NACO

India's voice against AIDS

Ministry of Health & Family Welfare,
Government of India
www.naco.gov.in

Counselling Module

for Transgender/Hijra Interventions

Table of Contents

LIST OF ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CMIS	Computerised Management Information System
DAC	Department of AIDS Control
DD	Double Deckers
F2M	Female-to-Male Transgendered People
FAQs	Frequently Asked Questions
FtM	Female-to-Male Transgendered People
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
H/O	History Of
HPV	Human Papilloma Virus
HRGs	High Risk Groups
HSV	Herpes Simplex Virus
ICTC	Integrated Counselling and Testing Centre
IDUs	Injection Drug Users
LGBTQI	Lesbian, Gay, Bisexual, Transgendered, Queer and Intersexed individuals
LGV	Lyphomagranuloma Venerum
M2F	Male-to-Female Transgendered People
MIS	Management Information System
MtF	Male-to-Female Transgendered People
MSM	Men Who Have Sex With Men
NACP	National AIDS Control Programme
NACO	National AIDS Control Organization
NGO	Non-Governmental Organisation
ORW	Outreach Worker
PLHIV	People Living with HIV/AIDS
PPTCT	Prevention of Parent to Child Transmission
RTI	Reproductive Tract Infections
SACS	State AIDS Control Societies
SRS	Sex Reassignment Surgeries
STI	Sexually Transmitted Infections
TB	Tuberculosis
TG/H	Male-to-Female Transgenders/Hijras
TI	Targeted Interventions
USAID	United States Agency for International Development
VDRL	Venereal Disease Research Laboratory

सत्यमेव जयते

डा. अरुण कुमार पण्डा, भा.प्र.से.
अपर सचिव
DR. ARUN K PANDA, IAS
Additional Secretary

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन
Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation

FOREWORD

The National AIDS Control Organization (NACO) has been implementing exclusive Targeted Interventions (TI) for the High Risk Group (HRG) of Transgender / Hijra People. There are 32 exclusive Transgender - Targeted Intervention and 200 Core composite interventions covering around 32,800 TGs/ Hijra. The capacity building of the various functionaries of TI is being carried out by experts through the State AIDS Control Societies (SACS) and other partners. But this has always been a challenge in the absence of formal training modules for TG TIs. To address this, NACO has come out with a set of training modules designed for different cadres involved in implementing NACP. These modules have been developed with rigorous consultation and deliberations with experts, and involvement of community members over a period of time.

The four training modules namely (i) Programme Management (ii) Induction (iii) Counseling (iv) Sex, Sexuality, Gender & Identity and Sexually Transmitted Infections training modules for Doctors have been developed to build capacities of above cadres to further the understanding of the implementation of NACP IV.

I would like to acknowledge the efforts which have gone into developing these modules. The contribution made by the Targeted Intervention (TI) Division and National Technical Support Unit (NTSU) of NACO for developing and coordinating with the various stakeholders to bring to fruition these training modules is recognized. I am grateful to all the community leaders and members who have contributed to the development of the various chapters. I would also like to acknowledge the technical and financial support of Public Health Foundation of India, under aegis of USAID supported Prevention, Private Sector and Evidence-based Programming (PIPPSE) project. I would also like to acknowledge the State AIDS Control Societies (SACS) and Technical Support Units (TSUs) for providing relevant input in the modules.

I hope that these training modules will help upgrade the skills of the frontline workers and strengthen the approaches and strategies of National Program for TG/H at the field level.

Dr. Arun K Panda
Additional Secretary

INTRODUCTION TO THE MODULE

The module has been designed to provide an overview of NACP-IV and various aspects of Counselling of male-to-female transgendered people.

What are the components of the module?

This is a four day training module. It has the following components: 1) Introduction to NACP-IV; 2) Role of the counsellor & Ethics of counselling; 3) Identity, Sex, Sexuality, and Gender; 4) Issues of male-to-female TG/H; 5) Sex Reassignment Surgery (SRS); 6) Sexually transmitted infections SRS (STI); 7) Condoms and Lubricants; 8) Basic Counselling Package; 9) Role of the family; 10) Disclosure; 11) Friendly services; 12) Violence; 13) Stigma & Discrimination; 14) Nutrition, Exercise, and HIV; 15) Creating referrals and Networks; 16) Record maintenance and Reporting; 17) Myths, misconceptions, and FAQs; and 18) Queries and Feedback.

There are seven exercises in this module. Though, we have provided instructions and time for each exercise, the facilitator may modify based on the requirement of the group.

Resources needed

The following resource materials would be required during the training:

- An LCD projector, computer (laptop or desktop) and screen. Flash Player ActiveX Control™ may be needed for running AV films
- Flipcharts, papers
- Handouts
- Marker pens, sketch pens
- Writing pads, ballpoint pens for participants
- PowerPoint™ presentation
- Audio-visual aids
- Required guidelines / manuals where necessary and appropriate
- Copies of the pre and post training assessment questionnaire and session schedule in sufficient numbers, matching the number of participants

Microphones, loudspeakers and amplifying system (multimedia) compatible with the computers. Organize projector and check computer connections and sound system well before

Training Methodology (suggested but not binding on the organisers and trainers) :

A. Introductions and Mapping Training Expectations:

1. Registration: At registration, hand over session schedule along with other materials that form part of the workshop kit.

2. Introduction by Facilitator: The facilitator welcomes the participants, introduces him/herself and explains the participatory nature of training and its importance in the success of the workshop.

3. Ice breaking: Use 'icebreakers' (of choice of the facilitator or any of the workshop participants) to relax

participants, introduce them to each other and energize them. Apart from getting to know each other, icebreakers create a welcoming environment for the training and makes participants more receptive for interactive learning

4. Mapping training expectations: After the introductions, facilitator encourages participants to share their expectations on this training. One of the trainees can volunteer to write the expectations from participants on flip chart. Facilitator might need to restructure the questions if they are not clearly stated by participants. After writing down the expectations, the facilitator classifies them according to themes. The flip chart is mounted on a board or the wall of the training hall for reference. This could serve as a reminder for the facilitator and other helpers to ensure that these training expectations are adequately met with during the training

5. Setting of Ground Rules of Training: After mapping the expectations of the trainees, sets the ground rules for the success of facilitation of the workshop. This should be done in consultation with the participants. The ground-rules agreed upon are then written on a flipchart for reference

B. Objectives of Training and Pre-training assessment

After the initial activity is over, explain the objectives of training using slides.

1. Explaining NACP-IV/DAC Mandate: To make the trainees understand the mandate of the National program on TG/H
2. To introduce the participants to key elements of TG/H programs deemed important for different cadres of staff working in the area of HIV prevention/ care (see elsewhere for different categories)

Pre-training assessment: Pre-training assessment questionnaires are distributed to all the participants. Give the participants 15 minutes to complete them. Explain that the broad objective of the pre/post assessment is for assessing the effectiveness of the training (and the trainers), not for assessing individual candidates performance. Explain at the outset that the same questionnaire will be distributed at the end of the training.

For Best Use of the Training modules

Role of the Trainer (Facilitator)

The role of the facilitator is to enable and empower participants to develop their knowledge on topics included in the training module. In order for them to do this, the facilitator should:

[1]*(Adapted from Pehchan Training curriculum which in turn is based on 'Human Rights and Prison: Trainers Guide on Human Rights Training for Prison Officials. 2005. United Nations, Office of the High Commissioner for Human Rights.)*

- Understand the areas in which the participants work and gather information and resources that can be used in their work at the field level
- The facilitator is expected to go through the curriculum and handouts to prepare well in advance before the session. S/he should feel confident to answer all the issues that will be raised through the toolkit
- Create a learning atmosphere where training exercises are designed in such a way to allow participants to share their experiences, ideas and views on various issues, including those traditionally considered taboo, such as gender, sexuality, etc.
- Ensure that each participant is comfortable and feels supported
- Be willing to look inside and assess his/her own attitudes and values that might affect the workshop
- Understand who the participants are and where they come from
- Remember that the information being provided may be new and quite different from what participants have learned earlier. Keep information and definitions simple

Training Methodology

A variety of methods are used for training, including brainstorming, group work, case studies, role plays and presentations. For optimum results and use of resources, the facilitator may adapt the suggested methodology to the intended audience. The goal is to use the most appropriate method or methods to build on existing knowledge and skills and hold the attention and interest of participants.

SCHEDULE

SR NO	TRAINING COMPONENT	DURATION
DAY 1		
1	Introduction game	30 minutes
2	Introduction to NACP-IV	1 ½ hours
3	Role of the Counsellor & Ethics of Counsel	3 hours
4	lingIdentity, Sex, Sexuality & Gender	2 hours
DAY 2		
1	Issues of male-to-female TG/H	2 hours
2	Sex Reassignment Surgery	1 hour
3	Sexually Transmitted Infections	1 hour
4	Condoms and Lubricants	1 hour
5	Basic Counselling Package	2 hours
DAY 3		
1	Role of the Family	1 hour
2	Disclosure	1 hour
3	Friendly Services	1 ½ hours
4	Violence	1 ½ hours
5	Stigma & Discrimination	2 hours
DAY 4		
1	Nutrition, Exercise, and HIV	1 ½ hours
2	Creating Referrals and Networks	1 ½ hours
3	Record Maintenance and Reporting	1 ½ hours
4	Myths, Misconceptions, and FAQs	1 ½ hours
5	Final queries and Feedback session	30 minutes

DAY 1

INTRODUCTION GAME

Objectives

- This is an ice-breaking session
- The participants will play the game and get introduced to the entire group

Duration: 30 minutes

Instructions

- Each participant will write five sentences about herself/himself
- Of these sentences, three will true and two will be false
- They will read these sentences to the whole group
- The other participants will state, which statements are true and, which are false

Notes to the facilitator

- This is called the Truth and Lies Game
- Although, this is one of the ice breaking games, there are other ice-breakers as well

INTRODUCTION TO NACP-IV

OBJECTIVES

- Understand the objectives of National AIDS Control Programme IV (NACP-IV)
- Understand the roles and responsibilities of counsellors in TIs

DURATION OF THE SESSION: 1 ½ hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

NACP-IV

PERIOD: 2012 TO 2017

KEY OBJECTIVES

- Reduce new infections by 50% (2007 Baseline of NACP-II)
- Provide comprehensive care and support to all persons living with HIV/AIDS (PLHIV) and treatment services for all those who require it

KEY STRATEGIES

Strategy 1: Intensifying and consolidating prevention services, with a focus on HRGs and vulnerable population

Strategy 2: Increasing access and promoting comprehensive care, support and treatment

Strategy 3: Expanding information, education and communication IEC services for (a) general population and (b) high risk groups (HRGs) with a focus on behaviour change and demand generation

Strategy 4: Building capacities at National, state, district and facility levels

Strategy 5: Strengthening Strategic Information Management Systems (SIMS)

GUIDING PRINCIPLES FOR NACP-IV

1. Continued emphasis on three ones - one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System

2. Equity

3. Gender

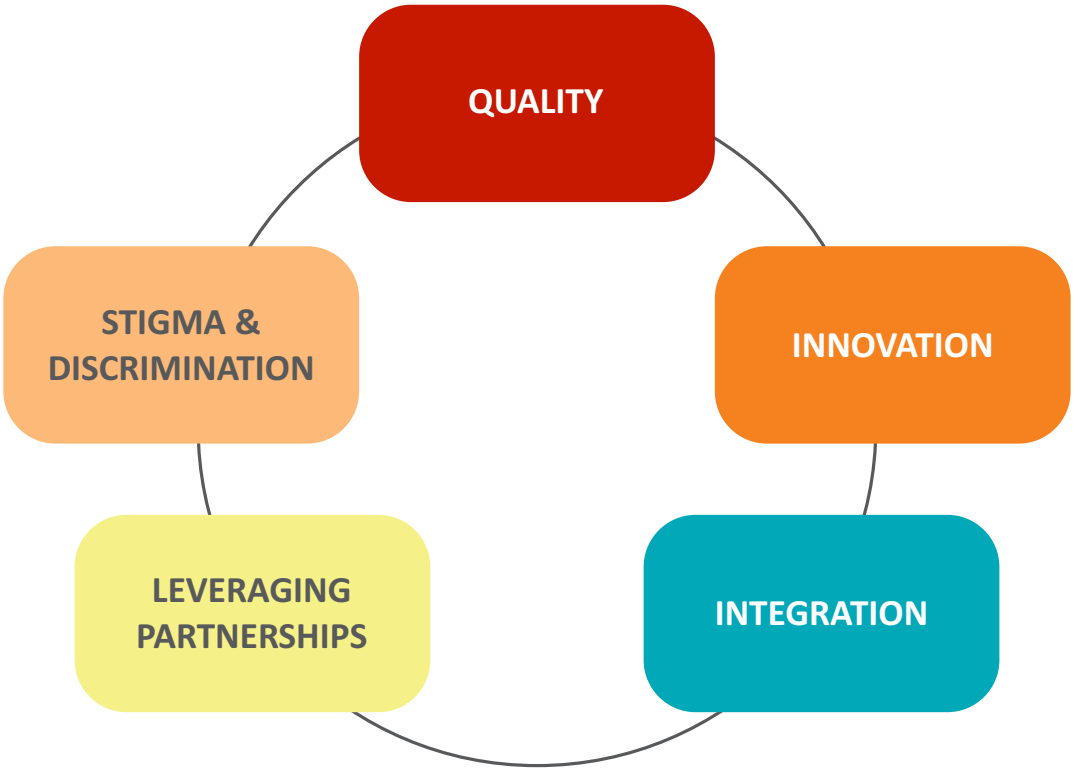
4. Respect for the rights of the PLHIV

5. Civil society representation and participation

6. Improved public-private partnerships

7. Evidence based and result oriented programme implementation

CROSS CUTTING AREAS OF FOCUS OF NACP-IV



KEY STRATEGIES UNDER NACP-IV

STRATEGY 1: INTENSIFYING AND CONSOLIDATING PREVENTION SERVICES

1. Saturating quality HIV prevention services to all HRG groups, based on emerging behaviour patterns and evidence
2. Strengthening needle-exchange Programme, drug substitution programme and providing Opioid Substitution Therapy (OST)
3. Reaching out to MSM and Transgender (TG) communities
4. Addressing the issues related to coverage and management of rural interventions
5. Providing quality STI/RTI services
6. Expand integrated counselling and testing center (ICTC) services and strengthen referral linkages
7. Strengthening positive prevention
8. Strengthening management structure of blood transfusion services
9. Implementing National EQAS for all participating labs at district and above for HIV related diagnostic services

STRATEGY 2: COMPREHENSIVE CARE AND SUPPORT AND TREATMENT

1. Scale-up ART Centres, LACs, and COEs ART services
2. Strengthening as follow-up of patients on ART and improving quality of counselling services at ART service delivery points
3. Comprehensive care and support services for PLHIV through linkages
4. Provide guidelines and training for integration in health care settings to National Rural Health Mission (NRHM) staff

STRATEGY 3: EXPANDING IEC SERVICES FOR GENERAL POPULATION AND HIGH RISK GROUPS WITH A FOCUS ON BEHAVIOUR CHANGE AND DEMAND GENERATION

1. Increasing awareness among general population in particular women and youth
2. Behaviour change communication strategies for HRG and vulnerable groups
3. Continued focus on demand generation of services
4. Reach out to vulnerable populations in rural settings
5. Extending services to tribal groups and hard-to-reach populations

STRATEGY 4: STRENGTHENING INSTITUTIONAL CAPACITIES

1. The programme management structures established under NACP will be strengthened further to achieve the NACP-IV objectives
2. Programme planning and management responsibilities will be enhanced at National, state, district and facility levels to ensure high quality, timely and effective implementation and supervision of field level activities to achieve desired programmatic outcomes
3. The planning processes and systems will be further strengthened to ensure that the annual action plans are based on evidence, local priorities and in alignment with NACP-IV objectives
4. Sustaining the epidemic response through increased collaboration and convergence, where feasible, with other departments will be given a high priority during NACP-IV
5. This will involve phased integration of the HIV services with the routine public sector health delivery systems, streamlining the supply chain mechanisms and quality control mechanisms and building capacities of governmental and non-governmental institutions and networks

STRATEGY 5: STRATEGIC INFORMATION MANAGEMENT SYSTEM (SIMS)

Under NACP-IV, it is envisaged to have an overarching Knowledge Management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use.

The strategy will ensure

- High quality of data generation systems such as Surveillance, Programme Monitoring and Research;
- Strengthening systematic analysis, synthesis, development and dissemination of Knowledge products in various forms;
- Emphasis on Knowledge translation as an important element of policy making and programme management at all levels; and
- Establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the programme

Some of the key initiatives under Strategic Information Management during NACP-IV include:

1. National Integrated Biological & Behavioural Surveillance (IBBS) among HRG & bridge groups
2. National Data Analysis Plan
3. National Research Plan
4. Transforming SIMS into an integrated decision support system with advanced analytic and Geographic Information System (GIS) capabilities
5. Institutionalising Data Quality Monitoring System (DQMS) for routine programme data collection
6. Institutionalising data use for decision making

ROLE OF THE COUNSELLOR & ETHICS OF COUNSELLING

ROLE OF THE COUNSELLOR

OBJECTIVES

- Understand the pillars and ethics of counselling
- Discuss the skills and techniques required for effective counselling

Duration of the session: 3 hours

Material required

- Chart paper/Whiteboard
- Marker pens
- Handouts

Introduction

- An important component of counselling is the relationship between the counsellor and client
- If the relationship is healthy – such the counselee can discuss all issues with the counsellor in an open and transparent manner – the counselling session has the best chance of being productive
- Often allowing someone to talk about their feelings to others can be healing. Thus, counselling provides an opportunity for individuals to feel 'heard' and accepted
- Often times, the counsellor may not be able to address all concerns in one session. Thus, often counselling is a multi-session process

DISCUSS THE FOLLOWING POINTS WITH COUNSELLORS?

- What is the role of counsellors?
- What do they specifically do in dealing with male-to-female transgendered people?

The responsibilities of counsellors

STI and HIV related services

- Increasing the uptake of services by clients
- Increasing the follow-up of clients
- Establishing referrals and networking for expanded STI/HIV care and support
- Provide information about STI, HIV/AIDS, opportunistic infections, healthy lifestyles and explore any myths and misconception and clarify the same
- Assist clients to correctly assess their risk for STI and HIV and motivate and help them to make plans for reducing their risk and help/enable/empower the client through the process of adaptation of healthy behaviours & coping with the same
- Act as an interface between the client and the provider, organize the treatment schedule, as follow-up, compliance to treatment, condom usage and partner management, Syphilis screening and other lab tests for STI/RTI
- Ensure that every HRG individual receives essential STI/RTI service package including early diagnosis and treatment of current STI episode, quarterly regular check-up, presumptive treatment of sex workers and biannual syphilis screening by closely working with respective TI NGO
- Explain and encourage HIV testing, establish referral services to other centres and network for expanded STI and HIV Care & Support - General Laboratory, ICTC, prevention of parent to child transmission (PPTCT), ART, community care centres (CCC), and TB-HIV etc.
- Ensure documentation of history taking, counselling and risk reduction plans and filling up and maintaining patient wise cards and clinic register
- Enhance condom negotiation skills with clients/regular partners

Sexuality and gender related services

- Discuss issues related to sexuality and gender identity
- Discuss issues about stigma and discrimination – at home, school, society, workplace
- Discuss about issues related to 'coming out' – to family members, friends, workplace etc.
- Discuss about the forms and expression of violence - at home, education institutes, social spaces, work place etc.
- Discuss strategies to address trauma and violence
- Refer the individuals to gender friendly services
- Discuss about gender reassignment surgeries with individuals who have expressed a desire to undergo these procedures

Positive Prevention Counselling

- Positive prevention improves HIV prevention, care and treatment efforts through meaningful involvement of People Living with HIV/AIDS
- Discuss issues about disclosure of HIV positive status – HIV positive individuals have a right to decide why, when, how and whom to disclose their status
- Provide intervention on ART treatment, including the nature and names of medicine, planning strategies to overcome difficulties in taking medicine regularly
- Reinforce HIV prevention messages, safer sex messages, reproductive options, early detection and treatment of opportunistic infections and STIs

ETHICS OF COUNSELLING

PILLARS OF COUNSELLING

EMPATHY	• Understand the emotions/feelings that the counselee is experiencing • *It is not sympathy - do not feel sorry for the counselee*
NON-JUDGEMENTAL	• The counsellor should not judge the counsellee based on personal values, standards and opinions • The counsellor should not discriminate
NON-DIRECTIVE	• The counsellor should not provide instructions or readymade solutions • The counsellors hould create a safe space, reflect, connect and work with the counsellee
CONFIDENTIALITY	• The counsellor should maintain confidentiality • The counsellor should also make it clear to the counsellee in the beginning that all the information will be confidential

ALWAYS START THE SESSION WITH AN INFORMED CONSENT; BRIEFLY DESCRIBE THE PROCEDURE TO THE COUNSELEES

THE COUNSELLOR SHOULD RESPECT THE PHYSICAL AND SOCIAL BOUNDARIES IN A COUNSELLING SESSION - MAINTAIN APPROPRIATE DISTANCE, DO NOT TOUCH THE COUNSELLEE, TRY NOT TO SOCIALISE WITH THE COUNSELEES

THE COUNSELLOR SHOULD MAINTAIN RECORDS OF ALL COUNSELLING SESSIONS (WITH PRIOR PERMISSION) AND KEEP THEM SAFE AND CONFIDENTIAL

THE COUNSELLOR SHOULD NOT HAVE SEXUAL-ROMANTIC INTERACTIONS WITH CURRENT COUNSELEES

THE COUNSELLOR SHOULD NOT DISCUSS THEIR PERSONAL ISSUES WITH THE COUNSELEE

THE COUNSELLOR SHOULD NOT GET ANGRY AND CRY IN FRONT OF THE COUNSELEE

COUNSELLING

IS

- It is a formal relationship between the counsellor and counselee
- It is collaborative and a facilitative process. The counsellor will not give instructions but just facilitate
- It is an equal process. The counsellor should not talk to the counselee from a position of power

IS NOT

- It is not friendship between the counsellor and the counselee
- It is not a 'teacher-student' relationship. The counsellor should not seem like a person who knows 'it all' and is teaching the counselee
- It is not a magical cure for all problems. The issues and all possible options will be discussed

Exercise 1

Duration: 30 minutes

Objectives

- Discuss various counselling skills
- Differentiate between effective and ineffective counselling skills

Requirements

- Chart paper/Whiteboard
- Flip chart
- Marker pens

Instructions

- All the participants will participate in the exercise as one large group
- The facilitator will draw two columns on the flip chart/drawing board
- One will be labelled 'effective counselling skills' and the other 'ineffective counselling skills'
- The facilitator will ask the participants to state some effective and ineffective counselling skills
- They will be noted on the flip chart/board

Effective counselling skills	Ineffective counselling skills

Notes to the facilitator

- The following skills can be discussed under the headings of effective and ineffective counselling skills

Effective counselling skills	Ineffective counselling skills
Use an appropriate language to question the client	Criticising the client
Using a good mixture of open and close ended questions	Avoiding eye contact
Reflecting	Ordering
Paraphrasing	Name-calling
Empathising	Non-interested in listening
Being Attentive	Appearing shocked
Following the discussion	Moralising
Focusing on the topic discussed	Judgemental attitude
Interested in listening	Constantly Interrupting
Open posture	Advising
Warmth	Messaging on the phone or answering calls
Non-judgemental attitude	Diverting from the topic
Genuineness	Condescending
Accepting that you may not know the exact answer and will get with the	Sympathising
Assertion and Refusal skills	Providing incorrect information
Negotiation skills	
Co-operation and teambuilding skills	
Community building skills	

IDENTITY, SEX, SEXUALITY & GENDER

OBJECTIVES

- Understand the concepts of identity to the group
- Clarity on the terms of sex, sexuality and gender
- Discussion on various components of the circle of sexuality
- Introduction to various stages in identity formation
- Understanding the various sexual and gender identities, particularly within the Indian context

DURATION OF THE SESSION: 2 hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets
- A list of skills will be discussed at the end

EXERCISE 2

Purpose of the exercise:

1) To introduce the concept of identity in the group members

Time: 30 minutes

Type of exercise: Individual type of exercise

Requirements:

Sheets of paper (one for each individual)
Flip charts with writing pens

Procedure to conduct the exercise

1) Ask the group to write a response to the question: Who are you?
Notes: They have to write words that describe their identity

2) They should write up to a maximum of 10 words to describe themselves

3) Now, ask them to read through the list and arrange them in a descending order (the most important description of themselves will be first and the least important will be last)

4) At this point ask two people to come forward and read their lists. They should do it one after the other. The facilitator of this exercise notes the list on the flip chart and initiates a discussion with the group about why they have chosen what they have chosen

5) The facilitator then asks group:
- How many have had similar takes on self?
- How many have had the same number?
- How many have had more?
- How many less than those written on the list?
- How many reached the maximum number (10) for the present exercise?
- What was the minimum number of words used to describe oneself?

The facilitator notes all of these on the flip chart

6) The facilitator then initiates the discussion of identity; introduces the concept of multiple identities and the interaction of identities. The definitions and concepts are provided in the next few pages

Identity:

- There are multiple definitions of identity. We will discuss all these definitions and characteristics of 'identity'
- Oxford English Dictionary: "Identity is the quality or condition of being the same in substance, composition, nature, properties, or in particular qualities under consideration; absolute or essential sameness; oneness"
- Eric Erikson's Definition: "Identity is the internal process by which one defines and integrates various aspects of self. It may be related to time in one's life"
- Sociological Definition: "Identity is the place an individual holds in the society and the various roles played"
- Some important features of identity are:
  - **Differentiation:** The way one differentiates from another – example "I am a man and she is a woman"
  - **Continuity:** It refers to the sense of sameness
  - **Categorisation:** It refers to the categorisation of individuals with similar characteristics – for example "We are all humans" or "We are all Indians" or "We are all doctors"
- It is important to remember that identity may be based on multiple aspects – example professional identity, religious identity, national identity, sexual identity, relationship identity
- Often multiple identities are present in the same individual – for instance, an individual may be a woman, a mother, a doctor, an Indian
- Identity is not a static phenomenon and it may change over time. Identity is also often contextual
  - For example, an individual within India may identify himself/herself based on state or ethnicity. However the same individual when out of India may identify himself/herself based on nationality
  - Another example – as compared with other professions an individual may identify himself/herself as a doctor but among doctors the same individual may identify himself/herself based on the specialty
- Kindly deal with the individual based on his/her predominant identity. Do not try to impose your perception on the individual
  - For instance, if a person uses the feminine pronoun to describe herself even if she is a biological male, use the same description

STAGES OF IDENTITY FORMATION

This model has been described by Troiden. He has highlighted these four stages of identity formation

Stage 1 - Sensitisation

This assumption in the individual is that they are heterosexual although they may observe that they are somewhat different that the others belonging to the same sex - e.g. in mannerisms, likings, interests etc.

Stage 2 – Identity confusion

This may be seen during adolescent period; they may start experiencing homosexual desires and feelings. However, inadequate knowledge about sexuality and experience of a new kind may often lead to this confusion and turmoil

Stage 3 – Identity Assumption

This individual starts accepting the homosexual identity and informs others as such. This is a variable process and may occur at different ages - this may involve the process of coming out

Stage 4 - Commitment

This individual is comfortable in the homosexual identity, lifestyle and starts living accordingly

STAGES OF IDENTITY FORMATION

The model of sexual identity formation has been described by Cass

Prestage: heterosexual identity

Identity confusion: where questioning same sex-gender affinity

Identity Comparison: there is some sort of acceptance about the new identity but there may be some sort of confusion

Identity tolerance: there may be a gradual acceptance of self-identity

Identity Acceptance: they start accepting their identity and start staying with others who have the same identity

Identity Pride: start valuing their new found identity and may be less receptive to heterosexual identity in others

Identity synthesis: gradually the individual starts accepting the whole identity and comes to term with the heterosexual identity as well

DISCUSSION

- Identity is not a constant phenomenon, but changes with time, roles, social milieu, geographic location, phase in life to name a few
- Identity is a matter of choice. Sometimes; however it may be imposed and then internalised
- While dealing with the clients try to ascertain their identity – how they would like to identify themselves. Even if they are all MSM they may have other identities that need to be understood
- Don't try to impose your identity on the individual while dealing with them on the field; understand their identities
- Identity is not often linear; each individual may have multiple identities. An interaction of these identities may lead to complex life situations. These have to be understood while counselling individuals
- The main identity assumed at that point of time, the problems associated with it and the interactions with other roles and responsibilities have to be understood. The solutions need to be framed within these identity issues. The negotiation skills have to be developed to address these issues
- Understanding the predominant identity will help the outreach workers to understand various issues related to the individual on the field; for example an individual may be more concerned about him being a son than his sexuality or he may be more concerned about his work status rather than safe sex practices. These issues will help you address the main concerns of these individuals

EXERCISE 3

Duration: 20 minutes

Objectives

- Able to comprehend the terms relevant for providing counselling to MSM and male-to-female TG/H

Requirements

- Chart paper/Whiteboard
- Marker pens
- Handout sheets for the exercise

Instructions

- The participants will work individually or in groups (preferably pairs)
- There are some statements or situations in the exercise
- The statements will be displayed on the white board or chart paper
- The participants will also be provided with the exercise handout
- There are four columns: sex, sexual orientation, gender expression and gender stereotypes
- Each column is further subdivided into Yes or No

- For each statement the participants have to choose whether the statement is best described or not by the heading of the column
- For example, a man does not do any house related work is 'gender stereotype' and the participant has to mark Yes in the column 'gender stereotype'
- The worksheet is on the next page

Sr No		Sex		Sexual orientation		Gender expression		Gender stereotype	
		Yes	No	Yes	No	Yes	No	Yes	No
1	A child born with male external genitals is called a 'male child'								
2	An adult male (who lives and behaves like a man) and is sexually attracted to another man (who also lives and behaves like a man)								
3	A child who was born as a biological male starts wearing female clothes and starts living like a woman and calls herself Nisha								
4	A child is born with female genitals – all the relatives present the new child with pink dresses, pink sheets and pink pillows								

Sr No		Sex		Sexual orientation		Gender expression		Gender stereotype	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1	A child is born with male external genitals and is called a 'male child'	√			√		√		√
2	An adult biological male (who lives and behaves like a man) and is sexually attracted to another biological male (who also lives and behaves like a man)	√		√		√			√
3	A child who was born as a biological male starts wearing female clothes and starts living like a woman and calls herself Nisha	√			√ (Although, people would like to presume, one should not presume about sexual orientation based on external appearances)	√			√
4	A child is born with female genitals – all the relatives present the new child with pink dresses, pink sheets and pink pillows	√			√		√	√	

SEX, SEXUAL ORIENTATION, GENDER, & SEXUAL ORIENTATION

SEX

- Refers to the biology and anatomy of the individual
- Can also be used to describe the act – for example we will have sex later in the day
- Someone is a biological male or female

SEXUAL ORIENTATION

- It represents the behavioural, psychological, romantic or erotic, sexual affection/attraction towards another person
- This affinity could be with someone from the opposite sex, someone from the same sex, or people from both the sexes
- Sexual orientation may be: Heterosexual, Homosexual or bisexual
- There could be male homosexuals or female homosexuals

GENDER

- It is the expression of one social, legal, or personal status
- It is a social construct and may change with time
- We may use the words masculine/feminine/TG for gender
- There could me male-to-female transgendered people or female-to-male transgendered people

SEXUALITY

- The term sexuality includes multiple components such as anatomical, physiological, biochemical processes, beliefs attitudes, psychological and behavioural expressions
- Other features such as identity, orientation, roles and personality; thoughts, feelings and relationships may also influence the sexuality of an individual
- The expression of sexuality is contextualised and may be influenced by ethical, spiritual, cultural and moral concerns

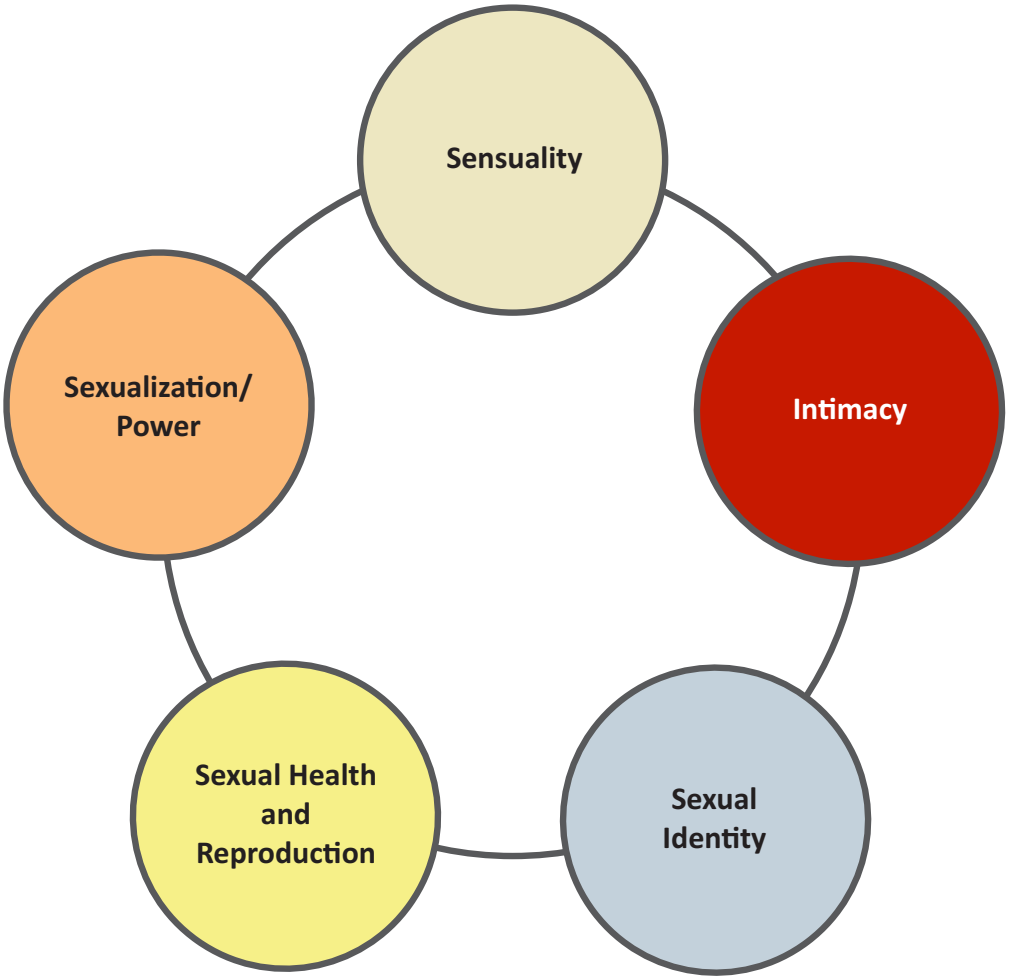
POSITIVE SEXUALITY

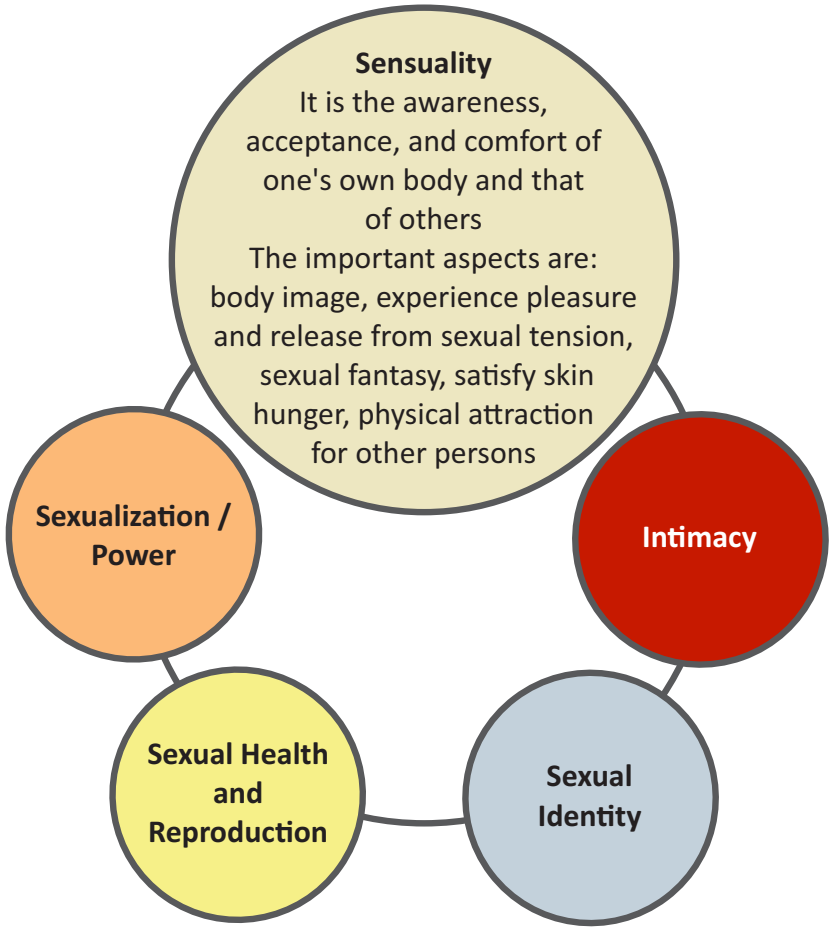
Some of the components of positive sexuality are:

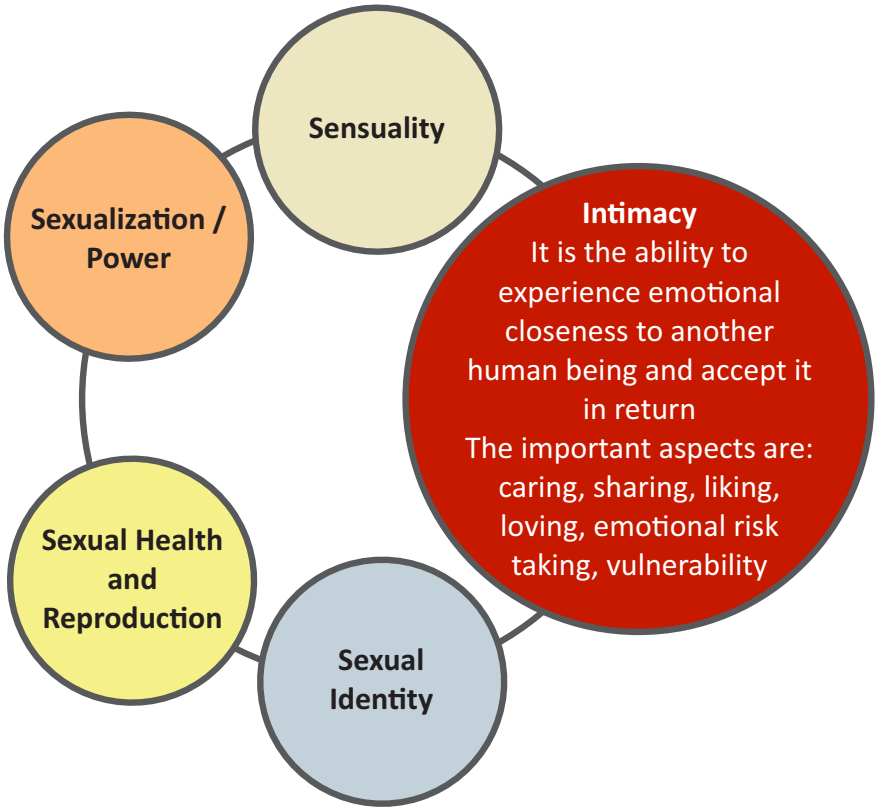
- Understand, appreciate and respect one's own sexuality and those of others
- Able to communicate with others in appropriate and respectful ways (discussion about intimacy, emotions, safe sex methods, be able to define boundaries)
- Understand and learn aspects of sexual health
- Should be able to take responsibility for sex safety and health (regular check-ups)

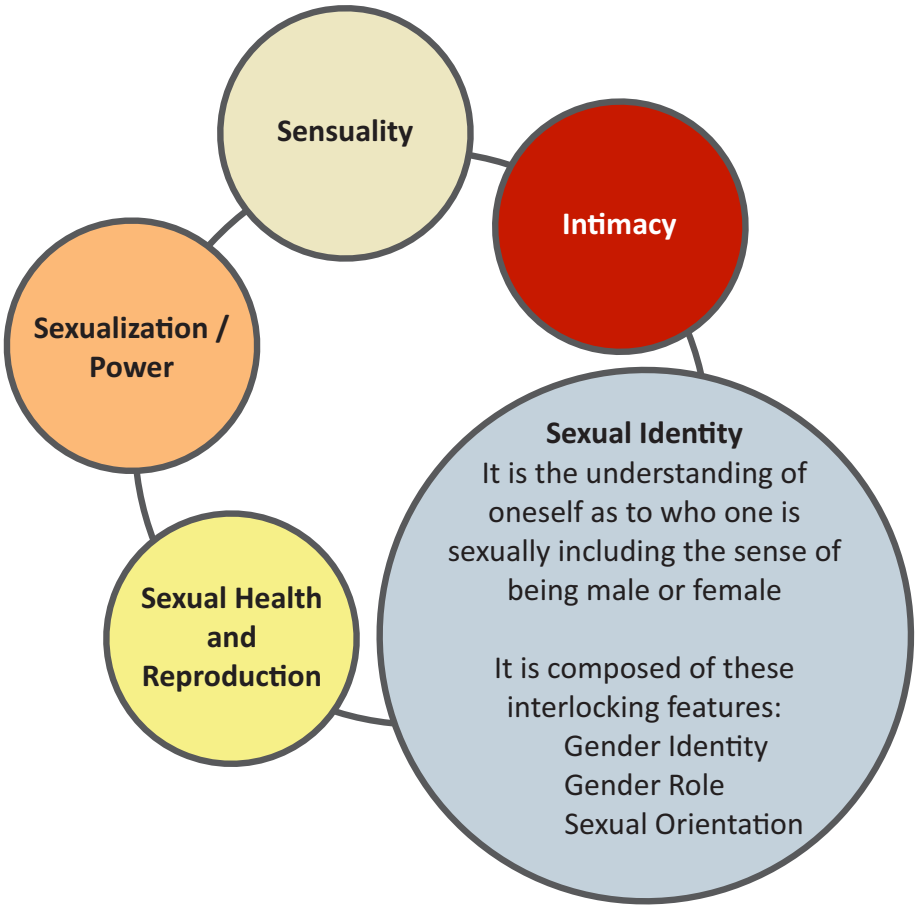
CIRCLE OF SEXUALITY

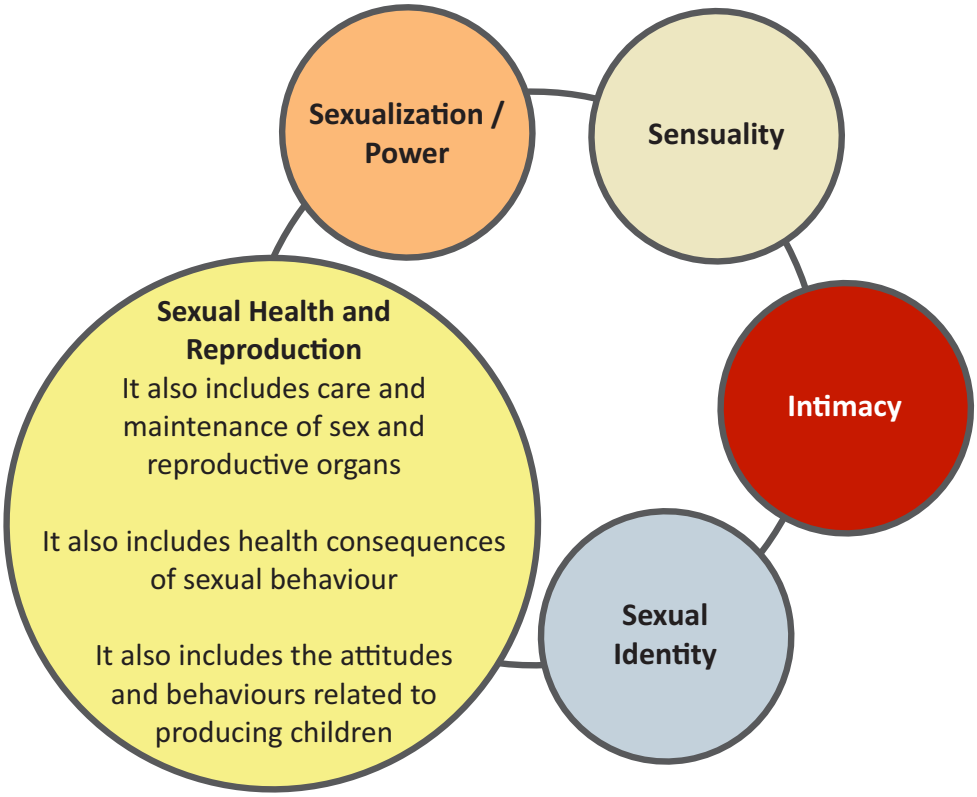
- This section is to make you aware of the different components of sexuality
- They are called as the 'circle of sexuality'
- At the end of this discussion you will understand what are the features of each component of this circle
- This may help you understand the issues of community and help in providing better service (as a part of the programme) to the community
- It is important to remember that it is generic and not restricted to MSM and TG people

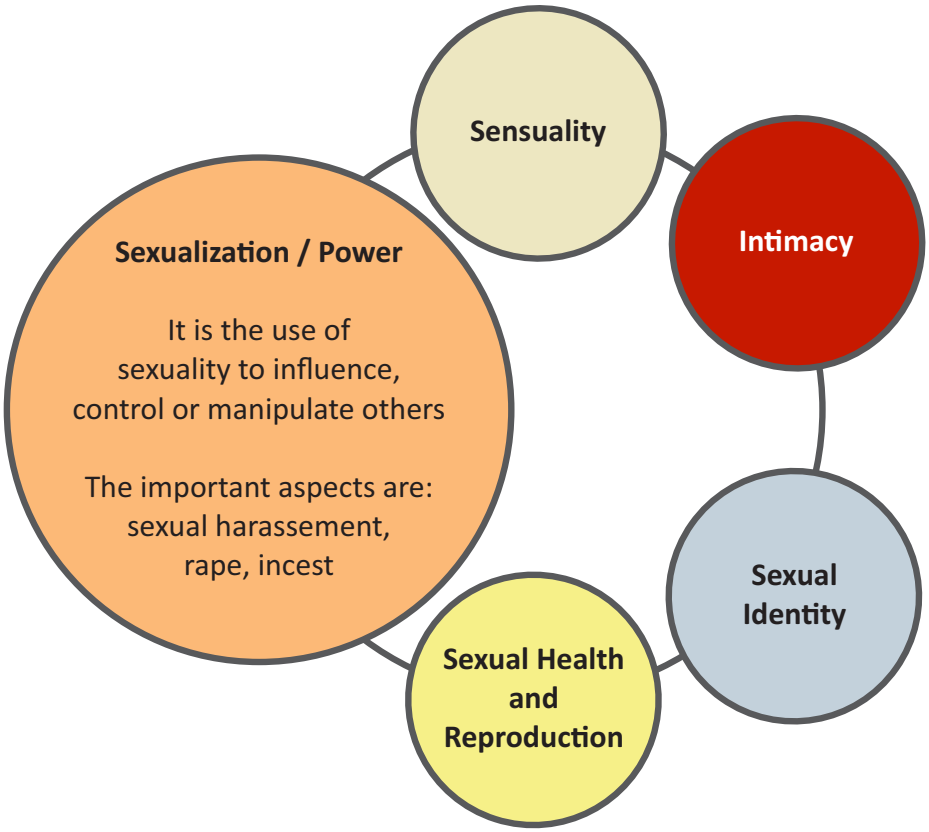



Sensuality
It is the awareness, acceptance, and comfort of one's own body and that of others
The important aspects are: body image, experience pleasure and release from sexual tension, sexual fantasy, satisfy skin hunger, physical attraction for other persons
Sexualization / Power
Intimacy
Sexual Health and Reproduction
Sexual Identity


Sensuality
Sexualization / Power
Intimacy
It is the ability to experience emotional closeness to another human being and accept it in return
The important aspects are: caring, sharing, liking, loving, emotional risk taking, vulnerability
Sexual Health and Reproduction
Sexual Identity


Sensuality
Intimacy
Sexualization / Power
Sexual Health and Reproduction
Sexual Identity
It is the understanding of oneself as to who one is sexually including the sense of being male or female
It is composed of these interlocking features:
Gender Identity
Gender Role
Sexual Orientation


Sexualization / Power
Sensuality
Sexual Health and Reproduction
It also includes care and maintenance of sex and reproductive organs
It also includes health consequences of sexual behaviour
It also includes the attitudes and behaviours related to producing children
Intimacy
Sexual Identity


Sensuality
Intimacy
Sexualization / Power
It is the use of sexuality to influence, control or manipulate others
The important aspects are: sexual harassement, rape, incest
Sexual Identity
Sexual Health and Reproduction

TERMINOLOGIES ASSOCIATED WITH GENDER

Terminology	Discussion
Gender Identity	It is the sense of being a man or woman or someone in between It may not necessarily be the same as the biological sex Gender identity is "the fundamental sense of belonging to one sex" It may be internal and not visible to others
Gender expression	When this identity is expressed externally in the social sphere it becomes a **gender expression** Every person has their own sense of gender expression, how they express their masculinity and/or femininity externally
Gender roles	They are the "shared expectations that apply to individuals on the basis of their socially identified gender" These are identifying actions and/or behaviours for each gender Some are according to the anatomical structure of the male or female body – example menstruation Other roles may be culturally determined – For example, rules about what 'men' and 'women' can do or should do. These roles may have nothing to do with the way the bodies are build (or anatomical function)
Gender stereotypes	**Gender stereotypes** are generalisations and expectations from individuals based on their gender expression For example, only women take care of children, men work as mechanics, as etc

SOME TERMINOLOGIES ASSOCIATED WITH

Terminology	Discussion
TRANSGENDER PEOPLE	This is the term used for individuals whose gender identity and expression are different from the biological sex assigned at birth This term is used to describe those who transgress social gender norms It may be used as an umbrella term which includes transsexuals, cross dressers, intersex persons and other gender variant persons TG PEOPLE may or may not have undergone sex reassignment surgery or be on hormonal therapy Recognizing and accepting someone for who they are upholds their dignity as a person They term 'trans' may also be used to describe them
Trans woman	Someone born as a male but identifies as a female Also described as male-to-female TG PEOPLE Also use terms such MtF and M2F
Trans man	Someone who is born as a female but identified as a male Also described as female-to-male TG PEOPLE Also use terms FtM or F2M
Transitioning	It may be noticed that all TGs are not at the same point in identity formation or gender expression. For example, some TGs may just wear female clothes or others may have undergone some form of breast enlargement surgery "Transitioning" refers to the process trans people undergo to live in their gender identity (for example, as male, female or as a third gender) Transitioning may also involve medical steps such as hormone treatment and surgeries Many of the steps aim to change how others perceive gender identity This may involve changes to outward appearance (such as wearing female clothes) wearing mannerisms or the name someone uses in everyday interactions Other aspects of transitioning focus on legal recognition, and often centre on changing name and sex details on official identification documents There are often overlaps, particularly in countries where it is difficult for people to informally change their name without going through a legal process

Transexual	It is an older term to indicate individuals whose gender identify is different from that of biological sex They may seek transition from male-to-female or female-to-male Some of them might have undergone sex change surgery and may be on hormone therapy
Intersex	When an individual is born with external genitalia or reproductive organs/sexual anatomy and/or chromosomes that do not correspond with any specific definition of a male or female There may be ambiguous genitals, both types of differences in the internal and external organs For E.g. a girl may have large clitoris or a child with small penis may have ovaries and uterus internally These may be apparent at birth or later in life This also includes hermaphrodites

OTHER TERMINOLOGIES ASSOCIATED WITH SEX, SEXUAL ORIENTATION & GENDER

Terminology	Discussion
Genderqueer	Term used by some individuals who identify as neither entirely male or female
Bi-gendered	Someone who has a significant gender identity that encompasses both genders, male and female. In some one of side may be stronger compared with the other. However, both the sides are present
Cross-dresser	Someone who dresses in clothing traditionally or stereotypically worn by the other sex, but who generally may intend to live full time as the other gender Some also use the older term "transvestite" to describe these individuals. However, the term transvestite is also considered as derogatory by some
Drag Queens	Males who dress up as women for performance in bars, clubs, or during parades However, some may use it in a derogatory fashion as well to refer to male-to-female transgendered people
Drag Kings	Female performers who dress up as men for performance in bars, clubs, or other events

OTHER TERMINOLOGIES ASSOCIATED WITH SEX, SEXUAL ORIENTATION & GENDER (CONTD.)

Terminology	Discussion
Gay	This term is to represent males who are attracted to males in a romantic, erotic and/or emotional sense In India 'gay' may be associated with social class, education, and media exposure In addition, some self-identified kothis may also identify themselves as gay due to their association with organisations working with HIV prevention and their friends The term may also be used to describe anyone who does not identify as heterosexual or LGBTQI community
Queer	It is used to refer to lesbian, gay, bisexual, and often TG people. It may be used as an alternative to 'gay' The term may also be used in a derogatory fashion by some; however, the term has also been reclaimed that was once used in a negative fashion
LGBTQI	An abbreviation used for lesbian, gay, bisexual, TG, queer and intersexed community

OTHER TERMINOLOGIES ASSOCIATED WITH SEX, SEXUAL ORIENTATION & GENDER (CONTD.)

Terminology	Discussion
Gender non-conforming or gender variant	Gender non-conforming encompasses people whose gender expression is different from societal expectations and/or stereotypes related to gender It is not necessary that all trans people are gender non-conforming For example, some trans women, just like other women, are very comfortable conforming to societal expectations of what it means to be a woman Similarly, some trans men simply wish to blend in among other men
Abstinence	A choice of not having sex for some reason This can be temporary (for a short period of time – example, during some religious holidays) or may be for a longer duration of time

Celibate	Do not have sex for some reason The reason may not be in the individual's control For example: A person who is locked up in a prison alone is celibate because there are no partners
Asexual	Not having any sexual attraction The person may or may not have sex An asexual person may or may not be abstinent An asexual person may or may not be celibate **Individuals who are celibate or abstinent are not necessarily asexual**

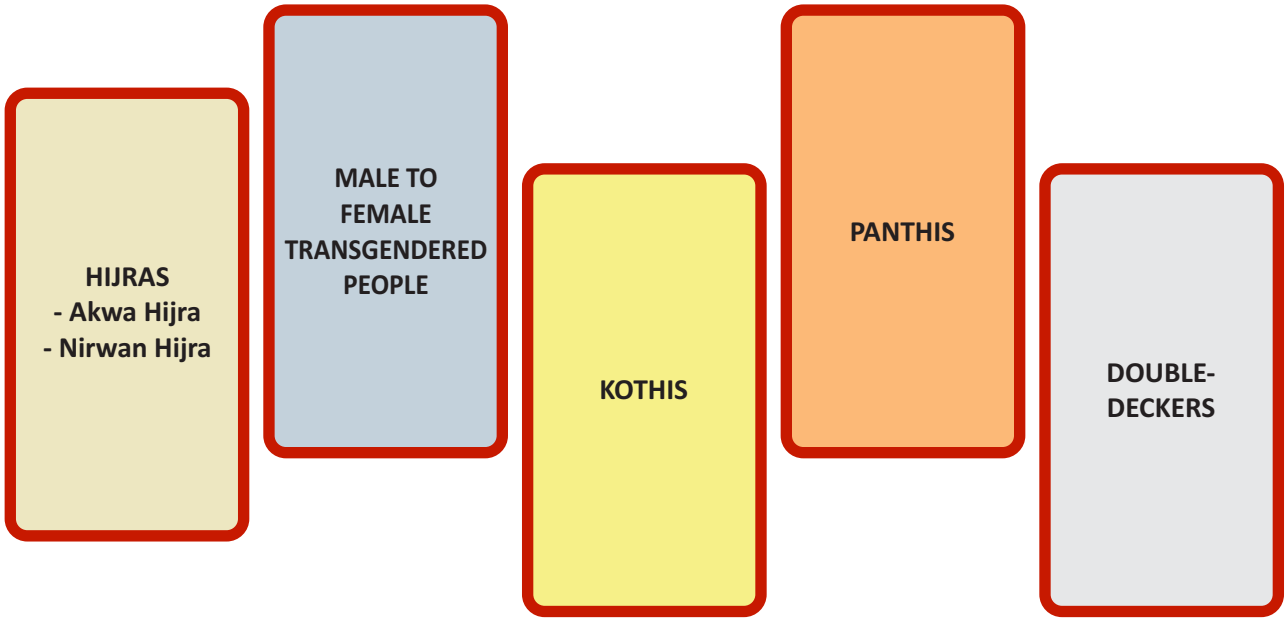
SEXUAL AND GENDER IDENTITIES IN INDIA

The purpose of this component of the training programme is to understand the various sexual and gender identities and the terms used in the Indian context.

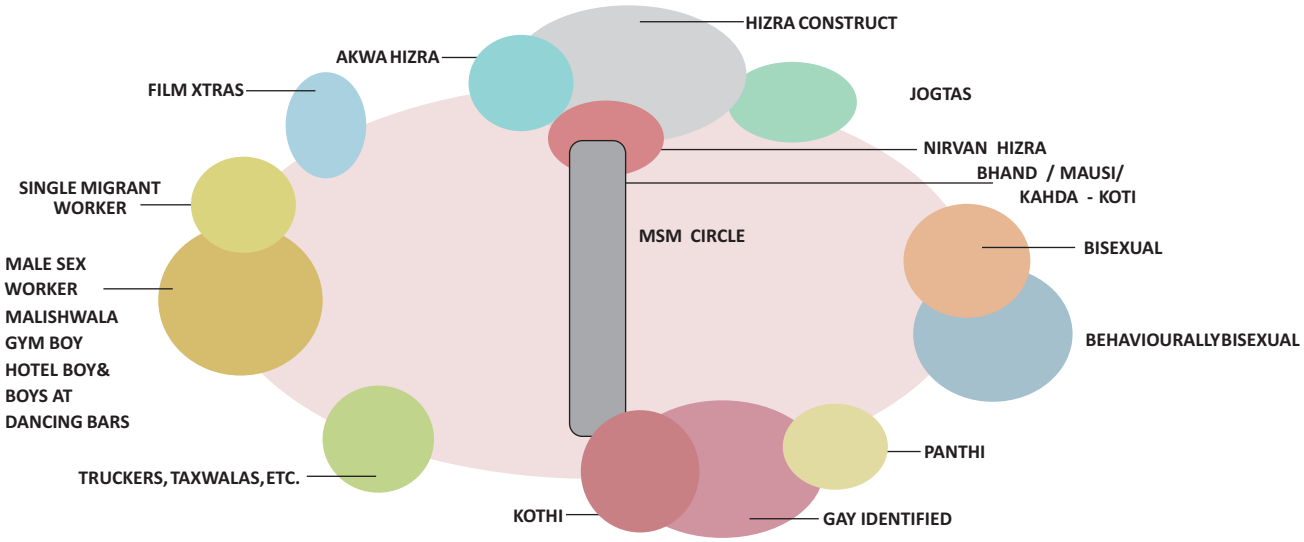
There will be a discussion on the MSM Circle. The circle had been developed by Mr. Ashok Row-Kavi and his colleagues from The Humsafar Trust, Mumbai.

We have to point out that the description of all these identities is by no means an exhaustive list of all identities. Each local area may have multiple other names or groups that can be added to this list.

MEN WHO HAVE SEX WITH MEN



THIS IS JUST A PICTORIAL REPRESENTATION AND THE COMPARTMENTS ARE NOT NECESSARILY SEGREGATED



Terminology	Discussion
Men who have sex with men	Also called as MSM, this in an umbrella term to include all men who have sex with other men (MSM) irrespective of their sexual identity A man may have sex with other men but still consider himself to be a heterosexual, or bisexual, or may not have any specific sexual identity at all Though the terminology was initially used to denote behaviour, many MSM use this as an identity as well In some areas of the country such as Manipur these terms are commonly used (B MSM and A MSM)
Kothis	'Kothi' are- "males who show obvious feminine mannerisms and who are thought to be mainly involved, if not only, in receptive anal/oral intercourse with men" “Kothis” are a heterogeneous group and a single definition or identity does to describe the heterogeneity The Kothi identified men may often have varying degrees of feminine mannerisms/behaviour. Some may cross dress in specific situations such as parties/dances/or for a sexual partner Some proportion of Kothis have bisexual behaviour and get married to a woman

	Kothis are generally of lower socioeconomic status and some engage in sex work for survival Some proportion of Hijra-identified people may also identify themselves as 'Kothis'. But not all Kothi-identified people identify themselves as TG or Hijras They are called 'B MSM' in Manipur
Dhoru kothis	Some of the kothis may also penetrate other men and are referred to as “dhoru kothis”
Pav-batla-wali-kothis	They may also get married to women and may also be behaviourally bisexual. These married effeminate men are also referred to as "pav-bata-wali-kothis"
Panthis or Ghadiyas or Giriyas	This is the identity given to seemingly 'masculine' looking men by kothis. These are usually considered to be 'the real men' who penetrate These men may not self identify themselves, although some may call themselves panthis The term Panthi is considered to be more of a label rather than an identity Some kothis may have steady panthis who are referred to as the partners, boyfriends or mard They are called 'A' MSM in Manipur Though they are usually the penetrative partners, it is possible that some might also get penetrated in certain situations A panthi may not necessarily identify with the kothi culture and consider himself as a heterosexual who just has sex with other men
Double deckers	This term is used individuals who get penetrated as well as penetrate Some of the Double Deckers (DDs) may not be as effeminate as kothis, or some kothis may call themselves DDs if they have been the penetrative partner in the past Many of these DDs may also have sex with women
Men who are vulnerable due to their occupation/ profession:	This group includes multiple categories that may be situational homosexual or engage in sex for monetary reasons Individuals such as maalish-waalas or masseurs, male film extras, hotel boys, beer-parlour boys, room boys, or truck cleaner boys may be vulnerable These may also be temporary situations and may change with passage of time

Hijras/Kinnars	Hijras are biological males who reject their 'masculine' identity in due course of time to identify either as women, or “not-men”, or “in-between man and woman”, or “neither man nor woman” Hijras can be considered as the western equivalent of TG transsexual (male-to-female) persons but Hijras have a long tradition/culture and have strong social ties formalized through a ritual called “reet” (becoming a member of Hijra community). There are regional variations in the use of terms referred to Hijras. For example, Kinnars (Delhi) and Aravanis (Tamil Nadu). They cross-dress; move in female attire with a portrayal of a female gender. Many of them do not live with their biological families and stay with the 'hijra gharanas'. These are usually headed by a Guru. They become Chelas or Shishyas of this Guru. Thus, they often live in parallel social structure. ***Akwa Hijras*** The Akwa Hijra have not yet removed their male external organs (penis and scrotum) and therefore, may also have penetrative sex with other men or women. ***Nirwan Hijras*** The Nirwan Hijras are the ones who have removed their male external organs ritually or they may also undergo a surgical procedure for emasculation.
Jogtas/Jogappas	Jogtas or Jogapp as are dedicated to the Goddess Renukha devi (Yellama) – whose temples are situated in Maharashtra and Karnataka. Jogta refers to the male servant and Jogti refers to female servant (as called as Devadasi). One becomes a Jogta or Jogti if it is a family tradition or if they find a Guru and they become their Chela or Shishya. Jogti Hijras are those who are servants of the Goddess as well as members of the Hijra community. This term may be used to differentiate them from heterosexual Jogtas who may or may not dress in woman's attire when they worship the Goddess. They are also different from Jogtis who are biological females. Jogti Hijras may refer to themselves as Jogtis or Hijras or Jogtas
Aravanis	The term used for Hijras in Tamil Nadu. They are defined as males who self-identify themselves as woman trapped in a male's body. Some advocate the use of the term 'Thirungani' to refer to them

Shiv-Shaktis	Shiv-Shakthis are males who are close to Goddess and have feminine gender expression They are inducted into the community by senior Gurus, who teach them various customs and rituals They are ritually married to a sword – representative of the male or Shiva, and they become wives of the sword They may cross dress as women
Eunuchs	This term sometimes, incorrectly, used to denote Hijras (who come under male-to-female TG people) This was used to refer to males who have undergone castration not necessarily by choice, but by accident, coercion or as a punishment. Hence, it is not technically correct to refer Hijras as 'Eunuchs.' Example in ancient times, some males were castrated to serve as guards in royal harems. Hijras voluntarily remove their male external genitalia (if they decide to remove them) Many of the community members do identify with this term and have often argued that this term should not be used in documents

CULTURAL ASPECTS OF HIJRAS/KINNARS IN INDIA

Some cultural aspects in India

As discussed above, the Hijras in a parallel social structure. The 'gharanas' are organisations headed by the 'Guru'. A “Guru” is a spiritual leader, an experienced older Hijra, and takes care of all the Chelas.

Some of the money generating activities of the Hijras include badhai, basti, or pun

- The hijras play musical instruments and dance on various occasions (such as birth of a child, marriage, and other auspicious events; this is called badhai
- Some Hijras also beg at various places (such as traffic signals or in trains); this is called basti
- Some may also be involved in sex work; this is called pun. Some may be involved in multiple activities

The culture also has been explored in the tribal communities. The tribal male-to-female TG people are called Yejjollu. The Yejju is tribal faith healer and some tribal festivals (such as Jakarrama festival or Kandi Kottalu) are not celebrated without them. They worship Majjigouri, Nookalamma, and Konda davata, and one of their important festivals is Puvvala festival that is celebrated during Shivaratri. They also maintain certain food and habit restriction to maintain their powers. They don't eat hare, wild rat, and long gourd. However, beef and pork are commonly eaten by them after pooja – which often involves animal sacrifice. The Yejju doesn't conduct deliveries, does not enter the house for 14 days in case of delivery, and 3 months in case of death. The Yejju is buried in sitting posture with complete female clothes.

SOME TYPES OF SEXUAL ACTS / PRACTICES

Terminology	Description	Some terms used by community members
Anal sex **Peno-Anal sex**	Insertion of penis in the anus Insertive partner – the person who inserts the penis Receptive partner – the partner in whose anus the penis has been inserted	Dhurana, water dhurana, peeche se lena
Oral sex **Peno-Oral sex**	Insertion of penis in the partners mouth Also receiving the partner's penis in one's mouth	Mooh mein lena, Komat karna, Blow job, Giving head
Peno-vaginal sex	Insertion of penis in the vagina	
Rimming	Stimulating the perianal region with the tongue	Chaatna
Fingering	Inserting the finger in the anus	
Fisting	Inserting the fist in the anus	
Body sex **Frottage**	Rubbing the bodies together. This may include rubbing of sexual organs with each other	
Foreplay	Sexual activity such as touching caressing, kissing, holding, sucking the breasts and body parts, erotic sensation and touching This often leads of sexual arousal and may/may not be followed by penetrative sex	
Inter-thigh sex	Rubbing the penis in between the thighs	Chapti mein lena
Orgy **Group sex**	Sex (penetrative/non-penetrative) involving more than one partner	

There are other forms of sexual activities such as erotic massages, phone sex, cyber sex, or playing with sex toys. Dildo is one of the commonly used sex toys. Anal dildos, specially designed for anal use are also available in silicone, jelly or glass. They are also made for prostatic stimulation.

IMPORTANT POINTS TO REMEMBER WHILE DEALING WITH CLIENTS

You should have knowledge about human sexuality and identity	It is important that you familiarise yourself with the anatomy and physiology of sexual health and identity The components discussed in 'circle of sexuality', different types of identities, stages of identity formation will help you with this information
You should be familiar with the language of sexuality	Be comfortable using scientific as well as non-scientific terms (words used by the community members or slangs) for sexual acts
You should be comfortable with your own sexuality and identity	You should be comfortable with your own sexuality and identity If you are uncomfortable with any sex act or behaviour, it will reflect in your non-verbal communication while dealing with your client If they sense any discomfort in your dealing, they may not discuss their problems with you

KEY MESSAGES ON IDENTITY

- Although theoretically identity may change over time, in most cases the identity is fixed for most Hijras and transwomen
- The MSM circle includes various identities and behaviours
- TG identity is not a mental illness
- Identity and behaviour are not often congruent. Thus, do not assume the sexual behaviour based on the identity
- Anal sex is not only limited to MSM and TG/Hijras. Some men may have anal sex with women as well
- As a health care provider, one has to understand some common identities in the community
- Do not try to impose an identity on the individual but try to use the same identity and gender expression as the person likes
- Ask a detailed sexual history about various types of sexual practices in all individuals
- As a health care provider, you have to examine all clients (penile examination, anal examination and oral examination)

DAY 2

ISSUES OF MALE-TO-FEMALE TRANSGENDER PEOPLE/HIJRAS

OBJECTIVES

- Conceptual clarity on medical and social issues faced by male-to-female TG people and hijras
- Understand the approach to handle male-to-female TG people and hijras in counselling settings
- Discuss various aspects of sex reassignment surgeries
- Understand various types of STIs in male-to-female TG people
- Discuss use of condoms and lubricants

DURATION OF THE SESSION: 2 hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Case study

INTRODUCTION

- It is important to understand the medical and social issues faced by the MtF TG people and hijras and it affect their health
- Knowledge of these issues will also help us approach them with great sensitivity in care settings

ISSUES FACED BY MSM & MALE–TO–FEMALE TRANSGENDER PEOPLE AND HIJRAS

HOMOPHOBIA

Homophobia is the fear and hatred of homosexuality (Oxford English Dictionary)

"The homophobic feelings may cause discomfort (even fear, anxiety) to individuals when they are in the presence of individuals that are reported to have same-sex relationships or affinity." It is further argued that homophobia is not just a response to an individual but has a lot of historical and cultural baggage attached to it.

TRANSPHOBIA

- Transphobia is also an important issue faced by male-to-female transgendered people
  - It is "emotional disgust towards individuals who do not conform to the society's gender expression"
  - Expressions of the transphobia could be as follows:
    - Heckling on streets
    - Using derogatory language for them on the streets
    - Violence against them on streets and in service areas
    - Forcing them to use male and female in forms
    - Using pronouns that do not conform with the gender expression
    - Medical admission in male wards
    - Discouraging them from sex reassignment surgeries
- Often people who identify as 'gay' or MSM or kothi may discriminate against male-to-female transgendered people. They may not include them in social events
- Many TG/H may have multi-layered stigma. For instance, they may be stigmatised because of their sexual orientation, gender expression, or sexual behaviour. In addition, someone is HIV infected then, there may be an additional stigma due their infected status – this multilayered stigma is referred to as **'onion-type' stigma**

VIOLENCE

- Many MTF TG/H are vulnerable to violence in various spaces
- They may face violence at home by their family members. They may not be allowed to conform to their gender expression. They may be asked to leave their biological families and/or denied right to property
- They may also face violence in the streets and may be subjected to forced sexual encounters
- They may face violence in the service areas – such as while accessing government services, health services, or by security personnel
- Thus, there is a need for health care facilities to be sensitive to sexual and gender expressions of MTF TGs

- The health care facility needs to develop a relationship with a (CBO) working for MSM and MtF, TG/H
- Since many individuals will approach the health care settings for care and treatment of violence, the health care provider should provide the immediate care for violence and then refer the individual for further support
- The CBOs may be approached for community help, legal and social help during moments of crises

ACCESS TO HEALTH CARE SERVICES

- Many MtF, TG/H may have poor access to health care services
- This may be due to the fact that in general many doctors may not be trained to address the health concerns of MtF, TG/H
- They also may have had bad experiences in health care settings in the past or may have experienced discrimination
- Even though the treating doctor may be sensitive to the MtF, TG/H, they may face discrimination by the other health care personnel in the settings. Thus, it is important that all the providers are sensitised to the issues of MtF, TG/H
- One should avoid giggling when they enter, should not give weird expressions, should not look at them unnecessarily or do not talk rudely to them

SUBSTANCE USE

- MSM and MtF,TG/H are at risk for excessive substance use
- Data have shown that MSM and MtF, TG/H may have a higher rate of use of tobacco and tobacco related products. Thus, they may be at risk for smoking related issues such as lung infections, lung cancer and oral cancers. It is quite likely that the panthi may force the use of tobacco products
- Similarly it is also reported that they also have higher rates of alcohol use and dependence. This puts them at risk for alcohol related disorders such as liver disorders, hepatitis, and cirrhosis. As discussed earlier, the panthi may force the use of alcohol. The MtF, TG/H may be subjected to violence and forced sex or unprotected sex
- There are reports of other substance use such as pharmaceutical products, weed, cocaine, ecstasy and other injectable drugs
- Thus, during care of MSM and MtF, TG/H, it will be important to enquire about substance use and appropriate referral services should be provided

HORMONE USE & INJECTABLE SILICONES

- Many MtF, TG/Hmay use hormones either in the form of oral pills or injectables – some common hormones used are oestrogens

- They are often unsupervised and taken because other peers are using them
- This may result in infections at injection sites, blood borne infections, high blood pressure, high blood sugar, and put them at risk to excessive blood clotting or heart diseases
- Apart from using hormones, many MtF, TG/H also use unsupervised injectable silicones or use by unqualified doctors. They may use silicone products to enhance their appearance. This may lead to infections at injection sites, blood borne infections, may cause disfigurement of the body part where used and may not be a good grade silicone
- Thus, it is important to enquire about the use of hormones or silicones. If they are using any products, then they should be discouraged from unsupervised use
- The hormones may have adverse effects if they are also taking ART. Hence, doctors should take detailed drug history

Other health concerns

- There may be excessive bleeding and sometimes even death after the nirwaan procedure
- Often, there are urinary problems such as repeated urinary tract infections, blockage of urine, or constriction of the urethra. Thus, there is a need to evaluate these complaints; the treatment may require antibiotics, catheterisation, dilatation, or even surgical intervention
- There may be surgical complaints and disfigurement after incorrect breast enhancement procedures. There may be incorrect breast enhancement, unequal breast sizes, or granuloma formation. Thus, there is a need to examine the breasts for any lumps and seek appropriate surgical referral

CULTURAL ASPECTS OF HIJRAS/KINNARS IN INDIA

- MSM and MtF, TG/H are at risk for mental health concerns
- The common mental health concerns are depression and anxiety
- Depression included features of feeling low, gloomy, sad and disgusted with life. This may be also due to internalised homophobia or experienced stigma and discrimination
  - Some of the features are feelings of gloom, sad, hopelessness, lonely, feeling of being rejected, worthlessness or discouraged
- Anxiety is another important mental health concern and it involves the feeling of being fearful or nervous
  - Some of the features are feelings of being afraid, irritable, confused, panicky, tense, or confused
- Suicidal tendency is another important health concern. It may be associated with other mental health concerns such as depression, alcohol and drug use, or chronic health problems. Some of the reasons are:
  - Coming to terms with one's sexual orientation or gender identity
  - Faced extreme levels of stigma and discrimination in social or professional life
  - Loss of loved one, unhappy relationships
  - Economic difficulties and other poverty situations

- It is important to enquire about such feelings and tendencies. If there is any risk appropriate psychiatric referrals should be ensured
- HIV infected MtF and Hijras may also be prone to mental health problems and psychiatric disorders

DISCUSSION OF COMMON PSYCHIATRIC DISORDERS IN HIV INFECTED INDIVIDUALS

Mood disorders	Depression, Bipolar disorder
Anxiety disorders	AIDS phobia, Health anxiety, Panic attacks, Post Traumatic Stress Disorder, Adjustment disorder
Substance use disorders	Alcohol dependence, IV Drug use, Cannabis use, Nicotine Dependence
Delirium	Hypoactive, Hyperactive
Cognitive disturbances	AIDS Dementia, minor cognitive disturbance, cognitive disorders due to opportunistic infections such as meningitis
Sleep disorders	Insomnia, hypersomnia
Psychosis	Schizophrenia-like, Acute Psychosis, ART related
Personality changes	Personality changes refer to signs of organic changes in personality including irritability, lack of motivation and poor personal care

GENERAL WARNING SIGNS OF MENTAL ILLNESS

- Inability to manage daily activities and cope with problems.
- Strange ideas (e.g., "Mahatma Gandhi talks to me")
- Long periods of sadness and indifference (as in the song "na koi umang hai, na koi tarang hai...")
- Significant changes in eating or sleeping patterns (eating and / or sleeping too much or too little for a number of days)
- Thinking or talking about suicide or harming oneself
- Excessive worries
- Extreme mood swings — feeling extremely happy or extremely sad
- Abuse of alcohol or drugs
- Excessive anger, hostility or violent behaviour

A person who shows any of these signs may have a mental illness and should be referred to a qualified mental health professional.

SEX REASSIGNMENT SURGERY

OBJECTIVES

- Understand basic concepts of SRS
- Discussion about various hormonal and surgical procedures in SRS

DURATION OF THE SESSION: 1 hour

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power point presentation
- Exercise sheets

SEX REASSSIGNMENT SURGERY

- This section will provide basic information on the procedures that may form a part of SRS
- The section also provides some information on side effects of hormone therapy

Definition of Sex Reassignment Surgery

- It is also called as SRS
- It is a combination of surgical procedures which changes one's body structure to reflect one's gender identity and gender expression. This may include surgeries for breast augmentation or breast enhancement or altering of genitals
- They are also called as Gender- Affirming Surgeries

We have discussed various aspects of feminising in the next pages

HORMONE THERAPIES

We have described feminising hormone therapies in this section. There may be masculinising hormone therapies as well (for FtM, TG people)

A) Feminising hormones

- Such as oestrogen, Oestrogen and testosterone, Oestrogen and testosterone blockers and progesterone, Only testosterone blockers

B) Effects of the hormone therapy

- Breast development, as body fat redistribution, softening of skin
- Less body and facial hair
- Smaller testes
- Reduced muscle mass and strength
- Reduced fertility
- Emotional changes

C) Side effects of hormone therapy

- Risk of blood clots
- Increased liver enzymes
- Weight gain
- Hypertriglyceridemia
- Gall stones
- High blood pressure and cardiovascular disease

D) Drug interactions of hormone therapy and HIV medications

- Certain interactions are reported with ART medication and oestrogen (mostly ethinyl estradiol)

- Certain interactions are reported with other medications which may be used in HIV infected individuals and oestrogen (mostly ethinyl estradiol)

SEX REASSIGNMENT SURGICAL PROCEDURES

A) Breast Augmentation Surgery

- It creates larger breasts and often the goal is to have breast and nipples with sensation
- A temporary breast tissue expander is inserted in the breast and later replaced by a permanent expander
- The nipple and areola are created in a feminine shape
- It is preferable that the individual should have taken hormones for at least 1 year unless there is some contraindication

B) Orchiectomy

- Surgical procedure to remove the testes
- The testes are removed from scrotum through an incision in the middle of the scrotum
- It is preferable that individual should have taken hormones for 1 years unless there is some contraindication

C) Vaginoplasty

- It is a surgical procedure to create a vagina
- It includes the removal of the penis, testes and scrotal sac
- The scrotum and testes are removed and the penile skin is made into labia and clitoral hood
- The glans is made into clitoris
- Vaginal space created between the rectum and bladder and penile skin is used to create the walls of the vagina
- Urethra is shortened and temporarily catherised
- There will be a vaginal tract created which will be capable of penetrative sex
- There will be a functional urethra
- It is preferable that individual should have taken hormones for 1 years unless there is some contraindication

F) Other procedures which may be used for feminising

- Facial feminising surgery
  - Reduction of Adam's apple
  - Facial bone reduction
  - Jaw surgery
  - Nose feminisation
  - Hair reconstruction
- Liposuction
  - Removal of abdominal fat
- Augmentation of buttocks
- Voice changes
  - Voice pitch elevation surgery
  - Voice therapy

DETAILS ABOUT SRS PROCEDURES – HORMONE THERAPY

A) Hormone Readiness

- It discusses the gender identity and feelings about the body
- It assesses the final goal of hormone therapy
- Assess the health history
- Describe the side effects of hormone therapy
- Assess the support systems, economic support and long term support

B) Mental health assessment for young individuals

- Understanding and expression of gender identity
- Emotional expression
- Experiences in the family, society, school and community
- Expectations from the therapy

C) Criteria for hormone therapy in adults

- Persistent well documented gender dysphoria
- Capacity to make a fully informed decision and consent procedure
- Age of majority
- Treatment of medical or mental health problems

DETAILS ABOUT SRS PROCEDURES – SURGICAL PROCEDURES

A) Surgical readiness assessment

- Discussion about gender identity and body feelings
- Expectations from the surgery
- Assessment of health history
- Discussion about the risk of surgery
- Assess the economic situation, support systems, and peer network
- Post surgical plan

B) Counselling indications

- Not sure if this is the right decision
- You have not discussed it with your family members in detail
- Mental health concerns (anxiety etc.)

C) Criteria for gender-affirming surgeries

- Persistent gender dysphoria
- Age of majority
- Able to consent
- Medical and mental health maintained

D) Before surgery

- Prepare emotionally
- Prepare physically
- Consult with the support system, family members, peers
- Prepare economically

SEXUALLY TRANSMITTED INFECTIONS

OBJECTIVES

- Understand different types of STIs in MTF, TGs
- Discuss some of the common symptoms and signs

DURATION OF THE SESSION: 1 hour

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

SEXUALLY TRANSMITTED INFECTIONS

Penile Ulcers	Chancroid Syphilis Herpes genitalis Lymphogranuloma venerum Granuloma inguinale
Urethral discharge	Gonococcus Chlamydia Trichomonas vaginalis
Inguinal swelling	Buboes due to Chancroid Lymphogranuloma venerum
Growths/Genital skin conditions	Genital warts Peri-anal/oral warts molluscum contagiousum
Scrotal pain	Epididymitis/Orchitis Gonococcal Non-gonococcal
Other symptoms (such as itching)	Genital scabies Public lice
Oral complaints of sore throat	**Pharyngitis** Gonococcal Non-gonococcal **Growths** Warts - HPV
Anal/Rectal complaints **Pain while defecation** **Pain in the abdomen** **Diarrhoea**	Proctitis Proctocolitis Enteritis

STIs

- MSM and MtF, TG/H are at risk for STIs – Oral/Ano-rectal and Genital
- They may be ulcerative STIs (such as herpes, chancroid, syphilis) or discharges (such as penile gonococcal and non-gonococcal urethritis/ano-rectal and oro-pharyngeal infections)
- They should be particularly evaluated for STIs in the peri-anal and anal region. They may have proctitis, proctocolitis or enteritis
- They may also have other STIs such as pubic lice, genital scabies, genital warts or genital molluscum contagiosum
- In addition, they are also at risk for STIs such Hepatitis B, or C, and HIV
- They may also be at risk for Hepatitis A
- MSM and MtF, TG/H should be periodically screened for STI at regular intervals, apart from offering services whenever they have symptoms/signs, irrespective when they had last consultation
- A detailed information on the STIs is provided later in the module

ANAL WARTS

- MSM and MtF, TG/H are at risk for developing anal papillomas /warts and cancers due to Human Papilloma Virus (HPV)
- It is advised that MSM and MtF, TG/H regularly undergo screening for anal papillomas and cancer. This should be in the form of anal pap smears
- If any changes are found, a specialist surgeon advice should be sought
- There are some international studies that do discuss HPV vaccination for young MSM and MtF, TG/H. However, currently, this is not spelled out in National guidelines for HRG in India

HEALTH PROBLEMS (contd.)

HIV

- MSM and MtF, TG/H are at risk for HIV
- They should undergo regular screening (assuming they are sexually active) for HIV. A screening every six months will be preferred
- Studies have shown that MTF, TG/H are at particularly high risk for HIV compared with MSM
- Though, there are discussions on pre exposure prophylaxis in literature, there are no such current recommendations in India
- However, if there is a case of sexual assault or forced sex with an MSM or MtF, TG, they should be evaluated for trauma in the genital and peri-anal region, screened for STIs and HIV, and offered post exposure prophylaxis

OTHER CANCERS

- MSM and MtF, TG/H should be assessed for other genital cancers (if they have external make genitals) based on the family history
- MtF, TG/H who have undergone nirwaan or sex reassignment surgery procedures may be at risk for prostate cancer even though the risk may be low

HEPATITIS VACCINATIONS

- It is recommended that MSM and MtF, TG/H be vaccinated for Hepatitis A and B. However, currently, this is not spelled out in National guidelines.
- Hepatitis may cause hepatitis, cirrhosis, liver cancer, or even liver failure
- Even though, they may also be at risk for Hepatitis C, the best way to avoid this infection is to have safe sex

CONDOMS AND LUBRICANTS

OBJECTIVES

- Understand use of male and female condoms
- Discuss different types of lubricants (advantages and disadvantages)

DURATION OF THE SESSION: 1 hour

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets
- Condoms for demonstration

CONDOMS

- Condoms are important for reduce the transmission of STIs (including HIV) and usually made of latex
- They are also called rubber, chocolate
- They should be used in all forms of sex: anal, vaginal, and oral
- They are one of the best ways to reduce the transmission of STIs
- Condoms are of two types: male condoms and female condoms

Best way to use a condom

- Use a new condom always every time you have sex
- Always check about the expiry date
- Store them in a proper place (usually a cool place where there is no direct sunlight)
- Do not try to blow or fill them with water to test for any holes. All condoms are tested and then packaged
- Use a new condom every time you have sex
- Condoms come in various sizes, flavours (such as strawberry, chocolate), and additional properties (such as ribbed)
- If you are allergic to latex, then you may use polyurethane condoms

HOW TO USE A MALE CONDOM

Step 1: Open Package

- Use a new condom each time you have sex
- Check that it has not expired and that the packaging has no holes by pressing the pack between your fingers
- Push condom to one side of package to allow room to tear open other side
- Remove condom carefully
- DO NOT use finger nails, teeth or sharp objects to open package or remove condom

Step 2: Put it on

- Squeeze closed top end of condom to make sure no air is inside (can make it break)
- Place condom over top of erect penis
- If the penis is uncircumcised, kindly pull the foreskin back before putting the condom on
- Put the condom on after the penis is erect (hard) and before any contact is made between the penis and any part of the partner's body
- If the condom does not have reservoir tip, pinch the tip enough to leave a half-inch space for semen to collect
- While pinching the half-inch tip, place the condom against the penis and unroll it all the way to the base.
- With other hand, unroll condom gently down the full length of the penis (one hand still squeezing top end)
- Even if the condom is lubricated, put more lubricant on the outside particularly while having anal sex

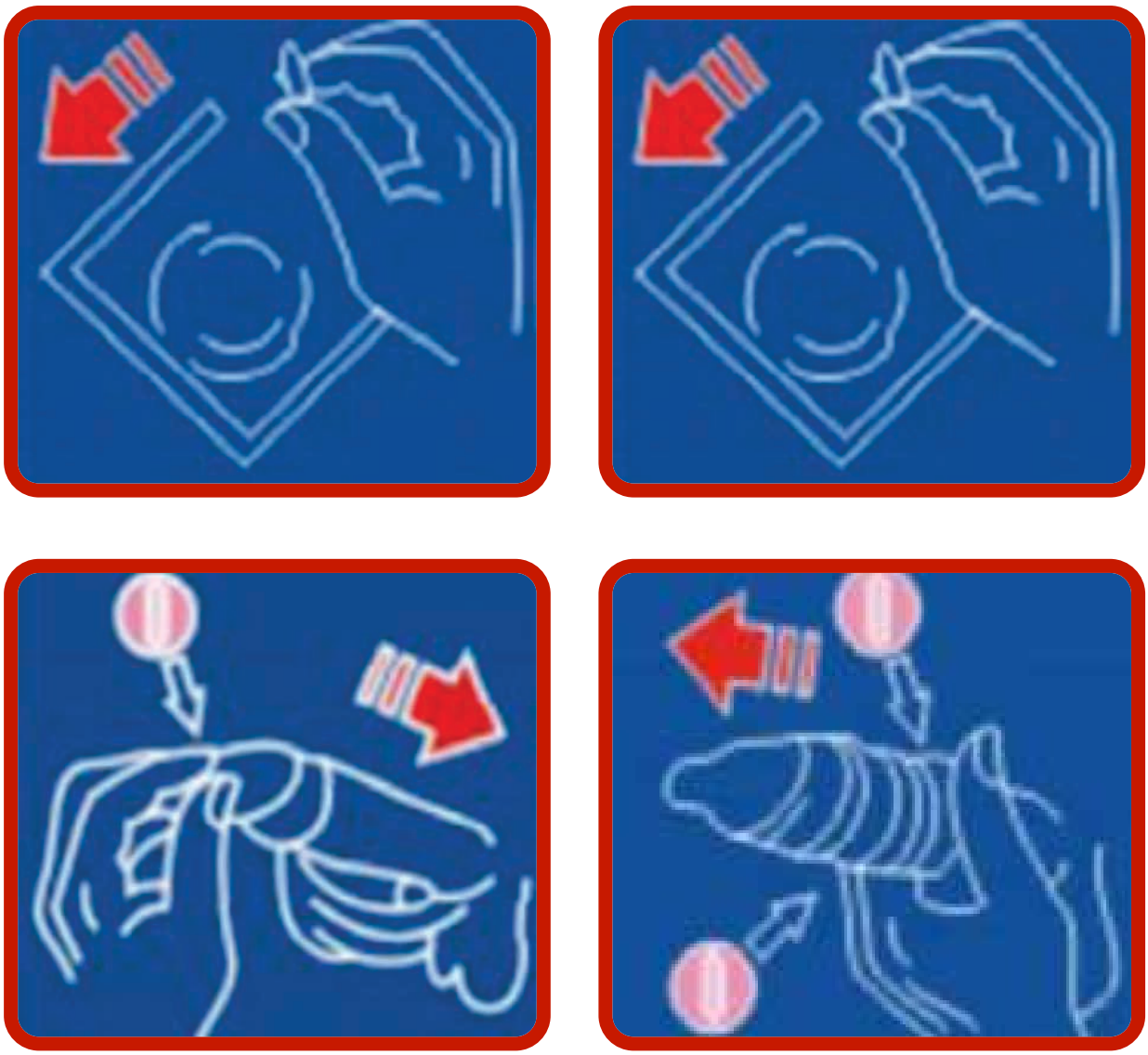
Step 3: During sex

- Make sure condom stays in place
- If it comes off, withdraw the penis and put on a new condom before intercourse continues
- Once sperm has been released into the condom (ejaculation), withdraw the erect penis and HOLD the condom in place on penis

Step 4: Dispose off the condom

- Remove condom ONLY when penis is fully withdrawn
- Keep both penis and condom clear from contact with your partner's body
- Knot the end of the used condom
- Place in tissue or bag before throwing it in dustbin
- DO NOT flush condoms down the toilet. It will block the system
- Wash your hands with soap and water after disposing the condoms

PICTORIAL REPRESENTATION – USE OF MALE CONDOM



LUBRICANTS

1) What are lubricants?

- They reduce the friction during sexual act
- By reducing friction, they:
  - Reduce the chances of condom breakage
  - Prevent irritation to the genital parts
  - It also prevents breakage of the skin
  - Increases the sexual pleasure

2) When should lubricants be used?

- They should be used during anal intercourse
- The anus does not expand as much as the vagina and also not have a natural lubricant
- Thus, if one has anal sex without lubrication, there are chances of tears and cuts to the lining of the rectum
- Thus, addition of lubricants will be helpful in reducing the friction during anal sex
- Particularly, if you are having anal sex for the first time will be useful for safety and comfortable sexual activity
- They can also be used during vaginal intercourse for additional comfort and safety

3) How to apply the lubricants?

- In general, the lubricants are applied to the outside of the condom in the insertive partner
- The lubricant may also be applied inside and around the anus or vagina
- Although many condoms are pre-lubricated, it is advisable to use lubricants along with them especially during anal sex

TYPES OF LUBRICANTS

	Water based lubricants	Silicone based lubricants	Oil based lubricants
Examples	K-Y Jelly, K-Y Water, Boots Lubricating, Durex Play	Wet platinum premium product ID Millenium, ID Pleasure	oil, baby oil, face creams, Vaseline, petroleum jelly, body lotions, ointments
Properties	• Considered to be among the safest lubricant • It is non-irritating and does not have any major effects on latex	• They are also safe to use with latex condoms • They are long lasting • They are not sticky • They do not dry out fast • Some individuals may find these lubricants to be more pleasurable	• They weaken the condoms • They may deteriorate the latex and break the condoms • They may also lead to infections in the rectum
Use during sex	It can be used during anal sex	It can be used during anal sex	THEY ARE NOT RECOMMENDED FOR ANAL SEX They may be used during masturbation
Issues	It may cause irritation in some individuals	Some of these products may be expensive, however since they are long lasting they can be economical in the long run	They should not be used for penetrative sex since they may destroy latex

BASIC COUNSELLING PACKAGE

OBJECTIVES

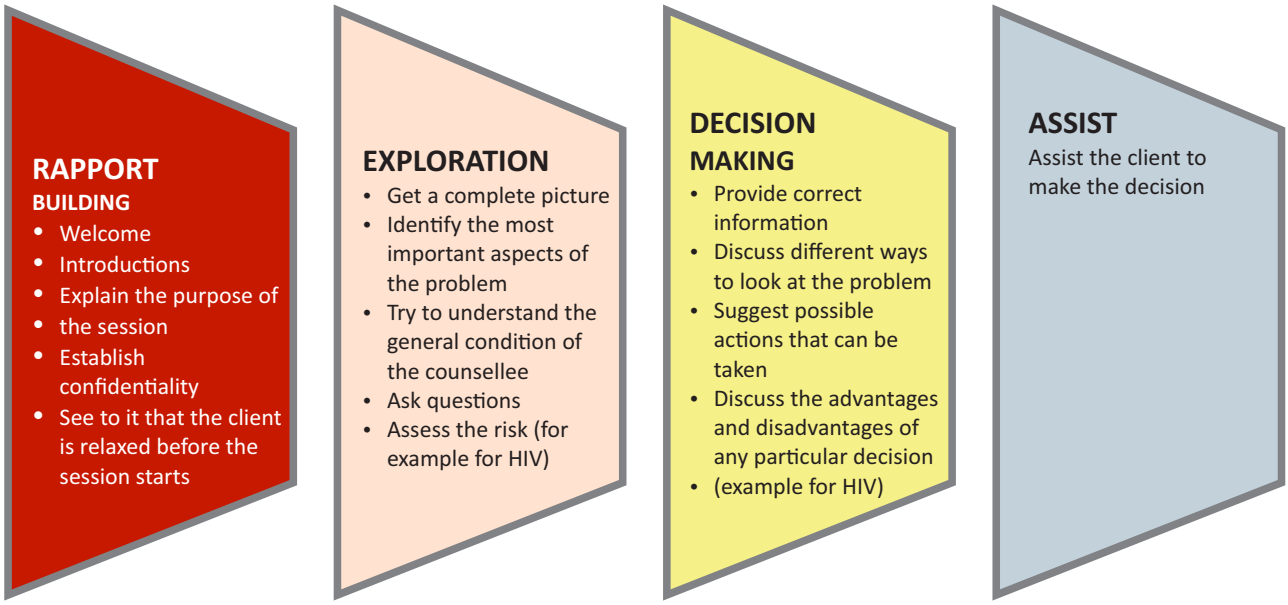
- Discuss various steps involved in Counselling
- Case studies in Counselling
- Understand some aspects of effective Counselling

DURATION OF THE SESSION: 1 hour

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets
- Case sheets
- Case videos

STEPS IN COUNSELLING REDA Approach



Exercise 4

Duration: 50 minutes

Objective

- Discuss and acquire skills for effective counselling

Requirements

- Case scenarios

Instructions

- This is a role play session
- The participants will be divided into four groups
- Each subgroup will have to work on each case
- Each group will identify one client and one counsellor
- They will enact the role play in front of the larger group
- All the participants and the facilitator will provide feedback on the role play
- They will discuss the 'effective' and 'ineffective counselling skills' used by the participants in each of the role plays

Case 1

Ragini a 22 year old male to female transgendered woman has had unprotected anal sex and would like to get examined for STIs

Instructions: The group has to work on rapport building

Case 2

Rahul a 20 year male comes to your clinic for HIV testing. This is his first visit to the centre

Instructions: The group has to work on exploring issues with the client

Case 3

Surekha is a 35 year old Hijra. She is trying to get more information on sex reassignment surgeries. She has come to you to get more information on SRS because she wants to undergo some procedures

Instructions: The group has to work on decision making

Case 4

Ravi is a 27 year old male. He has a steady relationship with Suresh, a 27 year old male. Ravi was detected HIV positive 2 weeks ago. He has not informed his partner yet. He wants to discuss this with you.

Instructions: The group has to work on assist

Notes to the facilitator

- The facilitator has to discuss and provide feedback on the following aspects in each of the cases
- **Case Scenario 1:**
  - The facilitator has to discuss verbal and non-verbal communication skills in rapport building
  - Discuss about welcoming the client, language, posture, smile, warmth, genuineness while discussing this case
- **Case Scenario 2:**
  - The facilitator has to discuss about risk assessment
  - Discuss about non-judgemental attitude, moralistic language and advise
- **Case Scenario 3:**
  - The facilitator has to discuss about technical information
  - They have to ascertain that the group is counselling and not advising the client
  - Discussion of various strategies for SRS
  - Discuss the points related to termination of the counselling session – such as goals, referrals and follow-up dates.
- **Case Scenario 4:**
  - The facilitator has to discuss about technical information – post-test counselling
  - They have to discuss about the current decision – will inform the partner/how will he inform
  - The facilitator has to discuss the components of follow-up counselling, setting up a date for follow-up, expectations in the follow-up session
  - The facilitator will also discuss the possibility of couple counselling

Exercise 5

Duration: 50 minutes

Objective

- Discuss various scenarios that may be experienced while

Requirements

- Case videos

Instructions

- This is a video session
- The participants will be divided into four groups
- Each subgroup will have to work on one video
- They will discuss the issues that have discussed in the video
- The other groups will provide feedback on the issues that have been highlighted by the primary group

Notes to the facilitator

CASE VIDEOS

Video 1

- Discussion about various types of identity
- All MSM may not have the same identity

Video 2

- Discussion about gender stereotypes

Video 3

- Discussion about coming out process
- Discussion about identity
- Discussion about support systems

Video 4

- Discussion about identity
- Discussion about TG/H

EFFECTIVE COUNSELLING SKILLS

Skill	Details	Example
Warmth and openness	• Maintain an open posture while attending a client • Welcome the client with warm words • Do not be cranky while addressing the client	"Hello, How are you today" "I will be discussing ... today"
Attentive	• Provide your full attention to the client • Maintain eye contact • Do not appear in a hurry or disinterested • Listen carefully to the client	Always express that you are interested in listening to the client "Let me summarise it for you..."
Follow the conversation	• Listen to the sequence of events, do not interrupt or cross-question the client • Do not be over inquisitive	"So, what else did you feel after the event?"
Empathise	• Try to be in the other person's shoes and understand the issues • Do not sympathise with the patient	Ask yourself – how would I feel if the same event would happen with me "I know it is difficult to stay alone when you like company..."
Paraphrase	• Try to paraphrase whatever has been discussed during the course of the counselling session	"So far you have discussed this.... and you are saying ..."
Reflect	• Try to reflect on all the issues that have been discussed in the counselling session and discuss your reflection with the client	"So you are saying that you were unhappy with the events..."

DAY 3

ROLE OF THE FAMILY

OBJECTIVES

- Discuss the concept of 'Family' within the cultural context
- Discuss some of the important issues in the Family

DURATION OF THE SESSION: 1 hour

MATERIAL REQUIRED

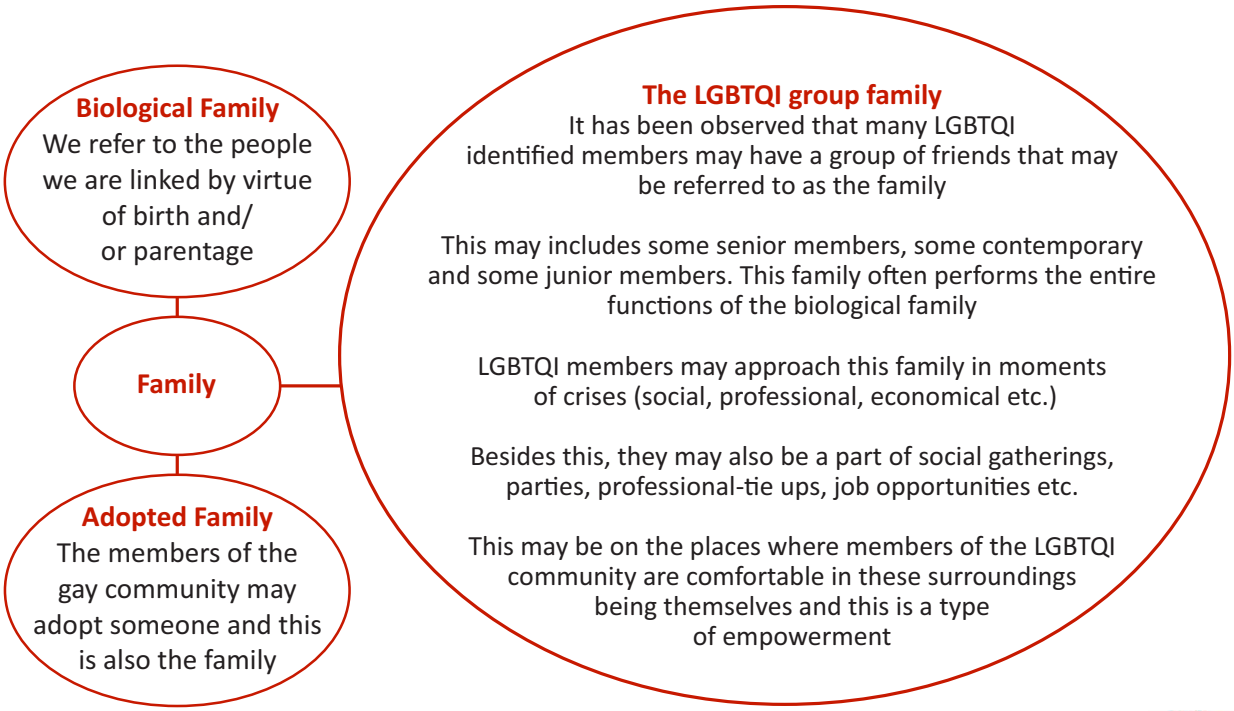
- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

WHAT IS A FAMILY?

One of the most common thought that crosses the mind when one speaks of the family is the biological family.

When we are talking in the LGBTQI sense, there may be multiple examples of the family.

For example, when someone says “he is a part of the family'; the expression usually means that the person is a member of the larger LGBTQI family.



The Transgender Family

Compared with MSM families, the TG families may be more formalised. There may be a head of the family 'guru' and other followers, the group referred to as the 'gharana'. The head of the family may have more authority than the elders in the MSM family (allocation of financial resources, social responsibilities, HIV prevention programmes, to name a few). This type of family almost runs as a parallel social structure within the society. Numerous such TG gharanas exist in the Indian society.

Discussion:

Some strategies for coming out to the family members:

- Discussion of MSM and TG issues (generally) with the family members
- Bring out the topic of certain movies/books/media that deal with MSM/TG issues
- Talk to the member closest to you if you have to start
- It's not their fault. Not due to bad/wrong/poor upbringing
- It's no one's fault
- You love them and expect the same from them
- It's not abnormal/perversion
- It will not be treated with some therapies
- Give them some time. Remember it took you a long time to accept yourself!

Issues in a family

LGBTQI members may have specific issues with the biological family members:

- They have to decide if/and when to come out to the biological family members
- They have to decide who all to come out in the family
- Other siblings in the family (brother v/s sister)
- Only child in the family
- Only male child in the family
- Financial situation of the family
- Parents living together/separated
- Dependence on the family (social, economic, professional etc.)
- Social status of the family?
- Access to other social support systems (MSM/TG groups, community organisations)
- Coming out as MSM or TG
- Decide to stay with the family afterwards or more out
- Have to take care of the family members
- Marital situation of the siblings

DISCLOSURE

OBJECTIVES

- Discuss concepts of disclosure including 'coming out'
- Understand the issues involved in disclosure

DURATION OF THE SESSION: 1 hour

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

DISCLOSURE

What is 'Coming Out?'

Commonly termed as 'coming out' in the western literature, disclosure is one of the important aspects of the LGBTQI identity. We would like to discuss disclosure over here within a broader framework of coming to terms with sexuality, sexual orientation and gender expression.

POINTS ABOUT DISCLOSURE

- Disclosure can mean different things for different individuals; this often leads to the issue of who does one disclose to
- First and foremost, an important aspect is acceptance of self and disclosure to self. Then there may be a disclosure to others in the society
- There may be a disclosure to some members of the community. Though, this is often not stressful as with others, it may have its own issues. For example, what if one does not fit exactly according to the expectations of the group one comes out? What if she is a TG but not ready to have the external genitals removed?
- Some individuals may try to be clear about their sexuality, sexual orientation, sexual preferences, and identity to some sympathetic straight friends. There is always a fear that some friends may not understand and they may end losing those friends
- Then there could be disclosure to family members
- There may be disclosures at work place to some work colleagues and even superiors. This may be easier said than done. It will also depend on the work atmosphere, the type of job, financial security and other factors. For example, for some it may be much easy to come out in the development sector or to people working on HIV/AIDS issues. If there work organisation has some ideological issues/differences it may be difficult to come out to them. In real life, sexual preferences and orientation at the work place are often well guarded. There may be a fear that one be discriminated against. Though, it might not be very obvious, subtle discrimination is likely to take place. Such types of discrimination are often hard to contest. Factors such as financial stability, available legal and social recourses are other factors that may play a role in such a disclosure
- Disclosure may mean different things to different people. For some, one is only out when s/he comfortable talking to media or press or in political platforms about one's sexuality, sexual preferences, and gender. For others, it is more at a personal level

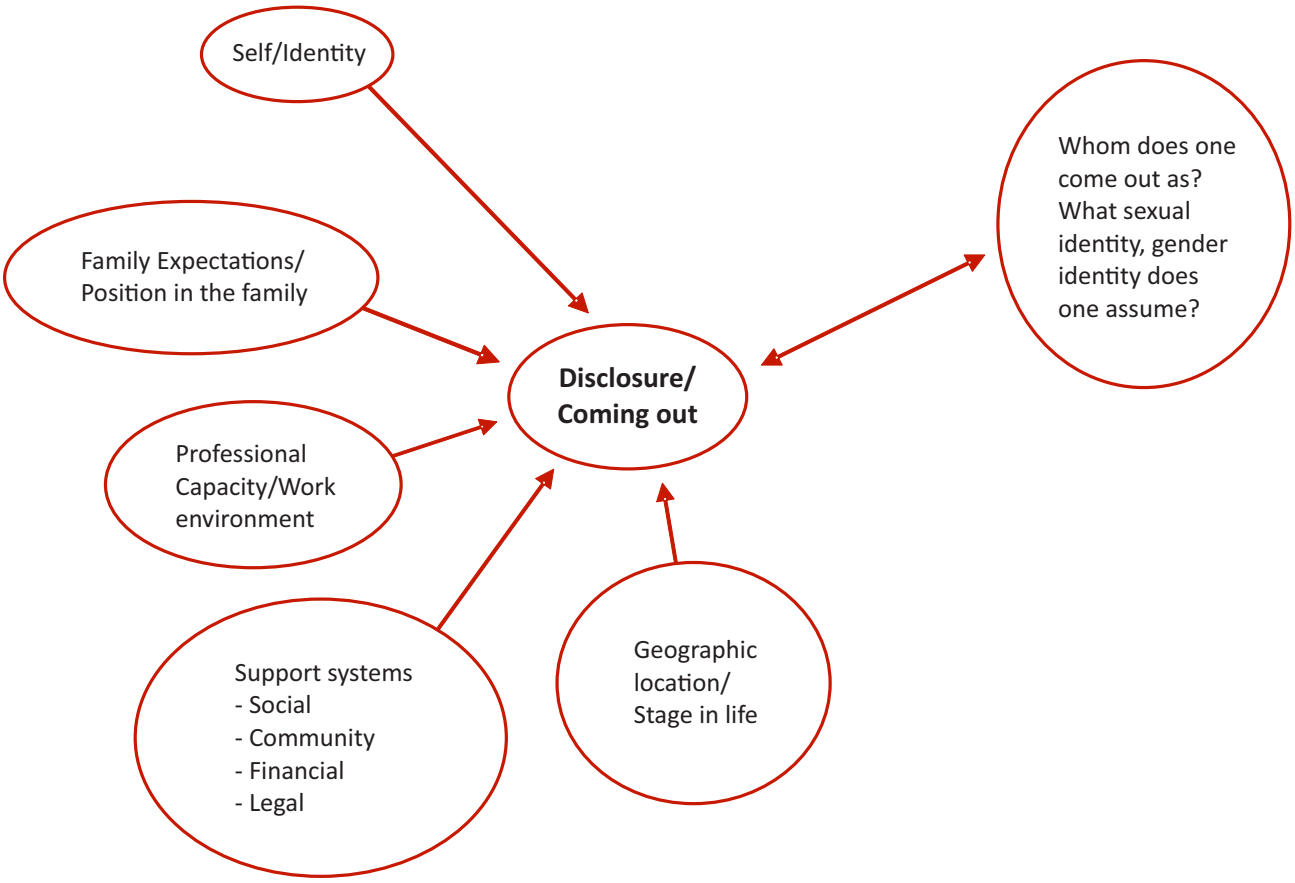
- Thus, disclosure and coming out will differ in different individuals. It may also depend on the stage of life they are in. Nowadays, it has been observed that many LGBTQI members are disclosing their sexuality, sexual preference, gender to others at relatively younger ages than before. However, some may still not be comfortable disclosing it till much later in life

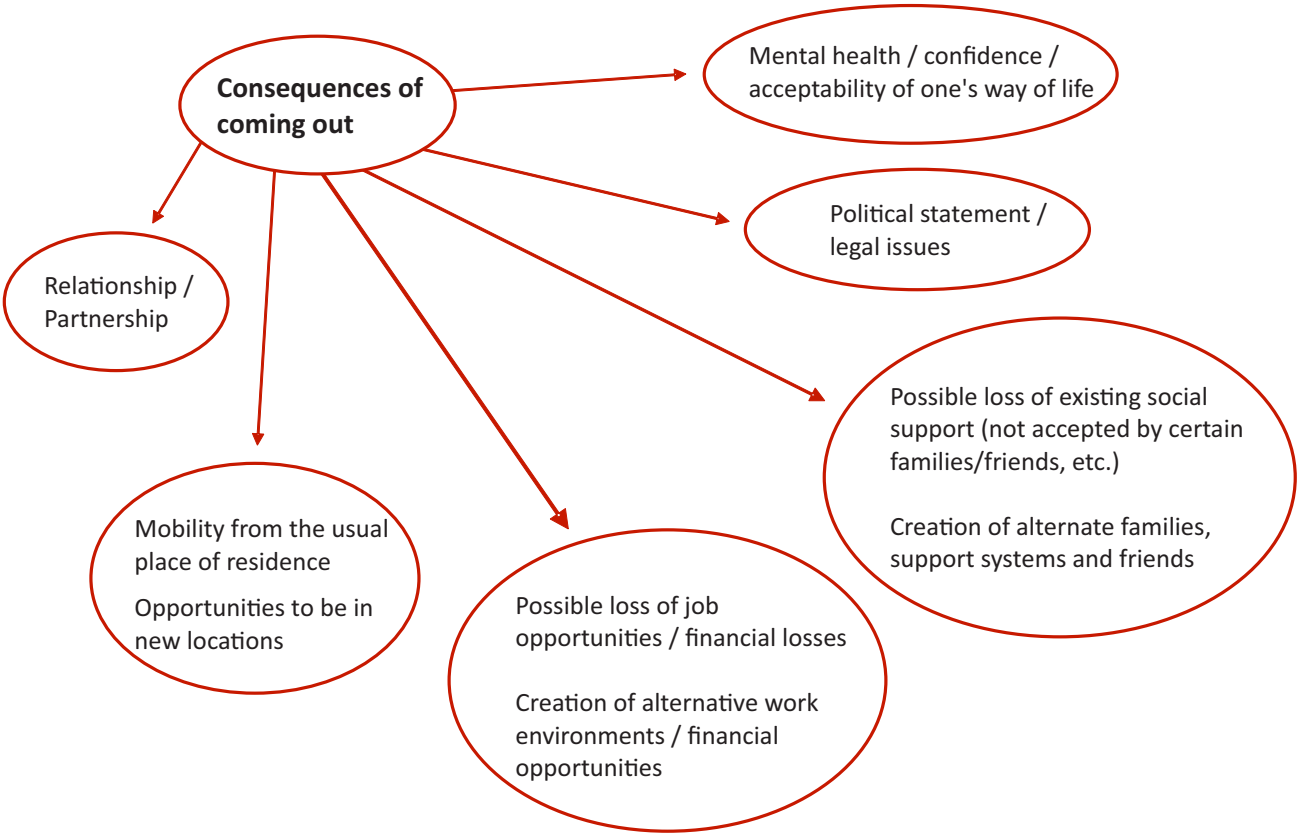
- Further, disclosure will also depend on the types of support one is assured of in the face of rejection by members whom they come out. This support can be in the form of social support, legal support and financial support to name some

- The location of an individual may play a role in the type of disclosure. For example, a person may be more comfortable moving around in LGBTQI groups in a geographical location where he is not known in social or professional circles e.g. in cities other than the place of residence or work. They may have partners or lovers in other cities but in the home city they may not disclosure their sexual preferences or partners

- Thus disclosure works at different levels in different cities. It may happen that gradually as they become comfortable with their self and sexuality, they may start moving in the LGBTQI circles in the home town as well. However, it is also possible that they may continue this of undisclosed/disclosed life

- This may also be the case with some TG. Some may move around as male-to-female TG in cities, however be dressed as men and may also have families in villages


Self/Identity
Family Expectations/
Position in the family
Professional
Capacity/Work
environment
Support systems
- Social
- Community
- Financial
- Legal
Disclosure/
Coming out
Geographic
location/
Stage in life
Whom does one
come out as?
What sexual
identity, gender
identity does
one assume?


Consequences of coming out
Mental health / confidence / acceptability of one's way of life
Political statement / legal issues
Relationship / Partnership
Possible loss of existing social support (not accepted by certain families/friends, etc.)
Creation of alternate families, support systems and friends
Mobility from the usual place of residence
Opportunities to be in new locations
Possible loss of job opportunities / financial losses
Creation of alternative work environments / financial opportunities

FRIENDLY SERVICES

OBJECTIVES

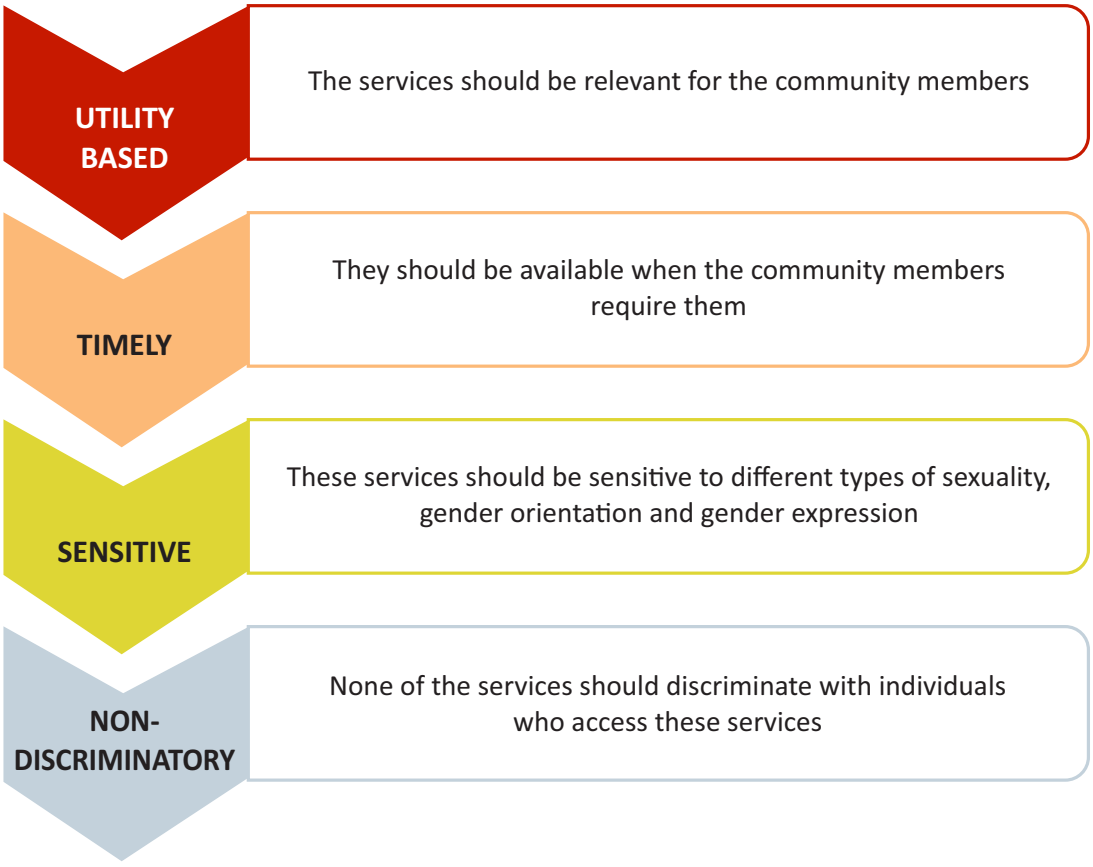
- Discuss the pillars of friendly services
- Understand various aspects of Friendly services

DURATION OF THE SESSION: 1½ hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

PILLARS OF FRIENDLY SERVICES



TYPES OF SERVICES

HEALTH SERVICES

HIV RELATED SERVICES

- Prevention services such as condoms, lubricants etc.
- Testing services such ELISA, Western Blots, CD4 counts, Viral loads, ARV resistance
- Treatment facilities as 1st line and 2nd line ARVs
- Hospitalisation facilities for severely ill
- Palliative care, Nursing care, Hospice care, Continuum of care in home settings

STI RELATED SERVICES

- Prevention services such as condoms, lubricants etc.
- Testing services such VDRL, Hepatitis B, Hepatitis C, HSV, urine tests
- Treatment facilities antibiotics, antifungals, and antivirals
- Hospitalisation facilities if required in cases of secondary and tertiary syphilis
- Vaccination services for Hepatitis B

GENERAL CARE

- Outpatient facilities for regular check-ups
- Inpatient services for illness and hospitalization facilities
- Investigation services for general illness, CT scans, MRI scans etc.

OTHER HEALTH SERVICES

MENTAL HEALTH SERVICES

- Psychiatric counselling services
- Suicidal thoughts and attempts: handling of these issues
- Inpatient services for severe cases

SEX REASSIGNMENT SURGERIES

- Pre surgery care
- Post surgery care

OTHER FEMINISATION SERVICES

- Breast implants
- Voice training
- Taking care of the hair issues (hair removal, laser treatment)

OTHER SERVICES

LEGAL SERVICES

- Handling issues related to police harassment
- Tackling blackmail faced by the community members
- Parental pressures and harassment by the family members
- Attempted Suicides
- Legal standing of SRS

GOVERNMENT/NATIONAL DOCUMENT SERVICES

- Identity cards such as Aadhaar Card, Driver's license, Ration card, PAN card. They should be gender sensitive
- Other important documents such as Passport
- Registration of property and Other documents

SOCIAL SECURITY SERVICES

- They should be made a part of various government schemes – National Health Mission, National Rural Employment Gurantee Act (NREGA), Jan Dhan Yojana
- They should be able to access various pension and health insurance schemes
- These services should be gender accommodating

Exercise 6

In this exercise, the participants will map out the barriers faced by the community members in accessing these services. There are two main types of barriers that we will highlight in this exercise – personal and structural

Type of exercise: It is a group exercise

Procedure

1) Divide the participants in two groups
2) Provide them sheets with columns as shown in the next pages
3) The participants have to discuss and add the barriers in the columns. They should be under the specific headings
4) For example:
   - TGs may not get drivers license with gender mentioned
   - There may not be any tertiary care centre in the neighbourhood
   - Someone may not have enough money for tests or vaccines
   - There is no direct transport available to reach the ART Centre
5) The members will also discuss ways and means to overcome these barriers and how the services can be made more accessible

Health	Legal	Government	Social Security
Personal	**Personal**	**Personal**	**Personal**
Structural	**Structural**	**Structural**	**Structural**

DEVELOP A DATABASE OF ALL THE FRIENDLY SERVICES AVAILABLE TO THE COMMUNITY MEMBERS

- Create a dataset of all the friendly services that are available to the community members
- Mention the nature of the services (health, legal, social services etc.)
- Note the time of the services
- Indicate if any emergency services are available or not
- Add the specific type of services available
- Note the details of the contact person at the centre
- Also indicate the different means of travel to reach the centre

We have provided a sample sheet on the next page

Sr. No	Name of the organisation	Complete address of the organisation	Type of services	Time of operation	Emergency services available	Specific services	Name of the contact person	Details of the contact person	How to reach there?
1.			Health	10:00 am to 5:00 pm	No	STI testing, HIV testing			

HOW TO MAINTAIN RELATIONS WITH FRIENDLY SERVICES

- Start by conducting simple training sessions for the service providers and adminstrators
- The sensitisation component should include: discussing the community; needs of the community; sexualities and gender. Remember, a lot of them may not know about these issues. However, if explained well many of them will be sensitive to the community
- Discuss some of the potential barriers that the community members have faced in the past and discuss the solutions to these barriers
- Include them in finding solutions to these barriers
- Inspite of all the efforts there may be some who may still be 'homophobic' and 'transphobic'. Don't lose heart over them. This is more important for new CBOs who are planning to develop relationships with service providers
- Also, one should know that some services take time. For example, in a public hospital the waiting times may be longer than usual. This is not because of the nature of the 'service provider'. One should not expect miracles in these changes
- One should also explain the community members the limitations of service providers. However, let them know that you have tried best to streamline the processes for them
- Update your database of service providers regularly – at least every six months

VIOLENCE

OBJECTIVES

- Discuss the concept of violence
- Understand different forms of violence
- Discuss 'crisis situations' and intervention required in crisis situations

DURATION OF THE SESSION: 1 ½ hours

MATERIAL REQUIRED

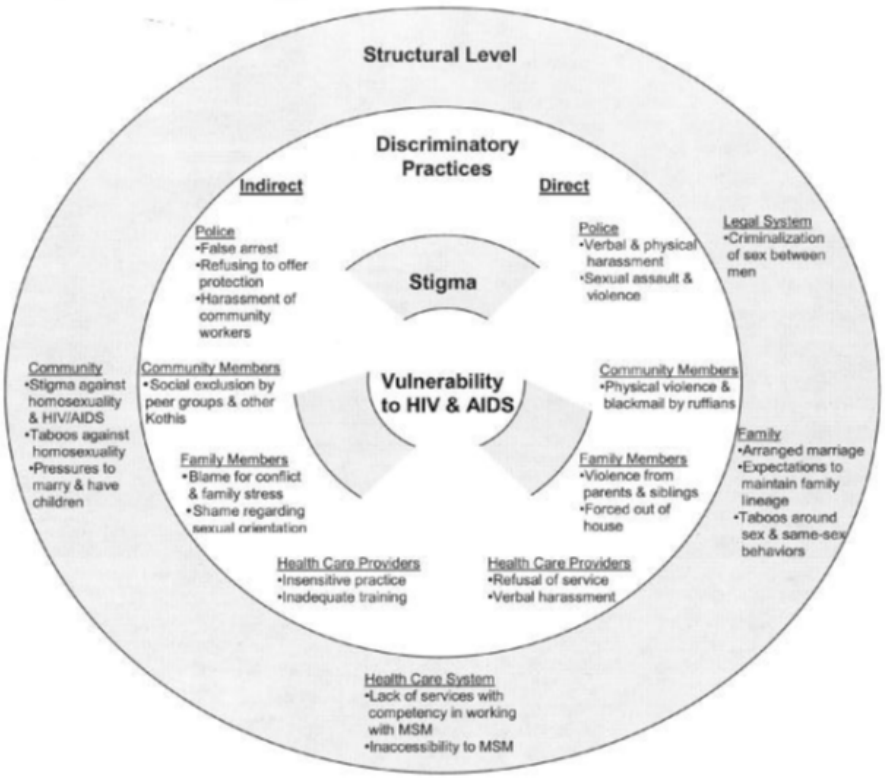
- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

VIOLENCE

- Many MTF, TG/H are vulnerable to violence in various spaces
- They may face violence at home by their family members. They may not be allowed to conform to their gender expression. They may be asked to leave their biological families and/or denied right to property
- They may also face violence in the streets and may be subjected to forced sexual encounters
- They may face violence in the service areas – such as while accessing government services, health services or by security personnel
- Thus, there is a need for health care facilities to be sensitive to sexual and gender expressions of MTF TGs:

  - The health care facility needs to develop a relationship with a CBO working for MSM and MtF ,TG/H
  - Since many individuals will approach the health care settings for care and treatment of violence, the health care provider should provide the immediate care for violence and then refer the individual for further support
  - The CBOs may be approached for community help, legal, and social help during moments of crises

STRUCTURAL VIOLENCE MODEL a



a Model proposed by Chakrapani et al (2007)

INTIMATE PARTNER VIOLENCE

It is a form of violence or "abuse" that occurs between two people who are in a close relationship/partners

TYPES OF IPV

A) EMOTIONAL VIOLENCE

- Name calling, blaming, intimidation, threats of physical violence

B) SEXUAL VIOLENCE

- Forced sex even with a steady partner

C) ECONOMIC/FINANCIAL VIOLENCE

- Withholding one's access to money and other resources, withhold basic necessities, stealing money from the TG/H

SOME INDICATORS OF INTIMATE PARTNER VIOLENCE

- Injuries are inconsistent with the explanation given by the counselees
- Many injuries in individual may be in different stages of healing – the person may have been hurt by the perpetrator multiple times
- The injuries may be bilateral (usually the arms and legs)
- There may be defensive posture injuries – for example, the injuries may be more common in areas of the body that are used for defense
- There may be multiple visits to the emergency room
- Some other complaints can be
  - Headache
  - Neck pain
  - Chest pain
  - Choking sensations

WHAT TO DO?

- Document the details (personal history, type of injuries, time of injury, time of presentation etc.)
- Discuss the details in a confidential space
- Treat the health effects of the violence (injuries or any other form of physical harm)
- Reassure the counsellee that they are not responsible for the violence
- Assess the immediate safety needs of the victim and future safety needs (for example – will the person experience same violence in the future)
- Discuss the legal ramifications of experiencing violence. If you are not well versed with different legal provisions, refer them to services that deal with legal issues of community members (including violence)
- Discuss follow-up medical and counselling visits
- If the partner is responsible for violence, then you may involve the partner in counselling
- Screen all counselees regularly for violence and the data should be used for advocacy with all stakeholders

COUNSELLING SURVIVORS OF SEXUAL ASSAULT

GENERAL PRINCIPLES

- Counsellors work as part of a team
- The survivor should not be pressurized to receive counselling
- Counsellors should sincerely practise active listening skills
- Immediate intervention can help minimize the severity of long-term psychological trauma

OBJECTIVES

- Help clients develop self-confidence and take control of their lives
- Overcome feelings of guilt or responsibility for the attack
- Help clients understand and articulate feelings of anger
- Help establish a link between the client and community services, and integrate them back into community activities
- Support the client in resolving family and community disputes (where appropriate)

CRISIS INTERVENTION

Introduction

Clients will experience problems and crisis situation. These situations arise due to social stigma associated with marginalized population and the emotional trauma caused by the infection or behavior associated with infection. The counsellor needs to address such issues. A counsellor needs skills in dealing with crisis situation and resolve problems.

Problem Solving Counselling

This is a structured and systematic approach to resolving problems that are linked to stressful circumstances. It is particularly suitable for clients whose life problems are adversely affecting or maintaining a stressful condition. It involves the patient identifying and listing problems and then considering what practical ways exist to solve or alleviate the problem. These solutions are tried and then reviewed.

Steps to structured problem solving

- ***Identify and clearly define the problem -*** A decision only exists because of a problem. The first thing that must be done is to clearly identify what the problem is; what is it doing (or not doing) for the person (e.g. poor adherence to treatment is an outcome due to lack of funds to travel for treatment); who is affected by it (client, family); and what the desired state should be
- ***Establish objectives and priorities -*** Rarely is there a time when there will be only one problem to deal with. Once you've determined what the problem is, the next step is to prioritize it in relation to the other ones currently experienced. Determining this priority involves three considerations: urgency, current overall impact and future impacts
- ***Consider possible causes-*** It is important to look for the root cause(s) of the problem. Doing so will undoubtedly help determine what the underlying problem really is
- ***Develop alternative solutions-*** Before deciding on a solution, draw up a list of feasible alternatives that will meet the client's needs. Perform this step within your time and budgetary constraints
- ***Evaluate the alternatives-*** Having determined alternatives, the client will need to evaluate the pros and cons of each alternative
- ***Choose the best alternative and implement it -*** After examining the alternatives the client should select the one which best addresses the problem defined in the first step and be sure to check that the selected alternative is the one which best meets their objectives and priorities
- ***Measure the results-*** The final step is to observe the results of the implementation. Was the decision the right one to make? Can it be improved? It cannot assume with full certainty that once the decision is implemented the outcome will fully meet the desired objective. However, the solution should be evaluated to ensure the outcome is at least consistent with the desired results -- some optimization after the fact is therefore, not out of the ordinary. This follow-up phase is therefore, a necessity

WHAT IS CRISIS COUNSELLING?

Crisis counselling focus is on single or recurrent problems that are overwhelming or traumatic. It usually is around 1 to 3 months. If a trauma or crisis is not resolved in a healthy manner, the experience can lead to more lasting psychological, social and medical problems. Crisis counselling may involve outreach, work with in a community and is not limited to office appointments.

Crisis patterns are of 2 types

- **Acute:** Intense emotional responses, agitation, impulsive behavior. Relatively short-lived
- **Chronic:** Less expressive, subdued, complains more, guilt, shame and depression. Risk of hurting themselves for a much longer period

Elements of Crisis Intervention Education

There is a natural ability within most people to recover from a crisis provided they have the support, guidance and resources they need. The very heart of crisis intervention is to face the impact of a crisis. In most cases, a crisis involves normal reactions, which are understandable, to an abnormal situation. An effective crisis counselling provides information, activities and structure that will help recover and move past the crisis. Confrontation through information and discussion may be an important part of crisis intervention.

Observation and awareness

A crisis in our life can be the result of low self-awareness or not recognizing the impact our behavior has on others as well as the impact it has on our self. Increasing your awareness can lead to choices that promote recovery and wellness. You can't help yourself if you cannot see the problem and how you may be contributing to the crisis.

Discovering and using potential

Every crisis represents an opportunity for personal growth and to discover highest potential and true self. The greatest hero in any crisis is the person who does not believe he or she is a hero, but is never-the-less prepared for the challenge by the undiscovered qualities and abilities that are only discovered when they are facing tragedy and the “inevitable” of life. While support is important, this does not mean that the person in crisis should not be allowed, encouraged and sometimes required to make decisions and take action to resolve the crisis and improve the quality of their life.

Understanding problems

It is the fundamental intention of all people to do the best they can with the resources and abilities they have during a crisis. During any crisis, it is important to recognize or discover our true and deepest intention. The client must keep their intentions in mind no matter what they do or how unskillfully they act. While the intent is usually to make life better, behavior can be misguided, misunderstood and less effective than they would hope. Self-understanding as well as understanding how others may keep them “stuck” are important keys to recovery.

Creating necessary structure

The most important aspect of crisis intervention and counselling is to provide a social “container” for

experience that will allow client to express, explore, examine and become active in ways that help insure the crisis is not prolonged. For each person, there are necessary activities and routines in life during times of distress that provide comfort and support. These do not include alcohol, medications or other drugs. Medications should only be used to prevent a physical or psychological breakdown. The purpose, duration, frequency and impacts of medications must be defined in order to make informed decisions.

Challenging irrational beliefs and unrealistic expectations

Few people, during times of crisis, have the necessary skills to fully examine what they are thinking, what they assume and what they expect from their self and from others. Thoughts, especially the ones that the individual does not look at, contribute a great deal to how they feel and what they do next in response to our feelings.

Breaking vicious cycles and addictive behavior

Many crises are the result of vicious cycles or addictions. For example, drug and alcohol use cannot only destroy our life, but it will confuse how the person actually feels about self, others and the world. One cannot know how they feel and what they truly want if their feelings are modified by chemicals, medications, alcohol and other drugs. A painful crisis can lead a person to avoid and escape how they feel. Unhealthy escape and avoidance of emotional pain and distress may involve the use of medication, drugs, alcohol, sex thrill seeking parties or working excessively. Taking the role of a "victim" can cause others to rescue a person in crisis.

Prolonging the crisis by refusal to deal with a crisis can create supportive relationships. When a person becomes dependent on others and "escapes" to feel better, a vicious cycle can develop. Vicious cycle start with behaviors that are intended to avoid or escape emotional pain, but ultimately this avoidance and escape behaviors create more problems or the same problem we are trying to avoid. The behaviors found in a vicious cycle can actually prolong a crisis.

Create temporary dependencies

During a crisis, it is often helpful to form brief relationships with others to gain support. Crisis counselling and intervention are very helpful and necessary. A healthy dependency is usually temporary and will always lead to increasing independency. Unhealthy dependencies are long term and create increasing dependency rather than independency.

Facing fear and emotional pain

A crisis is usually a time to fear or sadness. How a person responds is important. When a person faces the darkness in life, and they are not destroyed by fears, or sadness, they eventually discover there are no monsters. They discover they can survive. In time pain will fade. Facing emotional pain is the most healthy response. This does not mean the person should make themself miserable. But they should not expend a great deal of energy and become involved in activities that help avoid how feel and what they think. When people suffer, it is important to help them feel less alone in the world. It is important to help people in crisis solve the problems in their life. People in emotional pain need to be empowered and supported.

PHASES OF INTERVENTION

- **Initial Phase:**
  - Encouraging and supporting intense emotion. Allowing ventilation without rushing, empathizing through listening and reflection of feelings. Acknowledging that it is normal to feel distressed

- **Middle Phase:**
  - Client regains control. Why is the crisis happening now? What are the key issues? Economic, family, social, psychological, illness and sexuality
  - Assessment of client's condition: Is the client suicidal? Capable of harming others? What is his support system? What about his dependants?
  - Presenting and reframing the client's situation
  - Problem solving: Exploration of options and consequences

- **Final Phase:**
  - Counselor's role: Support, listener, partner, bridge between resources in the community and the client
  - Client begins experimenting with actions leading to resolutions
  - Counselor encourages new coping skills
  - Follow-up offered so that client can come back in need

Common Reactions to a Crisis

Reactions to a crisis or traumatic events vary considerably from person to person. Symptoms and reaction times are different for each individual. Common reactions to crisis can include changes in behavior, physical well-being, psychological health, thinking patterns, and social interactions. Some common signs and symptoms include:

- Disbelief
- Emotional numbing
- Nightmares and other sleep disturbances
- Anger, moodiness and irritability
- Forgetfulness
- Flashbacks
- Survivor guilt
- Hyper vigilance
- Loss of hope
- Social withdrawal
- Increased use of alcohol and drugs Isolation from others

STIGMA & DISCRIMINATION

OBJECTIVES

- Discuss concepts of stigma and discrimination
- Understand different forms of stigma
- Discuss the methods to deal with stigma

DURATION OF THE SESSION: 2 hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

STIGMA

It is to see some people wrongly as inferior or immoral because of a quality that mistakenly viewed as undesirable by society.

DISCRIMINATION

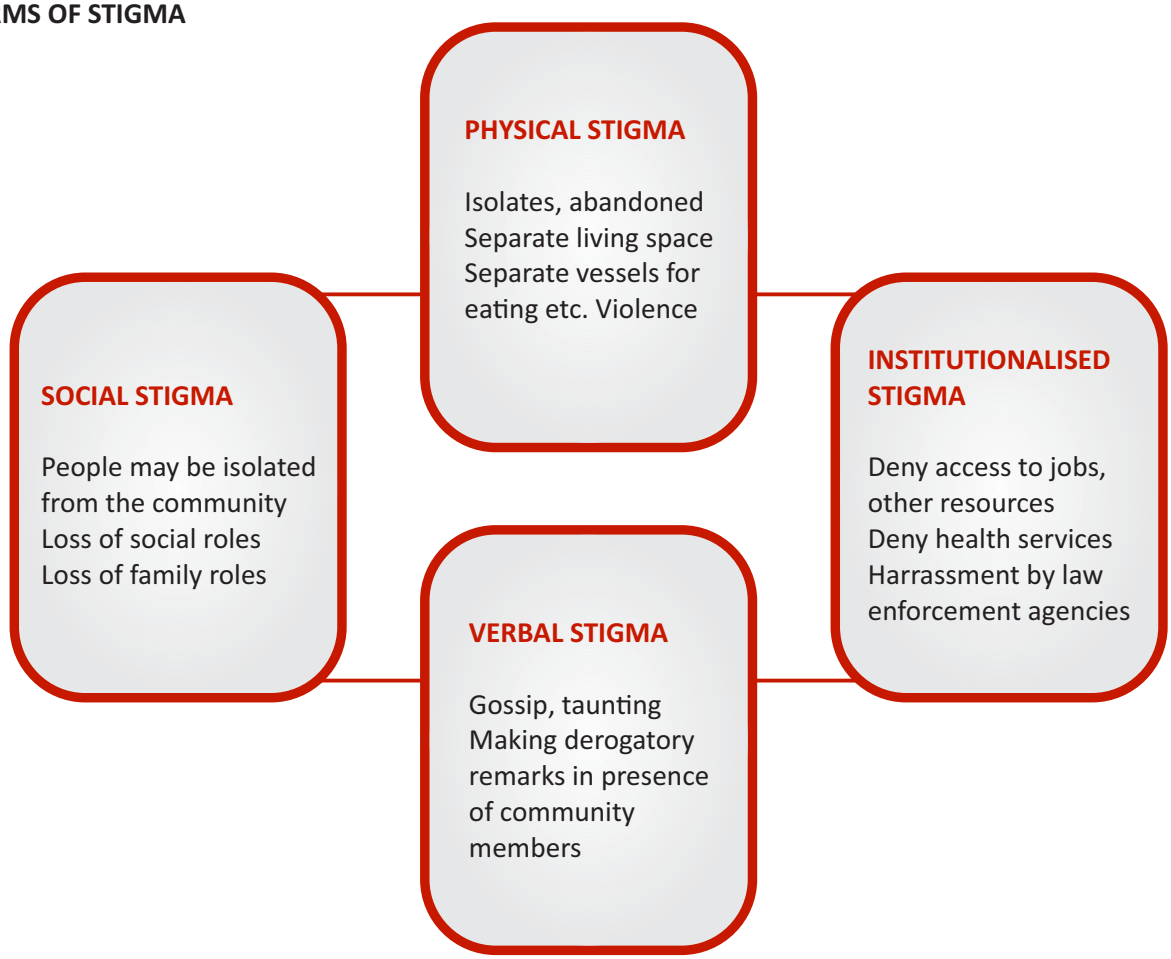
It is an unfair action against an individual because they belong to a certain stigmatised group.

PEOPLE MAY STIGMATISE AND DISCRIMINATE AGAINTS HIV INFECTED PEOPLE

This may be due to:

- Poor understanding and awareness about HIV and its transmission
- Mistaken fears about getting infected with HIV and about dying
- Mistaken moral judgments about HIV infected individuals
- Ignorant and Intolerant attitudes

FORMS OF STIGMA



SOME EFFECTS OF STIGMA

- Feel lonely
- Shame
- Stress
- Fear
- Lack of confidence
- Helplessness
- Frustation
- Despair
- Substance abuse

HOW TO DEAL WITH STIGMA

- IGNORE OR CHALLENGE THOSE WHO STIGMATISE YOU
- IT IS OKAY TO AVOID SITUATIONS OR PLACES WHERE YOU MAY EXPERIENCE STIGMA
- DISCUSS THIS WITH YOUR FRIENDS AND LOVED ONES
- JOIN SUPPORT GROUPS AND ATTEND MEETINGS
- DISCUSS THIS WITH A COUNSELLOR AND MENTAL HEALTH REFERRAL IF REQUIRED

LIVING POSITIVELY WITH HIV

- DON'T BLAME OTHERS OR YOURSELF FOR HIV
- VISIT A QUALIFIED DOCTOR EVERY THREE MONTHS
- LOOK FOR INFECTIONS AND TREAT THEM
- CARE WILL BE LIFELONG
- DO NOT ENGAGE IN RISKY BEHAVIOURS
- EAT AND DRINK HEALTHY FOOD
- JOIN A HIV POSITIVE SUPPORT GROUP

DAY 4

NUTRITION EXERCISE AND HIV

OBJECTIVES

- Understand the role of nutrition in HIV infected individuals
- Understand the role of exercise in HIV infected individuals

DURATION OF THE SESSION: 1 ½ hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

HEALTHY DIET IS IMPORTANT FOR PEOPLE LIVING WITH HIV/AIDS

Healthy and balanced nutrition should be one of the goals of counselling and care for people at all stages of HIV infection.

It will help the infected individual by:

- Maintaining body weight and strength
- Replacing lost vitamins and minerals
- Improving the function of the immune system and the body's ability to fight infection
- Extending the period from infection to the development of the AIDS disease
- Improving response to treatment; reducing time and money spent on health care
- Keeping HIV-infected people active, allowing them to take care of themselves, their family and children
- Keeping HIV-infected people productive, able to work, grow food and contribute to the income of their families

IMPORTANT POINTS FOR DIET

Nutrition:

Eat appropriate amounts of food and consume healthy foods from the different food groups, which are:

- **Proteins-** Dal, lentils, meat, fish, soya beans and nuts help build and maintain muscles
- **Carbohydrates-** Carbohydrates supply energy and can be found in grains, cereals, vegetables and nuts
- **Vitamins-** Vitamins are found in fresh fruits and vegetables, vitamins strengthen the immune system and help fight infections
- **Fats-** Fats should be consumed modestly. Put emphasis on monounsaturated fats found in nuts, seeds, vegetable oils and pulses while avoiding saturated fats, including butter and animal products such as lard and suet

Clean water:

Drink plenty of liquids. If you are not sure about the purity of your public water supply, boil your drinking water or use bottled water, if possible

Food hygiene:

1) Wash your hands carefully before food preparation
2) Keep raw and cooked food separate
3) Choose foods that are safe (avoid unpasteurized milk and wash fresh fruits and vegetables well)
4) Cook foods thoroughly
5) Eat foods soon after they are cooked

Stress and anxiety:
Minimize stress and anxiety. Having a social support network helps. Get regular exercise and adequate sleep

Avoid smoking:
Smoking damages the lungs and other organs and increases susceptibility to infection

Medical care:
Have regular medical follow-ups

Medicines:
Avoid unnecessary medicines and if you are on other medications not related to HIV, discuss them with your physician

What can I do if I'm having trouble eating?

- **If you don't have an appetite**—Try to eat your favorite foods. Instead of eating three big meals each day, eat six to eight small meals. Drink high-calorie protein shakes with your meals or between meals
- **If you have diarrhea**—Don't eat fried foods and other high-fat foods like potato chips. Don't eat high-fiber foods. Instead, eat bland foods like bread or rice
- **If you have mouth sores**—Avoid citrus fruits like oranges. Avoid very hot or cold foods. Don't eat spicy foods. Try not to eat hard foods
- **If you have nausea and vomiting**—Avoid drinking any liquid with your meals. Eat six to eight small meals each day instead of three large meals. Eat foods with a mild flavor. Eat foods at a medium temperature, not hot or cold. Sit and relax for 30 minutes after you eat

EXERCISES

- An aerobic exercise like walking will help make you stronger. It's good to begin exercising slowly. Little by little, increase the amount of exercise. For example, you might start walking for 20 minutes three times a week. Then, after you get a little stronger, you can increase the walking time to 30 minutes four times a week. Talk with your doctor before you start
- Weight lifting is also a good way to increase your strength. Start by trying to do a weight lifting exercise 10 times. This is called a "repetition." More than one repetition is called a "set." Try to do two sets of 10 repetitions. Rest for 90 seconds between each set
- You don't need to have fancy exercise equipment to do weight lifting. You can use books and other objects you have in the house. Start by lifting a weight that's comfortable for you and doesn't cause too much strain
- In the first week, do one or two different weight lifting exercises for each body part once or twice in the week. Start with a small weight in each hand. Each week increase the number of exercises you do and the number of times you exercise. Rest for 1 to 2 days between exercise sessions. When you're feeling sick, either exercise less or stop for a while
- You may try Yoga postures and meditation for healthy living

GENERAL RECOMMENDATIONS FOR TAKING CARE OF YOURSELF

- The body needs extra rest. Try to sleep for eight hours every night. Rest whenever you are tired
- Try not to worry too much. Stress can harm the immune system. Relax more. Relax with people you love, your family, your children and your friends. Do things you enjoy, e.g. listen to music or read a newspaper or a book
- Be kind to yourself. Try to keep a positive attitude. Feeling good is part of being healthy
- Take light exercise. Choose a form of exercise that you enjoy
- Find support and get good advice. Ask for advice from health workers. Many medical problems can be treated
- Ask for help and accept help when it is offered
- Stop smoking. It damages the lungs and many other parts of the body and makes it easier for infections to attack your body
- Alcohol is harmful to the body, especially the liver. It increases vulnerability to infection and destroys vitamins in the body; under the influence of alcohol you may forget to practise safe sex
- Avoid unnecessary medicines. They often have unwanted side-effects and can interfere with food and nutrition. If you do take medicines, read the instructions carefully

CREATING REFERRALS AND NETWORKS

OBJECTIVES

- Discuss details of creating referrals and networks
- Discuss the types of referrals
- Discuss the process of referral

DURATION OF THE SESSION: 1 ½ hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

WHAT IS A REFERRAL?

Referral is the process by which client needs are assessed and prioritized to provide assistance (e.g., need for HIV testing, TB treatment, financial assistance for travel or treatment) in accessing services. Referral should also include follow-up efforts necessary to facilitate initial contact with other service providers.

Referral does include ongoing support or management of the referral or case management. Case management is generally characterized by an ongoing relationship with a client that includes comprehensive assessment of medical and psychosocial support needs, development of a formal plan to address needs, substantial assistance in accessing referral services, and monitoring of service delivery.

Important instructions to the ANM/Counsellor

1. Any referral to a facility outside of a TI has to be with a referral slip
2. One copy of the referral slip will be retained by the facility referred to
3. Counsellor/ANM should go to the referred unit on designated day and gathers these referral slip
4. The referral slips are consolidated and reported under respective indicator

TYPICAL REFERRAL NEEDS

Clients should be referred to services that are responsive to their priority needs:

HIV testing:

All HRGs should be encouraged, motivated and referred to the ICTC for HIV testing. The community should undergo periodic HIV testing. The counsellor should be well aware of the procedures and operations at the ICTC. The client should be referred with a referral slip to the ICTC of their choice. The client should be requested to provide feedback on the visit. The counsellor should follow-up at the ICTC to check on the number of referrals who reach for HIV counselling and testing.

STI screening and Management:

HRG would require STI screening and management. Partner notification and testing should be encouraged. In case the HRGs have not followed for the monthly check-up, the ANM should ensure that Presumptive Treatment for STI is provided.

Medical evaluation, care, and treatment:

HIV-infected clients should receive or be referred to the ART center. Baseline assessments and treatment for opportunistic infections and related HIV-conditions are important for HIV-infected persons. In addition, coinfection with HIV (e.g., TB, STIs and hepatitis) can, if untreated, pose a risk.

Partner counseling and referral services:

Clients who are on treatment for STI should ensure their partners also access treatment. Similarly all PLHIVs should ensure their spouse and partners are tested for HIV. If found positive referral to ART should be ensured.

Reproductive health services:

Female partners who are pregnant or of childbearing age should receive or be referred to reproductive health services or PPTCT as the case may be.

Drug or alcohol prevention and treatment:

Clients who abuse drugs or alcohol should receive or be referred to substance or alcohol abuse prevention and treatment services.

Mental health services:

Clients who show symptoms of mental illness, acute depression, are suicidal should be referred to psychiatric services.

Legal services:

Some clients may express legal concerns- being evicted form house, losing a job, property issues etc. Such clients would require legal referrals. Legal services could also be required during crisis situation.

Other services:

Clients might have multiple needs that can be addressed through other HIV prevention and support services (e.g., assistance with housing, food, employment, transportation, child care, domestic violence, and legal services).

HOW TO REFER?

Assessing Client Referral Needs:

Assessment should include examination of the client's willingness and ability to accept and complete referral. All clients should be assessed for referral needs related to medical care, prevention and support services. A client may have multiple needs, prioritize these needs with the client is important. For some clients social needs may overpower medical needs. E.g. the client needs financial assistance for food, nutrition and transport to ART center. Unless the basic needs of clients are met, the client may not adhere to treatment. Hence prioritizing as per client needs is important.

Plan the Referral:

Referral services should be responsive to clients' needs and priorities and appropriate to their culture, language, sex, sexual orientation, age, and developmental level. In consultation with clients, providers should assess and address any factors that make completing the referral difficult (e.g., lack of transportation or child care, work schedule, cost). Research has indicated that referrals are more likely to be completed if services are easily accessible to clients.

Help Clients Access Referral Services:

Clients should receive information necessary to successfully access the referral service (e.g., contact name, eligibility requirements, location, hours of operation, telephone number). Clients must give consent before identifying information to help complete the referral can be shared. Counsellors can help clients identify needs and plan successful referrals. Referrals are more likely to be completed after multiple contacts with outreach workers.

Document Referral and Follow-Up:

ANM/Counsellor should assess and document whether the client accessed the referral services. If the client did not, the provider should determine why; if the client did, the provider should do documentation of referrals made, the status of those referrals, and client satisfaction with referrals should help providers better meet the needs of clients. Information obtained through follow-up of referrals can identify barriers to completing the referral, responsiveness of referral services in addressing client needs and gaps in the referral system.

ENSURE HIGH-QUALITY REFERRAL SERVICES

Providers of referral services should know and understand the service needs of their clients, be aware of available community resources, and be able to provide services in a manner appropriate to the clients' culture, language, sex, sexual orientation, age and developmental level, given local service system limitations.

CONTENTS OF A REFERRAL RESOURCE GUIDE

- For each resource, the referral resource guide should specify the following:
- Name of the provider or agency
- Range of services provided
- Target population
- Contact names and telephone and fax numbers, street addresses, e-mail addresses and hours of operation
- Directions, transportation information and accessibility to public transportation
- Competence in providing services appropriate to the client's culture, language, sex, sexual orientation, age and developmental level
- Eligibility, admission policies and procedures (e.g. care center)
- Papers the client needs to carry (e.g. ART center, ICTC test report, ration card address proof, filled request form)
- Client satisfaction

RECORD MAINTENANCE & REPORTING

OBJECTIVES

- Discuss details about monitoring
- Discuss various types of indicators (impact indicators, outcome indicators, programme outputs)

DURATION OF THE SESSION: 1 ½ hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

MONITORING FRAMEWORK UNDER NACP–IV

IMPACT INDICATORS

1. Reduction of new HIV infections (HIV Incidence):
Estimated number of Annual New HIV Infections (HIV Incidence)

2. Reduction in mortality among people living with HIV/AIDS (PLHIV):
Estimated number of annual AIDS-related deaths

3. Survival of AIDS patients on ART: Percentage of adults and children with HIV known to be on treatment at 24 months after initiation of ART at select ART centres

OUTCOME INDICATORS

Behavioural Change among MSM
Percentage of MSM
who report using a condom during sex with their last male partner (Target: 45% to 65% increase by 2017; 20% increase over the baseline of IBBS 2012-13)

PROGRAMME TARGETS

By 2017, NACP- IV will cover 9 lakh FSWs,
4.40 lakh MSMs including TG/H and 1.62 lakh IDUs through TIs

IMPORTANCE OF INFORMATION COLLECTION:

- **Achievement** – What has been achieved? How do we know that the project or event or an activity has caused the result?
- **Assessing progress** – Are the objectives being met?
- **Identifying strengths and weaknesses** – Where does the project need improvement and how can it be done or rectified? Are the original objectives still appropriate?
- **Checking effectiveness** – What difference has the project made? Can the impact be improved?
- **Sharing experiences** – Can the information help to prevent loopholes, mistakes or to encourage positive approaches

FLOW CHART OF THE MANAGEMENT INFORMATION SYSTEM FOR TIS

The Managing and information system (MIS) must be consistent and integrated at all levels. The MIS system at the NGO/CBO level needs to be linked to the SACS and to the National MIS system. Linkages and consistency at all levels are critical to ensure the efficiency of data management and the usefulness of information for decision making and programme planning, including assessing the progress of TIs. The flow chart below depicts the data flow from NGOs/CBOs to SACS and to NACO:

NGO/CBO
- MIS forms/reporting formats are filled
- MIS forms edited for completeness and quality
- Information from MIS forms used for planning and monitoring by the ORW and Project Manager

↓

State AIDS Control Societies
- Data syncronization
- Consolidation of MIS reports from each District (monthly, quarterly, annual)
- Analyse the data for tracking program performance
- Data shared with NACO

↓

National AIDS Control Organisation
- Consolidation of MIS reports from each state (monthly, quarterly, annual)
- Analyse the data for tracking programme performance
- Feedback provided to each state

DATA COLLECTION AT THE TI LEVEL

Which form?	What are the contents?	Who does it?	How frequent?	Who is responsible?
Patient register format (Form F) including Abscess management format (FORM F_1)	On every day the doctor fills in for each HRG patient visiting the clinic. It contains basic details of the HRG patient illness and other clinic history. For each patient one form during every visit to the clinic	Doctor	Daily (on clinic days)	Program Manager
Clinic Daily summary sheet (FORM FF)	During end of each clinic day. This register is a summary of the patient who has visited the clinic on a each day. The information from the filled in patient register format is transferred. It gives information at a glance on number of patients visited each clinic day and type of diagnosis and treatment provided	ANM/ counselor	Daily (on clinic days)	Doctor
Medicine Stock register. (FORM G)	During end of each clinic day. The register is maintained at the clinic for tracking of medicines – received, issued and balance	ANM/ counselor	Weekly	Program Manager

Referral slip and Registers. (FORM H)	As and when a patient is referred to a referral center (ICTC, ART, TB /DOT), this register is filled in with the details. The slips are in triplicate. The referred details from the slip are noted in the referral register which will be useful for tracking of referrals made in a given period	ANM/ counselor	Weekly	Program Manager
Counselling Register. (FORM I)	After every counselling session conducted. The register gives information on type of counselling done, duration of counselling, pre-post counseling etc. Each row contains information on one counselling session	ANM/ counselor	Weekly	Program Manager

FLOW OF DATA AND CHECKS AT THE TI LEVEL

- **Step 1:** All the HRGs will first meet Nurse (in absence of nurse, will meet counsellor)

- **Step 2:**
  - **For new case and for repeat case**
    - ***For new case (first time visit to project clinic)***

      If the HRG is coming first time to the clinic, the ANM/Counsellor will create a new file with the patient register form filled in. The ANM/Counsellor checks for ID number – whether already by the ORW. Ensures that the HRG is having project health card. The ANM/Counsellor fills in patient register form. After filling the patient register form, the nurse also fills in the medical register (maintained on daily basis for each HRG visiting the clinic which is like a day book) on the purpose of the visit and symptoms reported by the HRG. The ANM/Counsellor conducts pre counseling session and fills in the counselling register. After counseling, the HRG is sent to the doctor for further process

  - **For Repeat Cases**
    - When a HRG visits the clinic (who is not first time visitor to the clinic), the nurse tracks the patient register form kept at the NGO/CBO through Health Card brought by the HRG. The ANM/Counsellor notes down the purpose of the visit and symptoms as reported by the HRG in the medical register. The ANM conducts pre counseling session and fills in the counselling register. After counselling, the HRG is sent to the doctor for further process

- **Step 3:** The doctor after examining the patient and treatment given/recommended, fills in the patient register form (the requisite information to be filled in by the doctor) and send the HRG and the file back to the ANM for further process

- **Step 4:** ANM enters the information in the medical register on the diagnosis made and medicines prescribed by the doctor. She also gives medicines to the HRG as per prescription

- **Step 5:** ANM at the end of each clinic day, compares the number of visits made to the clinic from medical register with the drug register and referral registers and ensures all the entries made are correct and complete. This is also checked by the doctor by signing at the end of the each clinic day entries made are complete and correct by signing/initialing

- **Step 6:** ANM also tallies the drug stock register on the issues made during the day and balance at the end of each clinic day. (Each medicine should have a buffer stock of medicine, which will vary from medicine to medicine and from TI to TI)

- **Step 7:** The ANM prior to any weekly/monthly meetings will compile information on the
  - Number of individuals visited clinics
  - Type of visit made for general ailment, for STI treatment
  - Number of referral made etc.
  - Number of HRGs followed up for ICTC and STI

- **Step 8:** The ANM after sharing the clinic information in the weekly meeting hands over the clinic reporting form to MIS officer for entering into the CMIS on weekly basis

MYTHS, MISCONCEPTIONS & FAQs

OBJECTIVES

- Discuss common myths and misconceptions
- Summarise some concepts about identity in India
- Address some of the frequently asked questions

DURATION OF THE SESSION: 1 ½ hours

MATERIAL REQUIRED

- Chart paper/Whiteboard
- Marker pens
- Power Point presentation
- Exercise sheets

EXERCISE 7

Duration: 15 minutes

Objectives

- Summarise some concepts about identity in India

Requirements

- Sheets with questions
- Responses to the questions

Instructions

- The participants will work in three groups
- Each group has to prepare a response to the question
- Each group will have one leader
- The leader will describe the response with the rest of the participants
- The facilitator will help in addressing the questions
- The questions and the responses are in the next few pages
- The facilitator should remember that the responses are just a guide. The participants can also use their own examples for some of these questions

Question 1

ARE THE SEXUAL & GENDER IDENTITIES STATIC?

Question 2

ARE ALL HIJRAS INTERSEXED INDIVIDUALS?

Question 3

ARE ALL HIJRAS CASTRATED?

Question 1

ARE THE SEXUAL & GENDER IDENTITIES STATIC?

Question 2

ARE ALL HIJRAS INTERSEXED INDIVIDUALS?

Question 3

ARE ALL HIJRAS CASTRATED?

Response 1:

Answer: NO

EXPLANATION:

- These identities are not static
- Some of the identities may be fluid and people may assume different identities over different points in time
- Sometimes they may also have different identities during the same period depending on the context
  - For instance, someone may identify himself as a kothi and may not socialise with Hijras
  - However, later the same person may start identifying as Hijra. This identity may be that of an *Akwa Hijras*
  - Someone may remain an *Akwa Hijras* for a long period of time
  - Some others may go ahead with process of sex reassignment or Nirwaan and be identified as *Nirwaan Hijras*
  - It is quite likely that some of these may call themselves as trans-woman
  - It is also likely when they are in the process of sex reassignment, they may also identify as 'Transitioning'
  - In another instance, an individual may identify as a *Kothis*
  - However, the same person may identify as gay or queer in other situations
  - The same person will use the identity 'top' or 'bottom' if he is with other gay men
- Thus, it is not that all identities are separate water-tight and static compartments
- They may change over time
- People may have multiple identities at the same time as well

- As healthcare providers, we should just use the identity that has been told to us by the individual
- Also do not presume the sexual behaviour according to the identity. Ask about different types of sexual behaviours to all individuals who access health care
- Be sensitive while asking different sexual behaviours – if you find that some people are getting offended while answering questions about sexual acts, do not persist. Let them take their time to open up about their behaviours with you.

Response 2:

Answer: NO

EXPLANATION:

- As discussed earlier Hijras/Kinnars are a social and culturally different group of male-to-female transgendered people
- Thus, they are biological males who start identifying as 'women', not-men and form their own social groups
- They cross-dress; move in female attire with a portrayal of a female gender. They may call themselves Hijras
- Many of them do not live with their biological families and stay with the 'hijra gharanas'. These are usually headed by a Guru. They become Chelas or Shishyas of this Guru
- Thus, they often live in parallel social structure
- They may or may not have removed their male external genitalia
- Some reports have stated that there are about 10 lakh members of the Hijra community in India
- Intersexed individuals are born with external genitalia or reproductive organs/sexual anatomy and/or chromosomes that do not correspond with any specific definition of a male or female
- There may be ambiguous genitals, both types of differences in the internal and external organs
- These features may be apparent at birth or later in life
- Intersexed people may not identify with the Hijra culture
- There have been conflicting reports of prevalence of intersex – 0.018% to 1.7%

Response 3:

Answer: NO

EXPLANATION:

- As discussed earlier Hijras/Kinnars are a social and culturally different group of male-to-female transgendered people
- Thus, they are biological males who start identifying as 'women', not-men and form their own social groups
- They cross-dress; move in female attire with a portrayal of a female gender. They may call themselves Hijras
- Some Hijras may not have removed their external male organs (penis and scrotum). They are called *Akwa Hijras*
- Some of them may have undergone breast augmentation procedures and yet have male external organs. They may be transitioning as well
- Some Hijras may remove their male external organs by the ritual procedure or through a surgical procedure. They are *Nirwaan Hijras*

FREQUENTLY ASKED QUESTIONS

1) Why are some people transgender?

Answer: There is no simple or unitary explanation for why some people are TG. Researchers and Experts have suggested biological factors (genetic influences), prenatal hormones, fluctuations or imbalances in hormones as some potential factors. Others have suggested there is a link between TG identity and brain structure. Still others have suggested the role of psychological factors in the existence of TG people. Many trans people may feel that their gender identity has always been a part of them.
Finally, some individuals feel that everyone has a right to choose their gender presentation.

2) Have transgender people always existed?

Answer: TG people have been documented in Eastern and Western cultures, and many indigenous cultures. The meaning of gender non-conformity may vary from culture to culture.

3) Is being transgender a mental disorder?

Answer: NO. TG identity is not a mental illness that can be cured with treatment
Many TG people may not experience any distress – thus just identifying TG people does not constitute a mental disorder.
However, as discussed earlier many TG people may face discrimination at home, school or in the communities. They may sometimes be lonely. This may, sometimes, cause anxiety, depression, or other psychological problems. Thus, it is important to understand that these may be due to society's intolerance rather their own gender identity.

4) How many transgender people are there?

Answer: It may be difficult to get exact estimates of TG people in the community.
Some size estimation studies have been conducted in India. They reported that the size estimate of the TG population was 62,137 across various states of India.
However, it should be noted that no population studies that accurately describe gender identity and gender expression.

5) How should I address them? Which pronoun should I use?

Answer: Use the name and pronoun that the TG person uses. Do not insist on getting the male name/correct name. Also, do not change pronouns during the conversation to masculine gender.
If you are in doubt, ask politely.

6) How can I be supportive of transgender people?

Answer: Educate yourself about TG issues.

Be aware of your attitudes and biases. Try to address them.

Do not make assumptions about sexual orientation of TG.

Familiarise yourself with some support systems available for TG in your area.

QUERIES & FEEDBACK


Open the session for additional queries
Let the participants clarify their doubts
Discuss the roles and responsibilities once again
Feedback on the training program

BIBLIOGRAPHY

http://www.counseling.org/resources/competencies/algbtic_competencies.pdf
http://www.hivpolicy.org/Library/HPP001333.pdf
http://www.positiveprevention.ucsf.edu/CDROM/HTML/PDF/CUUGA01E.PDF
http://www.ahrf.org.uk/articles/postive_prevention.pdf
www.bibalex.org/supercourse/supercoursePPT/21011-22001/21301.ppt
http://strcjhk.org/training_model/training-mod-img/part.pdf
http://naco.gov.in/sites/default/files/STI%20counsellors%20trainers%20manual1.pdf
http://ncasc.gov.np/ncasc/Other%20publications/TI/Volume_4_MSM.pdf
http://ncasc.gov.np/ncasc/Other%20publications/TI/Volume_1_Introductio.pdf
http://tsipard.gov.in/strc/strc/NACO%20Trg%20Modules/ANM%20Training%20Counsellors%20module%20&%20PPTs/PPT/session-1.ppt.
http://pdf.usaid.gov/pdf_docs/Pnadu585.pdf
https://www.avert.org/living-with-hiv/health-wellbeing/taking-care-of-yourself
http://www.uncares.org/content/living-positively-hiv-and-aids
http://www.cdc.gov/hiv/basics/livingwithhiv/
https://webcache.googleusercontent.com/search?q=cache:Gi3WxX9MWeYJ:https://www.k4health.org/sites/default/files/Positive%2520Living%2520Module%2520final....doc+&cd=10&hl=en&ct=clnk&gl=in
http://naco.gov.in/sites/default/files/ICTC%20Refresher%20II%20Trainee%20Handout.pdf
http://www.naco.gov.in/sites/default/files/STI%20Counsellor%20Refresher%20Training%20Trainee%20Handout.pdf
http://www.naco.gov.in/upload/Final%20Publications/Operational%20Guidelines%20for%20Integrated%20Counseling%20and%20Testing%20Centres.pdf
http://indiahivinfo.naco.gov.in/sites/default/files/media-gallery/HIV%20Counselling%20Training%20Module.pdf

Presentation

COUNSELLING MODULE

for Transgender/Hijra Interventions

01 Counselling Module for Transgender/Hijra Interventions

Notes

THIS IS A FOUR DAY TRAINING MODULE.

It has the following components:

- Introduction to NACP IV
- Role of the counsellor & Ethics of counselling
- Identity, Sex, Sexuality, and Gender
- Issues of male-to-female transgender people/Hijras
- Sex Reassignment Surgery
- Sexually transmitted infections
- Condoms and Lubricants
- Basic Counselling Package
- Role of the family
- Disclosure

02 Counselling Module for Transgender/Hijra Interventions

Notes

THIS IS A FOUR DAY TRAINING MODULE.

It has the following components:

- Friendly services
- Violence
- Stigma & Discrimination
- Nutrition, Exercise, and HIV
- Creating referrals and Networks
- Record maintenance and Reporting
- Myths, misconceptions, and FAQs
- Queries and Feedback

Notes

DAY ONE

Notes

INTRODUCTION GAME

Objectives

- This is an ice-breaking session
- The participants will play the game and get introduced to the entire group

Duration: 30 minutes

Notes

INSTRUCTIONS

- Each participant will write five sentences/qualities about herself/himself
- Each participant has to write three sentences/qualities that are true about them
- Each participant also has to write two sentences/qualities that are false about themselves
- These sentences/qualities can be about their physical characteristics or likes/dislikes
  - E.g. the participant can say – I have wavy hair, I like apples, I do not like grapes
- Each participant will have to introduce themselves and read all the five sentences/qualities loudly
- The other participants will have to guess/determine the statements/qualities that are true and those that are false
- Sometimes the other participants may not be able to guess if the statement is true or false. In such a scenario, they will just say 'Don't Know'

Notes

INTRODUCTION TO NACP IV

Notes

OBJECTIVES

- Understand the objectives of National AIDS Control Programme NACP-IV
- Understand the roles and responsibilities of counsellors in Targeted Interventions (TIs)

DURATION OF THE SESSION: 1 ½ HOURS

Notes

NACP - IV

PERIOD: 2012 TO 2017

KEY OBJECTIVES

- Reduce new infections by 50% (2007 Baseline of NACP III)
- Provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it

09 Counselling Module for Transgender/Hijra Interventions

Notes

KEY STRATEGIES

- **Strategy 1**: Intensifying and consolidating prevention services, with a focus on HRGs and vulnerable population.
- **Strategy 2**: Increasing access and promoting comprehensive care, support and treatment
- **Strategy 3**: Expanding IEC services for (a) General population and (b) high risk groups (HRGs) with a focus on behaviour change and demand generation
- **Strategy 4**: Building capacities at national, state, district and facility levels
- **Strategy 5**: Strengthening Strategic Information Management Systems (SMS)

10 Counselling Module for Transgender/Hijra Interventions

Notes

GUIDING PRINCIPLES FOR NACP IV

- Continued emphasis on three ones - one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System.
- Equity
- Gender
- Respect for the rights of the PLHIV
- Civil society representation and participation
- Improved public private partnerships
- Evidence based and result oriented programme implementation.

Notes

CROSS CUTTING AREAS OF FOCUS OF NACP IV

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 1: INTENSIFYING AND CONSOLIDATING PREVENTION SERVICES

- Saturating quality HIV prevention services to all HRG, based on emerging behaviour patterns and evidence
- Strengthening needle exchange Programme, drug substitution programme and providing Opioid Substitution Therapy (OST)
- Reaching out to MSM and Transgender communities
- Addressing the issues related to coverage and management of rural interventions

13 Counselling Module for Transgender/Hijra Interventions

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 1: INTENSIFYING AND CONSOLIDATING PREVENTION SERVICES (contd.)

- Providing quality STI/RTI services
- Expand the ICTC services and strengthen referral linkages
- Strengthening positive prevention
- Strengthening management structure of blood transfusion services
- Implementing National EQAS for all participating labs at district and above for HIV related diagnostic services.anagement of rural interventions

14 Counselling Module for Transgender/Hijra Interventions

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 2: COMPREHENSIVE CARE, AND SUPPORT AND TREATMENT (CST)

- Scale up ART Centres, LACs, and COEs ART services
- Strengthening follow up of patients on ART and improving quality of counselling services at ART service delivery points
- Comprehensive care and support services for PLHIV through linkages
- Provide guidelines and training for integration in health care settings to NRHM staff

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 3: EXPANDING IEC SERVICES FOR GENERAL POPULATION AND HIGH RISK GROUPS WITH A FOCUS ON BEHAVIOUR CHANGE AND DEMAND GENERATION

- Increasing awareness among general population in particular women and youth
- Behaviour change communication strategies for HRG and vulnerable groups
- Continued focus on demand generation of services
- Reach out to vulnerable populations in rural settings
- Extending services to tribal groups and hard-to-reach population

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 4: STRENGTHENING INSTITUTIONAL CAPACITIES

- The program management structures established under NACP will be strengthened further to achieve the NACP-IV objectives
- Program planning and management responsibilities will be enhanced at national, state, district and facility levels to ensure high quality, timely and effective implementation and supervision of field level activities to achieve desired programmatic outcomes
- The planning processes and systems will be further strengthened to ensure that the annual action plans are based on evidence, local priorities and in alignment with NACP IV objectives

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 4: STRENGTHENING INSTITUTIONAL CAPACITIES (contd.)

- Sustaining the epidemic response through increased collaboration and convergence, where feasible, with other departments will be given a high priority during NACP- IV
- This will involve phased integration of the HIV services with the routine public sector health delivery systems, streamlining the supply chain mechanisms and quality control mechanisms and building capacities of governmental and non-governmental institutions and networks

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 5: STRATEGIC INFORMATION MANAGEMENT SYSTEM (SIMS)

Under NACP-IV, it is envisaged to have an overarching knowledge management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use.

The strategy will ensure

- High quality of data generation systems such as Surveillance, Programme Monitoring and Research
- Strengthening systematic analysis, synthesis, development and dissemination of knowledge products in various forms
- Emphasis on Knowledge Translation as an important element of policy making and programme management at all levels
- Establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the program

Notes

KEY STRATEGIES UNDER NACP IV

STRATEGY 5: STRATEGIC INFORMATION MANAGEMENT SYSTEM (SIMS)

Under NACP-IV, it is envisaged to have an overarching knowledge management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use.

The strategy will ensure

- High quality of data generation systems such as Surveillance, Programme Monitoring and Research
- Strengthening systematic analysis, synthesis, development and dissemination of knowledge products in various forms
- Emphasis on Knowledge Translation as an important element of policy making and programme management at all levels
- Establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the program

Notes

KEY STRATEGIES UNDER NACP IV

Some of the key initiatives under Strategic Information Management during NACP-IV include

- National Integrated Biological & Behavioural Surveillance (IBBS) among HRG & Bridge Groups
- National Data Analysis Plan
- National Research Plan
- Transforming SIMS into an integrated decision support system with advanced analytic and Geographic Information System(GIS) capabilities
- Institutionalising Data Quality Monitoring System for routine programme data collection
- Institutionalising data use for decision making

21 Counselling Module for Transgender/Hijra Interventions

Notes

NACP IV

- The key objectives of NACP IV are:
  - Reduce new infections by 50% (2007 Baseline of NACP III)
  - Provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it
- The cross-cutting areas of focus in the NACP IV are:
  - Quality
  - Innovation
  - Integration
  - Leveraging partnerships
  - Stigma and Discrimination

22 Counselling Module for Transgender/Hijra Interventions

Notes

ROLE OF THE COUNSELLOR & ETHICS OF COUNSELLING

Notes

OBJECTIVES

- Understand the pillars and ethics of counselling
- Discuss the skills and techniques required for effective counselling

Duration of the session: 3 hours

Notes

INTRODUCTION

- An important component of counselling is the relationship between the counsellor and client
- If the relationship is healthy – such the counselee can discuss all issues with the counsellor in an open and transparent manner – the counselling session has the best chance of being productive
- Often allowing someone to talk about their feelings to others can be healing. Thus, counselling provides an opportunity for individuals to feel 'heard' and accepted
- Often times, the counsellor may not be able to address all concerns in one session. Thus, often counselling is a multi-session process

Notes

RESPONSIBILITIES OF COUNSELLORS

STI and HIV related services

- Increasing the uptake of services by clients
- Increasing the follow-up of clients
- Establishing referrals and networking for expanded STI/HIV care and support
- Provide information about STI, HIV/ AIDS, Opportunistic infections, healthy lifestyles and explore any myths and misconception and clarify the same
- Assist clients to correctly assess their risk for STI and HIV and motivate and help them to make plans for reducing their risk and help/enable/empower the client through the process of adaptation of healthy behaviours & coping with the same
- Act as an interface between the client and the provider, organize the treatment schedule, follow up, compliance to treatment, condom usage and partner management, syphilis screening and other lab tests for STI/RTI

Notes

RESPONSIBILITIES OF COUNSELLORS

STI and HIV related services (contd.)

- Ensure that every HRG individual receives essential STI/RTI service package including early diagnosis and treatment of current STI episode, quarterly regular check up, presumptive treatment of sex workers and biannual syphilis screening by closely working with respective TI NGO
- Explain and encourage HIV testing, establish referral services to other centres and network for expanded STI and HIV Care & Support - General Laboratory, ICTC, PPTCT, ART, CCC, and TB-HIV etc
- Ensure documentation of history taking, counselling and risk reduction plans and filling up and maintaining patient wise cards and clinic register
- Enhance condom negotiation skills with clients/regular partners

Notes

RESPONSIBILITIES OF COUNSELLORS

Sexuality and gender related services

- Discuss issues related to sexuality and gender identity
- Discuss issues about stigma and discrimination – at home, school, society, workplace
- Discuss about issues related to 'coming out' – to family members, friends, workplace etc.
- Discuss about the forms and expression of violence - at home, education institutes, social spaces, work place etc.
- Discuss strategies to address trauma and violence
- Refer the individuals to gender friendly services
- Discuss about gender reassignment surgeries with individuals who have expressed a desire to undergo these procedures

Notes

RESPONSIBILITIES OF COUNSELLORS

Positive Prevention Counselling

- Positive Prevention improves HIV prevention, care, and treatment efforts through meaningful involvement of PLHIV
- Discuss issues about disclosure of HIV positive status – HIV positive individuals have a right to decide why, when, how, and whom to disclose their status
- Provide intervention on ARV treatment, including the nature and names of medicine, planning strategies to overcome difficulties in taking medicine regularly
- Reinforce HIV prevention messages, safer sex messages, reproductive options, early detection and treatment of opportunistic infections and STIs

Notes

PILLARS OF COUNSELLING

EMPATHY	• Understand the emotions/feelings that the counsellee is experiencing • *It is not sympathy - do not feel sorry for the counsellee*
NON-JUDGEMENTAL	• The counsellor should not judge the counsellee based on personal values, standards, and opinions • The counsellor should not discriminate

Notes

PILLARS OF COUNSELLING

NON-DIRECTIVE

- The counsellor should not provide instructions or readymade solutions
- The counsellors hould create a safe space, reflect, connect, and work with the counsellee

CONFIDENTIALITY

- The counsellor should not judge the counsellee based on personal values, standards, and opinions
- The counsellor should not discriminate

31 Counselling Module for Transgender/Hijra Interventions

Notes

ALWAYS START THE SESSION WITH AN INFORMED CONSENT; BRIEFLY DESCRIBE THE PROCEDURE TO THE COUNSELEES

THE COUNSELLOR SHOULD RESPECT THE PHYSICAL AND SOCIAL BOUNDARIES IN A COUNSELLING SESSION - MAINTAIN APPROPRIATE DISTANCE, DO NOT TOUCH THE COUNSELEE, TRY NOT TO SOCIALISE WITH THE COUNSELEES

THE COUNSELLOR SHOULD MAINTAIN RECORDS OF ALL COUNSELLING SESSIONS (WITH PRIOR PERMISSION) AND KEEP THEM SAFE AND CONFIDENTIAL

32 Counselling Module for Transgender/Hijra Interventions

Notes

THE COUNSELLOR SHOULD NOT HAVE SEXUAL-ROMANTIC INTERACTIONS WITH CURRENT COUNSELEES

THE COUNSELLOR SHOULD NOT DISCUSS THEIR PERSONAL ISSUES WITH THE COUNSELEE

THE COUNSELLOR SHOULD NOT GET ANGRY AND CRY IN FRONT OF THE COUNSELEE

33 Counselling Module for Transgender/Hijra Interventions

Notes

COUNSELLING

IS

- It is a formal relationship between the counsellor and counselee
- It is collaborative and a facilitative process. The counsellor will not give instructions but just facilitate.
- It is an equal process. The counsellor should not talk to the counselee from a position of power

IS NOT

- It is not friendship between the counsellor and the counselee
- It is not a 'teacher-student' relationship. The counsellor should not should not seem like a person who knows 'it all' and is teaching the counselee
- It is not a magical cure for all problems. The issues and all possible options will be discussed

34 Counselling Module for Transgender/Hijra Interventions

Notes

EXERCISE 1

Duration: 30 minutes

Objectives

- Discuss various counselling skills
- Differentiate between effective and ineffective counselling skills

Requirements

- Chart paper/Whiteboard
- Flip chart
- Marker pens

Notes

EXERCISE 1 (contd.)

Instructions

- All the participants will participate in the exercise as one large group
- The facilitator will draw two columns on the flip chart/drawing board
- One will be labelled 'effective counselling skills' and the other 'ineffective counselling skills'
- The facilitator will ask the participants to state some effective and ineffective counselling skills
- They will be noted on the flip chart/board
- A list of skills will be discussed at the end

Effective counselling skills	Ineffective counselling skills

Notes

Effective counselling skills	Ineffective counselling skills
Use an appropriate language to question the client	Criticising the client
Using a good mixture of open and close ended questions	Avoiding eye contact
Reflecting	Ordering
Paraphrasing	Name-calling
Empathising	Non-interested in listening
Being Attentive	Appearing shocked
Following the discussion	Moralising
Focusing on the topic discussed	Judgemental attitude
Interested in listening	Constantly Interrupting
Open posture	Advising

Notes

Effective counselling skills	Ineffective counselling skills
Warmth	Messaging on the phone or answering calls
Effective counselling skills	Ineffective counselling skills
Non-judgemental attitude	Diverting from the topic
Genuineness	Condescending
Accepting that you may not know the exact answer	Sympathising
Assertion and Refusal skills	Providing incorrect information
Negotiation skills	
Co-operation and teambuilding skills	
Community building skills	

Notes

IDENTITY, SEX, SEXUALITY, & GENDER

Notes

OBJECTIVES

- Understand the concepts of identity to the group
- Clarity on the terms of sex, sexuality, and gender
- Discussion on various components of the circle of sexuality
- Introduction to various stages in identity formation
- Understanding the various sexual and gender identities, particularly within the Indian context

DURATION OF THE SESSION: 2 hours

Notes

EXERCISE 2

Purpose of the exercise:
1) To introduce the concept of identity in the group members

Time: 30 minutes

Type of exercise: Individual type of exercise

Requirements:
- Sheets of paper (one for each individual)
- Flip charts with writing pens

Notes

PROCEDURE TO CONDUCT THE EXERCISE

1) Ask the group to write a response to the question: Who are you?
Notes: They have to write words that describe their identity

2) They should write up to a maximum of 10 words to describe themselves

3) Now, ask them to read through the list and arrange them in a descending order (the most important description of themselves will be first and the least important will be last)

4) At this point ask two people to come forward and read their lists. They should do it one after the other. The facilitator of this exercise notes the list on the flip chart and initiates a discussion with the group about why they have chosen what they have chosen

Notes

5) The facilitator then asks group:

- How many have had similar takes on self?
- How many have had the same number?
- How many have had more?
- How many less than those written on the list?
- How many reached the maximum number (10) for the present exercise?
- What was the minimum number of words used to describe oneself?

The facilitator notes all of these on the flip chart.

6) The facilitator then initiates the discussion of identity; introduces the concept of multiple identities and the interaction of identities. The definitions and concepts are provided in the next few pages

Notes

IDENTITY

Definitions

Oxford English Dictionary:
"Identity is the quality or condition of being the same in substance, composition, nature, properties, or in particular qualities under consideration; absolute or essential sameness; oneness"

Eric Erikson's Definition:
"Identity is the internal process by which one defines and integrates various aspects of self. It may be related to time in one's life"

Sociological Definition:
"Identity is the place an individual holds in the society and the various roles played"

Notes

IDENTITY

It is important to remember that identity may be based on multiple aspects – example professional identity, religious identity, national identity, sexual identity, relationship identity

Often multiple identities are present in the same individual – for instance, an individual may be a woman, a mother, a doctor, an Indian."

Notes

FEATURES OF IDENTITY

Differentiation
The way one differentiates from another
Example "I am a man and she is a woman"

Continuity
It refers to the sense of sameness

Categorisation
It refers to the categorization of individuals with similar characteristics
Example "We are all humans" or "We are all Indians" or "We are all doctors"

Notes

IDENTITY

- Identity is not a static phenomenon and it may change over time. Identity is also often contextual
  - For example, an individual within India may identify himself/herself based on state or ethnicity. However the same individual when out of India may identify himself/herself based on nationality
  - Another example – as compared with other professions an individual may identify himself/herself as a doctor but among doctors the same individual may identify himself/herself based on the specialty
- ***Kindly deal with the individual based on his/her predominant identity, Do not try to impose your perception on the individual***
  - ***For instance, if a person uses the feminine pronoun to describe herself even if she is a biological male, use the same description***

Notes

STAGES OF IDENTITY FORMATION (TROIDEN MODEL)

Stage 1 - Sensitisation

The assumption in the individual is that they are heterosexual although they may observe that they are somewhat different that the others belonging to the same sex - e.g. in mannerisms, likings, interests etc.

Notes

STAGES OF IDENTITY FORMATION (TROIDEN MODEL)

Stage 2 – Identity confusion

The may be seen during adolescent period; they may start experiencing homosexual desires and feelings. However, inadequate knowledge about sexuality and experience of a new kind may often lead to this confusion and turmoil.

Notes

STAGES OF IDENTITY FORMATION (TROIDEN MODEL)

Stage 3 – Identity Assumption

The individual starts accepting the homosexual identity and informs others as such. This is a variable process and may occur at different ages - this may involve the process of coming out

Notes

STAGES OF IDENTITY FORMATION (TROIDEN MODEL)

Notes

STAGES OF IDENTITY FORMATION

Prestage: Heterosexual identity

Identity confusion: Where questioning same sex-gender affinity

Identity confusion: Where questioning same sex-gender affinity

Identity synthesis: Gradually the individual starts accepting the whole identity and comes to term with the heterosexual identity as well

Identity confusion: Where questioning same sex-gender affinity

Identity Pride: Start valuing their new found identity and may be less receptive to heterosexual identity in others

Notes

DISCUSSION

- Identity is not a static phenomenon and it may change over time. Identity is also often contextual
- Identity is not a constant phenomenon, but changes with time, roles, social milieu, geographic location, phase in life to name a few
- Identity is a matter of choice. Sometimes; however it may be imposed and then internalised
- While dealing with the clients try to ascertain their identity – how they would like to identify themselves. Even if they are all MSM they may other identities that need to be understood
- Don't try to impose your identity on the individual while dealing with them on the field; understand their identities
- Identity is not often linear; each individual may have multiple identities. An interaction of these identities may lead to complex life situations. These have to be understood while counselling individuals

Notes

DISCUSSION (contd.)

- The main identity assumed at that point of time, the problems associated with it and the interactions with other roles and responsibilities have to be understood. The solutions need to be framed within these identity issues. The negotiation skills have to be developed to address these issues

- Understanding the predominant identity will help the outreach workers to understand various issues related to the individual on the field; for example an individual may be more concerned about him being a son than his sexuality or he may be more concerned about his work status rather than safe sex practices. These issues will help you address the main concerns of these individuals

Notes

EXERCISE 3

Duration: 20 minutes

Objectives
Able to comprehend the terms relevant for providing health care to MSM and male-to-female transgender people/*hijras*

Requirements
- Chart paper/Whiteboard
- Marker pens
- Handout sheets for the exercise

Notes

EXERCISE 2 (contd.)

Instructions
- The participants will work individually or in groups (preferably pairs)
- There are some statements or situations in the exercise
- The statements will be displayed on the whiteboard or chart paper
- The participants will also be provided with the exercise handout
- There are four columns: sex, sexual orientation, gender expression, and gender stereotypes
- Each column is further subdivided into Yes or No
- For each statement the participants have to choose whether the statement is best described or not by the heading of the column
- For E.g. a man does not do any house related work is 'gender stereotype' and the participant has to mark Yes in the column 'gender stereotype'
- The worksheet is on the next page

Notes

EXERCISE 1

	Sex		Sexual orientation		Gender expression		Gender stereotype	
	Yes	No	Yes	No	Yes	No	Yes	No
A child born with male external genitals is called a 'male child'								
An adult male (who lives and behaves like a man) and is sexually attracted to another man (who also lives and behaves like a man)								

57 Counselling Module for Transgender/Hijra Interventions

Notes

EXERCISE 1

	Sex		Sexual orientation		Gender expression		Gender stereotype	
	Yes	No	Yes	No	Yes	No	Yes	No
A child who was born as a biological male starts wearing female clothes and starts living like a woman and calls herself Nisha								

58 Counselling Module for Transgender/Hijra Interventions

Notes

EXERCISE 1

	Sex		Sexual orientation		Gender expression		Gender stereotype	
	Yes	No	Yes	No	Yes	No	Yes	No
A child is born with female genitals – all the relatives present the new child with pink dresses, pink sheets, and pink pillows								

59 Counselling Module for Transgender/Hijra Interventions

Notes

RESPONSES

	Sex		Sexual orientation		Gender expression		Gender stereotype	
	Yes	No	Yes	No	Yes	No	Yes	No
A child is born with male external genitals and is called a 'male child'	√			√		√		√
An adult biological male (who lives and behaves like a man) and is sexually attracted to another biological male (who also lives and behaves like a man)	√		√		√			√

60 Counselling Module for Transgender/Hijra Interventions

Notes

RESPONSES

	Sex		Sexual orientation		Gender expression		Gender stereotype	
	Yes	No	Yes	No	Yes	No	Yes	No
A child who was born as a biological male starts wearing female clothes and starts living like a woman and calls herself Nisha	√			√ (Although, people would like to presume, one should not presume about sexual orientation based on external appearances)	√			√

61 Counselling Module for Transgender/Hijra Interventions

Notes

RESPONSES

	Sex		Sexual orientation		Gender expression		Gender stereotype	
	Yes	No	Yes	No	Yes	No	Yes	No
A child is born with female genitals – all the relatives present the new child with pink dresses, pink sheets, and pink pillows	√			√		√	√	

62 Counselling Module for Transgender/Hijra Interventions

Notes

EXPLANATION OF TERMS

SEX	SEXUAL ORIENTATION	GENDER	SEXUALITY
Refers to the biology and anatomy of the individual	It represents the behavioural, psychological, romantic or erotic, sexual affection/ attraction towards another person	It is the expression of one social, legal, or personal status	The term sexuality includes multiple components such as anatomical, physiological, biochemical proce sses, beliefs attitu des, psychological, and behavioural expressions

Notes

EXPLANATION OF TERMS

SEX	SEXUAL ORIENTATION	GENDER	SEXUALITY
The term can also be used to describe the act – for example we will have sex later in the day	This affinity could be with someone from the opposite sex, someone from the same sex, or people from both the sexes	It is a social construct and may change with time	Some other features such as identity, orienta tion, roles and personality; thoughts, feelings, and relationships may also influence the sexuality of an individual

Notes

EXPLANATION OF TERMS

SEX	SEXUAL ORIENTATION	GENDER	SEXUALITY
Someone is a biological male or female	Sexual orientations can be Heterosexual, Homosexual, or bisexual	We would use the words masculine/ feminine/ transgender for gender	The expression of sexuality is contextualised and may be influenced by ethical, spiritual, cultural, and moral concerns

65 Counselling Module for Transgender/Hijra Interventions

Notes

EXPLANATION OF TERMS

SEX	SEXUAL ORIENTATION	GENDER	SEXUALITY
	There could be male homosexuals or female homosexuals. The terms for these are different and will be discussed in detail	There could me male-to-female transgendered people or female-to-male transgendered people	

66 Counselling Module for Transgender/Hijra Interventions

Notes

EXPLANATION OF TERMS

POSITIVE SEXUALITY

Some of the components of positive sexuality are:

- Understand, appreciate, and respect one's own sexuality and those of others
- Able to communicate with others in appropriate and respectful ways (discussion about intimacy, emotions, safe sex methods, be able to define boundaries)
- Understand and learn aspects of sexual health
- Should be able to take responsibility for sex safety and health (regular check-ups)

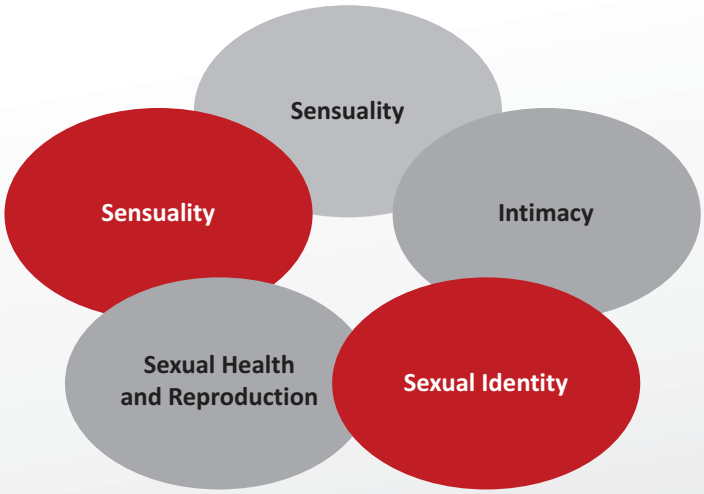
Notes

CIRCLE OF SEXUALITY

- This section is to make you aware of the different components of sexuality
- They are called as the 'circle of sexuality'
- At the end of this discussion you will understand what are the features of each component of this circle
- This may help you understand the issues of community and help in providing better service (as a part of the programme) to the community
- It is important to remember that it is generic and not restricted to men who have sex with men and transgender people

Notes

CIRCLE OF SEXUALITY



69 Counselling Module for Transgender/Hijra Interventions

Notes

CIRCLE OF SEXUALITY

What is Sensuality?

- It is the awareness, acceptance, and comfort of one's own body and that of others
- It is also the physiological and psychological enjoyment of one's body and that of others
- It allows to feel good about our body
- The important aspects are: body image, experience pleasure and release from sexual tension, sexual fantasy, satisfy skin hunger, physical attraction for other persons

70 Counselling Module for Transgender/Hijra Interventions

Notes

CIRCLE OF SEXUALITY

What is Sexual Intimacy?

- It is the ability to experience emotional closeness to another human being and accept it in return
- The important aspects are: caring, sharing, liking, loving, emotional risk taking, vulnerability

Notes

CIRCLE OF SEXUALITY

What is Sexual Identity?

- It is the understanding of oneself as to who one is sexually including the sense of being male or female
- It is composed of these interlocking features
  - Gender Identity
  - Gender Role
  - Gender Bias
  - Sexual Orientation

Notes

CIRCLE OF SEXUALITY

What is Sexual Health and Reproduction?

- It is the attitudes and behaviours related to producing children
- It also includes care and maintenance of sex and reproductive organs
- It also includes health consequences of sexual behaviour
- The important aspects are: Factual information about reproduction, anatomy of sexual organs and reproduction, feelings and attitudes, intercourse, reproduction

What is Sexualization?

- It is the use of sexuality to influence, control, or manipulate others
- The important aspects are: sexual harassement, rape, inces

Notes

SOME TERMINOLOGIES ASSOCIATED WITH TRANSGENDER PEOPLE

TERMINOLOGY	DISCUSSION
Gender Identity	It is the sense of being a man or woman or some other or someone in between. It may not necessarily be the same as the biological sex. Gender identity is "the fundamental sense of belonging to one sex". It may be internal and not visible to others.
Gender expression	When this identity is expressed externally in the social sphere it becomes a **gender expression** Every person has their own sense of gender expression, how they express their masculinity and/or femininity externally

Notes

SOME TERMINOLOGIES ASSOCIATED WITH TRANSGENDER PEOPLE

TERMINOLOGY	DISCUSSION
Gender roles	They are the "shared expectations that apply to individuals on the basis of their socially identified sex". These are identifying actions and/or behaviours for each gender. Some are according to the anatomical structure of the male or female body – example menstruation. Other roles may be culturally determined – For example, rules about what 'men' and 'women' can do or should do. These roles may have nothing to do with the way the bodies are build (or anatomical function).
Gender stereotypes	**Gender stereotypes** are generalisations and expectations from individuals based on their gender expression. For example, only women take care of children, men work as mechanics, etc..

Notes

SOME TERMINOLOGIES ASSOCIATED WITH TRANSGENDER PEOPLE

TERMINOLOGY	DISCUSSION
Transgender people	This is the term used for individuals whose gender identity and expression are different from the biological sex assigned at birth. This term is used to describe those who transgress social gender norms; often used as an umbrella term to mean those who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent/stereotypical gender roles. Recognizing and accepting someone for who they are upholds their dignity as a person. They term 'trans' may also be used to describe them
Trans woman	Someone born as a male but identifies as a female Also described as male-to-female transgendered people Also use terms such MtF and M2F

Notes

SOME TERMINOLOGIES ASSOCIATED WITH TRANSGENDER PEOPLE

TERMINOLOGY	DISCUSSION
Trans man	Someone who is born as a female but identified as a male Also described as female-to-male transgendered people Also use terms FtM or F2M
Transexual	It is an older term to indicate individuals whose gender identify is different from that of biological sex. They may seek transition from male-to-female or female-to-male. Some of them might have undergone sex change surgery and may be on hormone therapy

Notes

SOME TERMINOLOGIES ASSOCIATED WITH TRANSGENDER PEOPLE

TERMINOLOGY	DISCUSSION
Transitioning	Transitioning' refers to the process trans people undergo to live in their gender identity (for example, as male, female or as a third gender). Many of the steps aim to change how others perceive gender identity. These are sometimes called 'social gender recognition' and may involve changes to outward appearance, mannerisms or the name someone uses in everyday interactions. Other aspects of transitioning focus on legal recognition, and often centre on changing name and sex details on official identification documents. There are often overlaps, particularly in countries where it is difficult for people to informally change their name without going through a legal process. Transitioning may also involve medical steps such as hormone treatment and surgeries.

Notes

SOME TERMINOLOGIES ASSOCIATED WITH TRANSGENDER PEOPLE

TERMINOLOGY	DISCUSSION
Intersex	When an individual is born with external genitalia or reproductive organs/sexual anatomy and/or chromosomes that do not correspond with any specific definition of a male or female. There may be ambiguous genitals, both types of differences in the internal and external organs. For example a girl may have large clitoris or a child with small penis may have ovaries and uterus internally. These may be apparent at birth or later in life. This also includes hermaphrodites

Notes

OTHER TERMINOLOGIES

TERMINOLOGY	DISCUSSION
Genderqueer	Term used by some individuals who identify as neither entirely male or female
Bi-gendered	Someone who has a significant gender identity that encompasses both genders, male and female. In some one of side may be stronger compared with the other. However, both the sides are present
Cross-dresser	Someone who dresses in clothing traditionally or stereotypically worn by the other sex, but who generally may intend to live full time as the other gender. Some also use the older term “transvestite” to describe hese individuals. However, the term transvestite is also considered as derogatory by some.

Notes

OTHER TERMINOLOGIES

TERMINOLOGY	DISCUSSION
Drag Queens	Males who dress up as women for performance in bars, clubs, or during parades. However, some may use it in a derogatory fashion as well to refer to male-to-female transgendered people
Drag Kings	Female performers who dress up as men for performance in bars, clubs, or other events

Notes

OTHER TERMINOLOGIES

TERMINOLOGY	DISCUSSION
Gay	This term is to represent males who are attracted to males in a romantic, erotic and/or emotional sense In India ***'gay'*** may be associated with social class, education, and media exposure In addition, some self-identified *kothis* may also identify themselves as **gay** due to their association with organisations working with HIV prevention and their friends The term may also be used to describe anyone who does not identify as heterosexual or LGBTQI community

Notes

OTHER TERMINOLOGIES

TERMINOLOGY	DISCUSSION
Queer	It is used to refer to lesbian, gay, bisexual, and often transgender people. It may be used as an alternative to 'gay'. The term may also be used in a derogatory fashion by some; however, the term has also been reclaimed that was once used in a negative fashion
LGBTQI	An abbreviation used for lesbian, gay, bisexual, transgender, queer, and intersexed community

Notes

OTHER TERMINOLOGIES

TERMINOLOGY	DISCUSSION
Gender non-conforming or gender variant	Gender non-conforming encompasses people whose gender expression is different from societal expectations and/or stereotypes related to gender. It is not necessary that all trans people are gender non-conforming. For example, some trans women, just like other women, are very comfortable conforming to societal expectations of what it means to be a woman. Similarly, some trans men simply wish to blend in among other men.

Notes

OTHER TERMINOLOGIES

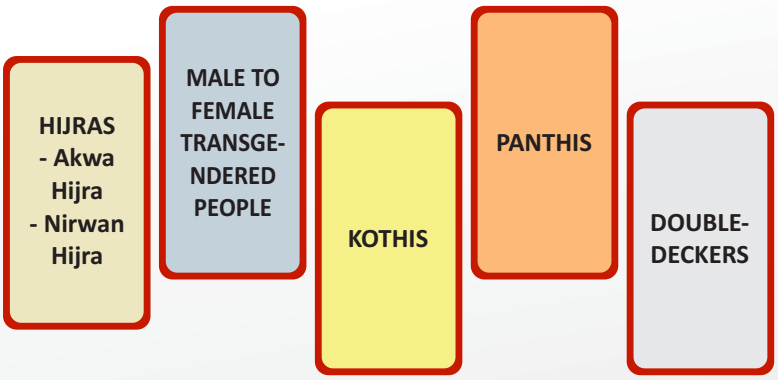
TERMINOLOGY	DISCUSSION
Abstinence	A choice of not having sex for some reason. This can be temporary (for a short period of time – example during some religious holidays) or may be for a longer duration of time.
Celibate	Do not have sex for some reason. The reason may not be in the individual's control. For example: A person who is locked up in a prison alone is celibate because there are no partners.
Asexual	Not having any sexual attraction. The person may or may not have sex. An asexual person may or may not be abstinent An asexual person may or may not be celibate **Individuals who are celibate or abstinent are not necessarily asexual.**

85 Counselling Module for Transgender/Hijra Interventions

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

MEN WHO HAVE SEX WITH MEN

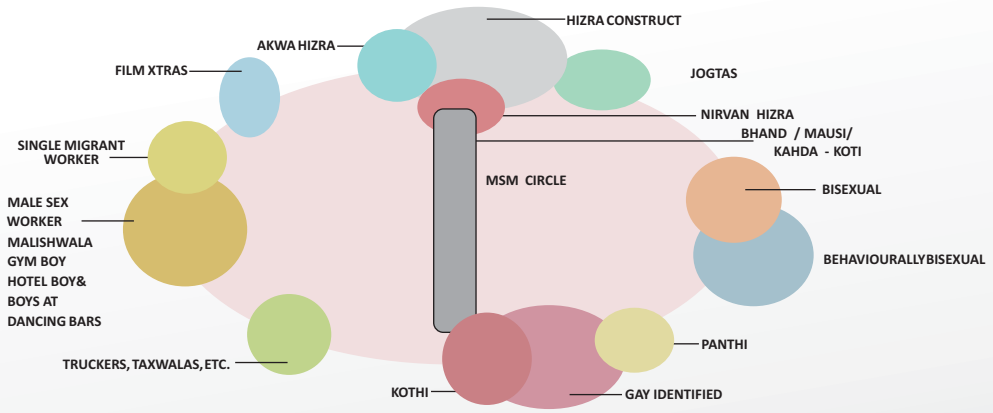


THIS IS JUST A PICTORIAL REPRESENTATION AND THE COMPARTMENTS ARE NOT NECESSARILY SEGREGATED

86 Counselling Module for Transgender/Hijra Interventions

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA



Developed by : The Humsafar Trust, Mumbai - India

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Men who have sex with men	Also called as MSM, this in an umbrella term to include all men who have sex with other men irrespective of their sexual identity. A man may have sex with other men but still consider himself to be a heterosexual or bisexual, or may not have any specific sexual identity at all. Though the terminology was initially used to denote behaviour, many MSM use this as an identity as well. It is quite possible that a man may have sex with other men but still consider himself to be a heterosexual or bisexual, or may not have any specific sexual identity at all. In some areas of the country such as Manipur these terms are commonly used (B and A).

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Kothis	*'Kothis'* are - "*males who show obvious feminine mannerisms and who are thought to be mainly involved mainly, if not only, in receptive anal/oral intercourse with men*". *Kothis'* are a heterogeneous group and a single definition or identity does to describe the heterogeneity. The *Kothi* identified men may often have varying degrees of feminine mannerisms/behaviour. Some may cross dress in specific situations such as parties/dances/or for a sexual partner. Some proportion of Kothis have bisexual behaviour and get married to a woman.

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Kothis (contd.)	Kothis are generally of lower socioeconomic status and some engage in sex work for survival. Some proportion of Hijra-identified people may also identify themselves as 'Kothis'. But not all Kothi-identified people identify themselves as transgender or Hijras. They are called 'B MSM' in Manipur.
Dhoru kothis	Some of the *kothis* may also penetrate other men and are referred to as '*dhoru kothis.*
Pav-batla-wali-kothis	They may also get married to women and may also be behaviourally bisexual. These married effeminate men are also referred to as *pav-bata-wali-kothis.*

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Panthis or Ghadiyas or Giriyas	This is the identity given to seemingly 'masculine' looking men by *kothis*. These are usually considered to be 'the real men' who penetrate. These men may not self identify themselves, although there are some who know about the *kothi* language and may call themselves *panthis.* The term *panthi* is considered to be more of a label rather than an identity. Some *kothis* may have steady *panthis* who are referred to as the partners, boyfriends or mard. They are called 'A' MSM in Manipur Though they are usually the penetrative partners, it is possible that some might also get penetrated in certain situations. A *panthi* may not necessarily identify with the *kothi* culture and consider himself as a heterosexual who just has sex with other men.

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Double deckers	This term is used individuals who get penetrated as well as penetrate. Some of the Double Deckers (DDs) may not be as effeminate as *kothis*, or some *kothis* may call themselves DDs if they have been the penetrative partner in the past. Many of these DDs may also have sex with women.
Men who are vulnerable due to their occupation/ profession:	This group includes multiple categories that may be situational homosexual or engage in sex for monetary reasons Individuals such as maalish-waalas or masseurs, male film extras, hotel boys, beer-parlour boys, room boys, or truck cleaner boys may be vulnerable. These may also be temporary situations and may change with passage of time.

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Hijras/Kinnars	*Hijras* are biological males who reject their 'masculine' identity in due course of time to identify either as women, or "not-men", or "in-between man and woman", or "neither man nor woman" *Hijras* can be considered as the western equivalent of transgender/ transsexual (male-to-female) persons but Hijras have a long tradition/culture and have strong social ties formalized through a ritual called "reet" (becoming a member of Hijra community). There are regional variations in the use of terms referred to Hijras. For example, Kinnars (Delhi) and Aravanis (Tamil Nadu).

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Hijras/Kinnars (contd.)	They cross-dress; move in female attire with a portrayal of a female gender. Many of them do not live with their biological families and stay with the '*hijra gharanas*'. These are usually headed by a *Guru*. They become *Chelas or Shishyas* of this Guru. Thus, they often live in parallel social structure.
Akwa Hijras	The *Akwa Hijras* have not yet removed their male external organs (penis and scrotum) and therefore may also have penetrative sex with other men or women.

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Nirwan Hijras	The Nirwan Hijras are the ones who have removed their male external organs ritually or they may also undergo a surgical procedure for emasculation.
Jogtas/Jogappas	*Jogtas or Jogappas are* dedicated to the Goddess Renukha devi (Yellama) – whose temples are situated in Maharashtra and Karnataka. *Jogta* refers to the male servant and *Jogti* refers to female servant (as called as Devadasi). One becomes a *Jogta* or *Jogti* if it is a family tradition or if they find a Guru and they become their *Chela* or *Shishya*. *Jogti Hijras* at those who are servants of the Goddess as well as members of the *Hijra* community. This term may be used to differentiate them from heterosexual *Jogtas* who may or may not dress in woman's attire when they worship the Goddess. They are also different from *Jogtis* who are biological females. *Jogti Hijras* may refer to themselves as *Jogtis* or *Hijras* or *Jogtas*

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Aravanis	The term used for *Hijras* in Tamil Nadu. They are defined as males who self-identify themselves as woman trapped in a male's body. Some advocate the use of the term *'Thirungani'* to refer to them
Shiv-Shaktis	Shiv-Shakthis are males who are close to Goddess and have feminine gender expression. They are inducted into the community by senior Gurus, who teach them various customs and rituals. They are ritually married to a sword – representative of the male or Shiva, and they become wives of the sword. They may cross dress as women.

Notes

SEXUAL AND GENDER IDENTITIES IN INDIA

TERMINOLOGY	DISCUSSION
Eunuchs	This term sometimes, incorrectly, used to denote Hijras (who come under male-to-female transgender people). This was used to refer to males who have undergone castration not necessarily by choice, but by accident, coercion or as a punishment. Hence it is not technically correct to refer Hijras as 'Eunuchs'. E.g., In ancient times, some males were castrated to serve as guards in royal harems. Hijras voluntarily remove their male external genitalia (if they decide to remove them)Many of the community members do identify with this term and have often argued that this term should not be used in documents.

Notes

CULTURAL ASPECTS OF HIJRAS/KINNARS IN INDIA

Some cultural aspects in India

As discussed above, the Hijras in a parallel social structure. The 'gharanas' are organisations headed by the 'Guru'. A Guru is a spiritual leader, an experienced older Hijra, and takes care of all the Chelas.

Some of the money generating activities of the Hijras include badhai, basti, or pun.

The hijras play musical instruments and dance on various occasions (such as birth of a child, marriage, and other auspicious events; this is called badhai. Some Hijras also beg at various places (such as traffic signals or in trains); this is called basti. Some may also be involved in sex work; this is called pun. Some may be involved in multiple activities.

Notes

CULTURAL ASPECTS OF HIJRAS/KINNARS IN INDIA

Some cultural aspects in India

The culture also has been explored in the tribal communities. The tribal male-to-female transgendered people are called Yejjollu. The Yejju is tribal faith healer and some tribal festivals (such as Jakarrama festival or Kandi Kottalu) are not celebrated without them. They worship Majjigouri, Nookalamma, and Konda davata, and one of their important festivals is Puvvala festival that is celebrated during Shivaratri.

They also maintain certain food and habit restriction to maintain their powers. They don't eat hare, wild rat, and long gourd. However, beef and pork are commonly eaten by them after pooja – which often involves animal sacrifice. The Yejju doesn't conduct deliveries, does not enter the house for 14 days in case of delivery, and 3 months in case of death. The Yejju is buried in sitting posture with complete female clothes.

Notes

SOME TYPES OF SEXUAL ACTS / PRACTICES

TERMINOLOGY	DESCRIPTION	SOME TERMS USED BY COMMUNITY MEMBERS
Anal sex **Peno-Anal sex**	Insertion of penis in the anus. Insertive partner – the person who inserts the penis. Receptive partner – the partner in whose anus the penis has been inserted.	**Dhurana, water dhurana, peeche se lena**
Oral sex **Peno-Oral sex**	Insertion of penis in the partners mouth Also receiving the partner's penis in one's mouth.	**Mooh mein lena, Komat karna, Blow job, Giving head**
Peno-vaginal sex	Insertion of penis in the vagina.	

Notes

SOME TYPES OF SEXUAL ACTS / PRACTICES

TERMINOLOGY	DESCRIPTION	SOME TERMS USED BY COMMUNITY MEMBERS
Rimming	Stimulating the perianal region with the tongue.	**Chaatna**
Fingering	Inserting the finger in the anus.	
Fisting	Inserting the fist in the anus.	
Body sex Frottage	Rubbing the bodies together. This may include rubbing of sexual organs with each other.	

Notes

SOME TYPES OF SEXUAL ACTS / PRACTICES

TERMINOLOGY	DESCRIPTION	SOME TERMS USED BY COMMUNITY MEMBERS
Foreplay	Sexual activity such as touching caressing, kissing, holding, sucking the breasts and body parts, erotic sensation and touching. This often leads of sexual arousal and may/may not be followed by penetrative sex.	
Inter-thigh sex	Rubbing the penis in between the thighs.	

Notes

SOME TYPES OF SEXUAL ACTS / PRACTICES

TERMINOLOGY	DESCRIPTION	SOME TERMS USED BY COMMUNITY MEMBERS
Orgy **Group sex**	Sex (penetrative/non-penetrative) involving more than one partner.	

There are other forms of sexual activities such as **erotic massages, phone sex, cyber sex, or playing with sex toys. Dildo is one of the commonly used sex toys. Anal dildos, specially designed for anal use are also available in silicone, jelly, or glass. They are also made for prostatic stimulation.**

Notes

IMPORTANT POINTS TO REMEMBER WHILE DEALING WITH SEXUAL HEALTH

You should have knowledge about human sexuality and identity	It is important that you familiarise yourself with the anatomy and physiology of sexual health and identity. The components discussed in 'circle of sexuality', different types of identities, stages of identity formation will help you with this information.
You should be familiar with the language of sexuality	Be comfortable using scientific as well as non-scientific terms (words used by the community members or slangs) for sexual acts.
You should be comfortable with your own sexuality and identity	You should be comfortable with your own sexuality and identity. If you are uncomfortable with any sex act or behaviour, it will reflect in your non-verbal communication while dealing with your client. If they sense any discomfort in your dealing, they may not discuss their problems with you.

Notes

KEY MESSAGES ON IDENTITY

- Although theoretically identity may change over time, in most cases the identity is fixed for most Hijras and transwomen
- The MSM circle includes various identities and behaviours
- Transgender identity is not a mental illness
- Identity and behaviour are not often congruent. Thus, do not assume the sexual behaviour based on the identity.
- Anal sex is not only limited to MSM and TG/Hijras. Some men may have anal sex with women as well.
- As a health care provider, one has to understand some common identities in the community.
- Do not try to impose an identity on the individual but try to use the same identity and gender expression as the person likes
- Ask a detailed sexual history about various types of sexual practices in all individuals
- As a health care provider, you have to examine all clients (penile examination, anal examination, and oral examination)

Notes

DAY TWO

Notes

ISSUES OF MALE-TO-FEMALE TRANSGENDER PEOPLE/ HIJRAS

Notes

OBJECTIVES

- Conceptual clarity on medical and social issues faced by male-to-female transgender people and *hijras*
- Understand the approach to handle male-to-female transgender people and *hijras* in counselling settings
- Discuss various aspects of sex reassignment surgeries
- Understand various types of sexually transmitted infections in male-to-female transgender people
- Discuss use of condoms and lubricants

DURATION OF THE SESSION: 2 hours

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

HOMOPHOBIA

- Homophobia is the fear and hatred of homosexuality (Oxford English Dictionary)
- "The homophobic feelings may cause discomfort (even fear, anxiety) to individuals when they are in the presence of individuals that are reported to have same-sex relationships or affinity" It is further argued that homophobia is not just a response to an individual but has a lot of historical and cultural baggage attached to it

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

TRANSPHOBIA

Transphobia is also an important issue faced by male-to-female transgender people

- It is "emotional disgust towards individuals who do not conform to the society's gender expression"

Expressions of the transphobia could be as follows:

- Heckling on streets
- Using derogatory language for them on the streets
- Violence against them on streets and in service areas
- Forcing them to use male and female in forms
- Using pronouns that do not conform with the gender expression
- Medical admission in male wards
- Discouraging them from sex reassignment surgeries

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

TRANSPHOBIA

- Often people who identify as 'gay' or MSM or *kothi* may discriminate against male-to female transgender people. They may not include them in social events
- Many *transgender/Hijras people* may have multi-layered stigma. For instance, they may be stigmatised because of their sexual orientation, gender expression, or sexual behaviour. In addition, someone is HIV infected then, there may be an additional stigma due their infected status – this multilayered stigma is referred to as '**onion-type' stigma**

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

VIOLENCE

- Many MTF transgender/*Hijras people* are vulnerable to violence in various spaces
- They may face violence at home by their family members. They may not be allowed to conform to their gender expression. They may be asked to leave their biological families and/or denied right to property
- They may also face violence in the streets and may be subjected to forced sexual encounters
- They may face violence in the service areas – such as while accessing government services, health services, or by security personnel

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

VIOLENCE

Thus, there is a need for health care facilities to be sensitive to sexual and gender expressions of MTF transgender people:

- The health care facility needs to develop a relationship with a Community Based Organisation (CBO) working for MSM and MtF transgender/*hijras*
- Since many individuals will approach the health care settings for care and treatment of violence, the health care provider should provide the immediate care for violence and then refer the individual for further support
- The CBOs may be approached for community help, legal, and social help during moments of crises

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

ACCESS TO HEALTH CARE SERVICES

- Many MtF transgender people/*Hijras* may have poor access to health care services
- This may be due to the fact that in general many doctors may not be trained to addressed the health concerns of MtF transgender people/*Hijras*
- They also may have had bad experiences in health care settings in the past or may have experienced discrimination
- Even though the treating doctor may be sensitive to the MtF transgender people/*Hijras*, they may face discrimination by the other health care personnel in the settings. Thus, it is important that all the providers are sensitised to the issues of MtF transgender people/*Hijras*
- One should avoid giggling when they enter, should not give weird expressions, should not look at them unnecessarily, or do not talk rudely to them

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

SUBSTANCE USE

- MtF transgender people/*Hijras* are at risk for excessive substance use
- Data have shown that MtF transgender people/*Hijras* may have a higher rate of use of tobacco and tobacco related products. Thus, they may be at risk for smoking related issues such as lung infections, lung cancer, and oral cancers. It is quite likely that the *panthi* may force the use of tobacco products
- Similarly it is also reported that they also have higher rates of alcohol use and dependence. This puts them at risk for alcohol related disorders such as liver disorders, hepatitis, and cirrhosis. As discussed earlier, the *panthi* may force the use of alcohol. The MtF transgender people/*Hijras* may be subjected to violence and forced sex, or unprotected sex
- There are reports of other substance use such as pharmaceutical products, weed, cocaine, ecstasy, and other injectable drugs
- Thus, during care of MtF transgender people/*Hijras*, it will be important enquire about substance use and appropriate referral services should be provided

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

- **HORMONE USE & INJECTABLE SILICONES**
- Many MtF transgender people/*Hijras* may use hormones either in the form of oral pills or injectables – some common hormones used are oestrogens
- They are often unsupervised and taken because other peers are using them
- This may result in infections at injection sites, blood borne infections, high blood pressure, high blood sugar, and put them at risk to excessive blood clotting or heartdiseases
- Apart from using hormones, many MtF transgender people/*Hijras* also use unsupervised injectable silicones or use by unqualified doctors. They may silicone products to enhance their appearance. This may be lead to infections at injection sites, blood borne infections, may cause disfigurement of the body part where used, and may not be a good grade silicone
- Thus, it is important to enquire about the use of hormones or silicones. If they are using any products, then they should be discouraged from unsupervised use. They should be referred to a centre that has expertise in sex reassignment surgery
- **The hormones may have adverse effects if they are also taking ART. Hence, Doctors should take detailed drug history**

Notes

ISSUES FACED BY MALE-TO-FEMALE TRANSGENDER PEOPLE AND HIJRAS

OTHER HEALTH CONCERNS

- There may be excessive bleeding and sometimes even death even after the *nirwaan* procedure
- Often, there are urinary problems such as repeated urinary tract infections, blockage of urine, or constriction of the urethra. Thus, there is a need to evaluate these complaints; the treatment may require antibiotics, catheterization, dilatation, or even surgical intervention
- There may be surgical complaints and disfigurement after incorrect breast enhancement procedures. There may be incorrect breast enhancement, unequal breast sizes, or granuloma formation. Thus, there is a need to examine the breasts for any lumps and seek appropriate surgical referral

Notes

MENTAL HEALTH ISSUES

- MtF transgender/*Hijras* people are at risk for mental health concerns
- The common mental health concerns are depression and anxiety
- Depression included features of feeling low, gloomy, sad, and disgusted with life. This may be also due to internalised homophobia or experienced stigma and discrimination

➢ Some of the features are feelings of gloom, sad, hopelessness, lonely, feeling of being rejected, worthlessness, or discouraged

- Anxiety is another important mental health concern and it involves the feeling of being fearful or nervous

➢ Some of the features are feelings of being afraid, irritable, confused, panicky, tense, or confused

Notes

MENTAL HEALTH ISSUES

- Suicidal tendency is another important health concern. It may be associated with other mental health concerns such as depression, alcohol and drug use, or chronic health problems. Some of the reasons are
  - Coming to terms with one's sexual orientation or gender identity
  - Faced extreme levels of stigma and discrimination in social or professional life
  - Loss of loved one, unhappy relationships
  - Economic difficulties and other poverty situations
- It is important to enquire about such feelings and tendencies. If there is any risk appropriate psychiatric referrals should be ensured
- HIV infected MtF and *Hijras* may also be prone to mental health problems and psychiatric disorders

Notes

MENTAL HEALTH ISSUES

Mood disorders	Depression, Bipolar disorder
Anxiety disorders	AIDS phobia, Health anxiety, Panic attacks, Post Traumatic Stress Disorder, Adjustment disorder
Substance use disorders	Alcohol dependence, IV Drug use, Cannabis use, Nicotine Dependence
Delirium	Hypoactive, Hyperactive
Cognitive disturbances	AIDS Dementia, minor cognitive disturbance, cognitive disorders due to opportunistic infections such as meningitis
Sleep disorders	Insomnia, hypersomnia
Psychosis	Schizophrenia-like, Acute Psychosis, ART related
Personality changes	Personality changes refer to signs of organic changes in personality including irritability, lack of motivation, and poor personal care

Notes

MENTAL HEALTH ISSUES

GENERAL WARNING SIGNS OF MENTAL ILLNESS

- Inability to manage daily activities and cope with problems
- Strange ideas (e.g., "Mahatma Gandhi talks to me")
- Long periods of sadness and indifference (as in the song "na koi umang hai, na koi tarang hai"
- Significant changes in eating or sleeping patterns (eating and / or sleeping too much or too little for a number of days)
- Thinking or talking about suicide or harming oneself

Notes

MENTAL HEALTH ISSUES

GENERAL WARNING SIGNS OF MENTAL ILLNESS

- Excessive worries
- Extreme mood swings — feeling extremely happy or extremely sad
- Abuse of alcohol or drugs
- Excessive anger, hostility, or violent behaviour

A person who shows any of these signs may have a mental illness and should be referred to a qualified mental health professional.

Notes

SEX REASSIGNMENT SURGERY

Notes

OBJECTIVES

- Understand basic concepts of sex reassignment surgery
- Discussion about various hormonal and surgical procedures in SRS

DURATION OF THE SESSION: 1 hour

Notes

SEX REASSIGNMENT SURGERY

- It is also called as SRS
- It is a combination of surgical procedures which changes one's body structure to reflect one's gender identity and gender expression. This may include surgeries for breast augmentation or breast enhancement, or altering of genitals.
- They are also called as Gender- Affirming Surgeries

Notes

HORMONE THERAPIES (FEMINISING HORMONE THERAPIES)

We have described feminising hormone therapies in this section. There may be masculinising hormone therapies as well (for FtM transgender people)

A) Feminising hormones

- Such as oestrogen, Oestrogen and testosterone, Oestrogen and testosterone blockers and progesterone, Only testosterone blockers

Notes

HORMONE THERAPIES (FEMINISING HORMONE THERAPIES)

B) Effects of the hormone therapy

- Breast development, Body fat redistribution, Softening of skin
- Less body and facial hair
- Smaller testes
- Reduced muscle mass and strength
- Reduced fertility
- Emotional changes

Notes

HORMONE THERAPIES (FEMINISING HORMONE THERAPIES)

C) Side effects of hormone therapy

- Risk of blood clots
- Increased liver enzymes
- Weight gain
- Hypertriglyceridemia
- Gall stones
- High blood pressure and cardiovascular disease

D) Drug interactions of hormone therapy and HIV medications

- Certain interactions are reported with ART medication and oestrogen (mostly ethinyl estradiol)
- Certain interactions are reported with other medications which may be used in HIV infected individuals and oestrogen (mostly ethinyl estradiol)

Notes

SEX REASSIGNMENT SURGICAL PROCEDURES

A) Breast Augmentation Surgery

- It creates larger breasts and often the goal is to have breast and nipples with sensation
- A temporary breast tissue expander is inserted in the breast and later replaced by a permanent expander
- The nipple and areola are created in a feminine shape
- It is preferable that the individual should have taken hormones for at least 1 year unless there is some contraindication

Notes

SEX REASSIGNMENT SURGICAL PROCEDURES

B) Orchiectomy

- Surgical procedure to remove the testes
- The testes are removed from scrotum through an incision in the middle of the scrotum
- It is preferable that individual should have taken hormones for 1 years unless there is some contraindication

Notes

SEX REASSIGNMENT SURGICAL PROCEDURES

C) Vaginoplasty

- It is a surgical procedure to create a vagina
- It includes the removal of the penis, testes, and scrotal sac
- The scrotum and testes are removed, and the penile skin is made into labia and clitoral hood
- The glans is made into clitoris
- Vaginal space created between the rectum and bladder, and penile skin is used to create the walls of the vagina
- Urethra is shortened and temporarily catherised
- There will be a vaginal tract created which will be capable of penetrative sex
- There will be a functional urethra
- It is preferable that individual should have taken hormones for 1 years unless there is some contraindication

Notes

SEX REASSIGNMENT SURGICAL PROCEDURES

D) Other procedures which may be used for feminising

- Facial feminising surgery
  - Reduction of Adam's apple
  - Facial bone reduction
  - Jaw surgery
  - Nose feminisation
  - Hair reconstruction
- Liposuction
  - Removal of abdominal fat
- Augmentation of buttocks
- Voice changes
  - Voice pitch elevation surgery
  - Voice therapy

Notes

DETAILS ABOUT SRS PROCEDURES – HORMONE THERAPY

A) Hormone Readiness

- It discusses the gender identity and feelings about the body
- It assesses the final goal of hormone therapy
- Assess the health history
- Describe the side effects of hormone therapy
- Assess the support systems, economic support, and long term support

B) Mental health assessment for young individuals

- Understanding and expression of gender identity
- Emotional expression
- Experiences in the family, society, school, and community
- Expectations from the therapy

Notes

DETAILS ABOUT SRS PROCEDURES – HORMONE THERAPY

C) Criteria for hormone therapy in adults

- Persistent well documented gender dysphoria
- Capacity to make a fully informed decision and consent procedure
- Age of majority
- Treatment of medical or mental health problems

Notes

DETAILS ABOUT SRS PROCEDURES – SURGICAL PROCEDURES

A) Surgical readiness assessment

- Discussion about gender identity and body feelings
- Expectations from the surgery
- Assessment of health history
- Discussion about the risk of surgery
- Assess the economic situation, support systems, and peer network
- Post surgical plan

B) Counselling indications

- Not sure if this is the right decision
- You have not discussed it with your family members in detail
- Mental health concerns (anxiety etc.)

Notes

DETAILS ABOUT SRS PROCEDURES – SURGICAL PROCEDURES

C) Criteria for gender-affirming surgeries

- Persistent gender dysphoria
- Age of majority
- Able to consent
- Medical and mental health maintained

D) Before surgery

- Prepare emotionally
- Prepare physically
- Consult with the support system, family members, peers
- Prepare economically

Notes

SEXUALLY TRANSMITTED INFECTIONS

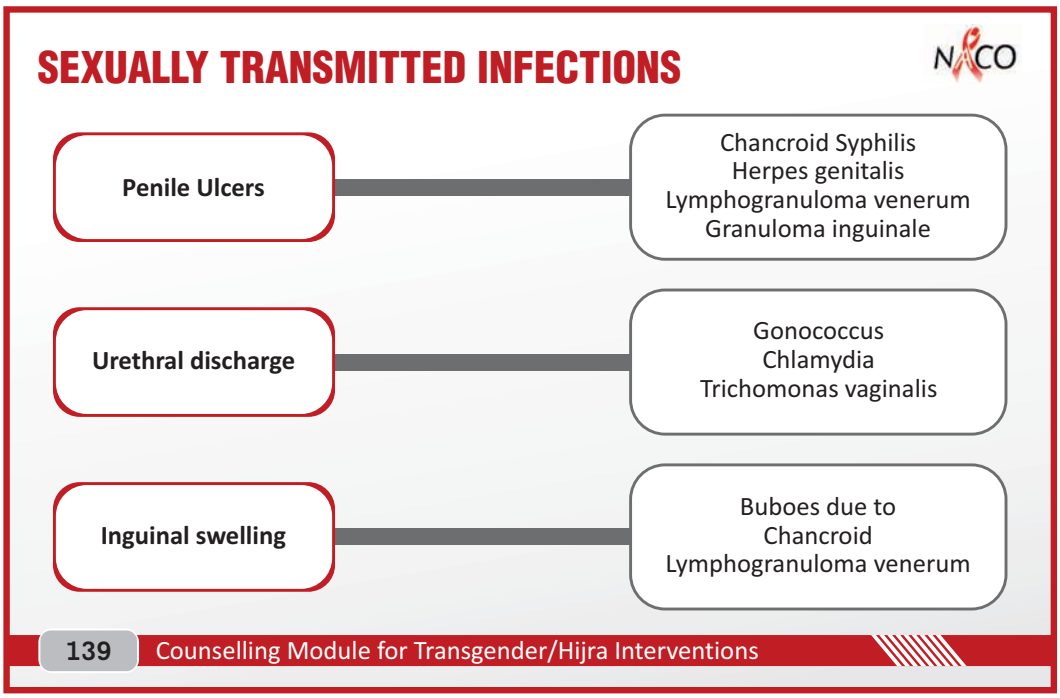
Notes

OBJECTIVES

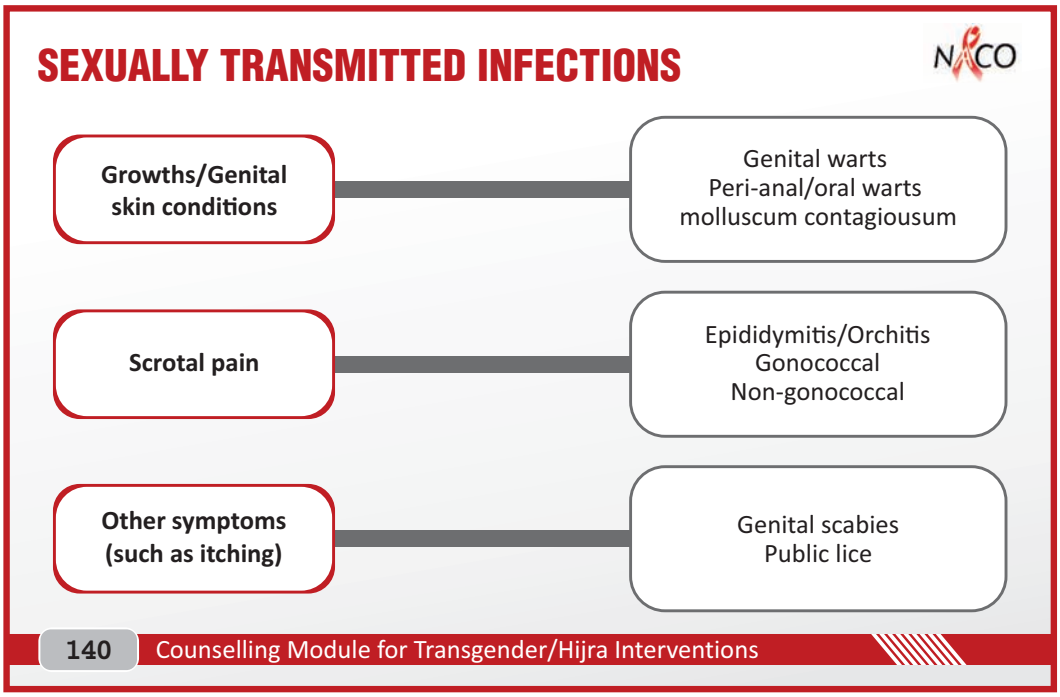
- Understand different types of STIs in male-to-female transgender
- Discuss some of the common symptoms and signs

DURATION OF THE SESSION: 1 hour

Notes

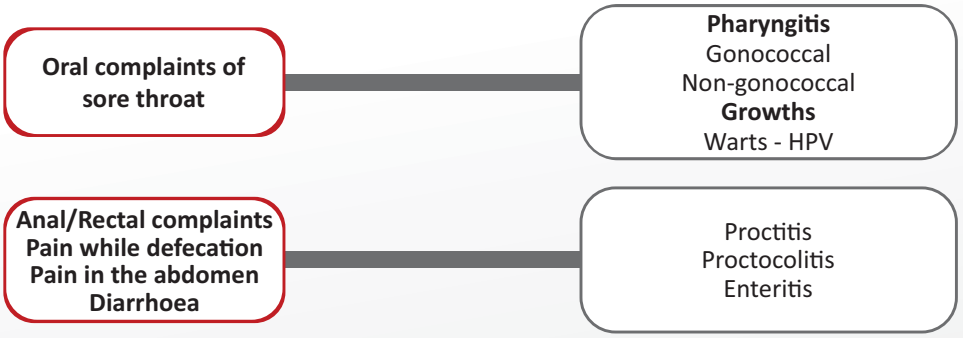

SEXUALLY TRANSMITTED INFECTIONS
NACO
Penile Ulcers
Chancroid Syphilis
Herpes genitalis
Lymphogranuloma venerum
Granuloma inguinale
Urethral discharge
Gonococcus
Chlamydia
Trichomonas vaginalis
Inguinal swelling
Buboes due to
Chancroid
Lymphogranuloma venerum
139
Counselling Module for Transgender/Hijra Interventions

Notes


SEXUALLY TRANSMITTED INFECTIONS
NACO
Growths/Genital skin conditions
Genital warts
Peri-anal/oral warts
molluscum contagiousum
Scrotal pain
Epididymitis/Orchitis
Gonococcal
Non-gonococcal
Other symptoms (such as itching)
Genital scabies
Public lice
140
Counselling Module for Transgender/Hijra Interventions

Notes

SEXUALLY TRANSMITTED INFECTIONS



Notes

STIs

- MSM and MtF transgenders/*Hijras* are at risk for STIs – Oral/Ano-rectal and Genital
- They may be ulcerative STIs (such as herpes, chancroid, syphilis) or discharges (such as penile gonococcal and non-gonococcal urethritis/ano-rectal and oro-pharyngeal infections)
- They should be particularly evaluated for STIs in the peri-anal and anal region. They may have proctitis, proctocolitis, or enteritis
- They may also have other STIs such as pubic lice, genital scabies, genital warts or genital molluscum contagiosum
- In addition, they are also at risk for STIs such Hepatitis B, or C, and HIV
- hey may also be at risk for Hepatitis A
- MSM and MtF transgenders/*Hijras* should be periodically screened for STI at regular intervals, apart from offering services whenever they have symptoms/signs, irrespective when they had last consultation .
- ***A detailed information on the STIs is provided later in the module***

Notes

ANAL WARTS

- MSM and MtF transgenders/*Hijras* are at risk for developing anal papillomas /warts and cancers due to Human Papilloma Virus (HPV)
- It is advised that MSM and MtF transgenders/*Hijras* regularly undergo screening for anal papillomas and cancer. This should be in the form of anal pap smears
- If any changes are found, a specialist surgeon advice should be sought
- There are some international studies that do discuss HPV vaccination for young MSM and MtF transgenders/*Hijras*. However, currently, this is not spelled out in National guidelines for HRG in India

Notes

HIV

- MtF transgender people/*Hijras* are at risk for HIV
- They should undergo regular screening (assuming they are sexually active) for HIV. A screening every six months will be preferred
- Studies have shown that MTF transgender people/*Hijras* are at particularly high risk for HIV compared with MSM
- Though, there are discussions on pre exposure prophylaxis in literature, there are no such current recommendations in India
- However, if there is a case of sexual assault or forced sex with an MSM or MtF transgender, they should be evaluated for trauma in the genital and peri-anal region, screened for STIs and HIV, and offered post exposure prophylaxis

Notes

OTHER CANCERS

- MtF transgender people/*Hijras* are at risk for cancers of the genital region
- They are at a risk for prostatic cancer, testicular cancer, penile cancer, and colon cancer
- Their risk should be assessed based on family history
- Even MtF transgender people/*Hijras* who have undergone *nirwaan* or sex reassignment surgery procedures may be at risk for prostate cancer even though the risk may be low

Notes

HEPATITIS VACCINATIONS

- It is recommended that MSM and MtF transgenders/*Hijras* be vaccinated for Hepatitis A and B. However, currently, this is not spelled out in national guidelines
- Hepatitis may cause hepatitis, cirrhosis, liver cancer, or even liver failure
- Even though, they may also be at risk for Hepatitis C, the best way to avoid this infection is to have safe sex

Notes

CONDOMS AND LUBRICANTS

Notes

OBJECTIVES

- Understand use of male and female condoms
- Discuss different types of lubricants (advantages and disadvantages)

DURATION OF THE SESSION: 1 hour

Notes

CONDOMS AND LUBRICANTS

CONDOMS

- Condoms are important for reduce the transmission of STIs (including HIV) and usually made of latex
- They are also called rubber, chocolate
- They should be used in all forms of sex: anal, vaginal, and oral
- They are one of the best ways to reduce the transmission of STIs
- Condoms are of two types: Male condoms and Female condoms

Best way to use a condom

- Use a new condom always every time you have sex
- Always check about the expiry date
- Store them in a proper place (usually a cool place where there is no direct sunlight)
- Do not try to blow or fill them with water to test for any holes. All condoms are tested and then packaged
- Use a new condom every time you have sex
- Condoms come in various sizes, flavours (such as strawberry, chocolate), and additional properties (such as ribbed)
- **If you are allergic to latex, then you may use polyurethane condoms**

Notes

HOW TO USE A MALE CONDOM

Step 1: Open Package

- Use a new condom each time you have sex
- Check that it has not expired and that the packaging has no holes by pressing the pack between your fingers
- Push condom to one side of package to allow room to tear open other side
- Remove condom carefully
- DO NOT use finger nails, teeth or sharp objects to open package or remove condom

Notes

STEP 2: PUT IT ON

CONDOMS

- Squeeze closed top end of condom to make sure no air is inside (can make it break)
- Place condom over top of erect penis
- If the penis is uncircumcised, kindly pull the foreskin back before putting the condom on
- Put the condom on after the penis is erect (hard) and before any contact is made between the penis and any part of the partner's body
- If the condom does not have reservoir tip, pinch the tip enough to leave a half-inch space for semen to collect
- While pinching the half-inch tip, place the condom against the penis and unroll it all the way to the base.
- With other hand, unroll condom gently down the full length of the penis (one hand still squeezing top end)
- Even if the condom is lubricated, put more lubricant on the outside particularly while having anal sex

Notes

HOW TO USE A MALE CONDOM

Step 3: During sex

- Make sure condom stays in place
- If it comes off, withdraw the penis and put on a new condom before intercourse continues
- Once sperm has been released into the condom (ejaculation), withdraw the erect penis and HOLD the condom in place on penis

Notes

HOW TO USE A MALE CONDOM

Step 4: Dispose off the condom

- Remove condom ONLY when penis is fully withdrawn.
- Keep both penis and condom clear from contact with
- your partner's body.
- Knot the end of the used condom.
- Place in tissue or bag before throwing it in dustbin
- DO NOT flush condoms down the toilet. It will block the system.
- Wash your hands with soap and water after disposing the condoms

153 Counselling Module for Transgender/Hijra Interventions

Notes

LUBRICANTS

1) What are lubricants?

- They reduce the friction during sexual act
- By reducing friction, they:
- Reduce the chances of condom breakage
- Prevent irritation to the genital parts
- It also prevents breakage of the skin
- Increases the sexual pleasure

154 Counselling Module for Transgender/Hijra Interventions

Notes

LUBRICANTS

2) When should lubricants be used?

- They should be used during anal intercourse
- The anus does not expand as much as the vagina and also not have a natural lubricant
- Thus, if one has anal sex without lubrication, there are chances of tears and cuts to the lining of the rectum
- Thus, addition of lubricants will be helpful in reducing the friction during anal sex
- Particularly, if you are having anal sex for the first time will be useful for safety and comfortable sexual activity
- They can also be used during vaginal intercourse for additional comfort and safety

Notes

LUBRICANTS

3) How to apply the lubricants?

- In general, the lubricants are applied to the outside of the condom in the insertive partner
- The lubricant may also be applied inside and around the anus or vagina
- Although many condoms are pre-lubricated, it is advisable to use lubricants along with them especially during anal sex

Notes

TYPES OF LUBRICANTS

	Water based lubricants	Silicone based lubricants	Oil based lubricants
Examples	K-Y Jelly, K-Y Water, Boots Lubricating, Durex Play	Wet platinum premium product ID Millenium, ID Pleasure	oil, baby oil, face creams, Vaseline, petroleum jelly, body lotions, ointments

157 Counselling Module for Transgender/Hijra Interventions

Notes

TYPES OF LUBRICANTS

	Water based lubricants	Silicone based lubricants	Oil based lubricants
Properties	• Considered to be among the safest lubricant • It is non-irritating and does not have any major effects on latex	• They are also safe to use with latex condoms • They are long lasting • They are not sticky • They do not dry out fast • Some individuals may find these lubricants to be more pleasurable	• They weaken the condoms • They may deteriorate the latex and break the condoms • They may also lead to infections in the rectum

158 Counselling Module for Transgender/Hijra Interventions

Notes

TYPES OF LUBRICANTS

	Water based lubricants	Silicone based lubricants	Oil based lubricants
Use during sex	It can be used during anal sex	It can be used during anal sex	***THEY ARE NOT RECOMMENDED FOR ANAL SEX*** They may be used during masturbation
Issues	It may cause irritation in some individuals	Some of these products may be expensive, however since they are long lasting they can be economical in the long run	They should not be used for penetrative sex since they may destroy latex

Notes

BASIC COUNSELLING PACKAGE

Notes

OBJECTIVES

- Discuss various steps involved in counselling
- Case studies in Counselling
- Understand some aspects of effective counselling

DURATION OF THE SESSION: 1 hour

Notes

STEPS IN COUNSELLING

- **REDA Approach**

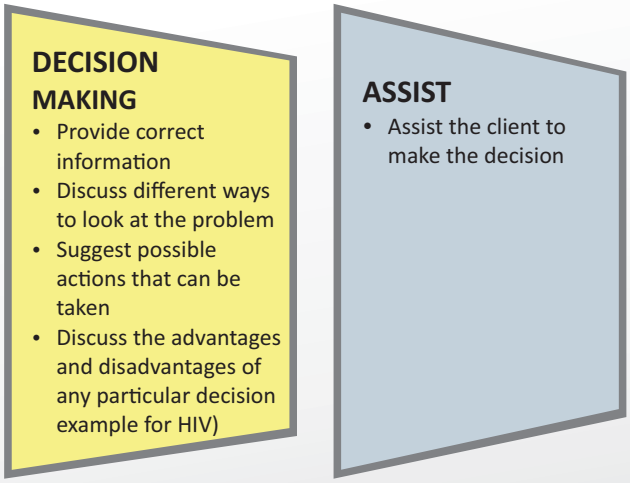
RAPPORT BUILDING
- Welcome
- Introductions
- Explain the purpose of the session
- Establish confidentiality
- See to it that the client is relaxed before the session starts

EXPLORATION
- Get a complete picture
- Identify the most important aspects of the problem
- Try to understand the general condition of the counsellee
- Ask questions
- Assess the risk (for example for HIV)

Notes

STEPS IN COUNSELLING

- **REDA Approach**



Notes

EXERCISE 4

Duration: 50 minutes

Objective

- Discuss and acquire skills for effective counselling

Requirements

- Case scenarios

Instructions

- This is a role play session
- The participants will be divided into four groups
- Each subgroup will have to work on each case
- Each group will identify one client and one counsellor
- They will enact the role play in front of the larger group
- All the participants and the facilitator will provide feedback on the role play
- They will discuss the 'effective' and 'ineffective counselling skills' used by the participants in each of the role plays

Notes

Case 1

Ragini a 22 year old male to female transgendered woman has had unprotected anal sex and would like to get examined for STIs

Instructions: The group has to work on rapport building

Case 2

Rahul a 20 year male comes to your clinic for HIV testing. This is his first visit to the centre

Instructions: The group has to work on exploring issues with the client

Notes

Case 3

Surekha is a 35 year old Hijra. She is trying to get more information on sex reassignment surgeries. She has come to you to get more information on SRS because she wants to undergo some procedures

Instructions: The group has to work on Decision Making

Case 4

Ravi is a 27 year old male. He has a steady relationship with Suresh, a 27 year old male. Ravi was detected HIV positive 2 weeks ago. He has not informed his partner yet. He wants to discuss this with you.

Instructions: The group has to work on Assist

Notes

NOTES TO THE FACILITATOR

The facilitator has to discuss and provide feedback on the following aspects in each of the cases

Case Scenario 1:

- The facilitator has to discuss verbal and non-verbal communication skills in rapport building
- Discuss about welcoming the client, language, posture, smile, warmth, genuineness while discussing this case

Case Scenario 2:

- The facilitator has to discuss about risk assessment
- Discuss about non-judgemental attitude, moralistic language, and advise

Notes

Case Scenario 3:

- The facilitator has to discuss about technical information
- They have to ascertain that the group is counselling and not advising the client
- Discussion of various strategies for SRS
- Discuss the points related to termination of the counselling session – such as goals, referrals, and follow-up dates.

Case Scenario 4:

- The facilitator has to discuss about technical information – post test counselling
- They have to discuss about the current decision – will inform the partner/how will he inform
- The facilitator has to discuss the components of follow-up counselling, setting up a date for follow-up, expectations in the follow-up session
- The facilitator will also discuss the possibility of couple counselling

Notes

EXERCISE 5

Duration: 50 minutes

Objective

- Discuss various scenarios that may be experienced while

Requirements

- Case videos

Instructions

- This is a video session
- The participants will be divided into four groups
- Each subgroup will have to work on one video
- They will discuss the issues that have discussed in the video
- The other groups will provide feedback on the issues that have been highlighted by the primary group

Notes

NOTES TO THE FACILITATOR

CASE VIDEOS

Video 1

- Discussion about various types of identity
- All men who have sex with men may not have the same identity

Video 2

- Discussion about gender stereotypes

Video 3

- Discussion about coming out process
- Discussion about identity
- Discussion about support systems

Video 4

- Discussion about identity
- Discussion about Transgender people/*Hijras*

Notes

EFFECTIVE COUNSELLING SKILLS

Skill	Details	Example
Warmth and openness	Maintain an open posture while attending a client. Welcome the client with warm words. Do not be cranky while addressing the client	"Hello, How are you today" "I will be discussing ... today"
Attentive	Provide your full attention to the client. Maintain eye contact Do not appear in a hurry or disinterested. Listen carefully to the client.	Always express that you are interested in listening to the client "Let me summarise it for you..."

Notes

EFFECTIVE COUNSELLING SKILLS

Skill	Details	Example
Follow the conversation	Listen to the sequence of events, do not interrupt or cross-question the client. Do not be over inquisitive	"So, what else did you feel after the event?"
Empathise	Try to be in the other person's shoes and understand the issues Do not sympathise with the patient	Ask yourself – how would I feel if the same event would happen with me "I know it is difficult to stay alone when you like company..."

Notes

EFFECTIVE COUNSELLING SKILLS

Skill	Details	Example
Paraphrase	Try to paraphrase whatever has been discussed during the course of the counselling session	"So far you have discussed this.... and you are saying ..."
Reflect	Try to reflect on all the issues that have been discussed in the counselling session and discuss your reflection with the client	" So you are saying that you were unhappy with the events..."

Notes

DAY THREE

Notes

ROLE OF THE FAMILY

Notes

OBJECTIVES

- Discuss the concept of 'Family' within the cultural context
- Discuss some of the important issues in the Family

DURATION OF THE SESSION: 1 hour

Notes

WHAT IS A FAMILY?

One of the most common thought that crosses the mind when one speaks of the family is the biological family.

When we are talking in the LGBTQ sense, there may be multiple examples of the family.

For example, when someone says “he is a part of the family’; the expression usually means that the person is a member of the larger LGBTQ family.

Notes

WHAT IS A FAMILY?

One of the most common thought that crosses the mind when one speaks of the family is the biological family.

When we are talking in the LGBTQ sense, there may be multiple examples of the family.

For example, when someone says “he is a part of the family’; the expression usually means that the person is a member of the larger LGBTQ family.

Notes

THE TRANSGENDER FAMILY

Compared with MSM families, the transgender families may be more formalised.

There may be a head of the family '*guru*' and other followers, the group referred to as the *'gharana'*.

The head of the family may have more authority than the elders in the MSM family (allocation of financial resources, social responsibilities, HIV prevention programmes, to name a few).

This type of family almost runs as a parallel social structure within the society. Numerous such TG *gharanas* exist in the Indian society.

Notes

DISCUSSION:

Some strategies for coming out to the family members.

- Discussion of MSM and TG issues (generally) with the family members
- Bring out the topic of certain movies/books/media that deal with MSM/TG issues
- Talk to the member closest to you if you have to start
- It's not their fault. Not due to bad/wrong/poor upbringing
- It's no one's fault
- You love them and expect the same from them
- It's not abnormal/perversion
- It will not be treated with some therapies
- Give them some time. Remember it took you a long time to accept yourself!

Notes

ISSUES IN A FAMILY

LGBTQ members may have specific issues with the biological family members:

- They have to decide if/and when to come out to the biological family members
- They have to decide who all to come out in the family.
- Other siblings in the family (brother v/s sister)
- Only child in the family
- Only male child in the family
- Financial situation of the family
- Parents living together/separated
- Dependence on the family (social, economic, professional etc.)

Notes

ISSUES IN A FAMILY (contd.)

LGBTQ members may have specific issues with the biological family members:

- Social status of the family?
- Access to other social support systems (MSM/TG groups, community organisations)
- Coming out as MSM or TG
- Decide to stay with the family afterwards or more out
- Have to take care of the family members
- Marital situation of the siblings

Notes

DISCLOSURE

Notes

OBJECTIVES

- Discuss concepts of disclosure including 'coming out'
- Understand the issues involved in disclosure

DURATION OF THE SESSION: 1 hour

Notes

DISCLOSURE

What is 'Coming Out?'

Commonly termed as 'coming out' in the western literature, disclosure is one of the important aspects of the LGBTQ Identity. We would like to discuss disclosure over here within a broader framework of coming to terms with sexuality, sexual orientation, and gender expression

POINTS ABOUT DISCLOSURE

- Disclosure can mean different things for different individuals; this often leads to the issue of who does one disclose to
- First and foremost, an important aspect is acceptance of self and disclosure to self.Then there may be a disclosure to others in the society

Notes

- There may be a disclosure to some members of the community. Though, this is often not stressful as with others, it may have its own issues. For E.g., what if one does not fit exactly according to the expectations of the group one comes out? What if she is a transgender but not ready to have the external genitals removed?
- Some individuals may try to be clear about their sexuality, sexual orientation, sexual preferences, and identity to some sympathetic straight friends. There is always a fear that some friends may not understand and they may end losing those friends
- Then there could be disclosure to family members

Notes

- There may be disclosures at work place to some work colleagues and even superiors. This may be easier said than done. It will also depend on the work atmosphere, the type of job, financial security and other factors. For E.g., for some it may be much easy to come out in the development sector or to people working on HIV/AIDS issues. If there work organization has some ideological issues/differences it may be difficult to come out to them. In real life, sexual preferences and orientation at the work place are often well guarded. There may be a fear that one be discriminated against. Though, it might not be very obvious, subtle discrimination is likely to take place. Such types of discrimination are often hard to contest. Factors such as financial stability, available legal and social recourses are other factors that may play a role in such a disclosure

Notes

- Disclosure may mean different things to different people. For some, one is only out when s/he comfortable talking to media or press or in political platforms about one' sexuality, sexual preferences, and gender. For others, it is more at a personal level

- Thus, disclosure and coming out will differ in different individuals. It may also depend on the stage of life they are in. Nowadays, it has been observed that many LGBTQ members are disclosing their sexuality, sexual preference, gender to others at relatively younger ages than before. However, some may still not be comfortable disclosing it till much later in life.

Notes

- Further, disclosure will also depend on the types of support one is assured of in the face of rejection by members whom they come out. This support can be in the form of social, legal and financial to name some.

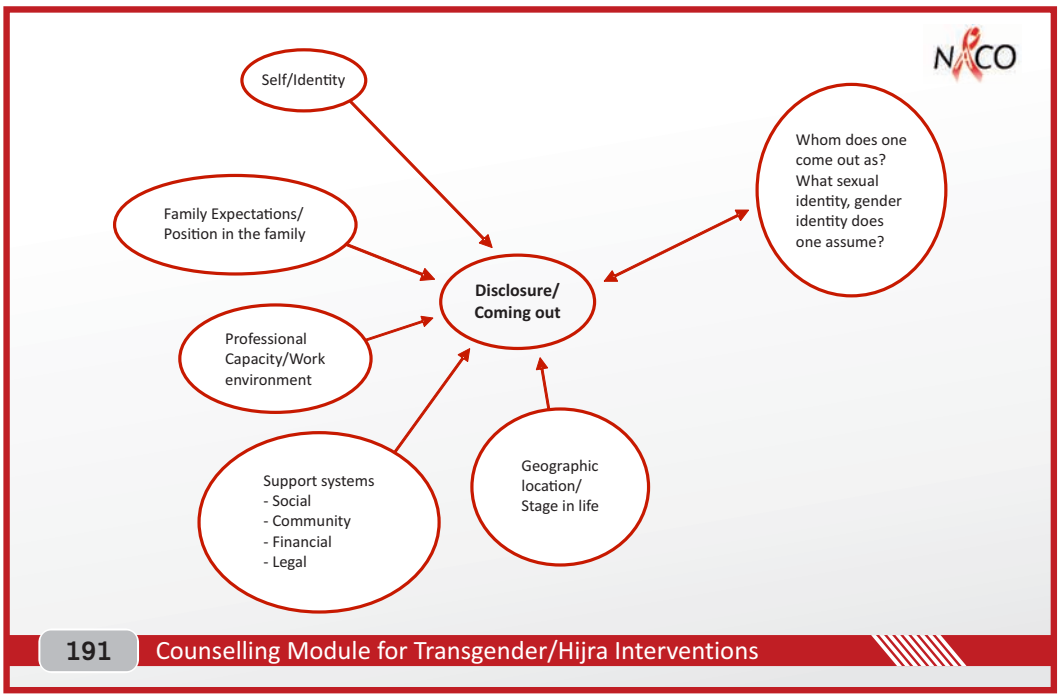
- The location of an individual may play a role in the type of disclosure. For example, a person may be more comfortable moving around in LGBTQ groups in a geographical location where he is not known in social or professional circles e.g. in cities other than the place of residence or work. They may have partners or lovers in other cities but in the home city they may not disclosure their sexual preferences or partners

Notes

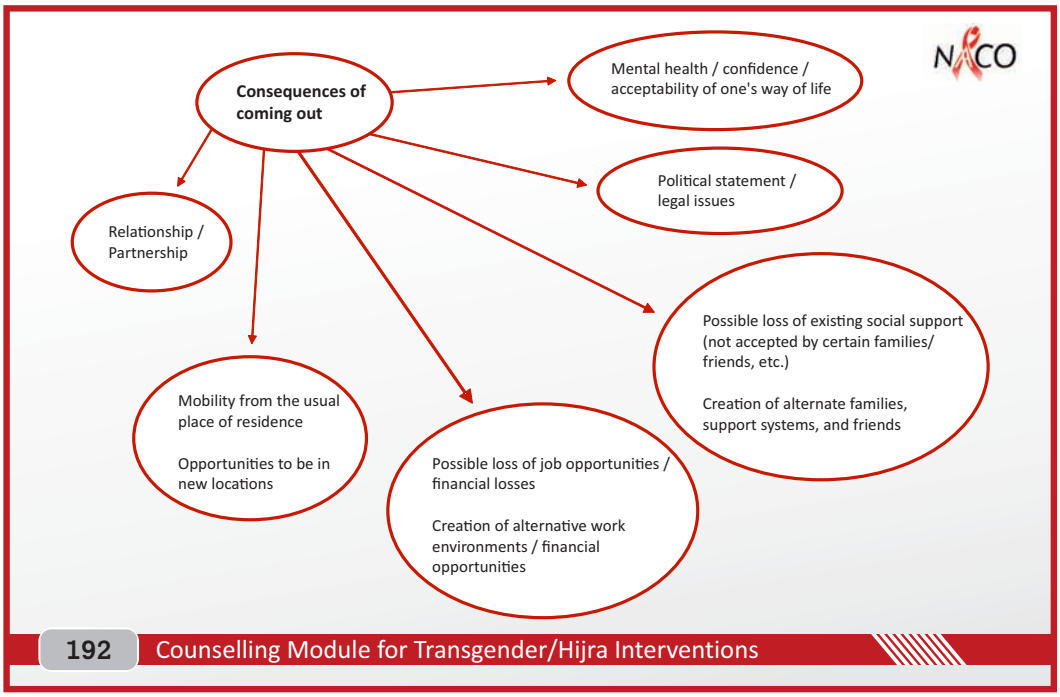
- Thus disclosure works at different levels in different cities. It may happen that gradually as they become comfortable with their self and sexuality, they may start moving in the LGBTQ circles in the home town as well. However, it is also possible that they may continue this of undisclosed/disclosed life

- This may also be the case with some transgender. Some may move around as male-to-female transgender in cities, however be dressed as men and may also have families in villages

Notes


Self/Identity
Family Expectations/
Position in the family
Professional
Capacity/Work
environment
Support systems
- Social
- Community
- Financial
- Legal
Disclosure/
Coming out
Geographic
location/
Stage in life
Whom does one
come out as?
What sexual
identity, gender
identity does
one assume?
191
Counselling Module for Transgender/Hijra Interventions

Notes


Consequences of
coming out
Mental health / confidence /
acceptability of one's way of life
Political statement /
legal issues
Relationship /
Partnership
Possible loss of existing social support
(not accepted by certain families/
friends, etc.)
Creation of alternate families,
support systems, and friends
Mobility from the usual
place of residence
Opportunities to be in
new locations
Possible loss of job opportunities /
financial losses
Creation of alternative work
environments / financial
opportunities
192
Counselling Module for Transgender/Hijra Interventions

Notes

FRIENDLY SERVICES

Notes

OBJECTIVES

- Discuss the pillars of friendly services
- Understand various aspects of Friendly Services

DURATION OF THE SESSION: 1½ hours

Notes

PILLARS OF FRIENDLY SERVICES

UTILITY BASED	The services should be relevant for the community members
TIMELY	They should be available when the community members require them

Notes

PILLARS OF FRIENDLY SERVICES

SENSITIVE	These services should be sensitive to different types of sexuality, gender orientation, and gender expression
NON-DISCRIMINATORY	None of the services should discriminate with individuals who access these services

Notes

TYPES OF SERVICES

HEALTH SERVICES

HIV RELATED SERVICES

- Prevention services such as condoms, lubricants etc.
- Testing services such ELISA, Western Blots, CD4 counts, Viral loads, Anti-retroviral (ARV) resistance
- Treatment facilities as 1st line and 2nd line ARVs
- Hospitalisation facilities for severely ill
- Palliative care, Nursing care, Hospice care, Continuum of care in home settings

Notes

TYPES OF SERVICES

HEALTH SERVICES

STI RELATED SERVICES

- Prevention services such as condoms, lubricants etc.
- Testing services such VDRL, Hepatitis B, Hepatitis C, HSV, Urine tests
- Treatment facilities antibiotics, antifungals, and antivirals
- Hospitalisation facilities if required in cases of secondary and tertiary syphilis
- Vaccination services for Hepatitis B

Notes

TYPES OF SERVICES

1) HEALTH SERVICES

2) GENERAL CARE

- Outpatient facilities for regular check-ups
- Inpatient services for illness and hospitalization facilities
- Investigation services for general illness, CT scans, MRI scans etc.

Notes

OTHER HEALTH SERVICES

OTHER HEALTH SERVICES

MENTAL HEALTH SERVICES

- Psychiatric counselling services
- Suicidal thoughts and attempts: handling of these issues
- Inpatient services for severe cases

SEX REASSIGNMENT SURGERIES

- Pre surgery care
- Post surgery care

OTHER FEMINISATION SERVICES

- Breast implants
- Voice training
- Taking care of the hair issues (hair removal, laser treatment)

Notes

OTHER SERVICES

LEGAL SERVICES

- Handling issues related to police harassment
- Tackling blackmail faced by the community members
- Parental pressures and harassment by the family members
- Attempted Suicides
- Legal standing of Sex Reassignment Surgeries

GOVERNMENT/NATIONAL DOCUMENT SERVICES

- Identity cards such as Aadhaar Card, Driver's license, Ration card, PAN card. They should be gender sensitive
- Other important documents such as Passport
- Registration of Property and Other Documents

Notes

OTHER SERVICES

SOCIAL SECURITY SERVICES

- They should be made a part of various government schemes – National Health Mission, NREGA, Jan Dhan Yojana
- They should be able to access various pension and health insurance schemes
- hese services should be gender accommodating

Notes

EXERCISE 6

In this exercise, the participants will map out the barriers faced by the community members in accessing these services. There are two main types of barriers that we will highlight in this exercise – personal and structural.

Type of exercise: It is a group exercise

Procedure

1) Divide the participants in two groups

2) Provide them sheets with columns as shown in the next pages

3) The participants have to discuss and add the barriers in the columns. They should be under the specific headings

Notes

EXERCISE 6 (contd.)

In this exercise, the participants will map out the barriers faced by the community members in accessing these services. There are two main types of barriers that we will highlight in this exercise – personal and structural.

4) For example:
- TG may not get drivers license with gender mentioned
- There may not be any tertiary care centre in the neighbourhood
- Someone may not have enough money for tests or vaccines
- There is no direct transport available to reach the ART Centre

5) The members will also discuss ways and means to overcome these barriers and how the services can be made more accessible

Notes

Health	Legal	Government	Social Security
Personal	Personal	Personal	Personal
Structural	Structural	Structural	Structural

Notes

DEVELOP A DATABASE OF ALL THE FRIENDLY SERVICES AVAILABLE TO THE COMMUNITY MEMBERS

- Create a dataset of all the friendly services that are available to the community members
- Mention the nature of the services (health, legal, social services etc.)
- Note the time of the services
- Indicate if any emergency services are available or not
- Add the specific type of services available
- Note the details of the contact person at the centre
- Also indicate the different means of travel to reach the centre

We have provided a sample sheet on the next page

Notes

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- Also indicate the different means of travel to reach the centre

We have provided a sample sheet on the next page

Notes

HOW TO MAINTAIN RELATIONS WITH FRIENDLY SERVICES

- Start by conducting simple training sessions for the service providers and adminstrators
- The sensitisation component should include: discussing the community; needs of the community; sexualities and gender. Remember, a lot of them may not know about these issues. However, if explained well many of them will be sensitive to the community
- Discuss some of the potential barriers that the community members have faced in the past and discuss the solutions to these barriers
- Include them in finding solutions to these barriers
- In spite of all the efforts there may be some who may still be 'homophobic' and 'transphobic'. Don't lose heart over them. This is more important for new CBOs who are planning to develop relationships with service providers

Notes

HOW TO MAINTAIN RELATIONS WITH FRIENDLY SERVICES (contd.)

- Also, one should know that some services take time. For example, in a public hospital the waiting times may be longer than usual. This is not because of the nature of the 'service provider'. One should not expect miracles in these changes
- One should also explain the community members the limitations of service providers. However, let them know that you have tried to best to streamline the processes for them
- Update your database of service providers regularly – at least every six months

209 Counselling Module for Transgender/Hijra Interventions

Notes

VIOLENCE

210 Counselling Module for Transgender/Hijra Interventions

Notes

OBJECTIVES

- Discuss the concept of violence
- Understand different forms of violence
- Discuss 'crisis situations' and intervention required in crisis situations

DURATION OF THE SESSION: 1 ½ hours

Notes

VIOLENCE

- Many MTF transgenders/Hijras are vulnerable to violence in various spaces
- They may face violence at home by their family members. They may not be allowed to conform to their gender expression. They may be asked to leave their biological families and/or denied right to property
- They may also face violence in the streets and may be subjected to forced sexual encounters
- They may face violence in the service areas – such as while accessing government services, health services, or by security personnel

Notes

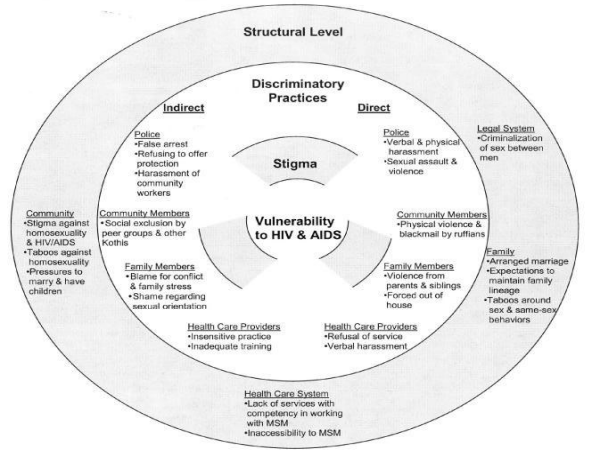
VIOLENCE (contd.)

Thus, there is a need for health care facilities to be sensitive to sexual and gender expressions of MTF transgenders:

- The health care facility needs to develop a relationship with a Community Based Organisation (CBO) working for MSM and MtF transgenders/*hijras*
- Since many individuals will approach the health care settings for care and treatment of violence, the health care provider should provide the immediate care for violence and then refer the individual for further support
- The CBOs may be approached for community help, legal, and social help during moments of crises

Notes

STRUCTURAL VIOLENCE MODEL



[a] Model proposed by Chakrapani et al (2007)

Notes

INTIMATE PARTNER VIOLENCE

It is a form of violence or "abuse" that occurs between two people who are in a close relationship/partners

TYPES OF IPV

A) EMOTIONAL VIOLENCE

- Name calling, blaming, name-calling, intimidation, threats of physical violence

B) SEXUAL VIOLENCE

- Forced sex even with a steady partner

C) ECONOMIC/FINANCIAL VIOLENCE

- Withholding one's access to money and other resources, withhold basic necessities, stealing money from the TG/Hijra

Notes

INTIMATE PARTNER VIOLENCE

SOME INDICATORS OF INTIMATE PARTNER VIOLENCE

- Injuries are inconsistent with the explanation given by the counselees
- Many injuries in individual may be in different stages of healing – the person may have been hurt by the perpetrator multiple times
- The injuries may be bilateral (usually the arms and legs)
- There may be defensive posture injuries – for example, the injuries may be more common in areas of the body that are used for defense
- There may be multiple visits to the emergency room
- Some other complaints can be
  - Headache
  - Neck pain
  - Chest pain
  - Choking sensations

Notes

INTIMATE PARTNER VIOLENCE

WHAT TO DO?

- Document the details (personal history, type of injuries, time of injury, time of presentation etc.)
- Discuss the details in a confidential space
- Treat the health effects of the of the violence (injuries or any other form of physical harm)
- Reassure the counsellee that they are not responsible for the violence
- Assess the immediate safety needs of the victim and future safety needs (for example – will the person experience same violence in the future)
- Discuss the legal ramifications of experiencing violence. If you are not well versed with different legal provisions, refer them to services that deal with legal issues of community members (including violence)
- Discuss follow-up medical and counselling visits
- If the partner is responsible for violence, then you may involve the partner in counselling
- Screen all counselees regularly for violence and the data should be used for advocacy with all stakeholders

Notes

INTIMATE PARTNER VIOLENCE

COUNSELLING SURVIVORS OF SEXUAL ASSAULT

GENERAL PRINCIPLES

- Counsellors work as part of a team
- The survivor should not be pressurized to receive counselling
- Counsellors should sincerely practise active listening skills
- Immediate intervention can help minimize the severity of long-term psychological trauma

Notes

INTIMATE PARTNER VIOLENCE

OBJECTIVES

- Help clients develop self-confidence and take control of their lives
- Overcome feelings of guilt or responsibility for the attack
- Help clients understand and articulate feelings of anger
- Help establish a link between the client and community services, and integrate them back into community activities
- Support the client in resolving family and community disputes (where appropriate)

Notes

CRISIS INTERVENTION

Introduction

Clients will experience problems and crisis situation. These situations arise due to social stigma associated with marginalized population and the emotional trauma caused by the infection or behavior associated with infection. The counsellor needs to address such issues. A counsellor needs skills in dealing with crisis situation and resolve problems.

Problem Solving Counselling

This is a structured and systematic approach to resolving problems that are linked to stressful circumstances. It is particularly suitable for clients whose life problems are adversely affecting or maintaining a stressful condition. It involves the patient identifying and listing problems and then considering what practical ways exist to solve or alleviate the problem. These solutions are tried and then reviewed.

Notes

CRISIS INTERVENTION

Steps to structured problem solving

- ***Identify and clearly define the problem*** **-** A decision only exists because of a problem. The first thing that must be done is to clearly identify what the problem is; what is it doing (or not doing) for the person (e.g. poor adherence to treatment is an outcome due to lack of funds to travel for treatment); who is affected by it (client, family); and what the desired state should be.

- ***Establish objectives and priorities*** **-** Rarely is there a time when there will be only one problem to deal with. Once you've determined what the problem is, the next step is to prioritize it in relation to the other ones currently experienced. Determining this priority involves three considerations: urgency, current overall impact, and future impacts.

Notes

CRISIS INTERVENTION

Steps to structured problem solving (contd.)

- ***Consider possible causes-*** It is important to look for the root cause(s) of the problem. Doing so will undoubtedly help determine what the underlying problem really is.

- ***Develop alternative solutions-*** Before deciding on a solution, draw up a list of feasible alternatives that will meet the client's needs. Perform this step within your time and budgetary constraints.

- ***Evaluate the alternatives-*** having determined alternatives, the client will need to evaluate the pros and cons of each alternative.

Notes

CRISIS INTERVENTION

Steps to structured problem solving (contd.)

- ***Choose the best alternative and implement it*** **-** After examining the alternatives the client should select the one which best addresses the problem defined in the first step and be sure to check that the selected alternative is the one which best meets their objectives and priorities.

- ***Measure the results-*** The final step is to observe the results of the implementation. Was the decision the right one to make? Can it be improved? It cannot assume with full certainty that once the decision is implemented the outcome will fully meet the desired objective. However the solution should be evaluated to ensure the outcome is at least consistent with the desired results -- some optimization after the fact is therefore not out of the ordinary. This follow-up phase is therefore a necessity.

Notes

CRISIS INTERVENTION

WHAT IS CRISIS COUNSELLING?

Crisis counselling focus is on single or recurrent problems that are overwhelming or traumatic. It usually is around 1 to 3 months. If a trauma or crisis is not resolved in a healthy manner, the experience can lead to more lasting psychological, social and medical problems. Crisis counselling may involve outreach, work with in a community and is not limited to office appointments.

Crisis patterns are of two types

- Acute: Intense emotional responses, agitation, impulsive behavior. Relatively short-lived
- Chronic: Less expressive, subdued, complains more, guilt, shame and depression. Risk of hurting themselves for a much longer period

Notes

CRISIS INTERVENTION

Elements of Crisis Intervention Education

There is a natural ability within most people to recover from a crisis provided they have the support, guidance and resources they need. The very heart of crisis intervention is to face the impact of a crisis. In most cases, a crisis involves normal reactions, which are understandable, to an abnormal situation. An effective crisis counselling provides information, activities and structure that will help recover and move past the crisis. Confrontation through information and discussion may be an important part of crisis intervention.

Observation and awareness

A crisis in our life can be the result of low self-awareness or not recognizing the impact our behavior has on others as well as the impact it has on our self. Increasing your awareness can lead to choices that promote recovery and wellness. You can't help yourself if you cannot see the problem and how you may be contributing to the crisis.

Notes

CRISIS INTERVENTION

Discovering and using potential

Every crisis represents an opportunity for personal growth and to discover highest potential and true self. The greatest hero in any crisis is the person who does not believe he or she is a hero, but is never-the-less prepared for the challenge by the undiscovered qualities and abilities that are only discovered when they are facing tragedy and the "inevitable" of life. While support is important, this does not mean that the person in crisis should not be allowed, encouraged and sometimes required to make decisions and take action to resolve the crisis and improve the quality of their life.

Notes

CRISIS INTERVENTION

Understanding problems

It is the fundamental intention of all people to do the best they can with the resources and abilities they have during a crisis. During any crisis, it is important to recognize or discover our true and deepest intention. The client must keep their intentions in mind no matter what they do or how unskillfully they act. While the intent is usually to make life better, behavior can be misguided, misunderstood and less effective than they would hope. Self-understanding as well as understanding how others may keep them "stuck" are important keys to recovery.

Notes

CRISIS INTERVENTION

Creating necessary structure

The most important aspect of crisis intervention and counselling is to provide a social "container" for experience that will allow client to express, explore, examine and become active in ways that help insure the crisis is not prolonged. For each person, there are necessary activities and routines in life during times of distress that provide comfort and support. These do not include alcohol, medications or other drugs. Medications should only be used to prevent a physical or psychological breakdown. The purpose, duration, frequency and impacts of medications must be defined in order to make informed decisions.

Notes

CRISIS INTERVENTION

Challenging irrational beliefs and unrealistic expectations

Few people, during times of crisis, have the necessary skills to fully examine what they are thinking, what they assume and what they expect from their self and from others. Thoughts, especially the ones that the individual does not look at, contribute a great deal to how they feel and what they do next in response to our feelings.

Notes

CRISIS INTERVENTION

Breaking vicious cycles and addictive behavior

Many crises are the result of vicious cycles or addictions. For example, drug and alcohol use cannot only destroy our life, but it will confuse how the person actually feels about self, others and the world. One cannot know how they feel and what they truly want if their feelings are modified by chemicals, medications, alcohol and other drugs. A painful crisis can lead a person to avoid and escape how they feel. Unhealthy escape and avoidance of emotional pain and distress may involve the use of medication, drugs, alcohol, sex thrill seeking, parties or working excessively. Taking the role of a "victim" can cause others to rescue a person in crisis.

Notes

CRISIS INTERVENTION

Breaking vicious cycles and addictive behavior (contd.)

Prolonging the crisis by refusal to deal with a crisis can create supportive relationships. When a person becomes dependent on others and "escapes" to feel better, a vicious cycle can develop. Vicious cycle start with behaviors that are intended to avoid or escape emotional pain, but ultimately this avoidance and escape behaviors create more problems or the same problem we are trying to avoid. The behaviors found in a vicious cycle can actually prolong a crisis.

Notes

CRISIS INTERVENTION

Create temporary dependencies

During a crisis, it is often helpful to form brief relationships with others to gain support. Crisis counselling and intervention are very helpful and necessary. A healthy dependency is usually temporary and will always lead to increasing independency. Unhealthy dependencies are long term and create increasing dependency rather than independency.

Notes

CRISIS INTERVENTION

Facing fear and emotional pain

A crisis is usually a time to fear or sadness. How a person responds is important. When a person faces the darkness in life, and they are not destroyed by fears, or sadness, they eventually discover there are no monsters. They discover they can survive. In time pain will fade. Facing emotional pain is the most healthy response. This does not mean the person should make themself miserable. But they should not expend a great deal of energy and become involved in activities that help avoid how feel and what they think. When people suffer, it is important to help them feel less alone in the world. It is important to help people in crisis solve the problems in their life. People in emotional pain need to be empowered and supported.

Notes

CRISIS INTERVENTION

PHASES OF INTERVENTION

- **Initial Phase:**
  - Encouraging and supporting intense emotion. Allowing ventilation without rushing, empathizing through listening and reflection of feelings. Acknowledging that it is normal to feel distressed

- **Middle Phase:**
  - Client regains control. Why is the crisis happening now? What are the key issues? Economic, family, social, psychological, illness and sexuality
  - Assessment of client's condition: Is the client suicidal? Capable of harming others? What is his support system? What about his dependants?
  - Presenting and reframing the client's situation
  - Problem solving: Exploration of options and consequences

Notes

CRISIS INTERVENTION

Final Phase:

- Counselor's Role: Support, listener, partner, bridge between resources in the community and the client
- Client begins experimenting with actions leading to resolutions
- Counselor encourages new coping skills
- Follow-up offered so that client can come back in need

PHASES OF INTERVENTION (contd.)

Final Phase:

- Counselor's Role: Support, listener, partner, bridge between resources in the community and the client
- Client begins experimenting with actions leading to resolutions
- Counselor encourages new coping skills
- Follow-up offered so that client can come back in need

Notes

CRISIS INTERVENTION

Common Reactions to a Crisis

Reactions to a crisis or traumatic events vary considerably from person to person. Symptoms and reaction times are different for each individual. Common reactions to crisis can include changes in behavior, physical well-being, psychological health, thinking patterns, and social interactions. Some common signs and symptoms include:

- Disbelief
- Emotional numbing
- Nightmares and other sleep disturbances
- Anger, moodiness, and irritability
- Forgetfulness
- Flashbacks
- Survivor guilt
- Hyper vigilance
- Loss of hope
- Social withdrawal
- Increased use of alcohol and drugs Isolation from others

Notes

STIGMA & DISCRIMINATION

Notes

OBJECTIVES

- Discuss concepts of stigma and discrimination
- Understand different forms of stigma
- Discuss the methods to deal with stigma

DURATION OF THE SESSION: 2 hours

Notes

STIGMA

It is to see some people wrongly as inferior or immoral because of a quality that mistakenly viewed as undesirable by society.

DISCRIMINATION

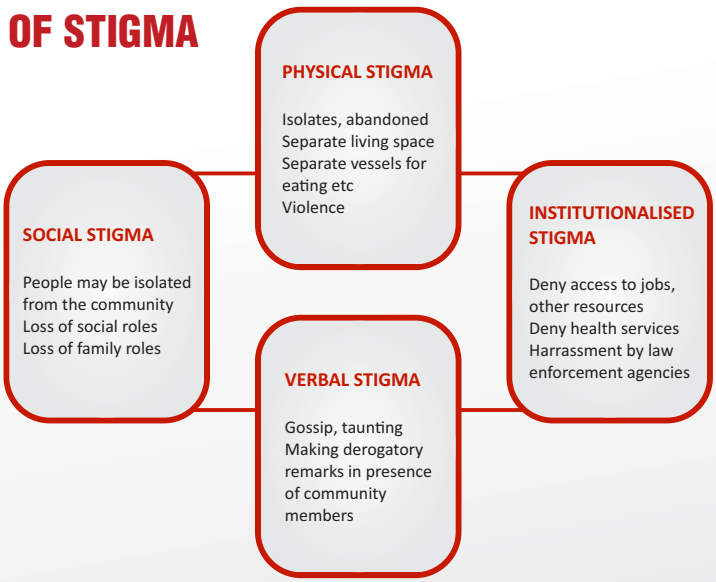
It is an unfair action against an individual because they belong to a certain stigmatised group.

PEOPLE MAY STIGMATISE AND DISCRIMINATE AGAINTS HIV INFECTED PEOPLE

- This may be due to
- Poor understanding and awareness about HIV and its transmission
- Mistaken fears about getting infected with HIV and about dying
- Mistaken moral judgments about HIV infected individuals
- Ignorant and Intolerant attitudes

Notes

FORMS OF STIGMA



Notes

SOME EFFECTS OF STIGMA

- Feel lonely
- Shame
- Stress
- Fear
- Lack of confidence
- Helplessness
- Frustation
- Despair
- Substance abuse

Notes

HOW TO DEAL WITH STIGMA

IGNORE OR CHALLENGE THOSE WHO STIGMATISE YOU

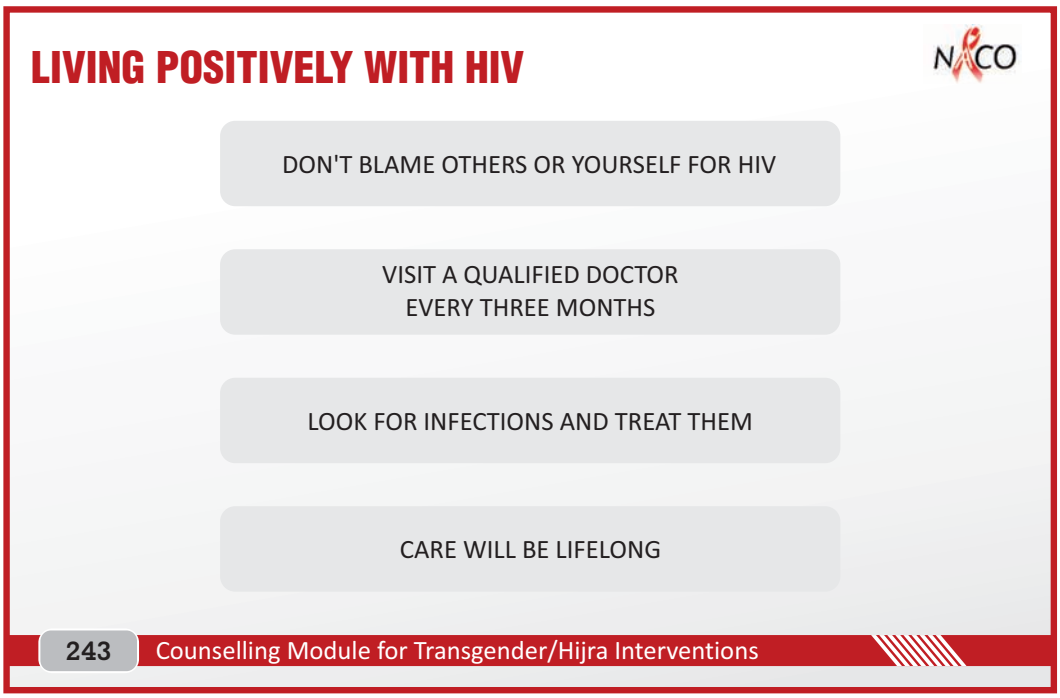
IT IS OKAY TO AVOID SITUATIONS OR PLACES WHERE YOU MAY EXPERIENCE STIGMA

DISCUSS THIS WITH YOUR FRIENDS AND LOVED ONES

JOIN SUPPORT GROUPS AND ATTEND MEETINGS

DISCUSS THIS WITH A COUNSELLOR AND MENTAL HEALTH REFERRAL IF REQUIRED

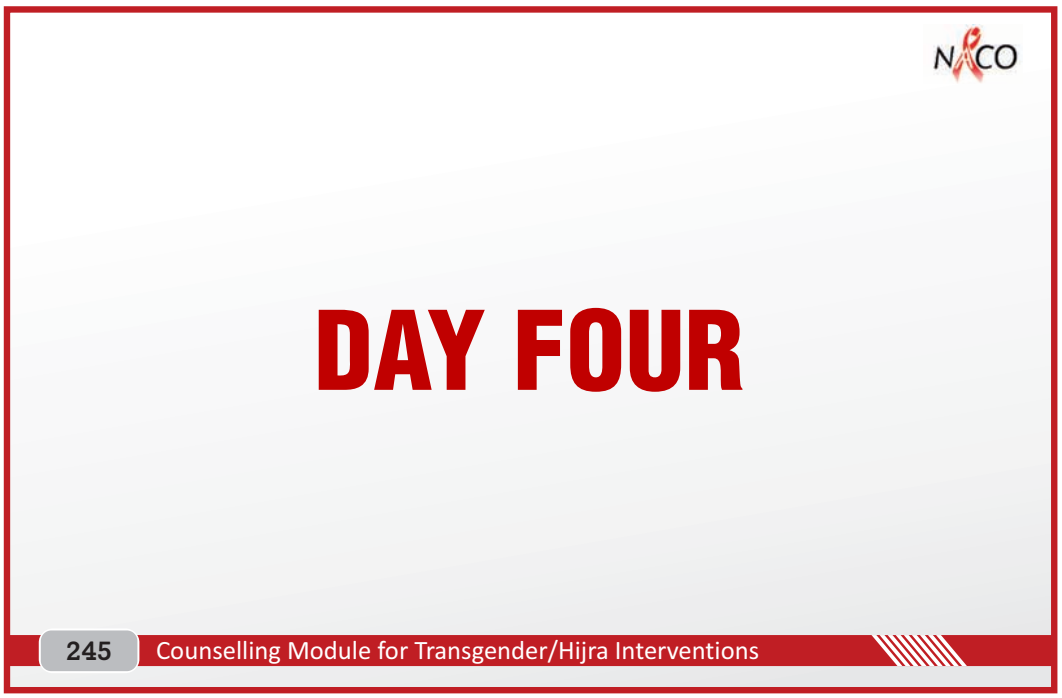
Notes


LIVING POSITIVELY WITH HIV
NACO
DON'T BLAME OTHERS OR YOURSELF FOR HIV
VISIT A QUALIFIED DOCTOR
EVERY THREE MONTHS
LOOK FOR INFECTIONS AND TREAT THEM
CARE WILL BE LIFELONG
243
Counselling Module for Transgender/Hijra Interventions

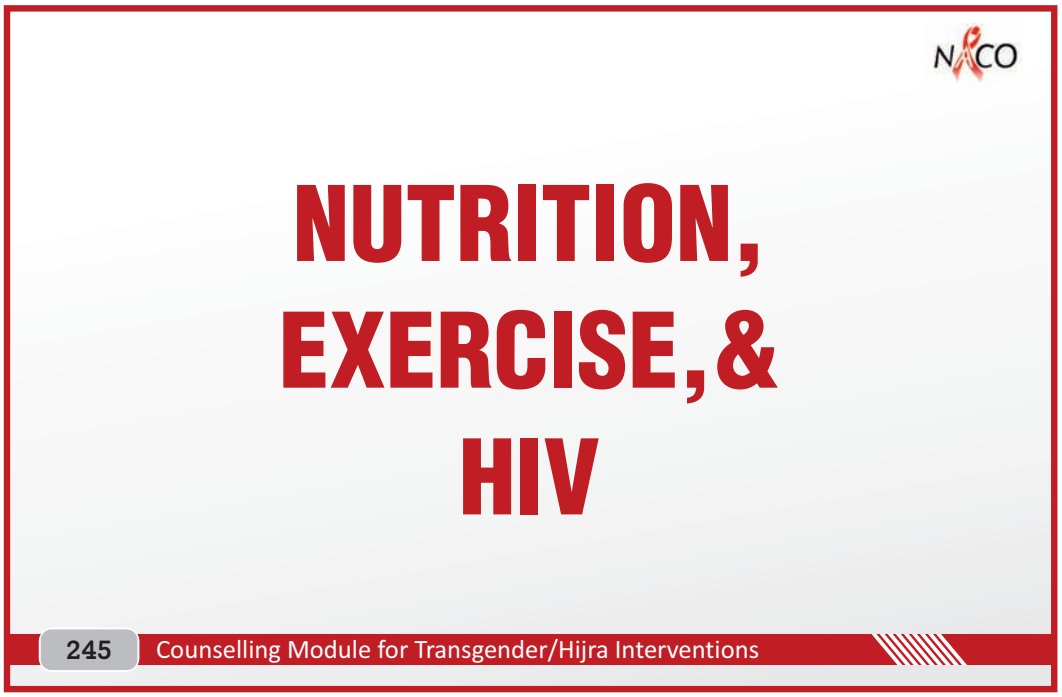
Notes


LIVING POSITIVELY WITH HIV
NACO
DO NOT ENGAGE IN RISKY BEHAVIOURS
EAT AND DRINK HEALTHY FOOD
JOIN A HIV POSITIVE SUPPORT GROUP
244
Counselling Module for Transgender/Hijra Interventions

Notes


DAY FOUR
245
Counselling Module for Transgender/Hijra Interventions

Notes


NUTRITION, EXERCISE,& HIV
245
Counselling Module for Transgender/Hijra Interventions

Notes

OBJECTIVES

- Understand the role of nutrition in HIV infected individuals
- Understand the role of exercise in HIV infected individuals

DURATION OF THE SESSION: 1 ½ hours

Notes

HEALTHY DIET IS IMPORTANT FOR PEOPLE LIVING WITH HIV/AIDS

Healthy and balanced nutrition should be one of the goals of counselling and care for people at all stages of HIV infection.

It will help the infected individual by:

- Maintaining body weight and strength
- Replacing lost vitamins and minerals
- Improving the function of the immune system and the body's ability to fight infection
- Extending the period from infection to the development of the AIDS disease

Notes

HEALTHY DIET IS IMPORTANT FOR PEOPLE LIVING WITH HIV/AIDS (contd.)

It will help the infected individual by:

- Extending the period from infection to the development of the AIDS disease
- Improving response to treatment; reducing time and money spent on health care
- Keeping HIV-infected people active, allowing them to take care of themselves, their family and children
- Keeping HIV-infected people productive, able to work, grow food and contribute to the income of their families

Notes

IMPORTANT POINTS FOR DIET

Nutrition:

Eat appropriate amounts of food and consume healthy foods from the different food groups, which are:

- **Proteins-** dal, lentils, meat, fish, soya beans and nuts help build and maintain muscles
- **Carbohydrates**-carbohydrates supply energy and can be found in grains, cereals, vegetables and nuts
- **Vitamins**-vitamins are found in fresh fruits and vegetables, vitamins strengthen the immune system and help fight infections
- **Fats**-fats should be consumed modestly. Put emphasis on monounsaturated fats found in nuts, seeds, vegetable oils and pulses while avoiding saturated fats, including butter and animal products such as lard

Notes

Clean water:
Drink plenty of liquids. If you are not sure about the purity of your public water supply, boil your drinking water or use bottled water, if possible.

Food hygiene:

1) Wash your hands carefully before food preparation.
2) Keep raw and cooked food separate.
3) Choose foods that are safe (avoid unpasteurized milk and wash fresh fruits and vegetables well).
4) Cook foods thoroughly.
5) Eat foods soon after they are cooked.

Stress and anxiety:
Minimize stress and anxiety. Having a social support network helps. Get regular exercise and adequate sleep.

Notes

Avoid smoking:
Smoking damages the lungs and other organs and increases susceptibility to infection.

Medical care:
Have regular medical follow-ups.

Medicines:
Avoid unnecessary medicines and if you are on other medications not related to HIV, discuss them with your physician.

Notes

WHAT CAN I DO IF I'M HAVING TROUBLE EATING?

- If you don't have an appetite—Try to eat your favorite foods. Instead of eating three big meals each day, eat six to eight small meals. Drink high-calorie protein shakes with your meals or between meals.
- If you have diarrhea—Don't eat fried foods and other high-fat foods like potato chips. Don't eat high-fiber foods. Instead, eat bland foods like bread or rice
- If you have mouth sores—Avoid citrus fruits like oranges. Avoid very hot or cold foods. Don't eat spicy foods. Try not to eat hard foods.
- If you have nausea and vomiting—Avoid drinking any liquid with your meals. Eat six to eight small meals each day instead of three large meals. Eat foods with a mild flavor. Eat foods at a medium temperature, not hot or cold. Sit and relax for 30 minutes after you eat.

Notes

EXERCISES

- An aerobic exercise like walking will help make you stronger. It's good to begin exercising slowly. Little by little, increase the amount of exercise. For example, you might start walking for 20 minutes three times a week. Then, after you get a little stronger, you can increase the walking time to 30 minutes four times a week. Talk with your doctor before you start.
- Weight lifting is also a good way to increase your strength. Start by trying to do a weight lifting exercise 10 times. This is called a “repetition.” More than one repetition is called a “set.” Try to do two sets of 10 repetitions. Rest for 90 seconds between each set.

Notes

EXERCISES (contd.)

- You don't need to have fancy exercise equipment to do weight lifting. You can use books and other objects you have in the house. Start by lifting a weight that's comfortable for you and doesn't cause too much strain.
- In the first week, do one or two different weight lifting exercises for each body part once or twice in the week. Start with a small weight in each hand. Each week increase the number of exercises you do and the number of times you exercise. Rest for 1 to 2 days between exercise sessions. When you're feeling sick, either exercise less or stop for a while.
- You may try Yoga postures and meditation for healthy living

Notes

GENERAL RECOMMENDATIONS FOR TAKING CARE OF YOURSELF

- The body needs extra rest. Try to sleep for eight hours every night. Rest whenever you are tired
- Try not to worry too much. Stress can harm the immune system. Relax more. Relax with people you love, your family, your children and your friends. Do things you enjoy, e.g. listen to music or read a newspaper or a book
- Be kind to yourself. Try to keep a positive attitude. Feeling good is part of being healthy
- Take light exercise. Choose a form of exercise that you enjoy
- Find support and get good advice. Ask for advice from health workers. Many medical problems can be treated

Notes

GENERAL RECOMMENDATIONS FOR TAKING CARE OF YOURSELF (contd.)

- Ask for help and accept help when it is offered.
- Stop smoking. It damages the lungs and many other parts of the body and makes it easier for infections to attack your body.
- Alcohol is harmful to the body, especially the liver. It increases vulnerability to infection and destroys vitamins in the body; under the influence of alcohol you may forget to practise safe sex.
- Avoid unnecessary medicines. They often have unwanted side-effects and can interfere with food and nutrition. If you do take medicines, read the instructions carefully.

Notes

CREATING REFERRALS AND NETWORKS

Notes

OBJECTIVES

- Discuss details of creating referrals and networks
- Discuss the types of referrals
- Discuss the process of referral

DURATION OF THE SESSION: 1 ½ hours

Notes

WHAT IS A REFERRAL?

Referral is the process by which client needs are assessed and prioritized to provide assistance (e.g., need for HIV testing, TB treatment, financial assistance for travel for treatment) in accessing services. Referral should also include follow-up efforts necessary to facilitate initial contact with other service providers.

Referral does include ongoing support or management of the referral or case management. Case management is generally characterized by an ongoing relationship with a client that includes comprehensive assessment of medical and psychosocial support needs, development of a formal plan to address needs, substantial assistance in accessing referral services, and monitoring of service delivery.

Notes

IMPORTANT INSTRUCTIONS TO THE ANM/ COUNSELLOR

1. Any referral to a facility outside of a TI has to be with a referral slip.
2. One copy of the referral slip will be retained by the facility referred to.
3. Counsellor/ANM should go the referred unit on designated day and gathers these referral slips.
4. The referral slips are consolidated and reported under respective indicators.

Notes

TYPICAL REFERRAL NEEDS

Clients should be referred to services that are responsive to their priority needs.

- **HIV testing:**
  All HRGs should be encouraged, motivated and referred to the ICTC for HIV testing. The community should undergo periodic HIV testing. The counsellor should be well aware of the procedures and operations at the ICTC. The client should be referred with a referral slip to the ICTC of their choice. The client should be requested to provide feedback on the visit. The counsellor should follow-up at the ICTC to check on the number of referrals who reach for HIV counselling and testing.

- **STI screening and Management**:
  HRG would require STI screening and management. Partner notification and testing should be encouraged. In case the HRG have not followed for the monthly check u, the ANM should ensure Presumptive Treatment for STI is provided.

Notes

TYPICAL REFERRAL NEEDS (contd.)

- **Medical evaluation, care, and treatment:**
  HIV-infected clients should receive or be referred to the ART center. Baseline assessments and treatment for opportunistic infections and related HIV-conditions are important for HIV-infected persons. In addition, coinfection with HIV (e.g., TB, STIs, and hepatitis) can, if untreated, pose a risk

- **Partner counseling and referral services:**
  Clients who are on treatment for STI should ensure their partners also access treatment. Similarly all PLHIVs should ensure their spouse and partners are tested for HIV. If found positive referral to ART should be ensured

- **Reproductive health services:**
  Female partners who are pregnant or of childbearing age should receive or be referred to reproductive health services or PPTCT as the case may be

Notes

TYPICAL REFERRAL NEEDS (contd.)

- **Drug or alcohol prevention and treatment:**
  Clients who abuse drugs or alcohol should receive or be referred to substance or alcohol abuse prevention and treatment services

- **Mental health services:**
  Clients who show symptoms of mental illness, acute depression, are suicidal should be referred to psychiatric services

- **Legal services:**
  Some clients may express legal concerns- being evicted form house, losing a job, property issues etc. Such clients would require legal referrals. Legal services could also be required during crisis situation

Notes

TYPICAL REFERRAL NEEDS (contd.)

- **Other services:**
  Clients might have multiple needs that can be addressed through other HIV prevention and support services (e.g., assistance with housing, food, employment, transportation, child care, domestic violence, and legal services)

Notes

HOW TO REFER?

Assessing Client Referral Needs:
Assessment should include examination of the client's willingness and ability to accept and complete referral. All clients should be assessed for referral needs related to medical care, prevention and support services. A client may have multiple needs, prioritize these needs with the client is important. For some clients social needs may overpower medical needs. E.g. the client needs financial assistance for food, nutrition and transport to ART center. Unless the basic needs of clients are met, the client may not adhere to treatment. Hence prioritizing as per client needs is important.

Notes

HOW TO REFER? (contd.)

Plan the Referral:

Referral services should be responsive to clients' needs and priorities and appropriate to their culture, language, sex, sexual orientation, age, and developmental level. In consultation with clients, providers should assess and address any factors that make completing the referral difficult (e.g., lack of transportation or child care, work schedule, cost). Research has indicated that referrals are more likely to be completed if services are easily accessible to clients.

Notes

HOW TO REFER? (contd.)

Help Clients Access Referral Services:

Clients should receive information necessary to successfully access the referral service (e.g., contact name, eligibility requirements, location, hours of operation, telephone number). Clients must give consent before identifying information to help complete the referral can be shared. Counsellors can help clients identify needs and plan successful referrals. Referrals are more likely to be completed after multiple contacts with outreach workers.

Notes

HOW TO REFER? (contd.)

Document Referral and Follow-Up:

ANM/Counsellor should assess and document whether the client accessed the referral services. If the client did not, the provider should determine why; if the client did, the provider should Documentation of referrals made, the status of those referrals, and client satisfaction with referrals should help providers better meet the needs of clients. Information obtained through follow-up of referrals can identify barriers to completing the referral, responsiveness of referral services in addressing client needs, and gaps in the referral system.

Notes

HOW TO REFER? (contd.)

ENSURE HIGH-QUALITY REFERRAL SERVICES

Providers of referral services should know and understand the service needs of their clients, be aware of available community resources, and be able to provide services in a manner appropriate to the clients' culture, language, sex, sexual orientation, age, and developmental level, given local service system limitations.

Notes

CONTENTS OF A REFERRAL RESOURCE GUIDE

For each resource, the referral resource guide should specify the following:

- Name of the provider or agency
- Range of services provided
- Target population
- Contact names and telephone and fax numbers, street addresses, e-mail addresses and hours of operation
- Directions, transportation information, and accessibility to public transportation
- Competence in providing services appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level
- Eligibility, admission policies and procedures (e.g. care center)
- Papers the client needs to carry (e.g. ART center ICTC test report, ration card address proof, filled request form)
- Client satisfaction

Notes

RECORD MAINTENANCE & REPORTING

Notes

OBJECTIVES

- Discuss details about monitoring
- Discuss various types of indicators (impact indicators, outcome indicators, programme outputs)

DURATION OF THE SESSION: 1 ½ hours

Notes

MONITORING FRAMEWORK UNDER NACP-IV IMPACT INDICATORS

1. Reduction of new HIV infections (HIV Incidence): Estimated number of Annual New HIV Infections (HIV Incidence)
2. Reduction in mortality among people living with HIV/AIDS: Estimated number of annual AIDS-related deaths
3. Survival of AIDS patients on ART: Percentage of adults and children with HIV known to be on treatment at 24 months after initiation of antiretroviral therapy at select ART Centres

Notes

MONITORING FRAMEWORK UNDER NACP-IV

OUTCOME INDICATORS

Behavioural Change among Men who have Sex with Men
Percentage of men who have sex with men who report using a condom during sex with their last male partner (Target: 45% to 65% increase by 2017; 20% increase over the baseline of IBBS 2012-13)

PROGRAMME TARGETS

By 2017, NACP- IV will cover 9 lakh FSWs, 4.40 lakh MSMs including TG/Hijras and 1.62 lakh IDUs through Targeted Interventions

Notes

IMPORTANCE OF INFORMATION COLLECTION:

- **Achievement –** What has been achieved? How do we know that the project or event or an activity has caused the result?
- **Assessing progress –** Are the objectives being met?
- **Identifying strengths and weaknesses –** Where does the project need improvement and how can it be done or rectified? Are the original objectives still appropriate?
- **Checking effectiveness –** What difference has the project made? Can the impact be improved?
- **Sharing experiences –** Can the information help to prevent loopholes, mistakes or to encourage positive approaches

Notes

FLOW CHART OF THE MANAGEMENT INFORMATION SYSTEM FOR TIS

The Managing and information system must be consistent and integrated at all levels. The MIS system at the NGO/CBO level needs to be linked to the SACS and to the National MIS system. Linkages and consistency at all levels are critical to ensure the efficiency of data management and the usefulness of information for decision making and programme planning, including assessing the progress of TIs. The flow charted below depicts the data flow from NGOs/CBOs to SACS and to NACO:

Notes

NGO/CBO
- MIS forms/reporting formats are filled
- MIS forms edited for completeness and quality
- Information from MIS forms used for planning and monitoring by the ORW and Project Manager

Notes

State AIDS Control Societies
- Data syncronization
- Consolidation of MIS Reports from each District (monthly, quarterly, annual)
- Analyse the data for tracking program performance
- Data shared with NACO

Notes

National AIDS Control Organisation
- Consolidation of MIS Reports from each state (monthly, quarterly, annual)
- Analyse the data for tracking programme performance
- Feedback provided to each State

Notes

DATA COLLECTION AT THE TI LEVEL

Which form?	What are the contents?	Who does it?	How frequent?	Who is responsible?
Patient register format (Form F) including Abscess management format (FORM F_1)	On every day The doctor fills in for each HRG patient visiting the clinic. It contains basic details of the HRG patient illness and other clinic history. For each patient one form during every visit to the clinic	ANM/ Counselor	Weekly	Program Manager.

Notes

DATA COLLECTION AT THE TI LEVEL

Which form?	What are the contents?	Who does it?	How frequent?	Who is responsible?
Clinic Daily summary sheet (FORM FF)	During end of each clinic day. This register is a summary of the patient who has visited the clinic on a each day. The information from the filled in patient register format is transferred. It gives information at a glance on number of patients visited each clinic day and type of diagnosis and treatment provided.	ANM/ Counselor	Daily (on clinic days)	Doctor

Notes

DATA COLLECTION AT THE TI LEVEL

Which form?	What are the contents?	Who does it?	How frequent?	Who is responsible?
Medicine Stock register. (FORM G)	During end of each clinic day. The register is maintained at the clinic for tracking of medicines – received, issued and balance. medicines – received, issued and balance.	ANM/ Counselor	Weekly	Program Manager.

Notes

DATA COLLECTION AT THE TI LEVEL

Which form?	What are the contents?	Who does it?	How frequent?	Who is responsible?
Referral slip and Registers. (FORM H)	As and when a patient is referred to a referral center (ICTC, ART,TB /DOT), this register is filled in with the details. The slips are in triplicate. The referred details from the slip are noted in the referral register which will be useful for tracking of referrals made in a given period.	ANM/ Counselor	Weekly	Program Manager.

Notes

DATA COLLECTION AT THE TI LEVEL

Which form?	What are the contents?	Who does it?	How frequent?	Who is responsible?
Counseling Register. (FORM I)	After every counseling session conducted. The register gives information on type of counseling done, duration of counseling, pre-post counseling etc. Each row contains information on one counseling session.	ANM/ Counselor	Weekly	Program Manager.

Notes

FLOW OF DATA AND CHECKS AT THE TI LEVEL

- **Step 1:** All the HRGs will first meet Nurse (in absence of nurse, will meet counselor)
- **Step 2:**
  - **For new case and for repeat case**
  - ***For new case (first time visit to project clinic)***

    If the HRG is coming first time to the clinic, the ANM/Counsellor will create a new file with the patient register form filled in. The ANM/Counsellor checks for ID number – whether already by the ORW. Ensures that the HRG is project health card. The ANM/Counsellor fills in patient register form. After filling the patient register form, the nurse also fills in the medical register (maintained on daily basis for each HRG visiting the clinic which is like a day book) on the purpose of the visit and symptoms reported by the HRG. The ANM/Counsellor conducts pre counseling session and fills in the counseling register. After counseling, the HRG is sent to the doctor for further process.

Notes

FLOW OF DATA AND CHECKS AT THE TI LEVEL

- ***For Repeat Cases***
  - When a HRG visits the clinic (who is not first time visitor to the clinic), the nurse tracks the patient register form kept at the NGO/CBO through Health Card brought by the HRG. The ANM/Counsellor notes down the purpose of the visit and symptoms as reported by the HRG in the medical register. The ANM conducts pre counseling session and fills in the counseling register. After counseling, the HRG is sent to the doctor for further process

- **Step 3:** The doctor after examining the patient and treatment given/recommended, fills in the patient register form (the requisite information to be filled in by the doctor) and send the HRG and the file back to the ANM for further process

Notes

FLOW OF DATA AND CHECKS AT THE TI LEVEL

Step 4: ANM enters the information in the medical register on the diagnosis made and medicines prescribed by the doctor. She also gives medicines to the HRG as per prescription.

Step 5: ANM at the end of each clinic day, compares the number of visits made to the clinic from medical register with the drug register and referral registers and ensures all the entries made are correct and complete. This is also checked by the doctor by signing at the end of the each clinic day on all the entries made are complete and correct by signing/initialing.

Step 6: ANM also tallies the drug stock register on the issues made during the day and balance at the end of each clinic day. (Each medicine should have a buffer stock of medicine, which will vary from medicine to medicine and from TI to TI).

Notes

FLOW OF DATA AND CHECKS AT THE TI LEVEL

- **Step 7:** The ANM prior to any weekly/monthly meetings will compile information on the
  - Number of individuals visited clinics
  - Type of visit made for general ailment, for STI treatment
  - Number of referral made etc
  - Number of HRGs followed up for ICTC and STI
- **Step 8:** The ANM after sharing the clinic information in the weekly meeting hands over the clinic reporting form to MIS officer for entering into the CMIS on weekly basis

Notes

MYTHS, MISCONCEPTIONS & FAQs

Notes

OBJECTIVES

- Discuss common myths and misconceptions
- Summarise some concepts about identity in India
- Address some of the frequently asked questions

DURATION OF THE SESSION: 1 ½ hours

Notes

EXERCISE 7

Duration: 15 minutes

Objectives

- Summarise some concepts about identity in India

Requirements

- Sheets with questions
- Responses to the questions

Notes

EXERCISE 7 (contd.)

Instructions

- The participants will work in three groups
- Each group has to prepare a response to the question
- Each group will have one leader
- The leader will describe the response with the rest of the participants
- The facilitator will help in addressing the questions
- The questions and the responses are in the next few pages
- The facilitator should remember that the responses are just a guide. The participants can also use their own examples for some of these questions

Notes

Question 1

ARE THE SEXUAL & GENDER IDENTITIES STATIC?

Question 2

ARE ALL HIJRAS INTERSEXED INDIVIDUALS?

Question 3

ARE ALL HIJRAS CASTRATED?

Notes

RESPONSE 1:

Answer: **NO**

EXPLANATION:

- ***These identities are not static.***
- ***Some of the identities may be fluid and people may assume different identities over different points in time***
- ***Sometimes they may also have different identities during the same period depending on the context***
  - For instance, someone may identify himself as a *kothi* and may not socialise with *Hijras*
  - However, later the same person may start identifying as *Hijra.* This identity may be that of an Akwa Hijra
  - Someone may remain an Akwa Hijra for a long period of time
  - Some others may go ahead with process of sex reassignment or *Nirwaan* and be identified as *Nirwaan Hijra*
  - It is quite likely that some of these may call themselves as trans-woman

Notes

RESPONSE 1: (contd.)

- It is also likely when they are in the process of sex reassignment, they may also identify as 'Transitioning'
- In another instance, an individual may identify as a *kothi*
- However, the same person may identify as ***gay*** or **queer** in other situations
- The same person will use the identity 'top' or 'bottom' if he is with other gay men

Notes

RESPONSE 1: (contd.)

- Thus, it is not that all identities are separate water-tight and static compartments
- They may change over time
- People may have multiple identities at the same time as well
- As health care providers, we should just use the identity that has been told to us by the individual
- Also do not presume the sexual behaviour according to the identity. Ask about different types of sexual behaviours to all individuals who access health care
- Be sensitive while asking different sexual behaviours – if you find that some people are getting offended while answering questions about sexual acts, do not persist. Let them take their time to open up about their behaviours with you

Notes

RESPONSE 2:

Answer: **NO**
EXPLANATION:

- As discussed earlier Hijras/Kinnars are a social and culturally different group of male-to-female transgendered people
- Thus, they are biological males who start identifying as 'women', not-men and form their own social groups
- They cross-dress; move in female attire with a portrayal of a female gender. They may call themselves Hijras
- Many of them do not live with their biological families and stay with the 'hijra gharanas'. These are usually headed by a Guru. They become Chelas or Shishyas of this Guru
- Thus, they often live in parallel social structure
- They may or may not have removed their male external genitalia

Notes

RESPONSE 2: (contd.)

- Some reports have stated that there are about 10 lakh members of the Hijra community in India
- Intersexed individuals are born with external genitalia or reproductive organs/sexual anatomy and/or chromosomes that do not correspond with any specific definition of a male or female.
- There may be ambiguous genitals, both types of differences in the internal and external organs.
- These features may be apparent at birth or later in life
- Intersexed people may not identify with the Hijra culture
- There have been conflicting reports of prevalence of intersex – 0.018% to 1.7%

Notes

RESPONSE 3:

Answer: **NO**
EXPLANATION:

- As discussed earlier Hijras/Kinnars are a social and culturally different group of male-to-female transgendered people
- Thus, they are biological males who start identifying as 'women', not-men and form their own social groups
- They cross-dress; move in female attire with a portrayal of a female gender. They may call themselves Hijras
- Some Hijras may not have removed their external male organs (penis and scrotum). They are called Akwa Hijras
- Some of them may have undergone breast augmentation procedures and yet have male external organs. They may be transitioning as well
- Some Hijras may remove their male external organs by the ritual procedure or through a surgical procedure. They are Nirwaan Hijras

Notes

1) Why are some people transgender?

Answer: There is no simple or unitary explanation for why some people are transgender. Researchers and Experts have suggested biological factors (genetic influences), prenatal hormones, fluctuations or imbalances in hormones as some potential factors. Others have suggested there is a link between transgender identity and brain structure. Still others have suggested the role of psychological factors in the existence of transgender people. Many trans people may feel that their gender identity has always been a part of them.
Finally, some individuals feel that everyone has a right to choose their gender presentation.

2) Have transgender people always existed?

Answer: Transgender people have been documented in Eastern and Western cultures, and many indigenous cultures. The meaning of gender non-conformity may vary from culture to culture.

Notes

3) Is being transgender a mental disorder?
Answer: **NO.**
Transgender identity is not a mental illness that can be cured with treatment
Many transgender people may not experience any distress – thus just identifying transgender people does not constitute a mental disorder.
However, as discussed earlier many transgender people may face discrimination at home, school, or in the communities. They may sometimes be lonely. This may, sometimes, cause anxiety, depression, or other psychological problems. Thus, it is important to understand that these may be due to society's intolerance rather their own gender identity.

4) How many transgender people are there?
Answer: It may be difficult to get exact estimates of transgender people in the community. Some size estimation studies have been conducted in India. They reported that the size estimate of the TG population was 62,137 across various states of India. However, it should be noted that no population studies that accurately describe gender identity and gender expression.

Notes

5) How should I address them? Which pronoun should I use?

Answer: Use the name and pronoun that the transgender person uses. Do not insist on getting the male name/correct name. Also, do not change pronouns during the conversation to masculine gender.
If you are in doubt, ask politely.

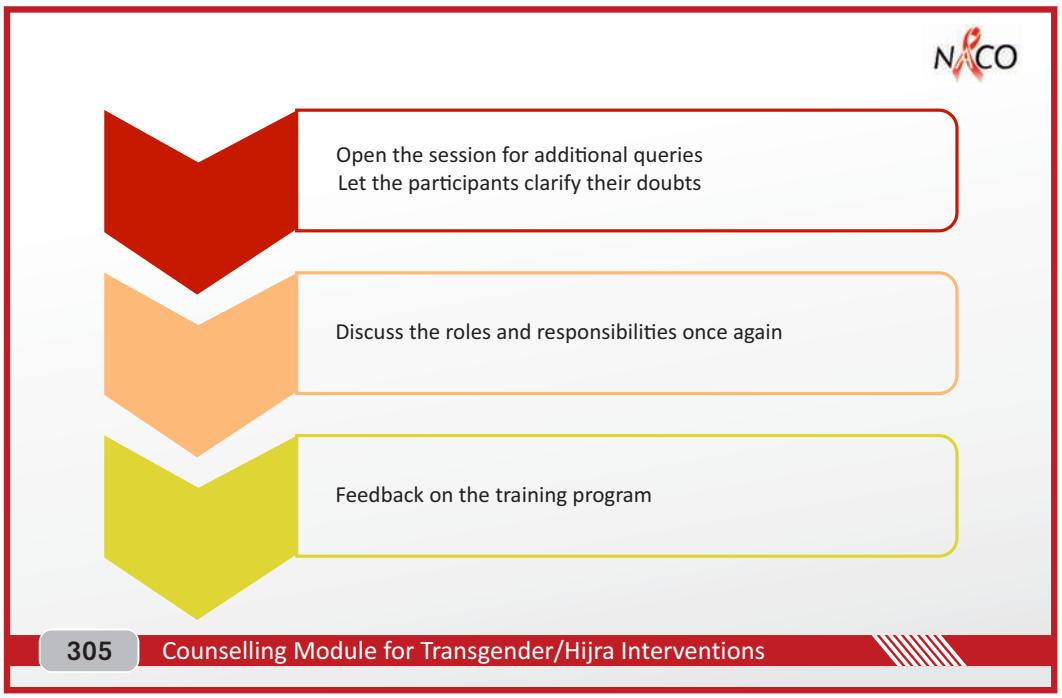
6) How can I be supportive of transgender people?

Answer: Educate yourself about transgender issues.
Be aware of your attitudes and biases. Try to address them.
Do not make assumptions about sexual orientation of transgender people.
Familiarise yourself with some support systems available for transgender people in your area.

Notes

QUERIES & FEEDBACK

Notes


Open the session for additional queries
Let the participants clarify their doubts
Discuss the roles and responsibilities once again
Feedback on the training program
305
Counselling Module for Transgender/Hijra Interventions

Notes


Thank You
306
Counselling Module for Transgender/Hijra Interventions

Notes

National AIDS Control Organization

6th Floor, Chandralok Building, 36 Janpath, New Delhi - 110001

Tele : 011 - 23325331, Fax : 011 - 43509935