

GENDER AND VIOLENCE IN KEY POPULATIONS

FACILITATOR'S GUIDE



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Acknowledgements

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Acronyms

CBO	Community-based Organization
CRT	Crisis Response Team
DLSA	District Legal Services Authority
MSM	Men who have Sex with Men
MTH	MSM, Transgender and Hijra
ORW	Outreach Worker
PE	Peer Educator
PWDVA	Protection of Women From Domestic Violence Act
SLSA	State Legal Services Authority
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TG	Transgender person(s)
TI	Targeted Interventions
WWH	Working Women Hostel



Preface



The LINKAGES project has been unique to Alliance India in many ways. The team worked in close partnership with Mumbai District AIDS Control Society, Maharashtra State AIDS Control Society, and Andhra Pradesh State AIDS Control Society at the state level and District AIDS Prevention Control Units & Technical Support Unit at the district level. The project worked with various Targeted Intervention programme community leaders and stakeholders to improve access to health and linkages to social welfare schemes and other community-friendly referrals. But one of the very important work that was done in Linkages is working on the structural barriers faced by key populations – mainly men who have sex with men, transgender women and women in sex work – in addressing violence through activation of crisis response teams in 50 plus TIs across six PEPFAR priority districts in Maharashtra and Andhra Pradesh under LINKAGES.

Gender and violence are two sides of coins that often are equally proportionate against women and transgenders. Discrimination and violence are two ways of expressing gender based power relations. Gender based discrimination and violence is faced by women in sex work and transgender women very regularly. To me it is single biggest reason for lack of access to them. While gender discrimination affects women and transwomen most, it is also restricting men and boys in their full person. As programmers we have to be sensitive to the same and systematically plan to mitigate it. For the first time, we have organized gender sensitization training for targeted interventions and designed systematic violence prevention and mitigation plans. The training spans three days broadly covering gender, violence and advocacy, it has been designed exclusively for TI implementing NGOs and CBOs to enhance the understanding of Gender of TI implementing staff and address the issues of violence through strengthening crisis response teams within the TI setup.

The experiences of sex workers and transwomen in the field have enriched this manual and I sincerely hope it will help people dealing with issues that are gender nuanced. I sincerely thank my team and the team of FHI and SACS for letting us live our ideology and bring the reality of people on the ground to a cognitive processing. I am keen to see the gender relations change some day but till then I am also keen to see that we are able to respond to the people in the field more humanely and holistically.

Sonal Mehta
Chief Executive
India HIV/AIDS Alliance



Overview

About LINKAGES

The LINKAGES project (Linkages across the continuum of HIV services for key populations affected by HIV) supported by The President's Emergency Plan for AIDS Relief (PEPFAR) and The United States Agency for International Development (USAID), PEPFAR and USAID, is a global initiative that helps countries to use evidence-based approaches to make comprehensive HIV services easily available to key populations (KPs) such as female sex workers (FSW), people who inject drugs (PWID), men who have sex with men (MSM) and transgender persons (TG); and to sustain those services. The project is implemented by FHI 360 in partnership with India HIV/AIDS Alliance in six priority districts of PEPFAR in Maharashtra and Andhra Pradesh. It works towards strengthening capacities to address structural barriers with a focus on the KPs. It aims to help civil society organizations and private-sector providers to plan, deliver and optimize these services at scale to reduce HIV transmission among KPs and extend life for those who are living with HIV. India HIV/AIDS Alliance is supporting the LINKAGES project in its endeavor towards reducing structural barriers among National AIDS Control Programme (NACP) Targeted Interventions (TIs) around health care providers (HCPs), violence mitigation and improving organizational capacities to improve and increase health access.

LINKAGES enhances HIV prevention and care by improving the outreach to KP; promote routine HIV testing and counselling; enroll those who are HIV positive into care and support interventions; and enable them to remain in care.

About India HIV/AIDS Alliance

The India HIV/AIDS Alliance (Alliance India) is a diverse partnership that brings together committed organizations and communities to support sustained responses to HIV in India. Complementing India's National AIDS Control programme, Alliance India works through capacity building, technical support, knowledge sharing and advocacy. Working in 34 states and Union Territories through its vast network of partners, Alliance India supports the delivery of effective, innovative, community-based HIV programs to KP living with/affected by the HIV epidemic.

Background

As per the India HIV Estimation 2015 report, the total number of people living with HIV (PLHIV) in India is estimated at 21.17 lakhs in 2015 while two fifth (40.5%) of total HIV infections are among females. In the most affected regions, young women are two to four times more likely to become infected than men. These trends point towards the need to consider the dynamics between the broader cultural and socio-economic conditions and the increased vulnerability of women to HIV. Therefore, it is essential to understand the gendered nature of the epidemic so as to achieve the United Nations 90-90-90 objectives for 2020: 90% of all people living with HIV will know their HIV status, 90% of people diagnosed with HIV will receive sustained treatment, and 90% of people receiving ART will achieve viral load suppression.

Women often experience inequitable gender norms and power imbalances that prevent them from being able to exercise their right and access health services, and often face multiple layers of disempowerment in their interactions with their sexual partners and other members of their community. These challenges influence their sexual and reproductive health (SRH) behaviours and choices and prove to be a barrier for effective outreach. Evidence also suggests that individuals' and communities' demand for HIV-related prevention and care services is directly impacted by the stigma surrounding HIV, which for the large part stems from the social constructs of masculinity and femininity.

The HIV response in India is firmly located within the rights framework. There exists an inextricable link between human rights, gender and HIV and AIDS. Available evidence establishes beyond doubt that safer sexual practices for HIV prevention can be adopted by individuals and communities on a sustained basis only when the gender relations between sexual partners with their social environment are equitable and based on mutual respect.

A thorough understanding of their situation is important for staff of Targeted Intervention (TI) projects and people working with KPs to positively impact their quality of life, their health and the health of their children and families. In this context, the LINKAGES project aims to strengthen the response of TIs to gender inequality, violence, stigma and discrimination against key populations.

Training objectives

This module is designed to help training participants:

- Enhance their understanding of stigma and discrimination
- Recognize the connection between criminalization and vulnerability to HIV
- Identify the various human rights violations that KPs are subject to,
- Learn about the laws that can be used to counter violence and stigma; and
- Develop strategies and action plans for the field context to address gender inequality and violence.

Intended audience

This module is meant for the training of Project Managers, counselors and outreach workers (ORW) of Targeted Intervention projects. Ideally, each training should not have more than 25–30 participants.

How to use this module

This module is organized into three interrelated sections that build on each other in terms of sequenced information delivery. The sections are further organized into sessions that develop the thematic areas.

Each session follows the following arrangement, although facilitators may choose to adapt the sequences and timings as per the requirements of the training:

- **Duration:** Approximate time required for the session
- **Materials required:** A suggested list of materials required during the training including audio-visual equipment, stationery, handouts, reference materials, pre and post training assessment forms and feedback forms
- **Learning objective(s):** Describes the desired learning objective expected to be achieved by participants by the end of the session
- **Methodology:** Describes step-by-step participatory methods that will be employed to engage participants in the learning process and conduct the session.
- **Notes to the facilitator(s):** Information on the topic or tips for facilitating an activity.
- **Handouts:** Print material for participants to be distributed before or during sessions
- **Additional resources for facilitators:** Detailed information related to topics covered in each session

Pre and post training assessment

Participants are required to complete a pre-training self-assessment questionnaire at the beginning. A post-training questionnaire will also need be completed at the end of the training. These will be analysed to assess the progress of the participants knowledge, attitude and skill through this training process.

Feedback forms

The participants will be given a brief feedback form at the end of each day's sessions. This feedback will help the facilitators' team and organizers to address any immediate concerns, as well as to help plan the subsequent sessions appropriately.

Facilitators are encouraged to:

- Read the training module completely before the workshop
- Identify participants' needs and what is important to them
- Be flexible. Use different teaching methods to enhance participation and retain interest

- Provide real-life situations and emphasize the application of learning to real problems
- Provide activities that require active participation of participants
- Establish an atmosphere of respect and understanding of differences
- Respect and encourage participants local knowledge and field experiences
- Engage participants as valued resources and encourage them to participate and share their experiences

Comprehensive reference notes are provided at the end of the manual. Facilitators should review these notes before commencement of the training.



Introductory session



Duration

40 minutes



Materials required

Flipchart/whiteboard, marker pens, copies of pre-test assessment forms

Step 1: Ice Breaker (15 minutes)

- Request participants to introduce themselves (name, place, what they identify as: gay, MSM, transgender persons, hijra, sex workers). Each participant has to sing a song that describes themselves or that inspires them. It could be in any language that they know, preferably the local language. They also have to briefly state the reasons behind their choice.
- Introduce the objectives of the workshop and the topics that will be covered during the course of the training



Note to facilitator

The topic of gender roles may generate defensiveness or hostility. Plan ways to diffuse potential arguments and maintain open and respectful discussion.

Discussing the topic calls for sensitivity and planning. Establish a safe learning environment. Support learners' efforts to process their feelings.

Step 2 (10 minutes):

Ask participants to help in setting ground rules to be followed for the duration of the training. The ground rules may be listed on a flipchart.

Step 3 (15 minutes):

Provide participants with copies of the pre-test assessment forms and request them to complete the self-assessment.



SECTION 1

GENDER ROLE, IDENTITY AND EXPRESSIONS

Outline of sessions

Session 1.1: Introduction to gender

Session 1.2: Understanding gender

Session 1.3: Gender inequality and vulnerabilities

Session 1.4: HIV and gender

SESSION 1.1

Introduction to gender



Duration

40 minutes



Materials required

Sheets of paper, pen, flip chart/white board, marker pens



Learning objective

After completing this exercise, participants will be able to illustrate the difference between gender and sex



Methodology

Step 1.1.1: Brainstorming (15 minutes)

Divide participants into two groups and provide them with sheets of chart paper. Ask them to list:

- What are typically 'female' jobs that men could do?
- What are typically 'male' jobs that women could do?

Put up the completed charts from each group and circle those that will be relevant to the discussions later. Ask the participants how they decided on what is a 'female' job and what is a 'male' job.

Discuss where their ideas came from. You could ask some of the following questions (add any questions of your own):

- Who decides what is female and male job?
- What messages about how to behave do girls receive at home? At school? From religious leaders? From the media?
- Do boys receive the same messages?

Step 1.1.2 Group Discussion (25 minutes)

Ask each participant if the term 'gender' refers to men, women or both? Based on the answers initiate a discussion on the concept of gender and how it refers to men as well as to women. Explain through the examples of gendered jobs in the word web on the board (from the previous exercise), how one could understand that:

- Gender refers to social constructs and expectations placed by society about how men and women should behave – such as roles, duties and relationships – that are defined by the society around us.
- Society often expects people to look and behave a certain way, depending on their biological sex. Men are usually expected to act and look ‘masculine’, and women, ‘feminine’.
- Gender varies from society to society and can be changed.
- Gender expression – like how we think, how we feel and what we believe we can and cannot do – is taught through the socially defined concepts of masculinity and femininity.
- In every society, gender norms and gender roles influence people’s lives, including their sexual lives.
- These norms and expectations can often act as barriers in accessing health services by attaching concepts of shame and stigma to women as well as persons belonging to the transgender and MSM community

Summarize the above discussion by sharing one of the popular definitions of the term gender as described below:



Note to facilitator

Select only one definition to avoid confusing the participants. Use the one that you feel will best help you set the tone for the rest of the day’s discussions.

Gender Definitions

- Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. (World Health Organization)
- The term “transgender” is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking or blurring of culturally prevalent stereotypical gender roles (NACO)
- Gender refers to the social identity of female and male human beings. It defines the boundaries of what women and men can and should be and do. It shapes and determines the behaviour, roles, expectations and entitlements of women and men in a particular society. (JAGORI)



Key message

Gender refers not only to women or men, but also to the relationship and power dynamics between and among people.



SESSION 1.2

Understanding gender



Duration

45 minutes



Materials required

Flipchart/chart paper, marker pens



Learning objective

After completing this exercise, participants will be able to describe ways in which gender characteristics are a social construct rather than a biological construct



Methodology

Step 1.2.1 Exercise A: Where do you stand? (30 minutes)

Write 'Society' and 'Biology' on two sheets of flip chart paper and stick them on opposite walls. Then ask participants to stand in a straight line in the centre of the room.

Read aloud one statement at a time (see below). After each statement, ask participants to move a step towards the walls labelled 'Society' or 'Biology' depending on whether they think the statement is socio-culturally or biologically based.

Statements

1. Girls are gentle; boys are not.
2. Having sex with her husband is a woman's duty.
3. Women can get pregnant; men cannot.
4. Men are good at logical and analytical thinking.
5. Real men don't cry.
6. Women can breastfeed babies; men cannot.
7. Women are creative and artistic.
8. Women have maternal instincts.
9. Men's voices break at puberty; women's voices don't.
10. Men have a greater sex drive than women.
11. Women like to dress up and wear makeup.
12. Men should be the wage earners of a family, not women.
13. In a heterosexual relationship or marriage, the man has to be older than the woman.

After all the statements have been read out, most people should be closer to the 'Society' wall since all but 3 of the 13 statements have a sociocultural basis. The statements that have a biological basis are: 'Women can get pregnant; men cannot', 'Women can breastfeed babies; men cannot' and 'Men's voices break at puberty; women's voices don't'.

Step 1.2.2: Discussion (10 minutes)

Ask participants to discuss the statements and explain their feelings about individual statements to each other. Ask:

- Which statements did you not at all agree are based on either biology or society, and why did you not at all agree?
- Which statements are examples of how society expects people to be and act based on their gender rather than innate qualities?
- Do you understand how gender is constructed by society? Can you give other examples of how we learn gender roles?

ALTERNATIVE EXERCISE

Exercise B

This exercise seeks to help participants understand the difference between biological 'sex' characteristics and socially constructed 'gender' characteristics.

Prepare two flipcharts, one labelled at the top with a post-it saying 'Men' and the other saying 'Women'. One by one, read the words and phrases in the list below and ask participants whether each one is generally associated with men or with women. Write the words on the appropriate flip chart. (Participants **MUST** choose 'Men' or 'Women', one or the other.) Try to avoid in-depth discussions over disagreements, telling participants that there will be time afterwards to discuss. Switch the 'Men' and 'Women' labels at the top of the flipcharts, so that the flipchart labelled 'Men' is now labelled 'Women' and vice versa. Leave the words as they are on the 'wrong' flipchart. Review the words on the flipcharts and ask participants whether it would be possible for each word to belong under the new label of 'men' or 'women'. For example, even though women are associated with "sewing", men can still sew. In cases like this, circle the word. However, "giving birth" is impossible for men. In these cases, cross the word out. Explain to participants that all the crossed-out words belong to the realm of "sex", i.e., they are things that are biologically determined. On the other hand, the circled words belong to the realm of "gender", i.e., they are socially determined. Use examples to explain that gender-determined activities are cultural and may be different in different cultures or at different points in time. Close the session with a quick summary of the difference between 'gender' and 'sex' to reinforce the concept.

List of words (adjust as necessary)

SEWING

COOKING

DRIVING TRUCKS

RESOLVING CONFLICTS

FARMING

CARING FOR CHILDREN

GIVING BIRTH

BREASTFEEDING

WEARING SKIRTS

GROWING A BEARD

CONSTRUCTION WORKER

COMMUNITY LEADER

Difference between gender and sex

After the exercise above, follow it by discussing two circumstances – first in which one is able to exercise their sexual or reproductive rights and second in which one cannot do so. Tally the responses of men vis-à-vis women. Discuss where do the differences come from? Why are they prevalent?

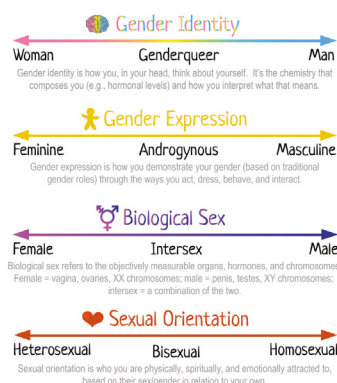
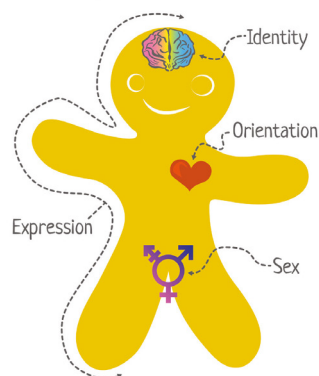
Explain the difference between gender and sex to the participants. While the word gender is used to describe socially determined characteristics, sex describes those which are biologically determined.

- Sex is something one is born with, whereas gender is imbibed through a process of socialisation.
- Sex does not change and is constant, whereas gender and consequent gender roles change and vary within and between cultures.
- Where sex is biological, gender is socially defined.

While most people are born either male or female (biological sex), they are taught appropriate behaviours for males and females (gender norms) – including how they should interact with others of the same or opposite sex within households, communities and workplaces (gender relations) and which functions or responsibilities they should assume in society (gender roles). In our patriarchal society, such defined gender norms, relations and roles often place women at a disadvantage and curb their basic human rights.

Step 1.2.3: Summarize (5 minutes)

The Genderbread Person



Note

- Until recently, our sex was considered to be unchangeable. Now it can be changed through medical intervention (sex reassignment surgery).
- Gender is not innate in the same way that our biology (sex) is believed to be. It refers to how societies view women and men, how they are distinguished, and the roles assigned to them. People are generally expected to identify with a particular gender that has been assigned (gender assignment) to them, from their sex at birth, and act in ways deemed appropriate to this gender.
- Gender is variable and can change from time to time, culture to culture, and sub-culture to sub-culture.
- The way girls and boys are socialised to be 'feminine' or 'masculine' is called gendering.
- It is important to distinguish between what society has constructed/created for each gender and what is biological. For example, the idea that men are strong and should not cry is created by society, whereas a woman giving birth is biological.
- SRH 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 to conceive them, and how many children to have.



Note to facilitator

The facilitator's own values should not interfere while teaching about sexuality. Remain neutral and avoid imposing your personal values on learners. You may wish to look for resources or support to help you reflect on your areas of discomfort or conflict regarding sexuality.



Key message

Gender is socially constructed, which means that it is determined by our social, cultural and psychological surroundings and environment.

SESSION 1.3

Gender inequality and vulnerabilities



Duration

1 hour



Materials required

White board, marker pens



Learning objectives

After this session, participants will be able to illustrate how gender inequality affects opportunities, including access to health services



Methodology

Step 1.3.1: Role Play (45 minutes)

Start this session with a role play. The idea behind the activity is to get the participants involved and reflect on their own experiences of gender inequality to be able to relate to problems in the field.

The participants are divided into smaller groups for the exercise. Each group gets 10 minutes to develop a role play to depict gender inequality and its outcomes



Note to facilitator

The following scenarios may be provided to the groups:

- *A newly married woman is under pressure from her in-laws to conceive a child. Her husband has become increasingly abusive – both verbally and physically*
- *A young girl is expected to drop out from school as her family is keen to get her married. They feel that it will be difficult to find a groom for a girl who is too highly educated*

Participants can take on the roles of husband, mother-in-law, village health worker, school teacher and so on. Each group then presents their role play to the larger group of participants.

More role plays can be developed if the session expects to bring our gender inequalities leading to lack of access of health services or exposure to risk and vulnerabilities.

Step 2: Discussion (15 minutes)

Based on the role play, initiate a discussion on the socially prescribed different roles for women and men. The participants must come up with examples from their own experiences of how gender norms, roles and relations result in differences between men and women in:

- Household-level investment in nutrition, care and education;
- Access to and use of health services;
- Experiences in health-care settings;
- Social impacts of ill-health; and
- Exposure to risk factors or vulnerability.



Key message

Gender inequality must be addressed in order to ensure equal opportunities and access to services.

SESSION 1.4

HIV and gender



Duration

1 hour



Materials required

PowerPoint slides, LCD projector, laptop, chart paper, marker pens, copies of case studies as handouts



Learning objectives

At the end of this session participants will be able to:

- Describe the relationship between HIV and gender inequality
- Explain how conventional gender roles can increase the likelihood that women and girls will face the risk of HIV or other sexually transmitted infections and unintended pregnancy



Methodology

Step 1.4.1: PowerPoint presentation (10 minutes)

Using PowerPoint slides, present the basic social, economic and biological factors that illustrate how HIV is a gender issue.



Note to facilitator

Please see Annex 1: Slides 1.4: HIV and gender. Also, kindly refer to the background information in Section C of the Additional Resources for Facilitators

Step 1.4.2: Group work (45 minutes)

Divide the participants in to 5 groups and provide them each with copies of the case studies provided in the handouts section.

Once they have read the case studies assigned to their respective groups, ask them to discuss and identify factors that make the subjects of the case studies vulnerable to HIV. Each group is asked to select a spokesperson who will present the main discussion points to the larger group.

Step 3 (5 minutes)

Summarize the main points of the discussion, supplementing the discussion points with detailed information, if necessary, from the notes in the Additional Resources for Facilitators section.



Key message

Major challenges to women's access to treatment and retention in care include:

- Stigma, discrimination and violence against women living with HIV
- Gender roles and responsibilities (including caregiving responsibilities)
- Violations of the right to privacy, confidentiality and bodily integrity within health settings
- Punitive laws, including criminalisation of persons from key populations.

Handouts

Case study 1: Empowering women who sell sex to be their own advocates

Sujatha is 24. She has engaged in sex work since she was 16 years old to help support her family. She knows that some of her friends also sell sex to support their families. While Sujatha uses some of her income to purchase alcohol and tobacco, it is not her sole motivation for engaging in sex work. Sujatha and many of her friends have experienced violence from their clients. They know their work is illegal and do not trust the police to intervene on their behalf. Clients are not required to use condoms, and Sujatha sometimes negotiates extra money by agreeing to unprotected sex. Despite having friends who have contracted HIV, she doesn't seek help or find out her HIV status because she is worried about the stigma she will suffer if people in her community find out about her drug use and her work.

Case study 2: Increasing support and services for transgender persons including those selling sex

Rupa came out to her family as a transgender person when she was 17. Her family threw her out and she started engaging in sex work to support herself. Constant police harassment and abuse by clients left Rupa depressed and frightened. She tried to find a government/NGO job but couldn't as all her legal documents were in the name of her male status. A month ago, Rupa was raped and beaten by a client who tried to kill her when he discovered that she was a transgender person. She couldn't go to the police because she was afraid of being arrested. Scared that she had been exposed to HIV, she went to the health clinic to get tested, but the health worker mocked her, refusing to call her by her female name. She ended up leaving without the PEP she was hoping to receive.

Case study 3: Supporting adolescents and young people living with HIV and increasing access to SRH education

Lalita suspected that she was different. Ever since she could remember, she and her parents took their medicine together every day, but her sister didn't. Lalita felt like she was always getting sick, but didn't know why. When she got meningitis at the age of 12, she lost a lot of weight and took a long time to recover. Then, when she was 16, her mother finally told her the truth: that Lalita and her parents were all living with HIV. She's not sure who she can talk to about her status aside from her parents, and is afraid what her friends



will say once they find out. Sometimes she gets sick of taking her medicine, and wishes she could just be like her sister and other 'normal' kids. At school, her teacher told them about sex, and how important it is to abstain from sex before marriage – but that left her with more questions than answers. Her mum told her that it was better to stay away from boys altogether. But that didn't help Lalita deal with her new feelings.

Some of her friends are having sex with their boyfriends, and their boyfriends buy them presents and help pay for books and school supplies. Yesterday, Lalita's friend Rose told her that she has started having sex with her husband. She explained to Lalita how they went to the health centre to get tested for STIs together, shared their results, and then went to buy condoms in preparation. Lalita worried that she would never be able to do that. She wants to get married and have a family someday but feels like that is impossible.

Case study 4: Reaching the female partners of men who have sex with men, with HIV prevention, treatment and care for themselves and their children

Madhu did not know why her babies kept dying. Plenty of other women in her family and community had babies at home and they almost never had any problems. Her husband said he didn't have the money to send her to the clinic, and she couldn't afford to pay for transport on her own. After their second child died, Madhu's husband also fell ill. The family spent what meagre resources they had to take him to the community's traditional healer. What Madhu didn't know was that her husband sometimes engaged in sexual activity with other men – something he felt he had to keep hidden from his wife, family and community. Four months after falling ill, her husband died. Madhu, pregnant for a third time, was starting to show signs of the same illness. She worried she did not have the money to seek medical treatment for herself, and was concerned about the well-being of her baby.

Case study 5: Disclosure

Ramesh a rickshaw driver by profession has many male sexual partners. He also frequents cruising sites in the city when time permits. Sometimes he interacts with the peer educators of the local Targeted Intervention programme who encourage him to use condoms consistently. Ramesh brushes aside the talks on condoms as he states that the 'fun' factor disappears from sex if condoms are used. Ramesh also has a 'serious' boyfriend named Raj with whom he is very attached. Raj too loves Ramesh but Raj is not aware about Ramesh's sexual history and lifestyle. One day, an unusually painful sensation in the anal region compels Ramesh to visit a private doctor. After physically examining him, the doctor suggests a few tests which are done quickly in the hospital. After some time, Ramesh emerges from the hospital sobbing as the doctor had been very harsh with him when his test results revealed that he was HIV positive and also had anal STI. The doctor further told him: "Don't visit this hospital again! We don't entertain immoral homosexuals!". As Ramesh is about to board his rickshaw his phone rings. He pulls out his phone – it is Raj calling from the other side. Ramesh stands baffled.





SECTION 2

GENDER AND ACCESS TO SERVICES

Outline of sessions

Session 2.1: Revisiting the basics: access to health services

Session 2.2: Stigma and discrimination

Session 2.3: Incorporating gender into HIV programming

Session 2.4: Contexts of violence

Session 2.5: Clinical care for survivors of sexual assault



SESSION 2.1

Revisiting the basics: access to health services



Duration

1 hour 10 minutes



Materials required

Flipchart/whiteboard, marker pens, paper, PowerPoint slides, LCD projector, laptop



Learning objectives

By the end of this session, the participants will be able to:

- Describe how gender inequality impacts HIV, condom negotiation and mental health of key populations
- Illustrate how women are vulnerable to HIV and could have difficulty in accessing HIV, STI and SRH services



Methodology

Step 2.1.1: HIV, STI and SRH for women (20 minutes)

- Distribute paper and pens and inform the participants that you are going to lead a small exercise. On the given paper, participants need to write down one word that comes to their mind when they hear the word HIV or AIDS, sexually transmitted infections (STIs) and sexual and reproductive health (SRH). Collect the responses and read them only at the end of this activity.
- Ask participants to list the common signs and symptoms of STIs that the participants are aware of. Supplement with information from the lists below:

Signs (Things you can see)

- ◆ Urethral discharge (green/yellow/whitish/colourless discharge)
- ◆ Genital ulcers (painless or painful)
- ◆ Blisters in the genital area
- ◆ Warts in the genital area
- ◆ Vaginal discharge

Symptoms (Things you experience)

- ◆ Lower abdominal pain
- ◆ Itching around the vagina

- ◆ Pain during urination or intercourse
 - ◆ Sore throat in people who have oral sex
 - ◆ Pain in and around the anus in people who have anal sex
 - ◆ Fever and body aches
 - ◆ Unexplained fatigue, night sweats and weight loss
- Ask who are at a greater risk of getting STIs and note these on the white board. This could include:
 - ◆ People who have multiple sex partners;
 - ◆ Women who have had sex with someone who has multiple sex partners; and
 - ◆ Women engaging in sex without using condoms.
 Add more to the list as required



Note to facilitator

Empower participants by saying that now since they are aware of the signs and symptoms, it is their responsibility to counsel people who have these symptoms to seek medical advice and treatment. Inform that as an outreach worker this will be one of their main responsibility areas.

- Invite participants to list the SRH needs of sex workers. This could include addressing areas such as:
 - ◆ Young girls and puberty
 - ◆ Irregular menstrual cycles
 - ◆ Family planning and contraceptive counselling
 - ◆ Emergency contraception
 - ◆ Safe pregnancy
 - ◆ Abortion and post-abortion care
 - ◆ Reproductive tract cancer screening (e.g. cervical, ano-rectal and prostatic cancers)
 - ◆ Personal Hygiene
- To wrap up, read out the words related to the words written by participants earlier. Check for myths and misconceptions broken through the session.

Step 2.1.2: Condom negotiation (15 minutes)

- Ask participants to volunteer one example of successful condom negotiation and another of an unsuccessful incident.
- Invite other participants to comment on factors that determined the success and failure in each of the examples
- Discuss existing barriers to condom negotiation (Please refer to the information in the Additional Resources for Facilitators section for details) and possible measures that can be taken to overcome the barriers
- Reinforce discussion points:

It is not sex work as a profession, but rather the act of unprotected anal and vaginal sex, that puts sex workers at risk. Therefore, a sex

worker who always uses condoms will be at less risk for HIV infection than a sex worker who never uses condoms. Sex workers do, however, encounter many pressures for not using condoms.

Step 2.1.3: Women and mental health (10 minutes)

Mental health issues such as anxiety, depression, suicidal tendencies and substance dependency (alcohol or drugs) affect many people in the general population. Sex workers may be particularly vulnerable to mental health problems, because of poverty, criminalization, marginalization, discrimination or violence.

Poor mental health may be a barrier to seeking testing or treatment for HIV, and to continuing in care for those who are HIV-positive. The effects of trauma can result in various symptoms ranging from physical to emotional. Some effects include:

- Difficulty in sleeping or nightmares
- Irritability
- Actively avoiding any reminders of the traumatic events
- Developing various phobias or fears that were not present beforehand
- Withdrawing socially from others
- Using alcohol and drugs to numb feelings

Depression, anxiety, lack of motivation or low self-esteem may affect a sex worker's ability to earn a living. Furthermore, for HIV-positive sex workers, depression can affect adherence to treatment which has a significant impact on their overall health. If a sex worker is depressed, he or she may be less motivated to practise safe sex with a client, and could potentially get into a risky situation. Anxiety can limit a sex worker's willingness to engage with others, which may include health care service providers. Some people who experience high levels of anxiety or depression may further be encouraged to turn to alcohol and other substances to cope with or numb their intense feelings so that they can return to work even in face of the anxiety and depression.

- Ask participants if they have encountered instances of mental health issues faced by the KP, and request them to share how these issues were addressed (or not) by the TI.



Note to facilitator

Explain that one way of identifying the presence of mental health issues that can be undertaken through TI staff is to interview the person(s) concerned, asking them to list noticeable changes. While interviewing, open-ended questions should be asked. Some of the questions that can be asked are:

- “Have there been any changes in your mood? Please describe them”
- “Have there been any changes in your thoughts about yourself, others or your surroundings? Kindly describe them?”

- “Have there been any changes in the way you see or hear things?” Please describe them”
- “How do you manage your stressful situations?”
- “Since when have these changes been present?”
- “How have you been dealing with them?”
- “How have these changes affected your personal, social and occupational functioning?”
- Supplement the examples provided with the following points on how to support mental health issues among sex workers:
 - ◆ Provide sex workers with a welcoming environment in which they feel comfortable to disclose information to a health care worker.
 - ◆ Sex worker patients should be continually monitored throughout their treatment in order for them to cope with the effects of their mental illness.
 - ◆ Health care workers should take into consideration the impact that mental illness may have on any other treatment they are providing to sex worker patients. For example, sex workers with mental illness may be neglectful in taking long-term medication or may find it difficult to return to a clinic for follow-up visits. These factors should be considered when developing a care and retention plan for a sex worker patient.
 - ◆ Attempts should be made to link sex worker mental health patients with supportive psychotherapy or other related services that may be available.

Step 2.1.4: Identifying barriers to accessing standard health services (15 minutes)

- Ask participants to share their thoughts from their experiences on what makes sex workers one of the most difficult-to-reach groups.
- Supplement responses with the points from the following list of probable reasons:
 - ◆ Fear of telling their family/partner;
 - ◆ Fear of being seen at the clinic by someone they know;
 - ◆ Fear that they might know one of the health workers;
 - ◆ Denial;
 - ◆ Concerns about pregnancy and MTCT;
 - ◆ Concern about transmitting HIV to others;
 - ◆ Concerns about illness and death;
 - ◆ Fear of violence from, or abandonment by, a partner or family;
 - ◆ Fear of losing job if others find out they are living with HIV;
 - ◆ Fear of loss of home and social support;
 - ◆ Concerns about maintaining health and questions about expected life span; and
 - ◆ Fear of experiencing stigma and discrimination within the health care setting.

- Discuss some of the major barriers that sex workers may face when trying to access health care services.
 - ◆ **Hours of operation:** The standard hours during which clinics are open for services may not be available to many sex workers, thereby preventing them from even having the opportunity to access care or treatment.
 - ◆ **Stigma and discrimination:** Stigma and discrimination can affect sex workers and prevent or discourage them from accessing health care services.
 - ◆ **Mobility:** Some sex workers are very mobile and do not stay in one particular community for too long. Other sex workers are migrants who may have only recently arrived in a community or country. Overall, the mobility of the sex worker community can make accessing health care challenging, as they may be unaware of the structure of the community-based health care.
 - ◆ **Lack of confidentiality:** Violations of confidentiality in the health care setting can be potentially dangerous for any particular patient. For sex workers, however, a breach in confidentiality can result in increased stigma and ridicule, and add to the difficulty of them visiting a particular clinic.



Note to facilitator

Inform participants that later in the day we will be talking about ways to overcome gender-related barriers to access to services and information.



Key message

Gender inequality negatively affects access to health and HIV-related services by key populations and therefore requires a comprehensive understanding of the underlying factors.

SESSION 2.2

Stigma and discrimination



Duration

1 hour



Materials required

PowerPoint slides, LCD projector, laptop, flipchart, marker pens, post-it note sheets/slips of paper and sticky tape



Learning objectives

By the end of this session, participants will be able to illustrate how unaddressed stigma and discrimination leads to internal and external barriers in health service access



Methodology

Step 2.2.1: Understanding stigma and discrimination (15 minutes)

- Using PowerPoint slides and updated data, illustrate the state of India's concentrated HIV epidemic.



Note to facilitator

Please see Annex 1: Slides 2.2

Adult HIV Prevalence	.26%
Female Sex Workers	2.2%
Men having Sex with Men	4.3%
Transgender Persons	7.5%
Injecting Drug Users	9.9%

Source: NACO Report, 2016–2017

- Present state and district level data to highlight current trends. An example is provided below:

State	ANC	FSW	MSM	TG	IDU
Maharashtra	0.44%	6.89%	9.91%	18.80%	14.17%
Andhra Pradesh	0.77%	6.86%	10.14%		3.05%

India HIV Estimations, 2015: Technical Report, National AIDS Control Organisation at p. 10
<http://www.naco.gov.in/sites/default/files/India%20HIV%20Estimations%202015.pdf>

State Epidemiological Factsheet, West and South States, NACO, September, 2017
<http://naco.gov.in/sites/default/files/Western%20Region%20-%20Vol%202%20revised.pdf>

The data indicates that key populations such as female sex workers (FSW), injecting drug users (IDU), men having sex with men (MSM), and transgender (TG) persons remain most vulnerable to HIV. Key populations are disproportionately affected by HIV and are stigmatised, discriminated, prone to violence, and often called 'vectors of the disease'.

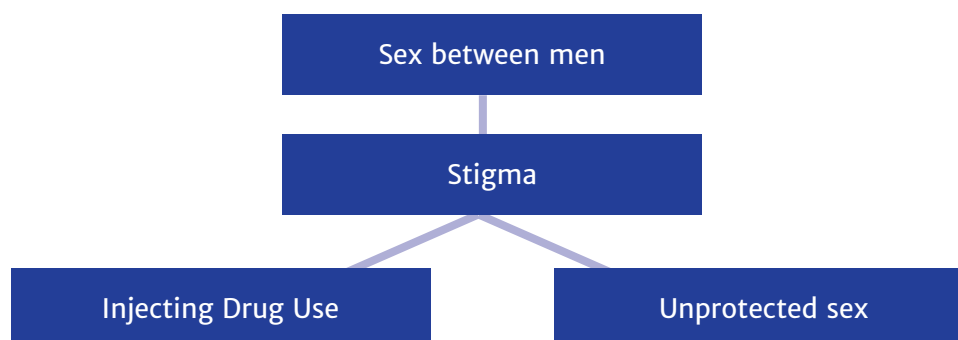
- Ask the participants:
 - ◆ Why are KP disproportionately affected by HIV?
 - ◆ Is it because of social, economic, legal, and/or political factors?
 - ◆ If yes, can they name few?
- Ask participants to define stigma and ask for examples. Ask participants to define discrimination and ask for examples. Encourage them to draw from experience. Post the definitions of stigma and discrimination on the wall and ask the participants if they agree with them.
- Use the following definitions and diagrams on PowerPoint slides to explain the difference between stigma and discrimination:



Note to facilitator

Please see Annex 1: Slides 2.2

Stigma: refers to undesirable attitudes and beliefs directed toward something or someone.ⁱ In case of PLHIVs, stigma is directed against them because of their HIV status, or their perceived HIV status. The stigma is more pronounced because HIV is seen as 'behavioural disease', i.e., infected due to one's own behaviour, unlike say cancer or TB. It is a common misconception in India that most gay men, sex workers and injecting drug users are suffering from HIV, thereby creating a myth that HIV only affects 'those people', and not 'people like us'.



Examples of stigmatizing behaviour:

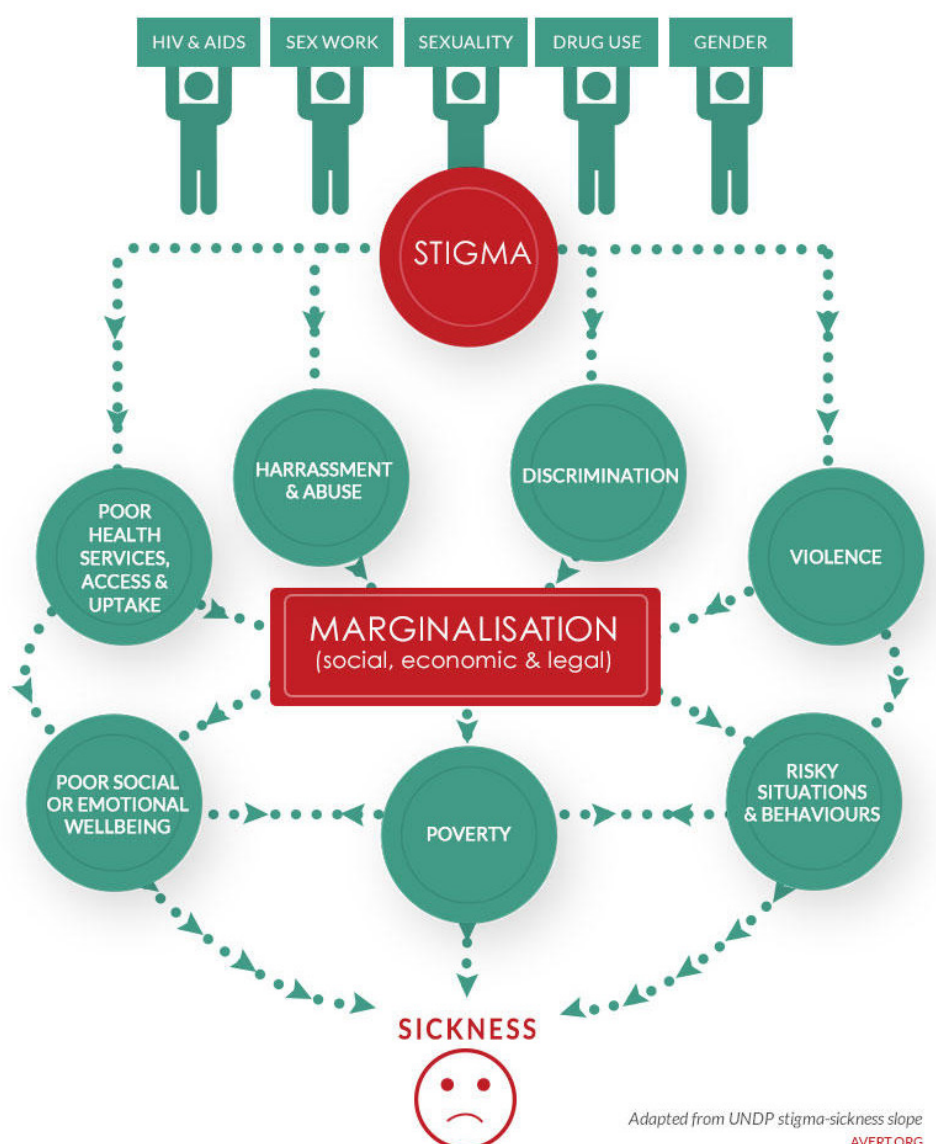
- Not shaking hands with PLHIV
- Making disparaging remarks against gay men, transgender persons or female sex workers
- Commenting that KPs 'deserve' HIV, owing to their behaviour.

(Ask participants to provide more examples from their own experiences)

It can be better understood through the following diagram:

HOW STIGMA LEADS TO SICKNESS

Many of the people most vulnerable to HIV face stigma, prejudice and discrimination in their daily lives. This pushes them to the margins of society, where poverty and fear make accessing healthcare and HIV services difficult.



Source: Avert org (<https://www.avert.org/professionals/hiv-social-issues/stigma-discrimination#HIV%20stigma%20and%20key%20affected%20populations>)

Discrimination: means treating someone unfairly or unequally, in comparison to others. It is often described as a distinction that is made about a person on the basis of their belonging, or being perceived to belong, to a particular group.



Discrimination can often result in violence and hate crimes against KPs in society and can also contribute to poor quality of treatment in healthcare facilities. Numerous forms of discrimination exist against KPs:

Some examples include:

- A young gay boy facing bullying and verbal abuse in his school from his peers and teachers because of his gender non-conforming behaviour;
- Sex workers not able to rent houses at affordable rates, owing to their profession;
- Transgender persons not treated properly in public hospitals by doctors and nurses.

Summarize: Discrimination is the act of treating people differently, while stigma refers to the beliefs/attitudes that an individual should be treated unfairly. In a given situation, stigma and discrimination act together to create an unequal society, which marginalises and excludes KP from social, economic, legal and political rights and privileges.

Step 2.2.2: Labelling Game (30 minutes)

Purpose	To understand stigma and stereotypes
Introduction	<p>The facilitator will prepare labels reflecting the existing stereotypes and derogatory terms used for the KPs, like <i>chakka gandhu</i>, <i>randi</i>, etc. There should be enough labels for all participants. Then another 10–15 labels should be prepared, having generic descriptions like doctor, nurse, health staff, project officer, counsellor, etc, which are not associated with stereotypes.</p> <p>The facilitator will then put the labels on the back of each participant without the participant seeing what label is being put.</p>
Activity	<p>The group will then mingle and chat with each other and behave with each other how the society will behave towards that person, as per that label, without telling the concerned person.</p> <p>After 7–8 minutes, ask the group to come back to their seats.</p> <p>The facilitator will then discuss the following:</p> <ul style="list-style-type: none"> • Who all can guess their labels? • How did one feel to be treated that way? • Why were they treated badly? • Should society label people and treat them in a demeaning manner? • How does one break the practice of labelling individuals? • Do we ourselves treat people badly based on how we label them? • Did this exercise make us think how we ourselves treat our friends, family, colleagues, partner? <p>The facilitator will then ask the participants to look at their labels, and see whether they had guessed their label right or not.</p> <p><i>Source: CDC Module on Stigma and Discriminationⁱⁱ</i></p>

Step 2.2.3: Healthcare stigma associated with women in sex work (10 minutes)

Activity: Mind-map

- When you hear the term 'sex worker', what is the first thing that comes to your mind? Ask participants to share a brief description

of what they think of as a 'typical' sex worker. Put keywords on the whiteboard. Consider the following questions:



- Discuss how stereotypes lead to perceptions and biases and create stigma. Bringing it closer home, with TIs often being the first contact for the key populations, ask the participants:
 - ◆ What is their experience of TIs?
 - ◆ Are the peer educators or outreach workers helpful?
 - ◆ What services do key populations avail in the TIs?
 - ◆ Have they faced stigma and discrimination?
 - ◆ Are there services that TIs don't provide?
 - ◆ Should TIs work on violence and rights of KPs?
 - ◆ What are the existing gaps in addressing stigma and discrimination? How should these gaps be addressed?
- Summarize: Critical role of TIs in combating stigma and discrimination
Over the years, the TI model has become most critical to the national HIV prevention and control programme in India. Several studies show that high intensity targeted interventions, especially for FSW populations in Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu, are responsible for a large decline in the incidence of HIV amongst antenatal women. (Kumar et al, 2009).ⁱⁱⁱ Consequently, the HIV prevalence in the general population has also decreased.



Key message

It is imperative to address the causes and consequences of stigma in order to ensure the health and well-being of key populations.

SESSION 2.3

The benefits of incorporating gender into HIV programming



Duration

45 minutes



Materials required

Flipchart/white board, chart paper, marker pens



Learning objectives

At the end of this session, participants will be able to list the benefits of incorporating gender into HIV programs



Methodology

Step 2.3.1: Discussion (15 minutes)

- Initiate discussion on how integrating gender equality and human rights-based interventions occur along a continuum: from gender-blind to gender-responsive and gender-transformative programmes.
- Use the definitions from the table below to distinguish between gender-blind, gender-responsive and gender-transformative interventions
- Divide the participants in to 3 groups and ask them to select a topic that best represents gender-blind, gender-responsive and gender-transformative approaches as per their work experience.



Note to facilitator

Examples for gender-blind approaches may include promoting male condoms in FSW interventions, promoting male condoms in interventions for women who inject drugs

Examples of gender-responsive interventions could include information, knowledge and availability of female condoms in interventions for sex workers

Examples of gender-transformative may include capacity building of women in sex work through trainings as paralegal volunteers, enabling them to address crises and violence among women in sex work

- Ask participants to reflect on their current TI programs and identify where in this continuum they can identify themselves

Table: Continuum of interventions on gender inequality:

	Gender-blind	Gender-responsive	Gender-transformative
Impact	<p>Fails to acknowledge the different needs or realities of women and men, girls and boys and transgender people. This can either be exploitative or accommodating.</p> <p>Exploitative interventions aggravate or reinforce existing gender inequalities and norms.</p> <p>Accommodating interventions work around existing gender differences and inequalities.</p>	<p>Recognizes the distinct roles and contributions of different people based on their gender and takes these differences into account. Attempts to ensure that women or girls will benefit equitably from the intervention.</p>	<p>Explicitly seeks to redefine and transform gender norms and relationships to redress existing inequalities</p>
Example	<p>The 'ABC' approach (Abstain, Be faithful and/or use a Condom)</p> <p>This approach fails to recognize the gendered power dynamics between couples (which are supported by social and cultural norms around gender and sexuality that make certain behaviors acceptable or unacceptable).</p>	<p>Promotion of female condoms and voluntary medical male circumcision</p> <p>These prevention approaches recognize different biological and socio-structural vulnerabilities to HIV and suggest gender-specific interventions to address them.</p>	<p>Stepping Stones approach</p> <p>This is a community-wide approach that encourages better communication between different members of the community.</p>

	Gender-blind	Gender-responsive	Gender-transformative
	<p>For example, in many societies, men are encouraged to have multiple sexual partners, and women are discouraged from challenging them about this. Doing so may lead to arguments or even violence.</p> <p>An individual alone cannot be responsible for the fidelity of both partners in a couple.</p> <p>Questions of abstinence, faithfulness and use of condoms all rest on the individual having the power to assert control over these behaviors, and as they are behaviors that are negotiated between couples (not just under the control of one individual) the more powerful partner is likely to control what happens. Often women lack power in relationships because they have less access to economic resources and sometimes they are dependent on male partners for their own and their children's survival.</p>	<p>Female condoms are the only women-controlled barrier method of prevention, recognizing that it is not always easy or possible for women, including young women, to ask for or to initiate condom use. While female condoms don't alleviate these gender dynamics, they give women the power to at least initiate condom use. Peer-led female condom education can include gender-transformative elements, for example by encouraging women to become familiar with their own bodies, opening a space for talking about sexual preferences and pleasure, and addressing challenging issues like IPV, forced and coerced sex. Voluntary medical male circumcision (VMMC) is a sex-specific biomedical intervention, recognizing biologically different vulnerabilities and protection. VMMC interventions can be gender neutral, but they can also open a space for talking about SRHR, HIV, sexuality, etc. with men and boys – which could also include 'transformative' elements as above</p>	<p>This approach recognizes and challenges gender- and age-related power relations by creating space for conversation within and between gender and age groups (older men, older women, younger men and younger women). It is based on participatory learning techniques where the participants drive the content of topic-focused sessions (thereby also challenging the power dynamic between – often external – facilitator and participants, and enhancing the notion that communities are best placed to uncover their own solutions). Sessions begin with creating safe spaces, addressing issues around communication and conflict resolution more generally, and build on these to include topics that are often taboo like gender, power, sexuality, HIV and IPV. After discussing issues in separate 'safe' groups, participants share their agreed conclusions with other groups to bring about better understanding of each other's' points of view and break traditional silences, mores, and beliefs</p>

Step 2.3.2: Addressing gender-related barriers to access to services and information (20 minutes)

- Divide participants into groups and request them to identify the activities that could be taken up by the TIs/NGO/CBO for improving access to services, resources required and also specify related advocacy issues that can be taken up around gender.
- Ask each group to present the key points of their group discussion to the larger group



Note to facilitator

If necessary, supplement with examples of the following opportunities for advocacy:

- *Influencing national policies to establish zero tolerance for violence against key populations*
- *Increasing access to justice for key populations*
- *Outlawing discrimination against women, key populations and people living with HIV*
- *Sensitizing health workers and law enforcement personnel to the rights, needs and priorities of key populations from the perspective of gender*
- *Influencing policies to expand use of mobile services in order to reach underserved groups, such as migrant workers, sex workers, transgender persons, and men who have sex with men.*



Key message

Interventions for key populations must consider and plan for the different needs of men, women and transgender persons in all their diversity.

SESSION 2.4

Contexts of violence**Duration**

1 hour

**Materials required**

PowerPoint slides, LCD projector, laptop, flip chart/whiteboard, marker pens

**Learning objectives**

By the end of this session, participants will be able to list the contexts, dynamics and factors that lead to violence against key populations

**Methodology****Step 2.4.1: Q&A (20 minutes)**

- Ask 4 volunteers from among the participants to assume the roles of persons representing the following KPs: transgender persons, MSMs, spouses/female partners of MSM, and persons engaged in sex work
- Request the volunteers to try and briefly answer the following questions in the context of their respective roles:
 - ◆ What are the issues that make you vulnerable to violence?
 - ◆ What are some of the accusations that are levelled against you?
 - ◆ What are some of the situations that have made you fear for your personal safety?
 - ◆ How have these circumstances impacted your access to health or other social benefits?
 - ◆ How can TIs help in responding most effectively to your situation?
- Ask other participants to reflect on these experiences of violence faced by KPs, focusing on the main factors responsible and possible support that TIs can provide

Step 2.4.2: PowerPoint presentation and discussion (15 minutes)

- Provide participants with definitions of violence and criminalization using PowerPoint slides

**Note to facilitator**

Please see Annex 1: Slides 2.4: Contexts of violence

- Reinforce the examples from the participants' experiences with the slides on contexts of violence including the following:
 - ◆ Workplace violence
 - ◆ Violence from intimate partners and family members
 - ◆ Violence by perpetrators at large or in public spaces
 - ◆ State violence
 - ◆ Laws and policies
 - ◆ Informal condition of transactions
 - ◆ Drugs and alcohol induced violence



Note to facilitator

For further details please refer to information in Section G – Session 2.4 of the Additional Resources for Facilitators section

Step 2.4.3: Role play (25 minutes)

- Divide participants into three small groups. Ask each group to develop and present a role play of 5 minutes each depicting violence in the relationship between an FSW and her partner. Based on the role plays, discuss the forms, contexts and consequences of the violence faced by KPs.
- Also ask participants to discuss various forms of violence and list them
- Conclude the session with a discussion of the consequences of violence and its implications using the following slide (*Please see Annex 1: Slides 2.4: Contexts of violence*):

Consequences of violence

- Violence by intimate partners faced by sex workers, MSM, and transgender/hijra persons often go unreported and unaddressed.
- Violence against sex workers associated with inconsistent condom use, and with increased risk of STI and HIV infection.
- Violence or fear of violence may prevent key populations from accessing harm reduction, HIV prevention, treatment and care, health and other social services.
- It may also obstruct access to services aimed at preventing and responding to violence (e.g. legal or health services).
- Discrimination against sex workers in shelters for those who experience violence may further compromise their safety.



Key message

Understanding violence as a very important structural barrier to access health services. And to realise that the contexts and factors leading to violence against key populations is essential to understand and respond to in developing strategies and responses for its mitigation

SESSION 2.5

Establishing referral support for survivors of sexual assault



Duration

25 minutes



Materials required

PowerPoint slides, LCD projector, laptop



Learning objectives

By the end of this session, participants will be able to identify methods to ensure support for survivors of sexual assault



Methodology

Step 2.5.1: PowerPoint presentation and discussion

- With the help of PowerPoint slides, describe the psychological and physical signs and symptoms indicative of domestic and intimate partner violence.



Note to facilitator

Please see Slides 2.5: Establishing referral support for survivors of sexual assault. Supplement with details from Section H – Session 2.5: Establishing referral support for survivors of sexual assault from the Additional Resources for Facilitators section)

- Discuss the ways through which TI staff can offer support to survivors of sexual assault. Please ensure that the following points are included:
 - ◆ Offer first-line support to survivors of sexual assault by any perpetrator.
 - ◆ Take a complete history to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe, including genitalia).
 - ◆ Offer emergency contraception to women presenting within five days of sexual assault, and ideally as soon as possible after the assault to maximize effectiveness.
 - ◆ Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor to determine whether HIV PEP is appropriate.

- ◆ Psychological support and care should be offered, including coping strategies for dealing with severe stress.
- ◆ Continue to offer support and care up to three months post-trauma

Referral linkages

- Divide participants into two groups: A and B.
- Ask Group A to collectively draw up a brief background for a survivor of sexual assault and. A volunteer is identified to act out the role of the survivor.
- Arrange for the volunteer to sit on a chair surrounded by 3-4 sheets of chart paper, and ask the other group members from Group A to be prepared to note significant points in the chart paper surrounding the 'survivor'.
- Members of Group B are required to ask the 'survivor' questions on the incident
- Based on the questions and answers, members of Group A will note relevant referrals that TIs can undertake and based on these points, create a Referral Network that TIs can employ



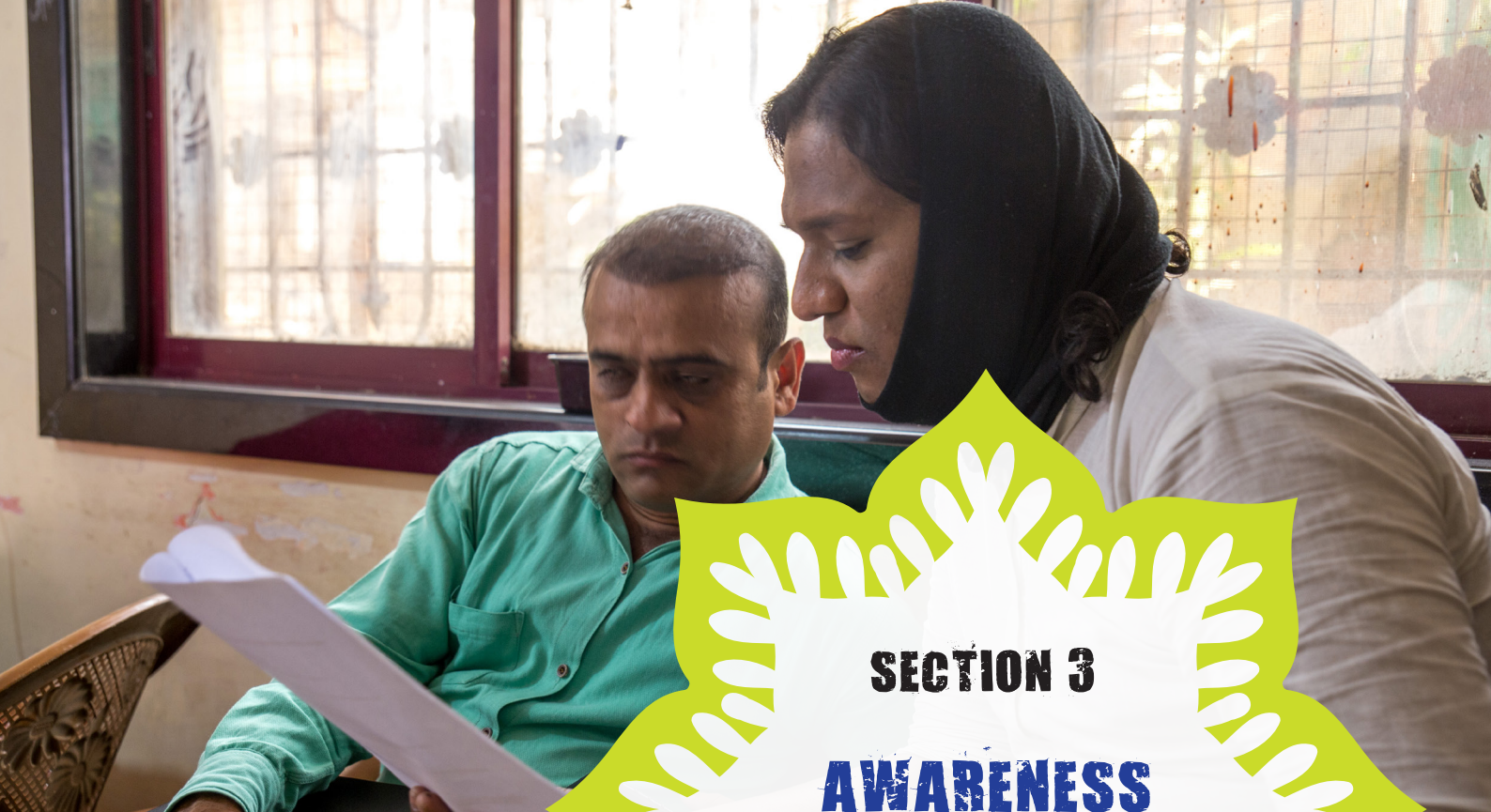
Note to facilitator

Please ensure that the session ends with a game or energizer that will help participants to de-role



Key message

TI staff have a significant role to play in recognizing signs of sexual assault and providing support for survivors.

A photograph of a man and a woman sitting together, looking at a document. The man is wearing a green shirt and the woman is wearing a white shirt and a black headscarf. They are in a room with a window in the background.

SECTION 3

AWARENESS ON LAWS AND POLICIES

Outline of sessions

Session 3.1: Constitutional rights of key populations

Session 3.2: Women-centric laws and policies

Session 3.3: Sex Workers' rights and law

Session 3.4: Legal rights related to MSM and gay men

Session 3.5: TG rights and law

SESSION 3.1

Constitutional rights of key populations



Duration

45 minutes



Materials required

White board, marker pens



Learning objective

By the end of this activity, the participants will be able to list and describe the various laws, regulations, policies governing rights of key populations.



Methodology

Step 3.1.1: Naming the Rights (15 minutes)

- Start the session by asking each of the participants:
 - ◆ Do they know of any constitutional rights? If yes, name a few.
 - ◆ What constitutional rights are their most favourite, if any, and why?
 - ◆ When is the Human Rights Day [10th December]? And why is that day celebrated as Human Rights Day?
 - ◆ When is Constitution Day celebrated [26th November]?
 - ◆ When is World AIDS Day [1st December]?
- Each participant gets one minute to respond. Note their responses, and ask them to remember their most preferred rights.

Step 3.1.2: Citing Violations of Rights (30 minutes)

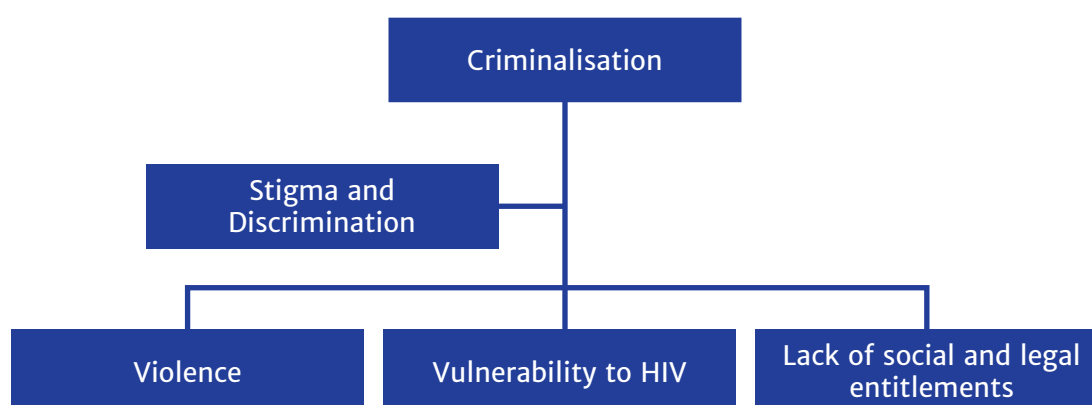
- Divide the participants in 5 groups (4-5 participants in each group) and assign each group one set of fundamental rights:
 - ◆ Right to Equality (Article 14) and Non-discrimination on grounds of 'sex', etc (Articles. 15 and 16)
 - ◆ Right to Life and Personal Liberty (Article 21) inclusive of bodily autonomy, privacy, dignity, health and livelihood
 - ◆ Freedom of Speech & Expression, Assembly, Movement, Residence, etc [Article 19(1)]
 - ◆ Protection against arbitrary arrest and detention [Article 22]
 - ◆ Right to Constitutional Remedies [Article 32]

- Each group gets 5 minutes each to cite three examples from their personal lives (each group has to decide 2–3 examples after discussion with the participants) when the fundamental right (which is allotted to each group) was violated.
- Identify common patterns from among the examples provided by the five groups
- Ask participants if they can name a few laws applicable to key populations. Supplement with the following examples:

Immoral Traffic (Prevention) Act, 1956	This Act outlaws soliciting by sex workers, thus interfering with their ability to work and earn.
Section 377, Indian Penal Code, 1860	This section earlier prohibited anal sex and oral sex between consenting adult homosexual men and transgender persons
Narcotic Drugs and Psychotropic Substances Act, 1985	This law penalises the use and possession of drugs, thus turning drug dependent persons into criminals

Criminal laws and other legal restrictions discourage sex workers, MSM, and transgender persons/hijras from accessing public health services, especially HIV prevention, treatment and care, in order to avoid penal sanctions. As a result, they are in constant fear of prosecution, and suffer poor physical and mental health outcomes. They further become vulnerable to police abuse and exploitation and face societal stigma and prejudice.

- Use the following diagram to explain the vicious cycle between criminalization, stigma and discrimination and vulnerability to HIV:



Key message

Empower key populations by educating them on the rights that can protect them

SESSION 3.2

Women centric laws and policies



Duration

30 minutes



Materials required

PowerPoint slides, LCD projector, laptop, copies of handout



Learning objectives

By the end of the session, participants will be able to recall and list available women-centric laws, policies and provisions in India



Methodology

Step 3.2.1: PowerPoint presentation and discussion

With the aid of PowerPoint slides, describe the following women-centric laws, policies and provisions available to citizens of India:



Note to facilitator

Please see Slides 3.2: Women centric laws and policies

1. Protection of Women from Domestic Violence Act (PWDVA), 2005
2. The Prohibition of Child Marriage Act, 2006
3. The Protection of Children from Sexual Offences (POCSO) Act, 2012
4. Medical Termination of Pregnancy Act, 1971
5. Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013
6. Indecent Representation of Women (Prevention) Act, 1986
7. National Commission for Women Act, 1990
8. Working Women's Hostel (WWH)
9. UJJWALA, 2007
10. Swadhar Greh



Note to facilitator

Provide participants with copies of the handout at the end of this section



Key message

All key populations must be made aware of the existing laws and policies that protect the rights of women and their entitlements thereof

Handout: Women centric laws and policies

1. Protection Of Women From Domestic Violence Act (PWDVA), 2005:

The **Protection of Women from Domestic Violence Act (PWDVA)**, instituted in 2005, is a legislation aimed at protecting women from violence in domestic relationships.

The definition of domestic violence is wide-ranging and it covers, mental as well as physical abuse, and also *threats* to do the same. Any form of harassment, coercion, harm to health, safety, limb or well-being is covered. Additionally, there are specific definitions for the following:

Physical abuse: Defined as act or conduct that is of such a nature as to *cause bodily pain, harm, or danger to life, limb or health or impair the health or development of the aggrieved person*. Physical abuse also includes assault, criminal intimidation and criminal force.

Sexual abuse: The legislation defines this as conduct of “sexual nature” that *‘abuses, humiliates, degrades or otherwise violates the dignity of a woman.’*

Verbal and emotional abuse: Insults/ ridicule of any form, including those with regard to inability to have a male child, as well as repeated threats

Economic abuse: Categorized as including deprivation of financial resources required for survival of the victim and her children, the disposing of any assets which the victim has an interest/stake in and prohibition/ restriction of financial resources which the victim is used to while in the domestic relationship.

Under the PWDVA, various reliefs are provided to the aggrieved women in case of violence by intimate partner or by anyone within the family. It covers domestic relationships between those who have lived together in a shared household and these people are:

- Related by consanguinity (blood relations)
- Related by marriage.
- Though a relationship in the nature of marriage (which would include live-in relationships)
- Through adoption
- Are family members living in a joint family

The act gives provisions for:

- Victim resources
Under the Act, victims should be provided with adequate medical facilities, counselling and shelter homes as well as legal aid when required.



- **Counselling: Section 14**
Counselling, as directed by the magistrate, should be provided to both the parties involved, or whichever party requires it, as ordered.
- **Protection Officers: Section 9**
Under the Act, Protection Officers should be appointed by the government in every district, who preferably should be women, and should be qualified. The duties of the Protection Officer include filing a domestic incidence report, providing shelter homes, medical facilities and legal aid for the victims, and ensuring that protection orders issued against the respondents are carried out.
- **Protection orders: Section 18**
Protection orders for the victim's safety can be issued against the respondent, and includes for when he commits violence, aid or abets it, enters any place which the victim frequents or attempts to communicate with her, restricts any form of assets of the victim or causes violence to people of interest to the victim.
- **Residence: Section 19**
The magistrate may choose to restrict the respondent from the place of residence of both the parties if they feel that it is for the safety of the victim. Additionally, the respondent cannot evict the victim from the place of residence.
- **Monetary relief: Section 20**
The respondent has to provide relief to the victim to compensate for loss, including loss of earnings, medical expenses, any expenses incurred due to loss of property by destruction, damage or removal, and maintenance of the victim and her children.
- **Custody of children: Section 21**
Custody of children should be granted to the victim as required, with visiting rights to the respondent if necessary.

2. The Prohibition of Child Marriage Act, 2006

The Prohibition of Child Marriage Act was made effective in 2007. The Act is armed with enabling provisions to prohibit for child marriage, protect and provide relief to victim and enhance punishment for those who abet, promote or solemnize such marriage. This act defines child marriage as a marriage where the groom or the bride are underage, that is, the bride is under 18 years of age or the boy is younger than 21 years. Parents trying to marry underage girls are subject to action under this law.



3. The Protection of Children from Sexual Offences (POCSO) Act, 2012

The Protection of Children from Sexual Offences (POCSO) Act, 2012 was enacted by the Government of India to protect children from offences of sexual assault, sexual harassment and pornography, while safeguarding the interest of the child at every stage of the judicial process, by incorporating child-friendly mechanisms for reporting, recording of evidence, investigation and speedy trial of offences through designated Special Courts.

4. Medical Termination of Pregnancy Act, 1971

The Act came into effect in 1972, was amended in 1975 and 2002. The aim of the Act is to reduce the occurrence of illegal abortion and consequent maternal mortality and morbidity. It clearly states the conditions under which a pregnancy can be ended or aborted and specifies the persons qualified to conduct the same.

5. Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013

To ensure women's safety at workplace, this Act seeks to protect them from sexual harassment at their place of work. Sexual harassment at workplace also includes – the use of language with sexual overtones, invasion of private space with a male colleague hovering too close for comfort, subtle touches and innuendoes.

6. Indecent Representation of Women (Prevention) Act, 1986

This Act prohibits indecent representation of women through advertisement or in publications, writings, paintings, figures or in any other manner.

7. National Commission for Women Act, 1990

The National Commission for Women (NCW) is a statutory body of the Government of India, established in January 1992. The NCW represents the rights of women in India and provides a voice for their issues and concerns. The subjects of their campaigns have included dowry, politics, religion, equal representation for women in jobs, and the exploitation of women for labour. They have also discussed police abuses against women. The National Commission for Women Act aims to improve the status of women and worked for their economic empowerment.

8. Working Women's Hostel (WWH)

Aims at providing safe shelter for single, widowed, divorced, separated, married but whose husband or immediate family does not reside in same area and for those who are under training for job.



9. UJJWALA, 2007

The Ministry of Women and Child Development launched a comprehensive scheme called 'Ujjwala' in 2007. Conceived primarily for the purpose of preventing trafficking on the one hand and rescue and rehabilitation of victims on the other. The scheme has five specific components: Prevention, Rescue, Rehabilitation, Reintegration and Repatriation of victims of trafficking.

The scheme also facilitates rescue of victims from the place of their exploitation and place them in safe custody in order to provide rehabilitation services, both immediate and long-term. The scheme is mainly implemented through NGOs.

It provides to the victims basic amenities/needs such as shelter, food, clothing, medical treatment including counselling, legal aid and guidance and vocational training. It also facilitates reintegration of the victims into the family and society at large.

10. Swadhar Greh

Provides shelter for women in difficult circumstances, widows, destitute and deserted women. The scheme envisions a supportive institutional framework for women victims of difficult circumstances so that they could lead their life with dignity and conviction. It envisages that shelter, food, clothing, and health as well as economic and social security are assured for such women. It also envisions that the special needs of these women are properly taken care of and under no circumstances they should be left unattended or abandoned which could lead to their exploitation and desolation. Administered by Women and Child Development ministry since 2001.

The benefits of the component can be availed by women above 18 years of age of the following categories:

- Women who are deserted and are without any social and economic support;
- ◆ Women survivors of natural disasters who have been rendered homeless and are without any social and economic support;
 - ◆ Women prisoners released from jail and are without family, social and economic support;
 - ◆ Women victims of domestic violence, family tension or discord, who are made to leave their homes without any means of subsistence and have no special protection from exploitation and/ or facing litigation on account of marital disputes; and
 - ◆ Trafficked women/girls rescued or runaway from brothels or other places where they face exploitation and Women affected by HIV/ AIDS who do not have any social or economic support. However, such women/ girls should first seek assistance under UJJAWALA Scheme in areas where it is in operation.



Women affected by domestic violence could stay up to one year. For other categories of women, the maximum period of stay could be up to 3 years. The older women above the 55 years of age may be accommodated for maximum period of 5 years after which they will have to shift to old age homes or similar institutions.

Swadhar Greh facilities can also be availed by the children accompanying women in the above categories. Girls up to the age of 18 years and boys up to the age of 8 years would be allowed to stay in the Swadhar Greh with their mothers.

Note: All the above mentioned Acts, benefits, protections are women centric and hence only stand to benefit women while marginalizing the Transgender population as they are not Trans inclusive. There are no specific Acts or laws till date which protects Transgender individuals from stigma, discrimination and violence.



SESSION 3.3

Sex workers' rights and law



Duration

1 hour



Materials required

PowerPoint presentation, LCD projector, laptop, white board, marker pens, handout: Consensus Statement by the Global Network of Sex Worker Projects (NSWP).



Learning objectives

By the end of this session, participants will be able to demonstrate the challenges faced by sex workers and describe the laws pertinent to sex work.



Methodology

Step 3.3.1: Skit Presentation (35 minutes)

The participants are divided into 4 groups. Each group has to enact a skit pertaining to a real-life situation faced by sex workers.

Group-1: Sex worker soliciting on the road

Group-2: Sex worker trying to get her child admitted to a school

Group-3: Sex worker sheltered in a Nari Niketan

Group-4: Sex worker negotiating condom use with her client

Each group gets 10 minutes to prepare, and then 5 minutes each to present their skit.

After the skit presentation, ask the participants:

- Was it difficult to enact the situations given to them?
- Have they personally faced the situations?
- Was there a common thread in all the skits?

Step 3.3.2: The Immoral Traffic (Prevention) Act (ITPA) (25 minutes)

Ask the participants:

- Is sex work illegal in India?
- Does the law only punish women sex workers?

- Is it easier to work in a brothel or with two or more sex workers or alone?
- Should parents/children of sex workers have access to their earnings from sex work?
- Should partners of sex workers have access to their earnings from sex work?
- Should sex workers be allowed to hire drivers, managers, security guards?

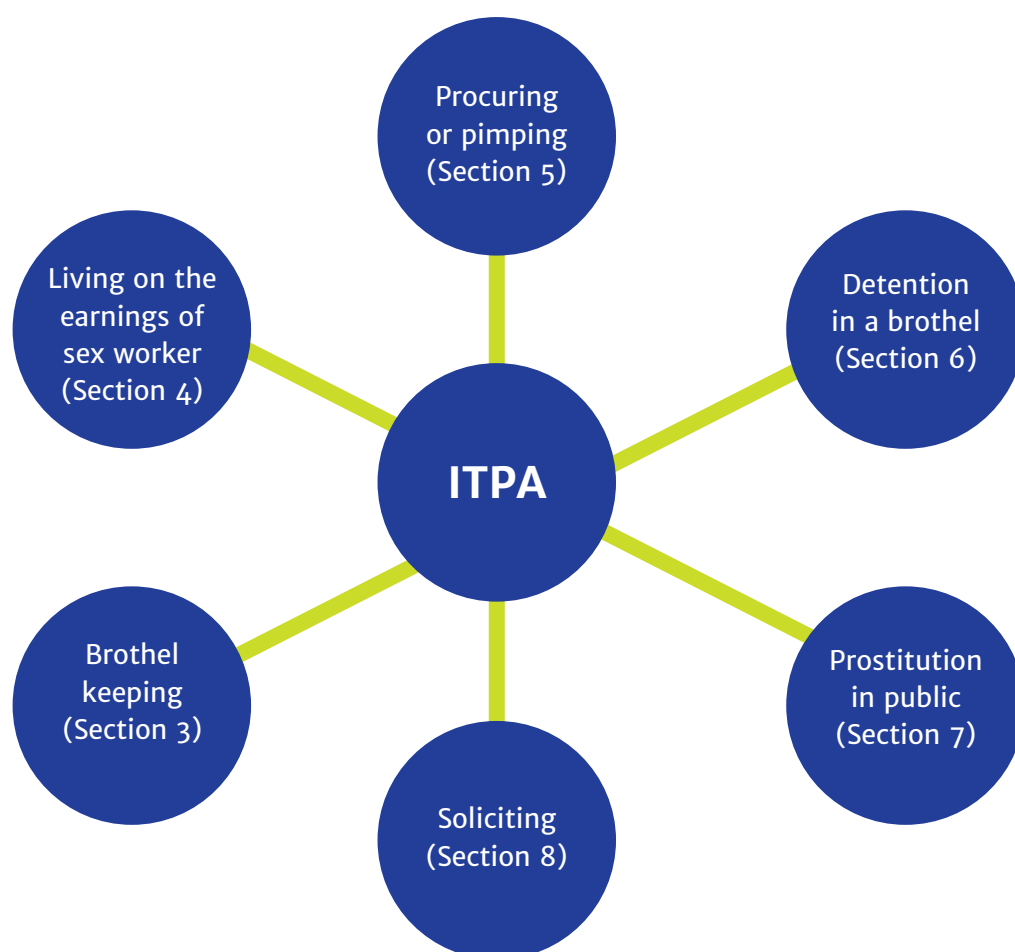
Position the responses against the ITPA. The ITPA lays down the law on sex work in India. It was enacted in 1956 to primarily punish the third parties who exploit sex workers. It was not intended to criminalise sex workers, but that exactly has happened. Most prosecutions under ITPA has been against the sex workers for soliciting.

Use to following slide to outline the offences under ITPA:



Note to facilitator

Please see Slides 3.3: Sex workers' rights and law





Note to facilitator

The points to be noted are:

- Sex work per se is not illegal in India.
- If a sex worker is doing sex work on her own, without involving another sex worker, then it is not illegal, and her house is not a brothel.
- A sex worker working in a brothel is not liable for any criminal sanction.
- A sex worker can spend her earnings from sex work on herself and her children under 18 years of age.

Ask the participants:

- Have they heard of the Panel set up by the Supreme Court for making recommendations on improving the lives and health of sex workers?
- What do they think about rehabilitation?
- Should all sex workers be rehabilitated?

The Supreme Court is currently deliberating on various aspects of sex work including rehabilitation. The Court has appointed a Panel to assist the Court on sex workers' issues, and the Panel has submitted 15 interim reports making various suggestions. (*Please see 'Additional Resources for Facilitator' section for details*)

Ask the participants:

- Are all sex workers trafficked?
- If someone joins sex work out of economic reasons, is it trafficking?
- Should we treat sex workers and victims of trafficking in the same manner?

The Government is currently drafting a law on human trafficking, despite Section 370, IPC, and there are concerns that that law would have a negative impact on the rights of the sex workers.

Provide participants with the handout: Consensus Statement by the Global Network of Sex Worker Projects (NSWP)



Key message

It is important to bear in mind that providing HIV prevention and treatment services is not meant to promote sex work, but to encourage health seeking behaviour by the sex workers and their clients.

Handout

Consensus Statement by the Global Network of Sex Worker Projects (NSWP)

A Consensus Statement issued by the NSWP outlines fundamental rights for sex workers of any gender, class, race, ethnicity, health status, age, nationality, citizenship, language, education level, disabilities and other status. The following eight rights have been identified in various international and national legal frameworks and in NSWP's global consultation:

1. The right to associate and organise – sex workers have a right to self-determine, self-organise and collectively advocate for their rights.
2. The right to be protected by the law – sex workers should have equal access to justice and ought to receive equal treatment before the law.
3. The right to be free from violence – sex workers have the right to be free from all forms of violence, including physical, psychological and sexual violence, as well as economic violence.
4. The right to be free from discrimination – sex workers have the right not to be discriminated against within the social system and institutions and to be treated equally in all contexts of social and everyday life.
5. The right to privacy and freedom from arbitrary interference – sex workers should not be subjected to arbitrary interference with their privacy, family, home or correspondence, nor to attacks upon their honour and reputation.
6. The right to health – sex workers have the right to enjoyment of the highest attainable standards of mental and physical health.
7. The right to move and to migrate – sex workers have the right to move within their city or country, leave their country and request entry into another country.
8. The right to work and free choice of employment – sex workers have the right to freely choose their livelihood, work in fair and safe working conditions, and have equal access to labour rights and protections.



SESSION 3.4

Legal rights relating to MSM and gay men



Duration

1 hour



Materials required

White board, marker pens



Learning objectives

By the end of this session, participants will be able to describe the various legal rights available to MSM.



Methodology

Step 3.4.1: Sharing about Sexuality (20 minutes)

Invite volunteers from among the participants to briefly cite two examples from their lives (or from the lives of people they know) when their sexuality was both positively and negatively reaffirmed in society. It could be examples from childhood, while studying, or employment settings.

Open discussion on the following:

- Do participants have any common experiences?
- Was it easier to cite negative experience than positive experience?
- How often do the negative instances occur?
- What are the two main reasons for the negative reinforcement of alternate sexuality?



Note to facilitators

If possible, arrange for a counsellor to be present at the session in case some of the participants require counselling

Explain that homosexuality is no longer considered to be a disease or a mental disorder. Both the American Psychiatric Association (APA) and the World Health Organisation (WHO) have removed homosexuality from the list of disorders. However, homosexuality is still seen as a mental disorder or disease, which can be 'cured'. Families routinely force their young gay children to go to dubious doctors, including psychiatrists, who claim to cure homosexuality. Many studies have documented how the belief still

exists amongst the medical community that homosexuality is a medical condition.^{iv} Conversion therapy, i.e., the practice of seeking to change a person's sexual orientation, which has been discredited the world over, continues unabated.

Ask the participants:

- Is being gay a crime?
- Have they heard of Section 377, IPC? If yes, what?
- What acts did this Section cover?
- Did Section 377 covered only homosexual men?
- Does any Section cover acts between two women?
- Did Section 377 cover only consensual sexual acts?
- Does Section 377 cover only sexual acts between adults?
- Have they ever been charged or know anyone who was charged under Section 377?

Step 3.4.2: Section 377



Note to facilitator

Though Section 377 has now been struck down, many people from the MSM and transgender/hijra communities in rural and remote areas still face harassment as the legacy of 377 continues in the form of stigma and discrimination till date.

Ask the participants:

- Have they ever been harassed or blackmailed owing to Section 377?
- Have they faced violence by police or *goondas*?
- Have they faced bullying or verbal abuse?
- Have they been told that homosexuality is unnatural or abnormal?
- Have they been told that homosexuality is a medical disorder?
- Have they faced discrimination in employment, health care facility?
- Have they been informed about safe sex practices?
- Have they felt lonely and isolated?
- Have they grown up feeling guilty and anxious?
- When in public, do they try to pass off as 'straight'?

Other laws used against gay men and MSM

Ask the participants:

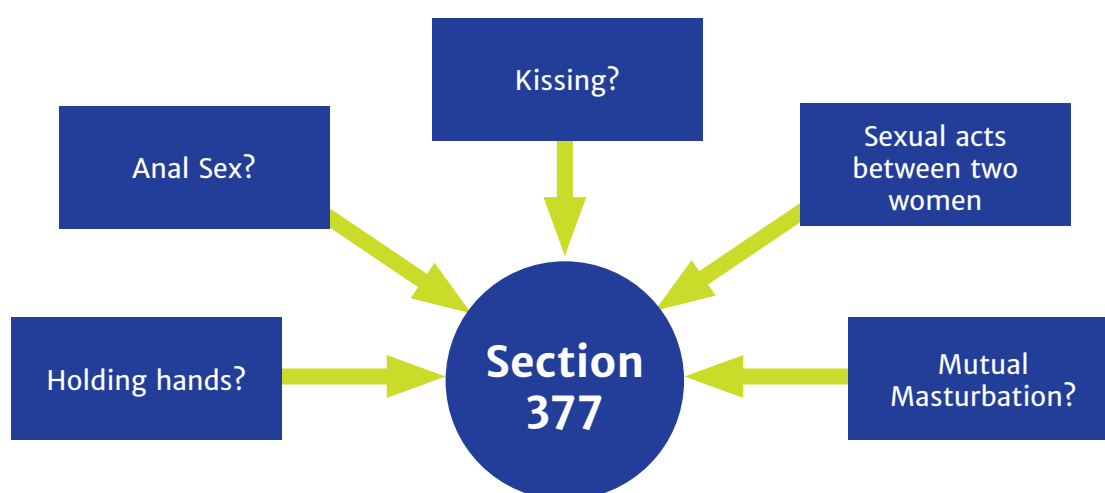
- Are there other laws that affect gay men and MSM?
- Have they been harassed or charged under other laws?
- Have they been rounded up by police when they were cruising at hotspots?
- Have they been accused of obscene behaviour?

For decades, gay men, TGs and MSM are targeted under local police laws, like *Bombay Police Act, 1951* or *Andhra Pradesh Police Act* either for allegedly creating public nuisance or for obscene acts. In particular, they are detained by police for hours, and face physical and sexual violence, extortion, etc.

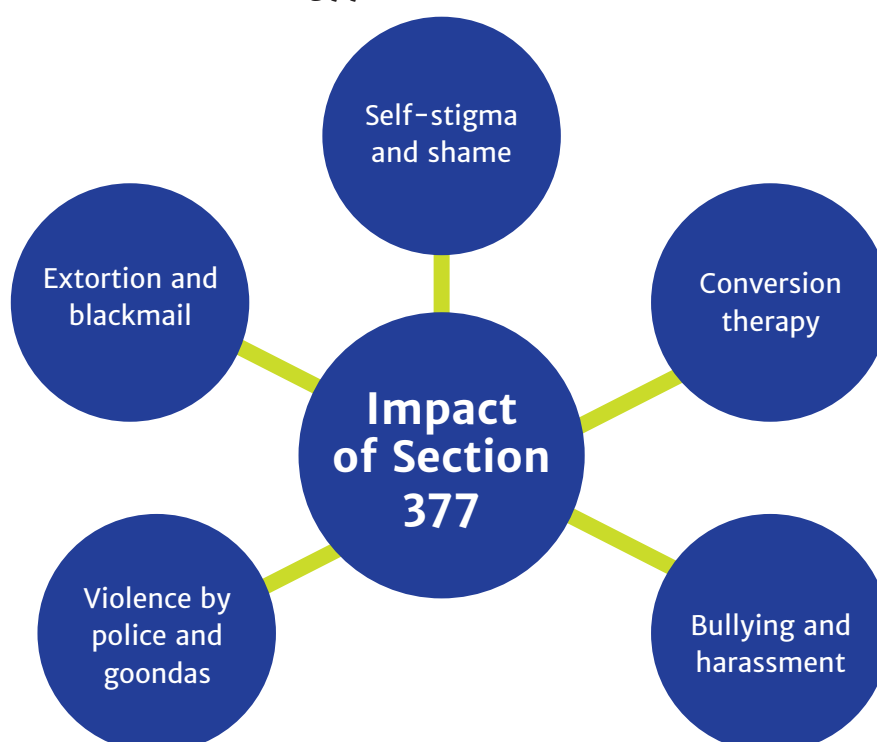
Scope and extent of Section 377

Section 377, Indian Penal Code ('IPC') was enacted by the British Colonial administration in 1860. It prohibited anal sex, oral sex, and any other penile non-vaginal sexual acts between two consenting adults. Indulging in such acts was punishable with imprisonment up to 10 years or life. Both heterosexual and homosexual individuals were covered. In effect, it criminalised both consensual and non-consensual sexual acts. At the same time, it treated acts between two adults, and between an adult and a minor in the same manner, i.e., made no distinction on the basis of age. Importantly, Section 377 penetration, i.e., penetration by a penis, the cornerstone of the offence. Section 377, however did not criminalise the homosexual identity.

Ask the participants which Acts were covered under Section 377:



Effect of Section 377



Although technically, Section 377 criminalised the homosexual ‘act’ and not the homosexual ‘identity’, it had the effect of criminalizing the ‘identity’ as well. Because it was predominantly homosexual/transgender persons who were associated with the sexual practices proscribed under Section 377, thus, Section 377 disproportionately targeted a class of persons, namely homosexual men, based on their sexual expression and identity. Thus, they were deprived from forming intimate sexual relationships, lest they became criminals.

The impact of Section 377 on the lives and health of homosexual men has been disastrous, to say the least. The fear of being non-normative gets instilled deep from childhood onwards, wherein any child who looks or behaves differently is subject to ridicule, bullying and discrimination in school. Since most gay men are not out in their workplaces, they often do not report instances of harassment, and abuse. In fact, those, who are even slightly effeminate or visibly gay, face scorn and ridicule on a daily basis. Studies have documented that 44% of employees in India had been subject to sexual orientation discrimination.^v

Constitutional Challenge to Section 377

Ask the participants:

- Does Section 377 violate any fundamental rights?
- Have they heard of the Naz Foundation case? If yes, what?
- Do they know about the status of the case?
- Should Section 377 be scrapped totally?
- Is there any utility of Section 377?
- Legislature or Judiciary? Who is better placed to change the law?

The validity of Section 377 was challenged by Naz Foundation (India), an NGO working on male sexual health issues, in the High Court of Delhi in December, 2001, on the ground that it violated fundamental rights of individuals. The Ministry of Home Affairs, Government of India, which is the nodal ministry for the enforcement of Section 377, argued that Section 377 ought to be retained, on the grounds of public morality and public health. At the same time, the Ministry of Health, Government of India took a different stand, stating that Section 377 was a major impediment to the HIV prevention interventions in India. In July, 2009, the High Court declared that Section 377, IPC, in so far as it criminalised adult consensual sexual acts in private, was violative of the fundamental rights to privacy, dignity, health, equality, and non-discrimination guaranteed under Articles 21, 14 and 15 of the Constitution of India.^{vi}

On appeal, the Hon’ble Supreme Court of India in *Suresh Kumar Koushal v. Naz Foundation (India) Trust*^{vii} in December, 2013, overruled the High Court decision, and reinstated Section 377. The Apex Court, in fact, referred to the LGBTI community as a ‘miniscule minority’, which added to the already existing stigma. Interestingly, the Government of India had

not appealed against the High Court decision. The Petitioners had filed a curative petition^{viii} against the Supreme Court decision.

However, recently, the Supreme Court, in a nine judges bench decision, upheld the fundamental right to privacy guaranteed under Article 21 of the Constitution.^{ix} The Court held that sexual orientation is an integral aspect of privacy and dignity of individuals.

Decriminalisation and Reading Down of Section 377, IPC

In June, 2016, 5 gay and lesbian persons filed another writ petition in the Supreme Court [*Navtej Johar & Ors. v. Union of India & Ors.*, Writ Petition (Criminal) No. 76 of 2016] challenging the validity of Section 377, IPC on the ground that it violated their fundamental rights to equality, non-discrimination, privacy, dignity, autonomy guaranteed under Articles 14, 15 and 21 of the Constitution. On 8th January, 2018, the Supreme Court referred this writ petition to a larger bench of 5 judges. Similar petitions were filed by other individuals and groups too, including Humsafar Trust & Anr. V. Union of India [Writ Petition (Civil) No. 100 of 2018]. The final arguments took place in July, 2018.

On 6th September, 2018, the Supreme Court in a five judge decision, delivered a landmark verdict striking down Section 377, IPC, in so far as it applied to consensual sexual acts between adults. In effect, homosexual men and transgender persons would no longer be criminalised for engaging in sexual acts, and for their identity. The Supreme Court categorically held that “*Section 377, IPC, so long as it criminalises consensual sexual acts of whatever nature between two competing adults, is irrational, indefensible, and manifestly arbitrary*” It further noted that LGBT persons are inhibited from openly forming and nurturing fulfilling relationships, thereby restricting rights of full personhood and dignified existence, as guaranteed in Articles 19(1) and 21 of the Constitution. Accordingly, the Court held that Section 377 violates the fundamental rights of equality, non-discrimination, freedom of expression, privacy, dignity, autonomy and health guaranteed under Articles 14, 15, 19(1), and 21 of the Constitution.



Key message

In India, MSM and transgender persons are no longer criminalized for their sexual preferences or identities under Section 377 but there is still no access to all the civil rights for the community.

SESSION 3.5

Transgender persons' rights and law



Duration

1 hour



Materials required

LCD projector, laptop, selected film(s), white board, marker pens, chart paper, copies of the handout: Transgender Persons (Protection of Rights) Bill, 2016.



Learning objectives

At the end of this session, participants will be able to identify and describe the legal provisions for the protection of transgender rights



Methodology

Step 3.5.1: Film screening and discussion (20 minutes)

First part is watching a brief audio-visual film on one year of recriminalisation (8 minutes) <https://www.youtube.com/watch?v=xuWzkzmLyro>

Or a film made by Multiple Action Research Group
<https://www.youtube.com/watch?v=aZ41WXbRqYE>

After they watch the film, ask the participants:

- What are their first thoughts?
- Did they feel anger, upset or hopeful?
- Do they know of Section 377 or other laws used against transgender persons?
- Should transgender persons engage with law? Or should they limit their focus on welfare benefits?
- Should *badhai* and *mangti* be made legal?
- What has been their experience of the legal system? Did they face discrimination? Stigma?

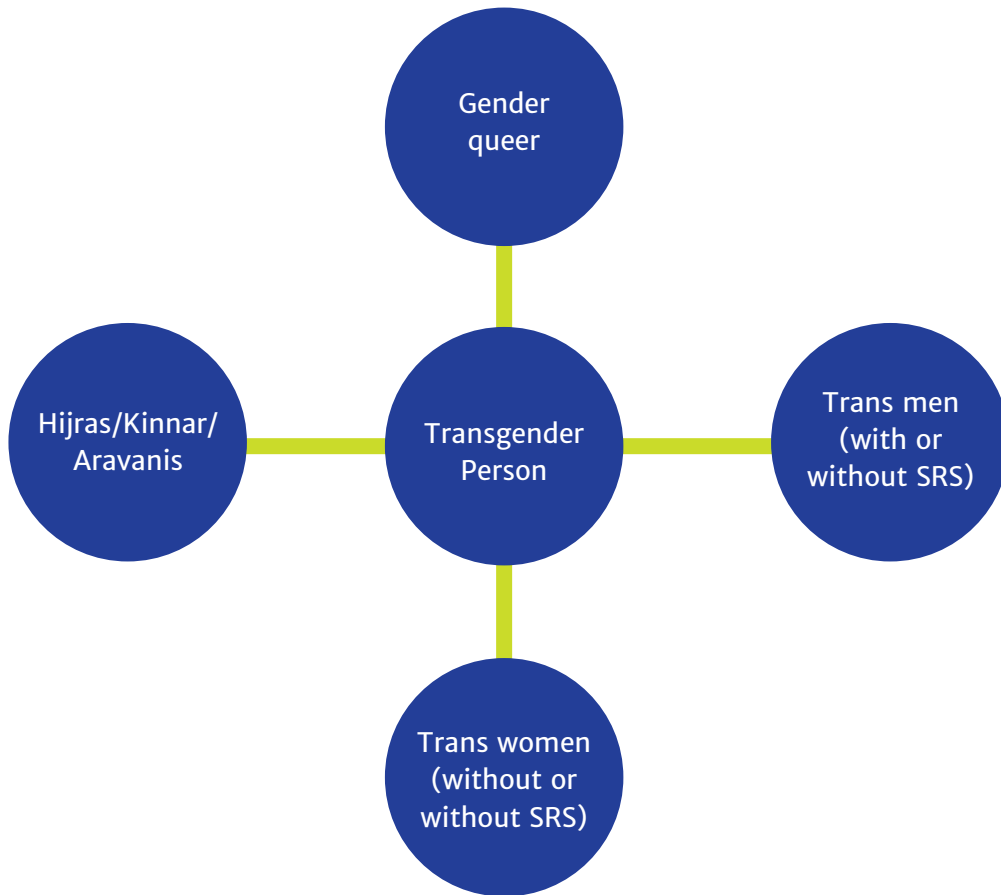
Who is a transgender person?

See diagram:



Note to facilitator

Please see Slides 3.5: Transgender persons' rights and law



Ask the participants:

- Have they heard the allegation that transgender persons/hijras steal children?
- Do they know of anyone who was accused of that?
- Have they heard the allegation that transgender persons/hijras have 'criminal tendencies'?

Till recently, the Indian legal system was based on the binary of male and female, based on the sex assigned at birth. It did not recognise either third gender, or those have transitioned from female to male or male to female, to align their physical characteristics with their gender identity. In fact, there was a law that even criminalised the identity of hijras.

Step 3.5.2: Laws pertaining to the TG community

With the aid of PowerPoint slides, explain the various existing laws that directly affect transgender community:

- The Criminal Tribes Act, 1871
- Section 377, 1860

- The Immoral Traffic (Prevention) Act, 1956
- Bombay Prevention of Begging Act (BPBA) 1959
- Other laws
- National Legal Services Authority (NALSA) vs. Union of India^x

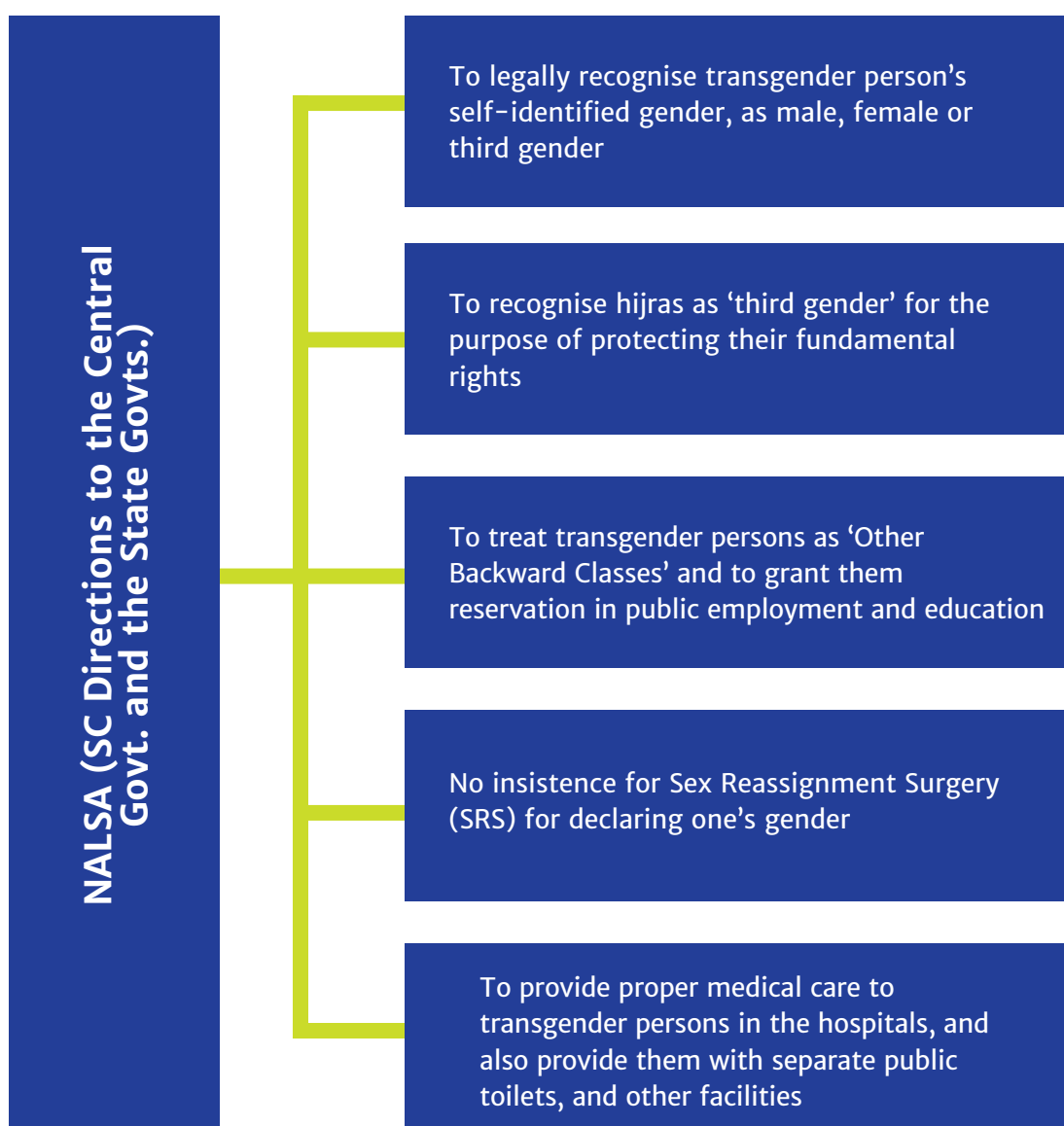


Note to facilitator

Please see Slides 3.5: Transgender persons' rights and law and refer to details provided in Section K – Session 3.5: Transgender Rights and Law in the Additional Resources for Facilitators

Open the floor for discussion with the aid of the following slide:

Directions of the Supreme Court in NALSA



Ask the participants about their experience after the NALSA judgment:

- Have they seen a change in their lives in the last 3 years?
- Has police violence decreased?
- Have they been able to access welfare benefits like health insurance, pension, educational scholarships, etc.?
- Have they managed to get their documents changed?
- Can they name at least two benefits that are given to transgender persons in their States?

Step 5.2.3: Transgender Persons (Protection of Rights) Bill, 2016 (40 minutes)

Ask participants:

- Have they heard of the Supreme Court judgment on transgender rights?
- When did they first hear about it?
- Is it applicable only to hijras?
- Does it cover transgender women and transgender men?



Note to facilitator

Provide participants with copies of the Transgender Persons (Protection of Rights) Bill, 2016.

http://www.prsindia.org/sites/default/files/bill_files/Transgender%20persons%20bill%20as%20passed%20by%20LS.pdf

Divide the participants into 5 groups and assign each group with one of the following sections of the bill:

- Group I: Definition of transgender [Section 2(i)] and Prohibition of Discrimination (Section 3)
- Group II: Sections 4–8 of the Bill (Chapter III)
- Group III: Sections 9–13 of the Bill (Chapters IV and V)
- Group IV: Sections 14–18 of the Bill (Chapters VI and VII)
- Group V: Section 19 of the Bill (Chapter IX)

Ask the participants to identify one good provision and two bad provisions, and instead of the bad provisions, what two provisions they want.

Each group gets 15 minutes to discuss, and then 5 minutes each to come and present their points.



Key message

As per the law, no transgender person can be discriminated on the basis of gender identity by the State.



SECTION 4

PLANNING AND IMPLEMENTING STRATEGIES

Outline of sessions

Session 4.1: Building trust and effective responses

Session 4.2: Access to justice and empowerment

Session 4.3: Establishment of crisis response systems

Session 4.4: Strategies to reduce violence, stigma and discrimination

SESSION 4.1

Building trust and effective responses**Duration**

25 minutes

**Materials required**

PowerPoint presentation, laptop, LCD projector, white board/flip chart, marker pens.

**Learning objectives**

By the end of this session, the participants will be able to describe the principles essential to gain the trust of key populations.

**Methodology****Step 4.1.1: Experience Speaks (15 minutes)**

Ask all participants to share from their experiences on how best to make initial contact with sex workers and other key populations for outreach work.

Supplement with the following points:

- Explain who you are and what you want.
- Reassure sex workers and others on the sex work scene that you are not police or journalists.
- Emphasize confidentiality.
- Do not expect people to fill in questionnaires on first contact or to give any details for some time (some people may choose not to at any point).
- Don't interfere with business, wait until the sex worker is free
- Make an immediate offer of condoms
- Give a card with your name and the project's name and phone number
- Have an official identity card available to show if requested and/or give the name and phone number of someone who can confirm your identity
- Be patient – building trusting relationships takes time

Step 4.1.2: PowerPoint presentation (10 minutes)

With the aid of PowerPoint slides [please see Slides 4.1: Building trust and effective responses], explain the following principles that are essential in building trust between health-care providers and key populations receiving services:

1. **Voluntary and informed consent:** Key populations have the right to decide on their own treatment and the right to refuse services. Health-care providers should explain all procedures and respect their choices if they choose to refuse examination or treatment.
2. **Confidentiality:** Confidentiality of patient information, including clinical records and laboratory results, should always be maintained to protect their privacy.
3. **Appropriate services:** Clinical services should be effective, of high quality, provided in a timely manner and address the needs of key populations.
4. **Accessible services:** Clinical services should be offered at times and places convenient for key populations. Where possible, services should be integrated or closely linked so that a broad range of health services can be accessed at a single visit.
5. **Responding to violence:** A health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Statistics show that abused women use health-care services more than non-abused women do. They also identify health-care providers as the professionals they would most trust with disclosure of abuse. Health professionals can provide assistance by facilitating disclosure; offering support and referral; providing the appropriate medical services and follow-up care.

A health-care provider should, as a minimum, offer first-line support when women disclose violence. First-line support includes:

- Being non-judgemental and supportive and validating what the woman is saying
- Providing practical care and support that responds to her concerns, but does not intrude
- Asking about her history of violence, listening carefully, but not pressuring her to talk or disclose information
- Helping her access information about resources, including legal and other services that she might think helpful
- Assisting her to increase safety for herself and her children, where needed
- Providing or mobilizing social support.
- Offering comfort and help to alleviate or reduce her anxiety

Take a complete history, recording events to determine what interventions are appropriate. Check with team manager for support

6. **Fostering community-led outreach:** In order to ensure the trust and confidence of key populations, it is important to employ educators and outreach workers who are themselves from the community concerned. This is because they:
 - ◆ Share a common experience that may decrease internalized stigma and increase self-worth and collective solidarity

- ◆ Are likely to be more comfortable discussing intimate details associated with sex work with someone who is experienced and knowledgeable
- ◆ Are more likely to follow up on referrals to services, adhere to treatments and engage in health-seeking and health-protective behaviours if they trust the person providing the advice
- ◆ Have knowledge of the sex work industry that can inform outreach activities to clients, managers, law enforcement and health-care providers.



Key messages

- Building trust leads to community empowerment and long-term meaningful participation.
- Key populations should be given the opportunity to participate in all other levels of the programme, including decision-making on programme implementation, management and governance.
- Capacity-building and mentoring should be a priority to enable key populations to take up these positions.

SESSION 4.2

Access to justice and empowerment



Duration

1 hour 35 minutes



Materials required

PowerPoint slides, LCD projector, laptop, white board, marker pens.



Learning objectives

At the end of this session, participants will be able to define rights violation and list the forms of legal recourse that can be accessed by key populations.



Methodology

Step 4.2.1: Role play (40 minutes)

Divide participants into 4 groups. Each group is given a problem, and they have to come out with a solution.

Group-1: Sex worker is arrested for soliciting from her own house.

Group-2: Gay man is being blackmailed on social media by another guy who he has never met

Group-3: Transgender woman is dismissed from a government job after she started transitioning.

Group-4: Hijra person is raped by a policeman.

Each group gets 10 minutes to discuss and then present the solution for 5 minutes each.

After the presentation, ask the participants:

- Did they find the task difficult? Was it unrealistic to look for solutions?
- When there is a violation, should they always seek relief or accept the violation?
- In case of violation, who is their first point of contact for intervention?

Any person, whose fundamental rights have been violated, can approach, either the Supreme Court (under Article 32) or the respective High Courts of the states where they are residing (under Article 226) for reliefs.

Step 4.2.2: Violation of rights in the context of HIV (15 minutes)

Ask the participants:

- Have they heard about the HIV Act?
- Should there be routine HIV testing?
- Should all KPs be mandatorily tested?
- Should disclosure of HIV status happen?
- Should peer educators and outreach workers be protected in law for doing HIV prevention activity?
- What can one do if one is discriminated because of HIV status?

With the help of PowerPoint slides, briefly describe the main features of the HIV (Prevention and Control) Act, 2017



Note to facilitator

Please see Slides 4.3: Establishment of Crisis Response Systems. For details, refer to Section L – Session 4.3: Establishment of Crisis Response Systems in the Additional Resources for Facilitators)

Step 4.2.3: Access to legal aid (40 minutes)

Employ an interactive approach to guide participants in discussing the following ways to access legal aid for key populations:

A. Approaching the Courts

Ask the participants:

- Have they ever filed an RTI?
- Have they met or engaged a lawyer?
- Have they had access to free legal aid?
- Have they attended legal awareness sessions?
- Have they ever filed a case in court?
- Have they made a complaint against violation?

Right to legal representation is one of the most important aspects of the fundamental right to fair trial guaranteed under Article 21 of the Constitution. This includes the right to free legal aid to those who cannot afford legal services otherwise. Accordingly, the State has an obligation to provide quality free legal aid to all poor and marginalised communities, especially the key populations.

- National Legal Services Authority has a mandate to provide free legal aid to sex workers and transgender persons. This is applicable to all State Legal Services Authorities and the District Legal Services Authorities.
- The Supreme Court in *Budhadev Karmaskar vs. State of West Bengal* had directed the NALSA, SLSAs and DLSAs to provide free legal aid to sex workers.^{xi}
- Targeted interventions, in collaboration with DLSAs or CBOs or NGOs working on HIV prevention, can offer legal assistance to KPs to challenge discriminatory actions and practices.

B. How to make a criminal complaint

Ask the participants:

- Have they ever made a criminal complaint, either for themselves or for their friends/peers?
- Have they gone to police station? If yes, how was the experience?
- If they were the victims, did the police make them feel like criminals?
- How tough or easy it was to file a complaint?
- Would they go alone or go with friends or CBO staff, or a lawyer to the police station?

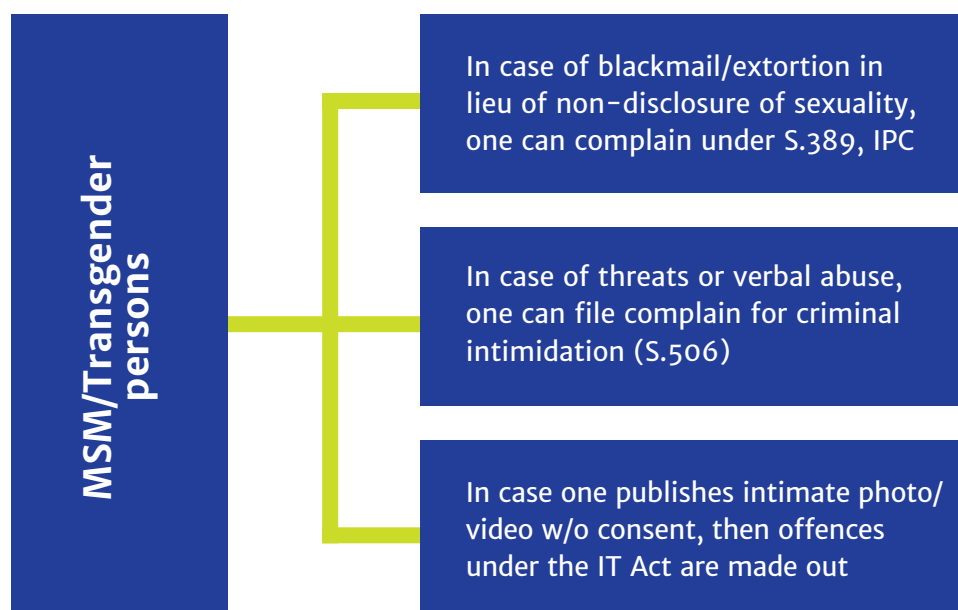
Points to be noted:

In case of rape or sexual assault of a sex worker, she can do the following

- She can lodge a FIR with the police station,^{xii}
- FIR has to be lodged only by a woman police officer,^{xiii}
- It is mandatory for the police to register the FIR,^{xiv}
- In case a police officer refuses to register the FIR, he or she is liable to be punished with imprisonment, ranging from six months to two years with fine,^{xv}
- She is also entitled to get free medical treatment in any hospital, whether public or private^{xvi}

In case of transgender/hijra persons, it is not so easy. Transgender identity is yet to be properly recognised in criminal law, despite NALSA. It is an open question whether a person will be treated in their birth sex or in their preferred gender in criminal law. But in one case, the Chhattisgarh High Court did entertain a complaint of rape filed by a transgender woman against a man under Section 375, IPC.^{xvii}

In case of gay men, the following criminal law provisions can be utilised:



C. Filing of Non Cognizable offences complains

Offences are divided into two categories: Cognizable and non-cognizable offences. In cognizable offences, police can arrest an accused without a warrant, while in non-cognizable offences (NC), police need an arrest warrant before arresting an accused. FIRs have to be registered in all cognizable offences, but in most non-cognizable cases, the police only records the complaint, and do not register the FIR.

D. If accused of a criminal offence:

Ask the participants:

- Have they been accused/charged of a criminal offence?
- Have they been arrested?
- Did they know about their legal rights when arrested?
- Did they get legal representation at the police station/court?
- How were they treated at the police station?

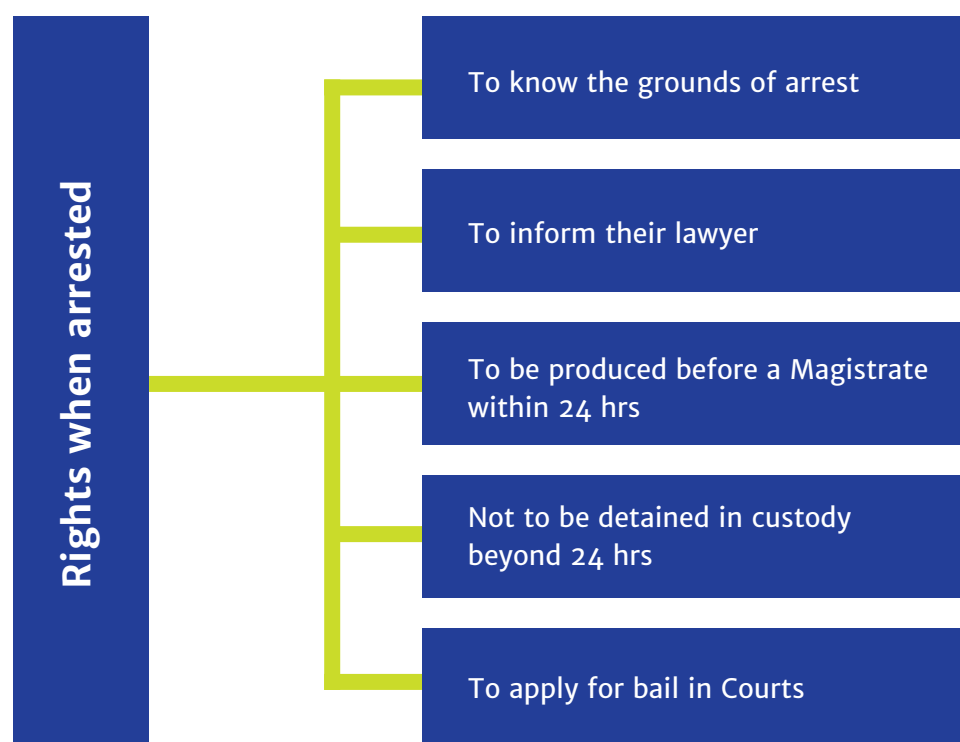
In case of a criminal complaint against a sex worker, the following important things are to be kept in mind:

- No woman can be arrested after sunset and sunrise, except in exceptional circumstances, with the prior permission of the Magistrate;^{xviii}
- An arrested woman can be searched only by another woman with strict regard to decency;^{xix}
- Any woman arrested on a bailable offence has a right to be released on bail from the police station;^{xx}
- Any woman arrested has a right to meet an advocate of her choice during interrogation;^{xxi}
- Any woman arrested for a non-bailable offence can apply for bail from the Court;^{xxii}

In case a gay man/transgender/hijra person is arrested, they have the following rights:

- Right not to be subjected to unnecessary restraint or handcuffed during arrest (S.49, CrPC)
- Right to be released on bail at police station if arrested under bailable offence [S.50 (2), CrPC]
- Obligation of police to inform the person nominated by the arrested person [S.50A(1), CrPC]
- Duty of the police to take reasonable care of the health and safety of the accused (S.55A, CrPC)

They have the following rights:



- Summarize the session, highlighting the role that the TI can play in creating awareness about the legal rights that key populations can access.



Key message

Inform and educate key populations about the forms of legal recourse available to them.

SESSION 4.3

Establishment of crisis response systems



Duration

45 minutes



Materials required

Flip chart or white board, marker pens



Learning objectives

By the end of this session, participants will be able to describe and contextualize crisis response systems and their functioning



Methodology

Step 4.3.1: What constitutes a crisis response system? (25 minutes)

Ask the participants:

- Are there existing crisis response systems in their districts?
- Are they effective? If not, what are the changes required?
- Are they community led?

Explain: Crisis response systems can be of many types. It could be a formal structure, or an informal group of individuals who help each other out, in times of crisis.

Crisis intervention work can be done for many reasons:

- In case of gay men being blackmailed by other men or police
- In case of violence faced by sex workers or transgender or hijra persons
- In case of eviction of gay men or transgender persons from their own homes
- In case of false cases filed against KPs
- In case of being arbitrarily detained in police stations

Initiate discussion on some of the effective methods to mitigate crises.

These could include the following:

- i. In every district, sex workers and MSM, transgender and. Hijra (MTH) populations create WhatsApp groups to inform each other of problems they face and share safety tips.

- ii. Out of those people, a crisis response team (CRT) is created of 10 individuals to deal with both sex workers and MTH issues. This team would be on call 24/7 to respond to any crisis pertaining to KPs in the district, and a helpline number will be circulated.
- iii. If a transgender person faces violence, she has the option of sending an immediate message to her MTH WhatsApp group, who would then contact the CRT, or call the CRT's helpline number.
- iv. The 10 members of CRT would be rotated every month so that members are not overburdened with the work of crisis intervention.
- v. A group of lawyers and a paralegal (from DLSAs and CBOs), medical professionals, social worker, women's rights activists and local party workers could be created in each district to assist in the crisis work, especially if it involves going to the police/magistrate/Court. In case of a crisis, the CRT will immediately alert this group.
- vi. Monthly meetings of the CRT should to be attended by representatives of the key populations as well as stakeholders', in order to discuss what actions have been taken in crisis cases, and what needs to be done in future. These meetings can also be used as a platform to share experiences/concerns and to suggest ways to improve the crisis work. One can also do trainings on rights and empowerment.
- vii. Apart from CRT, a three-member monitoring and documentation team can be created in each district (comprising two members from key populations and one from CBO).
- viii. A database should be created of the members of the crisis team and members of the stakeholders' team, and kept with the local CBO. The CRT's helpline number should be widely publicised.

Discuss the viability of establishing a local Advocacy Group. The following options can be considered:

- i. In each district, create a group of 7 individuals (4 persons from the community, and 3 non-community persons) to do advocacy on stigma and discrimination and violence.
- ii. This group can meet the local police authority, DLSAs, SLSAs, DAPCU (District AIDS Prevention and Control Unit) and SACS (State AIDS Control Societies), local MLAs/MPs, etc. to do advocacy and sensitisation of these authorities on the issues relating to sex workers and MTH rights. A sensitisation program can be organised every two months.

Step 4.3.2: Financial Viability of CRT (10 minutes)

Discuss possible ways to ensure continuity of crisis response work in the face of indefinite funding.

Note: It is true that most crisis intervention work is tied to project funding and when the project ends, crisis response work suffers as there is hardly ever separate funding for the work. At the same time, the work is critical for key populations and ought to be sustainable.

Accordingly, the following options can be suggested:

- i. In every district, all members of KPs who are part of the WhatsApp group can contribute Rs 100 or Rs 200 per month, depending upon the number of KPs in the district and the requirements of the CRT. This money can be collected by a designated person in the CRT or a CBO, and deposited in to a local bank. The funds can be utilised as per the requirements of the CRT.
- ii. The community members in each district can organise events such as cultural programs, plays, sports competitions, etc. once in every three months, and raise funds from the people who come to attend these events

Step 4.3.3: Monitoring the CRTs' work (10 minutes)

Seek suggestions from the participants on how best to monitor the CRT's functioning.

Note: Since crisis intervention work is not tied to any project work, it is important for the whole community of KPs to take ownership of the same. In this regard, local CBOs in each district could be engaged to work with the Monitoring Team to discuss ways to document the CRT work. This documentation could then be discussed in the monthly meetings.



Key message

Establish crisis response systems that are contextual and sustainable.

SESSION 4.4

Strategies to reduce violence, stigma and discrimination



Duration

2 hours



Materials required

Flip chart/white board, chart paper, marker pens, and copies of the post-test assessment questionnaire.



Learning objectives

At the end of this session, participants will be able to identify interventional strategies to reduce violence, stigma and discrimination.



Methodology

Step 4.4.1: Community Empowerment (45 minutes)

Divide participants into 4 groups. Each group is allotted one of the following situations:

- Group 1: Setting up a local crisis intervention centre to counter violence and stigma
- Group 2: Two demands of law reforms to be made to the local MP
- Group 3: Two issues to be taken by SLSAs/DLSAs (State Legal Services Authority/District Legal Services Authority)
- Group 4: Identify two strategies on advocacy with local media

Each group is allotted 15 minutes to discuss and then given 5 minutes each to present.

After the presentation, ask the participants:

- Have they ever been part of crisis interventions?
- Does crisis intervention work in all cases?
- Is it difficult to mobilise people for crisis intervention?
- Should TIs be involved in crisis intervention?
- Should advocacy on rights issues be incorporated as part of TI program?
- Have they met their local MPs/MLAs? Have they been responsive?
- Are there DLSAs in their districts? Do they function well?
- Have they received free legal aid from DLSAs?

- Has the local media been supportive? What are the ways to do advocacy with local media?

Step 4.4.2.: Role of CBOs and TIs in reducing violence, stigma and discrimination (10 minutes)

Emphasize on the crucial role of CBOs and TIs in reducing incidents of stigma and discrimination faced by key populations.

Suggest the following strategies that can be employed:

- Each CBO and TI in every district can designate half a day every week for KPs to come and share their concerns/issues
- They, especially CBOs, can provide backend support to CRT, in terms of logistics and financial assistance
- Regular training of KPs on their rights and violence mitigation can be conducted
- Can provide referral linkages with other service providers like ICTCs, district hospitals, DLSAs, Social Welfare departments, etc.
- Can have a mentor who would have knowledge of all government entitlements and welfare schemes in their districts and states, and assist the KPs to get access to those schemes
- Can provide total support to crisis intervention team and local advocacy group

Ask participants if they want to add to this list from their own experiences

Step 4.4.3: Advocacy Strategies (45 minutes)

Ask volunteers from among the participants to cite one advocacy strategy that will work best in their district, and the resources they need for the same. Inform them that each speaker will get 2 minutes each

After all participants have spoken, the facilitator will identify, along with the participants:

- Five most feasible ideas; and if they can be implemented in more than one district
- Resources to be mobilised; and if they can be mobilised locally

Step 4.4.4: Wrap-up and post-test assessment (20 minutes)

Conduct a quiz to check participants' learning. Divide participants into various groups. Ask a question to one group and allow other groups to judge whether the answer was correct or not. Some questions that could be asked are:

- What is gender?
- What is sex?
- How does gender inequality contribute to spread of HIV?
- What are the barriers to accessing health services?
- What is stigma?

- What are the types of stigma?
- What are the barriers to condom negotiation?
- What are the types and contexts of violence against sex workers?
- What are the SRH needs of women?



Key message

Reiterate that HIV is a gender issue and that key populations need a sensitive, patient and trusting approach for effective uptake of services.

Tackling violence, stigma and discrimination should have elements of public education and sensitization (Eg. National level annual advocacy events focusing on health and human rights of TGH communities: Hijra Habba)



Note to facilitator

Administer the post-test questionnaire and remember to thank the participants for their time and contributions.

Additional resources for facilitators

Section A – Session 1.2: Understanding Gender

Gender refers to the array of socially-constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to individuals, usually on the basis of their perceived biological sex. Societies typically promote the idea that there are only two genders and only two sexes. Sex is understood as determined by biology, whereas gender is an ‘acquired’ identity that is learned, changes over time, and varies widely within and across cultures.

There is a range of genders, gender identities, sexual orientations and gender expressions. In this sense, gender refers not only to women or men, but also to the relationship and power dynamics between and among people because of how they are defined by their communities and how they themselves identify and understand their gender.

The phrase ‘women in all their diversity’ is intended to capture ideas of power and of **intersectionality**, i.e. the idea that an individual stands at an intersection of multiple social experiences, often of discrimination or marginalization. For example, Rizwana, a woman in a slum may experience intersecting and intertwined forms of discrimination and violence because she is a woman; because she is Rizwana; because she is Muslim; and because of internal political situation and defining the area where she is living such as slum etc.

Sometimes this is referred to as ‘multiple and overlapping forms of discrimination’ or ‘compound discrimination’. In the context of HIV, we often talk about ‘women and girls’ as one key population, and about ‘people living with HIV’, ‘sex workers’, ‘people who use drugs’, ‘lesbian, gay, bisexual, transgender and intersex (LGBTI) communities’ and ‘adolescents’ as others – as if they are separate populations that don’t overlap. In reality all these groups overlap and intersect. For example, a woman who sells sex may also be a mother, a wife, a rural woman, a woman of a particular faith (or none), a lesbian, bisexual or transgender woman, a woman or young woman living with HIV, and a person who experiences intimate partner violence (IPV), and so on. By not considering the intersectional nature of all our identities, we risk creating silos in programming or making unrealistic divisions between different groups of women. At best, our programming will lack effectiveness – at worst we may risk entrenching stereotypes and doing harm.

Data:

More than half of the adolescents live in Asia. In absolute numbers, India is home to around 243 million i.e. 30% of India’s population belongs to the adolescent age group of 10–19 years. Adolescents constitute a sizable proportion of the Indian mothers. However, girls in India continues to faces discrimination from the womb.

It is estimated that more than 10 million female fetuses may have been illegally aborted in India since 1990s, and 500,000 girls were being lost annually due to female foeticide. It is estimated that 100,000 abortions every year continue to be performed in India solely because the fetus is female. There are significant differences in gender violence and access to food, healthcare, immunizations between male and female children. This leads to high infant and childhood mortality among girls, which causes changes in sex ratio.

Nearly 50% of adolescent girls aged between 15–19 years are underweight in India. Disparate, gendered access to resources appears to be strongly linked to socioeconomic status. Specifically, poorer families are sometimes forced to ration food, with daughters typically receiving less priority than sons. It is estimated that one in every two girls in India is malnourished and India has witnessed more than 27, 00,000 child deaths a year, with the figures for female children being much higher than male children.

53% of girls in the age group 5 to 9 years are illiterate and 75% of married Indian women were underage when they got married. According to Census 2011, the nine-year period to 2011 saw 15.3 million girls being married before they reached the age of 18 years, this is about 20% of all females married during that period. One out of six girl child dies due to gender discrimination and one out of every 10 women report instances of child sexual abuse.

Sexual Rights

Some aspects of sexuality are matters of human rights; these are often called sexual rights. Sexual rights include the right to:

- Choose sex partners and to form relationships based on choice and consent;
- Say yes or no to sex;
- Express sexuality, including the right to seek pleasure, in the context of consent;
- Enjoy bodily autonomy, free from sexual violence or exploitation;
- Obtain full and accurate information, education, and services; and
- Protect oneself against unwanted pregnancy and infection, including HIV.

Some ways in which sexual rights are curbed:

1. Social norms around gender and even laws related to sexuality can promote — or undermine — Men's and women's feelings of self-worth, dignity, health, and sense of belonging and well-being.
2. The media — including books, television, films, and music videos — generate images that influence our attitudes, feelings, and expectations about sexuality. Often, however, media images reflect narrow and misleading notions about sexuality.
3. All people should be able to participate in political, professional and civic life without discrimination. Sexual norms should not present obstacles to such participation. Unfortunately, some people may face discrimination, humiliation, or job loss because they do not follow prevailing sexual norms. For example, someone with a same-sex partner, an unmarried female who is sexually active or has more than one partner, or someone living with AIDS may suffer such bias.

4. Religions and religious leaders hold a range of perspectives on sexuality and may seek to influence norms and policies regarding sexuality and sexual rights issues. These norms and policies include, for example, those related to:
 - ◆ Sex education;
 - ◆ Abstinence and virginity;
 - ◆ Contraception and abortion;
 - ◆ Homosexuality; and
 - ◆ Marriage.

Religious fundamentalism has been seen to affect the lives of women and marginalized groups in numerous ways. Unmarried and single women are prevented from accessing sexual and reproductive health services and interventions by religious authorities, who serve as gatekeepers of culture. People living with HIV and AIDS are prohibited from accessing treatment and services as they are viewed as sinners and of low moral standards. Sexuality is considered taboo and sinful, thus limiting safe spaces for frank and positive dialogues on sexual and reproductive health and rights issues. Sexual minorities are unable to acknowledge and develop positive attitudes with regards to their sexuality and access SRHR services thus driving them underground. Abortion is restricted and criminalized, thus forcing women to avail unsafe and illegal abortions and thereby endangering their lives and health. Fundamentalists often propagate and fail to address sexual violations on women, marital rape, female genital mutilation and circumcision, honour crimes, forced and early marriages, mass rapes, restrictions on women's mobility, clothing and economic and political participation, trafficking, virginity tests and moral policing (Kasim, 2008) and undertake targeted violence on health professionals (Zia 2013).

Section B – Session 1.3: Gender inequality and vulnerabilities

Internal and External Barriers

Gender inequality creates barriers for women in various ways. Unfortunately, many barriers may keep women from obtaining the health services they need and deserve.

Internal and external barriers should be explained to the participants. Internal barriers like stigma, self-image or social conditioning inhibits women from access to information as well as services; or external barriers like income or workplace setting gives women lesser freedom to make decisions. Gender-based violence reflects and reinforces cultural norms about masculinity and male control and dominance.

Examples include:

- Girls are often reared to expect to have little control over their own bodies.
- Boys are often brought up to believe that males are superior to females and that men should dominate women.
- Many females are brought up to accept that men are entitled to be violent or that violence is an expression of a man's love. Some people even blame the victim

rather than holding a man responsible for being violent.

In addition to being a violation of human rights, violence against women is also a public health problem. Gender-based violence is also associated with higher prevalence of HIV and other STIs.

Section C – Session 1.4: HIV and gender

Background Information:

(NACO, 2008)

HIV is a gender issue because although HIV/AIDS affects both men and women, women are more vulnerable because of biological, economic and social reasons.

Biologically

Women are biologically more prone to HIV infection than men in terms of any single act of unprotected sex with an infected partner with the male to female transmission of the virus being 2 to 4 times higher.

- As receptive partners women have a larger mucosal surface exposed during sexual intercourse.
- Soft tissue in the female reproductive tract tears easily making it a transmission route for the microorganism.
- Vaginal tissue absorbs fluids more easily, including sperm, which has a higher concentration of HIV virus.
- Women are more likely than men to have other untreated STI.
- Bigger risk of acquiring HIV if the intercourse takes place at an age when the mucosal surface is still tender or when it is damaged due to rituals, diseases or sexual violence. HIV cannot penetrate intact skin or mucous membrane and enter the blood stream. It needs a break in the mucous membrane, e.g. an ulcer, through which it can enter the blood stream.

Socially

For women, risk-taking and vulnerability to HIV infection are increased by social norms that make it inappropriate for women to:

- Be knowledgeable about sexuality or to suggest condom use;
- Have negotiation skills, especially with a trusting partner;
- Be knowledgeable about the link between substance abuse and exchange of sex for drugs or money;
- Be knowledgeable about resorting to sex work especially migrant women and others with family disruption;
- Talk openly and have freedom of movement to access sexual health information and services; and
- Marry or have sex with older men who may have had more sexual partners.

In cultures where HIV is seen as a sign of sexual promiscuity, gender norms shape the way men and women infected with HIV are perceived, in that HIV-positive women face greater stigmatization and rejection than men.

Gender norms also influence the way in which family members experience and

cope with HIV and with AIDS deaths. For example, the burden of care often falls on females, while orphaned girls are more likely to be withdrawn from school than their brothers.

Economically

- Economically vulnerable women are less likely to end an abusive relationship.
- Women may exchange sex for money, food or other favours because of their economic situation.
- On matters such as buying of protection, household spending on health and access to healthcare, men tend to dominate the decision-making.
- Women employed in the informal economy and women who work at home, are less likely to have access to health insurance to cover the cost of testing, counselling and prescription drugs.

Hence, responses to the epidemic must build on an understanding of gender-related expectations and needs, and may need to challenge adverse norms. Women from high risk groups like sex workers may need further special considerations to overcome additional layers of disempowerment, marginalization and exclusion resulting from intersecting forms of stigma, discrimination and violence – often legitimated by laws that criminalize or fail to protect them.

Gender and HIV

Evidence gathered over the course of the epidemic shows that HIV flourishes in conditions of inequality and lack of accountability. In many countries, HIV prevalence continues to rise among women, especially adolescent girls, young women and women from key populations

1. Women and girls are at increased risk of contracting HIV, due to biological, social and behavioural factors. They often have less control over their sexual choices and bodily autonomy than men. Even if women aren't living with HIV, the virus has a significant impact on their lives, as women and girls are usually responsible for taking care of family and community members who are living with HIV.

The relationship between gender and HIV is constantly evolving. Many variables, such as education, income, age, ethnicity, race, disability, migrant status, health, location, and sexual orientation influence the links between HIV and gender. It is therefore important to consider the many ways in which gender and HIV interact. The relationship between gender and HIV is two-fold: while gender affects susceptibility to HIV and the impact of HIV, HIV also influences gender inequality and human rights more generally. Key contextual factors include:

- ◆ **the legal and policy environment** (such as laws that discriminate against women and girls; prohibit same-sex relations; or penalize gender identities that do not conform to gender norms and stereotypes)
- ◆ **the individual context** (such as drug use, sex work, coerced sex, experience or fear of GBV and the inability to negotiate sex and safer sex practices, or living with disability/ies)

- ◆ **the social context** (such as relationships between older men and younger women/girls, early or forced marriage, accessibility, acceptability, affordability and quality of health services and information available to different communities affected by or living with HIV, as well as access to economic resources and education). Worldwide, women and adolescent girls face alarming levels of violence.
2. There is a well-documented relationship between gender inequality, IPV and HIV.
 3. Gender-based violence – including IPV and sexual abuse – increases the risk of acquiring HIV. Women living with HIV are particularly likely to experience violations of their right to safety and bodily integrity.
 4. They are often discouraged from having children or, in some cases, face forced or coerced sterilisation and abortion. As a result of accessing more routine sexual and reproductive health (SRH) care – for example in the context of antenatal care – women are more likely to find out their HIV status than their male partners. Disclosure may expose them, not only to stigma and discrimination from their communities and even health-care providers, but potentially also to IPV or abandonment.
 5. Transgender women also face extremely high levels of violence, and often, nearly insurmountable barriers to SRH services and care. Gender affects the health outcomes of people living with HIV. More women are accessing antiretroviral therapy (ART) than men.
 6. Compared to men, however, women living with HIV often experience delayed access to treatment as well as poorer quality of care. In some cases, they are also more likely to have treatment interruptions and worse treatment outcomes.

A global review of women's access to HIV treatment and care (undertaken by UN Women and partners) revealed that there are also major gaps in the data around treatment and care for women living with HIV in all their diversity, and that while more women than men initiate ART, many women do not remain on treatment, and may even have lower rates of long-term retention in care than men. Findings revealed that major challenges to women's access to treatment and retention in care include:

- Stigma, discrimination and violence against women living with HIV
- Gender roles and responsibilities (including caregiving responsibilities)
- Violations of the right to privacy, confidentiality and bodily integrity within health settings
- Punitive laws, including criminalisation of women from key populations.

Section D – Session 2.1: Revisiting the basics: access to health services

Community awareness and building demand for voluntary HTC (HIV testing and counselling)

Community members should be informed about the benefits of knowing one's HIV status and about the availability of treatment if they are infected with HIV.

Pre-test information and counselling

- The pre-test session should focus on basic HIV information and information about the HIV testing process, and ensure that testing is voluntary.
- There is an absolute requirement to maintain confidentiality, not only about HIV results, but also about any other information provided during the counselling session, including the sex worker's engagement in sex work.

Post-test counselling

This counselling is provided when the test results are ready to be given to the client.

- Sex workers who are found to have HIV infection should be offered immediate referral for long-term care and treatment at a clinic or hospital whose staff are respectful of sex workers. They should also receive counselling about how to avoid transmitting HIV to others.
- Sex workers who are found to be HIV-negative should be provided with risk-reduction information specific to their individual risks, given access to condoms and lubricant, and counselled on strategies to negotiate safer sex.
- Mental health issues, such as anxiety and depression, should be assessed if the counsellor has been trained in these areas.

Repeat testing

Sex workers who test HIV-negative should be advised to return for repeat testing after four weeks or at least annually.

Family planning and contraceptive counselling

The basic steps in effective family planning and contraceptive counselling for sex workers are:

- Provide counselling to determine the sex worker's pregnancy intention.
- Discuss available methods of contraception
- Promote and provide condoms.

Emergency contraception

Emergency contraception may be provided to a woman who has had unprotected vaginal sex, is not currently using a contraceptive method and is not pregnant. It should be provided as soon as possible after unprotected sex, ideally within 72 hours, with a limit of 120 hours. (Effectiveness is reduced beyond 72 hours.) Emergency contraception should be accessible to sex workers and the frequency of its use should be monitored.

Since emergency contraception is not completely effective in preventing pregnancy and might not be efficient if used frequently, it is important to encourage sex workers to use a long-term family planning method.

Safe pregnancy

If a sex worker plans to become pregnant, she should be provided with information about safe pregnancy, including regular antenatal care, HIV and STI prevention and testing, appropriate nutrition and safe delivery.

Abortion and post-abortion care

Links to safe abortion services should be established. Sex workers should be informed about the risks of informal abortion methods. Sex workers should have access to appropriate post-abortion care to reduce related morbidity and mortality, and care for post-abortion complications should be provided. Sex workers should be counselled on family planning to prevent future unwanted pregnancies.

Cervical cancer screening

Human papilloma virus (HPV) is an STI that can cause cervical cancer. Cervical cancer screening promotes early detection of precancerous and cancerous cervical lesions and prevents serious morbidity and mortality. Information and services for cervical cancer screening and treatment should be provided to sex workers.

It is recommended that cervical screening be performed for every woman aged 30–49 at least once in her lifetime. Screening is usually done through Pap smear or HPV testing. Pre-cancerous and cancerous lesions should be treated immediately.

Women who are HIV-positive should be screened for cervical cancer regardless of age. Priority should be given to maximizing coverage of the risk age group and to ensuring complete follow-up of women with abnormal screening test results.

Mental health

Mental health issues such as anxiety, depression and substance dependency affect many people in the general population. Mental health and overall well-being are influenced not only by individual attributes, but also by the social circumstances in which people find themselves and the environment in which they live. Sex workers may be particularly vulnerable to mental health problems, because of poverty, criminalization, marginalization, discrimination or violence.

Poor mental health may be a barrier to seeking testing or treatment for HIV, and to continuing in care for those who are HIV-positive. The effects of trauma can result in various symptoms ranging from physical to emotional. Some effects that may be evident in sex worker patients follow:

- Difficulty in sleeping or nightmares
- Irritability
- Actively avoiding any reminders of the traumatic events
- Developing various phobias or fears that were not present beforehand
- Withdrawing socially from others
- Using alcohol and drugs to numb feelings

If a sex worker is unable to work because he or she is depressed, too anxious, or lacks motivation or self-esteem, the sex worker is then unable to earn a living. Furthermore, for HIV-positive sex workers, depression can affect adherence to treatment which has a significant impact on their overall health. If a sex worker is depressed, he or she may be less motivated to practise safe sex with a client, and could potentially get into a risky situation. Anxiety can limit a sex worker's

willingness to engage with others, which may include health care service providers. It may even minimise the sex worker's ability to work, see clients and support himself or herself. Some people who experience high levels of anxiety or depression may further be encouraged to turn to alcohol and other substances to cope with or numb their intense feelings so that they can return to work even in face of the anxiety and depression.

Barriers to condom use

Some of the barriers to condom use could stem from the following:

Client pressure: There is often pressure from sex workers' clients to have 'live' or 'skin to skin' sex (i.e. without condoms). Clients use many arguments to try to persuade sex workers to have sex without condoms: they argue that it will decrease their pleasure; that they will not be able to maintain an erection; that it will take them too long to orgasm; or that they might not be able to orgasm at all. Alternatively, they may assure sex workers that they are HIV negative.

Financial incentive. Clients often offer extra money for sex without a condom or may not engage a sex worker unless they have sex without a condom. Sex work is competitive and they risk losing the client and their business. Sex workers may also aim to exit the industry and tell themselves that taking short-term risks will enable them to make more money and exit quicker.

Rape and violence. Clients may use coercion and violence to force sex workers to have sex without a condom. Sex workers are also at risk of being raped by others, particularly by police and by intimate partners. In situations where women are forced into sex work, including cases of human trafficking, they do not have control over their circumstances, including whether or not to use condoms.

Existing HIV infection. Sex workers who are already HIV positive may have a fatalistic attitude, reasoning that they are already positive, not understanding the fact that they can be re-infected with another, possibly more virulent strain of HIV.

Mental health and substance abuse. Sex workers who use drugs and alcohol to cope with the stresses which are part of sex work are more likely to agree to have sex without a condom, use a condom incorrectly or agree to high-risk behaviours. Studies show that people who suffer from depression and other mental health problems are less likely to practise safer sex.

Condom breakage. There are several reasons why condoms break, but the most common reasons seem to be poor quality condoms, expired condoms, condoms not being large enough, rough sex and the use of oil-based lubricants with male latex condoms.

Intimate relationships. Many sex workers consistently use condoms with their clients, but do not use condoms consistently with their regular sexual partners.

Lack of condom availability or Lack of knowledge about condom use.

Unequal social power. Initiating a discussion about sex or sexual health may be considered inappropriate or taboo for women in general.

Section E – Session 2.2: Stigma and Discrimination

Why are sex workers stigmatised?

- Sexual frequency and sexual taboos
- The associations to HIV and fear of transmission
- Stigma as 'cheap' women
- The illegality of sex work
- Double or overlapping stigma

External Stigma

Most of the signs of external stigma are centred on the way people interact with one another. These may include the following:

- Avoidance
- Rejection
- Moral judgement
- Stigma by association
- Gossip
- Abuse
- Victimisation

Internal Stigma

Some signs of internal stigma include the following:

- Self-exclusion from services (including health services) or opportunities.
- Perceptions of self: Low self-esteem, sense of self-worth or other self-confidence issues, including low self-efficacy or a low perception of their ability to conduct a specific task, like accessing health care.
- Social withdrawal.

What effect does stigma have on sex workers?

Both internal and external stigma can gravely affect the health and well-being of sex workers. Sex workers may experience abuse by their clients or pimps, but because of internal stigma they may also not feel worthy enough to seek health care. When sex workers do seek health care, external stigma can often make their experiences less than ideal. For example, nurses within community clinics who stigmatise sex workers may use insulting language toward them or blame them for whatever current medical condition they may have. It can affect their mental health, lead to substance abuse and even suicide.

How can stigma toward sex workers be addressed?

- Treat all sex workers with complete respect
- Be careful to avoid using language that is stigmatising toward sex workers

- Lead by example or challenge stigmatising attitudes
- Train peer outreach teams to include sex workers

Section F – Session 2.3: The benefits of incorporating gender into HIV programming

The work with key populations is greatly enhanced by integrating a gender analysis and commitment to gender-responsive programming. Conducting a gender analysis with the help of interventions:

- Will ensure that particular attention is paid to the factors that increase the vulnerability and risks faced by women and girls in all their diversity.
- Is a rights-based approach towards women from key populations. It does not rely on a narrow approach created by 'modes of HIV transmission', nor does it assume that behavioural identities (i.e. women who have sex with women or sex workers) equate with risk.
- There is a pressing need for civil society organisations and community-based organisations to fully understand how to integrate a gender perspective into HIV programmes. This means addressing gender inequality as well as challenging the underlying factors that fuel HIV.

There is a critical need to better understand how gender shapes experiences of stigma and discrimination, health-seeking behaviour, and the uptake of HIV prevention, care and treatment services. It is important to take these layered realities into consideration at every level of the policy and programming cycle.

To do this, gender-responsive and gender transformative approaches need to be employed. This entails working to change gender roles and by promoting relationships that are fair and just in the distribution of benefits and responsibilities, as well as advocating for laws and policies that promote and protect gender equality, human rights and public health. In the best-case scenario, responses to HIV can change harmful social norms and practices, and transform gender relations based on principles of equity and equality. Efforts to integrate a gender perspective into HIV programmes will not only empower women and girls in all their diversity – unlocking their potential – but will also result in more equitable relations between all genders, and more effective HIV programming.

Ensuring the meaningful engagement and leadership of women and girls in their diversity in all aspects of HIV programming is key to a sustainable response. In fact, the resilience of many women and girls is a resource that can strengthen and fortify HIV responses. This requires that they be recognised and included in decision-making.

[Adapted from: International HIV/AIDS Alliance, February 2018. Gender-transformative HIV programming: Identifying and meeting the needs of women and girls in all their diversity. Good practice guide.]

Gender influences levels of HIV risk, access to prevention, treatment, care and support, and the ability to deal with the consequences of HIV. Gender norms and

inequalities indirectly increase HIV risk by limiting access to health services as well as formal and informal educational opportunities that can reduce the likelihood of acquiring HIV. Spousal permission may be required to use services, or women may not be able to access services, particularly SRH services, if the local service provider is male. Many women living with HIV fear abuse, rejection, abandonment and violence by health-care practitioners, as well as people in their families and communities.

Using a gender lens to analyse service availability, access, acceptability, affordability and quality for people living with HIV and from key populations reveals unequal access to treatment, care and support, depending on age, gender, sexual orientation and gender identity. As a result, interventions must consider and plan for the different needs of men, women and transgender people in all their diversity, such as ensuring 'women-friendly', 'key population-friendly' and 'adolescent-friendly' services in harm reduction and SRHR programmes. This also means ensuring treatment access in hard-to-reach communities, such as HIV and TB diagnosis and treatment services in female prisons, or HIV outreach in transgender communities, including provision of male and female condoms.

Despite ample evidence of the benefits of integrated approaches, services still tend to operate in isolation, for example:

- Key populations may face specific barriers, particularly if their identities or practices are criminalised, or if discriminatory laws hinder their access to services and information.
- Adolescent girls and young women living with HIV may not receive HIV related support beyond infancy or childhood.
- Although women living with HIV are at high risk of developing cervical cancer, the majority are never screened for it.
- Women living with HIV must often visit multiple service providers to secure a full complement of HIV treatment, care and support, as well as SRH services.
- Those who are not considered high risk, such as women who have sex with women, often find themselves ignored, resulting in a failure to deliver information and SRH and HIV services.
- While inadequate linkages between SRH and HIV services pose a challenge to all people living HIV, lack of family planning and the risk of unwanted pregnancies most negatively impacts women living with HIV.
- Women living with HIV are also often responsible for caring for ill family members, regardless of their own health.

Some laws explicitly discriminate against women, for example those requiring male consent to access health-care. Where HIV transmission or exposure is considered a crime, pregnant women are at significant risk of being charged, reinforcing cycles of vulnerability and violence against women and girls (VAWG).

Section G – Session 2.4: Contexts of violence

Violence

Violence is defined by the World Health Organization (WHO) as the intentional use of physical force or power, threatened or actual, against oneself, another person, or

against a group or community that results or has a high likelihood of resulting in injury, death, sexual or psychological harm, mal-development or deprivation of liberty.

In India, sex workers, MSM and transgender/hijra persons face endemic violence from police, goondas, anti-social elements, etc. as well as face institutional violence from educational institutions, employment sectors, health care settings, etc. Further, intimate partner violence (IPV) is also quite common, but less talked about, in light of the shadow of criminalisation that covers the lives of KP. However, several instances of violence at the hands of partners, faced by sex workers, MSM, and transgender/hijra persons have come to light, especially within the community, but the victims are highly reluctant to complain.

Another area of violence that is rarely discussed is the violence perpetrated within the *guru-chela* system prevailing within the hijra community. Many times, the *chelas* in their young age join a *gharana*, without being fully informed of all the rituals and practices that they have to follow, which sometimes could be exploitative. Many *chelas* have reportedly been beaten up by either their *gurus* or other *chelas* for not following the strict norms.

The linkages between stigma, discrimination and violence are well-established. Entrenched violence against KP is the most common occurrence in the HIV context, since it is considered 'fair game'. Disadvantaged and discriminated, MSM, FSW and transgender persons have hardly any social or legal capital to resist violence, or to claim redressal against violence.

Types of violence against KPs include:

- Violence faced by outreach workers and peer educators for doing condom distribution;
- Sexual assault against gay men and transgender persons/hijras;
- Constant verbal abuse against gay men and transgender persons/hijras;
- Physical assault and beating of gay men, transgender persons/hijras by police, goondas, etc.

Forms of violence

Physical violence

Being subjected to physical force which can potentially cause death, injury or harm. It includes, but is not limited to: having an object thrown at one, being slapped, pushed, shoved, hit with the fist or with something else that could hurt, being kicked, dragged, beaten up, choked, deliberately burnt, threatened with a weapon or having a weapon used against one (e.g. gun, knife or other weapon). These acts are operationally defined and validated in WHO survey methods on violence against women. Other acts that could be included in a definition of physical violence are: biting, shaking, poking, hair-pulling and physically restraining a person.

Sexual violence

Rape, gang rape (i.e. by more than one person), sexual harassment, being physically forced or psychologically intimidated to engage in sex or subjected to sex acts

against one's will (e.g. undesired touching, oral, anal or vaginal penetration with penis or with an object) or that one finds degrading or humiliating.

Emotional or psychological violence

Includes, but is not limited to, being insulted (e.g. called derogatory names) or made to feel bad about oneself; being humiliated or belittled in front of other people; being threatened with loss of custody of one's children; being confined or isolated from family or friends; being threatened with harm to oneself or someone one cares about; repeated shouting, inducing fear through intimidating words or gestures; controlling behaviour; and the destruction of possessions.

Human-rights violations

These should be considered in conjunction with violence against sex workers:

- Having money extorted
- Being denied or refused food or other basic necessities
- Being refused or cheated of salary, payment or money that is due to the person
- Being forced to consume drugs or alcohol
- Being arbitrarily stopped, subjected to invasive body searches or detained by police
- Being arbitrarily detained or incarcerated in police stations or detention centres without due process
- Being refused or denied health-care services
- Being subjected to coercive health procedures such as forced testing, sterilization, abortions
- Being publicly shamed or degraded
- Being deprived of sleep by force.

Criminalisation

The key reason why sex workers, gay men and transgender persons/hijras remain marginalised, and discriminated, and thus vulnerable to HIV is because they are criminalised by various laws in the country.

Contexts of violence

There are several contexts, dynamics and factors that put sex workers at risk for violence¹.

Workplace violence

This may include violence from managers (pimps or dealers), support staff, clients or co-workers in establishments where sex work takes place (e.g. brothels, bars, hotels).

Violence from intimate partners and family members

Stigmatization of sex work may lead partners or family members to think it acceptable to use violence to “punish” a woman who has sex with other men. It may be difficult for sex workers to leave an abusive relationship, particularly when

¹ Addressing Violence against Sex Workers

perpetrators threaten them, or have control due to ownership of a home, or the power to harm or refuse access to their children.

Violence by perpetrators at large or in public spaces

In most contexts, the antagonistic relationship with police creates a climate of impunity for crimes against sex workers that may lead them to be the targets of violence or of other crimes that may turn violent, such as theft. Some perpetrators specifically target sex workers to “punish” them in the name of upholding social morals, or to scapegoat them for societal problems, including HIV. Sex workers may also face violence from individuals in a position of power, e.g. nongovernmental organization (NGO) employers, health-care providers, bankers or landlords.

State violence

Sex workers may face violence from military personnel, border guards and prison guards, and most commonly from the police. Criminalization or punitive laws against sex work may provide cover for violence. Violence by representatives of the state compromises sex workers’ access to justice and police protection, and sends a message that such violence is not only acceptable but socially desirable.

Laws and policies

Laws like the ones that criminalize sex work, may increase sex workers’ vulnerability to violence. For example, forced rescue and rehabilitation raids by the police in the context of anti- trafficking laws may result in sex workers being evicted from their residences onto the streets, where they may be more exposed to violence. Fear of arrest or harassment by the police may force street-based sex workers to move to locations that are less visible or secure, or pressure them into hurried negotiations with clients that may compromise their ability to assess risks to their own safety. *(More on the laws in next activity)*

Violence against sex workers is not always defined or perceived as a criminal act. For example, laws may not recognize rape against transgender individuals as a crime, or police may refuse to register a report of sexual violence made by a sex worker. Sex workers are often reluctant to report violent incidents to the police for fear of police retribution or of being prosecuted for engaging in sex work.

Informal condition of transactions

Sex workers may also be made more vulnerable to violence through their working conditions or by compromised access to services. Some may have little control over the conditions of sexual transactions (e.g. fees, clients, types of sexual services) if these are determined by a manager.

Drugs and alcohol induced violence

The availability of drugs and alcohol in sex work establishments increases the likelihood of people becoming violent towards sex workers working there. Sex workers who consume alcohol or drugs may not be able to assess situations that are not safe for them.

Section H – Session 2.5: Establishing referral support for survivors of sexual assault

Signs and Symptoms of Domestic Violence

Psychological signs and symptoms

Recognizing the signs and symptoms of domestic violence begins by observing the behaviour of both the abuser and the person being abused. The abuser may appear overly controlling or coercive, attempting to answer all questions for the victim or isolating her or him from others. This type of behaviour may occur in the context of a visit to the doctor where the abuser refuses to let the victim out of his sight and attempts to answer all questions for the victim. You may even note emotional abuse actually taking place. In stark contrast, the person being abused may appear quiet and passive. He or she may show outward signs of depression such as crying and poor eye contact.

- Other psychological signs of domestic violence range from anxiety, depression, and chronic fatigue to suicidal tendencies and the battered woman syndrome—a syndrome similar to the post-traumatic stress disorder seen in people threatened with death or serious injury in extremely stressful situations (such as war).
- Substance abuse is also more common in the person enduring domestic violence than in the general adult population. The abuse of alcohol, prescription drugs, and illicit drugs may happen as a result of the violent relationship rather than being the cause of the violence.

Physical signs and symptoms

- Domestic violence may lead to specific injury types and distributions.
- These injury types and patterns may result from things other than domestic violence but should raise suspicion of abuse when present.
- Injury types seen more commonly in domestic-violence injuries than in injuries caused by other means are these:
 - ◆ Tympanic membrane (eardrum) rupture
 - ◆ Rectal or genital injury
 - ◆ Facial scrapes, bruises, cuts, or fractures
 - ◆ Neck scrapes or bruises
 - ◆ Abdominal cuts or bruises
 - ◆ Tooth loose or broken
 - ◆ Head scrapes or bruises
 - ◆ Body scrapes or bruises
 - ◆ Arm scrapes or bruises

Physical signs and symptoms of domestic violence that result from traumatic injury may seem similar to injuries resulting from other causes. But some injury types and locations may increase the suspicion of assaultive violence.

- The distribution of injuries on the body that typically occurs in the domestic-violence assault may follow certain patterns. Some frequently seen patterns of injury are as follows:
 1. Centrally located injuries:

- i. Injury distribution primarily involving the breasts, body, buttocks, and genitals.
 - ii. These areas are usually covered by clothing, concealing obvious signs of injury.
 - iii. Another central location is the head and neck, which is the site of up to 50% of abusive injuries.
- 2. Bilateral injuries: Injuries involving both sides of the body, usually the arms and legs
- 3. Defensive posture injuries: These injuries are to the parts of the body used by the woman to fend off an attack.
 - i. The small finger side of the forearm or the palms when used to block blows to the head and chest
 - ii. The bottoms of the feet when used to kick away an assailant
 - iii. The back, legs, buttocks, and back of the head when the woman is crouched on the floor

Common domestic violence injuries

- 1. Cigarette burns
- 2. Bite marks
- 3. Rope burns
- 4. Bruises
- 5. Welts with the outline of a recognizable weapon (such as a stick)
- 6. Pulled hair

Other physical clues

Injuries inconsistent with the explanation given:

- 1. The injury type or severity does not fit with the reported cause.
- 2. The mechanism of injury reported would not produce the signs of injury found on physical examination.

Injuries in various stages of healing:

- 1. Signs of both recent and old injuries may represent a history of ongoing abuse.
- 2. Delay in seeking medical attention for injuries may indicate either the victim's reluctance to involve doctors or his or her inability to leave home to seek needed care.

Non-injury physical signs and symptoms:

- 1. Individuals experiencing ongoing abuse and stress in their lives may develop medical complaints as a direct or indirect result.
- 2. Often, the person enduring domestic violence goes to the emergency department or clinic on multiple occasions with no physical examination findings to account for his or her symptoms.

Some typical medical complaints:

- 1. Headache
- 2. Neck pain
- 3. Chest pain
- 4. Heart beating too fast
- 5. Choking sensations

6. Numbness and tingling
7. Painful sexual intercourse
8. Pelvic pain
9. Urinary tract infection
10. Vaginal pain

Section I – Session 3.1: Constitutional rights of key populations

Constitutional Rights

The Constitution of India guarantees certain fundamental rights to all individuals, including MSM, transgender persons/hijra community and sex workers.

They include:

- Right to Equality (Article 14) and Non-discrimination on grounds of 'sex', etc (Articles. 15 and 16)
- Right to Life and Personal Liberty (Article 21) inclusive of bodily autonomy, privacy, dignity, health and livelihood
- Freedom of Speech & Expression, Assembly, Movement, Residence, etc [Article 19(1)]
- Protection against arbitrary arrest and detention [Article 22]
- Right to Constitutional Remedies [Article 32]

Thus, KPs are entitled to all fundamental rights enshrined in Part III of the Constitution. The State cannot enact laws in violation of fundamental rights guaranteed by the Constitution. In the context of HIV, these are reflected in the right to informed consent for HIV testing and treatment, confidentiality of one's health status, and non-discrimination in health care and employment settings as well as access to public services. However, the fundamental rights are not absolute, and are restricted by laws governing sex work, begging, and alternate sexuality.

Section J: Session 3.3: Sex Workers' Rights and Law

The Immoral Traffic (Prevention) Act, 1956: An Overview

(Lawyers Collective, HIV/AIDS Unit)

In India, the legal regime on sex work in India is laid down under the Immoral Traffic (Prevention) Act, 1956 ("ITPA"). ITPA does not proscribe sex work per se but penalises specific activities related to commercial sex. It also provides for rescue & rehabilitation of persons in sex work. The Act is implemented through Police & the Magistracy. Acts punishable under ITPA include:

- Brothel keeping (Section 3)
- Living on earnings of sex work (Section 4)
- Procuring, inducing or detaining for prostitution (Section 5 & 6)
- Penalties are higher where offences involve children (< 18 yrs)
- Prostitution in areas notified by Police & near public places (Section 7)
- Soliciting (Section 8)

All offences are cognizable i.e Police do not require a warrant to arrest or search. (Section 14). Police personnel entrusted with the implementation of the Act locally

(Special Police Officers) as well as at the national level (Trafficking Police Officers) are accorded special powers (Section 13) to raid, rescue & search premises suspected of serving as brothels (Section 15). Magistrates are authorized to order arrests & removal, direct custody of rescued persons, close down brothels & evict sex workers (Sections 16, 17, 18 & 20). The Act provides institutional rehabilitation for “rescued” sex workers. (Sections 19, 21, 23 & ITPA State Rules)

Implications

- Sex work *per se* is not illegal under the Act, but, its de facto criminalization through prohibition of soliciting, brothel & street work, has effectively undermined sex workers ability to claim protection of law
- Absence of safeguards has intensified violence & exploitation by brokers, agents & the mafia.
- Punitive provisions are inimical to public health interventions to reduce HIV.
- Fear of arrest, infringement by Police makes negotiation of safer sex difficult
- Peer educators carrying condoms are apprehended for “promoting sex work”
- Attempts to promote condom use in brothels have been aborted.
- Disempowerment of sex workers increases harms of HIV & Trafficking.

Specific Problems

I. Prohibition of Brothels

Section 2(a) defines “brothel” as “any house, room, conveyance or place or any portion of any house, room, conveyance or place which is used for purposes of sexual exploitation or abuse for the gain of another person or for the mutual gain of two or more prostitutes.” Section 3 provides punishment for keeping, running & managing a brothel. The term “mutual gain of two or more sex workers”, renders premises shared by sex workers illegal, including their residence. There have been several instances where sex workers have lost their homes & earnings under the guise of “closing down brothels”. As long as brothels remain illegal, universal condom use cannot be achieved.

II. Criminalisation of Earnings of Sex Work

Section 4 punishes adult persons being economically supported by sex workers including those living with sex workers. Therefore, aged parents, siblings, partner(s) and children over 18.yrs, who are dependent on sex workers are treated as criminals. In reality, a significant majority of persons, particularly women, turn to sex work to support their families including children & parents. Ironically, these very persons are punishable by law.

III. Penalties for Soliciting

Section 8 punishes a sex worker drawing attention of potential customers from a visible, conspicuous site, whether in a street or private dwelling. The criminalisation of soliciting is one of the most obvious legal problems for sex workers, who are faced with arrests, court hearings & convictions on a routine basis. Sex workers are arrested even when they’re not soliciting. Most plead guilty finding themselves in a vicious cycle of criminalization. Though this provision does nothing to prevent or abate trafficking, it is “most-used”, with maximum arrests & convictions being reported under Section 8, ITPA.

IV. Statutory Powers & Procedures:

ITPA confers wide powers on Police to conduct & Magistrates to order:

- **Raid**
Police can enter and search any premises on suspicion. Raids are often carried out in breach of statutory procedure for public witness, female Police etc. Violence, abuse & humiliation of sex workers is common. Raids impair sex workers' ability and result in increased harm.
- **Medical examination**
Section 15 (5A) mandates medical examination of persons removed from brothels for, inter alia detection of sexually transmitted diseases. Sex workers are reportedly forcibly tested for HIV & their results disclosed in open Court. This is contrary to national policy, which requires consent, confidentiality & counselling for HIV Testing.
- **Rescue & Rehabilitation**
Police can remove any person found in premises where sex work is carried out regardless of age & consent. Rehabilitation is synonymous with detention in State run homes for indefinite periods. Viable economic alternatives are either non-existent or unavailable to sex workers on account of stigma.
- **Expulsion of sex workers**
Sections 18 & 20 authorize Magistrates to close down brothels & expel persons from premises where sex work is being carried out, including their residence. Threatened with eviction, sex workers are forced to relocate with no access to health & HIV services.

Over the last 50 years, ITPA has often become a source of repression for sex workers, who face routine harassment & repeated arrests.

Other Relevant Laws

Until recently, there was no specific offence of trafficking in persons and the provisions contained in the Indian Penal Code, 1860 (IPC) were used to address the issue of trafficking. The Parliament has recently enacted the Criminal Law (Amendment) Act, 2013. This law incorporates new offences of trafficking of persons (Section 370) and exploitation of a trafficked person (Section 370A) in the IPC. These provisions make the acts of trafficking of a person for the purposes of physical exploitation or any form of sexual exploitation or engaging a trafficked person for sexual exploitation, punishable with rigorous imprisonment and fine. Importantly, they criminalise exploitation, i.e., non-consensual sex but not adult, consensual sex work.

Several other provisions of the IPC including public nuisance (Section 268), procurement of minor girl (Section 366A), importation of girl from foreign country (Section 366B), selling of a minor for purposes of prostitution, etc. (Section 372) and buying of a minor for purposes of prostitution (Section 373) are frequently used against sex workers. These are serious penal offences, providing for imprisonment up to ten years and without any opportunity for bail.

Supreme Court Panel on Sex Workers

The Supreme Court is currently deliberating on various aspects of sex work including rehabilitation (*Budhadev Karmaskar v. State of West Bengal*, Criminal

Appeal No. 135 of 2010). The Court has appointed a Panel to assist the Court on sex workers' issues, and the Panel has submitted 15 interim reports making various suggestions.

The purpose of the Panel is to:

- **Prevent Trafficking:** Formulating strategies and policies to prevent trafficking of persons.
- **Rehabilitate sex workers who wish to quit sex work:** Developing rehabilitation schemes and policies for those who want rehabilitation on their own and are not to be forcibly rehabilitated.
- **Promote conditions that allow for sex workers to live with dignity in accordance with Article 21 of the Constitution:** Those who want to continue in sex work should have access to better working conditions, health facilities, social security and education for their children.

Section K – Session 3.5: Transgender Rights and Law

The Criminal Tribes Act, 1871

This Act provided for the registration of criminal tribes and eunuchs in certain parts of India, and deemed the entire community of hijra persons as innately 'criminal' and 'addicted to the systematic commission of non-bailable offences'. It denuded the hijras of civil rights by prohibiting them from acting as guardians to minors, from making a gift deed or a will, or from adopting a son.

Though the Act was repealed in 1952, it resulted in massive marginalisation of hijras who were excluded from the mainstream society, thereby causing their socio-economic impoverishment.

Section 377, 1860

Section 377 was mostly used as an instrument for repeated harassment and physical abuse of transgender persons and hijras, including custodial rapes, illegal detention, daily extortion, etc. (PUCL-Karnataka report, 2003). The Delhi High Court, after being challenged by Naz Foundation, had recognized the role of Section 377 in perpetuating the socio-economic marginalization of TGs/hijras and held that Section 377 denies them 'full moral citizenship'.

Example

A transgender person was arrested and prosecuted under Section 377 on the ground that he was a habitual catamite, i.e., in a homosexual relationship with other men. At the time of his arrest, he was not engaging in any sexual acts. Though the Higher Court quashed the prosecution later, it did not remove the offending remarks against the accused in the lower court order.

Queen Empress v. Khairati (1884) ILR 6 ALL 204



After decriminalisation of homosexual acts, in September, 2018, transgender persons would no longer be criminalised under the provision, and the harassment should also reduce.

In Chennai, a transgender person was accused in a false case and repeatedly harassed, tortured, sexually abused at the police station by the police personnel. Unable to bear it, he self-immolated himself outside the police station.

The Madras High Court found the police officials guilty of committing drastic inhuman violence on the deceased, which was not only a human rights violation but also unbecoming of police officials who were supposed to safeguard the interest of the public. The State Government was directed to pay Rs. 5 lakhs as compensation to the deceased's family.

Jayalakshami v. State of Tamil Nadu (2007)4MLJ849



The Immoral Traffic (Prevention) Act, 1956

The transgender persons/hijras face deep-rooted discrimination and prejudice in most fields including education, employment, health care and housing. Thus, they are left with no option but to beg or engage sex work. Though there is no exact data on the number of transgender persons who engage in sex work, anecdotal evidence suggests that nearly 50% transgender persons are engaged in sex work. Most TGs face risk of arrest and harassment at the hands of the police as well as sexual abuse and violence, especially those who are into street sex work.

Bombay Prevention of Begging Act (BPBA) 1959

This Act prohibits begging, which includes soliciting or receiving alms, in a public place, whether or not under any pretence such as singing, dancing, etc., in certain parts of India, i.e., in Bombay and Delhi. Any person who is found begging can be arrested without a warrant, subject to a summary enquiry. If found guilty of begging, the person will be detained for a period of 1–3 years (in case of first time offender) and up to 10 years (in case of repeat offenders).

The Act has had a debilitating impact on the lives of transgender persons, especially hijras who have traditionally been involved in *badhai*, i.e., going to houses and offering blessings during marriage/child births in return for money. This is one of the few options available to transgender persons to earn their livelihood, since they lack educational and employment opportunities in the mainstream society. The Courts have refused to entertain petitions seeking legal recognition of the age-old practice of *badhai* or seeking alms.

Other laws

Transgender persons/hijras are routinely picked up under the public nuisance or obscenity laws, whether under the IPC or under local police laws. They are also charged for petty offences, like theft, etc. and are detained in police station for hours, often physically and sexually abused.

National Legal Services Authority vs. Union of India^{xxiii}

On 15th April, 2014, It upheld that transgender persons have a fundamental right to decide their gender, and to identify as male, female or third gender, independent of any medical evaluation. It also reaffirmed their constitutional rights to equality, non-discrimination, dignity, autonomy and freedom of gender expression guaranteed under Articles 14, 15, 19 and 21 of the Constitution.

Impact of NALSA

After NALSA, many High Courts have granted relief to transgender persons in cases of employment discrimination,^{xxiv} directing the school and college boards to change educational certificates, after SRS,^{xxv} recognised transgender person as head of household for the purposes of the Right to Food Act, 2013,^{xxvi} etc.

In terms of policy initiatives, many State governments have introduced welfare measures for transgender persons, including admission as transgender person in colleges and universities,^{xxvii} reservation in post graduate courses,^{xxviii} recruitment in Lok Adalat,^{xxix} pension given to older transgender persons,^{xxx} housing subsidies,^{xxxi} etc.

In terms of marriage and adoption, though NALSA does not explicitly mention the right of transgender persons to marry and adopt children, the principles of equality and non-discrimination enshrined in NALSA would go a long way to claim these rights. However, presently, no decision from the Courts exists in these issues.

After NALSA judgment, transgender persons have a right to be identified either as male/female/transgender person. The question is this applicable to criminal law? For e.g., it is not clear whether transgender persons who identify as women would be covered under Section 377 as male or female or as third gender.

Parliamentary Standing Committee Report on the TG Bill, 2016

Highlights of the Standing Committee Report (Submitted in July, 2017 in Lok Sabha)

- a. Definition of 'transgender person' should be revised, to keep it in line with NALSA;
- b. Grievance redressal mechanism to be provided, in case of discrimination;
- c. Screening committee to be made simple and easy, no physical examination required;
- d. Recognition of identity only as transgender, and not as male/female;
- e. Complaint Officers should be part of all establishments
- f. Retained the offence of enticing a transgender person into begging;
- g. The offence of sexual abuse is vague and needs to be specific.

Section L – Session 4.3: Establishment of Crisis Response Systems

HIV and AIDS (Prevention and Control) Act, 2017

The Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 was enacted by Parliament in April, 2017. It is meant for the protection of rights of people affected by HIV. The important features of the Act are:

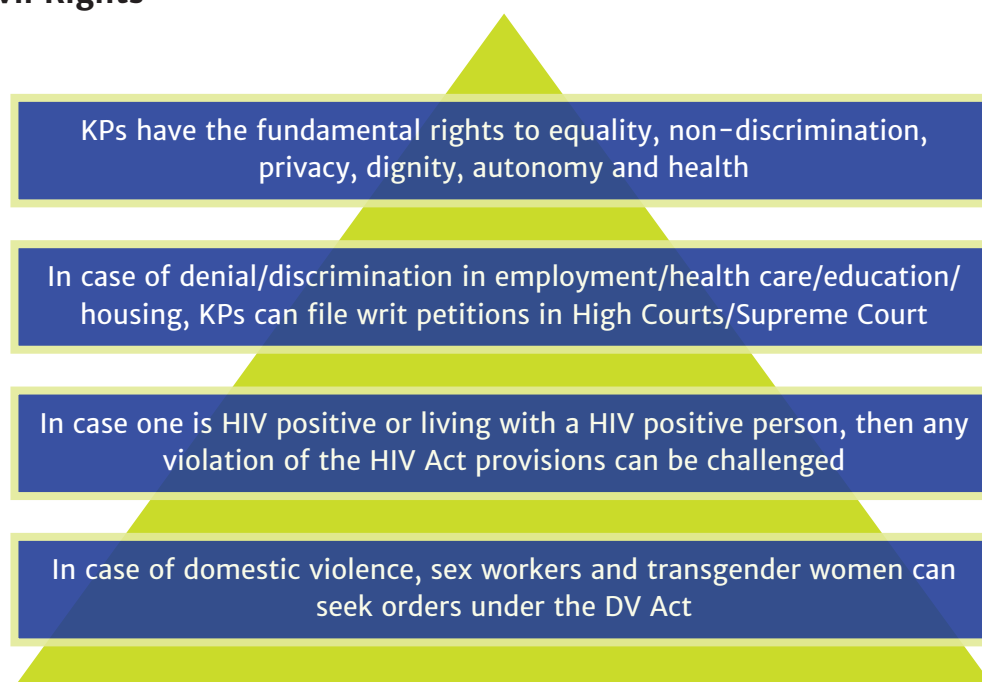
- i. Prohibition of discrimination against a HIV positive person or anyone living with a HIV positive person in employment, health services, educational establishments, public services, freedom of movement, insurance, etc. [Section 3]
- ii. Prohibition against hate speech [Section 4]
- iii. Informed consent for HIV testing (both pre-test and post-test counselling), and for HIV treatment, except in certain cases [Sections 5-6];
- iv. Confidentiality of HIV status is to be protected, except when disclosure is directed by the Court, or shared confidentiality, or when the partner is at a significant risk of transmission [Sections 8-9]
- v. Obligation of establishments to maintain confidentiality of HIV related information [Section 10]
- vi. Government to provide ART and OI management facilities, as far as possible [Sections 13-14]
- vii. Obligation of establishments to provide safe working environment [Section 19]
- viii. Establishment of complaint officer in establishments having more than 100 employees [Section 20]
- ix. Immunity to service providers from criminal or civil liability [Section 22]
- x. Appointment of Ombudsman by the State Governments to address grievances relating to discrimination under Section 3 and health facilities [Section 24]
- xi. Right to residence in a shared household and the right not to be evicted [Section 29]

Grievance Redressal under the Act

- If a HIV positive person is discriminated, or faces any health related violation, then that person can make a complaint to the Ombudsman for redressal, who has to decide within 30 days of the complaint.
- If a HIV positive person is discriminated in an establishment with more than 100 employees, then a complaint can be made to the Complaints Officer
- If a HIV positive person has been tested without consent, or confidentiality has been breached, then that person can file a suit in the local civil court for reliefs.

Protection of Rights of KPs

I. Civil Rights



Fundamental Right to Judicial remedy

The most important fundamental right is that of right to judicial remedy under Article 32 of the Constitution. Under Article 32, any person whose fundamental rights are violated by the state can approach the Supreme Court for redressing her claims. Similarly, under Article 226 of the Constitution, any person, whose fundamental rights are violated, can file a writ petition in the High Court of the states where they reside for redressal.

When a petition is filed in public interest, i.e., not for any individual grievance, but to bring to attention an issue pertaining to a large number of people, then it is called Public Interest Litigation (PIL). For e.g., *NALSA* was a PIL filed in Supreme Court to bring to the notice of the Court the problems faced by the transgender community.

Right to Information Act, 2005

Under the RTI Act, all citizens have the right to information, subject to certain exceptions.^{xxxii} Every public authority has an obligation to provide information to the public^{xxxiii} as well as publish all relevant facts while formulating important policies.^{xxxiv} Any person, who needs information from a public authority, can file an application to the prescribed authority specifying the information sought by her.^{xxxv} Such request shall be disposed of within 30 days of receipt of that application, or within 48 hours when the information concerns the life or liberty of a person.

One can file a RTI for the following information:

- To know the kind of welfare schemes and benefits meant for transgender persons/sex workers in their states,

- To know the status of their application, if they have applied for any welfare measure from the State Government;
- To know the functioning of transgender welfare boards in their states;
- To find out about the status of the implementation of directions in NALSA

II. Victims of Crimes

Because of their marginalised and criminalised status, MSM, transgender/hijra persons, and sex workers are often victims of gruesome physical and sexual assaults, and crimes with no legal redress. Some options include:

Physical Assault	Rape/Sexual Assault	Sexual Harassment/ Stalking
<ul style="list-style-type: none"> • One can file a complaint for causing hurt, grievous hurt, wrongful confinement, use of criminal force, etc. 	<ul style="list-style-type: none"> • Sex workers can file a complaint for rape under Section 375/376 • Gay men and transgender/hijra persons can complain under S.377 • Whether TG women covered under rape law not clear 	<ul style="list-style-type: none"> • Sex workers can complain for sexual harassment (S.354A), molestation with intention to disrobe (S.354B), stalking (Section 354D), voyeurism (S. 354C), molestation (S.509)

Section M – Session 4.4: Strategies to reduce violence, stigma and discrimination

Approaches to Advocacy

Advocacy is the art of convincing the law and policy makers to reform/change their policies for the benefit of affected groups. Advocacy could be of many types, including community-led advocacy, evidence-based advocacy, policy advocacy or media advocacy.

Community-led advocacy: This advocacy is meant to make the affected communities like sex workers, MSM, transgender or hijra persons, articulate their concerns themselves and voice their opinions about the kind of legal/policy changes required to make their lives better. This advocacy is participatory and empowering, since the community takes ownership of the initiative. In particular, focus should be made to properly train few select community leaders, who can then lead the whole community advocacy.

It is said that most effective advocacy is when the affected communities themselves advocate for change and lead from the front, instead of depending

on others. For e.g., one of the biggest examples of community-led advocacy and empowerment is Durbar Mahila Samanaya Committee (DMSC) at Sonagachi, Kolkata, wherein sex workers themselves mobilised and advocated for their rights and livelihood.

Evidence-led advocacy: This advocacy is aimed at building evidence of violence against affected communities by documenting the violations and violence faced by sex workers, MSM, transgender and hijra persons. This documentation can then be used to lobby with policy makers like police, bureaucrats, MPs, MLAs, government departments, etc. in order to sensitise them about the issues of KPs, and to make them aware of the rights of KPs. This documentation can be also strategically utilised in Courts to bring to attention the violence perpetrated on sex workers and MTH (MSM, transgender and hijra) persons. This advocacy again would be most effective, if the KPs themselves gather the evidence and document the violations.

Policy advocacy: This advocacy is aimed at targeting law and policy makers at local, state and national levels, in order to bring about the desired change in the laws/policies for advancing the rights of KPs. This could be done through meetings, writing letters/appeals/petitions, organising events, etc. The messaging has to be direct and precise.

Media advocacy: This advocacy is aimed at influencing public opinion by changing public attitudes towards KPs and creating awareness about rights of KPs amongst mainstream society. Stigma and discrimination against KPs can be reduced considerably, if there is greater awareness and sensitisation of common people towards KPs. This could be done through writing articles in media, having public awareness campaigns, regular interactions with media, especially vernacular and local media, etc.

Annex 1: PowerPoint Slides

Note to facilitators

Please adapt the PowerPoint presentations in advance of your workshop. They have been created for a specific audience and may need to be adapted to better suit local contexts, background of your participants and their level of experience. Terms, images and examples should be made relevant and contextually appropriate.

Slides 1.4: HIV and gender

HIV is a gender issue because although HIV/AIDS affects both men and women, women are more vulnerable because of biological, economic and social reasons.

(NACO, 2008)



Socially

For women, risk-taking and vulnerability to HIV infection are increased by social norms that make it inappropriate for women to:

- Be knowledgeable about sexuality or to suggest condom use;
- Have negotiation skills, especially with a trusting partner;
- Be knowledgeable about the link between substance abuse and exchange of sex for drugs or money;
- Be knowledgeable about resorting to sex work;
- Talk openly and have freedom of movement to access sexual health information and services; and
- Marry or have sex with older men who may have had more sexual partners.

Often, gender norms shape the way men and women infected with HIV are perceived, in that HIV-positive women face greater stigmatization and rejection than men.



Biologically

- Women are biologically more prone to HIV infection than men in terms of any single act of unprotected sex with an infected partner
- As receptive partners women have a larger mucosal surface exposed during sexual intercourse.
- Soft tissue in the female reproductive tract tears easily making it a transmission route for the microorganism.
- Vaginal tissue absorbs fluids more easily, including sperm, which has a higher concentration of HIV virus.
- Women are more likely than men to have other untreated STI.
- Bigger risk of acquiring HIV if the intercourse takes place at an age when the mucosal surface is still tender or when it is damaged due to rituals, diseases or sexual violence.

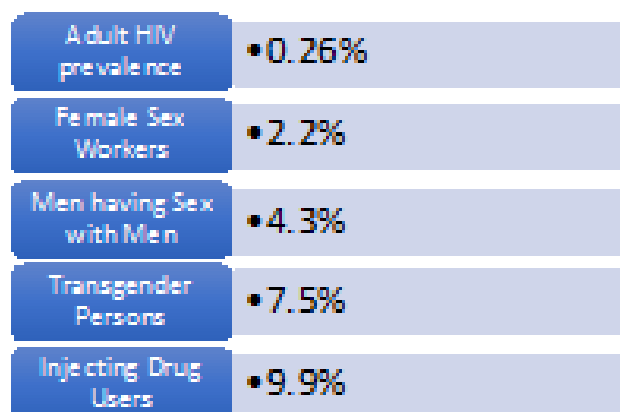


Economically

- Economically vulnerable women are less likely to end an abusive relationship.
- Women may exchange sex for money, food or other favours because of their economic situation.
- On matters such as buying of protection, household spending on health and access to healthcare, men tend to dominate the decision-making.
- Women employed in the informal economy and women who work at home, are less likely to have access to health insurance to cover the cost of testing, counselling and prescription drugs.



Slides 2.2: Stigma and discrimination



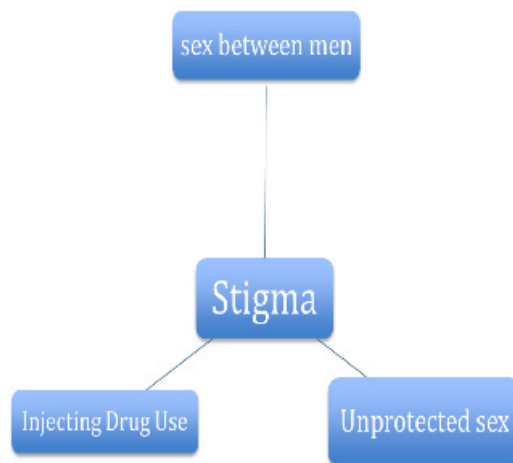
State	AUC	FSW	MDM	TC	IOU
Main crash tra	0.44%	5.99	9.91	19.93	14.17
Andth ra Pro dash	0.77%	5.95	10.14		9.05

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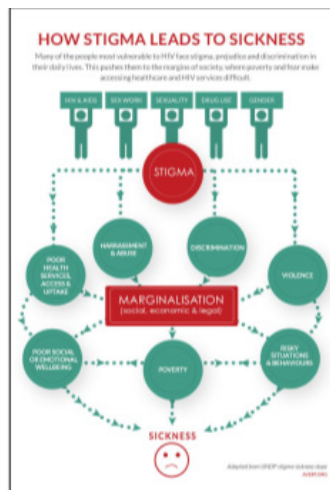
Stigma

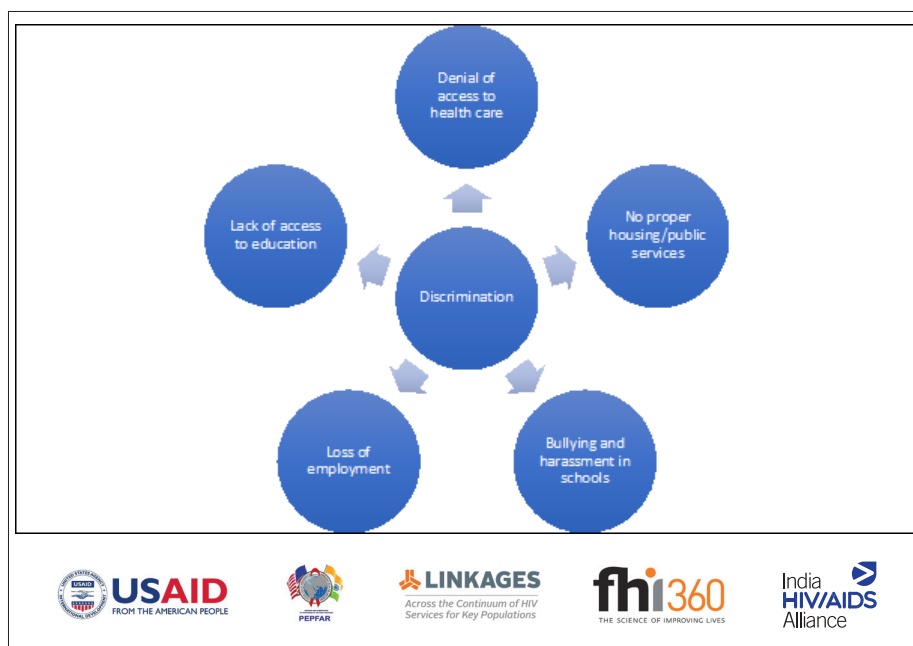
- Stigma refers to undesirable attitudes and beliefs directed toward something or someone. In case of PLHIVs, stigma is directed against them because of their HIV status, or their perceived HIV status. The stigma is more pronounced because HIV is seen as 'behavioral disease', i.e., infected due to one's own behavior, unlike say cancer or TB. It is a common misconception in India that most gay men, sex workers and injecting drug users are suffering from HIV, thereby creating a myth that HIV only affects 'those people', and not 'people like us'.



Discrimination

- Discrimination means treating someone unfairly or unequally, in comparison to others in the same position. Discrimination is the actual act of treating people differently, while stigma refers to the beliefs/attitudes that X should be treated unfairly. In a given situation, stigma and discrimination acts together to create an unequal society, which marginalises and excludes KPs from social, economic, legal and political rights and privileges. Numerous forms of discrimination exist against KPs:





Slides 2.2: Stigma and discrimination

Violence

- Violence is defined as the intentional use of physical force or power, threatened or actual, against oneself, or another person, which results in or likely to result in injury, death or psychological harm.
- In India, sex workers, MSM and transgender/hijra persons face endemic violence from police, goondas, anti-social elements, etc, as well as face institutional violence from educational institutions, employment sectors, health care settings, etc.
- Intimate partner violence is also quite common, but less talked about, in light of the shadow of criminalisation that covers the lives of KPs. However, several instances of violence at the hands of partners, faced by sex workers, MSM, and transgender/hijra persons have come to light, especially within the community, but the victims are highly reluctant to complain.
- Another area of violence that is rarely discussed is the violence perpetrated within the Guru-chela system prevailing within the Hijra community. Many times the *chelas* in their young age join a *gharana*, without being fully informed of all the rituals and practices that they have to follow, which sometimes could be exploitative. Many chelas have reportedly been beaten up by either their gurus or other chelas for not following the strict norms.

Logos at the bottom of the slide include: USAID (FROM THE AMERICAN PEOPLE), PEPFAR, LINKAGES (Across the Continuum of HIV Services for Key Populations), fhi360 (THE SCIENCE OF IMPROVING LIVES), and India HIV/AIDS Alliance.

Worst forms of violence against KPs include:

- Violence faced by outreach workers and peer educators for doing condom distribution;
- Sexual assault against gay men and transgender/hijra persons;
- Constant verbal abuse against gay men and transgender/hijra persons;
- Physical assault and beating of gay men, transgender/hijra persons by police, goondas, etc.



Criminalisation

- The key reason why sex workers, gay men and transgender/hijra persons remain marginalised, and discriminated, and thus vulnerable to HIV is because they are criminalised by various laws in the country.
- + Criminal laws and other legal restrictions discourage sex workers, MSM, and transgender/hijra persons from accessing public health services, especially HIV prevention, treatment and care, in order to avoid penal sanctions. As a result, they are in constantly in fear of prosecution, and suffer poor physical and mental health outcomes. They further become vulnerable to police abuse and exploitation and face societal stigma and prejudice.



Consequences of violence

- Violence by intimate partners faced by sex workers, MSM, and transgender/hijra persons often go unreported and unaddressed
- Violence against sex workers is associated with inconsistent condom use, and with increased risk of STI and HIV infection.
- Violence or fear of violence may prevent key populations from accessing harm reduction, HIV prevention, treatment and care, health and other social services
- It may also obstruct access to services aimed at preventing and responding to violence (e.g. legal or health services).
- Discrimination against sex workers in shelters for those who



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Slides 2.5: Establishing referral support for survivors of sexual assault

Psychological signs and symptoms of domestic violence

- The person being abused may appear quiet and passive. He or she may show outward signs of depression such as crying and poor eye contact.
- Other psychological signs of domestic violence range from anxiety, depression, and chronic fatigue to suicidal tendencies
- Substance abuse may result from the violent relationship



Physical signs and symptoms of domestic violence

Injury types seen more commonly in domestic-violence injuries than in injuries caused by other means are:

- Tympanic membrane (eardrum) rupture
- Rectal or genital injury
- Facial scrapes, bruises, cuts, or fractures
- Neck scrapes or bruises
- Abdominal cuts or bruises
- Tooth loose or broken
- Head scrapes or bruises
- Body scrapes or bruises
- Arm scrapes or bruises



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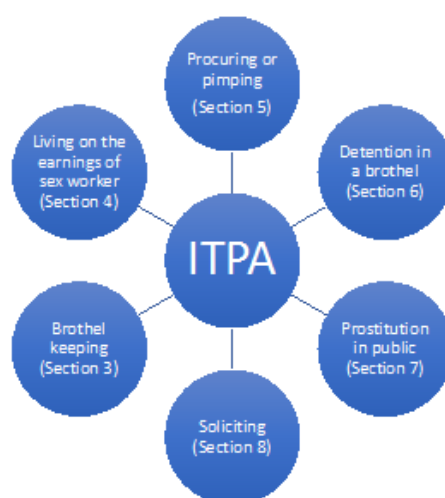
Slides 3.2: Women centric laws and policies

Women centric laws and policies

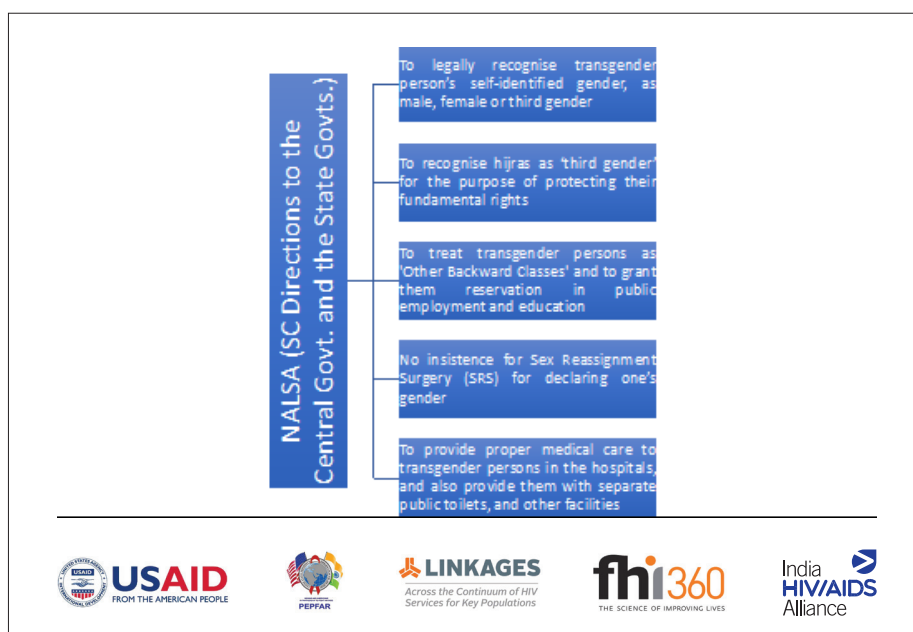
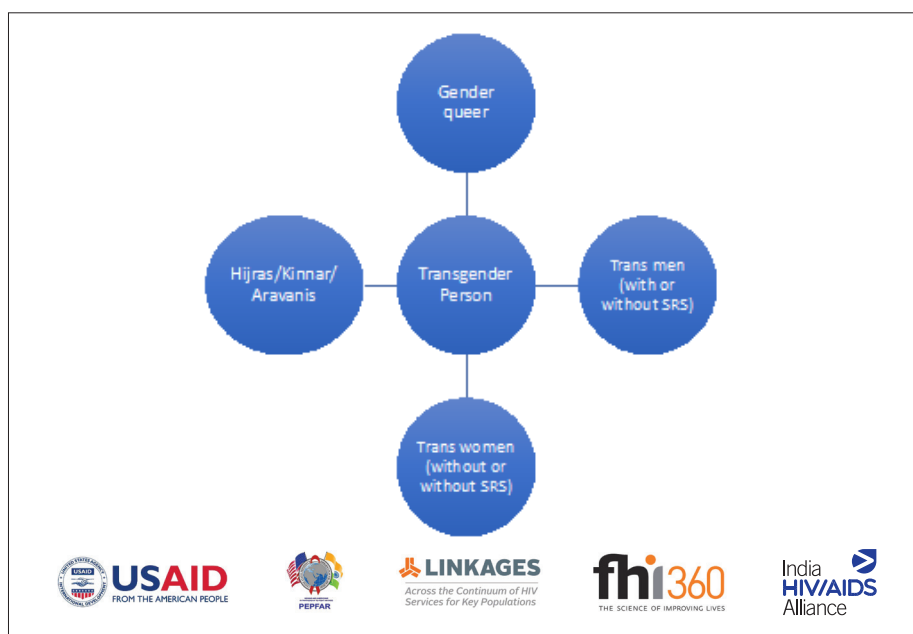
- Protection of Women from Domestic Violence Act (PWDVA), 2005
- The Prohibition of Child Marriage Act, 2006
- The Protection of Children from Sexual Offences (POCSO) Act, 2012
- Medical Termination of Pregnancy Act, 1971
- Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013
- Indecent Representation of Women (Prevention) Act, 1986
- National Commission for Women Act, 1990
- Working Women's Hostel (WWH)
- UIWALA, 2007
- Swadhar Greh



Slides 3.3: Sex workers' rights and law



Slides 3.5: Transgender persons' rights and law



Slides 4.1: Building trust and effective responses

Principles essential in building trust – HCPs and KPs:

1. Voluntary and informed consent
2. Confidentiality
3. Appropriate services
4. Accessible services
5. Responding to violence – first-line support
6. Fostering community-led outreach



Slides 4.3: Establishment of Crisis Response Systems

HIV and AIDS (Prevention and Control) Act, 2017 (1/2)

- Prohibition of discrimination against a HIV positive person or anyone living with a HIV positive person in employment, health services, educational establishments, public services, freedom of movement, insurance, etc. [Section 3]
- Prohibition against hate speech [Section 4]
- Informed consent for HIV testing (both pre-test and post-test counselling), and for HIV treatment, except in certain cases [Sections 5-6];
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- Obligation of establishments to maintain confidentiality of HIV related information [Section 10]



HIV and AIDS (Prevention and Control) Act, 2017 (2/2)

- Government to provide ART and OI management facilities, as far as possible [Sections 13-14]
- Obligation of establishments to provide safe working environment [Section 19]
- Establishment of complaint officer in establishments having more than 100 employees [Section 20]
- Immunity to service providers from criminal or civil liability [Section 22]
- Appointment of Ombudsman by the State Governments to address grievances relating to discrimination under Section 3 and health facilities [Section 24]
- Right to residence in a shared household and the right not to be evicted [Section 29]



Annex 2: Pre and post-test questionnaire

[To be administered at the beginning and end of training program]

1. Please tick whether the following statements are True or False:

Section 1

S.N	Statement	True	False
1.1	Gender roles are defined by the society around us		
1.2	Men should be the wage earners of a family, and not women		
1.3	Gender inequality creates barriers for women in accessing health services		
1.4	Women are biologically more prone to HIV infection than men		
1.5	Gender-based violence increases the risk of acquiring HIV		

Section 2

S.N	Statement	True	False
2.1	Lack of confidentiality in healthcare settings can be a barrier to accessing health services by key populations		
2.2	Stigma and Discrimination only affects MSM & TG		
2.3	It is not necessary for HIV programs to be gender-transformative		
2.4	Women have a right to say “no” if they don’t want to have sex with their husband		
2.5	Most women are abused by strangers. Women are safe when they are home		

Section 3

S.N	Statement	True	False
3.1	Lack of information on rights can make key populations more vulnerable to exploitation		
3.2	Domestic violence covers mental and physical abuse and also threats to do the same		
3.3	Sex work in itself is not illegal in India		
3.4	Homosexuality is no longer considered to be a disease or a mental disorder.		
3.5	The Supreme Court of India has granted legal recognition to transgender identity in India.		

Section 4


S.N	Statement	True	False
4.1	Healthcare providers should respect the decisions of the key population if they choose to refuse examination or treatment.		
4.2	No woman can be arrested after sunset and sunrise, except in exceptional circumstances, with the prior permission of the Magistrate		
4.3	Crisis response systems can have a formal structure or can be an informal group of individuals		
4.4	Community-led advocacy is the most effective form of advocacy		
4.5	TIs and CBOs do not have much role in reducing violence, stigma and discrimination		

Answer codes:

Sl. No.	Correct answers
1.1	True
1.2	False
1.3	True
1.4	True
1.5	True
2.1	True
2.2	False
2.3	False
2.4	True
2.5	False
3.1	True
3.2	True
3.3	True
3.4	True
3.5	True
4.1	True
4.2	True
4.3	True
4.4	True
4.5	False

Endnotes

- ⁱ Ibid
- ⁱⁱ CDC Module on Stigma and Discrimination related to MTCT, PMTCT-Generic Package Trainer Manual https://www.cdc.gov/globalaids/resources/pmtct-care/docs/tm/module_5tm.pdf
- ⁱⁱⁱ Thilakavathi S, Boopathi K, Girish Kumar CP, Santhakumar A, Senthilkumar R, Eswaramurthy C, et al. "Assessment of the scale, coverage and outcomes of the Avahan HIV prevention program for female sex workers in Tamil Nadu, India: is there evidence of an effect?" BMC public health. 2011;11 Suppl 6:S3.
- ^{iv} "Gay community reminds Indian doctors that there is nothing to cure" May, 17, 2016 Scroll.in <https://scroll.in/article/808048/queersagainstquacks-gay-community-reminds-indian-doctors-that-there-is-nothingtocure>
- ^v "In and Out: The Indian LGBT Workplace Climate Survey, 2016, A study by Mission for Indian Gay and Lesbian Empowerment (MINGLE) <http://www.gaystarnews.com/wp-content/uploads/2016/06/Indian-LGBT-Workplace-Climate-Survey-2016.pdf>
- ^{vi} Naz Foundation (India) Trust vs. NCT of Delhi & Ors. [(2009) 160 DLT 277 (Del)]
- ^{vii} (2014) 1 SCC 1
- ^{viii} Naz Foundation & Ors. vs. Suresh Kumar Koushal & Ors. [Curative Petition (Civil) No. 88 of 2014]
- ^{ix} Justice K.S. Puttaswamy vs. Union of India [Writ Petition (Civil) No. 494 of 2012, date of order: 24.08.2017]
- ^x (2014) 5 SCC 438
- ^{xi} Budhadev Karmaskar vs. State of West Bengal [Criminal Appeal No. 135 of 2010, date of order: 24.08.2011]
- ^{xii} Section 154, Code of Criminal Procedure, 1973
- ^{xiii} Proviso to Section 154, CrPC
- ^{xiv} The Supreme Court in Lalita Kumari v. Government of UP (2014) 2 SCC 1 held that registration of FIR is mandatory under Section 154 of the Code of Criminal Procedure, 1973 ('CrPC'), if the information discloses commission of a cognizable offence and no preliminary inquiry is permissible in such a situation.
- ^{xv} Section 166A (c)
- ^{xvi} Section 357C, CrPC
- ^{xvii} Shivam Santosh Dewangan vs. State of Chhattisgarh [2016 CriLJ 2819 (Chhattisgarh)]
- ^{xviii} Section 46(4), CrPC
- ^{xix} Section 51(2), CrPC
- ^{xx} Section 50(2), CrPC
- ^{xxi} Section 41D, CrPC
- ^{xxii} Section 437, CrPC
- ^{xxiii} (2014) 5 SCC 438
- ^{xxiv} Thanusu v. Tamil Nadu (2014) 6 MLJ 93, Nangai v. Supt. Of Police (2014) 4 MLJ 12, Nagalakshmi v. Director General of Police (2014) 7 MLJ 452,
- ^{xxv} S. Swapna vs. State of Tamil Nadu [Writ Petition (MD) No. 10882 of 2014, date of order 20.08.2014 (Madras High Court)], K. Gowtham Subramaniam vs. Controller of Examination [Writ Petition No. 7536 of 2017, date of order 01.06.2017 (Madras High Court)]
- ^{xxvi} Ashish Kumar Misra v Union of India, MISC. BENCH No. - 2993 of 2015, Allahabad High Court, order dated 15.4.2015
- ^{xxvii} <https://timesofindia.indiatimes.com/home/education/news/Transgenders-get-space-in-DUs-PG-admission-forms/articleshow/40135765.cms>
- ^{xxviii} <http://bangaloreuniversity.ac.in/wp-content/uploads/2015/06/PG-Admission-Rules-2016-17-11082016.pdf>
- ^{xxix} <http://www.hindustantimes.com/kolkata/west-bengal-gets-a-transgender-lok-adalat-judge/story-PoFwwMctcQtQ8UFjiT13MK.html>
- ^{xxx} <http://indiatoday.intoday.in/education/story/bpl-status-to-transgenders/1/685370.html>
- ^{xxxi} Ibid
- ^{xxxii} Section 3, RTI Act, 2005
- ^{xxxiii} Section 4(2), RTI Act
- ^{xxxiv} Section 4(1)(c), RTI Act
- ^{xxxv} Section 6(1), RTI Act



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This module has been developed for HIV/AIDS healthcare practitioners and outreach workers with steps to integrate and address gender-based issues into existing HIV programmes. It positions a gender sensitive response as critical to the achievement of sustained HIV services.

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