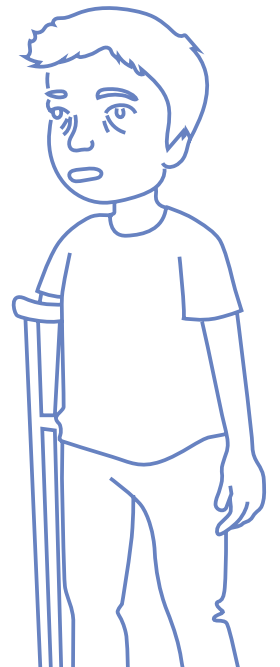
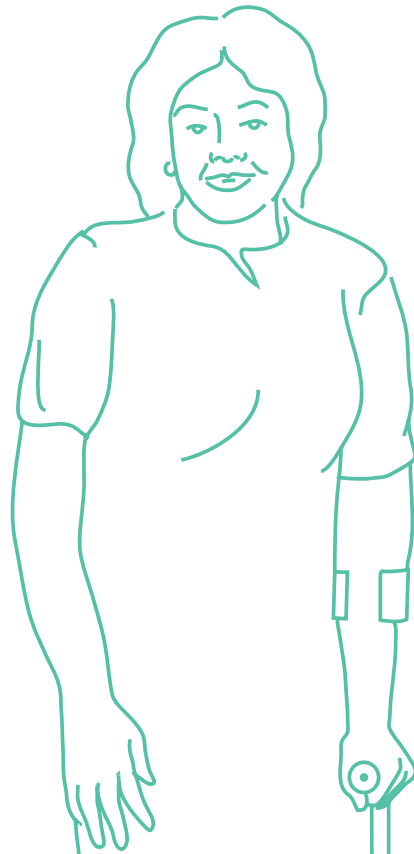




FACILITATORS' MANUAL

ON COMPREHENSIVE SEXUALITY EDUCATION
FOR YOUTH WITH LOCOMOTOR DISABILITIES



FACILITATORS' MANUAL ON COMPREHENSIVE SEXUALITY EDUCATION FOR YOUTH WITH LOCOMOTOR DISABILITIES

This Facilitators' Manual is a part of a project undertaken by a Delhi based organization Feminist Approach to Technology to develop a toolkit aimed at making Comprehensive Sexuality Education accessible for youth with locomotor disabilities. The manual is designed and developed in a way that the educators / trainers / teachers / therapists / occupational therapists / other professionals working with youth with locomotor disabilities can use it to train youth on Sexual and Reproductive Health and Rights.

Many exercises have been adapted from Basics and Beyond, manual for trainers, developed by TARSHI (Talking About Reproductive and Sexual Health Issues). And some of the exercises have been adapted from 'It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education' published by the Population Council, New York.

In a few cases, it has not been possible to trace the original creator of an exercise because the exercise had been widely used and much modified long before we encountered it.

The Facilitators' Manual has been made collectively by many partners of the project mentioned below.

PROJECT PARTNERS:

Feminist Approach to Technology (FAT); Shishu Sarothi; Cross The Hurdles; TARSHI

AUTHORS: Abha Khetarpal, Prabha Nagaraja, Nandini Rao

TESTING AND EDITOR: Gunjan Sharma, Priyanka Sarkar

NEEDS ASSESSMENT: Ankita Rawat, Nandini Rao, Vijay Rajkumar

MONITORING AND EVALUATION: Vijay Rajkumar

FUNDING PARTNER: The David and Lucile Packard Foundation

PUBLISHING YEAR: 2020

Attribution-NonCommercial-ShareAlike

CC BY-NC-SA

Videos, Podcasts, Comic Book and Quiz Book which can further aid the trainings are also available in FAT's website - www.fat-net.org/disability-and-sexuality-toolkit-youth

FACILITATORS' MANUAL ONCOMPREHENSIVE SEXUALITY EDUCATION FOR YOUTH WITH LOCOMOTOR DISABILITIES



INDEX

INTRODUCTION

NOTE TO FACILITATOR

MODULE 1: LET’S GET STARTED

- Chapter 1: Understanding Locomotor Disabilities
Session 1: Understand Various Locomotor Disabilities and Its Impact on Sexual Functioning
- Chapter 2: Understanding Disability and Sexuality Education
Session 2: Understanding Sexual and Reproductive Health Rights of People with Disabilities(Polarisation exercise)
Session 3: Including People with Disabilities (Case studies)
- Handout A: Defining Locomotor Disability
Handout B: Integrating Concerns Related to Disability In Our Work – Case Studies

MODULE 2: BASIC CONCEPTS ON SEX, SEXUALITY AND GENDER

- Chapter 3: Sex, Sexuality and Gender
Session 4: Male and Female Word Webs
Session 5: Memory Journey: Learning about Gender as a Child
- Chapter 4: Sexual Identity and Gender Identity
Session 6: Sex and Gender Identities (HC)
Session 7: Varieties of Sexual Expression
Session 8: Good Sex/Bad Sex
- Handout C: Basic Information on Sexual Identity and Gender Identity
Handout D: Varieties of Sexual Behaviour and Expression

MODULE 3: SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY

- Chapter 5: Sexual and Reproductive Anatomy and Physiology
Session 9: Learning Human Anatomy
- Chapter 6: Conception, Contraception and Abortion
Session 10: Conception and Pregnancy Basics
Session 11: Charting Contraception Choices
Session 12: Quiz on Female and Male Anatomy, Conception, Contraception and Abortion
- Chapter 7: Infertility and Assisted Reproductive Technologies
Session 13: Demystifying Infertility
- Chapter 8: HIV/AIDS, Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs)
Session 14: HIV and AIDS, RTIs and STIs
Session 15: Starting a conversation about sex and safety
- Chapter 9: Sexual Problems
Session 16: Demystifying Sexual Problems - Myths and Facts
Session 17: My Views on Sexual Problems

- Handout E Facilitator Copy: Diagrams of the Human Sexual and Reproductive Anatomy
Handout F Participant Copy: Diagrams of the Human Sexual and Reproductive Anatomy
Handout G: Basic Information on Conception and Pregnancy
Handout H: Information on Contraception.
Handout I : Questions on Anatomy, Conception, Contraception and Abortion
Handout J: Facilitator Copy: Myths and Facts on Infertility
Handout K: Participant Copy: Myths and Facts on Infertility
Handout L: Quiz Questions on HIV and AIDS, RTIs and STIs
Handout M: Facilitator Copy: Myths and Facts on Sexual Problems
Handout N: Participant Copy: Myths and Facts on Sexual Problems

MODULE 4 SEXUALITY, POWER AND ABUSE

- Chapter 10: Sexuality and Power
Session 18: Understanding Sexuality and Power
Session 19: Abuse of Power: Child Sexual Abuse
Session 20: Where on the line? The continuum between choice and coercion

- Chapter 11: Challenging Stigma and Discrimination
Session 21: Stigma and Identities
Session 22: Acting Out Stigma, Discrimination and Stereotyping Identities

- Handout O: Facilitator Copy: Myths and Facts About Child Sexual Abuse
Handout P: Participant Copy: Myths and Facts About Child Sexual Abuse
Handout Q: Case Studies on Sexual Choices and Sexual Coercion
Handout R: Stigma and Identities
Handout S: Acting Out Stigma and Discrimination and identifying stereotyping of identities (Case Studies)

MODULE 5: SEXUAL AND REPRODUCTIVE RIGHTS

- Chapter 12: Human Rights
Session 23: Human Rights Tree

- Chapter 13: Reproductive and Sexual Health and Rights
Session 24: My Reproductive Rights and Sexual Health and Rights

- Handout T: An Overview on Human Rights
Handout T1: Universal Declaration of Human Rights
Handout U: Basic Information on Reproductive and Sexual Health and Rights
Handout U1: Overview of the articles of the Convention on the Rights of Persons with Disabilities

MODULE 6 ETHICS, VALUES AND PRINCIPLES

- Chapter 14: Values and Principles
Session 25 : Clarifying Our Values
Session 26: Understanding our Values

- Handout V: Case Studies to Understand Our Values
Handout W: Guiding Principles for Working on Sexuality
Handout X : Five Core Values

INTRODUCTION

Disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives. Because of disability, activities may be limited in nature, duration and quality. A person's involvement in various life situations, like work, education, employment, relationships, personal maintenance, can be impacted.

Sexuality in a person with disabilities, like any other, is an inherent aspect and it cannot be neglected. Though sex education is an important area of curriculum, young people with disabilities receive little or no formal sexual health education, either in school or at home. Sexual health and safety of students with disabilities is also not prioritized because educators are more focused on other aspects of the students' well-being.

They often face barriers to information and services like inaccessible curriculum and dearth of educative material. The educators or the other professionals working with persons with disabilities are many times bewildered regarding the sexual manifestations of disabled students. Due to the misconceptions and social stigma associated with disabilities everyone remains silent on this topic and there are no teaching resources on sexual education for this population.

It is common for teachers to face difficulties in the classroom regarding the sexuality of students, either due to the lack of knowledge or wrong beliefs. Although they recognize it as relevant, they have difficulties in taking on the sexual education of students with disabilities, either due to feeling a lack of personal/academic preparation or even the fear of negative reaction from the student's families. These matters influence the teaching practice, thus leading to difficulties when offering guidance regarding the sexuality of students.

The topic of sexuality education is further complicated by the educator's attitudes toward the subject. They do not feel comfortable to include youth with disabilities in discussions about sex. Through our engagements with educators and facilitators working on the issues of disability and sexuality, they mention some of these points regarding imparting sexuality education to youth with disabilities:

- Inability to answer questions
- Uncertainty on of what children know or should know
- Confusion, anxiety and ambivalent attitudes toward sexuality of their children
- Confusing sexuality education with acts of sex/ how to have sex

Educators and facilitators should be well trained to answer questions and provide appropriate sex education without flinching so that students with disabilities are able to learn about sex and sexuality. on their own. Well trained educators can then provide opportunities to learn about the social contexts of sexuality and the responsibilities of exploring and experiencing one's own sexuality.

WHO CAN USE IT?

This is a training manual for educators / trainers / teachers / therapists / occupational therapists / other professionals working with youth or persons with locomotor disabilities on comprehensive sexuality education.

This resource is on sexuality, sexual health and reproductive health and rights of youth with disabilities and hence will be of value for educators working with persons with locomotor disabilities.

It can also be used as a resource book by individuals and organisations interested in a basic or more complex understanding of the themes of the manual. This manual (as part of the toolkit) would be also helpful in training educators/therapists who will be working in a comprehensive sexuality education program.

HOW TO USE THE FACILITATOR'S MANUAL?

The training manual contains six modules. The chapters and exercises in each module have been constructed and organised to systematically build on concepts and ideas. The manual can be used as per the facilitator's goals and the level of understanding and experience of the participants. A facilitator can pick and choose exercises from the modules that address issues relevant to the training group's needs and can tailor sessions accordingly. The manual can also be used in its entirety to conduct a comprehensive training programme. Each facilitator should evaluate the needs and level of understanding of the group being trained and choose topics and exercises accordingly.

THE STRUCTURE OF FACILITATORS' MANUAL

The facilitators' manual is a comprehensive set of lesson plans and resources, which aims to assist facilitators in integrating sexual health education for youth with disabilities. The ultimate goal is to support them in making better informed decisions about their sexual health.

The facilitator who uses this manual, experienced or not, while going through this section will ensure a more effective and comprehensive training.

EACH MODULE HAS THE FOLLOWING COMPONENTS:

MODULE INTRODUCTION: Every Module has an overarching theme and contains chapters that address different aspects of this theme.

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

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

PLEASE NOTE: The chapters and sessions are all in continuous numbering across the modules and the handouts are numbered alphabetically. All handouts for sessions are at the end of the module.

NOTE TO FACILITATOR

- Help participants examine barriers to the provision of sexual and reproductive health services for disabled people. For example, the location of a clinic on a top floor with no elevator/ramp would limit access for wheelchair users.
- Note the kinds of words being used. Do they reflect any values of the group; are participants shying away from sexual terms (masturbation, sex, vagina, and penis); are they focusing on a particular manifestation of sexuality (heterosexual, monogamous); are they using 'negative' terms (rape, pain, violence, abuse) or 'positive' ones (pleasure, fun, arousal). Bring these observations to participants' attention and ask for comments.
- Participants may be uncomfortable around the topic of sexuality, especially early on in the training. This can manifest as disruptive behaviour, offensiveness, defensiveness, non-participation or use of inappropriate humour to divert attention from their discomfort. Draw up ground rules at the beginning of the training and draw their attention to the ground rules to remind them of the attitude of respect/ openness they had agreed upon before the training.
- Be prepared for a feeling/show of discomfort by participants.
- As participants realise that sexuality is much more than acts of sex, they will begin to feel more confident dealing with real or imagined opposition from their communities. They will also begin to feel less inhibited about talking about sexuality.

- Pay attention to the terms listed out by the groups. Participants might include sexual or gender identities in the list of sexual expression. Point out that sexual behaviour or expression is different from identity. For example, homosexuality is a sexual identity, not behaviour.
- In the course of discussions or even in a session, discussions around acts of sex may come up. Participants may rate some acts as 'good' or acceptable or some, a 'bad', 'unacceptable', 'deviant' etc. This difference helps people see how subjective sexual preferences and experiences are and so cannot be judged.
- The examples of 'bad sex' may leave many participants feeling awkward. An in-depth discussion of this category is not essential but it is important to have, so participants reflect on where these ideas of bad sex may have arisen from and how the stigma they create can affect service-provision.
- The discussions can reveal values, judgments and prejudices that, to a large extent, will be challenged by the participants themselves. The facilitator can step in when required.
- Participants might get emotional during this discussion, especially if they have experienced stigma for not having children and due to the belief, that women with disabilities are inherently unfit to become mothers. Be alert to this and do not push people to speak unless they are willing to.
- Discussing sexual problems may be uncomfortable for some participants. Encourage participants to speak openly and freely and reiterate that there is no need for shame or discomfort when discussing these issues.
- Make sure that the discussion on sexual problems does not degenerate into a man vs. woman issue where each group feels more marginalised than the other.
- While power disparities can contribute to gender inequality, ensure that no discussion becomes a man-bashing exercise. Men with disabilities may also lack power, particularly around gender issues and sexuality.
- Make sure ideas of gender and physical disability are included in discussions and that ideas about power are inclusive. For example, the discussion should not centre only on a heterosexual/ male-female context. Ensure that the experiences of transgendered, transsexual, and homosexual people are also taken into account.
- Some participants may be defensive about these issues and feel that this could not happen in their communities or social groups. Point out that abuse is not spoken about openly even though it can occur in any community.
- Participants may not be familiar with some of the identities listed. If necessary, go through the identities beforehand. Participants may express discomfort around some identities, especially those that are new to them or those considered 'wrong' according to their culture/religion. Be sensitive to this and encourage participants to participate.

A SPECIAL INPUT

As you know this manual is mainly designed keeping the concept of comprehensive sexuality education (CSE) for people living with locomotor disabilities - PLW(LMD) in view, hence the facilitator must keep in mind that each exercise must be discussed keeping disability as a focus.

All discussions must include points on how the issue is linked with disability, locomotor disability in particular. You will find a few key points at the end of each module to help you raise some issues, you can use them as you like and definitely pick up more from the ongoing discussions in your group. But this is an important aspect – don't miss it out.

The location of the venue, be it a hotel, a training centre or even a home, must be accessible for the participants. Many of them may come on their own, so a very congested area will not be easy to manoeuvre. Similarly if an auto or two-wheeler/ car can't easily fit, then it will just make it very difficult for the participant particularly with crutches, callipers etc. Similarly if they have a vehicle to park – space must be available. Also if it's very far from their home, that too can be a deterrent. The venue needs to be close to a metro/ main bus stop so that the person can reach easily. Since many PW(LMD) prefer to drive to places themselves or/ and can't afford or manage to take other vehicles - check with them beforehand.

The selected room must be large enough with basic furniture – pushed out of the way. There can be no floor seating, so chairs must be easy to get into and out of, ensure enough space for wheelchairs to go around.

Bathrooms: Please check them out – yourself. A basic wheelchair will need at least a 28-inch-wide entry door and then space enough to rotate the chair, with a handle to hold to get on the commode and wash basin. A wiper/ cloth must be accessible to wipe the seat or floor clean if the person can. Door latches, knobs, napkins, tampons, tissues, towels, hand sanitiser and flush have to be within reach for the user.

Just one toilet on the floor, is not enough, PWLMD may take longer in a bathroom, so do bear that in mind.

Do NOT fall for the “disability friendly” tag – it usually means, just an elevator!! There should be no steps or anything raised to get into the lift. The lift must be large enough to be able to slide a wheelchair into. Last minute manoeuvres can be annoying, tiring and undignifying.

Some PLW(LMD) may need to bring a helper along – do inform the same to the Venue Staff so that they have a comfortable space to sit/ eat during the workshop.

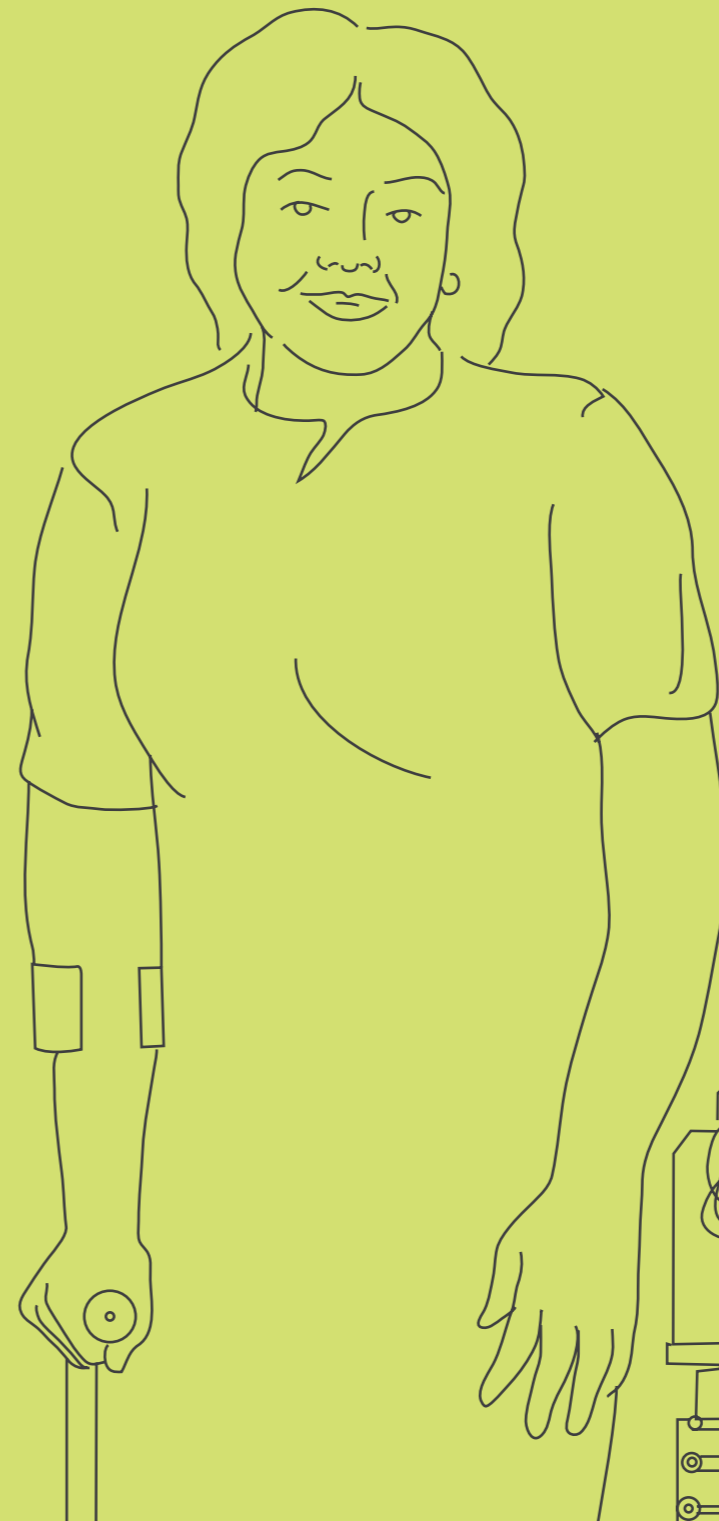
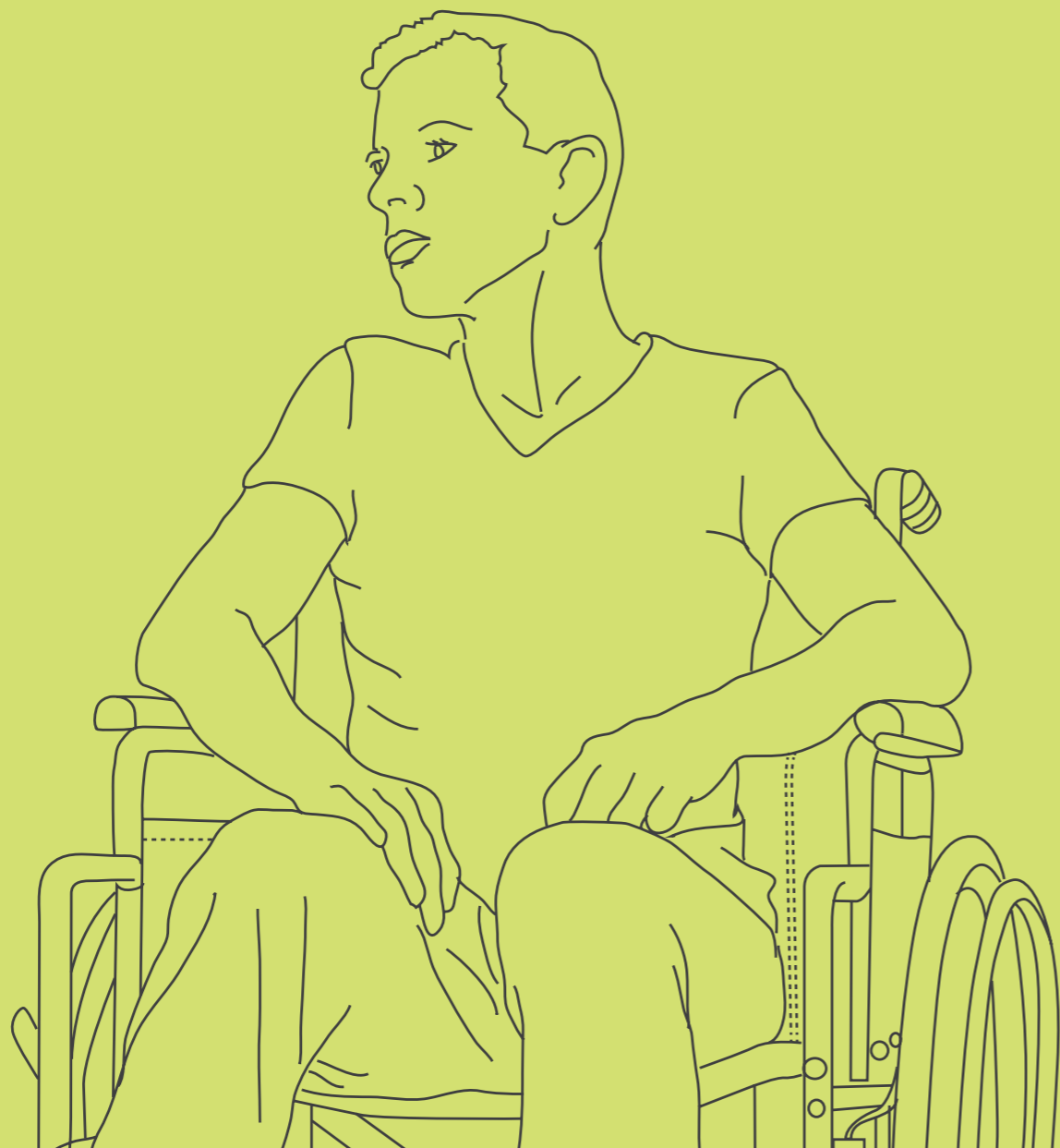
MODULE

1

LET'S GET STARTED

CHAPTER 1
UNDERSTANDING LOCOMOTOR
DISABILITIES

CHAPTER 2
UNDERSTANDING DISABILITY AND
SEXUALITY EDUCATION



CHAPTER 1: UNDERSTANDING LOCOMOTOR DISABILITIES

This chapter gives an idea of different kinds of locomotor disabilities. The participants and the facilitator/educators must understand how different physical conditions affect sexuality of an individual and how with proper management and with minor changes and adjustments one can have sexual pleasure.

CHAPTER OBJECTIVES

1. To let the participants understand various locomotor disabilities.
2. To make them aware about the impact of disability on sexual functioning.

SESSION 1: UNDERSTAND VARIOUS LOCOMOTOR DISABILITIES AND ITS IMPACT ON SEXUAL FUNCTIONING.

PURPOSE:	To give an overall idea of locomotor disabilities.
TIME:	30 mins
AGE:	18 and above
LITERACY LEVEL:	Literate
MATERIALS:	Blackboard and chalk/ Flip chart and markers
ADVANCE PREP:	Handout A: Defining Locomotor Disabilities

SESSION INSTRUCTIONS:

1. Ask them about what all they know about locomotor disabilities.
2. Inform them, that they need to identify if their physical condition would have any impact on their sexual functioning.
3. Introduce to them the following terms and ask them what they know about the terms:
 - A. LOCOMOTOR DISABILITY
 - B. SPINAL MUSCULAR ATROPHY
 - C. SPINAL CORD INJURY
 - D. MULTIPLE SCLEROSIS
 - E. POLIO
 - F. MUSCULAR DYSTROPHY
 - G. AMPUTATION
 - H. SPINA BIFIDA (SB)
 - I. CEREBRAL PALSY
 - J. DWARFISM
 - K. BRITTLE BONE SYNDROME
4. With each of these terms also ask if they know the impact these conditions have on sexual functioning of the body.
5. Distribute the handout among the participants when you summarise the points and discuss about effects on sexual functioning.

KEY MESSAGES:

1. Different physical conditions may change the way and individual performs daily activities.
2. Availability of accessible conditions can help persons with disabilities improve their quality of life.
3. If performing certain sexual activities becomes difficult, it does not mean that the person has become non sexual.
4. With proper management, counselling and expert advice one can enjoy sexual pleasure.

CHAPTER 2:

UNDERSTANDING DISABILITY AND SEXUALITY EDUCATION

Parents and other care-providers of adolescents with disabilities are often anxious with questions on sexuality. Some parents and other care – providers believe that giving information about the body and sexuality to their growing children will complicate their lives rather than enhancing it. This leads to de-sexualisation of disabled people. Many parents also feel that their children – especially their daughters – are more vulnerable to sexual abuse, and take extra precautions to protect them. Disabled people are often denied sexuality education and their sexual concerns are deemed inappropriate and thus ignored. Women with disabilities generally have fewer opportunities to explore their sexuality. Some of the barriers to accessing opportunities to information include lack of facilities to ease mobility for wheelchair users, lack of familiarity with sign language by hospital/ clinic staff and a lack of sexuality education material in Braille etc.

This chapter outlines some of the issues that people with disabilities face around their sexuality. The focus in this chapter is on the rights of people with disabilities to express their sexuality, access information and exercise choices for their sexual well-being. It emphasises that all humans are sexual beings, regardless of whether they are sexually active or not, have a disability or not, are young or old.

SEX EDUCATION

Sex education is a broad term used to describe education about human sexual anatomy, sexual reproduction, sexual intercourse, and other aspects of human sexual behaviour. It deals with topics like human sexuality and behaviour (e.g. safe sex practices and masturbation, and sexual ethics). Sex is a part of one's personality and sex education can help develop a complete personality. The objective of sex education is to help an individual to understand the body structures of men and women. It teaches children to establish and accept the role and responsibility of their own gender by acquiring the knowledge of sex. Understanding the differences and similarities between different genders in terms of body and mind will set up a foundation for their future development, their interpersonal relationship and in their acquaintances with friends and lovers.

SEXUALITY EDUCATION

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors (WHO draft working definition, 2006).

Comprehensive Sexuality Education (CSE) is about bodily changes – of puberty, growing up, physical differences, and at times, it is also about how adolescents feel in their body – do they like what they see? Are they happy and comfortable? Sexuality education is also as much about young people's likes, loves, and relationships, with each other, with teachers, with their parents and society at large, and at the same time it's about protection from abuse, violence, infections, hurt and the pain of break ups. It is about values and responsibilities, rights and duties. It is about sex too, what it is, the right time for it, who the 'right' person is, how and when to say no and when and why to say yes. It is about viewing sexuality affirmatively and responsibly. It views 'sexuality' holistically and within the context of emotional and social development. It recognizes that information alone is not enough and young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.

WHY DO WE NEED SEXUALITY EDUCATION FOR DISABLED?

Youth with disabilities require sexuality education so they can develop a positive attitude towards sexuality, their own body image and become aware about sexual abuse, sexually transmitted diseases and unplanned pregnancy. In addition, they are also vulnerable and need clarification about the difference of sexuality from sexual education, which contributes to the formation of attitudes toward their reproductive health.

CHAPTER OBJECTIVES

1. To familiarise participants with the meaning of disability and sexuality.
2. To encourage discussion about sexuality of disabled people, and what contributes to stigma and discrimination.
3. To familiarise participants with barriers faced by people with disabilities that prevent them from exercising their sexual and reproductive rights.

KEY MESSAGES

1. People with disabilities do not form a homogeneous group. For example, those with visual, hearing or speech impairments, intellectual disabilities, autism, restricted mobility or so-called ‘medical disabilities’ all encounter barriers of different kinds. Different disabilities have varied implications with respect to sexuality.
2. Words like impairment, handicap, and disability have different connotations. The term impairment implies a physical limitation. Visual impairment, for instance, means that a person’s eyesight falls below the determined standard. Disability, on the other hand, refers to the social impact on a person with any physical/mental impairment. This includes stigma, discrimination, pity, or non-inclusion. Disability imposes a barrier to accessing spaces and services available to others. The term handicap has a negative connotation by focusing on what a person is ‘lacking’, as opposed to the obstacles they encounter in a disabled-unfriendly society.
3. To protect children with disabilities, parents may de-sexualise them. Girls and women with disabilities have fewer opportunities to explore their sexuality.
4. Disabled people can experience stigma and discrimination at multiple levels. For example, disabled people may face additional stigma on account of their sexuality (if they are homosexual, bisexual, intersexed, transgendered), or their HIV status.
5. While it is important to highlight the additional disadvantage women with disabilities face, this should be done in a manner that affirms their right to speak for themselves. Otherwise there is a risk of disempowering them even more.
6. Disabled people have the right to information and services related to sexuality, sexual and reproductive health. Involving them in the planning and implementation of these services will ensure better quality, effectiveness and appropriateness.

SESSION 2: UNDERSTANDING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF PEOPLE WITH DISABILITIES

PURPOSE:	To understand that people with disabilities have the same sexual and reproductive rights
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL:	Anyone
ADVANCE PREP:	<ol style="list-style-type: none">1. Clear the room of furniture to make space for participants to move around in wheelchair or with crutches.2. Choose any three statements for discussion from the box below. Do some research or read up a bit before you begin discussion on these statements.3. Read through key messages so as to be prepared to lead a discussion on the selected topics.

SESSION INSTRUCTIONS

1. Designate one side of the room as the ‘Agree’ side and the other as the ‘Disagree’ side.
2. Read one statement at a time and allow time for discussion between those with different views before moving on to other statements.
3. You will read out a statement and participants must move to one or the other side of the room depending on whether they agree or disagree with the statement. Those who are undecided should move to a third designated spot in the room (the Don’t Know group).
4. Now, invite them to share why they have chosen to be on their side of the room.
5. Continue the discussion until the topic has been sufficiently discussed and analysed, but do not spend more than 15-20 minutes on a statement or participants may lose interest.
6. After discussing three different statements ask for general comments or you can also use the suggested questions below. Based on these discussions, share some of your opinions and thoughts about disability, sexuality and sexual and reproductive rights.
 - Have you thought about these issues before? If yes, have your views changed now? How? If no – why not?
 - Do you think you would change your opinion if the statement did not concern a person with a disability? How? Why?

POLARISING STATEMENTS

- a) People with physical disabilities can only marry or have relationships with other people with disabilities.
- b) People with intellectual disabilities should not get married.
- c) People with disabilities should not be allowed to have children.
- d) Women with disabilities should be sterilised.
- e) Genetic testing should be done during pregnancy to identify congenital disabilities, which will help people decide whether or not to continue with the pregnancy.
- f) It is a myth that people with disabilities are more vulnerable to sexual abuse.
- g) Disabled people can be sexually attractive to both disabled and non-disabled people.
- h) People with disabilities can be heterosexual/homosexual/ bisexual/transgender just like people who are not disabled.

KEY MESSAGES

1. People with disabilities also have sexual desires and concerns. These concerns must be acknowledged and addressed.
2. While some disabilities are more severe and may interfere with expression of sexuality, many disabled people can and do live full and meaningful sexual and reproductive lives. They have the right to do so, and it is society's responsibility to ensure that barriers to claiming these rights are removed.
3. While people with physical disabilities (visual or hearing impairment, or the loss of / inability to use limbs) may require assistance in performing their routine daily tasks, most are capable of making independent decisions. These include the decision to be sexually active, choice of sexual partner (whether that be a person of the same or another gender), and whether or not to marry or have children.
4. Those with severe intellectual disabilities may be able to perform their daily tasks, but may be unable to participate in any communication/ decision-making. Their desires must be taken into consideration as much as possible if a care-provider/parent is making decisions on their behalf.

SESSION 3: INCLUDING PEOPLE WITH DISABILITIES

PURPOSE:	1. To discuss barriers faced by people with disabilities in accessing information and services related to sexuality and reproductive health . 2. To understand how disabled people can be included in work related to sexuality, sexual and reproductive health and rights.
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL:	Anyone
MATERIALS:	Black board/chalk, Flip Chart/marker, Handout B: Integrating Concerns Related to Disability in Our Work
ADVANCE PREP:	Go through the questions in Handout B and make a note of discussion points beforehand.

SESSION INSTRUCTIONS:

1. Divide participants into three groups. Assign each group one scenario from Handout B and ask them to use the scenario and associated questions to discuss the case study. Give groups 20 minutes for this.
2. Invite each group to present their case study like a book reading session. After each case study ask for comments and reactions. Note some of these responses on a flipchart.

SUGGESTED QUESTION FOR THE FACILITATOR

- What did you think of this case study and how the groups dealt with the issue?
- How did the group resolve the issue? Would you have resolved it differently?
- Have you encountered similar situations around you or with you? If yes, what did you do?
- How realistic do you think it's is to incorporate concerns of people with disabilities in a place of work?
- Can you suggest some changes that an employer can make to accommodate persons with disabilities?
- How do you think PWD convince people in their workplace and community before asking for specific kinds of accommodation and workspace arrangement?

KEY MESSAGES

1. To understand how accessibility for people with disabilities is often excluded from policies or services.
2. The rights to sexual and reproductive health information and services of disabled people have always been overlooked. They also have rights to information about safe sex, contraception, abortion and professional medical opinion regarding their sexuality.
3. Some ways of including and discussing issues related to disability are simple, cost effective and do not require policy level changes. For example, advocacy and awareness generation materials could include some information specific to people with disabilities or how people with disabilities can access services. These materials could be provided in a more accessible format, for example, large print, Braille, audio tape, pictures etc.
4. It is important to train all staff at any work place on the rights of disabled people to equality and accessible information and services.
5. Barriers faced by people with different disabilities vary. Two people with the same type of disability will also have differing concerns.
6. We should not generalise or put all people with disabilities into one homogenous category.
7. Not all disabilities are visible (for example a hearing impairment) and this must be kept in mind, along with an awareness of the kinds of assistance differently disabled people may require.

FACILITATOR'S NOTE:

- Do read each of the key messages in these chapters.
- In Chapter 1, try and focus the discussion on the topics and take care not to get into the debate of “whose disability is easier” and “who is worst off” conversation. Emphasise on each person being unique in their disability.
- Every person deals with their disability in their own way and while participant do have a tendency to get into such debates, it unnecessarily sparks of debates which can go anywhere and impact the learning process.
- In this Chapter, never use people as “specimens” – even if they say so themselves. Remember that while a person may have a certain disability, they are still unique in their own disability as well.
- Do not make assumptions about the sexual concerns of people with disabilities. For example, disabled people can be attracted to people of the same or another gender. Similarly, it is not essential that they be married to be sexually active.

HANDOUT A:

DEFINING LOCOMOTOR DISABILITY

A. DEFINING LOCOMOTOR DISABILITY

Locomotor disability means a person's inability to perform activities associated with mobility and moving objects, from place to place. Such inability results from affliction of either, bones, joints, muscles or nerves. Those with locomotor disability may have to use assistive devices for mobility like leg braces, crutches, wheelchairs etc.

B. DISABILITY DUE TO SPINAL MUSCULAR ATROPHY

- Spinal muscular atrophy (SMA) is a genetic disease.
- It attacks nerve cells, called motor neurons, in the spinal cord.
- Muscles weaken which can affect walking, crawling, breathing, swallowing, and head and neck control.
- In severe cases, the muscles used for breathing and swallowing are affected.
- There is no cure but treatments help with symptoms and prevent complications. They may include machines to help with breathing, nutritional support, physical therapy, and medicines.
- It is much more likely to occur in males than in females.

EFFECT ON SEXUAL FUNCTIONING: SMA does not affect sensation and sexual functioning. It leads to muscle weakness and problem with hip movements. A person may have problems during intercourse but that can be managed by learning different positions and alternative methods of sexual pleasure. A woman may have problem in pregnancy due to weak pelvic muscles.

Expert advice must be taken for contraception.

C. DISABILITY DUE TO SPINAL CORD INJURY

- Spinal cord injuries (SCI's) can cause both loss of sensation and movement below the site of injury in persons who experience them.
- Depending on the location and severity of damage, the symptoms can vary widely, from pain or numbness to paralysis to incontinence.

- Other complications may include muscle weakness, pressure sores, infections, and respiratory problems.

EFFECT ON SEXUAL FUNCTIONING: Effect on sexual functioning: SCI affects sexuality both physically and psychologically. Depending upon the level of injury, erection in men is affected. Ejaculation is also affected. Men with SCI usually experience a change in their ability to biologically father a child. Some women have decreased vaginal lubrication and many may experience a change in surface sensation and ability to contract their muscles. Orgasm may take longer time to occur and/or it feels different. It is normal for most women to experience a brief pause in their menstrual cycle after SCI but the ability of women to have children is not usually affected once their period resumes. There can be problem with body image and fear of non-performance.

Expert advice must be taken for contraception.

D. DISABILITY DUE TO MULTIPLE SCLEROSIS

- Multiple sclerosis is a chronic disease that attacks the central nervous system.
- It affects the brain, spinal cord, and optic nerves.
- Women are more prone to get this disease than men.
- There may be numbness in the limbs.
- Severe cases may involve paralysis.
- There may be vision loss.
- Painful muscle spasms, involuntary movements and numbness are there with co-ordination and difficulty to balance as muscles might get stiff.

EFFECT ON SEXUAL FUNCTIONING: Fatigue; spasticity; bladder/bowel problems; sensory changes interfere with sexual activity. There can be impaired arousal; sensory changes; reduced vaginal lubrication; erectile dysfunction; inability to achieve orgasm.

Expert advice must be taken for contraception. Education, counselling and sexual aids can be useful as effective management of MS symptoms can also help.

E. DISABILITY DUE TO POLIO

- A polio survivor may have loss of reflexes, severe spasms and muscle pain, loose and floppy limbs, paralysis and deformed limbs, especially the hips, ankles, and feet.
- Some may develop deformity in spine.

EFFECT ON SEXUAL FUNCTIONING: Polio does not affect sexual functioning. Weakness in limbs might affect positioning. There are no issues with fertility both in men and women. A woman with polio can become pregnant but pre-natal and post-natal care are required. There can be issues of body image.

Expert advice must be taken for contraception. Proper information, counselling and education can sustain sexual pleasure.

F. DISABILITY DUE TO MUSCULAR DYSTROPHY

- Muscular dystrophy is a group of diseases that cause progressive weakness and loss of muscle mass.
- Some people may lose the ability to walk. They can have frequent falls, difficulty getting up from a lying or sitting position, trouble with running and jumping. Muscle pain and stiffness can cause problems.
- People may have trouble breathing or swallowing.

EFFECT ON SEXUAL FUNCTIONING: Women experience the physical weakness as the greatest hindrance in their sexual life. Erectile dysfunction is the most common difficulty for men. Exercise and therapy improve mobility and indirectly improves sexual health or interventions directly improving sexual health. Alternative means of sexual pleasure can be explored.

G. DISABILITY DUE TO AMPUTATION

- Amputation is the surgical removal of all or part of a limb or extremity such as an arm, leg, foot, hand, toe, or finger.
- Causes for amputation may include severe injury, cancerous tumor or serious infection.
- Amputees experience phantom limbs i.e. they feel body parts that are no longer there. These limbs can itch, ache, burn, and feel tense or they can feel as if they are moving.
- One may be able to have a prosthetic limb fitted.

EFFECT ON SEXUAL FUNCTIONING: Sexual function is rarely affected by lower limb amputation but physical and emotional adjustment to losing a limb takes a lot of time. Sexual positions that were once comfortable may now need adapting. The greatest hurdle in expression of sexuality is body image. Having sex is more comfortable without prosthesis. Patience, love and open communication are needed to rebuild sex life after amputation.

H. DISABILITY DUE TO SPINA BIFIDA (SB)

- Spina bifida is a birth defect where there is incomplete closing of the backbone and membranes around the spinal cord.
- It can lead to leg weakness and paralysis.
- There can be deformed feet, uneven hips and a curved spine.
- A person has bladder and bowel control problems and poor kidney function.

EFFECT ON SEXUAL FUNCTIONING: Sexuality of individuals may be affected by paralysis of the lower body/extremities. The person may need personal assistance, technical aids and/or adapted environment. There can be problems with erection and ejaculation, orgasm and inconsistency in the sense of touch. Latex allergy is common so non latex condoms should be used. There is a need for sexual counselling and medical intervention can increase sexual satisfaction.

I. DISABILITY DUE TO CEREBRAL PALSY

- Cerebral palsy(CP) is a group of disorders that affect balance, movement, and muscle tone.
- It affects muscles and a person's ability to control them.
- Limbs can be stiff and forced into painful, awkward positions.
- Muscle contractions can make limbs tremble, shake, or writhe.
- Balance, posture, and coordination can also be affected.
- Tasks such as walking, sitting, or tying shoes may be difficult for some, while others might have difficulty grasping objects.

EFFECT ON SEXUAL FUNCTIONING: Physical limitations like stiffness, tremors, incontinence and numbness can cause certain barriers. There can be lack of confidence in the expression of sexuality. Adjustment to postures, counselling and medical interventions can help the person.

J. DISABILITY DUE TO DWARFISM

- Dwarfism is short stature that results from a genetic or medical condition.
- Arms and legs are short with limited mobility at elbows.
- Head may be disproportionately large.
- There is curvature of the upper spine.
- The person may develop arthritis and problems with joint movement.

EFFECT ON SEXUAL FUNCTIONING: There are no major issues. There can be hip and joint pains which can cause barriers during sexual act.

K. DISABILITY DUE TO BRITTLE BONE SYNDROME

- Brittle bone disease is a genetic disorder that causes bones to break very easily.
- Physical disability is seen due to easy bleeding and bruising, bowing of the legs, curved spine, loose joints and weak muscles and tissue.
- Density of bones is less to support walking.

EFFECT ON SEXUAL FUNCTIONING: One has to be careful of the positioning during sex as there is always a risk of fractures. Body image can be an issue. Otherwise no major sexual dysfunction is found.

HANDOUT B:

INTEGRATING CONCERNS RELATED TO DISABILITY IN OUR WORK – CASE STUDIES

SCENARIO 1

An obese woman on a wheelchair visits a government hospital or a medical facility. She is unable to reach the foyer through the ramp as it is too steep for her to move the wheelchair through it. She had to ask a ward boy to help her. On reaching the reception she is unable to measure her body weight because there is no wheelchair accessible weighing machine. On asking the duty nurse – she says the doctor will make an assessment looking at her.

- What other barriers (than those mentioned) are there be for this person at the medical facility?
- How can these barrier be overcome?

SCENARIO 2

A waist down paralysed woman who uses a wheelchair gets pregnant but she wants to abort her pregnancy. When she reaches the abortion clinic, she finds it inaccessible.

- What are the visible and invisible barriers for this woman? How can these barriers be overcome?
- Whose support can be used from local organisations and the community to tackle these issues?

SCENARIO 3

You are an inspector from the Ministry of Welfare assigned the task of checking whether the family counselling centres in your city are friendly towards disabled people.

- What will you be looking for and what do you find?
- How can these barriers be overcome?
- Whose support can be used from local organizations and the community to tackle these issues?



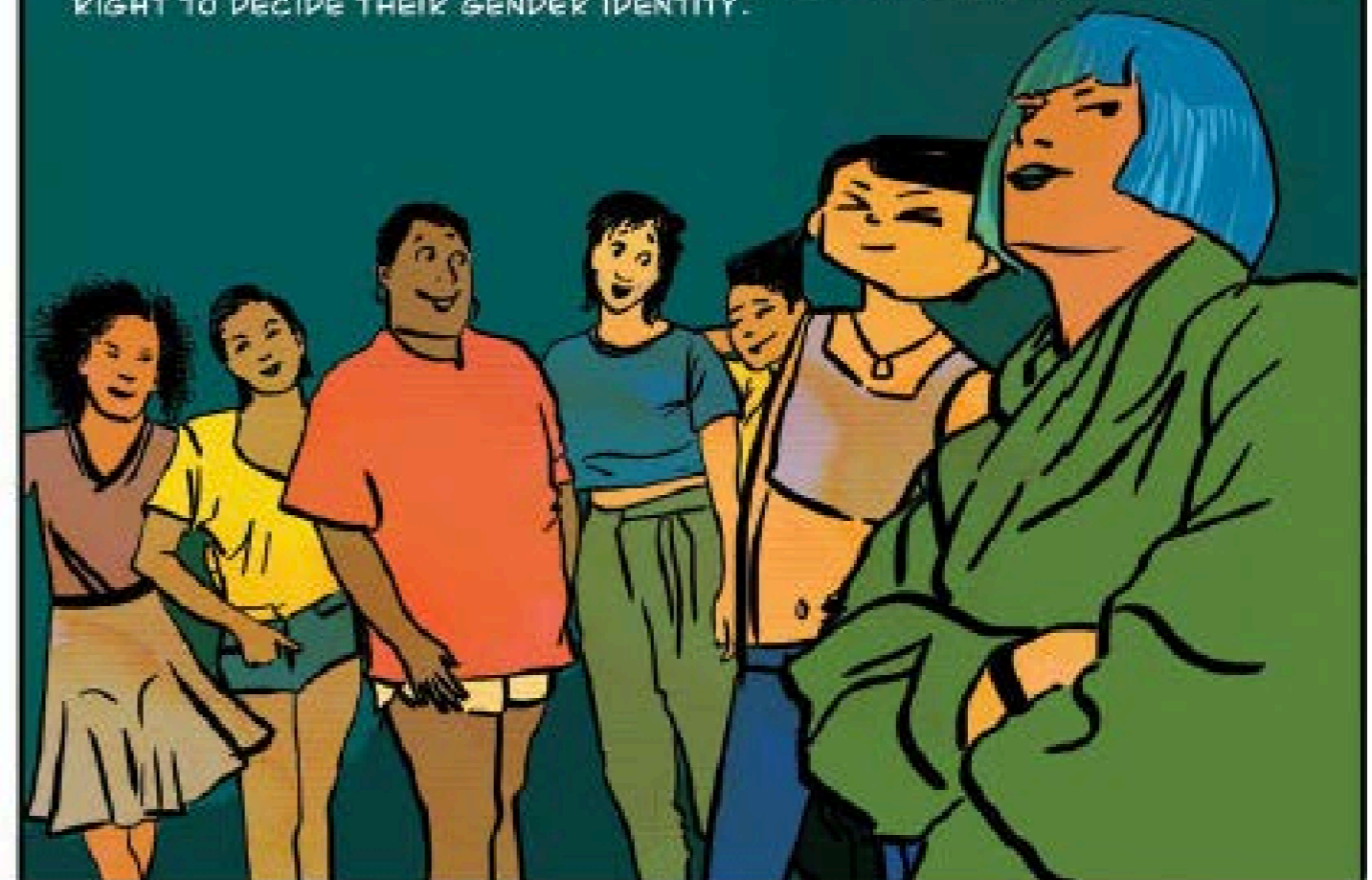
ALL HUMANS ARE BORN DIFFERENT - WITH SOME VARIATIONS AT MULTIPLE LEVELS. FOR EXAMPLE, SOMEONE CAN HAVE BOTH OVARIES AND TESTES, ANOTHER PERSON CAN HAVE MALE INTERNAL ORGANS AND FEMALE EXTERNAL ORGANS ETC. THERE CAN ALSO BE COMBINATIONS OF CHROMOSOMES DIFFERENT FROM THE MORE COMMON XX (FEMALE CHROMOSOME) OR XY (MALE CHROMOSOME), LIKE XXY.

IF A PERSON HAS BREASTS AND A UTERUS, IT'S NOT NECESSARY THAT THEY ARE FEMALE. SIMILARLY, HAVING TESTICLES, DOES NOT MAKE SOMEONE MALE. BEING A MALE OR A FEMALE ALSO DEPENDS ON THEIR GENDER IDENTITY.

SO, WHILE **SEX IS THE PHYSICAL CHARACTERISTICS, GENDER IDENTITY IS WHAT WE FEEL INSIDE.**

GENDER NORMS ARE A SET OF RULES THAT A SOCIETY CONSTRUCTS WHICH SPECIFY HOW MEN AND WOMEN SHOULD BEHAVE. THESE RULES ARE DIFFERENT FOR EACH REGION, COUNTRY OR COMMUNITY AND CAN CHANGE.

GENDER IDENTITY IS A PERSON'S SENSE OF THEIR OWN GENDER AND IT IS INFLUENCED BY THESE RULES. A PERSON MIGHT HAVE THE PHYSICAL CHARACTERISTICS OF ONE GENDER OR BOTH BUT ONLY THEY HAVE THE RIGHT TO DECIDE THEIR GENDER IDENTITY.



MODULE

2

BASIC CONCEPTS ON SEX, SEXUALITY AND GENDER

CHAPTER 3
SEX, SEXUALITY AND GENDER

CHAPTER 4
SEXUAL IDENTITY AND GENDER IDENTITY



CHAPTER 3: SEX, SEXUALITY AND GENDER

WHY A CHAPTER ON SEX, SEXUALITY AND GENDER?

Understanding sexuality involves identifying a wide range of issues, emotions, experiences and topics included under sexuality. This chapter addresses the differences between sex, sexuality and gender. It also clarifies a common misconception that persons with disabilities are non-sexual and answers questions about these topics. It deepens the understanding that sexuality is more than the act of sexual intercourse, that gender is socially constructed, and that there can be more than two genders. This chapter also gives participants a broad understanding of the connections of sexuality with gender as well as with disability, It also acts as a starting point for discussions on sexual and reproductive health, and rights of persons with disabilities that come up later in the manual.

CHAPTER OBJECTIVES

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

KEY MESSAGES FOR THIS CHAPTER

SEX AND SEXUALITY

1. Sexuality is more than acts of sex. It can mean a range of experiences that vary from person to person – for example to some it might mean sexual orientation, for others the freedom to express themselves and make choices regarding their body. These varied experiences and issues related to our body and mind can impact people's lives in significant ways.
2. Sexual and reproductive health decisions (for example, the decision to have or not have children, when to have them, to get married or not, to choose a sexual partner, or to have a husband/wife chosen by a family or community) cannot be isolated from issues of sexuality. This makes it even more important to understand and address sexuality.
3. Addressing sexuality helps reduce fear, myths and misconceptions surrounding the issue. It also enhances people's well-being by helping them lead safer and pleasurable sexual lives.

GENDER AND SEX

1. Gender is socially constructed, which means that it is determined by our social, cultural and psychological surroundings and environment. It is not innate in the same way that our biology (sex) is believed to be. Like gender, sexuality is also socially constructed. A person's expressions and experiences of sexuality are influenced and determined by the social environment.
2. Sex was considered to be constant and unchangeable until recently. Now it can be changed through medical intervention (sex reassignment surgery).
3. Some characteristics of being a male or female are determined biologically while some are determined by the society
4. Gender is variable and can change from time to time, culture to culture, and sub-culture to sub-culture.
5. Male and female roles that are socially determined are called gender roles. The way girls and boys are socialised to be 'feminine' or 'masculine' is called gendering.
6. Different cultures may value girls and boys differently and assign them different gendered roles, responsibilities and attributes.
7. Sexual and reproductive health decisions can be influenced by a person's gender. For example, in a marital relationship, it may be the man who has the power to decide whether to have children or not, when, and how many.
8. All people with disabilities are at risk of being denied their gender since they are not given the opportunity to fill important roles, such as mother, father, wife, lover etc
9. This can result in pressure on them to fulfil this expectation and restrict them from moving away from this gender-role

SESSION 4: MALE AND FEMALE WORD WEBS²

PURPOSE:	To understand through critical thinking what society says it means to be a “man” or a “woman,” and to discuss where these ideas come from.
TIME:	45 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Pen and paper, Flipchart and marker/black board and chalk
ADVANCE PREP:	Decide if you wish to add any characteristics that are particularly appropriate to the community participants belong to.

SESSION INSTRUCTIONS:

1. Divide participants into groups of four or five (depending on comfort, decide on single sex or mixed grouping).
2. Explain that the exercise will discuss the topic of gender and what society says it means to be a ‘man’ or a ‘woman’ and also how society views disability.
3. Ask each group to create webs of words that are often associated with being a ‘man’ and being a ‘woman’. Ask them to specifically think of some characters from the point of disability. Give each group 15- 20 minutes to make a word web for ‘man’ and another two to three minutes to make one for ‘woman’.
4. Write ‘Woman’ and ‘Man’ on the flipchart/black board . Under each word further make two columns labelled ‘biological’ and ‘social’. Ask groups to share their words from their webs in the following order:
 - One characteristic associated with being a man?
 - Is that characteristic biologically determined or socially determined? Help participants identify the category by asking questions and correcting them.
 - Add one new characteristic to the list from each group until you have all the responses for being a man. Refer to facilitator’s notes for this step.
5. Repeat this process for characteristics associated with being a woman. Refer to facilitator’s notes for this step.
6. Reserve ten minutes for a full-group discussion and summarise with the following points:
 - A few characteristics of males and females are biological. For example, only Voices break at puberty for males; only females can give birth or breastfeed.
 - But most characteristics associated with being male or female are socially

determined — not based on biology.

- Male and female roles that are socially determined are called gender roles. (Check if some of them have heard of this term before?)
- What feelings do you have about gender roles in our society? Do you agree with all aspects of how females are supposed to act and live? How males are supposed to act?
- Do PLWD and those who are not , face similar issues of gender, society and social conditioning?
- Do you agree with the common perceptions that males and females with disabilities are different from the non-disabled ones?
- What do you think gender equality means?

KEY MESSAGES

1. Gender is socially constructed, which means that it is determined by our social, cultural and psychological surroundings and environment. It is not innate in the same way that our biology (sex) is believed to be. Like gender, sexuality is also socially constructed. A person’s expressions and experiences of sexuality are influenced and determined by the social environment.
2. Sex was considered to be constant and unchangeable until recently. Now it can be changed through medical intervention (sex reassignment surgery).
3. Some characteristics of being a male or female are determined biologically while some are determined by the society
4. Gender is variable and can change from time to time, culture to culture, and sub-culture to sub-culture.
5. Male and female roles that are socially determined are called gender roles. The way girls and boys are socialised to be ‘feminine’ or ‘masculine’ is called gendering.
6. Different cultures may value girls and boys differently and assign them different gendered roles, responsibilities and attributes.
7. Sexual and reproductive health decisions can be influenced by a person’s gender. For example, in a marital relationship, it may be the man who has the power to decide whether to have children or not, when, and how many.
8. All people with disabilities are at risk of being denied their gender since they are not given the opportunity to fill important roles, such as mother, father, wife, lover etc
9. This can result in pressure on them to fulfill this expectation and restrict them from moving away from this gender-role

² Adapted from ‘What’s the Real Deal About Masculinity?’ (2008. Scenarios USA.)

HOMWORK

Finish and expand upon the following statement, either as a list, a letter, or a poem: “It’s not easy being a girl/a boy because...”

FACILITATOR’S NOTES

The exercise enables participants define ‘gender’ and to distinguish between biological characteristics attributed to males and females and characteristics which are socially determined. It also makes them understand that disability also is a social construct which depends on perceptions of society towards a disabled person.

Make sure that participants have many of the following words in their webs. (You may need to ask probing questions to generate specific responses.).

COMMON EXAMPLES OF WHAT PEOPLE ASSOCIATE WITH “BEING A MAN” INCLUDE:

physically strong, emotionally not expressive, a sexual predator, heterosexual, financially successful, in charge of a family, cool, a father, proud, powerful, athletic, brave, unafraid of violence, using violence, humorous, loyal to friends etc

COMMON CHARACTERS/EXAMPLES FOR WOMEN INCLUDE:

considerate, quiet, submissive, chatty, a good communicator, well groomed, emotionally weak, well organized/good at multi-tasking, nonviolent, modest, curvaceous, physically weaker than a man, caring, a mother.

SESSION 5: MEMORY JOURNEY: LEARNING ABOUT GENDER AS A CHILD

PURPOSE:	To enable participants strengthen critical thinking skills and share examples of how children absorb messages about gender roles and to consider these messages from a personal and a human right perspective.
TIME:	45 minutes (Step 5 may be assigned as homework.)
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Pen and paper, Flipchart and marker/black board and chalk
ADVANCE PREP:	Go on this memory journey yourself before conducting the activity. Memory activities can trigger difficult feelings for some participants. Give thought to how best to respond — and to whom you might turn — should any of the participants students need further support.

SESSION INSTRUCTIONS:

1. Ask participants to sit in a big circle. Have them bring pen and paper.
2. Explain that the exercise will explore what it means to grow up as a boy or as a girl. We will also try to explore if disability had any impact on growing up as a boy or a girl.
 - Ask them to relax, think back and take a short journey into their memories of childhood.
 - Ask them to think back to a time when they realized, they were being treated a certain way because of your sex. As they remember something, ask them to write it down.
 - Think of the feelings that come up as they recall that experience? Write down these emotions.
3. Let them know they will have the option to share your memory. After a few minutes, ask willing participants to share their memories, their experiences or feelings with the larger group. Please do mention that, that they do not have to share at all if they do not wish to.
4. After another five or ten minutes, ask:
 - What do these experiences tell us about the social attitudes and norms concerning the value and roles of girls and women? Of boys and men?
 - What do these experiences tell us about the perceptions and attitudes of society when a girl or a boy has some disability.
 - Thinking back to what we have learned so far, do these attitudes and norms seem fair to you? Why or why not?

- What are some changes that are required to be made to achieve equality between males and females?

[Note: If you run out of time, this step may be assigned as homework.]

Remind participants that different situations may have a range of outcomes. Offer them a chance to change the end of a story/experience. Explain to them that this can be done by:

- o Go back to a memory of a situation that you wrote about or one you heard about in your group. Write a new ending to the story, one that seems more inclusive – or against the norm, but possible.

KEY MESSAGES

1. Gender roles are reinforced subtly from early childhood.
2. It shapes attitudes and expectations in adulthood.
3. Children with disabilities are treated in a different way due to societal attitudes. This is the main cause of discrimination particularly marked in the case of girls who have some form of disability.

CHAPTER 4: SEXUAL IDENTITY AND GENDER IDENTITY

WHY A CHAPTER ON SEXUAL AND GENDER IDENTITY?

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

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

In many cultures and communities, there are often prescribed rules for 'appropriate' sexual and gender identities and sexual behaviour. Deviation from norm can often result in discrimination, stigmatisation, abuse, and ridicule. People with disabilities who also identify as LGBTQIA+ which translates to lesbian, gay, bisexual, transgender, queer (or those questioning their gender identity or sexual orientation), intersex, and asexual - are a diverse group who often feel marginalized within both the disability communities as well as within the LGBTQIA+ communities.

In this chapter participants examine and discuss the range of sexual and gender identities and behaviour, as well as the importance of respecting these diverse identities and behaviour while working on sexuality, sexual and reproductive health, and rights.

CHAPTER OBJECTIVES

1. To introduce participants with disabilities to the concepts of sexual and gender identity.
2. To familiarise participants with disabilities with the variety of sexual expression and behaviour.
3. To help participants with disabilities develop comfort when talking about these issues.
4. To help participants see the difference between sexual behaviour and sexual identity.

KEY MESSAGES FOR THE CHAPTER

1. Sexual identity and behaviour are not interchangeable concepts. For example, a man having sex with another man need not identify as homosexual or gay. He may identify as heterosexual; he may be attracted to women, be married and have children and at the same time engage in same-sex sexual behaviour.
2. The need for comprehensive sexuality education for YwDs is very pertinent and acute, and discussion of sexuality, contraception and abuse must be part of standard psychosocial assessment and anticipatory guidance for all teenagers, including those with chronic conditions.
3. Sex (whether a person has male genitalia, female genitalia, or both/neither male and female genitalia), gender identity (whether a person thinks of oneself as a man, woman, both, or as a different gender), and sexual identity (being heterosexual, bisexual, homosexual etc.) refers to different aspects of a person.
4. Every individual has multiple identities, which intersect in unique ways to make the person who s/he is. For example, someone may identify as a woman with disability, a mother, a lesbian, a daughter, and a nationalist. Identities are fluid, changing and personal. Stereotypes focus on only a single identity of an individual and may be used to judge the person unfairly.
5. Some varieties of sexual behaviour and expression go beyond what is conventionally acceptable. Those engaging in consensual sexual behaviour have the right to do so without fear of being judged or punished for their activities.
6. Coercive sexual behaviour of any kind, even between regular partners such as married couples, is unacceptable.

SESSION 6 : SEX AND GENDER IDENTITIES

PURPOSE:	To understand and define different sexual and gender identities and to examine common experiences and issues faced by disabled people with different identities.
TIME:	45 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Flipchart, chits of paper, Handout C: Basic Information on Sexual Identity and Gender Identity
ADVANCE PREP:	Write the identities on separate chits of paper for each participant, for example 'lesbian', 'female to male transsexual', man with disability, woman with disability etc.

SESSION INSTRUCTIONS:

1. Distribute one chit with an identity to each participant. Ask participants to take a couple minutes to read their chits. For the rest of the exercise they must make these identities their own. For example if a participant is lesbian in real life, she must adopt the identity of a transsexual if that is what her chit says.
2. Ask participants with their assumed identities to 'mingle' and create small groups with other identities with whom they have something in common. The commonalities could be related to a role they have in a community, a gender identity, the kind of work they do, the choices they have etc.

FOR FACILITATOR:

- If you find that people are not able to establish commonalities, raise questions to get them started. For example, what would a gay man have in common with a male person with disability in terms of their expectations or limitations in a community?*
3. After at least three small groups are formed, ask groups to discuss what they have in common in the context of their identities and prepare to present their discussions to the larger group. Give the groups 10 minutes for these discussions.
 4. Bring the groups back together to share their discussions. First each person in the group should introduce themselves and their identity and then a representative from the group should summarise their discussions. After the presentations, ask for questions and comments.

SUGGESTED QUESTIONS:

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

KEY MESSAGES

1. Sexual identity refers to how people define themselves based on whom they are sexually attracted to; whether they are attracted to people of the same gender, a gender other than their own, or to more than one gender. Gender identity refers to whether one thinks of oneself as a man, woman, both, or as a different gender.
2. Identities are not static. Individuals can identify in many different ways, and can change their sexual and gender identity throughout their lives.
3. Individual with disabilities and sexual identities are subjected to stigma and discrimination.
4. Stereotypes maintained by societies and communities contribute to stigma and discrimination against disabled as well as individuals with different gender and sexual identities.

FACILITATOR'S NOTE:

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

SESSION 7: VARIETIES OF SEXUAL EXPRESSION

- PURPOSE:**
1. To be aware of the diversity and variety of sexual behaviour and expression.
 2. To be comfortable discussing a range of sexual behaviour and expression.
 3. To discuss what kinds of restrict the youth with disabilities face during the expression of their sexuality.

TIME: 45 minutes

AGE GROUP: 18 and above

LITERACY LEVEL Literate

MATERIALS: Flipcharts, markers, pens/pencils, copies of **ADVANCE PREP:**
Read through Handout D and make sure you understand all listed terms.
Add a few of your own to the list if you wish.

SESSION INSTRUCTIONS:

1. Divide participants into groups. Distribute flipchart paper and markers to the groups. Instruct them to list out every kind of sexual behaviour they have heard of, engaged in, seen, or read about. Give them 20 minutes to complete this task.
2. Bring the groups back together and ask an assistant teacher to present the list from each group to the larger group.
3. After the presentations, distribute Handout D to participants. Ask for questions and comments.

SUGGESTED QUESTIONS:

- How did you feel when you did the listing? What kinds of behaviour did you hear about for the first time? What kinds of behaviour do you think are common in our culture/ community?
- Are there any limitations to the expression of your sexuality? If yes what are they? (raise the issue of disability while discussing)
- Do you think your disability would restrict you in getting involved in certain kinds of sexual behaviour?
- Do you think with assistance or with certain modifications you would be able to get engaged in different sexual behaviours?
- What kinds of behaviour would increase risk of infection or unwanted pregnancies? Do you think these are behaviours only engaged in by heterosexuals or also by non-heterosexuals?

KEY MESSAGES

1. People engage in a variety of sexual behaviour even if they are not discussed openly.
2. Persons with disabilities like to engage in different sexual behaviour and are ready to experiment.
3. It is important that the practice of any kind of sexual behaviour is with the consent of partners and with precautions to prevent transmission of STIs including HIV/ AIDS
4. Many forms of sexual behaviour and expression can take place between people of different genders and also those of the same gender. For example, oral sex can take place between two men, two women or a man and a woman, mutual masturbation can be satisfying for persons with limited mobility.
5. While some people may prefer not to engage in a certain type of behaviour, this does not mean it is wrong for others to enjoy it if it is consensual. For example, some people may find bondage and discipline unappealing, while others find it pleasurable. As long as there is mutual consent, this should not be judged as 'wrong' behaviour.
6. It is important for people with disabilities to be aware of different sexual activities and their own reactions to them. This helps them to be prepared and react appropriately when they hear about them during the course of their work.
7. Certain types of sexual behaviour are sometimes considered 'unnatural' or against 'nature'. This argument is simplistic because many kinds of behaviour, such as same-sex behaviour are practiced by animals and in 'nature'. Moreover, creating the label 'unnatural' for behaviour does not take into account the fact that human beings engage in a number of activities that animals do not (and therefore are 'unnatural') which are still acceptable, such as wearing clothes, sitting on chairs and travelling on wheels!
8. Being aware of the diversity of sexual expression can also help design information and services to help people with disabilities protect against potential adverse effects/ consequences of these behaviours. For example, with regard to conception, many believe that anal sex is a safe alternative to penile-vaginal sex. They may therefore engage in unprotected anal sex, which not only exposes them to risk of infection, but also does not rule out the risk of conception.

SESSION 8: GOOD SEX/BAD SEX

PURPOSE:	To understand and identify personal values related to sex and link them to stigma and discrimination.
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Flipchart, markers, chits of paper, two jars/baskets one marked Good Sex and the other Bad Sex.
ADVANCE PREP:	Prepare two flipcharts. Write Good Sex at the top of one flipchart, and Bad Sex on the other.

SESSION INSTRUCTIONS:

1. Distributes two slips of paper to each participant. Ask them to write sexual behaviours they consider Good Sex on one slip, and what they consider Bad Sex on the other. For example, Good Sex may elicit responses such as penile-vaginal sex or kissing, while Bad Sex may elicit responses such as anal sex. After participants have written their responses, the assistant teacher takes slips from the students and puts the slips into the appropriate containers.
2. Collect the two containers. Pass them around and have participants read out the responses for the Good Sex category one by one. Write these down on a flipchart. Do the same for the Bad Sex responses.
3. Once the listing is complete, ask participants to look at them and react/ make note of their observations. Ask for questions and comments.

SUGGESTED QUESTIONS:

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

KEY MESSAGES

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

FACILITATOR'S NOTE:

This exercise can be modified by:

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

1. Makes connections between
 - Individuals with disabilities have a right to practice and experience their sexuality as they choose.
 - Sex should not be coercive or forced, even between regular partners and/or spouses.
2. There is no doubt that all discussions on Gender will surely bring up the issue of disability, quite organically.
3. At time, being a woman, for instance, may be debilitating but being disabled may be much more so – so do be aware of that as well. What that may do is steer the conversation about being disabled away from the conversation on gender. However do discuss being of a certain gender and how that cuts across with also being disabled. Do hear and bring out discussions on say what do we usually attribute to say a man – do the same rules apply when he is disabled? What happens if it's a woman?
4. What about people with disability and of a different gender identity – what happens to gender and society then? You can talk about gender – how a wo/ man ought to be- what

if they are disabled and what if they are of a different sexual/ gender identity and they enjoy sex which is very taboo.

5. Where we cannot presume that PwD are not having sex at all – equally let us not presume that they all are – be it for practical reasons or that they are able to or they are ready to or that opportunities are presenting themselves.
6. Many may not even know what all happens in sex – let alone the various kinds of sex – do recognise this aspect as well.
7. Many points with regards to disability have been raised in the course of the Module it self – please do look for them to enhance the discussions.

HANDOUT C:

BASIC INFORMATION ON SEXUAL IDENTITY AND GENDER IDENTITY

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

ASEXUAL: An individual who feels no sexual attraction towards other individuals.

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

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

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

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

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

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

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

INTERSEXED PERSON: An individual born with the physical characteristics of both males and females. These individuals may or may not identify as men or women.

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

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

MAN: A person who identifies as a male and may or may not have male genitalia or reproductive organs like a penis or testes.

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

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

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

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

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

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

HANDOUT D:

VARIETIES OF SEXUAL BEHAVIOUR AND EXPRESSION

SOME DIFFERENT KINDS OF SEXUAL EXPRESSIONS

Anal sex or bum-fucking- It is inserting one's penis, dildo, fingers or other objects into a partner's anus.

Bestiality sexual interaction with animals that can include various types of contact, such as oral, anal, and vaginal intercourse.

Biting or love biting or sucking a partner's body (usually neck) hard enough to produce a mark or bruise.

Bondage and Sexual behaviour that includes parts of sadism and masochism.

Discipline- One partner is bound/restrained, submissive and is 'disciplined' or 'punished' physically or mentally by the dominant partner. This is sexually arousing to the partners and is mutually consensual or negotiated beforehand.

Oral sex or going down on, eating-A partner uses their mouth/tongue to stimulate a woman's genital area, licking out, suck off.

Dry sex-Increasing friction of penile-vaginal sex by drying the vagina with cloth or herbs. The friction is said to increase sexual pleasure for the man. Also increases the opportunity for tears and scrapes in the vagina and therefore the possibility of contracting a sexually transmitted infection including HIV.

Erotalia- Talking dirty, telephone sex- speech that is sexually arousing.

Phone sex- Generally over a phone, where verbal conversation is used as stimulation. This sort of sexual behaviour can be between partners or even a paid service.

Exhibitionism- Exposure of genitals for sexual gratification or having a strong desire to be observed by other people during sexual activity.

Fantasy - Imagining things that are sexually arousing.

Fetishism - Being sexually aroused by an inanimate object, e.g. shoes, underwear, leather etc.

Finger insertion or fingering or finger-fucking-Inserting one's finger/s into a partner's anus/vagina.

Fist insertion, fist- fucking - Inserting one's fist into partner's anus/vagina. This can be done gradually and may begin one finger at a time.

Fellatio, giving head, going down on - A male/ female partner uses their mouth/ tongue to stimulate a man's penis also known as blow job

Whipping -Being sexually aroused from whipping a partner or from being whipped by a partner.

Dry humping-Partners rub their bodies together for mutual sexual pleasure.

Kissing, smooching- Partners use their mouths to kiss a partner's mouth or other parts of the body.

Masturbation or solo sex- Giving sexual pleasure to one's own self, usually by touching/ rubbing your genitals. This can also involve fantasy, pornography and/or sex toys. Mutual partners sexually stimulating each other's genitals, usually by touching or rubbing with hands or sex toys. Can also refer to watching each other masturbate.

Pornography-Using movies/video, and/or reading stories of sexual acts for sexual arousal. Often in combination with masturbation.

Sado masochism (sadists),S & M - The sex between those who enjoy causing physical and/or emotional pain and those who enjoy it being directed at them (masochists). It can involve role play, whips, bondage etc.

Sex, sexual making love, fucking, screwing or intercourse-A male partner puts his erect penis into a woman's vagina. It can also include any penetrative sexual activity.

Sex toys, marital aids - 'Toys' refers to a wide range of devices used to arouse a person or their partner. Toys include dildos and vibrators also among others.

Sixty-nine-When a couple performs oral sex on each other at the same time.

Threesomes-Sexual activity involving three consenting adult people.

Voyeurism-Watching, peeping and getting sexual pleasure from watching others having sex, listening to others' sexual exploits, watching someone bathe etc.

MODULE

3

SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY

CHAPTER 5
SEXUAL AND REPRODUCTIVE ANATOMY
AND PHYSIOLOGY

CHAPTER 6
CONCEPTION, CONTRACEPTION AND
ABORTION

CHAPTER 7
INFERTILITY AND ASSISTED REPRODUCTIVE
TECHNOLOGIES

CHAPTER 8
HIV/AIDS, SEXUALLY TRANSMITTED
INFECTIONS (STIS) AND REPRODUCTIVE
TRACT INFECTIONS (RTIS)

CHAPTER 9
SEXUAL PROBLEMS



This module is largely an information based and information heavy module. Depending on the need of the participants, you may choose to do it the way you think the group will respond best, benefit most. A good way of doing it is a quiz style activity. Here is a suggestion. Use all the quiz style activities as they are – choose a few questions from each and make a combined list of questions, if you like. You can convert the lecture sessions into similar quiz style or even assign each group a topic to prepare a debate on. However there are three crucial issues here and they are:

1. Don't miss reading up and getting all your information in place .
2. Keep the aspect of disability in your mind always. Keep bouncing it back to the participants asking their opinion and life experiences on the issue.
3. Keep a check on time.

CHAPTER OBJECTIVES

1. To introduce participants with disabilities to the concepts of sexual and gender identity.
2. To familiarise participants with disabilities with the variety of sexual expression and behaviour.

CHAPTER 5: SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY

WHY A CHAPTER ON SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY?

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

CHAPTER OBJECTIVES

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

KEY MESSAGES FOR THE CHAPTER

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

SESSION 9: LEARNING HUMAN ANATOMY

- PURPOSE:**
1. To identify and label the parts of human sexual and reproductive anatomy.
 2. To describe the function of each part of the human sexual and reproductive system.
 3. To explore feelings of self-image related to anatomy and physiology.

TIME: 60 minutes

AGE GROUP: 18 and above

LITERACY LEVEL Literate

MATERIALS: **Handout E Facilitator Copy: Diagrams of the Human Sexual and Reproductive Anatomy, Handout F Participant Copy: Diagrams of the Human Sexual and Reproductive Anatomy**

ADVANCE PREP: Make copies of Handout F; review Handout E

SESSION INSTRUCTIONS:

1. Introduce the exercise, explaining that participants will be labelling and discussing different parts of the sexual and reproductive anatomy. While this may be a review for some, emphasise that this exercise is intended to ensure that all participants are at the same level of understanding.
2. Distribute Handout F. Begin with either the male or female external anatomy and continue to the corresponding internal anatomy. Go through each labelled part in the diagrams and invite participants to name the body part. If participants do not know the answer, tell them the name. Ask them to label their diagrams accordingly.
3. After each part has been labelled correctly, ask participants to describe the structure and function of each part. For example, 'the clitoris is a tiny, pea-sized organ above the urinary opening, hidden within the folds of the vagina, where the inner lips join. It is extremely sensitive to touch and when stimulated becomes firmer and slightly bigger. The only purpose of the clitoris is to provide sexual pleasure.' Fill in information not mentioned by participants from Handout E.
4. After going over the diagrams of male and female anatomy, ask for questions and comments.

Suggested Questions:

- What information was new to you? How does knowing about the parts and functions of the body affect your understanding of sexuality?
- Are there other names for parts of the sexual and reproductive anatomy? For instance some may know other words for penis or clitoris.

- What impact does use these types of words have in discussions of sexuality and health? After going through this exercise, do you feel more comfortable with the sexual and reproductive parts?
 - Would you feel comfortable going home and using a mirror to look at your own genitals, if you have not done so before?
5. End the session by giving participants markers or pencils and asking them to shade in or colour parts of the body. If they are comfortable ask them to share what they shaded or coloured and why.

KEY MESSAGES

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

CHAPTER 6:

CONCEPTION, CONTRACEPTION AND ABORTION

WHY A CHAPTER ON CONTRACEPTION, CONCEPTION AND ABORTION?

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

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

CHAPTER OBJECTIVES

1. Understand and describe the basic process of conception.
2. Describe current forms of contraception and their advantages and disadvantages.
3. Understand abortion options and procedures.
4. Engage in discussions on issues of conception, contraception and abortion, including selective abortion, the pressure to have children, particularly sons, as well as stigma and disapproval associated with contraception and abortion.
5. Talk about the role of conception in the life of person with disability

KEY MESSAGES FOR THE CHAPTER

1. Conception, contraception and abortion should be understood, as it plays an integral role in sexuality, sexual and reproductive health, and rights.
2. Understanding the basic processes of conception, contraception, and abortion provides a foundation for further discussion on the social norms and pressures that influence these choices.
3. Technical/scientific knowledge on conception should be balanced with a cultural, social and ethnic understanding of the process to make it more accessible to different sections of people.
4. Various contraceptive options are available to individuals, some of which use medical interventions and others that do not. The advantages and disadvantages of each option differ for each person.
5. Contraception options must also be viewed in terms of sexual and reproductive rights. Individuals have the right to information and access to contraception options, along with the right to sexual well-being. They also have and the right to determine whether and when to have a child.
6. Low awareness about the legal status and availability of abortion options can sometimes lead women to seek unsafe, illegal abortions that contribute to high rates of maternal mortality and morbidity.
7. Often the responsibility of preventing unwanted pregnancies falls unfairly on women. At the same time, women are often seen only as child-bearers/reproducers and their opinions/desires are overlooked in the reproductive decision-making process.
8. Having a disability and not being able to have children often becomes another tool to harass and subject people with disability to stigma and violence.
9. Both men and women can face stigma, men for being no "man enough", women for being "not woman enough"
10. PWD equally internalise these pressures and take on added pressures to want to look and seem "normal" and "capable"
11. PLWD are often not given enough room to make choices around their bodies particularly around reproductive health, pregnancy, contraception etc. Its almost as if their choices are pre decided on the basis of what others consider is "good for them"

SESSION 10: CONCEPTION AND PREGNANCY BASICS (LECTURETTE AND DEBATE)

PURPOSE:

1. To understand and describe the process of conception.
2. To analyse the role of pregnancy and childbearing in different communities and social groups.

TIME: 75 minutes

AGE GROUP: 18 and above

LITERACY LEVEL Anyone

MATERIALS: **Handout G: Basic Information on Conception and Pregnancy.**
Red and Yellow slips. Red for 'Agree' and Yellow for 'Disagree'. A glass bowl to put Agree/Disagree slips

ADVANCE PREP: **Handout G: Basic Information on Conception and Pregnancy**

SESSION INSTRUCTIONS:

1. Introduce the topic of conception to the group. Spend the first 15 minutes going over the process of conception as outlined in Handout G. This can also be done through rapid fire questions or leading discussion questions. While this may be a review for some participants, emphasise that a basic introduction is important to ensure that everyone is at the same level of understanding.
2. After going over the basics of Handout G ask for questions or comments.
Suggested Questions:
 - List out terms you have heard people use to describe pregnancy or conception.
 - Do these terms reflect social attitudes toward pregnancy?
 - What are the implications of using 'slang' terms? For example does saying that a woman is 'in trouble' to describe that she is pregnant have a moral implication?
 - What are societies' views and perceptions about disability and childbearing especially for women with disabilities?
 - How do culture, religion, and communities influence the knowledge and understanding of conception and pregnancy?
 - People often use medical terminology when talking about conception. How can you convey technical information in an easy manner that takes into account the socio-cultural context of the audience?
3. Now introduce the debate exercise. Divide the participants into two groups. Designate one group as the 'Agree to both statements' and the other group as the 'Disagree to both statements'. Read out the two statements.

4. Give the groups 20 minutes to construct arguments to support the viewpoint designated to them. Encourage participants to use personal experiences, and/or common attitudes from their communities in their arguments.
5. Now, invite each group to present their arguments in 5 minutes, after which, open the floor for a free debate, asking questions and highlighting points when appropriate. Make sure that one group/side does not dominate the discussion.

Suggested Questions:

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

KEY MESSAGES

1. Whether to have a child or not is an individual choice. All people, irrespective of marital status, sexual and gender identity, whether they have a disability or not have the right to make this choice. It is their reproductive right.
2. In many locomotor disabilities women can conceive easily but, they are not encouraged or expected to become mothers. This is against human rights.

FACILITATOR NOTES:

Participants might get emotional during this discussion, especially if they have experienced stigma for not having children and due to the belief, that women with disabilities are inherently unfit to become mothers. Be alert to this and do not push people to speak unless they are willing to.

MAKING CONNECTIONS:

- People who choose not to have children or are unable to have children are often stigmatised. This is particularly so with women, who may be ostracised or regarded poorly in these situations.
- All people, irrespective of marital status, whether with a disability or not, etc. have the right to decide whether to have children or not, how many, and when.
- If given proper knowledge and information women with disabilities can become full partners in decision making, and the experts on how their bodies respond.

SESSION 11: CHARTING CONTRACEPTION CHOICES

PURPOSE:	<ol style="list-style-type: none"> 1. To describe contraceptive methods and their efficacy. 2. Improved access to information about contraception would help women with disabilities make decisions about sex, pregnancy and parenting. 3. To discuss what contraception options and choices mean for sexuality and rights.
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Flipchart, tape, index cards/slips of paper with different forms of contraception written out from Handout H: Information on Contraception.
ADVANCE PREP:	<p>Review Handout H: Information on Contraception.</p> <p>Write out the contraception methods without their descriptions from Handout H onto separate index cards/slips of paper. Create three flipcharts with the titles ‘Very Effective’, ‘Somewhat Effective’, ‘Taking a Big Chance’.</p>

SESSION INSTRUCTIONS:

1. Divide the participants into two groups. Distribute the index cards equally between the groups. Ask participants to decide whether the forms of contraception on the index cards should be categorised as ‘Very Effective’, ‘Somewhat Effective’, or ‘Taking a Big Chance’ at preventing pregnancy.
2. For each method they should also write one advantage and one disadvantage on the index card. For example, male condoms are highly effective for the prevention of pregnancy and a major advantage is that they also protect against STIs and HIV. A disadvantage might be that it disrupts spontaneity during sex. After each method has been discussed, the groups can tape each index card to the appropriate categories on the flip chart or walls.
3. When all the cards are up, go through each category of efficacy and read aloud the methods. With each method, first invite participants to describe the method. After a method is described, read out the advantages and disadvantages.
4. Invite participants to add to the list. Make sure to correct any misclassification of a method. For example if condoms were put in the ‘Somewhat Effective’ group, it should be stressed that in fact condoms are 98% effective and should therefore be in the ‘Very Effective’ category. Also, fill gaps in information on the description or advantages and disadvantages of each method from Handout 3.4. After looking at each category ask for questions and comments. After this, begin a discussion on how contraception options may play a role in sexuality and rights.

SUGGESTED QUESTIONS:

- Do you have any questions about the methods? Are there some of these methods unavailable in your communities?
- Take a method from each category of efficacy. How does this method, with its pros and cons, relate to sexuality and rights? For example, from the ‘Very Effective’ category, oral contraceptive pills (OCPs) provide women with choice and the ability to prevent unwanted pregnancies. It can also be said, however, that a focus on OCPs continues to put the onus on women and does not recognise the importance of male responsibility in contraception.

KEY MESSAGES

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

FACILITATOR'S NOTE:

Making connections:

- While making a contraceptive choice, it is important to consider that not all contraception methods provide protection against STIs including HIV/AIDS.
- People who want to choose contraception should be given information and support in a non-judgmental manner.

SESSION 12: QUIZ ON FEMALE AND MALE ANATOMY, CONCEPTION, CONTRACEPTION AND ABORTION

PURPOSE:	To understand the basics of female and male anatomy, conception, contraception and abortion
TIME:	75 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	literate
MATERIALS:	Handout I: Question on Anatomy, Conception, Contraception and Abortion, Prizes
ADVANCE PREP:	<ol style="list-style-type: none">1. To keep score, make a column for each team playing the game on a flipchart.2. Keep some prizes ready for the winning team and the runners-up.3. Review Handout I: Question on Anatomy, Conception, Contraception and Abortion

SESSION INSTRUCTIONS:

1. Divide the participants into two or three teams. Encourage them to name their teams and write the names down in the columns on the flip chart for scoring.
2. Explain the game and the scoring to participants. For every correct answer, a team gets 10 points. If a team cannot answer a question, it is passed on to the next team, which gets 5 points if they answer correctly.
3. Read out one question at a time and give each team time to discuss their response before they answer. Clarify questions and doubts as they come up so that participants are clear about the information.
4. Once you have gone through all the questions, announce the winners, give them prizes, and distribute the handouts as a ready reckoner.

CHAPTER 7: CONCEPTION, CONTRACEPTION AND ABORTION

In many parts of the world, including India, bearing a child is often thought of as an essential contribution to one's family and community. The desire to have children and a family is common. This emphasis put on childbearing can make it difficult for those who are unable to have children. They endure personal, community and family ridicule, stigma, and at times, even abuse or violence.

According to the World Health Organization more than 80 million people worldwide experience infertility problems and a majority of them live in developing countries.

However, today a number of options exist for those who experience infertility, including adoption, surrogacy, and assisted reproductive technologies (ARTs).

This chapter on infertility and assisted reproductive technologies addresses some of these questions and the issues around them. It also addresses the attitudes, stigma and discrimination associated with infertility in many parts of the world, and how this is greatly affected by gender and related to reproductive rights.

CHAPTER OBJECTIVES

To have participants understand and explore

1. Infertility and its possible causes.
2. Treatments for infertility and the benefits and disadvantages of options such as assisted reproductive technologies, adoption and surrogacy.
3. Attitudes around infertility (in general) and the options available to deal with infertility.
4. Attitudes and stigma associated with infertility in the communities that participants live and work in.

KEY MESSAGES

- Infertility is defined as the inability to have a pregnancy occur after 12 months of unprotected sex. The cause for this can be in the man, the woman or in both.
- The causes of infertility vary. They can include but are not limited to birth/ hereditary/ genetic (congenital) conditions, consequences of untreated reproductive tract infections (RTIs) or sexually transmitted infections (STIs), poor reproductive health services and/ or poor nutrition and/or some kind of physical disability.

- Women may experience the negative consequences/stigma of infertility more than men, especially in countries where motherhood is highly valued. In such cases, women who do not have children may suffer stress and ridicule from the community, and sometimes even abuse and violence.
- Options exist for people who experience infertility, and want to have a child. These include assisted reproductive technologies (ARTs), adoption or surrogacy.
- ARTs can be successful in treating infertility and individuals should have access to this option.

SESSION 13: DEMYSTIFYING INFERTILITY

PURPOSE:	1. To discuss personal ideas and attitudes about infertility. 2. To discuss common myths about infertility and facts that can be used to dispel them.
TIME:	45 minutes
AGE GROUP:	21 and above
LITERACY LEVEL	Literate
MATERIALS:	Handout J: Facilitator Copy: Myths and Facts on Infertility, Handout K: Participant Copy: Myths and Facts on Infertility, pens/ pencils
ADVANCE PREP:	Review Handout J: Facilitator Copy: Myths and Facts on Infertility, and make copies of Handout K: Participant Copy: Myths and Facts on Infertility.

SESSION INSTRUCTIONS:

1. Distribute Handout K to each participant. Give participants 5 minutes to read through the Handout and decide whether each statement is a myth or a fact.
2. Review each answer separately by asking participants to share their responses to each statement. Ask for questions or comments and discuss each statement briefly.

SUGGESTED QUESTIONS:

- If the statement was a myth, do you think that people in the communities you live or work in believe this to be a fact?
- How could you dispel these myths and clarify misconceptions about infertility?
- Are there any additional ideas or statements about infertility you need clarification on?
- How do you think myths about infertility affect women and men who cannot have children?

KEY MESSAGES

1. There are many myths related to infertility. The perpetuation of these myths can alienate people in their communities. Women are usually more stigmatised for infertility.
2. Knowing the facts about infertility can help to dispel myths and the stigma related to it. It can also lead to the initiation of discussion about infertility in communities and social groups.
3. A common myth is that women are responsible for infertility, particularly if they decide to delay pregnancy with contraceptives.
4. Infertility is often the result of medical conditions, which may be birth/ hereditary/ genetic (congenital), the consequence of poor reproductive healthcare, or the effects of a reproductive tract infection or sexually transmitted infection.
5. Certain physical disabilities also lead to infertility.
6. After spinal cord injury, most men are infertile due to a combination of erectile dysfunction, ejaculatory dysfunction and semen abnormalities. They may have low sperm count. Spina bifida causes nerve damage that can affect sexual functioning due to erectile dysfunction. In women with traumatic brain injury, epilepsy and multiple sclerosis, the physiological effects of their condition may alter ovulation or hormone secretion.
7. Improved health services can decrease infertility among men and women. Diagnosing and early treatment of sexually transmitted infections (STIs) and reproductive tract infections (RTIs), regularising a woman's menstrual cycle, or treating a man's low sperm count, are some ways of doing this.
8. Reproduction and childbearing are not the only role for a woman in society. If a woman cannot have a child, it should not affect her status within her family or community.
9. Infertility can be a problem for people who want to have children. However not all people want to have children and have a right to make this choice.

CHAPTER 8: HIV/AIDS, SEXUALLY TRANSMITTED INFECTIONS (STIS) AND REPRODUCTIVE TRACT INFECTIONS (RTIS)

STIs including HIV/AIDS continue to affect millions of people around the world and impact certain regions and countries more than others. Despite this situation, many people and communities continue to react to these issues with indifference, discomfort, fear and anger, and stigmatise and discriminate against infected people. This creates obstacles to providing information for prevention of transmission and adequate treatment and care for people with HIV/AIDS and STIs. Reducing the risk of transmission and providing treatment and care for people living with these infections is crucial to health and well-being.

This chapter gives participants basic knowledge of HIV/AIDS, STIs, and reproductive tract infections (RTIs), including how these infections are transmitted, and how they can be prevented and treated.

CHAPTER OBJECTIVES

To have participants understand

1. Basic information on HIV/AIDS including routes of transmission, prevention, care and support and treatment.
2. Basic information on Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs).
3. The issues of stigma and discrimination associated with HIV/AIDS and STIs/RTIs.
4. Ways to approach and talk about HIV/AIDS, STIs and RTIs in their communities.

KEY MESSAGES FOR THIS CHAPTER

1. Knowledge of HIV transmission, prevention, treatment, and care is important to reduce risk of transmission and spread of the infection, and decrease the stigma and discrimination associated with HIV/AIDS.
2. Many STIs and RTIs are curable, however if left untreated they can have a serious impact on the health and well-being of people, by causing infertility, ectopic pregnancies or some cancers. STIs can also increase the risk of HIV transmission.

3. It should not be assumed that HIV is transmitted only in certain 'high risk groups' (such as sex workers or intravenous drug users). Infection can occur in people who are young or old, monogamous or non-monogamous, heterosexual, bisexual, or homosexual, women, men or transgendered people.
4. People have a right to confidentiality and privacy when they receive health care, including counselling and treatment for HIV/AIDS, STIs and RTIs. People also have the right to keep their HIV status confidential. Fear of their status being revealed may keep many from getting tested.
5. Placing blame on individuals and discovering who are the primary 'infectors' of HIV/AIDS or STIs is counterproductive and leads to stigma and discrimination.
6. A variety of factors cause infection: lack of information, lack of access to condoms or other protection, and inability to negotiate safer sex, among others.

SESSION 14: HIV AND AIDS, RTIS AND STIS

PURPOSE: To give participants idea about HIV and AIDS and to understand the basics of RTIs and STIs

TIME: 35 minutes

AGE GROUP: 21 and above

LITERACY LEVEL literate

MATERIALS: **Handout L: Quiz Questions on HIV and AIDS, RTIs and STIs,**

Prizes

ADVANCE PREP: Review Handout L: Quiz Questions on HIV and AIDS, RTIs and STIs. To keep score, make a column for each team playing the game on a flipchart. Keep some prizes ready for the winning team and the runners-up.

SESSION INSTRUCTIONS:

1. Divide the participants into two or three teams. Encourage them to name their teams and write the names down in the columns on the flip chart for scoring.
2. Explain the game and the scoring to participants. For every correct answer, a team gets 10 points. If a team cannot answer a question, it is passed on to the next team, which gets 5 points if they answer correctly.
3. Read out one question at a time and give each team time to discuss their response before they answer. Clarify questions and doubts as they come up so that participants are clear about the information.
4. Once you have gone through all the questions, announce the winners, give them prizes, and distribute Handout L.

KEY MESSAGES

- Knowledge of HIV/AIDS including modes of transmission, prevention, treatment, and counselling is essential. This gives people information to reduce the risk of transmission and spread of the disease.
- There are many myths and misconceptions about the modes of transmission of HIV and its effects on the body. These lead to fear and discrimination.
- People with HIV/AIDS often experience stigma and discrimination. It is necessary to work to reduce this stigma in order to reduce rates of transmission as well as to protect the rights of people to live lives with dignity and respect.

SESSION 15: STARTING A CONVERSATION ABOUT SEX AND SAFETY

PURPOSE: To enable participants to think about and practice how to start and have conversations on topics related to sex and safety; to strengthen critical thinking skills.

TIME: Steps in instruction 1 to 5: 40 minutes and
Steps in instruction 6 to 10: 40 minutes

AGE GROUP: 18 and above

LITERACY LEVEL Anyone

MATERIALS: Flip chart and markers , copies of scenarios

ADVANCE PREP: Review and modify the scenarios as needed. Plan your timing carefully and keep the role-playing brief.

SESSION INSTRUCTIONS:

1. Introduce the activity with the following questions:
 - Today we will practice having conversations about sexual safety.
 - We will also try and experience, how easy is it to talk about things related to sex? Why? What can make it easier?
2. Write the following topics on the board:
 - a. whether or not to have sex
 - b. previous sexual experience
 - c. sexually transmitted infections,
 - d. HIV and AIDS and previous drug use
 - e. using condoms

3. Ask the participants to form pairs. In pairs, ask them to start a conversation on any one topic on the board. Ask them to discuss what they feel is the best way to start a conversation with a potential sex partner. Write down at least one specific way to open the conversation.
4. Also decide when a first conversation should take place — when you meet? After a first kiss? When you are already in a sexual situation?
5. For each topic, ask one group to share their ideas; write their responses on the flip chart.

Suggested Questions:

- Does anyone want to share a different suggestion? (Add these to the list.)
 - Which ideas do you think might work and why? Are there any suggestions that you think may not be a good approach? Why?
 - When in a relationship should this first conversation take place? Why?
 - What can make it easier to have these types of conversations?
6. Explain that in the next step they will practice by thinking about how those conversations might go in real life through scenarios. Ask for two volunteers to act out a conversation about the first topic (whether to have sex). Ask them to come up with names for your characters, and try to be realistic.
[Insert the new names in reading the following scenario]:
“Rahul and Lina have been dating for a while now and have begun to feel close physically. Rahul is a spinal injury patient and wheelchair user. They both have not had sex. Neither is sure about the sexual or drug taking behaviour of the other before they began dating. Rahul believes that they could become more sexually involved and is really worried about HIV. Right now they are sitting and listening to music.”
 7. Ask everyone else to make notes about how the two volunteers are communicating.
 8. Facilitate a brief discussion, drawing on the following questions:
 - What went well? What might have been handled differently?
 - Was the conversation realistic?
 - Do you have any advice for Rahul or Lina?
 9. Repeat again with other volunteers with the following scenarios as time allows:
Ankita starts a conversation with Mohan about whether or not to have sex. Ankita has locomotor disability. They may or may not agree about what to do.
Charles starts a conversation with Meena about their previous sexual experience and drug use.
Hari and Maria have talked and they think they want to have sex. Maria has spinabifida. Hari starts a conversation with Maria about using condoms. [Instruct Hari privately that he does not want to have sex without a condom and instruct Maria privately that she does not want to use condoms.]

10. Wrap up with the following questions, writing key responses on the board:
 - Before you have a conversation like this, what do you need to think about yourself? [Probe for: how you feel, what you want, what you want to say.]
 - What are some tips for successful communication?
 - What are some tips for saying “no” respectfully?
 - What rights does each person have? [Probe for: the right to express your opinion, the right to say no, the right to protect your own health.]
 - Whose responsibility is it to start such conversations in a relationship? Why?

KEY MESSAGES

- It is very important to initiate conversations about sexual safety and health.
- Partners should be able to communicate well about safety and sexual health.
- Everyone has a right to say ‘no’ and protect one’s own health.
- Consent is very important.
- The relationship between HIV/AIDS and disability is a cause for concern as persons with disabilities are often at higher risk of exposure to HIV.
- Sexually transmitted infections (STIs) do not discriminate between people with disabilities and able-bodied people.
- PwDs (especially women and girls) are very vulnerable to sexual assault and violence.

FACILITATOR’S NOTE:

Facilitator may ask the second person may show awkwardness, might disagree, or might try to avoid the conversation. The job of the first person is to try to keep the conversation moving forward, at least a little bit.

CHAPTER 9: SEXUAL PROBLEMS

There are factors beyond physical problems that contribute to sexual problems. These can include psychosocial factors like relationships, gender, religion, ethnicity, and social environment. Poor health care services, lack of education on sexual and reproductive anatomy and physiology can also play a part in sexual problems.

This chapter explores what constitutes a sexual problem and examines how these may stem from social and cultural environments. It also looks at current trends to medicalise sexuality- whether by Western science or indigenous therapies - and how these may harm rather than resolve the sexual concerns of people.

CHAPTER OBJECTIVES

1. To have participants identify different sexual problems that people may face and the possible causes for these problems.
2. To dispel myths associated with sexual problems that exist among participants and their communities.
3. To have participants understand how to talk about sexual problems with partners and their community.

KEY MESSAGES FOR THE CHAPTER

1. Many ideas and a lot of the information about sexual problems may be false.
2. Most information that people have about sexual problems is incomplete or inaccurate. It is important to dispel these myths and misconceptions. It is important to understand the basis of sexual problems and work to dispel myths around these.
3. Sexual problems can be very common and discussing them need not cause shame or discomfort.
4. Shame, embarrassment and fear around sexual problems drives people to seek help through clandestine practitioners who take advantage of situations by prescribing expensive, ineffective or even harmful infusions, oils, potions or powders.
5. In heterosexual relationships, the reasons for sexual problems can be found in the man, the woman or in both. Assumptions based on prevailing ideas in society, that blame one or the other are inaccurate and harmful. It is also possible that the problem is not because anything is 'wrong' with either partner but because of other factors such as unresolved relationship issues or past experiences of abuse.

6. Some common sexual problems include early ejaculation, erection problems in men, painful intercourse and an inability to experience orgasm in women. Many disabling conditions such as lack of privacy, social inacceptability of PLWD having sex can produce sexual problems of desire, arousal, orgasm, or sexual pain in men and women. Sexual difficulties may arise from direct trauma to the genital area (due to either accident or disease), damage to the nervous system (such as spinal cord injury), or as an indirect consequence of a non-sexual illness (fatigue and lack of the desire or ability to engage in sexual activity).
7. Not all sexual problems need medical interventions. However, medical examination may be needed on occasion to diagnose the cause of some sexual problems.
8. In any relationship, the reasons for sexual problems can be multiple. Assuming that the problem is because of a particular partner is unfair and does not help to resolve the problem. Many times just getting over the discomfort of talking about sexual desire and intimacy, expressing one's likes and non-negotiables, being open and communicative about sex and pleasure to one's partners, may help get over the sexual problem with no or minimal medical intervention.

SESSION 16: DEMYSTIFYING SEXUAL PROBLEMS - MYTHS AND FACTS

PURPOSE:

1. To dispel myths and misconceptions about sexual problems.
2. To identify facts about sexual conditions and problems in persons with disabilities.

TIME: 45 minutes

AGE GROUP: 18 and above

LITERACY LEVEL Literate

MATERIALS: Handout M: Facilitator Copy: Myths and Facts on Sexual Problems, Handout N: Participant Copy: Myths and Facts on Sexual Problems, pens/pencils

ADVANCE PREP: Review Handout: M: Facilitator Copy: Myths and Facts on Sexual Problems; Make copies of Handout N: Participant Copy: Myths and Facts on Sexual Problems for each participant.

SESSION INSTRUCTIONS:

1. Distribute copies of Handout N to participants. Give them 5-10 minutes to read over the statements and write down whether each statement is a myth or a fact.
2. Review each statement separately by inviting participants to answer whether they thought it is a myth or a fact. After each statement ask for questions or comments and make sure to include the points mentioned in Handout M.

SUGGESTED QUESTIONS:

- If you thought the statement was a myth/fact are there people in your communities, social networks that think differently?
- How could you dispel misconceptions about this statement? For example, it is a myth that a woman is 'frigid' if she has pain during sex. What can be done to dispel this myth and promote better understanding of women's sexuality?
- Are there any additional ideas about sexual problems in disabled that you want clarity on?
- How do you think these myths affect women and men differently? (For example if a woman cannot have an orgasm is it accepted as usual/common? Whereas if a man cannot have an orgasm it is thought of as a problem)

KEY MESSAGES:

Refer to the key messages of the chapter above

FACILITATOR'S NOTE:

- Dividing participants into groups to discuss the statements, rather than asking them to fill out the handout individually. This may help ease discomfort since people may find it easier to broach the issue in a small group rather than with all participants. After the groups have discussed all the statements, bring them back together and invite participants to share the statements they thought were myths.

MAKING CONNECTIONS:

- Sexual problems can sometimes affect sexual pleasure. This does not mean that an individual is incapable of experiencing sexual pleasure, but may mean trying different or new sexual behaviours or talking about the issue with the partner/s.
- Knowledge of sexual and reproductive anatomy may help in understanding sexual problems.

SESSION 17: MY VIEWS ON SEXUAL PROBLEMS (OPINION CONTINUUM)

PURPOSE:

1. To examine the various opinions and ideas about sexual problems among participants.
2. To discuss the relationship between sexual problems, society and culture.

TIME: 60 minutes

AGE GROUP: 21 and above

LITERACY LEVEL: Anyone

MATERIALS: None

ADVANCE PREP: None

SESSION INSTRUCTIONS:

1. Divide the participants in two groups. Designate one as 'Strongly Agree' and the opposite as 'Strongly Disagree'.
2. Read out statements one by one from the list of statements below. After each, ask participants to put themselves in a group based on whether they strongly agree, strongly disagree or fall somewhere in between.
3. After participants have formed a group, invite them to explain their position and why they have chosen to stand at a particular point in the line. Spend 15-20 minutes discussing the statement and issues that arise before moving onto another statement.
4. After reading and discussing the statements ask the participants to return to their seats and invite questions and comments on the exercise.

SUGGESTED QUESTIONS:

- Did the exercise raise any new questions for you about sexual problems?
- How can you dispel myths and increase people's comfort in talking about sexual problems?
- Do you think there is equal consideration of men's and women's sexual problems?

STATEMENTS ON SEXUAL PROBLEMS:

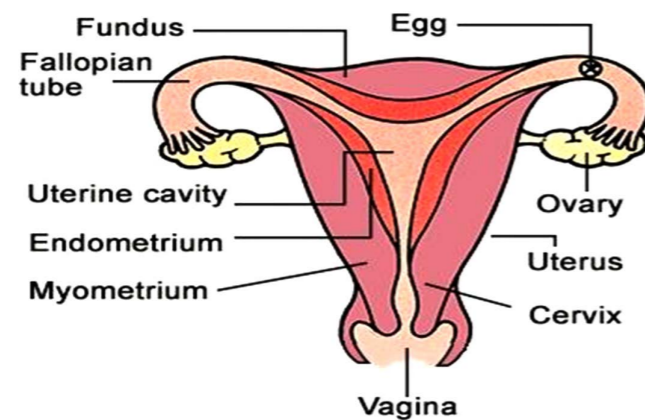
1. It is okay to take medication to help improve a sexual problem like impotence.
2. It is okay to use pleasure enhancing sprays and creams to prolong an erection during sex.
3. There is too much talk about sexual problems in the media.
4. Women's sexual problems are related to emotion and feelings while those of men are a result of physical problems.
5. It is better to just keep trying to have sex rather than seeking a doctor's help with a sexual problem.
6. The most important part of sex is having an orgasm.
7. All sexual problems are caused by physical conditions and can be treated by medicines alone.
8. Sexual problems are a part of ageing and need to be accepted as such rather than trying to get treated for them.

KEY MESSAGES:

1. Taboos around discussions of sexual problems or the blame placed primarily on women for these problems makes it harder to overcome sexual problems and discuss them openly. A person with a sexual problem should not be stigmatised.
2. Someone experiencing a sexual problem may still be capable of experiencing sexual pleasure since there are a variety of ways to experience pleasure. Sexual pleasure and preferences are individual and can change over time, similar to the way sexuality is individual and fluid.
3. Disability services and general practitioners must address the sexual needs of not only the patients but also their partners at times of need.
4. Women's sexual problems are often overlooked. Viewing them through the framework of men's sexual problems can make them feel embarrassed or inhibit their ability to talk about their problems. At the same time, cultural norms that expect men to 'know-it-all' and be in control also prevents them from seeking help with sexual problems.

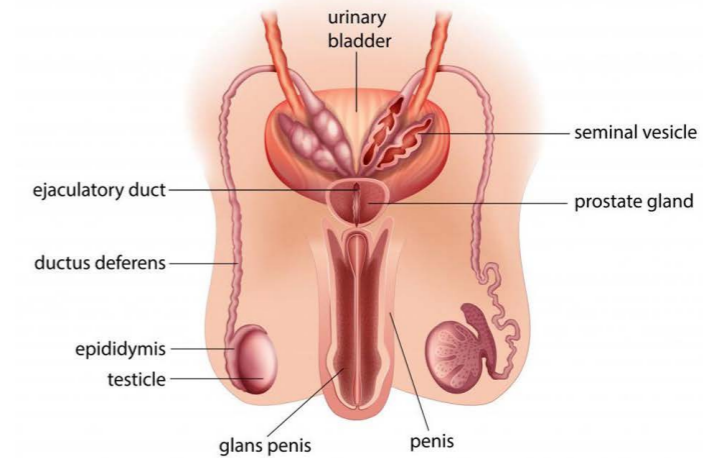
DIAGRAMS OF THE HUMAN SEXUAL AND REPRODUCTIVE ANATOMY

FEMALE REPRODUCTIVE SYSTEM



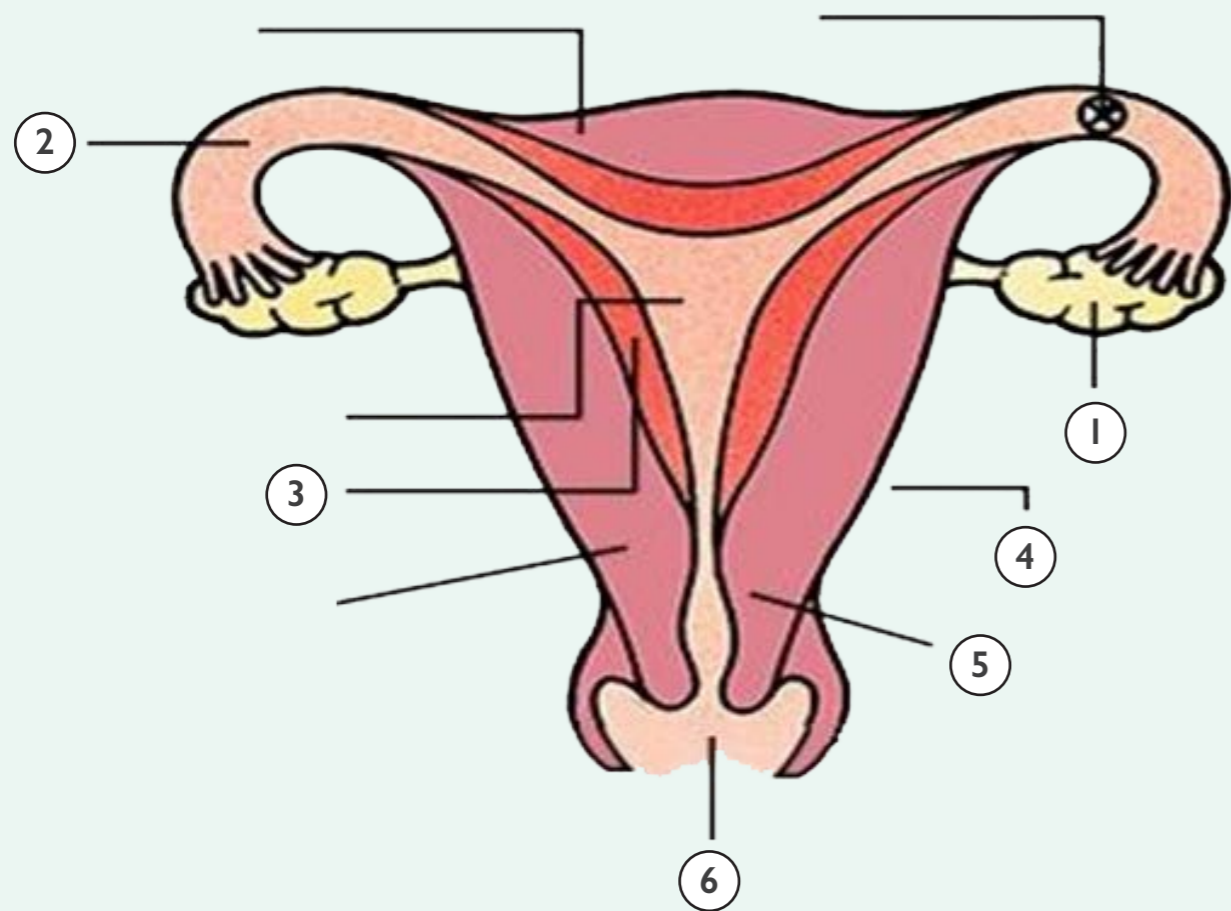
- 1. OVARIES:** Two organs each about the size of a walnut, located slightly below either side of the uterus. The ovaries have two purposes: to produce ova (eggs) and to produce hormones, including oestrogen, progesterone, and testosterone.
- 2. FALLOPIAN TUBES:** Connect the uterus to the ovaries. This is where fertilisation occurs. When an ovary releases an egg it travels through the fallopian tube into the uterus.
- 3. ENDOMETRIUM:** The uterine lining. This lining will thicken and grow during ovulation to prepare for a fertilised egg. If there is no egg fertilised, the endometrium that lines the uterus will be shed during menstruation.
- 4. UTERUS:** An organ in which a fertilised egg will attach and develop during pregnancy.
- 5. CERVIX:** The opening of the uterus. During conception sperm pass through the small opening of the cervix into the uterus to meet the egg in the fallopian tube. The cervix opens during childbirth to allow a baby to come out.
- 6. VAGINA:** Leads from the vulva to the uterus. It produces fluids that keep the vagina lubricated, clean and prevent infection. It stretches during sex and when giving birth. It is a sexual and reproductive organ.
- 7. VAGINAL OPENING:** Opening of the vagina.

MALE REPRODUCTIVE SYSTEM

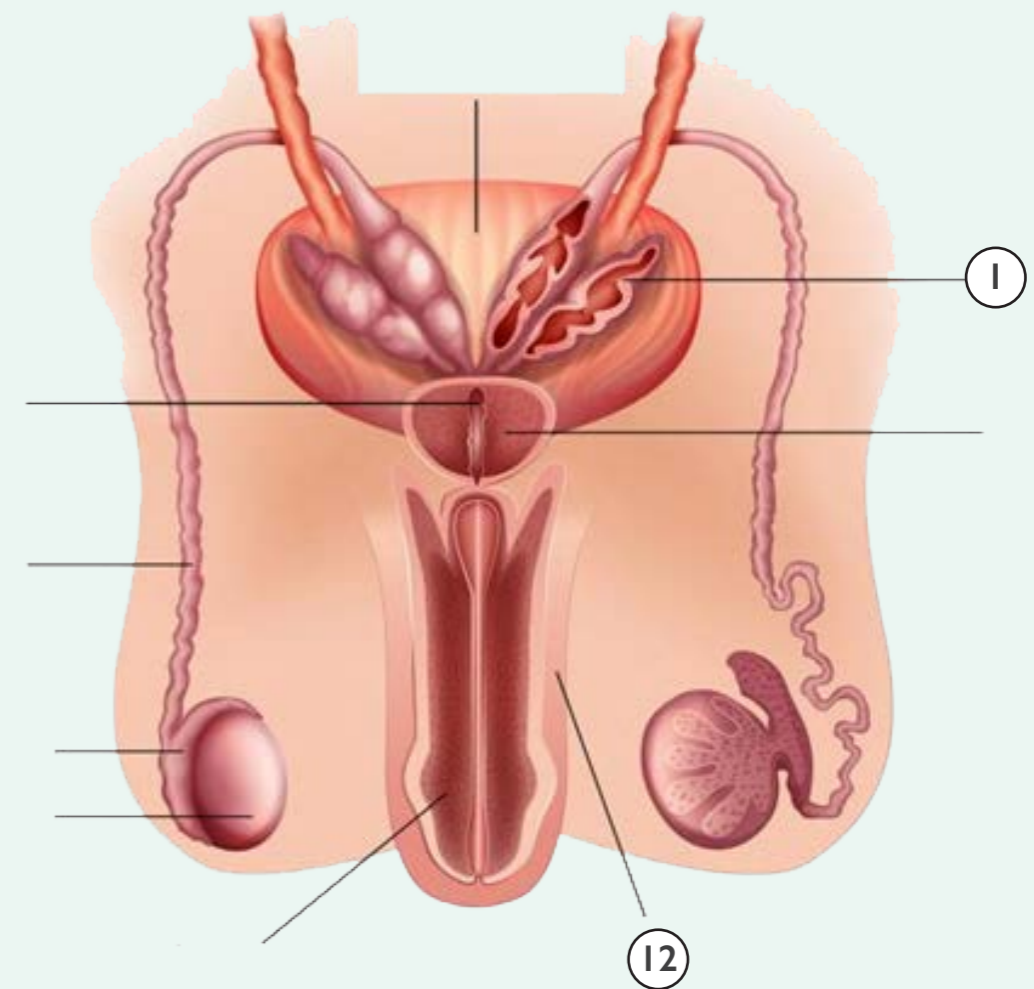


- 1. SEMINAL VESICLE:** Pair of glandular sacs that secrete some of the fluid that makes up semen.
- 2. RECTUM:** Connects the colon to the anus. Receives faeces from the colon. The rectum holds the faeces until it leaves the body.
- 3. PROSTATE:** Located just below the bladder and is the size of a walnut. It acts as both a reproductive and sexual organ. It secretes and stores a fluid that is part of semen. Some people derive sexual pleasure from the massaging or stimulation of the prostate gland. A muscle at the bottom of this gland prevents urine from being released during ejaculation.
- 4. COWPER'S GLAND:** Two pea sized glands at the base of the penis that secrete a clear fluid before and during sexual arousal and before ejaculation. This fluid is also known as pre-cum.
- 6. VAS DEFERENS:** A tube that carries sperm from the epididymis during ejaculation.
- 7. EPIDIDYMIS:** A pair of coiled tubes at the back of the testes that store the sperm until they are released during ejaculation.
- 8. TESTES:** Two egg-shaped organs located in the scrotum that are two hanging sacs located behind the penis. Testes produce sperm and male hormones called androgens, including Testosterone.
- 9. SCROTUM:** A sac hanging under the penis that holds the testes and protects them.
- 10. URETHRAL OPENING:** The outer part of the urethra and a common opening that carries urine and semen (ejaculate) outside the body.
- 11. GLANS PENIS:** The head of the penis that is very sensitive to touch.
- 12. PENIS:** The external male sexual and reproductive organ.
- 13. URETHRA:** A tube that carries urine and ejaculate through the penis out of the body. Urine and semen both go through the urethra, usually at separate times.
- 14. BLADDER:** An organ that stores urine. The urine leaves the bladder through the urethra.

HANDOUT E: PARTICIPANT COPY:
**DIAGRAMS OF THE HUMAN SEXUAL
AND REPRODUCTIVE ANATOMY**



FEMALE REPRODUCTIVE SYSTEM



MALE REPRODUCTIVE SYSTEM

HANDOUT HA:

BASIC INFORMATION ON CONCEPTION AND PREGNANCY

HOW DOES PREGNANCY OCCUR?

Pregnancy begins with fertilisation. The process of fertilisation starts with ovulation - a woman's ovary releasing an egg (ovum). Just before ovulation, the uterine wall begins to thicken with tissue and blood in preparation. After the egg is released, it travels into the fallopian tube, where it stays for three to four days. If a woman has sex with a man during this period and he ejaculates into her, the ejaculated semen can travel into the woman's vagina and uterus, and head up toward the fallopian tubes. Most sperm will die while travelling up toward the fallopian tubes, but some will make it up to the fallopian tube and try to meet the egg. When the egg and sperm meet and merge, fertilisation occurs. The fertilised egg then travels down the fallopian tube and attaches itself to the uterine wall, which will nourish the egg with blood and nutrients for the next nine months, and secrete increased levels of the hormone progesterone. This is when pregnancy has occurred.

WHAT HAPPENS IF THE EGG IS NOT FERTILISED OR ATTACHED TO THE UTERINE WALL?

If pregnancy does not occur the thickened uterine wall (endometrium) is not needed to nourish an egg and is shed. This lining, composed of tissue, blood, and mucous, will come out of a woman's vagina little by little for a period of two to eight days. This is called menstruation.

CAN A WOMAN GET PREGNANT FROM PRE-CUM OR IF A MAN EJACULATES NEAR HER VAGINA?

Yes, a woman can get pregnant any time sperm enters the vulva or is inside the vagina. This means that ejaculation near the vagina can also lead to pregnancy. This is possible when the vaginal lubrication (wetness) in the woman provides a medium for the sperm to swim into the woman's body. There is no way of knowing the probability of pregnancy when semen comes in contact with the vulva or vagina. Pregnancy can be determined using a home pregnancy test or more accurately through a pregnancy test done in a laboratory.

CAN WOMEN WITH LOCOMOTOR DISABILITIES GET PREGNANT?

Yes, in many locomotor disabilities women can get pregnant. Even in conditions of severe disability, such as tetraplegia/quadriplegia, close monitoring by a team of specialists including the spinal injury team and urological and gynaecological services could ensure maximum likelihood of conception and pregnancy.

DO WOMEN WITH DISABILITIES NEED SPECIAL KIND OF PRE-NATAL AND POST-NATAL SUPPORT AND CARE?

Women with disabilities should be encouraged early in their pregnancies to begin to identify supports, assistance, and modifications that may be needed to enable them to care for their babies. Emphasis should be on nutritional status, weight control, cessation of smoking and alcohol use, and treatment of any active symptoms or secondary conditions related to the disability.




BELOW ARE SOME TERMS COMMONLY USED IN RELATION WITH CONCEPTION:




- Amenorrhoea: The absence of menstrual periods that can be caused by pregnancy, menopause, breast-feeding, hormone imbalance, excessive dieting or exercise and stress, among other factors.
- Conception: The moment a fertilised egg attaches itself to the lining of the uterus and pregnancy begins.
- Embryo: A fertilised egg growing in the uterine lining becomes an embryo.
- Endometrium: The uterine lining, which will thicken and grow during ovulation to prepare for a fertilised egg. In the absence of fertilisation, the endometrium is shed during menstruation.
- Fertilisation: When an egg (ovum) meets and merges with a sperm in the fallopian tube.
- Ovulation: The process by which an egg (ovum) is released by the ovary. The process begins with the growth of 10 to 20 ovarian follicles. Most of these follicles will not mature and are reabsorbed by the body, but one follicle will produce a mature egg that will be released during ovulation. Ovulation begins when hormones are released from the pituitary and hypothalamus glands in the brain.
- Oestrogen: A hormone produced by the ovaries which among other things, signals the egg in the ovary to be released.
- Ovaries: Two organs, each about the size of a walnut, located slightly below either side of the uterus. The ovaries have two purposes: to produce eggs (ova) and hormones, including oestrogen and progesterone, and testosterone.
- Progesterone: A hormone produced by the ovaries. Among other things, oestrogen signals the lining of the uterus (endometrium) to thicken and grow in preparation for a fertilised egg.
- Zygote: After an egg is fertilised it changes its surface to prevent other sperm from entering. This fertilised egg is called a zygote.



HANDOUT G: BASIC INFORMATION ON CONTRACEPTION


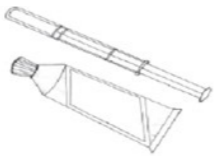
The chart below outlines general information on different forms of contraception. However, this list is not exhaustive in the facts, or in details of each method. Many of these methods may not be available everywhere. Often the most appropriate option for an individual should be discussed with a health care provider. If the chart notes that efficacy is 99% this means that 99 out of 100 people using the method properly each time will not get pregnant. Because of new developments in contraceptive technology, information can change on a regular basis. Therefore, up-to-date information on any of these and other forms of contraception, their availability and cost should be sought from health care providers in your area.

BARRIER METHODS

FORM OF CONTRACEPTION	CERVICAL CAP	DIAPHRAGM	FEMALE CONDOM
			
DESCRIPTION	A device made of thin soft latex (rubber) or silicone. It fits over the cervix. It is a physical barrier to prevent sperm from reaching the egg and to hold chemical spermicide to kill sperm.	A thin, circular dome with a flexible rim made of soft latex (rubber) or silicone. It is a physical barrier to block the cervix and prevent sperm from fertilising an egg and to hold chemical spermicide to kill sperm.	Approximately 3 inches wide and 7 inches long. Female condoms are made from soft, thin synthetic latex or latex. They're worn inside the vagina to prevent semen getting to the womb. It is open from one end and closed from another.
EFFICACY	68-91%	86-94%	79-95%
ADVANTAGES	Reusable after washing with soap and water. Can be inserted 6 hours prior to intercourse and left in up to 48 hours for multiple acts of intercourse if more spermicide is added. Doesn't interrupt intercourse. Few side effects. Can be discontinued at any time. Does not affect fertility.	Reusable after washing with soap and water. Can be inserted 6 hours prior to intercourse and left in up to 24 hours for multiple acts of intercourse. Few side effects. Does not affect fertility.	Reduces the risk of STI and HIV transmission. Can be used by those with latex allergies. Can be inserted up to 8 hours prior to intercourse. Can increase pleasure for both partners because the rim of the outer ring stimulates the clitoris and testes during sex. Does not affect fertility.
DISADVANTAGE	Does not reduce risk of STI and HIV. Some people may have allergic reactions to spermicides/ the latex. May be difficult for some women to insert. Need a health care provider to fit the cap (they come in different sizes).	Doesn't reduce risk of STI and HIV transmission. Some people may have allergic reactions to the latex or spermicides. May be difficult for some women to insert. Need a health care provider to fit the cap (they come in different sizes).	Can be expensive. It may be difficult to insert.
USAGE	Before using check for holes, tears or cracks. Apply spermicide to the cervical cap, and then insert it into the vagina and place the cap onto the cervix	Before using check for tears, cracks, or holes. Apply spermicide to the diaphragm and then insert it deep into the vagina. The front rim should be tucked behind the pubic bone. Make sure it covers the cervix.	Before using check for tears. Squeeze the smaller ring at the closed end of the condom and put it into the vagina. Make sure the large ring at the open end of the condom covers the area around the opening of the vagina. Add lubricant if needed while inserting.
OTHER INFORMATION	Should not be used if a woman is using other vaginal medications, like treatments for yeast infection, or during a woman's menstrual period. Should be replaced every year.	Should not to be used if a woman is using vaginal medications or during her period as it can increase the risk for toxic shock syndrome. Must replace after 3 years. A woman should also have her diaphragm refitted if she has had a child vaginally, gains or loses more than 9 kgs, or had an abortion or a miscarriage, as these can affect the way the cap fits.	Don't use the male and female condom together.

FORM OF CONTRACEPTION	MALE CONDOM	INTRA-UTERINE DEVICE (IUD) (HORMONAL AND NON-HORMONAL)	COMBINED ORAL CONTRACEPTIVE PILLS (COCS)
			
DESCRIPTION	A sheath of latex or plastic that is worn on the penis. Comes rolled up in a wrapper.	A small, flexible device, T-shaped, inserted into the uterus. There are 2 types of IUDs -non-hormonal (also known as a Copper T) and hormonal. Prevents fertilisation by altering the uterine environment.	Small tablets which come in monthly strips with clear labelling for use. It contain hormones.
EFFICACY	85-98%	92-99%	92-99%
ADVANTAGES	Reduces the risk of STI and HIV transmission (only the latex variety). May help delay ejaculation. Inexpensive and easily accessible. Available in various textures, flavours, sizes, colours and brands. Does not affect fertility.	The non-hormonal IUD can be left in place for up to 10 years. The hormonal IUD can be kept in place for up to 5 years. Does not interrupt intercourse.	Easy to administer. Reduces menstrual flow for some women. Can decrease the risk of some cancers, or benign breast disease. Doesn't interrupt intercourse. Increased dosages can also be used as emergency contraception.
DISADVANTAGE	May break or rip if used incorrectly. Some people with disabilities may have allergic reactions to the latex.	Doesn't reduce risk of STI and HIV. Some women may initially experience cramps or backaches. It can increase menstrual bleeding, cramping or spotting between menstrual periods. Needs to be inserted by a health care provider in clean hygienic surroundings. Increased risk for pelvic inflammatory disease	Does not reduce risk of STI and HIV transmission. Must be taken daily. Can cause temporary side effects such as nausea and breakthrough bleeding which usually last the first three months.
USAGE	Put the condom on after the penis is erect.	A health care provider will insert the IUD.	A doctor can help determine dosage and which COC is best for each woman and when to start the pills. One pill has to be taken everyday at the same time.
OTHER INFORMATION	Check expiry date. Latex condoms should not be used with oil based lubricants (like lotion or oil). Use the condom only once.	If any side effects are experienced within the first month after insertion, a healthcare provider should be contacted. Make sure the IUD is in place regularly. Fertility can return a month after an IUD is removed.	Should not be used by women who have blood clots, have migraine headaches or women over 35 years who smoke.

FORM OF CONTRACEPTION	IMPLANTS	INJECTABLE	MINI-PILL
			
DESCRIPTION	Small, plastic tubal implants that are inserted under the skin of a woman's arm. They release hormones that work to prevent sperm from entering the uterus and prevent ovulation.	An intramuscular injection contains hormone and is given every 12 weeks. This works to prevent ovulation and prevent sperm from entering the uterus.	A progestin only pill. It works to prevent sperm from entering the uterus. Also prevents ovulation.
EFFICACY	99%	97-99%	87-99%
ADVANTAGES	Lasts for 3 to 5 years. Does not interrupt intercourse.	For some injectables, protection against pregnancy can last for 3 months. Does not interrupt intercourse. Decreased risk for some cancers. Decrease in menstrual flow and in menstrual cramps. Can be used for women who are breastfeeding.	Easy to administer. Does not interrupt intercourse. Can be used by women who cannot take oestrogen. Women who are breastfeeding can use the mini-pill.
DISADVANTAGE	Doesn't reduce risk of STI and HIV. Can cause weight gain, irregular bleeding, and lower abdominal pain. Can be visible through the skin.	Does not reduce risk of STI and HIV. Possible side effects include weight gain, irregular bleeding, breast tenderness, headaches, mood swings, loss of bone density that can increase the risk for osteoporosis.	Does not reduce risk of STI and HIV transmission. Must be taken at the same time everyday. Women may have irregular periods or spotting in between periods.
USAGE	A health care provider will insert the implant under the skin in minor surgery. The implants are inserted within the first 7 days of a menstrual cycle.	A health care provider will administer the shot in the arm or buttocks.	Take one pill every day at the same time.
OTHER INFORMATION	Return to regular fertility after the implants are removed can take between 8-10 months.	On average, it takes a woman 4 months to return to regular levels of fertility after discontinuing an injectable.	Should not be used by women who have certain conditions or diseases such as liver disease or breast cancer. Fertility will return immediately or within a few months after discontinuing the mini-pill.

FORM OF CONTRACEPTION	THE PATCH	SPERMICIDES	VAGINAL RING
			
DESCRIPTION	A small adhesive patch. It contains hormones which are released into the blood and work to prevent ovulation and prevent sperm from entering the uterus.	Foams, creams, gels or tablets that are placed in a woman's vagina. They contain chemicals that kill sperm.	A soft, plastic, flexible ring that a woman inserts into her vagina. The ring releases hormones into the body that work to prevent ovulation and prevent sperm from entering the uterus.
EFFICACY	99%	71-82%	92-99%
ADVANTAGES	Does not interrupt intercourse. Can reduce menstrual flow for some women. Can decrease the risk of some cancers.	Can be left in for 6-8 hours.	Does not interrupt intercourse. Can reduce menstrual flow for some women. Decreases the risk of some cancers.
DISADVANTAGE	Does not reduce risk of STI and HIV transmission. Visible on the skin. Can cause possible skin irritations and temporary side effects such as nausea and spotting in between periods that usually last for the first three months of use.	Doesn't reduce risk of STI and HIV transmission May weaken latex condoms. Can have an unpleasant taste or smell.	Does not reduce risk of STI and HIV transmission. Some side effects can include irregular bleeding, breast tenderness, headaches, nausea, and weight gain. A woman with disability may find it difficult to insert.
USAGE	A new patch is applied each week for 3 weeks and no patch is worn on the 4th week. The patch can be worn on the lower, upper torso or arms, abdomen, buttocks.	Must be inserted 10-15 minutes before intercourse	Insert a new ring once a month. The ring is placed in vagina during the first 5 days of the menstrual period.
OTHER INFORMATION	Women who have blood clots, are breastfeeding, have migraine headaches or women who smoke should not use the patch. Efficacy is also lower for obese women	Should be used in conjunction with other barrier methods.	The ring should not be removed during sexual intercourse. Women who have blood clots, are breastfeeding, have migraine headaches or women who smoke should not use the vaginal ring

NON-HORMONAL / NON-CHEMICAL METHODS

FORM OF CONTRACEPTION	1. ABSTINENCE	2. BASAL BODY TEMPERATURE	3. BREAST FEEDING
DESCRIPTION	Choosing to abstain from any sexual activity, or refraining from any penetrative sexual acts (such as anal or vaginal sex), while participating in other sexual acts (such as oral sex).	A fertility awareness method (FAM), where a woman takes her body temperature each morning to determine the fertile phase in her menstrual cycle.	Exclusive breastfeeding for the 1st 6 months after childbirth produces prolactin, a hormone that suppresses ovulation.
EFFICACY	100%	75-99%	79-95%
ADVANTAGES	Nothing to purchase. Can be discontinued any time. Reduces the risk of STI and HIV transmission.	Nothing to purchase.	Nothing to purchase. Can be discontinued at any time.
DISADVANTAGE	Can transmit some STIs, such as syphilis if there is skin to skin contact during sexual activity other than intercourse.	Does not reduce risk of STI and HIV transmission. Takes time to learn the fertile phase	Does not reduce risk of STI and HIV transmission. Will only last for 6 months after delivery and only if the woman is exclusively breastfeeding.
USAGE	Can include periodic abstinence, in which an individual refrains from sexual activity from time to time.	Each morning as soon as a woman wakes up and records her temperature. A temperature rise indicates that ovulation has occurred.	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.
OTHER INFORMATION	Requires the cooperation of both partners.	Women are advised to not eat, drink, or smoke before taking their temperature.	Women who have HIV/AIDS may be advised to not breastfeed.
4. WITHDRAWAL METHOD			
DESCRIPTION	Man completely removes his penis from the woman's vagina before he ejaculates.		
EFFICACY			
ADVANTAGES	Nothing to purchase.		
DISADVANTAGE	Does not reduce risk of STI and HIV transmission. Highly ineffective at preventing pregnancy		
USAGE	Before ejaculating a man will remove his penis from the woman's vagina.		
OTHER INFORMATION	Requires that both partners to cooperate.		

PERMANENT METHODS

FORM OF CONTRACEPTION	TUBECTOMY OR TUBAL LIGATION	VASECTOMY
DESCRIPTION	A surgical procedure that blocks the fallopian tubes. Prevents an egg from traveling from the ovary to the uterus and sperm from reaching the egg to fertilise it.	A surgical procedure that seals the vas deferens preventing sperm from getting into semen. After a vasectomy, a man still produces semen but there is no sperm in it.
EFFICACY	Nearly 100%.	Nearly 100% effective.
ADVANTAGES	Does not interrupt intercourse. Permanently prevents pregnancy.	Does not interrupt intercourse. Permanently prevents pregnancy. Complications are rare.
DISADVANTAGE	Doesn't reduce risk of STI and HIV transmission. Complications can occur from the surgery. Reversal is difficult.	Does not reduce risk of STI and HIV transmission. Reversal surgeries are not highly successful.
USAGE	There are surgical and non-surgical options. The patient can leave soon after these procedures are completed.	A health care provider will cut and seal the two vas deferens. The patient can leave soon after the procedure is completed.
OTHER INFORMATION	Does not affect menstrual periods, ability to have an orgasm, and nor does it cause menopause.	Takes around 15-30 ejaculations after the operation to clear out the sperm already in the vas deferens. Does not affect ability to have an erection, ejaculation, or the ability to have an orgasm.

HANDOUT I:

QUESTIONS ON ANATOMY, CONCEPTION, CONTRACEPTION AND ABORTION

ROUND I: FEMALE AND MALE ANATOMY

NAME ONE EXTERNAL AND ONE INTERNAL REPRODUCTIVE ORGAN EACH IN WOMEN AND MEN.

FOR FACILITATOR

WOMAN – INTERNAL ORGANS	MAN – INTERNAL ORGAN
OVARIES	PROSTATE
FALLOPIAN TUBES	VAS DEFERENCE
UTERUS	
WOMAN -EXTERNAL ORGAN	MAN -EXTERNAL ORGAN
CLITORIS	PENIS
VULVA	SCROTUM
VAGINA	

Refer to the explanations on each of these terms given in Session 10: Learning Human Anatomy, Handout E of Module 3

WHAT IS THE CLITORIS AND WHAT IS ITS ROLE?

The clitoris is a pea-sized organ located above the urethra (urinary opening), where the inner lips of the vulva join at the top. The role of the clitoris is for sexual pleasure.

A WOMAN BLEEDS THE FIRSTTIME SHE HAS SEX – TRUE/FALSE AND WHY

The hymen is a much contested piece of tissue. If present, which it may not be in all women, it is a delicate collection of membranes located inside the vaginal passage. It is so delicate that it may tear in childhood or adolescence during cycling or exercising or any such activity. In some women, it can be stretched without tearing. It can vary in size and thickness, from woman to woman. Hence it is not necessary for a woman to bleed the first time she has sex.

IS MASTURBATION HARMFUL AND DO MEN AND WOMEN BOTH MASTURBATE?

Masturbation is an enjoyable and perfectly harmless activity. Both men as well as women masturbate. It does not matter how often you do it as long as it does not interfere with the other things you have to do or does not involve anyone else without their consent. Masturbation will not affect your sex life negatively. It is a legitimate sexual activity in its own right and does not cause weakness, stunted growth, pimples, or any psychological problem.

ROUND 2: MENSTRUATION, SPERM PRODUCTION AND CONCEPTION

WHAT IS MENSTRUATION

Menstruation occurs when the endometrium that lines the uterus sheds if the egg is unfertilized. Usually happens from two to eight days in the similar time every month, but this is not a necessity.

WHAT ARE NOCTURNAL EMISSIONS AND HOW CAN THEY BE CURED?

Nocturnal emissions, also called wet dreams or 'night fall', are a normal and common occurrence that usually begins sometime during puberty.

PLEASE EXPLAIN WHAT CONCEPTION AND PREGNANCY MEAN.

Conception is when an egg (ovum) is fertilised by a sperm.

Pregnancy occurs when the fertilised egg attaches to the uterine wall and begins to secrete increased levels of certain hormones that thicken the uterine wall and cause a woman to stop having her menstrual periods.

HOW LONG CAN SPERMS LIVE INSIDE A WOMAN'S BODY?

Sperm can live in a woman's body for up to 6 days.

CAN A WOMAN GET PREGNANT FROM PRE-CUM OR IF A MAN EJACULATES NEAR HER VAGINA?

Yes, a woman can get pregnant anytime the sperm enters the vulva or is inside the vagina. This means that ejaculation near the vagina can also lead to pregnancy. This is possible when the vaginal lubrication (wetness) in the woman provides a medium for the sperm to swim into the woman's body. There is no way of knowing the probability that pregnancy will occur when semen comes in contact with the vulva or vagina. Pregnancy can be determined using a home pregnancy test or more accurately through a pregnancy test done in a laboratory.

Also, a woman can get pregnant from pre-cum- a small amount of fluid that the man ejaculates before he comes. The man does not feel this fluid leaving his body and the woman does not feel it entering her.

ROUND 3: CONTRACEPTION

WHAT ARE TWO OPTIONS FOR NON-HORMONAL CONTRACEPTION?

Answers can include the male condom, female condom, cervical cap, non-hormonal intrauterine device.

CAN A WOMAN GET PREGNANT IF SHE HAS INTERCOURSE DURING HER PERIOD?

There is a very small chance of this happening. Sperm can live up to 6 days in the cervical mucus of a woman's vagina and ovulation can sometimes occur soon after the last day of a woman's period. It is also possible for the woman to ovulate during her period, though this is not very common.

NAME THREE TYPES OF HORMONAL CONTRACEPTION OPTIONS. ARE ANY MALE HORMONAL CONTRACEPTIVE PILLS AVAILABLE?

Answers can include oral contraceptive pills, hormonal intra-uterine device, injectables. Women/girls with locomotor disabilities must consult with their doctors before taking these pills.

No, there are currently no male oral contraceptive pills; however there is research being done to develop such an option.

WHAT ARE EMERGENCY CONTRACEPTION PILLS?

Emergency contraceptive pills are pills with higher dosages of the hormones found in regular oral contraceptive birth control pills. These can be taken up to five days after unprotected sex or contraceptive failure to prevent pregnancy. Women/girls with disabilities must consult with their doctors before taking these pills.

ROUND 4: ABORTION

WHAT ARE AN INDUCED AND A SPONTANEOUS ABORTION?

A spontaneous abortion occurs when a pregnancy terminates without any medical or surgical interventions, as in a miscarriage. Induced abortions involve surgical or medical procedures to terminate a pregnancy.

WHAT IS A MEDICAL ABORTION?

A medical abortion uses a combination of two hormonal drugs, an anti-progesterone and prostaglandin, to end a pregnancy. It can be used to end a pregnancy up to 6-8 weeks of pregnancy in India. Please check legal status and availability of this procedure in your region.

WHAT ARE SOME SIDE EFFECTS FROM AN ABORTION?

Side effects can include cramping and bleeding, nausea, dizziness, diarrhoea, vomiting, and back pain.

TRUE OR FALSE: IF A WOMAN HAS AN ABORTION, SHE WILL BE UNABLE TO HAVE CHILDREN IN THE FUTURE.

False. If a woman has a safe abortion without severe complications, she can still get pregnant in the future.

HANDOUT J: FACILITATOR COPY: MYTHS AND FACTS ON INFERTILITY

PAINFUL PERIODS CAN CAUSE INFERTILITY.

MYTH. Painful periods are common in many women. They are neither a sign of infertility nor an indication that a woman will be infertile.

HAVING IRREGULAR PERIODS CAN CAUSE INFERTILITY.

MYTH. Irregular menstruation does not cause infertility. Regular periods are important in that there are more opportunities to be fertile and get pregnant, but irregular periods are not a sign of infertility.

IF A WOMAN IS UNABLE TO CONCEIVE, THERE IS A GREATER LIKELIHOOD OF SOMETHING BEING WRONG WITH HER RATHER THAN WITH HER PARTNER.

MYTH. When people seek assistance for infertility, the cause can be the woman, the man, both, or unknown. In 30% of cases men have a problem, in 30% of cases women have a problem, in 30% both men and women have a problem, and in 10% of the cases the reasons are unknown.

PRAYER AND FAITH CAN HELP A WOMAN GET PREGNANT.

MYTH. Faith and belief are important and personal aspects to many people's lives. However with infertility, particularly if the causes are medical or unknown (for example low sperm count or blocked fallopian tubes), these cannot be cured solely with prayer.

MASTURBATION CAUSES A LOSS OF SEMEN AND CAN PREVENT A MAN FROM IMPREGNATING A WOMAN.

MYTH. Masturbation is an enjoyable and harmless activity and does not cause loss of semen that would prevent a woman from getting pregnant. Semen that contains sperm is constantly being produced in the testes. Production is constant, and masturbation will not deplete the supply.

IF A WOMAN RELAXES AND CONCENTRATES HARD ENOUGH ON GETTING PREGNANT IT WILL HAPPEN

MYTH. Concentrating hard on getting pregnant cannot mitigate the medical causes of infertility, which may or may not respond to treatment. Stress reduction and relaxation exercises may help the woman/couple cope better with their situation and with any treatment they are undergoing.

IF YOU ENJOY SEX YOU ARE MORE LIKELY TO GET PREGNANT.

MYTH. Sexual pleasure and ability to get pregnant are not connected.

A WOMAN CONCEIVES ONLY IF BOTH SHE AND HER PARTNER HAVE AN ORGASM.

MYTH. While sexual pleasure is important, even if a man or woman does not have an orgasm and a man ejaculates into or near a woman's vagina, there is a possibility of pregnancy. A man's pre-cum also contains sperm and can cause pregnancy.

USING ANY FORM OF CONTRACEPTION WILL LIMIT THE CHANCES OF GETTING PREGNANT IN THE FUTURE.

MYTH. Using hormonal contraceptive methods such as oral contraceptive pills or injectables will prevent a pregnancy. When stopped, fertility returns within a short period. The length of time to return to normal fertility levels depends on the individual and type of contraceptive. Contraceptives such as condoms, however, are a one-time preventative and do not affect a person's ability to get pregnant the next time they have unprotected sex.

FERTILITY AND FEMININITY ARE STRONGLY LINKED.

MYTH. The ability of a woman to have a child is not connected to her femininity. Nor is her desire to have a child or decision to not have a child. People have the right to choose whether they want a child or not, regardless of gender.

A WOMAN IS FERTILE AND ABLE TO CONCEIVE APPROXIMATELY 14 DAYS PRIOR TO HER NEXT MENSTRUAL PERIOD AND 4-6 days before she begins ovulation.

FACT. This is when most women are most easily able to get pregnant.

PEOPLE WHO CANNOT CONCEIVE CAN FACE STIGMA AND DISCRIMINATION.

FACT. Stigma and discrimination can affect people who are unable to have children, particularly women. There are cases of women being emotionally, mentally or physically abused by their husbands and families for not being able to have children, treated violently by their community, and are blamed for the lack of children when the cause may in fact lie with her partner.

IF A WOMAN AND MAN CANNOT HAVE A CHILD, IT IS USUALLY THE WOMAN'S FAULT.

MYTH. Infertility can result from the woman, the man or from both. Families and communities often blame the woman for problems in conception, even when the cause can just as easily lie in the man.

SOMETIMES THE CAUSES OF INFERTILITY CANNOT BE DETERMINED.

FACT. About 10% of infertility cases are due to unexplained reasons.

ONE OF THE MAIN PREVENTABLE CAUSES OF INFERTILITY IS SEXUALLY TRANSMITTED INFECTIONS.

FACT. Sexually transmitted infections (STIs) are one of the primary causes of infertility and can be prevented. STIs such as chlamydia and gonorrhoea are examples of STIs that if left untreated can cause infertility in men and women.

WHEN A MAN IS INFERTILE, THIS MAY BE A RESULT OF LOW SPERM COUNT.

FACT. A low sperm count is one reason a man may be infertile.

IN VITRO FERTILISATION IS WHEN A MAN'S SPERM AND A WOMAN'S EGGS ARE MIXED TOGETHER OUTSIDE OF THE WOMAN'S BODY AND INSERTED INTO THE WOMAN.

FACT. With in-vitro fertilisation (IVF) a woman's eggs are harvested (removed from her ovaries), fused with sperm, and re-implanted into the woman's uterus. In many cases, multiple eggs are implanted.

PEOPLE IN SAME-SEX RELATIONSHIPS CAN USE ASSISTED REPRODUCTIVE TECHNOLOGIES (ARTS) TO HAVE A CHILD.

FACT. ARTs, such as in vitro fertilisation or intrauterine injection, can be used by same-sex people or single women to have a child.

ASSISTED REPRODUCTIVE TECHNOLOGIES (ARTS) ARE A SIMPLE AND EASY WAY TO HAVE A CHILD.

MYTH. Some ART procedures can be painful and uncomfortable. Certain medications and hormonal injections can have side effects and cause discomfort. Procedures to remove the eggs and to re-implant them into the woman can be particularly uncomfortable and painful. Since the success rates of such procedures are low, the stress and disappointment of a failed attempt can add to the stress.

ASSISTED REPRODUCTIVE TECHNOLOGIES (ARTS) WILL WORK FOR EVERYONE WHO TRIES THEM.

MYTH. Most ARTs and fertility procedures have a less than 30% success rate.

TECHNOLOGIES TO DETERMINE THE SEX OF A CHILD ARE COMMON.

FACT. Pre-implantation genetic diagnosis can be used to determine the sex of the child. This procedure determines if there are any genetic abnormalities by removing a single cell from the embryo and testing it. This practice could be ethically dangerous.

ASSISTED REPRODUCTIVE TECHNOLOGIES (ARTS) ARE USUALLY MORE ACCESSIBLE TO PEOPLE IN A HIGHER SOCIO-ECONOMIC GROUPS.

FACT. ARTs are an expensive option for people and are more easily available to people with a higher disposable income.

SOME COUNTRIES/RELIGIONS/COMMUNITIES ALLOW PEOPLE TO DIVORCE OR TAKE ANOTHER WIFE IF THE WOMAN CANNOT HAVE A CHILD.

FACT. Some communities place a high importance on childbearing and the burden of this falls on a woman. If a woman is unable to have a child, some families and communities allow and encourage the man to take another wife to fulfil this child-bearing function.

HANDOUT K: PARTICIPANT COPY: MYTHS AND FACTS ON INFERTILITY

Instructions for participants: Indicate whether each statement below is a Myth or a Fact. Write (M) for a myth and (F) for a fact.

1. Painful periods can cause infertility.
2. Having irregular periods can cause infertility.
3. If a woman is unable to conceive, there is something wrong with her and not her partner.
4. Prayer and faith can help a woman get pregnant.
5. Masturbation causes a loss of semen and can prevent a man from impregnating a woman.
6. If a woman relaxes and concentrates hard enough on getting pregnant it will happen.
7. You are more likely to get pregnant if you enjoy sex.
8. A woman conceives only when both she and her partner have an orgasm.
9. Using any form of contraception will limit a woman's chances of getting pregnant in the future.
10. Fertility and femininity are strongly linked.
11. A woman is fertile and able to conceive approximately 14 days prior to her next menstrual period and 4-6 days before she begins ovulation.
12. People who cannot conceive face stigma and discrimination.
13. If a woman and man cannot have a child it is usually the woman's fault.
14. The causes of infertility sometimes remain unknown.

15. A main preventable cause of infertility is sexually transmitted infections.
16. When a man is infertile, this may be a result of a low sperm count.
17. In vitro fertilisation is when a man's sperm and a woman's eggs are mixed together outside the body and then inserted into the woman's womb.
18. People in same-sex relationships can use assisted reproductive technologies (ARTs) to have a child.
19. Assisted reproductive technologies (ARTs) are a simple and easy way to have a child.
20. Assisted reproductive technologies (ARTs) will work for everyone who tries them.
21. Assisted reproductive technologies (ARTs) can be used to determine the sex of the child.
22. Assisted reproductive technologies (ARTs) are usually more accessible to people of a high socio-economic group living in urban areas.
23. Some countries/religions/communities allow people to divorce or take another wife if the woman cannot have a child.

HANDOUT L:

QUIZ QUESTIONS ON HIV AND AIDS, RTIS AND STIS

ROUND 1: HIV AND AIDS

1. WHAT IS HIV? WHAT IS AIDS?

HIV stands for Human Immuno-deficiency Virus. Within the body of a person infected with HIV, millions of new HIV viral particles are created every day. HIV by itself is not an illness and while it can lead to AIDS, this progression can take several years. An HIV infected person can lead a healthy life for years.

AIDS stands for Acquired Immune Deficiency Syndrome. AIDS severely weakens the body's defences making it possible for other diseases to successfully manifest themselves.

2. HOW IS HIV TRANSMITTED?

There are four routes of transmission for HIV: 1) unprotected sex with an infected person; 2) infected mother to child, either during pregnancy, delivery or through breastfeeding; 3) through contaminated blood and blood products (including organ and tissue transplants); and 4) sharing of unsterilized infected needles, syringes and other medical equipment like dentists' instruments.

3. HOW CAN A PERSON FIND OUT IF THEY HAVE HIV?

The most common HIV tests look for the presence of HIV antibodies in a person's blood or saliva. Within three months of infection with HIV, the body's immune system is able to produce a detectable level of HIV antibodies. When these antibodies are present, a person tests positive.

4. WHAT ARE THE CONDITIONS FOR TRANSMISSION OF HIV THROUGH UNPROTECTED SEX?

A person must be infected with HIV to pass it to another person. Unprotected penetrative vaginal intercourse is the most common route of HIV transmission, while anal sex - whether male-to-male or male-to-female poses a higher risk for transmission. It is rare but possible to acquire HIV through oral sex, particularly if the person has ulcers or sores in their mouth. Kissing and other non-penetrative sexual activities do not pose a risk for HIV transmission.

RTIS AND STIS

5. WHAT ARE RTIS? WHAT ARE STIS? ARE STIS THE SAME AS RTIS?

RTI stands for Reproductive Tract Infection. RTIs refer to infections that affect the reproductive tract. RTIs are caused by an overgrowth of organisms that are normally present in the vagina or when bacteria or micro-organisms are introduced into the reproductive tract during sexual contact or through medical procedures.

STI stands for Sexually Transmitted Infection. STIs refer to infections that are transmitted through sexual contact.

No, some STIs can be RTIs, but not always. Similarly, some RTIs are also STIs but not always. In many cases, STIs have more serious health consequences.

6. NAME TWO SEXUALLY TRANSMITTED INFECTIONS (STIS). ARE MOST STIS CURABLE?

There are a number of STIs that include Chlamydia, Gonorrhoea, Herpes, Trichomoniasis, and Chancroids. Please see Handout 2.19 for a full list of possible STIs.

Yes, many STIs are curable using antibiotics.

7. IS HIV INFECTION AN STI? IS THERE A RELATIONSHIP BETWEEN STIS AND HIV TRANSMISSION?

Yes, HIV is also considered an STI because transmissions can occur through the sexual route.

Yes. A person with an STI has an increased risk of acquiring HIV as well as an increased risk of transmitting HIV.

8. HOW CAN THE RISK OF MOST STI TRANSMISSION BE REDUCED?

A person can reduce the risk of STI transmission by using a condom during sex; getting screened and tested for STIs (both if symptoms do and do not exist since many STIs can be asymptomatic); and getting treatment for themselves and their partner/s. It is important to abstain from sexual contact during the course of treatment and during outbreaks of some STIs such as herpes.

9. WHAT ARE TWO COMMON SYMPTOMS FOR MANY STIS?

An unusual discharge, pain during urination, ulcers or sores around the genitals and skin irritations are the symptoms of an STI.

10. WHAT DOES AN ASYMPTOMATIC STI MEAN? HOW CAN A PERSON FIND OUT IF THEY HAVE AN STI OR RTI?

Asymptomatic means that most people will not have symptoms if they have the STI. For example, nearly 70% of women who have chlamydia or gonorrhoea are asymptomatic.

Because people feel fine and have no symptoms of infection, they may delay getting tested and subsequently treated for the STI. Getting tested by a health care provider is important even if symptoms are not present.

11. IF UNTREATED, WHAT ARE SOME OF THE CONSEQUENCES OF AN STI? ONCE CURED OF AN STI, YOU CANNOT CONTRACT IT AGAIN: TRUE OR FALSE?

Infertility, pelvic inflammatory disease in women, some cancers, epididymitis, and ectopic pregnancy are some consequences. If a woman is pregnant, certain STIs can cause her to go into pre-term delivery or the baby can develop adverse health conditions such as conjunctivitis, brain damage or even death.

False. Even if you have been treated and cured of an STI, you can contract this or any other STI again.

12. PEOPLE WHO HAVE STIS ARE PROMISCUOUS AND LACK GOOD MORALS: TRUE OR FALSE?

False. A person can get an STI from a regular sexual partner, from two partners or from twenty. The 'moral correctness' of a person's life and choices should not be judged by anyone.

HANDOUT M: FACILITATOR COPY: MYTHS & FACTS ON SEXUAL PROBLEMS

1. MEN ARE MORE SEXUAL THAN WOMEN.

MYTH. Women are just as sexual as men.

2. IF A MAN CANNOT EJACULATE HE HAS A MEDICAL PROBLEM.

MYTH. If a man cannot ejaculate it may be a medical problem; however it may also happen because of other reasons. In addition, one instance of this situation does not indicate a sexual problem. Most men with spinal cord injury cannot ejaculate during sexual intercourse. Some have retrograde ejaculation, which occurs when semen travels backward into the bladder.

3. IF A MAN CANNOT EJACULATE, IT IS THE FAULT OF HIS PARTNER.

MYTH. Sexual problems are not the fault of the person experiencing them or their partner. There can be medical, psychological or societal reasons for them.

4. WOMEN ARE FRIGID IF THEY CANNOT HAVE SEX OR FIND IT PAINFUL.

MYTH. Painful sex or the inability to have penetrative sex can be caused by medical, social or psychological factors. Frigidity is an inaccurate description, and also has derogatory connotations of a woman 'being cold' and 'unresponsive' sexually.

5. SEXUAL PLEASURE MAY BE REDUCED BY FOCUSING ON PERFORMANCE.

FACT. Focusing on reaching orgasm or 'performing' well may sometimes decrease sexual pleasure and arousal and preventing the person from reaching orgasm. In such cases, it can be defined as a sexual problem. Women with certain disabilities or those who are certain medications can have problem with arousal and lubrication.

6. SEX IS PERFECT THE FIRST TIME IT IS EXPERIENCED.

MYTH. The first time an individual has sex can be pleasurable, painful, uncomfortable or anything in between. There is never any right or wrong way to experience sex and if it is a painful or uncomfortable experience it can result from many factors.

7. MASTURBATION DOES NOT CAUSE SEXUAL PROBLEMS LIKE ERECTILE DYSFUNCTION OR PREMATURE EJACULATION IN MEN.

FACT. Masturbation is a safe and enjoyable activity that is not harmful in any way. Both men and women masturbate. Masturbation does not affect one's sex life negatively. It does not cause weakness, stunted growth, pimples, or any psychological problems.

8. IF A WOMAN IS NOT SATISFIED IN A HETEROSEXUAL RELATIONSHIP, IT IS BECAUSE THE MAN'S PENIS IS NOT BIG ENOUGH FOR HER.

MYTH. If the penis is about 2 inches long when erect, a man can arouse and satisfy his partner. This is because the first 1.5-2 inches of a woman's vagina has the maximum nerve endings, responsible for sensation. More than the vagina, it is the clitoris, located outside the vagina, above the urethra (urinary opening) that is sensitive to stimulation. The length of the penis has nothing to do with a woman's ability to experience sexual pleasure. It is technique, not size, that matters.

9. IF A WOMAN DOESN'T FEEL PAIN THE FIRST TIME SHE HAS SEX WITH A PARTNER, IT MEANS THAT SHE HAS HAD SEX BEFORE.

MYTH. Often people think that women will experience pain the first time they have sex because the hymen, a thin and highly elastic membrane present in the vagina, will rip from penetration of the penis. The hymen may, however, tear during the course of running, cycling or exercising, or at any point in life; not necessarily related to sexual activity. It is also possible that an intact hymen stretches during intercourse but does not tear. Therefore the presence or absence of an intact hymen and/or pain during intercourse does not indicate whether or not a woman has had sex before. There is no 'proof of virginity' for either a woman or a man.

10. THE LONGER A MAN TAKES TO EJACULATE, THE BETTER, BECAUSE HIS PARTNER WILL FEEL MORE PLEASURE AND ENJOYMENT.

MYTH. Sexual pleasure is subjective and cannot be generalised. Some partners may feel more pleasure if a man takes a long time to ejaculate while others may not.

11. A MAN'S FAILURE TO GET AN ERECTION CAN BE ATTRIBUTED TO A COMBINATION OF PHYSICAL AND PSYCHOLOGICAL PROBLEMS.

FACT. Inability to get an erection can be because of psychological problems such as nervousness about not being able to 'perform' or discomfort with a partner, as well as physical problems related to health conditions or the side-effects of medications or drugs. Inability to maintain erection or have an erection is also seen in certain kinds of physical disabilities.

12. WOMEN WHO MASTURBATE ARE OVER-SEXED AND THEIR PARTNERS WILL FIND IT DIFFICULT TO SATISFY THEM.

MYTH. Masturbation is not a sign of being 'over-sexed'. Both men and women masturbate. Masturbation is one of the safest sexual practices, and a way of experiencing pleasure without the risk of unwanted pregnancies or contracting STIs including HIV/AIDS. Sex therapists believe that if one is able to have a healthy sexual relationship with one's own body, chances are that they will enjoy sex with a partner more.

13. WOMEN MAY EXPERIENCE PAIN DURING SEX FOR REASONS OTHER THAN INFECTIONS OR INJURY.

FACT. Pain during sex can be from physical causes, and also emotional and psychological ones, such as discomfort with a partner or the partner's sexual technique.

HANDOUT N: PARTICIPANT COPY: MYTHS & FACTS ON SEXUAL PROBLEMS

State whether each statement is a Myth or a Fact and give reason

1. Men are more sexual than women.
2. If a man cannot ejaculate, he has a medical problem.
3. If a man cannot ejaculate, it is his partner's fault.
4. Women are frigid if they cannot have sex or find it painful.
5. Sexual pleasure can be reduced if the focus is on 'performance'.
6. Sex is perfect the first time one has it.
7. Masturbation does not cause sexual problems like erectile dysfunction and premature ejaculation in men.
8. If a woman is not satisfied in a heterosexual relationship, it is because the man's penis is not big enough for her.
9. If a woman doesn't feel pain the first time she has sex with a partner, it means that she has had sex before.
10. The longer a man takes to ejaculate, the better, because his partner will feel more pleasure and enjoyment.
11. A man's failure to get an erection can be attributed to a combination of physical and psychological problems.
12. Women who masturbate are over-sexed and their partners will find it difficult to satisfy them.
13. Women may experience pain during sex for reasons other than infections or injury.

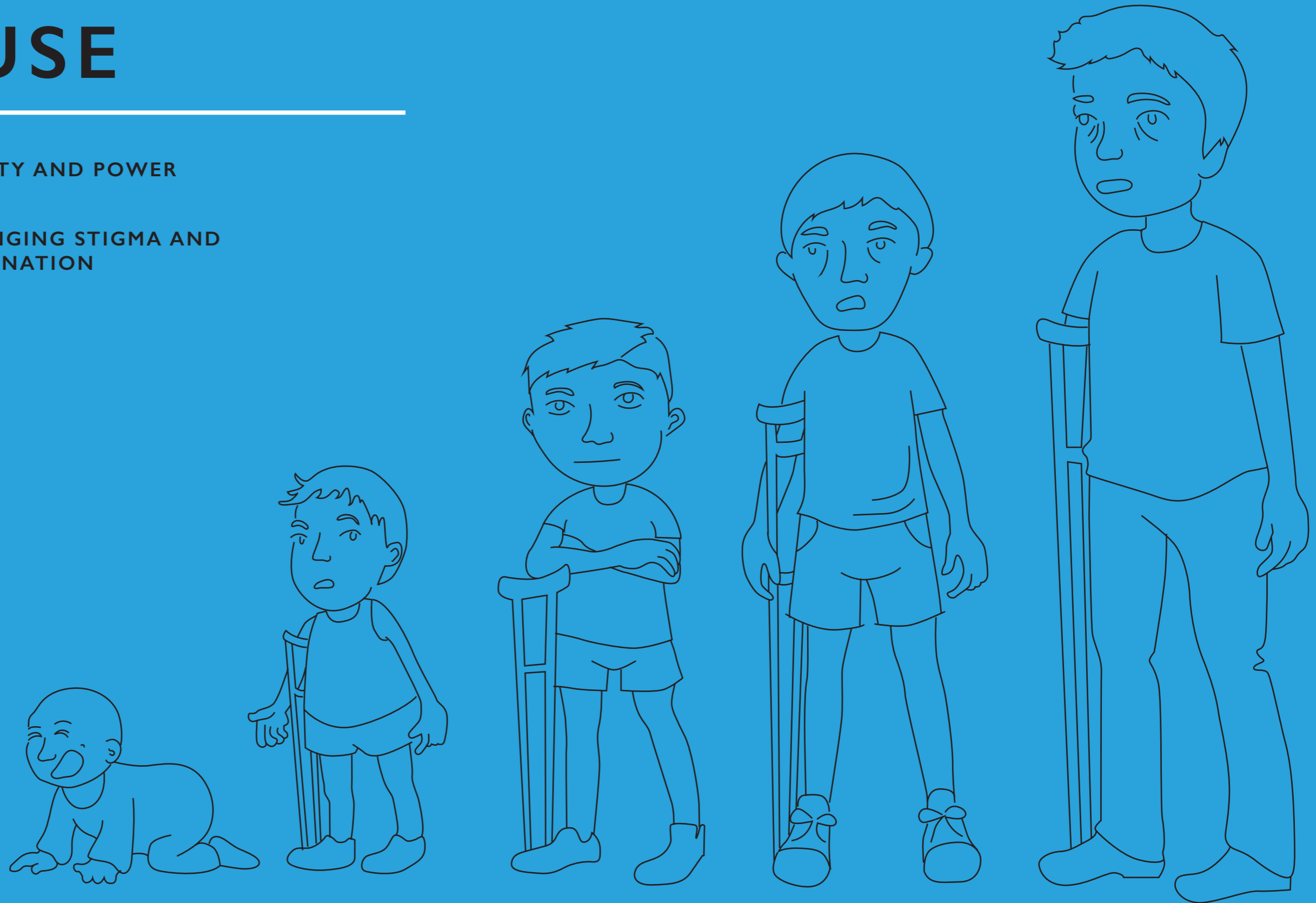
MODULE

4

SEXUALITY, POWER AND ABUSE

CHAPTER 10
SEXUALITY AND POWER

CHAPTER 11
CHALLENGING STIGMA AND
DISCRIMINATION



CHAPTER 10: SEXUALITY AND POWER

WHY A CHAPTER ON SEXUALITY AND POWER

This chapter examines power and its connection to sexuality, sexual and reproductive health and human rights. It examines the role and influence of power in the lives of people and communities we work with. For example, sexual assault and abuse of persons with disabilities— whether in the form of gender-based violence, rape, intimate partner violence, or child sexual abuse – can be better understood through the lens of power and use of power.

However, we must recognize that power is not always abusive. When consensual, exchanging power can also be affirmative and contribute to sexual pleasure. Abuse occurs when a power exchange loses the elements of consent and choice.

This chapter covers a number of concepts related to power, such as power that comes from having certain opportunities, to power examples in situations of gender-based violence and child sexual abuse, among others.

CHAPTER OBJECTIVES

1. To have participants define and understand the concept of power.
2. To have participants connect the concept of power to issues of sexuality, sexual and reproductive health and human rights.
3. To dispel myths and introduce facts about existing forms of sexual violence and abuse.

KEY MESSAGES

- Power operates under many influences and is experienced in different ways. These experiences vary with age, class, caste, gender, educational status, disability, access to services, and HIV status among others.
- There are many players/people who influence an individual's decisions and thereby hold some power in their lives. These can be community, family, and larger political or legal systems.
- Power imbalances are not only confined to certain genders and sexual identities. Persons with disabilities also suffer due to such imbalances. For example, women are not always the ones who experience gender-based violence; transgendered people can also face this form of violence.
- Changing political climates and the people we are connected to can continually alter

how we view and experience the power dynamics in our lives.

- Power can manifest itself in inequalities, violence, and abuse against persons with disabilities. However not all power is abusive or negative. Power exchanges can also provide sexual pleasure. It is in non-consensual situations that power is abused.
- Choice and power are never absolute and all choices are based on the situations and contexts of people's lives.

SESSION 18: UNDERSTANDING SEXUALITY AND POWER

PURPOSE: 1. To define the concept of power.
2. To relate the concept of power to sexuality.

TIME: 60 minutes

AGE GROUP: 18 and above

LITERACY LEVEL Anyone

MATERIALS: Flipchart, markers

SESSION INSTRUCTIONS:

1. Divide the participants into two groups. Give the groups 15 minutes to discuss and list out answers to the following questions:
Group 1: What do you think you have the power to do in your life? What do you think has power over you in your life? What gives you power?
Group 2: Where/when has power been used against you in your life? Where/when have you used power over others in your life? Do you think your disability denies you power?
2. Bring the groups back together to present their list and ideas. Write these on a flipchart and after all the group presentations, ask for questions and comments:

SUGGESTED QUESTIONS:

- Do you agree or disagree with the comments from each group? Do you have any comments or statements to add?
 - What can you say about power from these lists? Is it always positive or always negative? Can you define what power is from these lists?
 - Which players (people, organisations, political entities) from these lists are involved in the power one may/may not have?
3. After this discussion, ask participants to return to their groups and relate their questions to their sexuality this time. Give the groups 15 minutes to answer the following new statements:
Group 1: What do you think you have the power to do in your life with respect to your sexuality in the presence of physical disability? What/who do you think has power over your sexuality?
Group 2: Where/when has power been used against your sexuality because of disability? Where/when have you used your power over others especially in the context of sexuality?

4. Bring the groups back together to present their responses. Write these out on the flipchart. After presentations, ask for questions and comments.

SUGGESTED QUESTIONS:

- What can you say about power and its relationship to sexuality from these lists? Is it always positive or negative? Who are the people involved in the power you may/may not have?
- Do you think being a disabled person you have more or less power when it comes to issues related to your sexuality compared to other areas of your life?

KEY MESSAGES:

- Power can mean many things, from having access to services, to being able to express emotions, ideas and needs.
- Power has many influences and is experienced differently by each person. These experiences can vary with age, class, caste, gender, educational status, disability, HIV status and access to services.
- Those with greater opportunities because of their social groups and/or their family/ caste/class/race enjoy more benefits and power to make choices in their lives.
- Those people who lack access to opportunities may be 'left behind'. Human rights speak of equal access to opportunities for all people and help give people from different walks of life a level playing field.
- Power is expressed and experienced in many individual ways, can change over time and can be difficult to assess. Changing political climates and the people in our lives can continually alter how we view and experience power dynamics.
- Power can manifest itself in inequalities, ableism, violence, and abuse, but not all power is abusive or negative. Power exchanges can manifest as consensual sexual behaviour and provide sexual pleasure. It is only when consent and choice are removed that power is abusive.

SESSION 19: ABUSE OF POWER: CHILD SEXUAL ABUSE

PURPOSE:	1. To discuss and develop awareness of issues surrounding child sexual abuse. 2. To learn facts about child sexual abuse and how it relates to power.
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Flipchart, markers, index cards/slips of paper, Handout O: Facilitator Copy: Myths and Facts About Child Sexual Abuse, Handout P: Participant Copy: Myths and Facts About Child Sexual Abuse
ADVANCE PREP	Review Handout O; write out each of the statements from Handout P on separate index cards/slips of paper.

SESSION INSTRUCTIONS:

1. Introduce the topic of child sexual abuse to the participants. Use the points from key messages as reference.
2. Distribute the index cards/slips of paper with statements from Handout P. Ask participants to read their statements aloud one at a time. After each statement, ask the group if they believe it to be a myth or a fact. The facilitator should fill in any gaps in information and give relevant information provided in Handout O. It may be useful to write some key points on the flip chart beforehand.
3. After going through all the statements, ask for questions or comments.

SUGGESTED QUESTIONS:

- Are there any other thoughts about child sexual abuse you want to share? Are these myths or facts?
- Why are there so many myths associated with child sexual abuse?
- How does child sexual abuse relate to the concept of power? Does it imply and involve an imbalance of power in any relationship?

KEY MESSAGES:

- Child sexual abuse exists all over the world, in different cultures and communities.
- Child sexual abuse includes any exploitative sexual activity by a person who, by virtue of their power over a child, due to age, strength, position or relationship uses the child to meet their sexual or emotional needs.
- Children with disabilities may be more vulnerable to abuse because they are in close contact/proximity with care-providers and may not have the ability to communicate

this abuse to anyone.

- Children with disability many times are not sure of what is happening to them or their bodies, and nor are they able to clearly express their own discomfort – because of which, many times, these issues do not even come to the surface.
- The child sexual abuse a child with disability is undergoing is often swept under the carpet as a “mistake” the child is making in understanding the affections of an adult
- Alongside, the fact that a disabled body is not seen as “attractive”, society and care givers/ family members further perpetuate this idea that “this can’t happen to a disabled person - because they are “unappealing/ unattractive.
- It is important to know the signs and issues related to child sexual abuse, to identify abusive situations, and to address them. Being on the alert for signs of child sexual abuse, such as changes in a child’s behaviour in school, increased aggression, bruises, STIs or urinary tract infections, or changes in the way children interact with adults and the way they use language can help identify and prevent child sexual abuse.
- Parents should speak with children about ‘good’ and ‘bad’ touch and make sure children are comfortable telling them if someone touches them inappropriately. Children who have been abused need to be reassured that the abuse was not their fault.
- Incest and abuse are different. Incest is sexual activity between individuals with familial relations. While abuse can occur between family members, it can also occur between non-family members.
- Paedophilia and child sexual abuse are not the same. Paedophiles are individuals who derive sexual pleasure and excitement only from fantasising or engaging in sexual activity with children. Child sexual abusers are individuals who have sexual relationships with adult partners and at the same time engage in sexual activity with children, which can include contact and non-contact behaviour such as fondling, kissing, forcing them to perform oral sex, or making them watch sexual acts, listen to excessive talk about sex or pose for sexual photos etc.

THIS EXERCISE CAN BE MODIFIED BY:

- Ensure that the next day also is a session day. Giving Handout P to participants to take with them rather than going over the topic. This may be best for groups with survivors of abuse who may not want to discuss the issue at length or are already aware of the issues.
- If they have any concerns or want to discuss or raise a point, they can discuss the same the following day at the session.

SESSION 20: WHERE ON THE LINE? THE CONTINUUM BETWEEN CHOICE AND COERCION

PURPOSE:	To enable participants describe the continuum of sexual choices; to recognize cases where sex is voluntary but not wanted; to clearly understand the right to say no to sex; to strengthen abstract thinking skills.
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Flipchart and markers; copies of the selected case studies; a long piece of rope or sturdy string; paper clips (or tape); coloured markers, if available, Handout Q: Case Studies on Sexual Choices and Sexual Coercion
ADVANCE PREP	Modify the handout as indicated in Handout Q: Case Studies in Sexual Choice and Sexual Coercion. Make four copies of the set of case studies you select.

SESSION INSTRUCTIONS:

1. Attach a string horizontally across the room. At one end label: “Completely forced, not desired” and at the other end label: “Fully voluntary, desired.”



2. Introduce the topic and explain that there is a continuum between sex that is forced and completely undesired and sex that is fully voluntary and desired. Ask:
 - What do we call sex that is forced? After they respond, add the word “rape” at that end of the continuum.
 - If a person agrees to have sex, does that always mean that he or she actually wants to have sex?

FOR FACILITATOR: *After they respond, ask: When sex is voluntary but not really wanted, would that be at one end of the string or somewhere in between the two ends? The answer is somewhere in between.*

3. Divide participants into four groups. Give each group a case study and a set of paper clips. Explain:
 - Read over each scenario in your group. Then talk it over and decide where on the string — the 0–10 continuum — you think the case study falls.
 - Mark the case with your names [with a coloured marker if available]. Then attach it with a paper clip at the place on the string where you have decided it fits.
4. Circulate among the groups and offer help. Allow them to spend extra time discussing their views even if they do not complete all the case studies.
5. After 15 minutes, ask someone from one group to read the first case study and explain where on the 0–10 continuum his/her group put it and why. Allow two to three minutes for the other groups to indicate where they put it on the continuum; encourage them to discuss any differences of opinion. Repeat this process for each case study.
6. Reserve twenty minutes at the end to discuss the following questions:
 - Forcing someone to have unwanted sex is a violation of that person’s human rights. By a show of hands, who believes that forced sex is common among young people? Who thinks it is rare?
 - If someone agrees to have sex, does it mean that they are doing it out of their own free will? [Note whether boys respond to this question similarly to how girls respond.]
 - Are girls and boys equally likely to have sex in a situation that is not forced but also not desired? [Probe: Do you think girls and boys usually share equal power in sexual relationships? What about adult men and women?] [Note: Emphasize that even if a situation does not fall at the extreme “forced” end of the spectrum it may, nonetheless, be unacceptable.]
 - Does a person always know whether his or her partner really wants to have sex? What are some ways to be sure? [Probe for: Ask the person! Talking it over together beforehand is best. What if you ask and your partner is not sure what he or she wants?]

CHAPTER 11:

CHALLENGING STIGMA AND DISCRIMINATION

People face stigma and discrimination on a daily basis if they are seen as different and therefore not as good as or lesser than the rest of society. These may be disabled people, young/unmarried sexually active people, people with more than one sexual partner, bisexuals, sex workers, older sexually active people, intersexed people, those who are HIV positive, people with mental illness and a range of other identities and practices that 'mainstream' society considers inappropriate or wrong. Stigmatized or marginalized people are often forced to adopt ways of living that can increase their vulnerability. For example, transgendered people in many countries are marginalised, resulting in restricted access to information, services and social support. Disabled people face barriers to Comprehensive Sexuality Education and their sexual and reproductive health is always neglected. This chapter increases participant awareness of diverse identities and choices, and emphasizes on rights for all people regardless of their identity or sexual behaviour. It also provides participants an opportunity to examine the consequences of stigma, discrimination and marginalisation and explores strategies to eliminate these attitudes and treatment.

CHAPTER OBJECTIVES

1. To have participants understand issues related to stigma, discrimination, and marginalisation in the context of sexuality.
2. To have participants recognise the adverse effects of stigma, discrimination and marginalisation on health and well-being.

KEY MESSAGES

- Stigma is a mark of shame or discredit to an individual or group and can be attributed to anyone who is considered different and/or 'deviant'.
- Discrimination means unfair treatment of a person or group on the basis of their identity, practices, race, caste, appearance etc.
- Marginalisation or the social process of becoming/being made marginal (especially as a group within the larger society) is a means to keep someone away from power, because of the choices they make in their identities, practices or appearance.
- Stereotyping is an oversimplified conception, opinion, or image of people or things. Judging others on the basis of stereotypes leads to prejudice, which is a precursor to stigma, discrimination and marginalisation.

- Ethnicity, gender, class, sexual identity, caste, disability are just some variables that can be used to stigmatise and discriminate.
- Culture regulates the lives of all people, but it does not do this uniformly. Some people/groups are regulated more than others. For example people who appear 'different' may be more regulated because they do not 'fit' into socially and culturally prevalent norms in terms of the way they look (fair, dark, disabled, tall, fat, thin etc.), behave or live.
- Most people engage in a variety of sexual behaviours other than those considered conventional even if they do not talk about it. Those engaging in sexual behaviour with mutual consent, without threat or coercion, have the right to do so without fear of being judged or punished. On the other hand, coercive sexual behaviour of any kind, even between regular partners or married partners, is wrong and unacceptable.
- In today's world, we are influenced by more than one set of cultures, traditions, and practices; we have multiple identities. Stigma can be experienced at multiple levels. For example, a woman with a disability who loves other women could face triple discrimination because of her gender, disability and sexual identity.

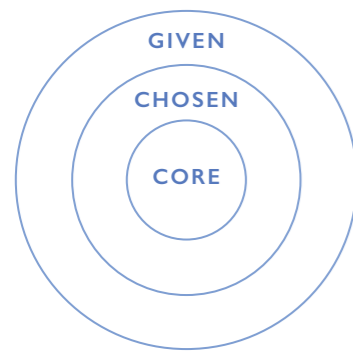
SESSION 21: STIGMA AND IDENTITIES

PURPOSE:	To examine stereotypes related to various identities and how these can stigmatise, discriminate and marginalise.
TIME:	45 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Flipchart with concentric circles drawn, Handout R: Stigma and Identities
ADVANCE PREP	Make copies of Handout R: Stigma and Identities for each participant.

SESSION INSTRUCTIONS:

1. Distribute Handout R to each participant along with a flip chart. Ask everyone to write the various identities listed in the handout in concentric circles, based on the level of stigma and discrimination they experience in their societies/communities. For example, identities that experience the least amount of discrimination will fall into the innermost circle, whereas the outermost circle will have the most marginalised identities. Give participants 10-15 minutes to fill the chart paper.
2. Invite participants to present their charts and explain the basis upon which they categorised identities. After 4-5 people have shared their views, ask for questions or comments.

This can also be done as a group work.



SUGGESTED QUESTIONS:

- Were there similarities among the least marginalised people? The most marginalised? How does society stigmatise some of these identities?
- What do the similarities indicate about certain identities? Are there some groups such as married men that experience the least stigma and most opportunities in society?
- Are there stereotypes associated with any of these identities? How would these stereotypes cause discrimination or marginalisation of those concerned?
- Who creates these stereotypes and decides what is 'normal'? Why/ How are these stereotypes and this marginalisation maintained? For example, do media images of certain identities help perpetuate these attitudes or do laws or customs in a community maintain this marginalisation?

- Do you think this kind of stigma is common? Is it different for persons with disabilities?
- Have you experienced or observed this form of stigma and discrimination in your community?
- What are the effects of this kind of discrimination on those experiencing it, on the community they live in, and accessing services related to sexuality and sexual and reproductive health?

KEY MESSAGES:

- Sexual identity refers to how people define themselves based on whom they are sexually attracted to - whether they are attracted to people of the same gender, a gender other than their own, or to many genders.
- Gender identity refers to whether a person thinks of themselves as a man, woman, or a different gender. As with sexual identity, many cultures and communities have prescribed rules for appropriate gender identities based on the biological sex of a person.
- Though they are connected, stigma, discrimination and marginalisation are different; a person can experience one without the other. For example, a person may be stigmatised for being a lesbian but because of other factors in her life (income, class, caste, race) she may not be marginalised.
- Often the more 'different' a person appears from the 'norm' in society, the greater the discrimination and marginalisation faced.
- Stereotypes maintained in society and communities contribute to stigma and discrimination against certain gender and sexual identities.
- Stigma and discrimination can result in violence, abuse or denial of services and information for individuals.

FACILITATOR'S NOTE:

- Participants may not be familiar with some of the identities listed. If necessary, go through the identities beforehand.
- Participants may express discomfort around some identities, especially those that are new to them or those considered 'wrong' according to their culture/religion. Be sensitive to this and encourage participants to participate.

SESSION 22: ACTING OUT STIGMA, DISCRIMINATION AND STEREOTYPING IDENTITIES

PURPOSE:

1. To identify stigma in day-to-day situations and experiences.
2. To discuss common stereotypes and reactions to these stereotypes.
3. To explore the origin of these stereotypes, how people and communities use them and their effects on individuals.

TIME: 90 minutes

AGE GROUP: 18 and above

LITERACY LEVEL: Anyone

MATERIALS: **Handout S: Acting Out Stigma and Discrimination and identifying stereotyping of identities (Case Studies)**

ADVANCE PREP: Make copies of Handout S: Acting Out Stigma and Discrimination and identifying stereotyping of identities (Case Studies)

SESSION INSTRUCTIONS:

1. Divide participants into small groups. Distribute a case study scenario from Handout S to each group. Ask participants to read their case study and answer the questions following it. Give them 25-30 minutes to discuss the case.
2. Bring participants back to the large group. Ask each small group to present a 3-5 minute summary of their discussion of the case. After each presentation, ask for questions and comments.

SUGGESTED QUESTIONS:

- How can you advocate to change attitudes that cause such stigmatisation?
- Were there any common forms of stigma and discrimination among the role-plays? Anything specific you saw involving persons with disabilities?
- Are the attitudes or stereotypes reflected in the case studies common in your community?
- What are the possible effects of this type of stereotyping? How would you advocate to change these attitudes?
- How do these cases illustrate stereotypes that are prevalent in society around the roles that men and women are expected to play? Are they positive or negative?
- How do these stereotypes impact people, especially those with disabilities in their day-to-day lives?
- How does this relate to human rights and sexuality, especially for persons with disabilities?

KEY MESSAGES:

- While extreme forms of stigma and discrimination resulting in violence or abuse sometimes get public attention, day-to-day subtle discrimination and marginalisation can also have devastating effects. For example, if homosexuals are denied jobs because of their sexual identity, it can have multiple impact: apart from diminishing their ability to be financially stable, it can cause low self-esteem and emotional distress.
- Often people with disabilities may be discriminated against unintentionally. It is important to raise consciousness on how people can stigmatise and marginalize others in their daily actions and environments.
- Marginalisation often results in exclusion of those most in need of care, information and services. For example, by refusing to acknowledge that sexual activity is common among young people or between men, these groups are denied information and access to sexual health services which would help them stay safe and healthy.
- Stereotypes of gender and sexual identities are commonly found and used by communities who do not understand the diversity of identities.
- Stereotypes can lead to prejudice, fear, shame, stigma and discrimination. They limit access to information and services to large groups of people by assuming that they do not deserve or require the information.
- Stereotypes and prejudice stem from lack of information about people who are considered different from oneself; some examples could include people with disabilities, those with different gender identities from one's own or those in the sex industry (sex workers, bar dancers and performers in peep shows, live sex shows, etc).
- In order to decrease stereotypes and allow people to live with respect and dignity, it is important to broaden knowledge and understanding of different identities and choices and be aware of the rights of all people.

HANDOUT O: FACILITATOR COPY:

MYTHS AND FACTS ABOUT CHILD SEXUAL ABUSE

ONLY GIRLS ARE VULNERABLE TO CHILD SEXUAL ABUSE.

MYTH: Both boys and girls are vulnerable to sexual abuse. However, since most available research on child sexual abuse focuses on the abuse of girls, statistics show a higher number of girls are abused than boys. Existent research on boys shows that boys tend to report abuse differently, denying it often or behaving as though they enjoyed it. This suggests that more boys are abused than we know, and more research is needed to get an accurate picture of the situation.

AN ABUSER CAN BE SOMEONE WHO KNOWS OR IS RELATED TO THE CHILDREN WHO THEY ABUSE.

FACT: Many times an abuser is a relative, acquaintance or friend of the family.

CHILD SEXUAL ABUSE (CSA) CAN INCLUDE BOTH CONTACT AND NON-CONTACT SEXUAL BEHAVIOUR.

FACT: CSA can include but is not limited to the following behaviours - fondling, kissing, being forced to perform oral sex, rape or other penetrative sex, made to watch sexual acts, forced to listen to inappropriate talk about sex, sexually fondled while being bathed, shown sexual movies or other pornography, made to pose for sexual photos etc.

PAEDOPHILES AND CHILD MOLESTERS ARE THE SAME.

MYTH: Child sexual abusers or child molesters can belong to the categories of either paedophiles or child molesters. Paedophiles are sexually fixated on children alone, while child molesters are people who have sexual relationships with adult partners and at the same time engage in sex or sexual behaviour with children as well.

CHILD SEXUAL ABUSE ONLY HAPPENS IN WESTERN COUNTRIES.

MYTH: This is a popular misconception. Child sexual abuse is a universal problem, affecting millions of children across the world. Although this is a problem worldwide, more reporting and research is available from western countries. Presently, extensive data on the prevalence of child sexual abuse in India is not available but this does not mean that it does not occur in the country.

CHILDREN WITH A DISABILITY CAN ALSO BE SEXUALLY ABUSED.

FACT: Children with disabilities are easy targets for abusers (if they are not mobile, they cannot move away from an abuser, for example), they may be unable to report the abuse because they cannot communicate or be understood by their care-providers or worse still if they are being abused by those who also care for their daily needs. Considering that almost 12 million children in India are disabled, the possible prevalence of sexual abuse of disabled children in India is alarming. This is even more of a problem because of societal denial of child sexual abuse, and because disabled children are often viewed as 'asexual' and hence not protected from possible abuse like their non-disabled siblings and peers may be. They are also denied any information on sexuality. Another damaging myth is that disabled children cannot be abused, since abusers find them unattractive and feel sorry for them is.

PLAYING DOCTOR OR OTHER TYPES OF CHILD PLAY IS ALWAYS SEXUAL ABUSE.

MYTH: Child sexual abuse has to do with an imbalance or exertion of power. If two friends of the same age play doctor, it is not child sexual abuse. In the same situation, however, if there is a difference in age - such as a 12 year old and a 4 year old, or children of different caste/class/races playing together - issues of power being exerted by one child over another may arise, in which case, it could be abusive.

CHILDREN WITH DISABILITIES WHO ARE SEXUALLY ABUSED MAY NOT TELL OTHERS FOR MANY REASONS AND EVEN DENY THE ABUSE.

FACT: While a small percentage of children report abuse when it happens, others may find it difficult to tell anyone because of multiple fears that accompany disclosure: fear of remembering, fear of losing love from their family, fear of shame, fear of blame or not being believed. Often children share a relationship with their abusers, especially when the latter is a parent or a family member and this makes it difficult for them to disclose the abuse to others for fear of being taken away from them. Another important factor that prevents disclosure is the children's lack of vocabulary to describe abusive sexual acts that they may be subject to.

CHILD SEXUAL ABUSE MOST OFTEN OCCURS IN LOWER CLASS FAMILIES.

MYTH: Child sexual abuse occurs in all socio-economic classes. Education and social class are no guarantees against abuse.

CHILD SEXUAL ABUSERS ALL SHARE THE SAME PROFILE AND CHARACTERISTICS.

MYTH: Sexual abusers of children can be anyone - fathers, mothers, siblings, stepparents, grandparents, and other family members (uncles, aunts or cousins), neighbours, caregivers, religious leaders, teachers, coaches, or anyone else who is in close contact with children. While more cases of men abusers are reported, there are a small proportion of women that sexually abuse children as well.

SEXUALLY ABUSED CHILDREN FORGET ABOUT THEIR ABUSE WHEN THEY BECOME ADULTS. IT IS BETTER TO FORGET ABOUT THE ABUSE ANYWAY.

MYTH: Individuals who experienced abuse as children deal and react to the abuse in different ways. Some may think little about the abuse as they get older and put the abuse behind them as much as they can, while others may have a tougher time recovering from such an experience and need more support and counselling to move forward. Either way, dismissing the feelings and emotions of a person, even years after the abuse, is insensitive and denies them the opportunity to speak about the experience.

HANDOUT O: PARTICIPANT COPY:

MYTHS AND FACTS ABOUT CHILD SEXUAL ABUSE

Indicate whether each statement below is a Myth or a Fact. Write (M) for a myth and (F) for a fact.

- Only girls are vulnerable to child sexual abuse.
- An abuser can be someone who knows or is related to the children they abuse.
- Child sexual abuse (CSA) can include both contact and non-contact sexual behaviour.
- Paedophiles and child molesters are the same.
- Child sexual abuse only happens in western countries.
- Children with a disability can also be sexually abused.
- Playing doctor or other types of child play is always sexual abuse.
- Children with disabilities who are sexually abused may not tell others for many reasons and even deny the abuse.
- Child sexual abuse most often occurs in lower class families.
- Child sexual abusers all share the same profile and characteristics.
- Sexually abused children forget about their abuse when they become adults. It is better to forget about abuse anyway.

HANDOUT Q:

CASE STUDIES IN SEXUAL CHOICE AND SEXUAL COERCION

INSTRUCTIONS:

Select some case studies (or write your own case studies). Be sure that your final selection includes at least one case in which a boy feels pressured to have sex. Modify them to be suitable and meaningful for participants.

MOHAMMAD AND AMMA: Mohammad wants to have sex but his wife Amma does not feel like tonight. She has been taught that it is a wife's duty to have sex whenever her husband wants it unless she feels sick or is menstruating, so she has sex with Mohammed.

NINA AND SUMIT: Nina, age 22, has been going out with Sumit for about six months. Nina is a person with disability and uses a wheel chair. Sumit has told her several times that he is attracted towards her and really wants to have sex with her, but only if she wants to. Nina feels unsure and is scared to go for it because of her body image issues but she thinks that she should do what her boyfriend wants. She knows other young women have sex with their boyfriends and is concerned that Sumit might leave her if she doesn't, although Sumit has never threatened to do so. The next time they are intimate, they have sex.

JACOB AND GRACE: Jacob and his friend Grace are alone at home. Grace is married and her husband is out for work. Jacob is a person with disability and uses crutches and leg braces. Grace really feels bad for Jacob as he hasn't been married because of his disability. Grace is always lonely in the absence of her husband. They both have developed liking for each other. Grace shows her compassion towards him by offering sex to Jacob. She tells him that she wants to make him happy but Jacob is not much interested in an intimate relationship. But Grace doesn't listen to him and tries to convince him and starts removing her clothes, unzips him and has oral sex. Jacob feels confused and is not sure what to do.

HARI AND MEENA: Hari and Meena have been kissing passionately. Meena is a girl with locomotor disability. When Hari starts to undress Meena, she tries to stop him and says, "No." Hari thinks she wants more but that she is worried about admitting it. So he keeps trying. After trying to push Hari away and saying "no" for five minutes, she eventually stops struggling and just lies there. Hari goes ahead and has intercourse with her.

AJIT AND ANILA: Ajit and Anila have met only a couple of times, always with supervision. They both have disabilities but of different kind. Their parents have arranged their marriage. Anila has been taught that everything related to sex is shameful. She has heard that it hurts the first time and will make her bleed. She is really scared. She hardly knows Ajit and feels ashamed at the thought of his touching her body. She isn't interested in having sex and doesn't feel excited, but she knows that when you get married, you must have sex on the wedding night. She lets Ajit have sex with her on their wedding night.

SHRUTI AND SEEMA: Shruti is in love with her classmate – Seema. But she is very nervous to say anything to her. She feels her having cerebral palsy will come in the way of her feelings. She thinks though its kind of "cool" these days to be gay so no one will judge her for that. She decides to come out to Seema – about being gay. Seema doesn't say much – but has been asking her to "show me how you people have sex".

ARJAN AND SALEEM: Arjan with macular degeneration (loosing vision in the eye) and has lost 80% of his eyesight. But his father's good job has given him a wonderful life. He has studied abroad, has a diploma in salsa dancing, is well dressed and lives quite an upmarket lifestyle. Saleem and he seem to be getting on very well, though Saleem also has a girlfriend he has said. Of late, Arjan and Saleem hang out and the rest of the group feels its more than just friendship. One of them, Saavan, asks Arjan if they are ""hooking up"". Arjan laughs and says – "Hell, Yeah!!" Saavan tries to warn Arjan that Saleem is not such a great guy – he's too smart, he will use Arjan. Arjan again laughs and says, "Bro, that's fine, I know, perhaps I am doing the same".

MANISH AND PAMMI: Manish, who is an above the knee amputee, and Pammi are in a relationship, they work in the same office Manish has wanted to keep it very quiet all these years – he feels he will be judged for being gay, and disabled and being in a relationship with a non disabled guy. All this will come in the way of his work – he feels. But of late some tensions have been brewing between him and Pammi. Pammi feels Manish is going away from him and in one office party – gets a little tipsy and hold Manish's face in his hands and kisses him on the mouth, in front of the office.

HANDOUT R: STIGMA AND IDENTITIES

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

BISEXUAL: An individual who is sexually attracted to people of the same gender and to people of a gender other than their own, and/or an individual who identifies as being bisexual.

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

ASEXUAL: An individual who is not sexually attracted to other individuals.

TRANSGENDER PERSON: An individual who does not identify with her/his assigned gender. Transgendered people may or may not identify as homosexual, bisexual or heterosexual. For example transgendered people can be men who dress, act or behave as women do, but do not necessarily identify as homosexuals.

TRANSSEXUAL: An individual who wants to change from the gender they are born as to another gender. Surgery, hormonal treatments, or other procedures can be used to make these changes. People in this group may or may not identify as homosexual, bisexual or heterosexual.

INTERSEX PERSON: An individual born with some or all physical characteristics of both males and females. They may or may not identify as men or women.

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

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

QUEER: Those who question the heterosexual framework of identity and relationships. This can include homosexuals, lesbians, gays, intersexed and transgendered people as well as heterosexuals. To some this term is offensive, while other groups and communities have adopted it as a statement of empowerment to assert that they are against a dominant heterosexual framework, and dissatisfied with the labels used to categorise people on the basis of sexuality.

TRANSVESTITE: An individual who dresses in the clothing typically worn by people of another gender for sexual arousal and gratification. Often transvestites are men who dress in the clothing typically worn by women.

FEMALE TO MALE TRANSSEXUAL: A person born as a woman who wants to change her gender to become a man. Surgery, hormonal treatments, or other procedures may be used to make these changes. This individual may or may not identify as homosexual, bisexual or heterosexual.
Male to female transsexual: A person born as a man who wants to change his gender to become a woman. Surgery, hormonal treatments, or other procedures may be used to make these changes. This individual may or may not identify as homosexual, bisexual or heterosexual.

MARRIED WOMAN: A woman who is in a committed relationship with another person that is legally recognised by the state/country she lives in.

MARRIED MAN: A man who is in a committed relationship with another person that is legally recognised by the state/country he lives in.

Unmarried woman: A woman who is not in a committed relationship with another person, which is legally recognised by the state/country, she lives in.

SINGLE PERSON: A person not married or in any committed relationship with another person.

SEXUALLY ACTIVE MAN: A man who engages in sexual activities.

SEXUALLY ACTIVE WOMAN: A woman who engages in sexual activities.

SEX WORKER: A person who negotiates and performs sexual services for remuneration. Some use this term to mean only prostitution, while others use the term to refer to those in the sex industry such as porn actors, bar girls, striptease dancers, performers in peep shows, live sex shows etc. This is not the social or psychological characteristic of a class of women, but an income-generating activity or form of employment for women, men and transgendered people .

HANDOUT S:

ACTING OUT STIGMA AND DISCRIMINATION AND IDENTIFYING STEREOTYPING OF IDENTITIES (CASE STUDIES)

CASE STUDY 1

Mr. and Mrs. Sharma decide to ask their tenants to leave well before their lease expires. This is because they have been hearing rumours that the two men are lovers.

- What stereotypes are presented in this case?
- Who and what create these stereotypes/representations?
- Do you think the landlord has a good reason to be concerned?
- How do these stereotypes affect relationships and society in general?
- How can these stereotypes be changed?

CASE STUDY 2

Rajeev is a sixteen-year-old boy with locomotor disability. He walks with leg braces and crutches. He is living in a large city. He goes to school, spends time with his friends, and loves spending time at home with his family. Rajeev likes to take care of himself. He is well dressed and makes sure his nails are clean and filed and his hair is well groomed. He waxes his arms and chest (even though he has barely any hair yet), and likes using his sister's moisturizers and creams. His family thinks it is funny that he spends more time grooming himself than his sister, and teases him. Rajeev also gets teased at school for the way he looks and behaves. There are three boys who especially pick on him, call him names and sometimes throw paper or garbage at him. They say that he is gay, a girl, and shouldn't be allowed in school. He is also teased and bullied for his disability.

Rajeev reacts strongly to the teasing sometimes, but does not want to change the way he acts or dresses. But he feels if he doesn't, he will always have to deal with this kind of ridicule and abuse.

Questions:

- What does Rajeev's behaviour indicate?
- Do you think Rajeev should change the way he dresses or acts in school or at home?
- How did the stereotypes displayed by his family and school mates get created?
- What impact do these stereotypes have on Rajeev's relationships with his family/friends and in society in general?

- How can these stereotypes (disability, gender and sexual identity stereotypes) be changed?

CASE STUDY 3

Soni who is a wheelchair user has been in love with Ali. They studied together at the University and have been going out since their first year of post-graduation. Now they have decided to marry. Soni is the daughter of a prominent, well-respected Hindu family. She has a sister, brother and a large extended family. The girls of her family are said to be as dutiful as they are beautiful and the boys are considered 'real men': strong, courageous and highly regarded in their businesses as honest and upright. Ali comes from a Muslim family, not as wealthy as Soni's but very well-respected in their home-town.

Everyone is shocked to know Soni's decision of marriage and that too with a Muslim boy. Soni's parents are unhappy at her choice of husband. Her father even tells her that once she returns to her family, away from her college, she will change her mind.

Ali's mother is also distressed. She doesn't want her son to marry a disabled girl. The family tries to convince Ali to forget the marriage, but so far it has not worked and Ali has not changed his mind.

Questions:

- What stereotypes are presented in this case?
- How do the stereotypes displayed by the families of caste/race/religion/disability get created?
- Who and what create these stereotypes/representations?
- Do you think the parents have a good reason to be concerned?
- How do these stereotypes affect relationships and society in general?
- How can these stereotypes be changed?

CASE STUDY 4

Onima is a single parent with two children one of who has a locomotor disability (LMD). One day she sees her children fighting and hitting some other children. When she goes to stop them, her kids tell her that the fight happened because the other kids were calling them names particularly the one with the disability and abusing them with comments such as "you are handicapped – you cant do anything for yourself what will you do to us?".

Questions:

- How was stigma and discrimination portrayed in the case studies?
- Do you think this kind of stigma is common? Is it different for persons with disabilities?
- Have you experienced or observed this form of stigma and discrimination in your community?

- What are the effects of this kind of discrimination on those experiencing it, on the community they live in, and accessing services related to sexuality and sexual and reproductive health?
- How this gets amplified for persons with disabilities?

CASE STUDY 5

Tanya, is a person who walks with calipers. She is well qualified for the job she has applied for and initial email and telephone communication between them has been positive. After two rounds of face-to-face interviews and many attempts to follow up, however, she has not got an affirmative response from them. Finally she is called for a meeting with the manager who seems uncomfortable. Tanya is told that 'she does not fit the look' of the organisation. The organisation is very traditional and cannot accommodate her 'type' of person.

Questions:

- What is the discrimination that is presented in the case?
- Is there a stereotype presented here?
- How do the stereotypes displayed by the organisations regarding caste/ race/ religion/ disability get created?
- Who and what create these stereotypes/representations?
- Do you think that Tanya should have gotten the job?
- How do these stereotypes affect relationships and society in general?
- How can these stereotypes be changed?

CASE STUDY 6

Amir is the 16-year-old son of conservative parents. His parents are sending him to live for a few months with his relatives in nearby town to 'toughen' him up. They say that he is too sensitive – cries when "small" things happen to him, and is shy and 'weak'.

Questions:

- How was stigma and discrimination portrayed in the case studies?
- Do you think this kind of stigma is common? Is it different for persons with disabilities?
- Have you experienced or observed this form of stigma and discrimination in your community?
- What are the effects of this kind of discrimination on those experiencing it, on the community they live in, and accessing services related to sexuality and sexual and reproductive health?
- How this gets amplified for persons with disabilities?

CASE STUDY 7

Sasha is 24 and her family is looking for a suitable man for her to marry. Sasha's father had a brief episode of mental illness in his youth, which some people in their extended family know about. Sasha overhears a conversation between a family members on what they ought to do to get her married off to the next person who agrees

Questions:

- How was stigma and discrimination portrayed in the case studies?
- Do you think this kind of stigma is common? Is it different for persons with disabilities?
- Have you experienced or observed this form of stigma and discrimination in your community?
- What are the effects of this kind of discrimination on those experiencing it, on the community they live in, and accessing services related to sexuality and sexual and reproductive health?
- How this gets amplified for persons with disabilities?

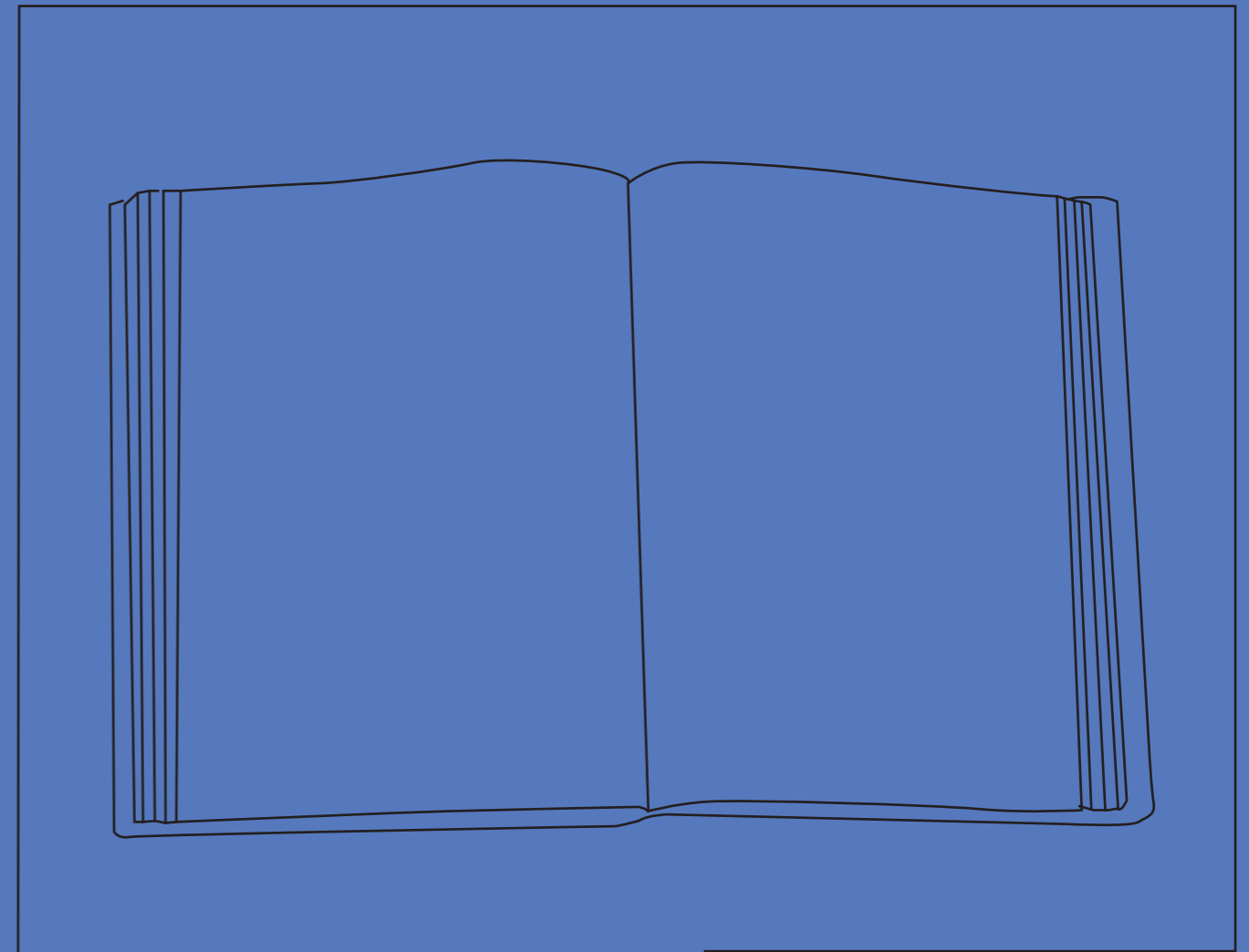
MODULE

5

SEXUAL AND REPRODUCTIVE RIGHTS

CHAPTER 12
HUMAN RIGHTS

CHAPTER 13
REPRODUCTIVE AND SEXUAL HEALTH
AND RIGHTS



CHAPTER 12: HUMAN RIGHTS

WHY A CHAPTER ON HUMAN RIGHTS?

Everyone has the right to life, liberty and security of person (Article 1 of the Universal Declaration of Human Rights). Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Part of Article 2 of the Universal Declaration of Human Rights). The human rights system has expanded and developed, as have the ways in which people use and recognise human rights.

This chapter provides a basic understanding of human rights, why a human rights framework can be an effective approach to health and advocacy, how to use the human rights system and its framework, and how to make linkages and discuss connections between human rights, sexuality and sexual and reproductive health.

CHAPTER OBJECTIVES

1. To inform participants about the basics of human rights.
2. To briefly outline the history of the human rights system and structure including the charters, treaties, conventions, agencies, and governing bodies included in this structure.
3. To discuss a rights-based approach to sexuality, sexual and reproductive health, and advocacy.

KEY MESSAGES

- Human rights system has a wide range of rights, from the right to health to the right to freedom from torture. All these rights are essential to individual's well-being and dignity. The creation of a human rights system is an important way of upholding and making States accountable to respect, protect and fulfil these rights for all people.
- While human rights have been placed into a codified system, they are not just a conceptual/ theoretical system but can be concretely applied to each person's life.
- If the facilitator is unfamiliar with regional policies on human rights or the human rights doctrines and treaties signed by their respective countries, it may be useful to do research on these issues before conducting the exercises.

SESSION 23: HUMAN RIGHTS TREE

- | | |
|-----------------|--|
| PURPOSE: | <ol style="list-style-type: none"> 1. To understand and describe the concept of human rights and relate it to our own life and needs. 2. To understand and discuss a rights-based approach to health and advocacy. |
|-----------------|--|

TIME:	90 minutes
--------------	------------

AGE GROUP:	18 and above
-------------------	--------------

LITERACY LEVEL	Semi-literate
-----------------------	---------------

MATERIALS:	Paper, scissors, tape, markers, pen/ pencils, Handout T: An Overview on Human Rights
-------------------	---

ADVANCE PREP	Review Handout T and Handout T1.
---------------------	---

SESSION INSTRUCTIONS:

1. Divide participants into small groups.
2. Give each group scissors, markers, tape and paper. The participants will use these materials to construct a human rights tree.
3. To construct the human rights tree, first instruct participants to draw a trunk for the tree. They should then use the paper to cut out leaves for the trees (these do not need to be perfectly shaped). On each leaf, ask participants to write one right necessary to lead lives equal in respect and dignity. These rights can range from the right to health to the right to own property, the right to vote etc. Give participants 20-25 minutes to construct their tree.
4. After they complete the trees, invite each group to come up and present their tree to the large group and explain the process and contents of their tree. After all the presentations, ask for questions and comments.

SUGGESTED QUESTIONS:

- Are there similarities between the trees? Are some rights on all the trees? Why? Do these common rights indicate something about the communities, countries, and states we come from or our general needs? Would it be different for groups from another country or region?
- Are all these rights equally important, with no single right being more important than another? Do these rights support and have connections with each other?
- Should people always have these rights? What would happen if they were taken away?
- Do you understand these basics of human rights and how they are organised?

- Can you see connections between these rights and the rights you wrote down on your human rights trees? Do you see how the current social structures, systems and socio-political environment can uphold the rights you wrote on your trees?
 - Are there any flaws in the way the system has been defined and set up?
5. Keep these human rights trees up on the walls throughout the training to refer to and observe whether ideas and attitudes about rights change or evolve during the training.
 6. Distribute Handout T to each participant and read through this with them. Ask for questions or comments.

KEY MESSAGES

1. While human rights have been arranged into a codified system, they are not just a theoretical framework and do apply to each person's life. This can be seen in the links between what is written on the trees and the formal system outlined in Handout T and Handout T1.
2. Human rights as a system encompasses a wide range of rights, from the right to health to the right to freedom from torture. They are all essential to individual well-being and dignity.
3. Human rights are not the same as laws. Ideally, laws help to protect and fulfil human rights, but this is not always so. For example, some countries in South and Southeast Asia do not have laws that recognise or provide protection against marital rape, which violates the right of an individual to live a life free from violence and abuse.

CHAPTER 13:

REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

WHY A CHAPTER ON REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

In essence, reproductive rights concern the rights of people to reproduce, or not reproduce, free of discrimination, coercion and violence. Access to sexual and reproductive health services for people with physical disabilities is largely neglected, and people with physical disabilities are generally excluded from sexual and reproductive health education. Reproductive rights are meant to create the conditions in which reproduction can be controlled by women and men. These rights are borne out of reproductive health that emphasises the 'physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life' (World Health Organisation (WHO)). Reproductive rights and reproductive health are often discussed at the same time as sexual rights and sexual health. For example, individuals can choose to lead a sexual life whether or not they want to reproduce. At the same time, reproductive rights may merge or overlap with sexual rights, as when making a choice to have children or not. This decision could be influenced by the choice to be sexually active or not in the context of a heterosexual relationship, unlike in the case of a same-sex couple contemplating alternative reproductive technologies.

This chapter discusses reproductive health and rights. It also highlights the overlaps and distinctions between sexual and reproductive health and rights, and engages participants in discussion and analysis of these topics. For more information on United Nations Convention on Rights for Persons with Disabilities (UNCRPD) see Handout U1.

CHAPTER OBJECTIVES

1. To have participants understand what reproductive and sexual rights mean.
2. To have participants discuss the connections between reproductive and sexual rights and reproductive and sexual health.
3. To have participants examine the differences and overlaps between reproductive health and rights, and sexual health and rights.
4. To shift participants from a conceptual understanding to practical application of a rights-based approach to advocacy.

KEY MESSAGES FOR THIS CHAPTER:

1. All individuals including persons with disabilities have the right to make reproductive choices based on their circumstances, needs, desires and preferences.
2. Individuals with disabilities also have the right to make their reproductive choices free of fear or coercion from family, society and the State (for example, as in the case of population policies).
3. Reproductive rights mean having access, options, and services related to reproduction as well as the right to choose when, how and with whom these options and services are accessed.
4. Reproductive and sexual health and rights encompass a wide range of services, choices and information that should be available to a person. It is the responsibility of the State to ensure that these services are in place.
5. It is important to remember that the rights of any single person cannot infringe upon those of another. The reproductive rights of women are given priority over those of men because women bear more of the physical and emotional consequences of a pregnancy. Therefore the choice to have a child or not, or to have an abortion or not, is hers to make.
6. Whilst everyone has the right to rights, for persons with disabilities access Sexual and Reproductive Rights is even more difficult due to multiple reasons.

SESSION 24: MY REPRODUCTIVE RIGHTS AND SEXUAL HEALTH AND RIGHTS

PURPOSE:	To understand and discuss what is meant by reproductive rights.
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Any
ADVANCE PREP	Read Handout U - Basic Information on Reproductive and Sexual Health and Rights and make sure you understand all aspects of the definitions mentioned there. Read the questions on reproductive rights, sexual rights and select 4-5 questions from each set. Think of possible responses to the questions and how they relate to reproductive rights as described in the definitions.

SESSION INSTRUCTIONS:

1. Divide the participants into pairs or triads and have them sit together in the room.
2. Read out one question at a time from Handout U and allow participants 3 to 5 minutes to discuss it in their pairs or triads.
3. After this, change the combination of participants in the pairs/triads. Read out another question and allow new partners to discuss the questions for 3-5 minutes before moving onto the next question. Ideally each participant should have an opportunity to speak to every other.
4. Continue moving the line and asking new questions until you finish all questions. Have the group return to their seats to discuss the exercise.

SUGGESTED QUESTIONS:

- What did you learn from this exercise? What questions were easier to discuss? Why?
- Were there any questions you had not thought of before? How did you react when you heard them?
- In your discussions, who was considered to have a greater say in questions related to reproduction (i.e., men, women, family, community and others)? Why? What does this mean?
- Can you describe experiences in your life or any practical examples that come to mind relating to these definitions?

Give participants copies of Handout U and have them read it over.

KEY MESSAGES

1. All individuals including persons with disabilities have the right to make reproductive choices based on their circumstances, needs, desires and preferences.
2. Individuals with disabilities also have the right to make their reproductive choices free of fear or coercion from family, society and the State (for example, as in the case of population policies).
3. Reproductive rights mean having access, options, and services related to reproduction as well as the right to choose when, how and with whom these options and services are accessed.
4. Reproductive and sexual health and rights encompass a wide range of services, choices and information that should be available to a person. It is the responsibility of the State to ensure that these services are in place.

FACILITATORS NOTE:

- Keep in mind the exercise is very interesting and participatory but the bigger chunk of time and energy must be spent in discussing as many of the statements as possible – take your pick.
- Also, it is a very mobile exercise – so see how you can adjust the group. People with lesser mobility stand/ sit still and people with higher mobility change paces as described in the instructions. IF this does not work – don't worry. Then just mix up partners as much as you can, without causing too much discomfort to the group. The idea is for people to engage with a variety of opinions and voices.

HANDOUT T: DEFINING HUMAN RIGHTS

Human rights are a kind of promise/ undertaking containing two elements: what has been promised, for example, equality, non-discrimination, access to education and a binding duty to respond and make the promise a reality. Human rights are the freedoms and standards we must have in our lives to live in dignity and respect. They are universal, indivisible, interlinked and inalienable.

ARE THERE LIMITS TO THESE RIGHTS AND/OR HOW AN INDIVIDUAL CAN CARRY OUT THESE RIGHTS?

In living or trying to achieve these rights, you cannot unfairly encroach upon the rights of someone else. For example, an individual has the right to own property. However if when exercising this right an individual unfairly takes away or steals another person's property, s/he is now infringing on the other person's right to own property. Defining what a fair limit is and how far an individual or the State can go before infringing on another person's right, is also the subject of rights debates.

WHAT IS A RIGHTS-BASED APPROACH?

A rights-based approach considers the needs and well-being of each person, rather than the overall outcomes of a population to assess if the approach is appropriate. For example: A rights-based approach to health would work to guarantee that every individual with disability has access to health services that respond to their needs, and will allow them to assess the right services to use based on their needs and choices.

Human rights can be complex for people with disabilities to understand and apply effectively, especially in the context of sexuality and reproductive health.

HOW ARE RIGHTS ENFORCED AND SUPPORTED?

It is the duty of the State (i.e. the nation or Government) to ©these rights.

RESPECT: This means that the State and its agents cannot violate, abuse, or deny a person's rights.

Protect: This means the State must prevent a third party from violating, abusing, or denying a person's rights and if this happens, it must have a legal or other mechanism to respond to the harm, including penalties to the third party for such actions.

FULFIL: This means the State must take steps to organize all of its structures - including budgets, administration, legal structures and others - so that it can respond to right based needs. It will also work to improve conditions or create infrastructure to allow for people to access a right if they are not able to already do so.

Example: If looking at the right to vote, a State must respect that right by not preventing any person from voting, such as women, disabled or non-landowners. To protect this right, the State must

ensure that there are no barriers against any person who is able and willing to vote:

HOW CAN HUMAN RIGHTS VIOLATIONS BE REPORTED AND MONITORED?

Human rights issues can be brought up and challenged in at least three ways: on a national/ domestic level, on a regional level, or an international level. In some cases it is necessary to begin at the national level before moving to other human rights systems, but in general advocacy, one can use all three at the same time.

KEY PLAYERS IN ADVANCING HUMAN RIGHTS

They are Special Rapporteurs and Treaty Committees. These entities can drive forward new issues and standards, as well as fulfil existing international laws and standards. For information on UNCRPD (United Nations Convention on Rights for Persons with Disabilities)

Special Rapporteurs: These rapporteurs are independent experts on various issues (such as violence, housing etc.) of the UN system and are mandated to 1) write general reports submitted to a governmental human rights body; 2) go on two country missions each year to assess the rights conditions and prepare a report; 3) take up communication and complaints and when applicable take these up with respective governments. They can use any applicable international human rights standard in making their case. For example the Special Rapporteur for the persons with disabilities has the mandate to, among others, research and gathers information on violations of the rights of persons with disabilities, recommend on how to better promote and protect their rights, and to provide technical assistance to that purpose.

TREATY COMMITTEES:

These are groups of experts with oversight over each treaty on rights. The UN system has created a number of treaties (also referred to as charters, protocols, and covenants). Treaties, covenants and conventions are all international formal legal documents. These documents outline agreements between States that sign them. Every country that ratifies a treaty has agreed to the responsibilities laid out in the treaty/covenant and will make them part of their domestic legal obligations. Every country that ratifies must also send in a report on how this treaty is being followed. NGOs and other civil society groups can send in a shadow report to contradict or highlight areas that may be missed in the country report. Treaty committees can also hear complaints from individuals that claim human rights violations. The Committee on the Rights of Persons with Disabilities (CRPD), consists of a group of 18 independent experts (currently, most of them persons with disabilities), oversees promotion and implementation of the Convention. The experts are nominated by individual countries and then elected by the States that have ratified the Convention. All States are obliged to report regularly to the Committee on how the rights embodied in the Convention are being implemented in each of their countries. The Committee in turn, makes comments and suggestions for further progress, based on each of the reports. Civil society organizations and national human rights institutions also contribute to the reviews. The Committee is responsible for interpreting the Convention.

HANDOUT 11:

UNIVERSAL DECLARATION OF HUMAN RIGHTS

The Universal Declaration of Human Rights is a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures.

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 be independent, trust, non-self-governing or under any other limitation of sovereignty.

ARTICLE 3: Everyone has the right to life, liberty and the 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 him by the constitution or by 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 and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

ARTICLE 11:

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his 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 his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

ARTICLE 13:

1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

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 to 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 realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

ARTICLE 23:

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

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 himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

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 he is the author.

ARTICLE 28: Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

ARTICLE 29:

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.
2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

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

ARTICLE 30: Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

HANDOUT U: BASIC INFORMATION ON REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

Reproductive Health is defined by the World Health Organisation (WHO) as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth. (http://www.who.org/html/definition_.htm)

Reproductive Rights are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (ICPD Programme of Action, para 7.3)

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

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services; seek, receive and impart information related to sexuality;

- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage; decide whether or not, and when, to have children;
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others. (WHO 2002)

HOW ARE REPRODUCTIVE HEALTH AND RIGHTS DIFFERENT FROM SEXUAL HEALTH AND RIGHTS?

Reproductive health refers to health in the context of reproduction, not only of heterosexual people of the reproductive age group (between 15 to 45 years), but also people who are younger, older, lesbian, gay, with disabilities and non-procreative. Health-related issues of infertile people and those who seek assisted reproductive technologies are also part of reproductive health.

Sexual health refers to health around sexual matters independent of reproduction, and deals with issues like the prevention and cure of sexually transmitted infections (STIs), including HIV/ AIDS, and sexual problems. Sexual health is a sexual right in itself, but it is also a necessary condition for the fulfilment of sexual rights.

Sexual rights refer to the rights of all people to decide about matters related to their sexuality freely and responsibly. Because they deal with sexuality independent of reproduction, they are wider in their scope. In addition to safety from violence, they offer the promise of a right to pleasure and life enriching experiences. Because of their de-linking from reproduction, sexual rights also include the right to diverse forms of sexual expression, identity and practice. Therefore sexual rights also apply to people practicing non-heterosexual and non-reproductive sexualities and actively bring men into the picture.

QUESTIONS ON REPRODUCTIVE RIGHTS

1. What do you think is a good example of a 'reproductive right'?
2. How has a reproductive health choice impacted your life in any way? Give an example or two if you feel comfortable sharing.

3. What messages does your community/society give people about:
 - i. people with disability and abortion
 - ii. people with disability and adoption?
4. Does your society/community treat women with children differently from women without children?
5. Do you think you/people in your community could be married and not have children?
6. Do you think you/people in your community could stay single and have children?
7. Do you think women and men face similar pressures to be:
 - i. Married
 - ii. Parents
8. Who usually makes contraceptive choices: a woman, her partner, family, neighbors, any others?
9. Reproductive health is only a concern for people in a sexual relationship: Agree or Disagree?
10. Choosing not to have children is also a reproductive right. Agree or disagree?

QUESTIONS ON SEXUAL HEALTH AND RIGHTS

1. Have you ever exercised your sexual rights?
2. Has a sexual choice impacted you anyway?
3. Does the community or society you live in convey any messages on your sexual rights because of your disability?
4. Does the community or society you live in convey any messages on non-monogamous relationships?
5. Do you think men and women face similar pressures of abstaining from sex until marriage? In what other areas related to sexuality do you find similarities and differences?
6. Do you think men and women deal similarly and equally with the expectation of being in a sexual relationship and how so?
7. Sexual health is about having 'healthy' or 'good' sex: Do you agree or disagree?
8. Sexual health is of concern only to those in a sexual relationship: Do you agree or disagree?
9. To avoid rape or sexual harassment, women should not dress in revealing clothes: Do you agree or disagree?
10. Do you think sexual pleasure is a right? Why?
11. Homosexuals should access separate sexual health services from heterosexuals: Do you agree or disagree?
12. Do you think forced sexual activity is acceptable in marriage? Why or why not?
13. Transgender and disabled people also have the right to information on sexuality and sexual pleasure: Do you agree or disagree and why?
14. If a husband has sex with his wife against her wishes, it is a violation of her sexual rights: Do you agree or disagree and why?
15. People with disabilities can and do have sexual desires: Do you agree or disagree and why?

HANDOUT UI:

OVERVIEW OF THE ARTICLES OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

OVERVIEW OF THE ARTICLES OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Articles 1-4 are foundational Articles that articulate the purpose, definitions and general principles of the Convention and establish general obligations for States Parties.

ARTICLE 5: EQUALITY AND NON-DISCRIMINATION

Everyone is entitled to the equal protection and benefit of the law without discrimination.

ARTICLE 6: WOMEN WITH DISABILITIES

Countries must take all appropriate measures to ensure that women with disability are able to fully enjoy the rights and freedoms set out in the Convention.

ARTICLE 7: CHILDREN WITH DISABILITIES

The best interests of the child must be a primary consideration in all actions concerning children with disability.

ARTICLE 8: AWARENESS-RAISING

Countries must raise awareness of the rights, capabilities and contributions of people with disability.

ARTICLE 9: ACCESSIBILITY

People with disability have the right to access all aspects of society on an equal basis with others including the physical environment, transportation, information and communications, and other facilities and services provided to the public.

ARTICLE 10: RIGHT TO LIFE

People with disability have the right to life. Countries must take all necessary measures to ensure that people with disability are able to effectively enjoy this right on an equal basis with others.

ARTICLE 11: SITUATIONS OF RISK AND HUMANITARIAN EMERGENCIES

Countries must take all necessary measures to ensure the protection and safety of all people with

disability in situations of risk, including armed conflict, humanitarian emergencies and natural disasters.

ARTICLE 12: EQUAL RECOGNITION BEFORE THE LAW

People with disability have the right to recognition as people before the law. People with disability have legal capacity on an equal basis with others in all aspects of life. Countries must take appropriate measures to provide support to people with disability so that they can effectively exercise their legal capacity.

ARTICLE 13: ACCESS TO JUSTICE

People with disability have the right to effective access to justice on an equal basis with others, including through the provision of appropriate accommodations.

ARTICLE 14: LIBERTY AND SECURITY OF PERSON

People with disability have the right to liberty and security of person on an equal basis with others.

ARTICLE 15: FREEDOM FROM TORTURE OR CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

People with disability have the right to be free from torture and from cruel, inhuman or degrading treatment or punishment.

ARTICLE 16: FREEDOM FROM EXPLOITATION, VIOLENCE AND ABUSE

People with disability have the right to be protected from all forms of exploitation, violence and abuse, including their gender based aspects, within and outside the home.

ARTICLE 17: PROTECTING THE INTEGRITY OF THE PERSON

Every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others.

ARTICLE 18: LIBERTY OF MOVEMENT AND NATIONALITY

People with disability have the right to a nationality and liberty of movement.

ARTICLE 19: LIVING INDEPENDENTLY AND BEING INCLUDED IN THE COMMUNITY

People with disability have the right to live independently in the community.

ARTICLE 20: PERSONAL MOBILITY

Countries must take effective and appropriate measures to ensure personal mobility for people with disability in the manner and time of their choice, and at affordable cost.

ARTICLE 21: FREEDOM OF EXPRESSION AND OPINION, AND ACCESS TO INFORMATION

People with disability have the right to express themselves, including the freedom to give and receive information and ideas through all forms of communication, including through accessible formats and technologies, sign languages, Braille, augmentative and alternative communication, mass media and all other accessible means of communication.

ARTICLE 22: RESPECT FOR PRIVACY

People with disability have the right to privacy. Information about people with disability, including personal information and information about their health should be protected.

ARTICLE 23: RESPECT FOR HOME AND THE FAMILY

People with disability have the right to marry and to found a family. Countries must provide effective and appropriate support to people with disability in bringing up children, and provide alternative care to children with disability where the immediate family is unable to care for them.

ARTICLE 24: EDUCATION

People with disability have a right to education without discrimination. Countries must provide reasonable accommodation and individualised support to maximise academic and social development.

ARTICLE 25: HEALTH

People with disability have the right to the enjoyment of the highest attainable standard of health without discrimination.

ARTICLE 26: HABILITATION AND REHABILITATION

Countries must take effective and appropriate measures to enable people with disability to develop, attain and maintain maximum ability, independence and participation through the provision of habilitation and rehabilitation services and programmes.

ARTICLE 27: WORK AND EMPLOYMENT

People with disability have the right to work, including the right to work in an environment that is open, inclusive and accessible.

ARTICLE 28: ADEQUATE STANDARD OF LIVING AND SOCIAL PROTECTION

People with disability have the right to an adequate standard of living including food, water, clothing and housing, and to effective social protection including poverty reduction and public housing programmes.

ARTICLE 29: PARTICIPATION IN POLITICAL AND PUBLIC LIFE

People with disability have the right to participate in politics and in public affairs, as well as to vote and to be elected.

ARTICLE 30: PARTICIPATION IN CULTURAL LIFE, RECREATION, LEISURE AND SPORT

People with disability have the right to take part in cultural life on an equal basis with others, including access to cultural materials, performances and services, and to recreational, leisure and sporting activities.

ARTICLE 31: STATISTICS AND DATA COLLECTION

Countries must collect information about people with disability, with the active involvement of people with disability, so that they can better understand the barriers they experience and make the Convention rights real.

MODULE

6 ETHICS, VALUES AND PRINCIPLES

CHAPTER 14
VALUES AND PRINCIPLES



CHAPTER 12: HUMAN RIGHTS

WHY A CHAPTER ON VALUES AND PRINCIPLES?

Programmes and services must consider local and cultural sensitivities. In order to be effective and accessible, the development, implementation, and evaluation of programmes and services must be consistent with the cultural and community context. Different women and men have different needs, identities, choices, and life circumstances. Therefore, all women and all men do not have the same sexual concerns. Programmes must cater to the diversity among and within groups of people they serve. Also, programmes need to consider that people may have special needs based on different factors such as urban or rural location, sexual orientation, illness, culture, age, or disability.

Working on issues of sexuality, sexual and reproductive health, and rights requires an awareness of social values, as both personal and cultural values give meaning to people's lives and shape their behaviour and attitudes. This includes how people choose to express their sexuality and their reproductive or sexual health choices. At times these values influence people's health and well-being. For example, in many parts of the world there is a 'culture of silence' around talking about sexual issues and disability. Consequently, many people, especially women with disabilities, do not seek professional help for sexual health concerns, which is detrimental to their health and well-being.

In this chapter, participants will look at personal, professional, community, and cultural values. They will examine how these can change over time and how they are shaped by experiences, belief systems, and social and cultural surroundings. Acquiring clarity about these values allows for more effective work and advocacy and can be helpful in the resolution of value conflicts in ways that increase the autonomy of individuals and communities.

KEY MESSAGES

1. The basic values of choice, dignity, diversity, equality and respect underlie the concept of human rights. These affirm the worth of all people.
2. It is important to relate the values of choice, dignity, diversity, equality and respect to sexuality, sexual and reproductive health and rights in order to be able to work more effectively in these fields.
3. Developing Guiding Principles before conducting a project/ program/campaign can help people work effectively in a day to-day context.
4. Although core values can seem unconnected and difficult to apply in daily work, principles based on them and followed by organizations/workers can ensure that these values are carried out in the work being done.

SESSION 26: CLARIFYING OUR VALUES

PURPOSE:	To identify and clarify the practical applications of the Guiding Principles for working on Sexuality.
TIME:	60 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Handout V: Case Studies on Clarifying Our Values and Handout W: Guiding Principles for working on Sexuality.
ADVANCE PREP	Make copies of Handout V for each participant. Read Handout W to be abreast with Guiding Principles for working on Sexuality.

SESSION INSTRUCTIONS:

1. Divide the participants into small groups. Assign each group one of the case studies from Handout V. Give the groups 20-30 minutes to read the case studies and answer the corresponding questions.
2. Ask participants to return to the larger group and invite each small group to share their cases studies and discussions. After each presentation, ask for reaction and questions from other participants

SUGGESTED QUESTIONS:

- Do you agree with the conclusions of the group? Would you suggest an alternative?
- How did the application of the Guiding Principles help characters in the case?

KEY MESSAGES:

1. It is important to relate the values of choice, dignity, diversity, equality and respect to sexuality, sexual and reproductive health and rights in order to be able to work more effectively in these fields.
2. Using a positive, affirming approach to sexuality, rather than one based on fear, addresses both the pleasure and safety aspects of sexuality. A perspective that affirms sexuality encourages safer sexual practices, relationships and greater well-being.
3. Privacy has different meaning different for different people and ethical obligations differ in specific situations.
4. Persons with disabilities are often at higher risk of exposure to HIV. This is because PwDs (especially women and girls) are very vulnerable to sexual assault and violence.
5. People with physical disability can also face stigma and discrimination because of the myths and lack of information about it.

6. It is important to represent issues in sexuality, sexual violence, sexual and reproductive health and rights without bias so as to avoid further stigmatization and discrimination.
7. Women and girls with disabilities face widespread violence
8. Everyone has a equal responsibility to end violence against women and girls with disabilities

FACILITATOR’S NOTE:

To enhance on the key messages please refer to the Handout W: Guiding Principles for working on Sexuality. This exercise can be modified by:

- Choosing one or two cases to read together and discuss as a larger group. This can be helpful for groups having trouble with the concepts of the Guiding Principles and/or to focus the group on an issue that is pertinent to them.

**SESSION 27:
CLARIFYING OUR VALUES**

PURPOSE:	To identify and clarify the practical applications of the Guiding Principles.
TIME:	45 minutes
AGE GROUP:	18 and above
LITERACY LEVEL	Literate
MATERIALS:	Handout on Five Core Values, Flip chart/marker
ADVANCE PREP	Make copies of handout for each participant

SESSION INSTRUCTIONS:

1. Divide participants into five groups. Give each of the groups a value each and give them 15 mins to discuss the value
2. Ask them to create a short story, poem, song on the value, or on what the value represents, but the name of the value should not come anywhere in their story/poem/song. Eg. If the word is the value is respect – the word respect should not be directly used.
3. Ask the participants to come back to the larger group and one by one groups can present their story/song/poem. Ask the rest of the participants to guess the value represented.
4. Keep facilitating and moderating until the right value has been identified. Write the values on a chart paper.
5. Close the discussion by explaining the five core values and how they relate to sexuality, sexual and reproductive health, and rights.

KEY MESSAGES:

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

they relate to work on the ground. Being able to articulate the importance of these values correctly helps put them into practice and improves the quality of the service being provided or the communication material being prepared.

FACILITATOR'S NOTE:

Participants may be unsure how to enact a particular word or have trouble guessing the word for some of the values, especially if they do not understand its meaning. If the whole group cannot guess the word within 5 minutes, ask for synonyms, give them other hints or just tell them the word and have a discussion around it.

Participants may be confused because of the complexity of ideas in this exercise. Assure them that this is just the beginning, and these concepts will become clearer and more concrete during the training.

Other issues and topics may emerge during group work. For example, a group might do a skit on diversity illustrating different sexual or gender identities. This might arouse questions from the rest of the group. Avoid addressing these in depth at this point, and assure participants that these issues will be covered later so that the focus remains on the values that inform one's work.

THIS EXERCISE CAN BE MODIFIED BY:

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

MAKING CONNECTIONS:

The core values mentioned in this exercise underlie the principle of human rights. Values inform ethics and ethical principles, which can be then confided to guide people's work.

HANDOUT V:

CASE STUDIES TO UNDERSTAND OUR VALUES

CASE STUDY 1

School A is well known and respected in the city. It has recently taken the decision to introduce sexuality education for students including students with disabilities who are 14 years and older. The school authorities have approached a local NGO that is well respected in the community and has experience working on these issues to help. However, discussions between the school authorities and NGO staff have been stalled because the school is not comfortable with the idea of giving sexuality education to students with disabilities and do not want them to attend these classes. But the NGO thinks this will help students with disabilities talk freely about their concerns. The NGO staff has also said that they will respond to any questions by the students, including those on abortion and masturbation, and they may include a contraceptive demonstration if the need arises.

Questions:

- Do you agree with the school's approach? Why or why not?
- What Guiding Principles and values is the NGO trying to uphold by taking this stand with the school?
- How could the issue between the two be resolved?

CASE STUDY 2

Kavita, who has locomotor disability, is confused about some changes in her body and decides to speak to her sister-in-law about them. Kavita tells her sister-in-law that she is scared of the procedure of abortion because of her husband's refusal to use condoms, also, oral contraceptive pills are not advisable in her physical condition.

Questions:

- What should Kavita do in this situation?
- How can ask her husband be cooperate with her?
- What Guiding Principles and values would help you examine this case?

CASE STUDY 3

Ruchika has been working as a healthcare worker in a government run mother and child clinic for the past five years. Sonali has spinal muscular atrophy (a kind of locomotor disability), comes to the clinic with her mother. Sonali is 16 years in age. Sonali's mother wants to take some advice on menstrual management of Sonila. Ruchika suggests that they should go for hysterectomy or removal of uterus so that Sonali gets rid of her periods every month.

Questions:

- Do you agree with Ruchika in this case? Do you think she is violating any of the Guiding Principles or values?
- What other options should Ruchika consider?

CASE STUDY 4

Ramya, a 32-year-old woman with disability goes to the gynaecologist for a routine check-up. The doctor on duty asks Ramya why she has come for a check-up when she is disabled and she must be sexually inactive. Ramya says that she has read that women should undergo routine gynaecological check-ups after the age of 30 years, which is why she is here. The doctor looks concerned and asked again and adds on that she is also not married.

Questions:

- Should the doctor be asking Ramya such questions?
- What Guiding Principles and values should the doctor think of in this situation?

CASE STUDY 5

Dilip who has locomotor disability and walks with leg braces and crutches was very nervous about going to the voluntary counselling and HIV testing centre and STI clinic across the road from his college campus. His partner had insisted that they both go in for a check-up. He knew that his partner had other relationships before him and was afraid of what the tests would reveal. More than that, he was afraid of how his partner and he would be treated by the clinic staff. If the tests reveal that one or both of them have any infection, will the clinic staff inform Dilip's parents or the college authorities? His fears were dispelled when he read the information handout about the clinic and its activities. He felt reassured enough to take a chance and visit the clinic.

Questions:

- How should the staff treat Dilip when he goes to the clinic?
- What Guiding Principles should the staff uphold, that will reduce Dilip's fears?
- What kind of information do you think could have convinced Dilip to go to the clinic?

HANDOUT W:

GUIDING PRINCIPLES FOR WORKING ON SEXUALITY

BASED ON COMMON GROUND: PRINCIPLES FOR WORKING ON SEXUALITY, TARSHI 2001

AFFIRMATIVE APPROACH TO SEXUALITY: Sexuality is a complex, yet pleasurable and enriching part of people's lives. It can also have unwanted negative consequences and place one at risk of pain, disease, and violence. Messages received by people about sexuality mostly focus on its negative aspects and evoke feelings of fear, shame or guilt. Most programmes centre only on the importance of safer sex. They focus on unwanted pregnancy, STIs, and HIV, for example, as dangerous consequences of sexuality without acknowledging that pleasure is an equally important component of sexuality. Using a positive, affirming approach to sexuality, rather than one based on fear, addresses both the pleasure and safety aspects of sexuality. A perspective that affirms sexuality encourages safer sexual practices, relationships and greater well-being.

AUTONOMY AND SELF-DETERMINATION: Autonomy means the ability and right of individuals to make choices and decisions. Women and men have the right to make their own free and informed choices about every aspect of their lives, including their sexuality. Making decisions on behalf of others does not encourage autonomy. For women and men to make informed choices, they must have complete information about options.

RESPONSIVENESS TO CHANGING NEEDS: Women's and men's needs for information on sexuality and services change over time and throughout their life cycles. With the social, cultural, and technological changes that take place over time, emerging options, issues, and concerns will also differ. The sexual concerns of people also change in keeping with corresponding physical, emotional, and social changes. For example, an older woman going through menopause requires specific gynaecological interventions that differ from those needed by a younger woman.

COMPREHENSIVE UNDERSTANDING OF SEXUALITY: Issues of sexuality are complex and affect many aspects of a person's life. Programmes and services must take this into account and integrate emotional, psychosocial and cultural factors in planning and service delivery. For example, people with low self-esteem may not feel entitled to negotiate safer sexual behaviour. Improving their self-esteem will enhance their desire and capacity to take care of themselves.

CONFIDENTIALITY AND PRIVACY: Sexuality touches upon intimate aspects of people's lives. Everyone has a right to privacy and confidentiality. If people feel that their privacy and confidentiality are threatened, this will deter them from seeking information and services. This means that people have the right to seek anonymity, to not feel under compulsion to share information, and also the right to demand that information about them not be divulged to a third party. Services and programmes must ensure these rights. For example, counselling and health services must be provided in spaces where confidentiality is maintained and people feel safe enough to speak about their concerns without being overheard.

CULTURAL SENSITIVITY: Cultural perceptions about issues of sexuality differ among different groups and communities. Programmes and services must consider local and cultural sensitivities. In order to be effective and accessible, the development, implementation, and evaluation of programmes and services must be consonant with the cultural and community context. Considering cultural practices, traditions, beliefs and values of a community, and using culturally appropriate language enhances community acceptance of sexuality programmes and services.

DIVERSITY: Different women and men have different needs, identities, choices, and life circumstances. Therefore, their sexual concerns also differ. Programmes must cater to the diversity among and within the groups of people they serve. Programmes also need to take into consideration the special needs of people based on different factors such as urban or rural location, sexual orientation, illness, culture, age, or disability.

GENDER EQUITY: Programmes based on gender equity recognise the need to provide for women and men, girls and boys, to have equitable access to information, services and education that promote sexual well-being. Messages and programmes must cater to needs specific to each gender, but without perpetuating stereotypes or double standards about gender and sexuality. For example, programme staff should be careful in their words and actions to not perpetuate the stereotype that young men rather than women need to learn about sexuality, and also that women need to know about contraception.

NON-JUDGMENTAL SERVICES AND PROGRAMMES: People have different value systems, based upon which they make sexual choices. Providers and educators must respect the values that others hold and refrain from imposing their own values and judgements upon them. A non judgmental atmosphere encourages people to discuss their sexual concerns and access sexuality and sexual health information and services. For example, both an unmarried sexually active young woman and an unmarried sexually active homosexual older man need to be ensured acceptance and comfort before they visit a sexual health clinic.

ACCESSIBLE PROGRAMMES AND SERVICES: Accessibility entails more than availability of services. It includes issues of quality, activity, confidentiality, staffing, and capacity to cater to a range of needs. Women and men are more likely to use and be responsive to programmes and services that are non-threatening, provided by skilled and sensitive staff, available at times that do not conflict with their other obligations/schedules, and provided in safe, accessible locations. For example, a sexual health clinic for young people is more accessible if it is located in a place well connected by public transport and known to offer a range of services. If the clinic is known to offer only treatment for STIs, chances are that not many young people will go there.

PREVENT VIOLENCE, EXPLOITATION AND ABUSE: Many people experience their sexuality or initiation into sexual activity in violent, exploitative and abusive circumstances. Programmes and services must emphasise that consent and equity between partners are necessary conditions for healthy sexual relationships. Consensual sexual relationships are based on mutual respect and concern for one's own and one's partners' physical, mental and sexual well-being.

HANDOUT X: FIVE CORE VALUES

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

- CHOICE
- DIGNITY
- DIVERSITY
- EQUALITY
- RESPECT

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

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

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

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

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

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



<https://www.fat-net.org>