say no to sex without fear of abuse.
 - I will be treated at a hospital/clinic with respect and dignity.
 - I can use a contraceptive whenever I want to.
 - I am able to participate in community events like marriage.
 - I do not face any discrimination at my workplace.
 - I can negotiate with my partner with regard to the number of children I would like to have.
 - I can carry on with my daily life without fear of the law.
 - I have access to HIV prevention information that is specific to my needs.
 - I can engage in activities that give me sexual pleasure in the privacy of my home.
 - I can access HIV treatment without fear of disclosure.
 - I can openly declare who I am.
 - I can have a sexual relationship with whomever I want.
 - I can insist on using a condom without fear of abuse.
- Once everyone is in their new positions, ahead or behind the starting line, blow a whistle to indicate they should run towards the finishing line.
 - Once the exercise is over, ask participants to go back to their original positions and facilitate a discussion by asking the following:
 - Did they enjoy the activity?
 - Who were you?
 - What did you learn from this exercise?
 - Who are the discriminated and marginalised in our society?
 - Are there different layers of discrimination (gender, sexuality, class, caste, and so on) within each discriminated category?

¹⁴ Dalit is a designation for a group of people traditionally regarded as untouchable. Dalits are a mixed population, consisting of numerous social groups from all over India

- Was it easier or more difficult for some people to reach the finishing line, and if so why?
- If the finishing line represents access to SRHR services and entitlements, what does the activity say about how gender and other social relations may expand or restrict a KP member's ability to access services and realise their rights?

Activity 7: Sex, Gender, and Violence

Estimated time: 45 minutes

- Ask participants to sit quietly where they are and imagine something, some place, or some person, anything that makes them feel totally safe.
- Read out brief scenarios describing forced pregnancy, sex selective abortion, marital rape, forced and/or underage marriage, eve teasing, police violence against transgender/hijra and MSM, rape of sex workers, eviction of women living with HIV, and domestic violence.

Suggested scenarios

- Sania has been married for a year. She is studying history at a local college and wants to finish her education before she has children. Her husband, however, does not allow her to use contraceptives as he wants her to get pregnant as soon as possible so that no one can question his virility.
- Parvati has two daughters whom she loves with all her heart. But her husband and in-laws are not happy with her as she has failed to provide a male child. When she becomes pregnant again, they take her to a doctor who does an ultra-sound test to detect the sex of the foetus. When they find that the foetus is female, they force Parvati to undergo an abortion.
- Roja works all day in the fields. When she is home from the field, she has to prepare food for her husband, children, and in-laws, and do other household chores. When she comes to bed she is tired to her bones. Every night her husband insists she has sex with him. Some nights she complies reluctantly just to avoid unpleasantness. In any case, she does not find her husband sexually attractive. Most nights she refuses, but her husband takes her by force. She once tried complaining to her mother-in-law, saying if this continues she will report to the local police that her husband rapes her. Her mother-in-law and her husband had laughed and said how can a woman be raped by her husband.
- Pinky is 14, happy in her school, playing with friends, and looking forward to a life full of promises. One day a group of people from the neighbouring village comes to their home and Pinky is dressed up by her mother and introduced to them. Next day her father told her that she is going to get married into that family that had visited them. Pinky cries her heart out, saying she is too young, she has not even finished the school. But her parents do not pay any attention to her protests, saying she has reached puberty and has to be safely married off before she gets into any mischief with boys. A month after, Pinky gets married.

- Every day when Mary leaves home for her office, a group of boys hanging out at bus stop pass sexual comments and makes lewd gestures at her. She tries to ignore them, pretending not to have seen them. The boys' comments and gestures get more and more coarse till one day one of them grabs hold of her and sexually molests her. People standing at the bus stop do not even seem to notice the incident.
- A group of MSM and transgender/hijras get together every evening at a local park. One day a police contingent rush into the park, bashes them up, and herds them off to the police station saying they are harmful to the society by being unnatural and deviant. After more abuse and beating at the police station, they are allowed to leave only after giving up whatever money they had with them.
- Shabnam is a sex worker, living and working in a brothel area. A local criminal, Raju, wants to have sex with her. Shabnam refuses as she does not want to get involved with a local boy; they are trouble without an end. One night Raju forces himself into her room and rapes her. He feels safe in doing so as he is sure no one will believe a sex worker can be raped.
- Sunita is a widow and is living with HIV. Her in-laws say she was the one who brought HIV into their home and infected their son. Although their home was built by Sunita's husband and Sunita had inherited a share in it, after her husband's death the in-laws throw her out of the house.
- Kitty is a successful film star in Mumbai - young, rich, and beautiful. She is in a relationship with one of the most popular heroes of the Mumbai film industry. They make a glamorous couple. But he insults her in public, throws tantrums if she talks to other men, and beats her regularly.

- Ask participants to discuss each scenario and identify the following:
 - In the situations described, what rights do the individuals subjected to violence may have?
 - How could the violence have been prevented or mitigated?
 - What are the consequences for the person subjected to the violence?
 - Where could they seek support from?
- End the session by facilitating an interactive discussion on how gender based violence is persistent and widespread; cuts across all classes; can happen in the privacy of home or in public; is used to subordinate or punish women and anyone else who is perceived to have transgressed gender norms; and is very difficult to prevent or mitigate because social institutions see it as 'normal'.

Concluding Activity: What Did We Learn From the Session?

Estimated time: 15 minutes

- Ask participants to stand quietly with their eyes closed.
- Quietly ask the following questions and ask participants to silently reflect on if and how they apply to them.

Suggested questions:

- Have you ever been discriminated because of your education?
 - physical shape?
 - caste?
 - religion?
 - earn your living?
 - sexual preference?
 - marital status?
 - health status?
 - gender?



Key Learnings

Participants will be able to do the following:

- Understand and articulate how gender relations are socially constructed and are different from biological sex.
- Identify the ways in which gender differentiation creates inequality of power between genders.
- Identify the material practices such as gender division of labour and resources that keep these inequalities in place.
- Identify how gender and other social relations impact on access to resources for key populations.

SESSION 4



Sex, Sexuality, and Key Populations



Objectives

- To strengthen participants' understanding about:
 - Sex and sexuality
 - The continuums of sexual orientation and gender identities
 - how sexuality underpins the lived experiences of PLHIV and most KP groups
- To enable participants to appreciate sexuality as being more than acts of sex and develop confidence and comfort around discussion of sexuality.



Material Required

- Chart papers, markers, and double sided adhesive tapes.
- A big, light plastic or rubber ball. You can also make a ball by tying crumpled newspapers with a piece of string.



Notes for Facilitators

Sex and Sexuality¹⁵

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

¹⁵ TARSHI, 2006, *Basics and Beyond: A Manual for Trainers - Integrating Sexuality, Sexual and Reproductive Health, and Rights*

- Sexuality as a concept has been explored for many years. There are many definitions of sexuality that cover the various components of sexuality. Sexuality encompasses many ideas and is subjective. Any definition of sexuality needs to reflect this diversity which is why it would be longer and more complex than expected to define sexuality. The definition of sexuality has been evolving along with our understanding of sexuality. While there is no single agreed upon definition, the following definition of sexuality provides a basic and fairly comprehensive understanding of sexuality:

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors.” (WHO, 2002)

- Sexuality is how an individual thinks, feels and acts about ones own body and that of others.
- Sexuality is multidimensional, socially constructed, and is shaped by gender and sexual norms in any given context.
- Sexuality is more than acts of sex. It can mean a range of experiences that vary from person to person—for example, to some it might mean sexual orientation, for others the freedom to express themselves and make choices regarding their body.
- Sexual orientation refers to whom an individuals is sexually attracted to; whether they are attracted to people of the same gender, a gender other than their own, or to more than one gender.
- Sexual identity refers to the label people use to define their individual sexuality (e.g., lesbian, gay, panthi, kothi, double-decker, queer). A number of different things contribute to an individual’s sexual identity, such as the person’s sexual orientation, sexual behavior and preferences, and gender identity.
- Sexual and gender identities are not static. Individuals can identify in many different ways and can keep changing their sexual and gender identity throughout their lives. Sexual orientation and gender roles are both experienced across a continuum that can change over a person’s lifetime.
- Many different individuals and their sexual and gender identities are subjected to stigma and discrimination. The more ‘different’ a person is from the established norm, the more discrimination they face.
- Stereotypes maintained by societies and communities contribute to stigma and discrimination against certain gender and sexual identities.
- These varied experiences and issues related to sexuality can impact people in significant ways. Sexual and reproductive health decisions (for example, the

decision to have or not have children, when to have them, to get married or not, to choose a sexual partner, or to have one's husband/wife chosen by a family or a community) cannot be isolated from issues of sexuality. This makes it even more important to understand and address sexuality.

- A person who identifies oneself as a transgender/hijra has a gender identity that does not correspond with their biological sex. A person who changes from one side of the biological sex spectrum to the other through undergoing hormone replacement and/or sex reassignment surgery is known as a transsexual. People who are intersex are born with ambiguous genitalia and often the doctor or parents take the decision for the infant on which sex they should be. This choice could well be the wrong choice; therefore, intersex persons advocate against doctors or parents making the choice for infants.
- A question that may be raised is that if gender and sexual identities are all fluid, then we could possibly change people of homosexual orientation to heterosexual orientation. However, the key here is that all of these spectrums are related to self-identification, rather than as labels that can be used by others for us or by us for others. Just like one cannot force another person to fall in love with someone, one cannot force a person who identifies as homosexual to fall in love with/desire someone of the opposite sex or vice versa.

Suggested Activities

Activity 1: What Do We Understand by Sex and Sexuality?

Estimated time: 30 minutes

- Ask participants to stand in a circle. Explain to the participants that you are going to throw a ball to each participant and as a participant catches the ball, she or he has to immediately shout a word she or he associates with sex and throw the ball back at you. No participant can repeat a word that has already been used.
- Now throw the ball to each participant in a random sequence. Make sure you throw the ball at each participant and everyone gets a chance to say a word they associate with sex.
- Record their responses on a chart paper.
- Once again throw the ball at participants in random sequence, with the participant who catches the ball calling out words or phrases they think of when they hear the word sexuality. Again record their responses on chart paper.
- Facilitate a discussion by asking participants the following:
 - Are there any words missing? What are they and why do participants think they were left out?
 - Are their words recorded which participants may not have associated with sex or sexuality before?
 - How is sex different from sexuality?
- End this activity by reading out the WHO definition of sexuality.

Activity 2: Continuums of Sexual Orientation and Gender Identity

Estimated time: 45 minutes

- Tell the following story to the participants, taking care not to use any pronoun that indicates the gender of the main character:

Kiran's life and loves

Kiran's mother is very proud of Kiran. And she has reason to be. Kiran is a diligent student, doing very well in the secondary school in the small town they live in. Yet Kiran always finds time to help out Kiran's mother with housework, and looking after the smaller children. Sometimes Kiran goes off to play cricket with Kiran's friends in the neighbourhood, or to explore the forest nearby, just like other children of Kiran's age. But even when having fun with friends, Kiran remembers to collect firewood for Kiran's mother. Then time comes for Kiran to join high school in the nearest city. Kiran's teachers convince Kiran's mother to let Kiran stay in the school boarding and start high school, as Kiran is such a bright student and has earned a scholarship too.

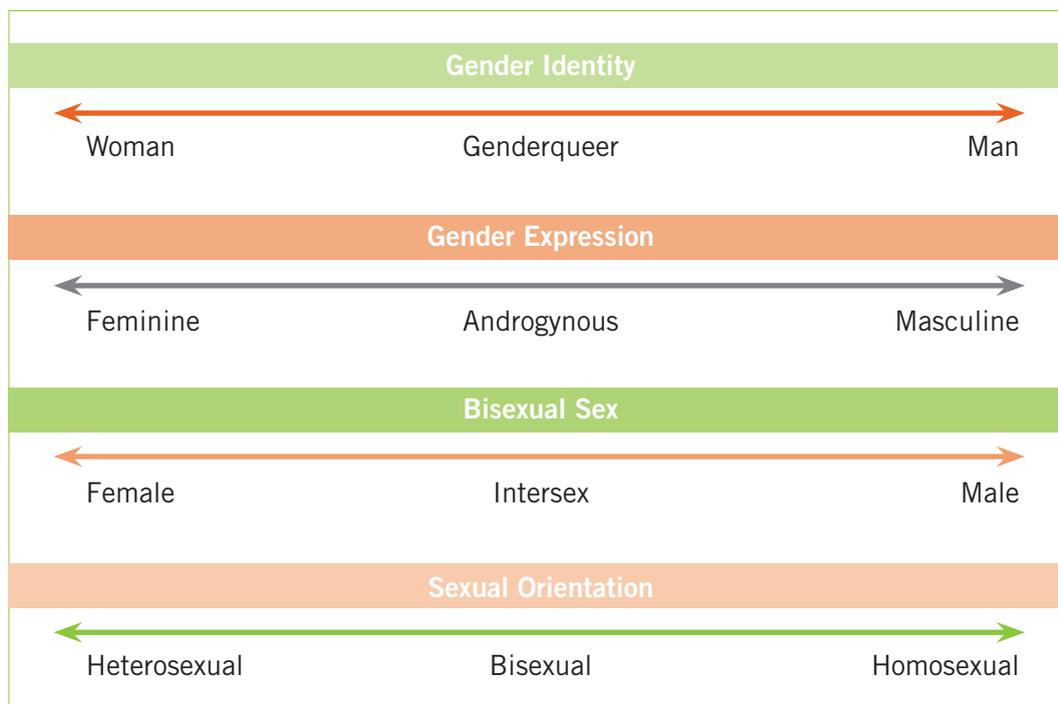
In the high school, Kiran discovers the joy of physics, hockey, music, and love. Kiran falls in love with Kiran's classmate Ayesha. As teenagers they are both a little awkward in expressing their feelings for each other, yet they feel strong sexual attraction, and swear eternal love and vows to stay together no matter what future holds for them.

Before Kiran could finish the high school, Kiran's mother falls sick and Kiran has to go back home to take care of the family as Kiran's mother was the only wage earner in the family. Kiran, young of age and with no qualification or experience, finds it very hard to find a job in the town. A friend suggests sex work, saying Kiran will be able to earn enough for their family as Kiran is beautiful and young. Kiran consults another friend who is already working as a sex worker in the town and starts working. A year later, Kiran meets Thomas, a handsome older man working in a big private company, who had come to Kiran as a client. Once again Kiran falls in love. Thomas too becomes very fond of Kiran and, discovering Kiran's interest in studying, encourages Kiran to continue with education. Thomas supports Kiran's family while Kiran resumes studying.

Kiran qualifies as a computer repair person and finds a job in the town, which Kiran supplements with occasional sex work. Today Kiran is happily married with a child.

- Ask participants to think about the story, and raise their hands if they think Kiran is a woman. Ask those who have raised their hands why they think Kiran is a woman.
- Ask other participants to explain why they think Kiran is a man. Let two groups discuss and debate their reasons for identifying Kiran's gender. Ask participants if anyone had considered Kiran to be transgender/hijra.

- Present the following diagram to participants (draw the diagram on a chart paper beforehand) and lead a discussion on how we all make assumptions and projections about gender roles and how they are performed in society; how sexuality and sexual orientation are not static but are fluid and can change over time.



<http://itspronouncedmetrosexual.com/2011/11/breaking-through-the-binary-gender-expained-using-continuums/>

Activity 3: In My Language

Estimated time: 30-45 minutes, depending on the number of participants.

- Go around the room and ask each participant to name the languages that they speak. Divide participants into groups according to the common languages they speak; for example, English group, Gujarati group, Hindi group, Marathi group, Tamil group, or Telugu group. Make sure in each group all members speak the language of the group.

Note for facilitators: *If participants speak the same language, you can divide them into groups according to their age.*

- Ask each group to brainstorm all of the words and expressions in the language of the group, including multiple words for the same—whether in formal, bookish language, everyday language, slang, or in languages of specific communities such as hijra— used to describe the following and note them on a chart paper:
 - Women (overall)
 - Men (overall)
 - Effeminate men (men who ‘behave like women’)
 - Masculine women (women who ‘behave like men’)
 - People attracted to people of a different gender
 - Women attracted to other women
 - Men attracted to other men

- People attracted to others of the same and other gender
- People who have both 'male' and 'female' biological features
- Reconvene in plenary and ask each group to present their words or expressions, explaining what they mean, and in what context the word is used.
- Reflect collectively the following:
 - Are there expressions for each of these sexual and gender 'categories' in all languages? If not, which 'categories' do not have names?
 - What kinds of metaphors are used to express gender identity? And sexuality?
 - Is there a word equivalent to 'heterosexuality'? If not, why do we think that is?
 - Is there terminology to describe masculine women or feminine men? Is it linked or does it imply a sexual orientation or only a gender identity?
 - Do gender terms relate to biology or social roles?
 - What do the words for same sex/gender desire, or men or women having multiple sexual partners, say about how people who speak the language feel about them?

Activity 4: Sexual and Gender Identities with Regard to PLHIV and Other KPs

Estimated time: 30-45 minutes

- Ask participants to stand in a circle. Go around the circle and assign an identity to each participant. Call out the identities as you assign them so everyone knows who has got what identity. (The identities can be sexually active heterosexual married woman, gay man, lesbian woman, hijra, kothi, female to male transgender, male to female transgender, etc.)
- Ask participants to think of the identity that has been assigned to them. For the rest of the exercise they must make these identities their own. For example, if a participant is heterosexual woman in her real life, she must adopt the identity of a hijra if that is what she has been assigned to act as for the exercise.
- Ask participants to assume their assigned identities and mingle and create small groups with other identities with whom they have something in common. The commonalities could be related to a role they have in the community, their gender, the kind of work they do, the stigma and discrimination they may experience, and the sexual freedom they may or may not have.

Note for facilitators: *If you find people who are not able to establish commonalities, raise questions to get them started: for example, what would a gay man have in common with a lesbian woman in terms of their relationship with their family members?*

- After at least three small groups are formed, ask groups to discuss what they have in common in the context of their identities.
- Facilitate a discussion in plenary by asking the following:
 - Were there any identities participants had not heard of before or would like to know more about?
 - Were any particular gender or sexual identity missed out?
 - Were there any stereotypes that emerged from the groups (such as, all gay men are promiscuous; hijras should only beg for alms (mangti), etc)?

Concluding Activity: What Did We Learn from the Session?

Estimated time: 15-20 minutes

Ask participants to sit in a circle. Ask each participant to think of one thing that she or he would tell her 18-year-old daughter, granddaughter, niece, or a neighbour about sexuality.



Key Learnings

Participants will be able to do the following:

- Understand that sexuality is more than acts of sex.
- Identify what the range of different sexual identities can be in their contexts.
- Articulate how sexuality and sexual identities—like gender identities—are socially constructed and are mediated by other social relations.
- Understand that sexual and reproductive health decisions, such as with whom, when, where, or how to have sex, whether to have children or not, etc., are inevitably linked with one's sexuality.
- Understand how sexuality impacts on the lives of PLHIV and other KPs.



SESSION 5



Recognising Sexual and Reproductive Health Within the Framework of Rights



Objectives

- To strengthen participants' understanding of the concept of human rights in relation to health, particularly SRH.
- To familiarise participants with basic human rights and understanding them in context with the real life situations.
- To familiarise participants with sexual and reproductive rights.
- To enable participants to analyse the ways in which human rights, including sexual and reproductive rights, of PLHIV and other KPs are violated.



Material Required

- Chart papers, markers, and double sided adhesive tapes.
- Print-outs of hand-outs on UDHR, case studies, and IPPF Charter on Sexual and Reproductive Rights.



Notes for Facilitators

Human Rights¹⁶

- The ethical principles about how people should treat each other are widely viewed as universal. These principles are called human rights.
- Although people have a personalised view of what rights mean, one fundamental understanding about rights is egalitarianism; that is, every human being is equal and everyone is equally entitled to basic rights and protections. The other equally important principle is that rights

¹⁶ India HIV/AIDS Alliance, *Fact Sheets on Sexual and Reproductive Health and Rights*

should be the same for everyone; that is, rights are universal. This means they apply to all of us. They are not conditional and cannot be taken away from us, no matter whether we are boys or girls, rich or poor, married or unmarried, whatever our religion, colour, nationality, sexual orientation, disability, or health status (for example, being HIV-positive).

- UDHR is the first international statement to use the term “human rights” and it has been adopted by United Nations General Assembly on December 10, 1948. All countries, including India, are signatories of UDHR and are committed to uphold them. Although all of us should be able to enjoy our human rights, in reality we do not always do so.
- When a country ratifies a human rights treaty, its government is bound by the international law to give effect to the human rights contained therein by respecting, protecting and fulfilling the various rights; governments are thereby required to bring their domestic laws, policies and practices in line with any international or regional treaty to which it is a party. Consequently, international human rights law may be a useful tool for advancing sexual and reproductive rights.
- The four key principles of the human rights are:
 - Universal – human rights are applicable everywhere and at all times.
 - Interdependent and interrelated – all rights are linked; for example, the right to education is linked to the right to health, and vice versa.
 - Accountability – countries and individuals have a responsibility to promote and respect human rights, as well as report violations.
 - Indivisible – all rights must be fulfilled, with the exemption of none.

Please see Annex 4 for detailed information about the UDHR, fundamental rights in the Indian constitution, the Protection of Human Rights Act 1993.

Suggested Activities

Activity 1: Human Rights Survey¹⁷

Estimated time: 30-45 minutes

- Hand out a list of ‘rights’ (given below) and ask participants to quickly choose six rights that they do not want to lose in their own life.

List of ‘rights’:

The right to . . .

. . . give my permission before people do things for me

. . . go out to see a film with my friends

. . . go to bed when I want to

. . . read whatever I want, when I want to

. . . not disclose my sexual and gender identity

. . . have a sexual relationship

. . . disclose my sexual and gender identity without fear of reprisals

¹⁷ Adapted from activity developed by Georgie McCormick, Family Planning Association.

- . . . use public transport
- . . . have children
- . . . control my own earnings and savings
- . . . dress the way I want to
- . . . be listened to
- . . . choose my own method of birth control
- . . . legal redress when I experience discrimination
- . . . make my own decisions about who I have sex with and when
- . . . have more than one sexual partner in life
- . . . express my opinion and have it valued
- . . . be on my own when I want to
- . . . say YES and NO when I want to
- . . . make decisions regarding my own welfare
- . . . make decisions regarding my family and children's welfare

- Ask participants to take turns and explain in plenary the following:
 - The six rights they did not want to lose.
 - Why they chose these six rights?
 - The impact on their lives if they lost those six rights.

- In plenary, lead a discussion on the following:
 - How did it feel doing this exercise?
 - Was it difficult to identify the six rights?
 - What issues did the exercise bring up?
 - What rights were selected by everyone?
 - Why are these rights important?

- Explain that the purpose of this 'survey' is to help simplify the concept of human rights (as enshrined in the UDHR and make it applicable to our personal lives.

Activity 2: Tree of Rights

Estimated time: 45 minutes

- Divide participants into two groups through the energiser. Tell one group to think of themselves as women living with HIV and the other group to think of themselves as male sex workers.
- Ask each group to draw a trunk and branches of a tree on a chart paper. Then ask them to draw larger leaves on the branches of the tree. Ask participants to write or draw on each leaf a symbol of one right that they think is necessary for leading a life of equality and dignity.
- Ask each group to discuss the following questions relating to rights when they write up or draw the rights on the leaves. Encourage participants to hear the opinions of everyone in the group and then to try and reach a group consensus on their ideas.
 - What are some of my rights?
 - Who 'gives' or 'takes away' rights?

- Do I need to have any special right because I am a woman living with HIV or a male sex worker?
- What are my rights in relation to health, especially sexual and reproductive health?
- Ask the groups to present their rights trees in plenary and ask for comments and questions.
- Make a short presentation summing up key elements of the Universal Declaration of Human Rights (UDHR).
- Ask participants to mark the similarities between the two trees, and lead a participatory discussion on universality, indivisibility, inter-linkages, and inalienability of rights.
- Help participants to match the rights they have put up on the leaves with the human rights enshrined in UDHR. You may distribute a hand-out on UDHR to participants for this activity.

Activity 3: Violation of Human Rights of PLHIV and Other KPs

Estimated time: 60 minutes

- Distribute one case study to each group. Also give each group the hand-out on UDHR.

Case Study 1

It took Aarti three years and a lot of love and support from her friends and family to accept her HIV status. She no longer feels the shame and hurt she felt in the early days of her diagnosis. Doctors told Aarti that there are medications she can take that can help her stay healthy longer, but she has not followed up on that information. She now wants to know where she could get these medications since she wants to improve her health. Unfortunately, when she returns to the clinic that diagnosed her as HIV positive, she discovers that it has closed down. Aarti lives in a fairly remote village which has only one clinic – the one that has now closed down. She decides to ask one of her co-workers where she could go to get the medication. When she asks the co-worker about the clinic, she tells her that she is HIV positive. The co-worker is not sure about a clinic but says she will try and find out for her.

The next day when Aarti comes to work, she is asked by her supervisor to come into his office. He informs her that they are cutting back on staff and will need to fire her. Aarti is shocked and asks why this is happening and who else is being fired. Since she is insistent, the boss tells her that only she is being let go because of her poor performance over the past year. Aarti explains that she has always done her job well and never received any complaints before. She also tells her boss that she needs the job to help support her family but her boss is unresponsive to her pleas. Aarti goes home dejected and upset and not sure what she should do next: she has no job, needs money to get the medicines she needs for her HIV treatment, and is also unsure where to get these medications. She feels alone and confused about what to do.

Case Study 2

Ahmed is a transgender living in a large city. While it has been difficult to identify as a transgender, Ahmed is happy with his life and has friends and a community he is comfortable with and is content to remain in the city for years to come. With this in mind, Ahmed decides to purchase an apartment. He sets his sight on one: a modest apartment in a good neighbourhood and is up for sale. Ahmed needs a loan to buy the flat and decides to try his luck with a local bank.

Ahmed goes to the bank with his request. The loan officer at the bank asks Ahmed to fill out the loan application and tells him that the process of getting the loan should be fairly straightforward because the loan amount is not very large. Also, Ahmed has documents to show that he will be able to repay the loan effortlessly. Ahmed begins to fill out the form, but has a problem with the section that asks for gender, and has only male and female as options. Ahmed does not consider himself to be exclusively male or female and cannot tick one or the other category. Ahmed communicates his dilemma to the loan officer and asks if he can add another category. The loan officer is confused, and tells Ahmed that he must choose one of the gender options in order to get the loan. Again Ahmed protests and tries to explain the situation, but the loan officer will not listen and simply tells Ahmed to make a choice or forget about the loan.

- Ask each group to analyse their case study and discuss the following questions by referring to the hand-out on UDHR:
 - Are any of the person's rights being violated? Which ones?
 - What would be the responsibility of the state in the context of protecting this person's rights?
 - What can the person do in order to claim her/his rights in this context?
- Ask participants to return to plenary and invite each group to share their case study and their analysis. Facilitate a discussion referring to the UDHR to emphasise state's obligation to protect and promote the protagonists' health and human rights.

Activity 4: Sexual and Reproductive Rights

Estimated time: 60 minutes

- In plenary, ask participants to brainstorm what are sexual rights and what are reproductive rights.
- Note down the responses on a chart paper and say you will come back to them at the end of the activity.
- Divide the participants into two groups and give each group a scenario.

Suggested scenarios

Scenario 1

A 19 year old sex worker comes to your NGO health clinic, asking for a check-up because she has vaginal discharge. During examination, you notice that she has bruises all over her body, including around her genitals. When you ask her about the bruises, she tells you that she fell down the stairs.

Scenario 2

A young woman comes to your network meeting and says that she is pregnant. She says that when she went for antenatal check up at the local hospital, they took her blood without explaining why. Later they informed her that she was HIV positive and should opt for an abortion. She however wants to have the child.

- Ask each group to discuss how they would respond to the situation. What rights have been violated in the scenario given to them? What kind of support can they provide?
- Based on their discussion, ask each group to prepare a five minute skit or role-play to act out the advice they will provide in their scenario.
- Ask the first group to perform their skit. Ask participants from the other group to come up and participate in the skit, adding new characters or replacing original characters, to show what else could be done in the given scenario.
- Repeat the same process for the second group.
- Correct misconceptions and ask participants to review the chart paper(s) with the components of sexual and reproductive rights they had mentioned earlier. Ask them if they would like to change or add anything.
- Present the International Planned Parenthood Federation (IPPF) Charter of Sexual and Reproductive Rights,¹⁸ explaining that the IPPF Charter on Sexual and Reproductive Rights identifies a broad range of sexual and reproductive health issues that fall within the scope of twelve basic human rights. These twelve rights have been sourced from four international human rights treaties, including the Universal Declaration of Human Rights, which have been ratified by a range of countries world-wide.

IPPF Charter of Sexual and Reproductive Rights:

- The right to life
- The right to liberty and security of the person.
- The right to equality and to be free from all forms of discrimination
- The right to privacy
- The right to freedom of thought
- The right to information and education

¹⁸ *Sexual Rights: An IPPF Declaration (2008), International Planned Parenthood Federation (IPPF), U.K.*

- The right to choose whether or not to marry and to found and plan a family
- The right to decide whether or when to have children
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to freedom of assembly and political participation
- The right to be free from torture and ill treatment

Activity 5: Violation of Sexual and Reproductive Rights

Estimated time: 45 minutes

- Ask participants to sit in a circle and pair up with their neighbour on their left.
- Read out examples of violation of sexual and reproductive rights (listed below). After reading out each example, ask participants to group in pairs and discuss the following questions:
 - Which rights are violated in this situation?
 - What would you do if this were your friend?
 - If you were the highest policy maker of your country, what would you do to address this issue?

Examples of violations of sexual and reproductive rights

- A sex worker is forced to have sex against her will.
 - A man faces discrimination and abuse at his workplace because he has sex with other men.
 - A doctor turns a young woman away from an abortion clinic because she is unmarried.
 - A woman living with HIV is beaten up by her husband because she refused to have unprotected sex with him.
 - A local NGO is shut down because they were providing information about safer sex to children living on the streets.
 - A young MSM suffering from anal STI does not get any treatment from the local STI clinic as the doctor does not even ask him about his sexual and medical history.
 - A young woman living with HIV is sterilised without her knowledge or consent.
 - A doctor refuses to provide STI services to a young male sex worker and reports to his parents.
 - A man living with HIV is denied information about safe ways to have a baby with his wife because the doctor thinks that people living with HIV should not have children.
 - Young people in school are not provided with sexuality education because it is banned.
- Take a few responses for each example.
 - Conclude the session by leading a discussion of how violations of sexual and reproductive rights can take many different forms. And how some of these violations are so common that they are typically overlooked, excused, or seen as culturally 'normal'.

Concluding Activity: What Did We Learn?

Estimated time: 15 minutes

- Ask participants to sit in a circle.
- Ask each participant to share what they found most surprising in this session.



Key Learnings

Participants will be able to do the following:

- Relate their of rights to the international statues.
- Understand that often human rights of PLHIV and other KPs are violated by the state because of who they are.
- Understand that sexual rights relate to a person's sexuality, sexual orientation, gender identity, and sexual health.
- Understand that reproductive rights relate to a person's fertility, reproduction and reproductive health. There is some overlap between the two concepts.
- Appreciate that all persons, including PLHIV, are entitled to these rights and they are necessary for their development and well-being.
- Appreciate that PLHIV and other KPs have the right to choose if, when, how many, and with whom to have children.

SESSION 6



Sexual and Reproductive Health



Objectives

- To familiarise the participants with definitions of sexual health and reproductive health and with different components of SRH.
- To strengthen participants' knowledge about sexual and reproductive organs and their functions.
- To familiarise participants with the range of sexual and reproductive health issues experienced by PLHIV and other KPs.
- To strengthen participants knowledge about available SRH services and service providers for different SRH components.
- To enable participants to identify and address barriers to access of SRHR services and entitlements by PLHIV and other KPs.
- To enable participants to explore ways to address stigma and discrimination against PLHIV and KPs at SRH service settings.
- To enable participants to ascertain the opportunities for maximising service access for PLHIV and other KPs through integrating HIV and SRH services, and ascertain the risks and strategies for mitigating those.



Material Required

- Chart papers, markers, double sided adhesive tapes



Notes for Facilitators

- Sexual health is defined as a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO's working definition, 2002)

- Reproductive health is defined as a state of complete physical, mental, social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes. (WHO's working definition, 2002)
- Key components of SRH
 - Family planning information, counselling and services, including emergency contraceptives
 - Prevention and treatment of STIs (including HIV) and RTIs
 - Antenatal, post-partum and delivery care and infant care
 - Safe abortions and post-abortion care
 - Prevention and treatment of infertility and sexual dysfunction
 - Diagnosis and treatment of cancers of the reproductive system
 - Addressing harmful practices
 - Addressing gender based violence against women, transgender/hijras, and men
 - Promoting gender equality and a positive attitude towards sexuality
- Key SRH events and health issues
 - Pregnancy
 - Delivery
 - Miscarriage
 - Menstrual disturbances
 - Abortion and complications related to abortion (incomplete abortion, bleeding, infection, post-abortion fever)
 - STI
 - HIV counselling and/or voluntary testing
 - Sexual inadequacy
 - Premature ejaculation
 - Family-planning counselling and services

For more information on SRH please see annex 6.

Suggested Activities

Activity 1: Defining Sexual and Reproductive Health

Estimated time: 30 minutes

- Start the activity with an energiser.

Suggested energiser

Ask participants to sit in a circle. Ask each of them to imagine “if my vagina could speak, what would it say?” and share that in the larger group. Ask male participants to imagine if they had a vagina and if it could speak, what it would say.

- Divide participants into small groups and provide each group with two different colours of sticky notes.

- Ask each group to brainstorm what constitutes sexual health and reproductive health.
- Ask them to write only one term on one sticky note, ensuring sexual health terms are all on one colour and reproductive health terms are all on the other colour.
- On a large flipchart draw two columns marked sexual health and reproductive health.
- Ask groups to stick their sticky notes on the relevant columns.
- Discuss the differences and commonalities between sexual and reproductive health, ensuring that you highlight the following:

Important aspects	
Sexual health	Reproductive health
<ul style="list-style-type: none"> ● Positive approach to sexuality ● Pleasure and safety ● Sexual rights ● Emotional 	<ul style="list-style-type: none"> ● Positive definition of health ● Healthy sexual lifestyle ● Reproductive capability ● Reproductive freedom ● Contraceptive information and services ● Safe pregnancy and childbirth ● Healthy children ● Mental and social aspects besides physical ones

Differences	
Sexual health	Reproductive health
<ul style="list-style-type: none"> ● Emotional ● Relationships ● Communication ● Self-control ● Common language ● Preventive behaviour 	<ul style="list-style-type: none"> ● Physical ● Childbearing ● Treatment ● Medical control ● Specialised language ● Preventive measures

- Conclude by summing up the key components of SRH referring to the responses from the participants.

Activity 2: Sex, Desire, Pleasure, and Our Bodies

Estimated time: 60 minutes

- Start the activity with an energiser.

Suggested energiser

Ask participants to stand in a line in order of their heights. Ask each participant to name one thing they really like about sexual act.

- Divide participants into two groups. You can divide the group according to gender; that is, ask those who think of themselves as women to form one group and those who think of themselves as men to form the second group. Or you can divide the group randomly if participants are not evenly balanced in terms of gender.
- Give chart papers and coloured markers to both groups and ask each group to draw 'body maps' by asking someone from their group to lie down on the paper and then asking another member of the group to trace the outline of their body on to the paper. Ask the women's group to draw the outline of a woman's body and ask the men's group to draw the outline of a man's body.
- Ask each group to label all possible parts of the body that can be used for having sex. Ask them to either draw these directly onto the drawings or to draw them on pieces of paper and then stick them on.

Note for facilitators: *The list should include, but not be limited to, the following sexual organs: penis, urethral opening, testicles, and scrotum for men. Vagina, labia, vulva, clitoris, urethral opening, pubic hair, buttocks, anus, breasts, and nipples for women.*

- Ask the two groups to put up their body maps next to each other on a wall and explain what they have drawn on the map and why. Encourage others to ask questions about the drawings and to make any comments or additions.
- Ask specifically if they want to make any changes if the body map is of a transgender—either male to female or female to male.
- Ask the larger group to further discuss how a person can be sexually stimulated. Encourage participants to name different sexual acts that can happen between men and women, men and men, and women and women. The list can include: kissing; hugging; oral sex; licking/rimming (licking the anus); touching/caressing; masturbation and mutual masturbation; rubbing and pressing bodies together; massage; thigh sex; breast sex; anal sex; fetishism (being sexually excited by a particular object, e.g., leather); sadomasochism; golden showers (urinating on someone else); scatting (using faeces during sex); voyeurism; exhibitionism; telephone sex; talking sexually; using sex toys; making videos; fingering; and fisting. For each sexual act ask who engages in that kind of sexual act. Clarify myths and misconceptions.
- Ask participants to reflect if the sexual organs they had listed should be expanded to include other human organs such as skin, lips, eyes, and brain.
- Now ask participants to draw the reproductive organs of their characters and share in plenary.
- Wrap up the session by clarifying misconceptions.

Activity 3: Come Let Us Talk

Estimated time: 45 minutes

- Ask participants to go back to their groups, taking their body maps with them. Tell them the woman whose body they have drawn is a 49-years-old widowed woman living with HIV, and the man is a 35-years-old male sex worker.
- As participants in each group to discuss the following:
 - What sexual and reproductive event and ill-health issues have the person ever experienced and where in the body?

- What such a person usually does to address these sexual and reproductive events and ill-health issues?
- Are there better ways of addressing these problems or dealing with these events?
- Ask each group to go to the other group and explain what they have discussed.
- Facilitate a discussion clarifying misconceptions and adding facts if they are left out and help participants to identify, in their own words, SRH events and ill-health issues.

Activity 4: Service Map with Matrix Ranking

Estimated time: 60 minutes

- Divide participants into four groups. Keep the groups as cohesive (in terms of the members being from the same state or same organisation) as possible.
- Assign a key population group to each group (transgender/hijra living with HIV, a street based sex worker, a young kothi, and a rural married woman living with HIV).
- Ask each group to select a real geographical area (a village, a small town, or an area in a city) that at least some members of the group know quite well. Ask them to draw a map of the area including a few main landmarks.
- Ask participants to include in the map any places or people that their key population group could visit to get SRH services.
- Ask participants to put against each intervention what SRH services they provide.
- Ask them to identify factors that make a particular service attractive to their key population group (such as distance, cost, behaviour of service providers, confidentiality, effectiveness of services provided, availability and timing, and so on).
- Now ask the participants to rank the services marked as important in a matrix in terms of how accessible they are to their key population group.

Note for facilitators on facilitating matrix ranking: In order to rank and score the services participants have identified in a matrix, first ask them to draw a table. Ask them to put the different services they have identified in the first vertical column. Then ask them to put the different factors (distance, cost, behaviour of service providers, confidentiality, effectiveness of services provided, timing, etc.) which make the KP group assigned to them like or dislike a particular service in the first horizontal row. Then ask them to give a score from one to five to each of the service for each of the factor, with one denoting very good and five denoting bad.

	Distance	Cost	Behaviour of service providers	Confidentiality	Effectiveness	Timing	...
Service A							
Service B							
Service C							

Score: 1= very good; 2 = good; 3 = average; 4 = needs improvement; 5 = bad

Ask participants to add up the scores for each service. The services that score more are the ones that need to be improved.

- After some discussion, ask the participants what changes (both in terms of physical infrastructure and also people, their skills and values) need to take place for making SRH services more accessible for their key population group.
- Now ask the group to make a series of brief drawings outlining the steps necessary for the change to happen and debate which steps are critical and who has to initiate and follow up on those steps.
- Facilitate a gallery walk so that participants can review other groups' service maps.

Activity 5: When I Went to the Hospital...

Estimated time: 60 minutes

- Divide participants into three groups with an energiser.
- Assign the following characters to each group: (a) an MSM seeking STI services at a district headquarters hospital; (b) a young woman living with HIV seeking contraceptive services at a PHC; (c) a sex worker living with HIV seeking antenatal services at a government medical college and hospital.
- Ask each group to draw a map representing their character's journey to a SRH service point, starting from their homes (including different destinations within the service point), indicating who they interact with at every point of their journey. Ask the participants to analyse and draw who or what either helped them in accessing services or made it difficult. Ask them to think carefully about what stigma and discrimination the KP character assigned to their group may encounter and why.
- After some discussion, ask the participants what changes (both in terms of physical infrastructure and also people, their skills and values) need to take place for making SRH services more accessible for their KP character.
- Now ask the group to make a series of brief drawings outlining the steps necessary for the change to happen and debate which steps are critical and who has to initiate and follow up on those steps.
- Ask each group to present their drawings in plenary.
- Finish the session by asking participants to collectively reflect on what they shared and learned during the session that would be useful for them in improving access of KPs and PLHIV to SRH services and particularly address issues of stigma and discrimination.

Activity 6: Margolis Wheel

Estimated time: 30-45 minutes

- Ask participants to discuss the most difficult problem that KPs and PLHIV face in accessing SRH services and entitlements. Go round the group, correct misconceptions, challenge prejudices, and make sure that each person has a different problem.
- Arrange the group in two circles so that there is an inner and an outer circle, with pairs facing each other. Explain that the inner group members are 'consultants' and the outer group members have come to get their advice. The outer group members have two minutes with each consultant to explain their particular barrier or difficulty and ask them for advice on how to address it.
- Start the clock. After two minutes ask all those in the outer circle to move round to the next consultant and ask for advice for the same problem. Repeat this until those in the outer circle are in their original places. Now ask the pairs to swap round so that those in the outer circle now become the consultant. Repeat the activity.

- Finish the session by asking participants to share the best advice they got for their particular problem. Ask if anyone did not get satisfactory advice and ask the group to comment.
- Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful for them.

Activity 7: Through the Looking Glass

Estimated time: 45 minutes

- Divide participants into small groups.
- Ask the groups to draw two different pictures of SRH service providers in government hospitals. One of the characters they draw represents someone who routinely refuses SRH services to PLHIV and other KPs. The other character represents someone who provides quality services to these groups without stigmatising them. Now ask the participants details about the two imaginary persons in the drawings. Help them to build up a story around the drawings by asking them the following:
 - What are the names of the imaginary persons?
 - Where do they live and work?
 - What are their working conditions like?
 - What are their values and attitudes toward patient care?
 - Why do they find it hard or easy to provide SRH services to people living with and most at risk of HIV?
- When the two stories are complete, ask the participants to think of things that would help the person in the first drawing become more like the person in the second drawing. After some discussion, ask them to settle on one (or more, depending on the time available) change that would really help the person in the first drawing to provide quality and stigma-free SRH services to PLHIV and other KPs.
- Now ask the participants to make a series of brief drawings outlining the steps necessary for the change to happen and debate which steps are critical and who has to initiate and follow up on those steps.
- Finish the session by asking the participants to reflect on what they shared and learned during the session that would be useful for them.

Activity 8: Integration of HIV and SRH Services

Estimated time: 45 minutes

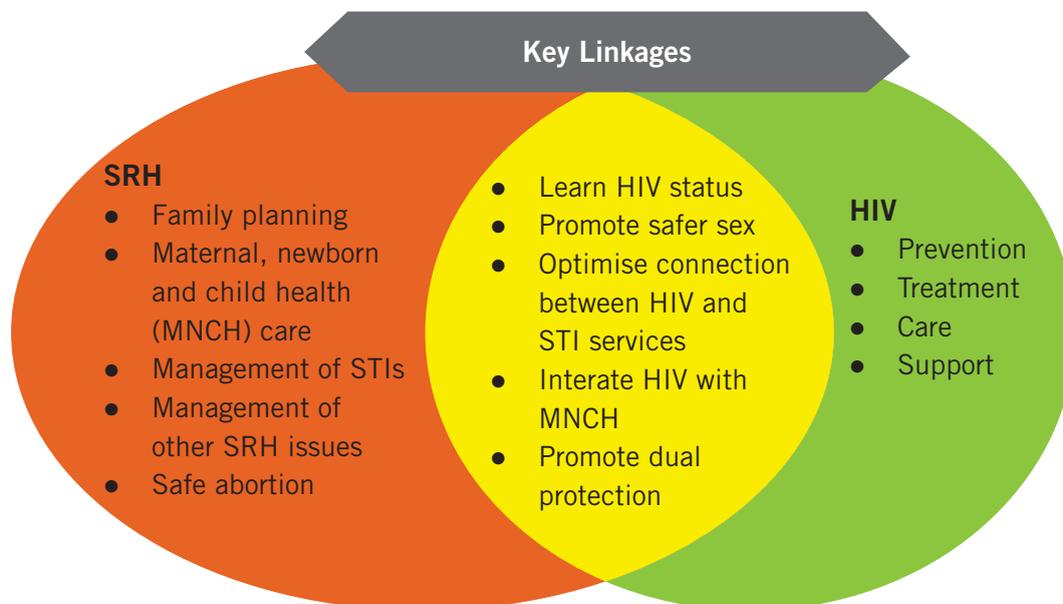
- Divide the participants into three groups and assign different service delivery points to each group: government health service provider, private service provider, NGO service provider.

Note for facilitators: *You can also assign them service delivery points at different levels such as primary health care centre, district hospital, and tertiary health centre.*

- Provide each group with an empty venn diagram (with two overlapping circles) on a flipchart. Ask them to discuss what SRH and HIV services their assigned service provider delivers. Ask them to put the SRH services in one circle, HIV services in the other, and the services that are common to SRH and HIV in the overlapping section.

- Discuss all the flipcharts together by putting them up on a wall together and compare.
- Also put up a flipchart with the completed framework which you have prepared earlier and summarise the areas of integration (mostly family planning and STI services). Point out the necessity of linkages with other kinds of services that need to be made through referral, i.e., care and support, income generation, violence shelter/legal support, etc.

A framework for priority linkages



- Ask participants to go back to their original groups and assign one key actor in integration to each group: PLHIV and other key population members who will use the services; service providers; and health policy makers.
- Ask each group to discuss what will be the rationale for integrating HIV and SRH services for their assigned actors and what will be the possible risks.
- Lead an interactive discussion in plenary and using group responses discuss the rationale for integration and linkages of SRHR and HIV services; explain that a one-model-fits-all approach will not work and that the emphasis should be on client-centeredness. Also discuss the potential *risks* key populations may have and how they can be mitigated.

Concluding Activity: What Did We Learn?

Estimated time: 15 minutes

- Ask participants to sit quietly with their eyes closed.
- Name female and male sexual and reproductive organs one by one and ask participants to silently reflect on what they have learned in the session about the fundamentals of sexual and reproductive health.



Key Learnings

Participants will be able to:

- Define sexual and reproductive health and identify different components of SRH.
- Identify sexual and reproductive organs and their functions and articulate diversities of sexual pleasure.
- Categorise sexual and reproductive events and ill-health experienced by PLHIV and other KPs and identify available SRH services and service providers for different SRH components.
- Identify and address barriers to access of PLHIV and other KPs to SRHR services and entitlements.
- Devise strategies for addressing stigma and discrimination against PLHIV and KPs at SRH service settings.
- Explore the opportunities for maximising service access for PLHIV and other KPs through integrating HIV and SRH services, and develop strategies for mitigating the risks.



SESSION 7



Advocacy for Improving Access to SRHR for PLHIV and Other KPs



Objectives

- Enable and develop participants understanding on advocacy.
- To strengthen the participants' skills in planning and implementing advocacy work to address SRHR of PLHIV and other KPs.



Material Required

- Chart papers, markers, double sided sticky tapes



Note for Facilitating

This session will work best if participants can work on real advocacy issue from their work context rather than using a hypothetical one. If possible, divide participants into cohesive, organisational groups so that they can have shared knowledge about their working areas and key populations they work with.

Quick References¹⁹

- Advocacy is nothing new. Individuals and groups have always tried to influence people in power, in their private lives and as a part of their work. It is possible to advocate for ourselves or for other people.
- Advocacy is only one approach to strengthen key populations and PLHIV's access to SRHR. Other approaches include capacity building; generating demand among key populations and PLHIV for SRHR; provision of good SRHR services; training of SRHR service providers

¹⁹ The technical notes and many of the activities of this session are cited or adapted from International HIV/AIDS Alliance, *Advocacy in Action: A toolkit to support NGOs and CBOs responding to HIV/AIDS*, June 2002

to be sensitive to rights of key populations and PLHIV; and so on. Advocacy can make all these other approaches more effective by gaining the support of people in power and changing the social environment as well as policies and practices within which we work.

- There are many different interpretations of what ‘advocacy’ includes, and there is no single agreed international definition of advocacy. Organisations and individuals often have very different ideas about advocacy, which can cause problems when working together. Therefore it is important to collectively develop a working definition of advocacy for any programme or project, which will form the basis of providing technical support on advocacy.
- Different ways of doing advocacy
 - Advocacy can take many different forms; for example, it can be written, spoken, sung, or acted.
 - It can also vary in time it takes, from one hour to more than several years.
 - We can do advocacy work on our own or with others. We can do it for our rights and entitlements or for others.
- Involvement of people affected by the advocacy issue. Some of the most powerful advocacy methods are led by the people affected by the problem or issue.
- Proactive or reactive advocacy. Sometimes advocacy work is forced on us – the problem or issue is already there, and we use advocacy to reduce the problem. This is reactive advocacy. At other times it is possible to plan for the future, to ‘set the agenda’ and use advocacy to create a positive environment or prevent a problem before it happens. This is proactive advocacy. It is important to have a clear vision of what we want to achieve. This can help us to decide what changes are necessary to reach a solution that will solve (or at least improve) the issue or problem we have identified.
- Advocacy action plan
 - Planning advocacy work is similar to planning other activities – it is easier to plan appropriate activities if we first identify aims and objectives.
 - We need to understand the difference between an aim, objectives and activities. Aim is the long-term result that you are seeking. Objective is a short-term target that contributes towards achieving the long-term aim; objectives describe the ‘outcome’ (end result) of activities. For example, when we are travelling on a journey from a village to the capital city, the aim is to arrive in the capital city before the night; objective is to arrive at each town and village along the road in good time. We then have a choice of strategies to fulfil our objectives (for example, going by bus, by car, walking, etc.), and then specific actions (for example, catch the 203 bus to Dhaka). Without a clear aim and objectives, it is very difficult to evaluate our work. Unless you know your destination, you cannot know if you have arrived!

Objectives should be ‘**SMART**’:

Specific in stating what will be done

Measurable to allow monitoring and evaluation

Appropriate for your vision, mission and aim

Realistic in relation to your potential capacity and experience

Time-bound in relation to when the work will be done.

- Advocacy methods: There are no simple rules for choosing the best advocacy methods. Your choice will depend on many factors: a) the target person/group/institution; b) the advocacy issue; c) your advocacy objective; d) the evidence to support your objective; e) the skills and resources of your coalition; and f) timing (for example, external political events, when a law is still in draft form, immediately before a budgeting process, time of year, stage of advocacy process).

Suggested Activities

Activity 1: Defining Advocacy

Estimated time: 15 minutes

- In plenary ask the participants to call out words they associate with advocacy.
- Note the words or their pictorial representations on chart paper. Add any word or key concepts you feel are missing, after discussing them with the participants.
- Using the words, develop a working definition of advocacy that will be used for the workshop. Put up the definition on a chart paper, and keep it on display for the rest of the sessions on advocacy, for reference.
- Ensure the definition includes the following:
 - Advocacy aims to change laws, policies, or practices of institutions (at local, state, national or global levels).
 - Advocacy is directed at people with power within those institutions, or people who have power over or can influence those institutions.

Activity 2: Advocacy Framework

Estimated time: 45 minutes

- Divide participants into four groups through an energiser and distribute coloured cards and markers to them.
- Ask each group to brainstorm and identify what should be the different steps in developing an advocacy framework. Ask each group to write down or draw a picture on individual coloured cards representing each step.
- Ask each group to present the any of the three steps they have identified by miming them to the other groups, while the members of the other groups have to try and identify from the miming what each step is. After the first group has done their miming, ask the next group to mime three different steps.
- In plenary facilitate a discussion to collectively agree on the essential steps in an advocacy framework. Arrange the coloured cards on the floor in a sequence to develop an advocacy framework.
- Ensure that the steps include the following:
 - Identify the issue or the problem
 - Analyse the problem to set advocacy objectives
 - Identify targets for advocacy
 - Identify allies and resources
 - Build coalition or alliances
 - Gather evidence
 - Identify opportunities and threats
 - Identify advocacy methods
 - Develop an advocacy plan
 - Implement, monitor, and evaluate the advocacy work

Activity 3: Setting Advocacy Objectives

Estimated time: 60 minutes

- Ask the participants to reconvene in their small groups. Assign a KP character to each group. Assign a character that the group members already work with or have in-depth knowledge about.
- Ask each group to do a service map and matrix ranking²⁰ and select which SRH service would be critical to improve to ensure that the KP character assigned to them has ones SRH needs and rights fulfilled. Advise them to select a service that is important but had scored high in the matrix ranking.
- In each group, ask participants to draw a symbol of the service they have selected in the centre of a chart paper and reflect on why do their assigned characters, or people like them, cannot access the service. Remind them that they have already identified some of the barriers, such as cost, distance, lack of confidentiality, etc., when they did the matrix ranking.
- Ask them to draw a picture of the barriers in balloon connected to the picture of the service in the middle.
- Ask them ‘why is it so?’ or why does that barrier exist? Ask them to draw in an interconnected balloon the reasons why the barrier exists.
- Ask them to continue the questioning: ‘why is it so?’, adding further reasons in connecting balloons until they can think of no more.
- Ask them to repeat the process for each of the barriers they have identified.
- Ask the participants to reflect among themselves what the diagram says about the following:
 - What are the most important reasons for the barrier to exist?
 - What aspect of the barrier would need to be addressed through advocacy?
 - What will the advocacy activity be?
 - What can the advocacy activity change?
 - Who does the advocacy activity target?
 - What will be the desired outcome of the advocacy activity?
- Based on the above analysis ask each group to develop the advocacy objectives for the problem of their group. Ask them to ensure that their advocacy objectives are SMART (specific, measurable, appropriate, realistic, and time-bound).
- Ask each group to present their advocacy objectives in plenary, explaining why they set those objectives to others. Clarify misconceptions or sharpen the objectives if necessary.
- At the end of the session ask each group to keep their chart papers, as they will need them for developing advocacy action plans.

Activity 4: Who are Our Advocacy Targets and Who are Our Allies?

Estimated time: 45 minutes

Note for facilitators: For the activity in this session, participants have to draw a venn diagram. For this they have to draw a symbol of their organisation in the middle of the chart, along with their advocacy aim. Then they have to discuss who their advocacy targets are, depending on which institutions or people have decision

²⁰ See Session 6 Sexual and Reproductive Health, Activity 4 for instructions.

making power to influence the advocacy objectives. Then they have to analyse (1) how influential or critical they are for meeting the advocacy objectives; (b) how easy it is for their organisation to have an access to these institutions or people; and (c) how likely these institutions and people are to support the advocacy cause. Depending on this analysis, they then have to draw different sizes of circles for each institution and people they have selected as advocacy targets above the symbol of their organisation, and draw thinner or thicker lines to join them with their organisation.

Size of circle = influence on advocacy objective

Distance from participants' organisation = closeness of relationship

Thickness of line = support for advocacy objective

They have to do the same process for depicting their potential allies below the symbol of their organisation on the chart paper.

- Ask participants to stay in their groups.
- Ask each group to draw a venn diagram of all the groups, organisations, government departments, religious leaders, individuals, and so on, who could be targeted to influence the changes identified in their advocacy objective. It may help to classify them as direct and indirect targets and to show the links between direct and indirect targets. Encourage the groups to be as specific as possible – for example, the Ministry for Home Affairs, head of the department of the district hospital, etc. The diagram should show the following:
 - How close the relationship is between each target and your organisation?
 - How much they agree with your advocacy objectives?
 - How much influence they have over the advocacy objectives?
- Ask them to add the following against each target:
 - How will you access the target?
 - What is the target's position on the advocacy issue?
 - How to influence the target?
- Ask participants to then add the potential allies to the diagram. Ask them to address the following questions in identifying their potential allies:
 - Who else could have a positive impact on the issue that has been chosen?
 - Who else is already working on this issue?
 - Who are usually your 'natural' allies? Are they true allies for this issue?
 - Are they happy to work in a coalition?
- Ask the participants to include the following in their diagram, for each ally:
 - What they will gain by joining your alliance?
 - What they can offer to the advocacy work?
 - What are their limitations?
- Ask the groups to present their analysis through a gallery walk, and elicit helpful suggestions from members of other groups.
- Finish the session by facilitating a discussion on how coalition building can work.

Activity 5: Gathering Evidence for Advocacy

Estimated time: 45 minutes

- Ask participants to stay in their existing groups.
- Ask each group to discuss what kind of information and evidence they will need to support their advocacy work for each of the targets they have selected.
- Ask them to make four columns in a chart paper with the following headings on each column:

Target for advocacy	Information/evidence needed to influence the target	From whom, where and how to get the information	Possible risks and how to minimise them

- Ask participants to fill in the columns in as much detail as possible.

Activity 6: Choosing Advocacy Methods

Estimated time: 30-45 minutes

- Ask each group to discuss their collective experiences about methods they had used to influence people in power (within their family, community, their CBO or NGO, in government institutions etc.) to change policies or practices in favour of KPs and/or PLHIVs.
- Ask them to use a chart paper and depict the methods and the corresponding targets.
- Ask groups to share the methods they had used in plenary and facilitate a discussion on whether they are advocacy methods and whether other methods, not included in their lists, can be also added.
- Sum up the session by asking participants to re-visit the different steps of the advocacy framework and discuss if they have any questions about any of the steps. Tell each group to keep all their chart papers, as they will have to refer to them in order to develop an advocacy action plan.

Activity 7: Developing Advocacy Plan

Estimated time: 60 minutes

- Ask participants to stay in their groups.
- Ask participants to develop an action plan for advocacy to address the problem their group had identified. Explain that their plan should clearly indicate the following:
 - Advocacy aim
 - Objectives (that are SMART)
 - Advocacy targets for each objective
 - Advocacy activities or methods related to each objective
 - What opportunities or threats may be there for carrying out the advocacy activity and how will they use or mitigate them?
 - Resources required (for example, if they need support from other allies beyond the coalition, specific technical support, financial support, etc.)
 - Who will be responsible for leading and participating in the activity?

- Evidence required to support the activity and how will that be gathered?
- Timeframe for the activity
- Expected outcome of the activity
- How will the outcome be monitored and results fed back into advocacy action planning and implementation?
- Ask participants to use creative methods to present their action plan—they can perform a small skit, or develop a collage from pictures in magazines — anything as long as it is not a plan written up on a chart.

Concluding Activity: What Did We Learn from the Session?

Estimated time: 15 minutes

- Ask participants to sit in a circle.
- Ask each of them to mention one thing from the session they have learned not to do.



Key Learnings

Participants will be able to do the following:

- Develop a working definition of advocacy.
- Identify the different steps of an advocacy framework.
- Analyse a problem they want to advocate about.
- Set advocacy aim and objectives.
- Ensure that the advocacy objectives are 'SMART'.
- Identify and prioritise targets (influential individuals, groups or institutions) for advocacy action.
- Identify allies, i.e., individuals, groups or institutions that can assist in achieving their advocacy objectives.
- Identify the ways of building and sustaining coalitions for advocacy.
- Identify ways of gathering information and evidence for advocacy.
- Identify which advocacy methods can be used appropriately for different advocacy interventions.
- Develop an action plan of activities to achieve advocacy aim and objectives.



SESSION 8



Basics for Providing Technical Support



Objectives

- To enable participants to develop an understanding on technical support.
- To enable participants to explore participatory principles, approaches, methods for providing technical support.



Material required

- Chart papers, markers, double sided adhesive tapes



Notes for Facilitators

*Key skills required for participatory facilitation:*²¹

- **Planning:** The facilitator learns about the group before the session to help develop clear goals, design an appropriate programme, and select appropriate methodology.
- **Listening:** The facilitator listens to the group and tries to make sense out of what is going on. They also clarify and help to organise information.
- **Flexibility:** The facilitator can adapt to the needs of the group, handle multiple tasks, and has the confidence to try new things.
- **Focus:** The facilitator has direction and knows where to go next.
- **Encouraging participation:** The facilitator can draw out individuals, involve everyone and use humour, games or music to encourage an open, positive environment.
- **Managing:** The facilitator guides the group through the programmes, sets limits, encourages ground rules, provides models and checks on progress and reactions.

²¹ VSO, *Participatory Approaches: A facilitator's guide* (2009)

- Questioning: The facilitator knows how to ask questions that encourage thought and participation.
- Promoting ownership: The facilitator helps the group take responsibility for their own work and helps them to reflect on necessary follow-up work.
- Building rapport: The facilitator demonstrates responsiveness and respect for people, is sensitive to emotions, watches body language, and helps to construct relationships within the group.
- Self-awareness: The facilitator examines their own behaviour, learns from mistakes, is honest and open about the limits to their knowledge, and shows enthusiasm.
- Managing conflict: The facilitator encourages the group to handle conflict constructively and helps the group come to an agreement and consensus.
- Broadening discussion: The facilitator encourages different points of views and uses techniques and examples to get the group to consider different frames of reference.
- Presenting information: The facilitator uses clear and concise language, gives explicit instructions, and is confident with visual, written, graphical and oral methods.

Suggested Activities

Activity 1: What is Technical Support or Capacity Building?

Estimated time: 30 minutes

- Ask participants to brainstorm what are the objectives of providing technical support.
- Note down the responses on a chart paper.
- Explain that providing technical support or building capacity both are conceptual approaches that focus on helping people to analyse and understand the barriers that they face in achieving their stated goals while enhancing their capabilities that will allow them to achieve measurable and sustainable results.

Technical support aims to strengthen the following:

- Motivation of people.
- Skills and knowledge of people to be better able to address their issues.
- Ability of people to demand and access necessary services and interventions.
- Ability of people to access necessary peer and social support to address their issues.
- Analytical skills of people to be better able to address other barriers to their well-being.

Activity 2: Knotty Problem: Who are the Experts?

Estimated time: 15-20 minutes

- At the beginning of the exercise ask one participant to volunteer to go out of the room.
- Other participants stand in a circle and join hands. Keeping their hands joined, they move in any way that they want, twisting and turning and creating a 'knot'.
- Once they have made a quite complicated knot, ask the volunteer to come back to the room and try to unravel the knot by giving verbal instructions without the

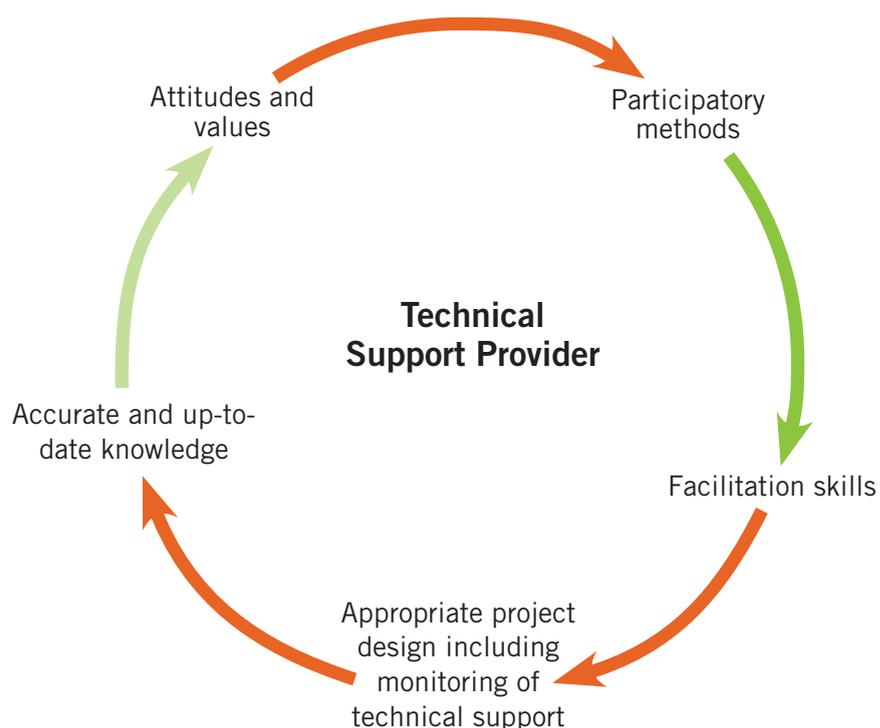
participants having to let go of one another's hands. The other participants must follow the instructions exactly, without trying to help the volunteer to succeed in unravelling the knot.

- If the volunteer is unsuccessful, then ask the participants to unravel the knot themselves without letting go of one another's hands, by guiding each other gently, without anyone giving instructions.
- End the session by asking participants if they can relate what happened during the game with the discussions they just had around defining technical support.
- Also ask the participants what lessons they can draw from the game about good practices for providing technical support and note down their responses on a chart paper.

Activity 3: Key Components for Providing Technical Support

Estimated time: 45 minutes

- Ask the participants to brainstorm what are the key components of providing technical support for enhancing PLHIV and other KPs access to SRHR.
- Ask them to note down each component they think of on separate sticky notes or small cards.
- Prepare five chart papers with the following labels: HIV and SRHR content specific to PLHIV and other KPs; participatory, analytical, problem-solving methods; positive attitudes and values towards key populations and sexuality and gender; empathetic facilitation skills; and appropriate projected design to facilitate and monitor technical support. Post them around the room.
- Arrange the sticky notes or cards from the participants on each chart as appropriate.
- Divide participants into five random groups. Assign one of the five components of technical support to each group.
- Ask each group to debate which component among the five is most important for providing technical support effectively.
- Conclude the debate by drawing a consensus that all components are inter-dependent and equally critical for providing technical support effectively.



Activity 5: Are We Listening?

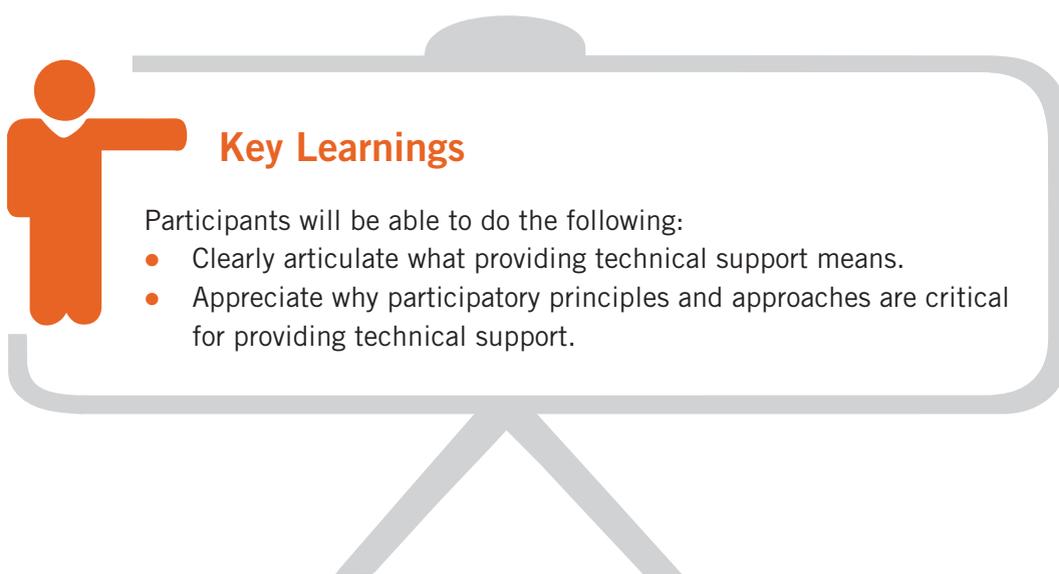
Estimated time: 30 minutes

- Explain to the participants that listening is the most fundamental facilitation skill for any facilitator because all the other facilitation skills cannot be done without listening.
- Ask participants not to write down anything while solving a riddle that you will read out to them.
- Read out aloud: You are a bus driver. At the first stop 12 people get on. At the next stop three people get off and five get on. At the third stop, one gets off and six get on. At the fourth stop, five get on eight get off. At the fifth stop, nine get off and three get on. At the sixth stop, three get off and seven get on. What is the name of the bus driver?
- The answer is of course your name! It is likely that most participants will not get the answer immediately.
- Reflect on what happened by asking the following questions:
 - Why did most people not know the answer? (missed the beginning, side-tracked, assumed what the problem was)
 - What is the difference between hearing and listening?
- Conclude the discussion by drawing participants' attention to how this relate to listening as a facilitator? (Listen to the inputs and opinions of participants without judging or comparing them, picking up their main points and common elements, etc.)
- Ask the participants to form groups of five and write down on a flipchart a list of the do's and don'ts for listening as facilitator under the following headings: 'A good facilitator will ...' and 'A good facilitator will not...'
- Display the flip-charts and let everybody walk around and read them.

Concluding Activity: What Did We Learn from the Session?

Estimated time: 15 minutes

- Ask participants to sit in a circle.
- Ask each participant to give one example of what they usually do or don't do as a good facilitator.



SESSION 9



Closing the Workshop



Objectives

- To allow the participants to provide their evaluation about the workshop.
- To bring the workshop to a close.

Activity 1: Looking Back

Estimated time: 15-20 minutes

- Ask participants to stand up and walk around the room and form random groups of four people each.
- Ask each group to discuss the following:
 - What was useful in the workshop?
 - What could have been improved?
 - Do they feel the need for further capacity building support in any particular area?
- Take a round of responses from the groups who volunteered.
- Alternatively, or in addition to it, you can also put up a chart with the key themes of the workshop for the participants to put their scores against, based on how the session related to the themes according to them.

Key themes of the workshop	Key population and PLHIV issues	Gender, sex, sexuality, and rights	SRHR related to KPs and PLHIV	Advocacy
Knowledge				
Values and attitudes				
Activities used				
Facilitation skills				

Score: 1=very satisfactory; 2=satisfactory; 3=could be improved.

Activity 2: Parting Gifts

Estimated time: 15-20 minutes

- Ask participants to sit in a circle. All the facilitators should also join the circle.
- Ask them to think for a moment and decide what particular quality, skill, or knowledge they would like to give to their neighbour to the left, as a goodbye gift, which will make that person work effectively towards improving access of KPs and PLHIV to SRHR services and entitlements.
- Start the process by passing your gift to your neighbour: having up-to-date and correct information about SRHR, ability to respect rights of KPs and PLHIV, ability to acknowledge the knowledge and insights of KPs and PLHIV, ability to think critically and creatively, ability to challenge misconceptions non-judgmentally and non-threateningly, etc.
- End the session by thanking everyone involved in the workshop.

In the closing session of the workshop, you can also ask the participants to individually fill in a post-training summary evaluation form. An example of such a form is given in annex 3.

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Additional Resources

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- The Oxfam Gender Training Manual, 1994, Oxfam, Oxford.
- UNAIDS, 2011, *Terminology Guidelines*, revised version, October 2011.
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Annex 1

Example of a Training Workshop Agenda

Day	Session 1 90 minutes		Session 2 90 minutes		Session 3 90 minutes		Session 4 90 minutes
1	Introduction to the workshop		Beyond labels: Understanding key populations and PLHIV issues, including their risks and vulnerabilities to HIV		Talking about gender: Sex vs. gender and gender division of labour and resources		Sex and sexuality and how they impact on SRHR
2	<i>Feedback from participants on previous day</i>	Tea/coffee break (30 minutes)	Human rights vulnerabilities and discrimination	Lunch break (60 minutes)	Social exclusion and consequences for SRHR and HIV	Tea/coffee break (30 minutes)	SRHR and KPs and PLHIV – the right to decide about having children
	Sexual and reproductive health: SRH needs and health seeking practices of KPs and PLHIV						
3	<i>Feedback on previous day from participants</i>		Understanding sexual and reproductive rights of KPs and PLHIVs		Addressing stigma and discrimination against KPs and PLHIV at SRH service settings		Improving access to SRHR for KPs and PLHIV
	Accessing sexual and reproductive health services and addressing barriers for KPs and PLHIV						
4	<i>Feedback on previous day from participants</i>		Analysing barriers to SRHR access for KPs and PLHIV and defining advocacy objectives		Who are our targets and who are our allies? How will we build coalitions with our allies?		Getting prepared: gathering evidence for advocacy and selecting advocacy methods
	Defining advocacy for the EC PLHIV project						
5	<i>Feedback on previous day from participants</i>	Practice session continued	Presenting advocacy action plan	Wrap-up			
	Planning advocacy for the EC PLHIV project – practice session						

Annex 2

An Example of Pre-test and Post-training Questionnaire

1. A street based female sex worker living with HIV is pregnant and is in her first trimester. She wants to keep the child. As her counsellor, you should advise her to:
 - Opt for an abortion as she will transmit HIV to the child.
 - Access PPTCT services to ensure that she minimises the risk of transmitting HIV to the child and then opt for sterilisation to avoid future risk of pregnancy.
 - Access PPTCT to ensure the safety of her child to be; access ART services for herself to manage the current pregnancy safely, and manage her own HIV infection; and access family planning counselling services and goods , so that she can be in charge of her fertility.
 - None of the above
2. A man living with HIV is sexually active. As his ART counsellor you should advise him to
 - Practice safe sex at all times to protect himself as well his sexual partner/s.
 - Concentrate on adhering to his treatment and staying healthy rather than squandering his energy on sexual misadventures.
 - Disclose his HIV status to his sexual partner/s before initiating any relationship.
 - Desist from having sex as there is always a risk of him transmitting HIV to his sexual partner/s.
 - None of the above.
3. A woman living with HIV has come to the local health care facility for delivery of her baby. As the attending doctor you:
 - Refer her to the district hospital as you do not want to take the risk of possible HIV transmission among your other patients.
 - Refer her to the district hospital as you do not have the necessary equipment and supplies to protect yourself from getting infected with HIV.
 - Practice universal precaution and infection control protocols and deliver the baby at your facility.
 - None of the above.
4. You are the programme manager of a targeted intervention among MSM and transgender/hijra for HIV prevention. A transgender/hijra from your project area approaches you seeking support for undergoing sex reassignment surgery:
 - You acknowledge her need but cannot help her in this, as this is not part of your NGO's mandate of HIV prevention.
 - She should not interfere with nature and accept her biological gender identity.
 - You link her up with government facilities offering sex reassignment surgery and follow up to ensure that she gets proper services.
 - None of the above.
5. In a health facility it is necessary to have separate BP-instrument, stethoscope, weighing machine, examination table, and waiting spaces for persons who are HIV-positive.
 - True
 - False

6. Universal declaration of human rights says that all human being irrespective of their age, sex, sexual orientation, ethnicity, religion, or wealth should enjoy all rights equally. However, in practice, some rights are more important than others for specific groups of people.
- True
 - False
7. Building coalition for advocacy is essential as it adds weight to the issue and allows sharing of resources, skills, and experiences.
- True
 - False
8. The law says that all clients coming to a public or private health facility or hospital *must* be tested for HIV for the benefit of the patient and the protection of the service providers and other patients.
- True
 - False
9. Universal precautions should be used *only* when caring for people with HIV.
- True
 - False
10. Please read the statements below carefully and tick the response that is nearest to what you *feel*.
- a) HIV is a just penalty for immorality.
 Yes May be No
- b) If women could be prevented from selling sex for money, HIV will not spread.
 Yes May be No
- c) Women with HIV should not have children; it puts both the child and the mother at risk.
 Yes May be No
- d) Same sex activity is imported from western cultures.
 Yes May be No
- e) Men having many or multiple sex partners are the ones who spread HIV in our community.
 Yes May be No
- f) I would be ashamed if someone in my family were infected with HIV.
 Yes May be No
- g) Extra precautions being taken in the sterilisation of instruments used on HIV-positive patients.
 Yes May be No

Annex 3

An Example of Post-training Summary Evaluation Form

What are the **three most useful things (or topics)** you learned during this workshop?

How would you rate the **content** covered in this workshop?

Comprehensive Adequate Less than adequate

How would you rate the **quality of facilitation** of sessions of this workshop?

Excellent Good Not engaging enough

To what extent do you expect this workshop will make a **difference** in the way you work?

1 2 3 4 5

No difference

Tremendous difference

How would you rate the **logistics** of this workshop?

Excellent Good Needs improvement

Annex 4

Human Rights, Fundamental Rights and Associated Provisions

The UDHR has 30 articles:

Article 1

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it is independent, trust, non-self-governing, or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted to the individual by the constitution or by the law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10

Everyone is entitled in full equality to a fair public hearing by an independent and

impartial tribunal in the determination of ones rights and obligations and of any criminal charge against the individual.

Article 11

(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to the law in a public trial at which one has had all the guarantees necessary for ones defence.

(2) No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with ones privacy, family, home, correspondence, or to attacks upon ones honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

(1) Everyone has the right to freedom of movement and residence within the borders of each state.

(2) Everyone has the right to leave any country, including ones own, and to return to ones country.

Article 14

(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.

(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

(1) Everyone has the right to a nationality.

(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

(2) Marriage shall be entered into only with the free and full consent of the intending spouses.

(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the state.

Article 17

(1) Everyone has the right to own property alone as well as in association with others.

(2) No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

(1) Everyone has the right to freedom of peaceful assembly and association.

(2) No one may be compelled to belong to an association.

Article 21

(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

(2) Everyone has the right of equal access to public service in his country.

(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realisation, through national effort and international co-operation and in accordance with the organisation and resources of each state, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work, and to protection against unemployment.

(2) Everyone, without any discrimination, has the right to equal pay for equal work.

(3) Everyone who works has the right to just and favourable remuneration ensuring for oneself and one's family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of ones interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

(1) Everyone has the right to a standard of living adequate for the health and well-being of oneself and of ones family, including food, clothing, housing, medical care, necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond ones control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

(1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts, and to share in scientific advancement and its benefits.

(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which one is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realised.

Article 29

(1) Everyone has duties to the community in which alone the free and full development of ones personality is possible.

(2) In the exercise of ones rights and freedoms, everyone shall be subject only to such limitations as are determined by the law solely for the purpose of securing due

recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any state, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Fundamental Rights²²

Every independent country also prepares a constitution of its own. The constitution is a legal document according to which the government of a country functions. The constitution should take into consideration international ideas about human rights, which are ethical principles about how we should treat each other. This means that each person is entitled to the same protections, no matter who they are. The responsibility for protecting, respecting and fulfilling human rights rests on governments. In reality, however, countries vary in the degree to which they fulfil this responsibility. In some cases, constitutions and laws of a country do not take all human rights fully into account.

Fundamental Rights in Indian Constitution

Fundamental rights guaranty civil liberties such that all Indians can lead their lives in peace and harmony as citizens of India. These include individual rights common to most liberal democracies, such as equality before law, freedom of speech and expression, and peaceful assembly, freedom to practice religion, and the right to constitutional remedies for the protection of civil rights by means of writs such as habeas corpus. Violation of these rights result in punishments as prescribed in the Indian Penal Code or other special laws, subject to discretion of the judiciary. The fundamental rights are defined as basic human freedoms which every Indian citizen has the right to enjoy for a proper and harmonious development of personality. These rights universally apply to all citizens, irrespective of race, place of birth, religion, caste, or sex. Aliens (persons who are not citizens) are also considered in matters like equality before law. They are enforceable by the courts, subject to certain restrictions.

The following are the seven fundamental rights recognised by the Indian constitution:

1. Right to equality, including equality before law, prohibition of discrimination on grounds of religion, race, caste, gender, or place of birth, and equality of opportunity in matters of employment, abolition of untouchability, and abolition of titles.
2. Right to freedom which includes speech and expression, assembly, association or union or cooperatives, movement, residence, and right to practice any profession or occupation (some of these rights are subject to security of the state, friendly

²² India HIV/AIDS Alliance, *Fact Sheets on Sexual and Reproductive Health and Rights*

relations with foreign countries, public order, decency, or morality), right to life and liberty, right to education, protection with respect to conviction in offences and protection against arrest and detention in certain cases.

3. Right against exploitation, prohibiting all forms of forced labour, child labour, and traffic in human beings.
4. Right to freedom of religion, including freedom of conscience and free profession, practice, and propagation of religion, freedom to manage religious affairs, freedom from certain taxes, and freedom from religious instructions in certain educational institutes.
5. Cultural and educational rights preserving right of any section of citizens to conserve their culture, language or script, and right of minorities to establish and administer educational institutions of their choice.
6. Right to constitutional remedies for enforcement of fundamental rights.
7. Right to elementary education.

The Protection of Human Rights Act, 1993

The Protection of Human Rights Act, 1993 is landmark legislation in India to protect human rights. The Act came into effect on September 28, 1993. The Act lays down various measures and systems at different levels and ensures government responsibility towards human rights protection. Under this Act, the National Human Rights Commission (NHRC) of India was constituted in 1993 as an autonomous public body responsible for the protection and promotion of human rights in India.

Sexual and Reproductive Rights

Sexual and reproductive rights (SRR) are not all contained in any one human rights instrument or treaty. Instead, different international instruments and treaties make references in parts to SRR, starting from the International Conference on Population and Development (ICPD) Programme of Action. When human rights relate to people's sexuality and reproduction we call them 'sexual rights' or 'reproductive rights'. Sexual and reproductive rights sometimes overlap, and many of these rights are acknowledged in international agreements.

Reproductive Rights

Reproductive rights are for all of us. They are the rights of people to decide whether to give birth to a child or not, without discrimination, coercion or violence. They allow us to control our own reproduction. Everyone should have the choice to have or not have children and freedom to decide if, when, and how many. Everyone should have access to information, choices, and services related to reproductive health and choices, including family planning. Everyone should have access to health care services for pregnancy and reproduction and the right to make decisions without harassment, discrimination, coercion, or violence.

In reality, people face many barriers to exercising their sexual and reproductive rights. Unfortunately, some of these barriers and violations are so common they are typically overlooked, excused or seen as culturally 'normal'.

Annex 5

Common Myths and Misconceptions about HIV²³

HIV is the same as AIDS

HIV is an acronym for human immunodeficiency virus, a virus that causes AIDS (acquired immunodeficiency syndrome). While this virus is the underlying cause of AIDS, not all HIV positive individuals have AIDS, as HIV can remain in a latent state for many years. HIV usually progresses to AIDS, defined as possessing a CD4+ lymphocyte count under 200 cells/μl or HIV infection with an opportunistic-infection.

There is now a cure for AIDS

Highly active anti-retroviral therapy (HAART) in many cases allows the stabilisation of the patient's symptoms, partial recovery of CD4+ T-cell levels, and reduction in the level of HIV virus in the blood to low or near-undetectable levels. Disease-specific drugs can also alleviate symptoms of AIDS and even cure specific AIDS-defining conditions in some cases. Medical treatment can reduce HIV infection in many cases to a survivable chronic condition, analogous to diabetes. Antiretroviral treatment, known as post-exposure prophylaxis (PEP), reduces the chance of acquiring an HIV infection when administered within 72 hours of exposure to HIV. However, these advances do not constitute a cure, since current treatment regimens cannot eradicate latent HIV from the body. High levels of HIV-1 (often HAART-resistant) develop if treatment is stopped, if compliance with treatment is inconsistent, or if the virus spontaneously develops resistance to an individual's regimen. These problems mean that while HIV positive people with low virus load in their blood are less likely to infect others, the chance of transmission always exists. In addition, people on HAART may still become sick.

Sexual intercourse with a virgin will cure AIDS

The myth that sex with a virgin will cure AIDS is prevalent in sub-Saharan Africa and other places. Sex with an uninfected virgin does not cure an HIV infected person, and such contact will expose the uninfected individual to HIV, potentially further spreading the disease. This myth has gained considerable notoriety as the perceived reason for certain child sexual abuse incidents, including the rape of infants.

Sexual intercourse with an animal will avoid or cure AIDS

In 2002, the National Council of Societies for the Prevention of Cruelty to Animals (NSPCA) in Johannesburg, South Africa, recorded beliefs amongst youths that sex with animals is a means to avoid AIDS or cure it if infected. This belief is by no means restricted to Africa. As with "virgin cure" beliefs, there is no scientific evidence suggesting a sexual act can actually cure AIDS, and no plausible mechanism by which it could do so has ever been proposed.

²³ Adapted from UNAIDS, *HIV/AIDS and Human Rights* <http://www.unaids.org>

HIV antibody testing is unreliable

Diagnosis of infection using antibody testing is a well-established technique in medicine. HIV antibody tests exceed the performance of most other infectious disease tests in both sensitivity (the ability of the screening test to give a positive finding when the person tested truly has the disease) and specificity (the ability of the test to give a negative finding when the subjects tested are free of the disease under study). Many current HIV antibody tests have sensitivity and specificity in excess of 96% and are therefore extremely reliable. Positive HIV antibody tests are usually followed up by retests and tests for antigens, viral genetic material and the virus itself, providing confirmation of actual infection.

HIV can be spread through casual contact with an HIV infected individual

One cannot become infected with HIV through day-to-day contact in social settings, schools, or in the workplace. One cannot be infected by shaking someone's hand, by hugging or "dry" kissing someone, by using the same toilet or drinking from the same glass used by an HIV infected person, or by being exposed to coughing or sneezing of an infected person. Saliva carries a negligible viral load, so even open-mouthed kissing is considered a low risk. However, if the infected partner or both partners have blood in their mouth due to cuts, open sores, or gum disease, the risk is higher. The Centers for Disease Control and Prevention (CDC is the national public health institute of the United States) has only recorded one case of possible HIV transmission through kissing (involving an HIV-infected man with significant gum disease and a sexual partner also with significant gum disease), and Terence Higgins Trust (a British charity that campaigns on various issues related to AIDS and HIV) says that this is essentially a no-risk situation.

Other interactions that could *theoretically* result in person-to-person transmission include caring for nose bleeds and home health care procedures, yet there are very few recorded incidents of transmission occurring in these ways.

One can get HIV from mosquitoes

Because HIV is spread through blood, people have worried that biting or bloodsucking insects might spread HIV. Several studies, however, show no evidence to support this — even in areas with lots of mosquitoes and cases of HIV. When insects bite, they do not inject the blood of the person or animal they have last bitten. Also, HIV lives for only a short time inside an insect.

HIV survives for only a short time outside the body

HIV can survive at room temperature outside the body for hours if dry (provided that initial concentrations are high), and for weeks if wet (in used syringes/needles). However, the amounts typically present in bodily fluids do not survive nearly as long outside the body—generally no more than a few minutes if dry. Again, the amount of time is longer if wet, especially in syringes/needles and related equipment.

An HIV infected mother should not have children

All women have the right to choose whether and when to have children. HIV infected women are still fertile, although in late stages of HIV disease a pregnant woman

may have a higher risk of miscarriage. Normally, the risk of transmitting HIV to the unborn child is between 15% and 30%. However, this may be reduced to just 2–3% if patients carefully follow PPTCT guidelines.

Being HIV positive means life is over

In the early years of the HIV epidemic, the death rate from AIDS was extremely high. But today, antiretroviral drugs allow HIV positive people — and even those with AIDS — to live much longer, normal, and productive lives.

Only men who have sex with men or inject drugs can become infected by HIV

Most men do become HIV positive through sexual contact with other men or through injection drug use. However, men and women also become HIV positive through heterosexual contact.

People on HIV treatment cannot transmit the virus

When HIV treatments work well, they can reduce the amount of virus in your blood to a level so low that it does not show up in blood tests. Research shows, however, that the virus is still “hiding” in other areas of the body. It is still essential to practice safer sex so you will not make someone else become HIV-positive or acquire a different strain of HIV.

If both or all sexual partners are HIV positive, there’s no reason for practising safer sex

Practicing safer sex can protect all sexual partners from becoming exposed to other (potentially drug resistant) strains of HIV and other STIs.

HIV positive individuals can be detected by their appearance

Due to media images of the effects of AIDS, many people believe that individuals infected with HIV will always appear a certain way, or at least appear different from an uninfected, healthy person. In fact, disease progression can occur over a long period of time before the onset of symptoms, and as such, HIV infections cannot be detected based on appearance. The only way to know one is HIV positive is to get tested.

Practices such as recreational drug use, having multiple sexual partners, selling or buying sex, men having sex with men—not HIV—account for AIDS

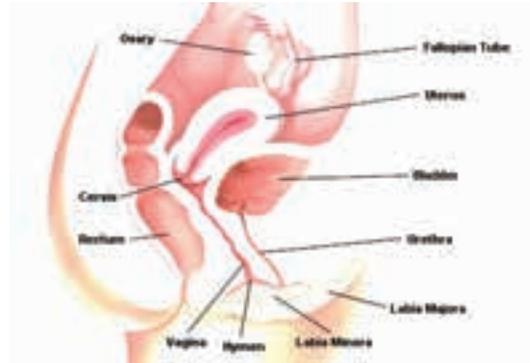
Compelling evidence from HIV prevention interventions from across the world show it is *unsafe* sexual or injecting practices that expose people to risk of HIV infections, not the practice itself. Also, as more often than not, people engaging in such practices are criminalised, stigmatised, and socially excluded. Therefore, they are more vulnerable to exposure to HIV risks as structural factors severely limit their access to appropriate and supportive quality health care and compromises their motivation to seek the health care needed.

Annex 6

Notes on Sexual and Reproductive Health

1. External and internal sexual and reproductive organs and their functions

Female



Vulva: A woman's external sexual organs together are called the vulva — they are not clearly visible because they lie within the folds of the skin. What is visible is the outer part that, around puberty, begins to get covered by hair. This hair is called pubic hair. The vulva is like a fleshy V-shape between a woman's legs and includes the Mons Veneris (or mound of Venus), the outer lips (*labia majora*), inner lips (*labia minora*), the clitoris, the hymen, the urinary opening (urethra) and the vaginal opening. The Mons Veneris (or mound of Venus) is the pad of fatty tissue that covers the pubic bone below the abdomen but above the outer and inner lips (labia). It protects the pubic bone from the impact of sexual intercourse and is sexually sensitive in some women. The outer lips are lip-like structures mostly made of skin and fatty tissue, which extend on either side of the vulva. They usually entirely or partially cover the other parts of the vulva. Protection is their main function. The inner lips are two soft folds of skin between the outer lips and to either side of the opening of the vagina.

Clitoris: The clitoris is a tiny (about the size of a small pea) structure, at the top of the vulva above the urinary opening, hidden within the folds of the inner lips where they join. The clitoris is the most sensitive part of the female genitals, and the only organ in the body that exists solely for sexual pleasure.

Hymen: The hymen is a fold of mucous membrane which surrounds or partially covers the external vaginal opening. Generally the hymen has holes through which the menstrual blood can come out of the vagina. Women and girls have hymens of different shapes and sizes. A few women are born without hymen. Having a hymen is often associated with being virgin (one who has never had penetrative sexual intercourse through the vagina). Bleeding during intercourse is thought to be linked to breaking of hymen which proves that the woman has never had intercourse before. The truth is that most often bleeding occurs if the vagina gets hurt. Hymen can break while exercising, cycling, dancing, or masturbation. Sometimes the hymen may not break even during sexual intercourse, especially if lubrication is used. Having a hymen

is not a sign of virginity. In rare cases, the hymen has no holes or openings and the menstrual blood cannot escape. Girls having such *imperforate* hymen will require surgical procedure to correct the condition. Imperforate hymen is suspected when a girl who does not menstruate after reaching puberty but who may complain of cyclical pain in the lower abdomen.

Urethral opening: The urethra is the transport tube leading from the bladder to discharge urine outside the body. In females the urethra is shorter than in the male and opens above the vaginal opening.

Anus: The anus is an opening lying behind the vulva and between the buttocks at the end of the rectum from which solid waste (faeces) leaves the body. The anus is full of thousands of nerve endings both inside and outside, making it very sensitive. For some women, the anus is an erogenous zone that can respond to sexual touch and stimulation. However since there is little natural lubrication in the anus it is subject to injury. So it is important to use plenty of water based lubricant like KY jelly and condoms for protection from injury and infections.

Vagina: The vagina is a female internal sex organ that begins on the outside at the vaginal opening and extends about three to five inches inside, ending at the cervix, or neck of the uterus. The vagina consists of three layers of tissue. The mucosa is the layer on the surface that can be touched. It consists of mucous membranes and is a surface similar to the lining of the mouth. But unlike the smooth surface of the mouth lining, the vagina contains folds or wrinkles. The next layer of tissue is a layer of muscle, concentrated mostly around the outer third of the vagina. The third, innermost layer consists of fibrous tissue that connects to other anatomical structures.

G-spot: (Grafenberg spot) also known as the urethral sponge is located on the front inner wall of the vagina behind the pubic bone is an erotic zone in many women. When rubbed by the penis or fingers, it generates sexual pleasure.

Cervix: It is the lower portion of the uterus that opens into the vagina. The cervix is the opening that sperm must pass through in order to reach the egg. During delivery, the baby also goes through the cervix as it exits the uterus and enters the vagina. The cervix dilates to about four inches in diameter during labour.

Uterus: The uterus or the womb is a pear-shaped, muscular reproductive organ where a normal pregnancy develops. The uterus is normally about the size of a woman's fist. It stretches many times that size during pregnancy. The muscles in the uterine walls can expand to accommodate the growing fetus and contract in order to help push the baby out during labour.

Fallopian tubes: There are two fallopian tubes, each attached to a side of the uterus. There are 20–25 finger-like structures (fimbriae) at the ends that hover just above the ovaries and work to collect the mature egg when it is released. Once the egg is in the fallopian tube, tiny hairs in the tube's lining help push it down the narrow passageway toward the uterus. It is in the fallopian tubes that fertilisation of the egg (egg mating with the sperm) will take place.

Ovaries: Ovaries are two small, almond-shaped glands that produce eggs. The ovaries also make the sex hormones oestrogen and progesterone. An egg is released from the ovary roughly every 28 days in a process called ovulation.

Rectum: The rectum is the end portion of the colon, which is the long open-ended tube that extends from the anus to the small intestine. It consists of a single layer of cells that is highly susceptible to tearing.

The breast: The female breasts contain the mammary glands, which secrete milk used to feed infants. Although the primary function of the breasts is production of milk for the new born baby, the female breasts play an important part in female sexual behaviour. Stimulation of the female breasts enhances the sexual pleasure of a woman.

Male

Penis: The penis is the anatomically male copulatory organ. It has a long shaft and enlarged bulbous-shaped tip called the glans penis, which supports the foreskin. When the anatomically male person becomes sexually aroused, the penis becomes erect and ready for sexual activity. Erection occurs because sinuses within the erectile tissue of the penis get filled with blood. The arteries of the penis are dilated while the veins are passively compressed so that blood flows into the erectile cartilage under pressure.

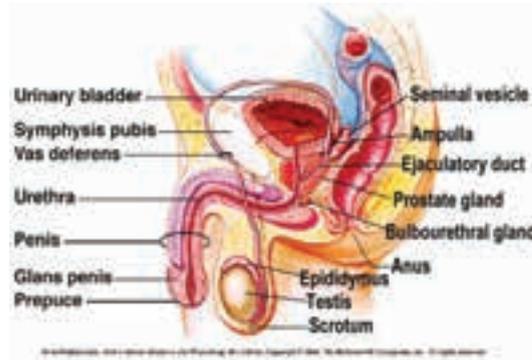
Scrotum: The scrotum is a pouch-like structure that hangs behind the penis. It holds and protects the testes. It also contains numerous nerves and blood vessels. During times of lower temperatures, the muscle contracts and pulls the scrotum closer to the body, giving it a wrinkled appearance. The scrotum remains connected with the abdomen or pelvic cavity by the inguinal canal. (The spermatic cord, formed from spermatic artery, vein and nerve bound together with connective tissue passes into the testis through inguinal canal.) It can also be stimulated for pleasure.

Epididymis: The epididymis is a whitish mass of tightly coiled tubes cupped against the testicles. It acts as a maturation and storage place for sperm before they pass into the vas deferens, tubes that carry sperm to the ampullary gland and prostatic ducts.

Vas deferens: The vas deferens, also known as the sperm duct, is a thin tube approximately 17 inches long that starts from each epididymis to the pelvic cavity.

Testes: The testes, also known as the testicles, are the anatomically male gonads, the organs that produce sperm cells. The testes are egg-shaped structures that grow to be about one inch long and rest inside the scrotum. The testes also produce hormones, including testosterone, which stimulates the production of sperm cells and facilitates male maturation.

Accessory glands: Three accessory glands provide fluids that lubricate the duct system and nourish the sperm cells. They are the seminal vesicles, the prostate gland, and the bulbourethral glands (Cowper glands).



Seminal vesicles: Seminal vesicles are sac-like structures attached to the vas deferens at one side of the bladder. They produce a sticky, yellowish fluid that contains fructose. This fluid provides energy to sperm cells and aids in their mobility. This fluid forms major part of the ejaculate or semen.

Prostate gland: The prostate gland surrounds the ejaculatory ducts at the base of the urethra, just below the bladder. The prostate gland produces a fluid that helps nourish the sperms and contributes to additional semen. Stimulation of prostate gland can be very erogenous.

Semen: Semen is a liquid mixture of sperm cells, prostate fluid and seminal fluid that is ejaculated from urethra during sexual stimulation. Approximately 1.5 to 5 ml of semen is ejaculated in each act and may contain 20-150 million sperms/ml.

Bulbourethral glands: The bulbourethral glands, also called Cowper glands, are two small glands located on the sides of the urethra just below the prostate gland. These glands produce a clear, slippery fluid that empties directly into the urethra. It produces substances related to nourishment of spermatozoa.

Rectum: The rectum is the end portion of the colon, same as in women.

Anus: The anus is at the end of the rectum from which solid waste (faeces) leaves the body. The anus is full of thousands of nerve endings both inside and outside, making it very sensitive. The anus is an erogenous zone that can respond to sexual touch and stimulation. During sexual arousal the anus tightens. Same as in women, there is little natural lubrication in the anus so it is important to use plenty of water based lubricant like KY jelly and condoms for protection from injury and infections.

2. Menstruation and menstrual hygiene

Menstruation is the normal, periodic discharge of blood and tissue from the lining of the uterus, occurring about every 28 days in women of reproductive age. The onset of menstruation, called menarche, happens at puberty. Menstruation - having periods - is part of the female reproductive cycle that starts when women become sexually mature at the time of puberty. At this time, the process of ovulation starts wherein each month an egg is released by one ovary. As eggs in ovaries start maturing in preparation for monthly release, the uterus also starts preparing for receiving the fertilised egg. The lining of the uterus becomes thick and soft. If the egg is not fertilised, the thick

lining of uterus is no longer needed. The lining starts breaking and blood along with parts of lining and unfertilised egg are passed out as menstrual flow. The bleeding generally lasts 3-7 days and this period is called menstrual period. The process of egg maturation and thickening of uterus lining restarts and menstruation is repeated every month.

The menstrual cycle will repeat throughout life, unless interrupted by pregnancy or long-acting hormonal contraception, until menopause (cessation of menstruation, around age 51-52).

Because menstrual blood flows out of the body it needs to be absorbed by something for reasons of hygiene and convenience.

Products to manage menstruation:

Sanitary napkin, towel or pad: Pads may be made of different materials. The ones that are available in the market are in the form of a thick cotton pad encased in a synthetic material. They may be belt-less, in which case you have to take off the adhesive strip and stick the pad on to your panties. They may also come with a thin belt, in which case the ends of the napkin are kept in place by the belt. Sanitary napkins come in a range of prices. Home made pads are most commonly used in India, made up of cloth, gauze and/or cotton.

Tampon: Tampons are cylindrical and absorbent and are meant to be inserted into the vaginal passage to absorb the menstrual blood. They are quite convenient and easy to wear if you know how to insert them. All you need to do is place the tip of your finger in the depression at the bottom end of the tampon (where the string is attached). A squatting position makes insertion easier. Put the tampon at the entrance of your vagina and gently but firmly slide it in till the base of the tampon is about an inch inside the opening of your vagina. If you do not insert it this far, the tampon will not 'sit' properly and may cause you discomfort while walking. Tampons cannot get lost in the body.

In some places sex workers insert cotton in the vagina to soak menstrual blood. This is preferred because the cotton remains inside and client cannot see anything from outside. But care has to be taken to properly take out all the cotton pieces from the vagina so that all pieces of cotton are out of the vagina; otherwise serious infection can follow.

Menstrual cup: Menstrual cup is a type of cup or barrier worn inside the vagina during menstruation to collect menstrual fluid. Unlike tampons and pads, the cup dams menstrual fluid rather than absorbing it. Menstrual cups are safe when used as directed, and no health risks related to their use have been found.

Menstrual Hygiene

- Always use a clean sanitary towel or tampon to absorb the blood.
- Sanitary towels/ tampons need to be changed frequently (at least every four to six hours) in order to prevent bad odour or infections.
- If menstrual pads made of cloth are being reused, they should be washed and dried in the sun before reuse. Many times in order to hide them from others, these

clothes are dried in damp hidden places. As these clothes remain moist they provide excellent breeding ground for infection causing organisms. If you are using a cloth which is to be reused, it should be washed thoroughly and disinfected by drying in the sun.

- Maintain good genital hygiene during your periods. There is no reason why you should not bathe, wash your hair, etc.

3. Temporary Contraception methods

Condom: Condom is sheath of latex or plastic that is worn on the penis. Most are made of thin latex rubber. They are known by many different brand names. They work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy and also keep infections in semen, on the penis, or in the vagina from infecting the other partner. They have no side effects and are very effective in providing protection against pregnancy and infection. All men and women can safely use condoms, except those with severe allergic reaction to latex rubber. People who are allergic to latex can use condoms made out of other substances such as polyurethane or animal membranes. Although highly effective, the major question that is associated with it is the consistency and the correctness of its use. Often women have lesser power to negotiate for condom use with their male partners and since the condom is often associated with HIV, partners in intimate relationships find it hard to talk about its use as it may imply having sex with other partners. *Condoms are completely safe for PLHIV, giving dual protection both from pregnancy and infection.*

Female condoms are a polyurethane pouch that has a flexible ring at both ends and fits into the vagina. They work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also they keep infections in semen, on the penis, or in the vagina from infecting the other partner. They can be highly effective if consistently used. Some women like them because they feel that they have more control. Female condom is a female initiated and controlled method, is an effective contraceptive, reduces the risk of transmission of STIs including HIV, and can be used by those with latex allergies. It can be inserted up to 8 hours prior to intercourse. However, female condoms are expensive and can make a crackling sound during intercourse, which some people find upsetting. *As ordinary condoms they are completely safe for use by HIV positive women and give dual protection from both pregnancy and infection.*

Combined oral contraceptive pills (COCPs) are usually made from two types of hormones (oestrogen and progestogen). They prevent pregnancy by stopping the production and release of eggs from the ovaries. Most pills are based on a 21-day cycle. One pill needs to be taken every day preferably at the same time for 21 days, then stopped for 7 days at which time one should have menstruation. The pill is also available in a 28-day pack which contains 21 pills with hormones and 7 pills without hormones, or placebos. The last 7 pills help to serve as a reminder of when one should start taking a new strip of pills again. The pill is an effective, reversible form of birth control which may also have health benefits for many women. Advantages include immediate return of fertility, more regular cycles, less pain and reduced menstrual blood flow, improvement in acne, and lower risk of certain cancers including cancer of the ovaries and endometrium (the lining of the uterus). Breakthrough bleeding or spotting is common during first three cycles of OCP use. If the problem persists after

the fourth cycle, it is important to consult the doctor. Nausea may occur during the first three cycles of OCP use. Taking the pill at bedtime or with food may be helpful. They do not protect against infections and are not recommended for the following: lactating mothers; women with lumps, swellings or discharge from breasts; women over 40 years of age; smokers above 35 years of age; and women with high blood pressure and history of heart disease. *HIV positive women on ART may use COCPs but they are NOT advised for HIV positive women on TB medication (Rifampicin). Also, there are some concerns about interaction with some classes of ARV drugs. It is important to consult the doctor before starting the OCP.*

Emergency contraceptive pills (ECPs) contain higher doses of the same hormones (oestrogen, progestin, or both) found in regular combined oral contraceptive pills. Taken after unprotected sexual intercourse, such pills can prevent pregnancy from occurring. They work primarily by preventing or delaying the release of eggs from the ovaries (ovulation) or by somewhat preventing the already fertilised egg to get implanted into the lining of the uterus. ECPs do not work if a woman is already pregnant. ECPs should be taken as soon as possible after unprotected sex. Usually only one pill has to be taken within 72 hours of unprotected intercourse. Some users report slight irregular bleeding for 1–2 days after taking ECPs, monthly bleeding that starts earlier or later than expected in the week after taking ECPs, nausea, abdominal pain, fatigue, headaches, breast tenderness, dizziness, and vomiting. They do not protect against infections. However, it is important to remember that emergency contraceptive pills are to be used during emergencies and not as a regular method of contraception. ECPs do not cause an abortion and should not be confused with the abortion pill. If a woman is already pregnant when she takes ECPs, it will not interrupt the pregnancy nor will it harm the foetus. Taking ECPs will not impact on a woman's ability to become pregnant in the future. *Women with HIV, and those on antiretroviral therapy, can safely use ECPs.*

Intrauterine device (IUD) is a small, flexible plastic frame with copper wire or copper sleeves on it. Almost all brands of IUDs have two strings, or threads, tied to them that hang through the opening of the cervix into the vagina. IUDs work chiefly by preventing sperm and egg from meeting or by preventing the implantation of the fertilised egg to the walls of the uterus. A hormonal IUD also contains a substance called progestin which thickens the mucous from the cervix to prevent sperm from entering the uterus. It is inserted into a woman's vagina through her uterus by a trained provider. A provider can remove the IUD by pulling gently on the strings with forceps. An IUD is a highly effective contraceptive and different versions provide protection for as long as 3, 5, 7 or even 10 years. It does not interfere with sex and can be inserted right after childbirth (except hormone releasing IUDs). Return to fertility is almost immediate. IUDs can increase menstrual bleeding, spotting between periods and menstrual cramps. There is an increased risk of Pelvic Inflammatory Disease (PID) in the first 20 days after insertion. It does not protect from STIs including HIV. Copper T/IUD can also be used as an emergency contraceptive, that is, if inserted soon after unprotected sex it can reduce one's risk of getting pregnant by more than 99%. Copper-T IUD is much more effective than emergency contraceptive for this purpose. *Asymptomatic HIV positive women and those on ART can safely use IUD. However, IUD is not recommended for HIV infected women with high risk of STIs*

(gonorrhoea /Chlamydia). Positive women should get an STI check up before inserting an IUD.

Injectable contraceptives are a hormone (progestin) containing injection that is given intramuscularly. The shot slowly releases the hormone into the body. This primarily prevents ovulation and thickens cervical mucus to prevent entry of sperms into the uterus. This is given every three months and remains effective for the same time period. It is a highly effective contraceptive that does not interfere with sexual intercourse and women experience less heavy menstrual flow and reduced menstrual cramps. Injectable contraceptives do not protect against STIs, including HIV. They could lead to weight gain, irregular periods, sometimes heavy bleeding, breast tenderness, headaches, mood swings, and loss of bone density. Return of fertility often takes several months longer after stopping injectable contraceptives. As per the *WHO guidelines released in 2012, the women living with HIV can use all types of hormonal contraceptives (oral pills, implants, patch, progestrone alone injections) without restriction as the current evidence does not show clear association between hormonal contraceptives and HIV acquisition. Male or female condom MUST be used consistently along with to ensure HIV infection is not transmitted to non-infected partners. Use of hormonal contraceptives can be an important strategy to reduce mother-to-child transmission of HIV*²⁴.

Implants: Small plastic tubal *implants* are inserted under the skin of a woman's arm; these implants slowly release hormones. They primarily work by thickening mucus from the cervix to prevent sperms from entering the uterus and prevent ovulation. A health care provider will insert the implant under the skin in minor surgery. The implants are inserted within the first seven days of a menstrual cycle. They can cause weight gain, irregular bleeding and lower abdominal pain. They can be visible through the skin. Return to fertility after the implants are removed can take 8-10 months.

Spermicides such as pessaries, foams, creams, gels, suppositories, or tablets are placed in a woman's vagina; they contain chemicals that kill sperms. The spermicide has to be put deep into the vagina. It must be inserted 10-15 minutes prior to intercourse and has to be left in place for 6-8 hours after having sex. They are moderately effective and can be left in for 6-8 hours. They are most effective when used along with other barrier methods like condoms. Some women like them because they are controlled by the woman and increase vaginal lubrication. They may weaken latex condoms making them less effective. They can have an unpleasant taste or smell. Irritation in or around the vagina, particularly with very frequent use, is common. They do not provide protection against STIs, including HIV. They can be used alone, with a diaphragm, or with condoms. *If a woman is at higher risk of HIV infection, frequent use of spermicides that contain nonoxynol-9 may increase the likelihood of transmission and therefore not recommended.*

Vaginal ring is soft flexible plastic ring that a woman inserts into her vagina. The ring slowly releases oestrogen and progesterone hormones into the body. They primarily

²⁴ (WHO Technical Statement. Hormonal Contraception and HIV. 16th Feb 2012. http://whqlibdoc.who.int/hq/2012/WHO_RHR_12.08_eng.pdf?ua=1)

work to prevent ovulation and thicken cervical mucous to prevent sperms from entering the uterus. They are 92-99% effective in providing contraception. The ring is placed anywhere in the vagina. The ring is kept in place for three weeks and is removed by the beginning of the fourth week (a week with no ring in place). A woman has her period during the week the ring is out. A new ring is inserted at the end of the fourth week. It is important to start each new ring on time for greatest effectiveness. They do not interrupt intercourse. They can reduce menstrual flow for some women. They also decrease the risk of some conditions and diseases such as pelvic inflammatory disease (PID) and some cancers. Side effects include irregular bleeding, breast tenderness, headaches, nausea and weight gain or inflammation of the vagina (vaginitis) and white vaginal discharge. Typically, irregular bleeding happens for the first few months and then bleeding becomes lighter and more regular. Other side effects can include: headaches, irritation, redness. Return of fertility is immediate. The ring should not be removed during sexual intercourse. Women who have blood clots, are breast feeding, have migraine headaches, or women over 35 years who smoke should not use the vaginal ring.

Diaphragm is a thin circular dome with a flexible rim made of soft latex (rubber) or silicone. It provides a physical barrier to block the cervix and prevents sperm from fertilising an egg and holds chemical spermicides to kill sperms. Before using check for tears, cracks or holes. Apply spermicides to the diaphragm and then insert it deep into the vagina. Make sure that it covers the cervix. It is reusable after washing with soap and water and can be inserted six hours prior to intercourse and left in up for 24 hours for multiple acts of intercourse. Contraceptive efficacy is high if used consistently and correctly. Many women like it because it is something that the women themselves can initiate. Return of fertility is immediate. Some women may have allergic reactions to the latex or spermicides. It comes in different sizes and requires fitting by a specifically trained provider. *If a woman is at higher risk of HIV infection, very frequent use of spermicides that contain nonoxynol-9 may increase the likelihood of transmission. Also, the spermicide used along with the diaphragm may not be safe for use by HIV positive women.*

Permanent methods

Male sterilisation (vasectomy) is a surgical procedure that seals the vas deferens (the tube through which sperms come and mix with the semen) preventing sperms from getting into semen. After a vasectomy, the man still produces semen but there is no sperm in it. It does not affect the ability to have erection, ejaculation and orgasm. It does not interrupt intercourse and permanently prevents pregnancy; complications are rare. On the other hand, it does not reduce risks of STIs and HIV transmission. It takes about 15-30 ejaculations after the operation to clear out the sperms already in the vas deferens – during this time an alternative contraceptive should be used. The procedure can be reversed surgically.

Female Sterilisation (tubectomy) is a surgical procedure that cuts or blocks the fallopian tubes. The procedure prevents an egg from travelling from the ovary to the uterus and sperm from reaching the egg to fertilise it. It does not interrupt intercourse, permanently prevents pregnancy and does not reduce risk of STIs and HIV transmission. Reversal surgeries are not highly successful. *For HIV positive women,*

there could be surgical complications. Therefore, risk of surgery needs to be balanced with benefits.

Other methods

Calendar/rhythm method requires recording and calculating the number of days in a woman's menstrual cycle to determine the fertile phase in the cycle. During the fertile period pregnancy can be prevented by voluntarily avoiding sexual intercourse or using another contraceptive method. To practice this method, keep a written record of each menstrual cycle, counting from the first day of one menstrual period up to but not including the first day of the next. Keep records of six cycles. To find the start of the fertile days, take the shortest cycle recorded and subtract 18. To find the end of the fertile phase, take the longest cycle recorded and subtract 11. It is an inexpensive method and can help a woman better understand her reproductive physiology. However, it does not reduce risk of STI and HIV transmission. Also, it takes time for the woman to learn the fertile phase and requires a commitment for recording the menstrual cycle of this month. The method may be difficult to use for women with irregular periods

Cervical mucous methods require checking the texture, colour and quality of the secretions from the cervix coming out of the vagina to determine a woman's fertile period. During the fertile period, pregnancy can be prevented by voluntarily avoiding sexual intercourse or using another contraceptive method. Check the mucous each day for several months. The mucous that flows out just before ovulation is sticky and thick. Secretions during ovulation are clear, slippery and can be stretched between the fingers. After fertile phase, there is little or no mucous. It does not reduce the risk of STI and HIV transmission and it takes time to learn the fertile phase and requires a commitment to check the cervical mucous everyday. This method is not applicable for women with abnormal discharge.

Lactational amenorrhea method: Exclusive breastfeeding for the first six months after childbirth produces prolactin, a hormone that suppresses ovulation. It requires that a woman has not had a period since delivery. A woman must breastfeed at least six times a day (every four hours) from both breasts. It is an inexpensive method that can be discontinued at any time. It does not reduce risk of STI and HIV transmission. Will only last for six months after delivery and only if the woman is exclusively breastfeeding. *HIV positive women are recommended to use condom also (i.e., dual protection).*

Withdrawal method is a method in which the man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia. It works by keeping sperm out of the woman's body. It is not effective as pre-cum or pre-ejaculate also contains sperm and could make the woman pregnant.

Selecting a method of contraception is matter of personal choice for each woman. Therefore, they need correct, up-to-date, and non-judgemental counselling and availability of a range of contraception methods and follow-up care and advice.

4. Conception and pregnancy

Each month, one of a woman's two ovaries, releases a mature egg. The egg is released and travels into the fallopian tube where it remains until a single sperm penetrates it during fertilisation. The egg can be fertilised for about 24 hours after ovulation. On average, ovulation and fertilisation occurs about two weeks after the last menstrual period. If no sperm is around to fertilise the egg, the egg and the corpus luteum will degenerate and pass out through the vagina as menstrual bleeding. Then the cycle repeats itself.

An average ejaculation discharges 40-150 million sperm which swim upstream toward the fallopian tubes to fertilise an egg. Fast-swimming sperm can reach the egg in a half an hour, while others may take days. The sperm can live up to 48-72 hours. If sperm does meet and penetrate a mature egg after ovulation, it will fertilise it.

Within 24-hours after fertilisation, the egg begins dividing rapidly into many cells. It remains in the fallopian tube for about three days. The fertilised egg (called a zygote) continues to divide as it passes slowly through the fallopian tube to the uterus where it gets embedded in the wall (a process called implantation). Some women notice spotting (or slight bleeding) for one or two days around the time of implantation. The wall of uterus becomes thicker and the cervix is sealed by a plug of mucous.

Human chorionic gonadotropin (hCG) is a hormone present in the blood within about a week of conception. It is the hormone detected in a blood or urine pregnancy test, but it usually takes three to four weeks for levels of hCG to be high enough to be detected by pregnancy tests.

Pregnancy is the term used to describe when a woman has a growing foetus inside of her. In most cases, the foetus grows in the uterus. Human pregnancy lasts about 40 weeks or just more than 9 months, from the start of the last menstrual period to childbirth. The foetus floats in the amniotic fluid. During pregnancy the amniotic fluid increases in volume as the foetus grows. This fluid is constantly circulated by the baby swallowing and 'inhaling' existing fluid and then "exhaling" and urinating out the fluid. The amniotic fluid also protects the foetus from outside injury by cushioning sudden blows or movements.

The placenta is an organ that connects the developing foetus to the wall of the uterus. It supplies the foetus with nutrients from the mother's body, and allows foetal waste to be disposed of through the mother's kidneys.

During pregnancy, if the mother is HIV positive, the HIV virus can pass on to the growing baby in the uterus. However, with proper implementation of prevention of parent to child transmission (PPTCT) the chance of transmission is reduced to 1%. According to the latest PPTCT guidelines from Department of AIDS Control (DAC), based on WHO guidelines released in June 2013, all pregnant and breastfeeding HIV positive women will be given lifelong triple ARV regardless of their CD4 count both for their own health and to prevent vertical HIV transmission from mother-to-child. According to these guidelines, treatment with triple drug ARV (Tenofovir+Lamuvudine+Efavirenze) is initiated as soon as a pregnant woman is diagnosed with HIV regardless

of CD4 count or clinical stage. The treatment can be given even in first trimester of pregnancy and is continued for life, thus providing protection for future pregnancies as well. The baby is given Nevirapine immediately after birth and continued daily for six weeks. If the pregnant mother is already on ART, same regimen is continued and baby is given Nevirapine after birth up to six weeks. The baby is to be tested for HIV through DNA-PCR testing at six weeks, six months, six weeks after stopping breastfeeding, and 18 months as part of Early Infant Diagnosis.

Antenatal care (ANC)

Antenatal care (ANC) refers to the medical and nursing care recommended for women before and during pregnancy. The aim of good ANC is to detect any potential problems early, to prevent them if possible (through recommendations on adequate nutrition, exercise, vitamin intake, etc.), and to direct the woman to appropriate specialists, hospitals, etc., if necessary. WHO recommends at least four ANC visits during pregnancy. The Indian guidelines on ANC suggest that along with a minimum of three ANC visits, a woman should receive two tetanus toxoid (TT) injections and consume 90 or more iron–folic acid (IFA) tablets.

During pregnancy, one must look out for following warning signs. Presence of any of the following signs or symptoms warrants immediate medical attention as these symptoms may be indication of serious underlying problems:

- Bleeding from vagina at any time of pregnancy.
- Severe vomiting and nausea. Vomiting in the first three months is common but if it becomes so severe that you are not able to eat or drink anything, dehydration may occur and therefore doctor must be informed.
- Regular strong contractions before the due date. If a woman is in her third trimester and thinks she is having contractions, call the doctor right away. If it is too early for the baby to be born, the doctor may be able to stop the labor.
- Swelling of feet, hands and face, severe persistent headache, dizziness or blurry vision.
- Sudden gush of water from vagina – this may mean breaking of water bag before the labour has started and can lead to infection in the baby.
- Sudden severe continuous pain in lower abdomen.
- High fever (more than 101 F) with chills.
- Absence of fetal movements.
- The doctor should also be consulted in case of the following:
 - Presence of blisters or sores in genitalia
 - Extreme tiredness and pale eyes, tongue and palms
 - Excessive weight gain or too little weight gain

Sex during pregnancy

If the woman so desires, it is usually safe to have sex during pregnancy. Some doctors recommend that all women stop having sex during the first three months of pregnancy as the foetus has still not implanted well to the wall of the uterus. They fear that contractions during orgasm could cause miscarriage. Some also suggest that women avoid sex during the final weeks of pregnancy, just as a safety precaution, because semen contains a chemical that may actually stimulate contractions and therefore cause premature delivery. Usually there is no risk to the foetus from sex during

pregnancy. The baby is fully protected by the amniotic sac and the strong muscles of the uterus. There's also a thick mucous plug that seals the cervix and helps guard against infection. The penis does **not** come into contact with the foetus during sex. Many women find that their desire for sex fluctuates during certain stages in the pregnancy. During late stages, some women find it difficult to have sex due to their larger body size. On the other hand, some women find sex more pleasurable. Certain sexual positions may be more comfortable during pregnancy than others. Positions in which the pregnant woman is on top or on her side will avoid putting additional weight or pressure on her abdomen.

Possible complications related to conception and pregnancy

Infertility refers to the biological inability of a man or a woman to contribute to conception, although the term may also be used to describe a condition when a woman is unable to carry a pregnancy to full term. Infertility in men is most often caused either because sufficient numbers of (sometimes none at all) sperms are not produced or because of problems with the sperm's ability to reach the egg and fertilise it. Problems with ovulation account for most cases of infertility in women. Without ovulation, there are no eggs to be fertilised. Less common causes include blocked fallopian tubes due to pelvic inflammatory disease, physical abnormalities of the uterus or uterine fibroids (growths in the uterus). Another possible cause is endometriosis, a condition in which the type of cells similar to the ones that normally grow inside of the uterus (endometrial cells) start to grow in locations outside of the uterus). A woman's chances of pregnancy reduce to some extent after the age of 30 years.

An *ectopic pregnancy* is a complication of pregnancy in which the fertilised ovum is developed in any tissue other than the uterine wall. Most (98%) ectopic pregnancies occur in the fallopian tubes (often called tubal pregnancies). An ectopic pregnancy is a medical emergency and, if not treated properly, can lead to the death of the woman.

5. Childbirth

The process of normal childbirth is categorised in three stages of labour: the first stage starts with regular contractions that open up the cervix and lasts until the cervix is fully opened (dilated) to about 10 cm diameter. The second stage of the labour begins when the cervix is fully dilated and concludes with the birth of the baby. The third stage is from the birth of the baby to the delivery of the placenta and membranes. It is important that the entire placenta be removed from the uterus. If any part of the placenta is not expelled, it may cause heavy bleeding (postpartum haemorrhage) and the mother may bleed to death. In some cases, childbirth is done through *caesarian section (or C-section)* by removing the infant through a surgical incision in the abdomen and the uterus, to lift out the baby and placenta. Then the incision is closed.

If the mother has an outbreak of herpes or she has HIV but has not received anti-HIV drugs that greatly reduce the risk of the baby becoming infected during birth, caesarean section may be performed to reduce risk of transmission of HIV to the baby. If the mother has received the drugs, it is not necessary to do a caesarean section for an HIV positive mother unless there are complications related to delivery and the

baby's position. However, all pregnant women living with HIV must have institutional delivery.

Possible complications related to childbirth

Breech presentation is where the baby's head is not the part pressing against the cervix. Instead the baby's bottom or legs are positioned to enter the birth canal first, instead of the head. The risks of vaginal delivery with breech presentation are much higher than with a head-first presentation and the mother and attending practitioner will need to weigh the risks and make a decision on whether to deliver via a caesarean section (see below under caesarean sections) or attempt a vaginal birth. If the labour is not progressing as it should or if the baby appears to be in distress, the doctor may opt for assisted *delivery (forceps or suction)*. A forceps is a spoon-shaped device that is placed around the baby's head or mild suction force is applied to the baby's head so the doctor can pull the baby gently out of the vagina.

Complication specific to HIV positive women

HIV positive women are more likely to have complications like premature labour, fever, infections, babies with low birth weight, and infections after birth. Infections after birth may cause more difficulty for HIV positive women if their bodies are less responsive to the antibiotics usually given to treat such infections. In the absence of ARV therapy during pregnancy, the risk of a woman having an HIV-infected child is between 25 to 35 percent. Children who contract HIV may be infected in the uterus, during delivery or through breastfeeding.

Other complications

Uterine prolapse: A combination of muscles and ligaments in the pelvis called the pelvic floor support the uterus and vagina, to keep them in their correct position inside the pelvis. Giving a number of vaginal births, frequent heavy lifting especially after childbirth, frequent straining during bowel movements, and normal ageing process can all weaken the muscles and ligaments in the pelvis (pelvic floor). These can result in prolapse, a condition where the pelvic floor can no longer support the organs in their proper positions. Prolapse of the uterus and vagina are more common. The most common symptom is a sensation of 'something coming down below'. A prolapse may also cause difficulties with sexual intercourse. Performing pelvic floor exercises on a daily basis to strengthen the muscles of the pelvic floor is recommended. Some times surgical repair is done. Sometimes the uterus has to be removed.

Fistula is a serious medical condition brought on by inadequate care during childbirth, in which a hole develops between rectum and vagina or between bladder and vagina. Fistula is preventable. An *anal fistula* is a chronically inflamed, abnormal tunnel between the anal canal, and the outer skin of the anus. It often drains watery pus which can irritate and cause itching and discomfort. Some of its causes are a healed sore in rectal area, inflammation on the intestinal wall, TB, gonorrhoea, and cancer of large intestine.

6. Breastfeeding and HIV

A significant dilemma faced by HIV-positive mothers is whether to breastfeed their infants: in doing so, they risk transmitting the virus through breast milk; to pursue

formula feeding comes with its own set of risks, including a higher rate of infant mortality from diarrhoeal illnesses, while reducing transmission of HIV. Treatment of mothers and/or their infants with antiretroviral drugs is a strategy that has been employed for several decades to reduce HIV transmission through pregnancy and delivery, but the effect of ART during breastfeeding is still under research. Emerging evidence indicates exclusive breastfeeding is much safer than mixed feeding (the supplementation of breastfeeding with other foods), and should be encouraged even in settings where ART for either the mother or infant is not readily available. The research published regarding maternal treatment with highly active antiretroviral therapy (HAART) during pregnancy and the breastfeeding period suggests maternal HAART can drastically reduce the risk of transmission of HIV. Infant prophylaxis has been intensively studied in several trials and has been shown to be as effective as maternal treatment with antiretrovirals, reducing the transmission rate after six weeks to as low as 1.2%.

7. Abortion

An abortion is the termination of a pregnancy by the removal or expulsion of an embryo or foetus from the uterus. An abortion can occur spontaneously due to complications during pregnancy which is called spontaneous abortion or miscarriage. Abortion can also be induced in which case it is called induced abortion. When abortion is induced medically, it is called medical termination of pregnancy (MTP).

Methods of abortion during different stages of pregnancy

Up to 7 weeks

Abortion by medicines: These medicines work by causing the uterus to contract and squeeze out the pregnancy. The first medicine that the woman has to take is mifepristone (RU486). After this, a second medicine called misopristol has to be taken. The combined effect of these two drugs usually causes the woman to have a complete abortion. They should be only given in situations where the woman can reach a medical provider quickly if she has any complications and needs treatment. This must be taken under medical supervision only.

Up to 12 weeks

Abortion by suction (vacuum aspiration, MVA): Pregnancy is removed by suction using a special tube (cannula) that is put into the uterus through the vagina and the cervix. It is also done manually (MVA) by a special syringe that is used to remove pregnancy. It takes about 10 minutes and is quite safe and effective.

Abortion by scraping (dilation and curettage, DC): The pregnancy is scraped out with a curette, a small spoon shaped instrument which is slightly bigger and sharper than the cannula. So the cervix has to be stretched open which causes some pain and cramping. It costs more than vacuum aspiration and the woman is put under general anaesthesia before the procedure. It needs an operating setup.

Surgical abortion up to 12 weeks of pregnancy can only be carried out by a registered medical practitioner in a health care facility approved by the government.

Women living with HIV/AIDS are prone to more spontaneous abortions and infections from unsafe abortions. Access to safe abortion is essential for improving the health of women with HIV.

Unsafe abortion methods that are resorted to by many women

- Putting sharp objects into the vagina or the womb
- Putting herbs like milk of cactus, black horse gram in the vagina or the womb
- Putting substances such as bleach, lye, ashes, soap, or kerosene into the vagina
- Taking medicines or traditional remedies to cause abortions
- Hitting one's abdomen in a bid to terminate pregnancy
- Massaging one's abdomen
- Going to an untrained practitioner

All of these practices can be very dangerous. Every year, thousands of women bleed to death or die of infection after unsafe abortions.

Sex-selective abortion

Sex-selective abortion is the targeted abortion of a foetus based upon its sex. This is done after a determination is made usually by ultrasound that the foetus is of an undesired sex. These practices are especially common in some places where cultural norms value male children over female children. A society may exhibit a widespread bias towards having children of a specific gender, either due to cultural biases or economic concerns (e.g., male children may be more employable in the future and thus provide more financial support). When combined with frequent social sex selection, this bias may produce a gender imbalance like unnaturally high male/female ratios in the population. This is also connected to discrimination, potential violence and abuse of women and girls. The practice is legally banned in India.

Laws related to abortion

Abortion in India has been legal since 1971 ever since the Parliament has passed the MTP (Medical Termination of Pregnancy) Act in India. Under the MTP act, an abortion can be carried out not later than the end of five months (twenty weeks) of pregnancy but it is safer to do it as soon as possible preferably, within the first three months of pregnancy. Under the MTP act, an abortion carried out within the first three months (12 weeks) should be authorised by a trained doctor (doctor having training and experience in gynaecology and obstetrics) but after this period, consultation of one or more trained doctors is necessary for safety of the woman. According to the MTP Act, pregnancy may be terminated for the following reasons:

- Threat to life or to the mental or physical health of the mother.
- Risk of abnormality of the unborn child.
- Pregnancy resulting from rape (not applicable to marital rape; rape within marriage is not recognised as rape under Indian law).
- Failure of contraception.

Though abortion has been legal for decades, unsafe abortions far outnumber legal procedures in India. Unsafe abortions are responsible for many deaths that are avoidable. Factors for unsafe abortions include a dearth of trained providers, inadequate training facilities, and legal restrictions on who can provide abortion services. This

situation is compounded by the fact that millions of Indian women remain unaware that abortion services are legal and available, including for adolescents and unmarried women which in turn results in backstreet abortions by quacks leading to infection and death. Add to this, there is judgmental attitude of service providers, especially when unmarried girls or sex workers seek abortion services.

In 1996, a law was enacted in India that banned the use of prenatal testing for sex selection. Doctors are only allowed to test foetuses for genetic and congenital abnormalities. Yet the law looks better on paper than in practice. Advertisements for ultrasounds often carry a hidden message: that doctors will use the tool to reveal the sex of the unborn, opening the way to abort “negative” results, meaning females. This is a live example of how discrimination and abuse against women and girls starts even before birth.

Autonomy to choose

‘Pro-choice’ describes the political and ethical view that a woman should have complete control over her fertility and when, whether and how she becomes pregnant. Sometimes people use the term very specifically to refer to a woman’s choice about whether to continue or terminate a pregnancy. But the guarantee of *reproductive rights* is broader than just abortion. It includes access to comprehensive sexual education; access to safe and legal abortion, contraception, and fertility treatments; and legal protection from forced abortion. Individuals and organisations who support these positions make up the pro-choice movement. The opposite position is usually called ‘pro life’, although it would be more accurate to refer to it as the anti-choice position. It is a political and ethical view which maintains that foetuses and embryos are persons and that their right to live is equal to or greater than the woman’s right to make her own decisions about her pregnancy. Pro-life campaigners argue that a woman’s reproductive rights must be secondary to foetal rights and that, therefore, abortion should be criminalised as murder. Underlying this view are strong patriarchal notions that view women’s bodies being owned by others. In countries where abortion is illegal or inaccessible, there is a high incidence of desperate women and girls resorting to illegal abortions that result in serious injury or death.

8. Sexually transmissible infections (STIs) and reproductive tract infections (RTIs)

Sexually transmissible infections (STIs), also known as sexually transmitted diseases (STDs), are infections primarily passed from person to person by sexual contact. Some STIs can be passed to a baby during pregnancy, delivery, or breastfeeding, causing serious complications. Some STIs, including HIV, can also be passed through unclean surgical instruments, injection needles and skin-cutting tools, as well as transfusions of infected blood. STIs are part of a broader group of infections known as reproductive tract infections (RTIs). RTIs include infections of the female reproductive system that are not caused by sexual contact, including infections caused by an imbalance of normal reproductive tract micro-organisms (such as yeast infections) or are acquired during medical procedures (often when there is a failure in aseptic technique). STIs and other RTIs can lead to serious complications, including infertility, chronic pain, and even death, especially if they are not detected and treated early. No cure exists for HIV infection or AIDS. STI infection significantly increases the risk of acquiring or transmitting HIV.

Syndromic Management of STI/RTI²⁵

A syndrome is a group of symptoms that patients describe, combined with the signs that providers observe during examination. Many STIs/RTIs can be identified and treated on the basis of characteristic symptoms and signs. Symptoms and signs can be grouped together into syndromes—upper respiratory infection, gastroenteritis, and vaginal discharge are examples of common syndromes. It is often difficult to know exactly what organism is causing the syndrome, and treatment may need to cover several possible infections.

Syndromic management refers to the approach of treating STI/RTI symptoms and signs based on the organisms most commonly responsible for each syndrome. A more definite or etiological diagnosis may be possible in some settings with sophisticated laboratory facilities, but this is often problematic. Laboratory tests require resources, add to the cost of treatment, may require clients to make extra visits to the clinic, and almost always result in delays in treatment. For these reasons, syndromic management guidelines are widely used for syndromes such as lower abdominal pain, urethral discharge and genital ulcer.

WHO has developed simple flowcharts (also called algorithms) to guide health care providers in using the syndromic approach to manage syndromes.

Syndromic algorithm	Rationale for use
Syndromic algorithms for urethral discharge in men and genital ulcers in men and women are both effective and practical.	Gonorrhoea and chlamydia are among the important causes of urethral discharge. Syphilis and chancroid are among the important causes of genital ulcers. Properly used, these algorithms permit health care workers to provide effective treatment for symptomatic patients. They are simple and can be used even in remote areas as long as the necessary medicines are available. Equally important, syndromic management of these problems prevents new infections by providing curative treatment without delay and breaking the chain of infection.
The syndromic approach to lower abdominal pain in women is widely used, even in developed countries.	Gonorrhoea and chlamydia are among the important causes of lower abdominal pain in women. This approach is designed to offer effective treatment to women with symptoms that could indicate pelvic inflammatory disease. Health care providers should realise that some women managed with this algorithm might not actually have PID (false positives). Treatment is justified, however, because of the severe consequences—including infertility and ectopic pregnancy—that often follow PID that is left untreated or not treated early.
Syndromic algorithms for women with symptoms/signs of vaginal discharge work well for vaginal infections but not generally for cervical infections.	Vaginal infection (bacterial vaginosis, trichomoniasis or yeast infection) is the main cause of vaginal discharge. Vaginal discharge algorithms are not designed to detect the more serious and often asymptomatic cervical infections. At present, accurate detection of gonococcal and chlamydial cervicitis requires expensive laboratory tests, which are not available in most settings. In some special situations, treatment for cervical infection is justified.

²⁵ World Health Organisation: *A guide to essential practice of Sexually transmitted and other reproductive tract infections*

The syndromic approach delivers effective STI treatment quickly to people when they first come for care. The syndromic approach is ideal for primary health care settings. It focuses on the most common STIs that can be cured and is user-friendly because it offers medical care that patients can appreciate and get to easily.

9. Cancer of the cervix

Cancer of the cervix, a preventable disease, is one of the commonest cancers in women world-wide and a leading cause of cancer deaths. Globally, nearly half a million women are newly diagnosed with invasive cervical cancer annually. Majority of these women have never been screened for the disease. If current trends continue, by year 2050 there will be over one million women newly diagnosed with cervical cancer. Nearly all cases of this cancer are associated with a virus called human papilloma virus (HPV). There is no treatment for HPV infection. Of more than one hundred HPV genotypes, HPV types 16 and 18 are associated with 70% of the cervical cancer cases. Low-risk types can cause genital warts or infections of no clinical consequence.

A woman has more risk of developing cancer of cervix if she has had sex with a person infected with the cancer causing viruses or began having sex at an early age (before the age of 18) with a person infected with the HPV virus (because the membrane covering an underdeveloped cervix is more fragile and can be penetrated more easily by the virus). Smoking, douching or taking certain hormonal medications like OCPs increases the risk of developing cancer of the cervix.

HPV infection differs from other STIs, however, in that HPV infection can occur even with non penetrative sex (after ejaculation just outside the vagina, for example). There is a long delay between infection and invasive cancer. Cancer of the cervix begins with HPV infection. Persistent infection with high-risk types can lead to precancerous abnormalities in the cervix. If not treated, they can progress to cancer of the cervix. Usually, women get HPV between their late teenage years and early thirties. Most often, cancer is found much later, usually after age 40, with peak incidence around age 45.

There is increase in the risk of cervical cancer developing in *HIV-positive women*. Women with a weakened immune system due to the HIV virus are more likely to develop cancer of the cervix. In fact, cancer of the cervix is sometimes the disease that first suggests a diagnosis of AIDS. HIV-positive women should have pap smears (screening technology) more frequently than HIV-negative women. They should have a smear when they are first diagnosed with HIV, six months after this, and then every year. There is some evidence that women who take ARVs after treatment for precancerous cervical changes or cervical cancer and have an undetectable viral load are less likely to develop a recurrence of the condition.

Prevention of cancer of the cervix

Secondary prevention: Secondary prevention is achieved through screening (pap smear) and treatment of identified precancerous lesions.

Primary prevention: Two vaccines are currently available that, if given to adolescent girls before their sexual debut, can be effective against limited number of strains

of HPV. However, as adolescent girls are unlikely to disclose their sexual debut to parents or doctors, it is difficult to determine at what age the vaccine should be given. Although successful in developed world, pap smear has found little success in the developing world in detecting cancer especially because of non-availability due to limited resources and infrastructure. Efforts are being made to scale up alternate low cost screening methods in resource poor settings.

10. Menopause

Menopause is the time in a woman's life when her menstrual cycles are absent for at least one year. The ovaries stop functioning and she no longer menstruates. It is a normal part of life, just like puberty. A woman's body has a finite number of eggs in her ovaries and, eventually, no more eggs will be released from the ovaries for fertilisation. As one ages, the female hormones that regulate ovulation and menstruation begin to decline. Both oestrogen and progesterone, responsible for signalling to the body when it is time to ovulate and menstruate, decline and ovulation and menstruation will become irregular, eventually stopping altogether. When one no longer gets one's periods, one has entered the menopausal phase.

Many women are anxious, worried and even scared about going through menopause. It can be difficult to stop menstruating and no longer be able to bear children. However, many women find menopause to be a happy and exciting time in their lives. One is no longer bound to periods and hormones and can live without the worry of pregnancy. Through education and acceptance, menopause can become one of the most enjoyable stages in a woman's life.

A surgical procedure, called hysterectomy, removes the uterus. This surgery puts an end to the menstrual cycle but does not affect menopause, which still occurs naturally. Induced, sudden, or surgical menopause happens if both of the ovaries are removed by surgery. Chemotherapy, radiation treatment, or ovarian malfunction can also cause premature menopause.

Menopause occurs in three major stages. The first stage of menopause is known as *peri menopause*. The first signs of menopause are irregular periods and spotting due to fluctuating hormone levels in your body. Although it is still possible to get pregnant during peri menopause as eggs may be released from the ovaries, ovulation will probably be sporadic. Peri menopause can last anywhere from two to five years, but some women can remain in this stage of menopause for up to 15 years. Fluctuating hormone levels will probably cause some menopause symptoms like hot flashes, night sweats, and irritability. The second stage of menopause occurs when one's periods no longer arrive. This stage is called *menopause* and usually occurs around the age of 50 or 51 but menopause may occur as early as the 30s or as late as the 60s and there is no test to predict the age at which menopause will occur. In order to be in menopause, periods have to be absent for at least a year without being ill, pregnant, breastfeeding, or using certain medicines, all of which also can cause menstrual cycles to cease. The final stage of menopause is called *post menopause*. At this stage, menopause symptoms like hot flashes, headaches, and mood swings begin to decrease gradually as oestrogen levels decline and the body stops producing progesterone. However, the woman is

at an increased risk for developing osteoporosis, heart disease, and urinary tract infections during this time.

Different women may experience *signs and symptoms* of menopause to different degrees. It is not necessarily or only *changes in menstruation*. This might be what one notices first. One's periods may no longer be regular. They may be shorter or last longer. One might bleed less than usual or more. But if the periods have stopped for 12 months in a row, and one still has spotting, one should see a health care provider. The following can be other symptoms:

- **Hot flashes:** A hot flash is a feeling of heat in one's face and over the surface of one's body, which may cause the skin to appear flushed or red as blood vessels expand. It can be followed by sweating and shivering. Hot flashes that occur during sleep are known as night sweats.
- **Sleeping problems:** Lack of sleep can affect one's mood, health, and ability to cope with everyday stress.
- **Vaginal changes:** Changing oestrogen levels can cause the vagina to get drier and thinner. Effects may include itching, burning, and pain on and after penetration. This could make sexual intercourse uncomfortable. It also makes the vaginal tract and the urinary tract more vulnerable to infections. The effects may include itching, burning, and pain on and after penetration. A water-based vaginal lubricant or prescription based oestrogen replacement creams and tablets can help restore moisture and vaginal health. Atrophic vaginitis is a condition associated with post menopause, especially if the ovaries have surgically been removed. This can result in high risk of infection. Symptoms include burning, itching, painful intercourse, and a thin watery discharge that can be tinged with blood.
- **Urinary problems:** One may have leaking, burning or pain when urinating, or leaking of urine when sneezing, coughing, or laughing. Due to lack of female sex hormones in postmenopausal women, amongst other things the urinary system is more easily irritated by cystitis. Cystitis is a urinary bladder disease of unknown cause characterised by urinary frequency (as often as every 10 minutes), urgency, pressure and/or pain in the bladder and/or pelvis. Pain typically increases as the bladder fills and reduces after voiding. However some patients report pain with urination, often in the urethra.
- **Change in sexual feelings:** During menopause one may experience that feelings about sex are changing. One could be less interested or one could feel freer and sexier after menopause as the risk of pregnancy is absent (after one full year without a period). However, the risk for STIs, such as gonorrhoea or even HIV is still there. It is important to use a condom to protect from infection.
- **Weight fluctuation:** Weight gain or increase in body fat especially around the waist is seen around menopause.
- **Osteoporosis:** Oestrogen helps control bone loss. So losing oestrogen around the time of menopause causes women to begin to lose more bone than is replaced. In time, bones can become weak and break easily. This condition is called osteoporosis.
- **Heart disease:** After menopause, women are more likely to have heart disease. Changes in oestrogen levels may be part of the cause.
- **Psychological and emotional changes:** Oestrogen, which is linked to depression, explains why there are higher depression rates in women than in men. However,

as the estrogen level decreases before menopause, the risk of depression also decreases. There are other factors that cause depression during menopause. Menopause is also associated with some changes in body tissues and symptoms such as hot flashes that can cause not only physical discomfort but also occasional social discomfort and sleeping disorders. Emotional changes like mood swings, irritability and depression may be attributed to some of these symptoms and bodily changes. Other emotional changes can be triggered by changes in this point of life: children leaving home, career disappointments, or fear of aging.

Hormone therapy (HT)

If used properly, hormone therapy (once called hormone replacement therapy or HRT) is one way to deal with the more difficult symptoms of menopause. This can involve the use of either estrogen alone or with another hormone called progesterone, or progestin in its synthetic form. The two hormones normally help to regulate a woman's menstrual cycle. Progestin is added to estrogen to prevent the overgrowth (or hyperplasia) of cells in the lining of the uterus. This overgrowth can lead to uterine cancer. If one has not had a hysterectomy, one would receive estrogen plus progesterone or a progestin; if undergone hysterectomy, one will receive only estrogen. As with all treatments, HT has both possible benefits and possible risks; it is important to talk about these issues with a doctor. If one decides to use HT, one should use the lowest dose that helps and for the shortest time needed. HT can help with menopause by reducing hot flashes; treating vaginal dryness; slowing bone density loss; improving sleep (and thus decrease mood swings).

For some women, HT may increase their risk of blood clots, heart attack, stroke, breast cancer, and gall bladder disease. Those who think they are pregnant, have problems with vaginal bleeding, have had certain kinds of cancers (such as breast and uterine cancer), have had a stroke or heart attack, have had blood clots, have liver disease, have heart disease *should NOT take HT for menopause*.

It is important to see a doctor in case the following side effects occur while taking HT: vaginal bleeding, tenderness or swelling of breasts, headaches, mood changes, and nausea.

Contraceptives during menopause

A woman reaches menopause when her ovaries stop releasing eggs (ovulating). Because bleeding does not happen every month as menopause approaches, a woman is considered no longer fertile once she has gone 12 months in a row without having any bleeding. To prevent pregnancy until it is clear that she is no longer fertile, an older woman can use any method if she has no medical condition that limits its use. By itself, age does not restrict a woman from using any contraceptive method. Because bleeding does not come every month in the time before menopause, it is difficult for a woman whose bleeding seems to have stopped to know when to stop using contraception. Thus, it is recommended to use a family planning method for 12 months after last bleeding in case bleeding occurs again. She no longer needs contraception once she has had no bleeding for 12 months in a row.

Cancer of the cervix and menopause

Because progression from HPV infection to invasive cancer is slow, usually taking decades, it is seen more frequently in women in their 40s and 50s. During the early years of menopause, called peri-menopause, periods become irregular, sometimes heavier, sometimes lighter, and eventually, they stop altogether. However, while most women assume this abnormal or unusual bleeding is a normal part of menopause, which it can be, it could also be a sign of trouble. Therefore, any symptoms of unusual bleeding after menopause should be checked. Other symptoms of cancer of the cervix after menopause could be pelvic pain, increased vaginal discharge, and bleeding after intercourse.

11. Integration and linkages of SRH and HIV services to maximise service access for key populations *Linkages* refers to policy, programmatic, services and advocacy synergies between SRH and HIV. Linkages also involve addressing the social and structural issues that make people vulnerable to sexual and reproductive ill health and HIV. *Integration* refers to different kinds of SRH and HIV interventions and services that can be joined together to enhance access and utilisation.

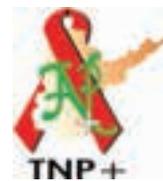
Bi-directional integration and linkages mean that SRH components can be linked to HIV programmes, and HIV components can be linked to SRH programmes.

Different approaches to integration

- **One-stop shop** provision of comprehensive and integrated services, such as drop-in centres or clinics that provide HIV services (HIV counselling and testing, prevention, care and treatment) with SRH services (family planning, STI, prevention of vertical transmission/PMTCT), maternal, new-born and child health (MNCH), safe abortion). For example, the Kenya AIDS NGOs Consortium (KANCO)'s RAY Drop-in-Centre for Most at risk populations (MARPs) specifically Commercial Sex Workers.
- **Referrals** approach, whereby an HIV service (community or clinic based) provides information and referrals for a SRH service. For example, the Network Support Model in Uganda trains people living with HIV to improve access to prevention, care, treatment and support. It offers community-based palliative care, adherence counselling and HIV prevention. Some are selected as Network Support Agents who accompany and empower PLHIV to use existing government community-based wrap-around health services, including family planning, prevention of vertical transmission/PMTCT, and STIs.
- **Physical and functional integration** of different services in the same room; same provider, same facility but different rooms; same provider but in different rooms or at different times; combination of services received in one visit — all types of integration are possible; there is no blueprint.

Five key areas of integration and linkages: Increasing access to voluntary HIV testing and treatment; promoting safer sex; optimising connection between HIV and STI services; integrating HIV with MNCH; promoting dual protection from HIV, STIs and unintended pregnancies.

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