Identity, Gender and Sexuality

Pehchan Training Curriculum
MSM, Transgender and Hijra Community Systems Strengthening

Facilitator Guide
Identity, Gender and Sexuality
Pehchan Consortium Partners

India HIV/AIDS Alliance (www.allianceindia.org)

Pehchan Focus: National coordination and grant oversight

Based in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national program, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations most vulnerable to HIV, including men who have sex with men (MSM), transgenders, hijras, people who use drugs (PWUD), sex workers, youth, and people living with HIV (PLHIV).

Alliance India Andhra Pradesh

Pehchan Focus: Andhra Pradesh

Alliance India supports a regional office in Hyderabad that leads implementation of Pehchan in Andhra Pradesh and serves as a State Lead Partner of the Bill & Melinda Gates Foundation.

The Humsafar Trust (www.humsafar.org)

Pehchan Focus: Maharashtra, Madhya Pradesh, Goa, Gujarat and Rajasthan

For nearly two decades, Humsafar Trust has worked with MSM and transgender communities in Mumbai, Maharashtra. It has successfully linked community advocacy and support activities to the development of effective HIV prevention and health services. It is one of the pioneers among MSM and transgender organisations in India and serves as the national secretariat of the Indian Network for Sexual Minorities (INFOSEM).

Pehchan North Region Office

Pehchan Focus: Punjab, Delhi, Uttar Pradesh and Bihar

Alliance India supports a regional implementing office based in Delhi that leads implementation of Pehchan in four states of North India.

Solidarity and Action Against The HIV Infection in India (SAATHII) (www.saathii.org)

Pehchan Focus: West Bengal, Manipur, Orissa and Jharkhand

With offices in five states and over 10 years of experience, SAATHII works with sexual minorities for HIV prevention. SAATHII works closely with the West Bengal's State AIDS Control Society (SACS) and the State Technical Support Unit and is the SACS-designated State Training and Resource Centre for MSM, transgender and hijra.

South India AIDS Action Programme (SIAAP) (www.siaapindia.org)

Pehchan Focus: Tamil Nadu

SIAAP brings more than 22 years of experience with community-driven and community development focussed programmes, counselling, advocacy for progressive policies, and training to address HIV and wider vulnerability issues for MSM, transgender and hijra community.

Sangama (www.sangama.org)

Pehchan Focus: Karnataka and Kerala

For more than 20 years, Sangama has been assisting MSM, transgender and hijra communities to live their lives with self-acceptance, self-respect and dignity. Sangama lobbies for changes in existing laws that discriminate against sexual minorities and for changing public opinion in their favour.
Contents

About this Module ........................................................................................................................................................ 2
About Pehchan ............................................................................................................................................................ 2
Training Curriculum Overview .............................................................................................................................. 2
Preface ........................................................................................................................................................................ 3
General Acknowledgements ................................................................................................................................ 5
Module Acknowledgments: Identity, Gender and Sexuality ................................................................................ 7
About the Identity, Gender and Sexuality Module ................................................................................ 9
  Module Reference Materials ................................................................................................................................. 9
Activity Index ................................................................................................................................................................ 10
  Activity 1: Introduction to Identity, Gender and Sexuality Module ....................................................................... 11
  Activity 2: Introduction to Identity ................................................................................................................... 12
  Activity 3: Sex, Sexuality and Gender Terminology ..................................................................................... 14
  Activity 4: Understanding Gender and Sexual Identity Formation .................................................................. 19
  Activity 5: Stigma, Discrimination and Homophobia .................................................................................... 22
  Activity 6: Psychological Issues Related to Identity, Gender and Sexuality ................................................... 28
  Activity 7: Wrap-up ................................................................................................................................................. 30
Annexure 1: Notes on Identity, Gender and Sexuality ................................................................................. 31
About this Module

This module is designed to help training participants: 1) gain a broad understanding of language and concepts relating to identity, gender and sexuality; 2) understand differences in gender, sex and sexuality; and 3) become familiar with the experience of stigma and discrimination in the lives of men who have sex with men (MSM), transgenders and hijras. In the Pehchan programme, this module is used to introduce principles of identity, gender and sexuality to CBO Programme Managers, Programme Officers, Counsellors, and Outreach Workers.

About Pehchan

With financial support from the Global Fund, Pehchan is building the capacity of 200 community-based organisations (CBOs) for men who have sex with men (MSM), transgenders and hijras in 17 states in India to be more effective partners in the government’s HIV prevention programme. By supporting the development of strong CBOs, Pehchan addresses some of the capacity gaps that have often prevented CBOs from receiving government funding for much-needed HIV programming. Named Pehchan, which in Hindi means ‘identity’, ‘recognition’ or ‘acknowledgement,’ this programme will reach 453,750 MSM, transgenders and hijras by 2015. It is the Global Fund’s largest single-country grant to date, focused on the HIV response for vulnerable sexual minorities.

Training Curriculum Overview

In order to stimulate the development of strong and effective CBOs for MSM, transgender and hijra communities and to increase their impact in HIV prevention efforts, responsive and comprehensive capacity building is required. To build CBO capacity, Pehchan developed a robust training programme through a process of engagement with community leaders, trainers, technical experts, and academicians in a series of consultations that identified training priorities. Based on these priorities, smaller subgroups then developed specific thematic components for each curricular module.

Inputs from community consultations helped increase relevance and value of training modules. By engaging MSM, transgender and hijra (MTH) communities in the development process, there has been greater ownership of training and of the overall programme among supported CBOs. Technical experts worked on the development of thematic components for priority areas identified by community representatives. The process also helped fine-tune the overall training model and scale-up strategy. Thus, through a consultative, community-based process, Pehchan developed a training model responsive to the specific needs of the programme and reflecting key priorities and capacity gaps of MSM, transgender and hijra CBOs in India.
Preface

As I put pen to paper, a shiver goes down my spine. It is hard to believe that this day has come after almost five long years! For many of us, Pehchan is not merely a programme; it is a way of life. Facing a growing HIV epidemic among men who have sex with men (MSM), transgender, and hijra communities in India, a group of development and health activists began to push for a large-scale project for these populations that would be responsive to their specific needs and would show this country and the world that these interventions are not only urgently needed but feasible.

Pehchan was finally launched in 2010 after more than two years of planning and negotiation. As the programme has evolved, it has never stepped back from its core principle: Pehchan is by, for and of India’s MSM, transgender and hijra communities. Leveraging rich community expertise, the Global Fund’s generous support and our government’s unwavering collaboration, Pehchan has been meticulously planned and passionately executed. More than just the sum of good intentions, it has thrived due to hard work, excellent stakeholder support, and creative execution.

At the heart of Pehchan are community systems strengthening. Our approach to capacity building has been engineered to maximise community leadership and expertise. The community drives and energises Pehchan. Our task was to develop 200 strong community-based organisations (CBOs) in a vast and complex country to partner with state governments and provide services to MSM, transgender and hijra communities to increase the effectiveness of the HIV response for these populations and improve their health and wellbeing. To achieve necessary scale and sustain social change, strong CBOs would require responsive development of human capital.

Over and above consistent services throughout Pehchan, we wanted to ensure quality. To achieve this, we proposed a standard training package for all CBO staff. When we looked around, we found there really wasn’t an existing curriculum that we could use. Consequently, we decided to develop one not only for Pehchan but also for future efforts to build the capacity of community systems for sexual minorities. So began our journey to create this curriculum.

Building on the experience of Sashakt, a pilot programme supported by UNDP that tested the model that we’re scaling up in Pehchan, an involved process of consultations and workshops was undertaken. Ideas for each module came from discussions with a range of stakeholders from across India, including community leaders, activists, academics and institutional representatives from government and donors. The list of modules grew with each consultation. For example in Sashakt, we had a single training module on family support and mental health; in Pehchan, we decided that it would be valuable to split these and have one on each.

Eventually, we agreed on the framework for the modules and the thematic components, finding a balance between individual and organisational capacity. Overall, there are two main areas of capacity building: one that is directly related to the services and the other that is focused on building capable service providers. Then we began the actual writing of the curriculum, a process of drafting, commenting, correcting, tweaking and finalising that took over eight months.
Once the curriculum was ready to use, trainings-of-trainers were organised to develop a cadre of master trainers who would work directly with CBO staff. Working through Pehchan’s four Regional Training Centers, these trainers, mostly members of MSM, transgender and hijra communities, provided further in-service revisions and suggestions to the modules to make them succinct, clear and user-friendly. Our consortium partner SAATHII contributed particularly to these efforts, and the current training curriculum reflects their hard work.

In fact, the contributors to this work are many, and in the Acknowledgements section following this Preface, we have done our best to name them. They include staff from all our consortium partners, technical experts, advocates, donor representatives and government colleagues. The staff at India HIV/AIDS Alliance, notably the Pehchan team, worked beautifully to develop both process and content. That we have come so far is also a tribute to vision and support of our leaders, at Alliance India and in our consortium partners, Humsafar Trust, SAATHII, Sangama, and SIAAP, as well as in India’s National AIDS Control Organisation and at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva.

We would like to think of the Pehchan Training Curriculum as a game changer. While the modules reflect the specific context of India, we are confident that they will be useful to governments, civil society organisations and individuals around the world interested in developing community systems to support improved HIV and other health programming for sexual minorities and other vulnerable communities as well.

After two years of trial and testing, we now share this curriculum with the world. Our team members and master trainers have helped us refine them, and seeing the growth of the staff in the CBOs we have trained has increased our confidence in the value of this curriculum. The impact of these efforts is becoming apparent. As CBOs have been strengthened through Pehchan, we are already seeing MSM, transgender and hijra communities more empowered to take charge, not only to improve HIV prevention but also to lead more productive and healthy lives.

**Sonal Mehta**
Director: Policy & Programmes
India HIV/AIDS Alliance
New Delhi
March 2013
General Acknowledgements

The Pehchan Training Curriculum is the work of many people, including community members, technical experts and programme implementers. When we were not able to find training materials necessary to establish, support and monitor strong community-based organisations for MSM, transgenders and hijras in India, the Pehchan consortium collectively developed a curriculum designed to address these challenges through a series of community consultations and development workshops. This process drew on the best ideas of the communities and helped develop a responsive curriculum that will help sustain strong CBOs as key element of Pehchan.

We would like to take this opportunity to acknowledge the contributions of those who helped in taking this process forward, including (in alphabetical order): Ajai, Praxis; Usha Andewar, The Humsafar Trust; Sarita Barapanda, IWW-UK; Jhuma Basak, Consultant; Dr. V. Chakrapani, C-Sharp; Umesh Chawla, UNDP; Alpana Dange, Consultant; Brinelle D’Sourza, TISS; Firoz, Love Life Society; Prashanth G, Maan AIDS Foundation; Urmij Jadav, The Humsafar Trust; Jeeva, TRA; Harleen Kaur, Manas Foundation; Krishna, Suraksha; Monica Kumar, Manas Foundation; Muthu Kumar, Lotus Sangama; Sameer Kunta, Avahan; Achniva Lahiri, PLUS; Meera Limaya, Consultant; Veronica Magar, REACH; Magdalene, Center for Counselling; Sylvester Merchant, Lakshya; Amrita Nanda, Lawyers’ Collective; Nilanjana, SAFRG; Prabhakar, SIAAP; Priti Prabhughate, ICRW; Nagendra Prasad, Ashodaya Samithi; Revathi, Consultant; Rex, KHPT; Amitava Sarkar, SAATHII; Dr. Maninder Setia, Consultant; Chetan Sharma, SAFRG; Suneeeta Singh, Amaltas; Prabhakar Sinha, Heroes Project; Sreeram, Ashodaya Samithi; Suresh, KHPT; Sanjhanthi Veul, JHU; and Roy Wadia, Heroes Project.

Once curricular framework was finalised, a group of technical and community experts was formed to develop manuscripts and solicit additional inputs from community leaders. The curriculum was then standardised with support from Dr. E.M. Sreejit and streamlined with support from a team at SAATHI, led by Pawan Dhall. This process included inputs from Sudha Jha, Anupam Hazra, Somen Acharya, Shantanu Pyne, Moyazzam Hossain, Amitava Sarkar, and Debjyoti Ghosh Dhall from SAATHII; Cairo Araijo, Vaibhav Saria, Dr. E.M. Sreejit, Jhuma Basak, and Vahista Dastoor, Consultants; Olga Aaron from SIAAP; and Harjyot Khosa and Chaitanya Bhatt from India HIV/AIDS Alliance.

From the start, the Government of India’s National AIDS Control Organisation has been a key partner of Pehchan. In particular, Madam Aradhana Johri, Additional Secretary, NACO, has provided strong leadership and steady guidance to our work. The team from NACO’s Targeted Intervention (TI) Division has been a constant friend and resource to Pehchan, notably Dr. Neeraj Dhingra, Deputy Director General (TI); Manilal N. Raghvan, Programme Officer (TI); and Mridu, Technical Officer (TI). As the programme has moved from concept to scale-up, Pehchan has repeatedly benefitted from the encouragement and wisdom of NACO Directors General, past and present, including Madam Sujata Rao, Shri K. Chandramouli, Shri Sayan Chatterjee, and Shri Lov Verma.

Pehchan is implemented by a consortium of committed organisations that bring passion, experience, and vision to this work. The programme’s partners have been actively engaged in developing the training curriculum. We are grateful for the many contributions of Anupam Hazra and Pawan Dhall from SAATHII; Hemangi, Pallav Patnaik, Vivek Anand and Ashok Row Kavi from the Humsafar Trust; Olga Aaron and Indumati from SIAAP; Vijay Nair from Alliance India Andhra Pradesh; and Manohar from Sangama. Each contributed above and beyond the call of duty, helping to create a vibrant training programme while scaling up the programme across 17 states.
India HIV/AIDS Alliance’s Pehchan team has been untiring in its contributions to this curriculum, including Abhina Aher, Jonathan Ripley, Yadvendra (Rahul) Singh, Simran Shaikh, Yashwinder Singh, Rohit Sarkar, Chaitanya Bhatt, Nunthuk Vunghoihkim, Ramesh Tiwari, Sarbeshwar Patnaik, Ankita Bhalla, Dr. Ravi Kanth, Sophia Lonappan, Rajan Mani, Shaleen Rakesh, and James Robertson. A special thank-you to Sonal Mehta and Harjyot Khosa for their hard work, patience and persistence in bringing this curriculum to life.

Through it all, the Global Fund to Fight AIDS, Tuberculosis and Malaria has provided us both funding and guidance, setting clear standards and giving us enough flexibility to ensure the programme’s successful evolution and growth. We are deeply grateful for this support.

Pehchan’s Training Curriculum is the result of more than two years of work by many stakeholders. If any names have been omitted, please accept our apologies. We are grateful to all who have helped us reach this milestone.

The Pehchan Training Curriculum is dedicated to MSM, transgender and hijra communities in India who for years, have been true examples of strength and leadership by affirming their pehcha-n.
Module Acknowledgments: Identity, Gender and Sexuality

Each component of the Pehchan Training Curriculum has a number of contributors who have provided specific inputs. For this component, the following are acknowledged:

**Primary Author**
Dr. Maninder Singh Setia, Consultant

**Compilation**
Dr. E. M. Sreejit, Consultant

**Technical Input**
Vaibhav Sarai, Consultant; Olga Aaron, SIAAP; and Debiyoti Ghosh, SAATHII

**Coordination and Development**
Vahista Dastoor, C4D Consultant
Pawan Dhall, SAATHII

**References**
About the Identity, Gender and Sexuality Module

<table>
<thead>
<tr>
<th>No.</th>
<th>C1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Identity, Gender and Sexuality</td>
</tr>
</tbody>
</table>
| Pehchan Trainees | • Project Officers  
• Counsellors  
• Outreach Workers |
| Pehchan CBO Type | Pre-TI, Ti Plus |
| Training Objectives | By the end of this module, the participants will:  
• Gain a broad understanding of terms such as ‘identity’, ‘sexuality’ and ‘gender’ and how they are related to issues of stigma and discrimination;  
• Develop an understanding of different types of sexual identities;  
• Understand the limitations and challenges in defining ‘identity’;  
• Develop an understanding of stigma and discrimination from an MTH perspective; and  
• Be able to develop strategies to deal with stigma and discrimination. |
| Total Duration | One day. A day’s training typically covers 8 hours. |

Module Reference Materials

All the reference material required to facilitate this module has been provided in this document and in relevant digital files provided with the Pehchan Training Curriculum. Please familiarise yourself with the content before the training session.

Attention: Please do not change the names of file or folders, or move files from one folder to another, as some of the files are linked to each other. If you rename files or change their location on your computer, the hyperlinks to these documents in the Facilitator Guide will not work correctly.

If you are reading this module on a computer screen, you can click the hyperlinks to open files. If you are reading a printed copy of this module, the following list will help you locate the files you need.

| Audio-visual Support | Short-film titled ‘Identity, Gender and Sexuality Case Series’. |
| Annexures | Annexure 1 titled ‘Notes on Identity, Gender and Sexuality’. |
## Activity Index

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity Name</th>
<th>Time</th>
<th>Material¹</th>
<th>Audio-visual Resources</th>
<th>Take-home material</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction to Identity, Gender and Sexuality Module</td>
<td>10 minutes</td>
<td>N/A</td>
<td>Short-film: ‘Identity, Gender and Sexuality Case Series’</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Introduction to Identity</td>
<td>40 minutes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>Sex, Sexuality and Gender Terminology</td>
<td>1 hour</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Understanding Gender and Sexual Identity Formation</td>
<td>1 hour 30 minutes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>Stigma, Discrimination and Homophobia</td>
<td>1 hour 30 minutes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>Psycho-social Issues</td>
<td>45 minutes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>Wrap-up</td>
<td>30 minutes</td>
<td>N/A</td>
<td>N/A</td>
<td>Annexure 1 on ‘Notes on Identity, Gender and Sexuality’</td>
</tr>
</tbody>
</table>

¹ Overhead projector, laptop, sound system and whiteboard should be provided at every training.
Activity 1: Introduction to Identity, Gender and Sexuality Module

<table>
<thead>
<tr>
<th>Time</th>
<th>10 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Be able to articulate the objectives of this training module.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>Short-film titled ‘Identity, Gender and Sexuality Case Series’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Welcome the participants and then screen the short-film titled ‘Identity, Gender and Sexuality Case Series’. After the film ends, initiate an interactive discussion to set the tone for the rest of the day. You could ask some of the following questions (add any questions of your own) to set the ball rolling:

• How do we define ourselves? Why are these definitions important to us?
• How do we talk about our sexual desire?
• Why do we sometimes keep our desires a secret? Why are we scared to disclose them?
• Why does disclosure sometimes result in violence of different kinds, such as emotional/social/economical/political?

List keywords from the participants’ responses on the board, circling those that you feel will be relevant to discussions that will happen later in the day.

Wrap-up the activity by introducing participants to the objectives of this training module, and relate the objectives to the earlier discussion. Explain that the day’s training will cover the following topics:

• What is identity and how is it formed?
• The various sexual identities and gender-related identities that people adopt.
• How certain sexual and gender identities are linked to stigma and discrimination.
• Strategies to deal with stigma and discrimination.
Activity 2: Introduction to Identity

**Time**  
40 minutes

**Learning Outcomes**  
By the end of this activity, participants will:

- Be able to define the term ‘identity’ and understand some of its characteristics.

**Materials**  
Few sheets of paper and pen.

**Audio-visual Support**  
N/A

**Take-home Material**  
N/A

**Methodology**

Ask for (or select randomly) two volunteers for this exercise and give each of them a sheet of paper and a pen. Tell each volunteer to imagine that s/he is meeting a stranger who asks the question, ‘Who are you?’ Each volunteer should write at least ten words (or phrases) that best describe his/her identity.

After five minutes, ask them to read through the list, rearranging the words (or phrases) in a descending order, with the word that they feel best describes their identity coming at the top and the one that is less fitting than the first coming after, and so on.

Ask two other participants to come forward and read the lists made by the first two volunteers’ to the rest of the group. Write the lists down on a flip-chart and discuss with the group why the volunteers have chosen those words to describe themselves.

Ask the rest of the participants the following questions and list their responses on a flip-chart:

- How many of you would:
  - Describe yourselves in the way the volunteers described themselves?
  - Have had descriptions similar to those of the volunteers?
  - Matched all the 10 descriptions listed on the chart paper?
  - What words have you used to describe yourself that were not included in the list?

Initiate a discussion on the concept of identity based on the responses elicited during the above exercise. Explain how through the examples provided by some of the participants one could understand that:

- There are multiple forms of identity, based on race, religion, ethnicity, nationality, sex, sexual orientation, gender, occupation, personal relation, etc.;
- One person can have more than one of these different identities. Also, a person may consider one identity to be more important than another; and
- Identities may change with time or place, and it is important to know that identity is situational and temporal.
- Multiple identities can evoke different responses from the same person to a question, depending on what identity the person has adopted when she/he is asked the question. For instance, a man can have several roles, such as that of a son, lover, husband, worker, and so on. Depending on what role he is playing, his answer to the same question might vary from role to role. Also, when two people playing a similar role are asked the same question, they might very similar answers. For example, a corporate executive and a homemaker at a parent-teacher meeting may both respond to a question in a similar manner, i.e. in the capacity of a parent.
• A man who is comfortable identifying himself as a homosexual in a group of similar friends may not declare his sexual identity at his workplace, where his identity as a productive employee may be more important. This shows that identity is situational and has an impact on a person’s day-to-day life.
• It is important to understand that identity is a matter of choice and presentation. For instance, if a person wears a women’s attire, it might be because he wants to portray himself as a woman. However, a person in a man’s attire might present himself as a woman in all other respects, and consider himself to be transgender (TG); it is the person’s choice to represent herself/himself the way she/he wants.

Using the whiteboard, explain any one of the popular definitions of the term ‘identity’ as described below. (Select only one definition to avoid confusing the participants. Use the one that you feel will best help you set the tone for the rest of the day’s discussions).

• The quality or condition of being the same in substance, composition, nature, properties, or in particular qualities under consideration, or absolute or essential sameness or oneness. (The Oxford Dictionary, 2010)
• 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. (Erikson, 1968)
• [Identity is a] place an individual holds in the society and the various roles played. For example, the same person can be a manager at the workplace, a father at home, a son at his parents’ home. (Mead, 1934)
• For example, people may identify themselves as belonging to a particular organisation/club/city/country, etc. (Deaux, 2000)

Summarise the key learnings of the session that outreach workers (ORWs), counsellors and advocacy officers need to be sensitive to when working with MSM, transgenders, and hijras (MTH):

• Identity is not always constant; it might change with factors such as time, roles, social milieu, geographic location, and phase in life.
• Identity is a matter of choice. Sometimes, however, it may be forced and the person then internalises it over a period of time.
• While dealing with outreach clients, try to understand more about their identity: how they would like to identify themselves? Even if they seem to be MSM, there may other identities that they would want to be identified with.
• Identities are often exclusive; moreover, each individual may have multiple identities. An interaction of these identities may lead to complex life situations. This should be borne in mind while counselling individuals.
• Do not try to impose your identity on an individual while dealing with him/her in the field.
• Recognise that although there is one main identity assumed by a person at any given point, it may clash with other roles and responsibilities of the person.
• Understanding a person’s predominant identity will help ORW to understand various issues related to that individual in the field. For example, an individual may be more concerned about his relationship with his parents rather than his sexuality, or he may be more concerned about his work status rather than safe sex practices.
Activity 3: Sex, Sexuality and Gender Terminology

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Know how sex, sexuality and gender create identities and how these identities often overlap and contradict each other; and</td>
</tr>
<tr>
<td></td>
<td>• Identify local and regional variations of sexual and gender identities and learn how labeling these identities can be limiting and can complicate the definition of ‘identity’.</td>
</tr>
</tbody>
</table>

| Materials | N/A |
| Audio-visual Support | N/A |
| Take-home Material | N/A |

Methodology

Part I: Sexuality and Sexual Orientation

Begin by asking the participants the following: what you understand by sex? Or, what is sex?

After the participants answer, follow it by describing it as ‘an individual’s anatomical or biological characteristics that help in classifying people (male, female, transgender, intersex, etc.)’.

Introduce the term ‘sexuality’. Explain that:

- It is a broader term than sex and includes components such as anatomy, identity, and behavior.
- The expression of sexuality is also influenced by one’s sexual orientation and sexual desires.
- It also includes other components such as the gender identity that society assigns or thrusts upon us by expecting males to act masculine, and females to act feminine.
- Sexuality also includes the social roles that one finds oneself playing; this may refer to one’s familial obligations, parental obligations, or desire to be a parent.

Note to Facilitator

First, present the terms relating to sex, sexuality and sexual orientation. Keep in mind that some of these terms will have more relevance meaning for some participants than others. Then explain the terms ‘gender’ and ‘gender identity’.

Then, introduce the terms that qualify or surround the various sexual and gender identity terminologies. Emphasise that a person can have more than one gender and/or sexual identity, and they might seem to contradict each other. For example, a person can be a hijra, a transgender person or an MSM and might also be married to a woman and have children.

This is a limitation of identity categories; no single identity can completely encompass one’s entire history, desire, or life.

It is important for the participants to realise that since identities can be fluid, they can change over a person’s lifetime and, because there are several other influences (such as familial, economic, and social), a person might be forced to accept certain identities as well.

These limitations of identity make our work more complex because we need to avoid fixed assumptions about any identity.
Sexual orientation, as mentioned above, is one of the expressions for the term ‘sexuality’. It includes romantic or erotic affection/atraction towards another person. It could be towards a person of the opposite sex or gender, the same sex or gender, or to both sexes or more than one gender.

**Sexual Orientation: Homosexuality, Heterosexuality, and Bisexuality**

- When people express love, affection, and eroticism towards others of the same (biological) sex. Such individuals are referred to as homosexuals. There are both male homosexuals and female homosexuals. Male and female homosexuals are described by different terms to indicate their homosexuality (e.g. ‘gay’ for males and ‘lesbian’ for females).
- When people express love, affection, and eroticism towards the opposite sex. Such individuals are referred to as heterosexuals.
- When people express love, affection, and eroticism towards both sexes, such individuals are referred to as bisexuals. They may also have a steady partner of either sex.

### Part II: Gender

Explore the different aspects of ‘Gender’. Describe the term as below:

- Gender is an individual’s social/ legal/personal status. We use terms such as man/woman and masculine/feminine to describe these aspects.
- Gender identity is the sense of being a man or a 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.
- When gender identity is expressed externally in the social sphere, it becomes a ‘gender expression’.
- Gender roles are shared expectations that apply to individuals on the basis of their socially identified sex. A person’s gender role also signifies the way in which she/he behaves or appears in the social space. This may vary in different cultural settings. This perception is according to the expectations of the society in that particular setting.

### Part III: Gender and Sexual Identities

This section will introduce the participants to some sexual and gender identities.

**Men who have sex with men (MSM)**

Referred to as MSM, this is an umbrella term to include all men who have sex with other men irrespective of their sexual identity. This definition is based on behaviour.

This term was coined by public health professionals in the 1990s to understand transmission of HIV and other sexually transmitted infections (STIs) among men who have sex with men, regardless of identity.

So it is important to understand that a man who self-identifies as gay or bisexual may not only be sexually active with men, and a man who self-identifies as heterosexual or ‘straight’ may be sexually active with men and/or transgenders as well as women. ‘MSM’ is sometimes used as an identity category for homosexual or gay men, even though it was developed as a term to describe behaviour.

To summarise, the term ‘MSM’ is used to describe men who have sex with other men regardless of how they identify themselves. Though the term ‘gay’ is often used in to describe such men, ‘gay’ is more seen as reflecting a social or cultural identity. In certain areas of India, such as in Manipur, terms such as ‘B-MSM’ and ‘A-MSM’ are used.

**Note to Facilitator**

Please note that the terms given in this activity are just starting points for discussion. Ask participants to create their own list with terms from the region/state they belong to and ask them the differences between each term so that they realise the limitations of thinking of an identity in a fixed, concrete way.
(signifying receptive and penetrative sexual partners, respectively). Some kothis (see below) or gay-identified men may also identify themselves as MSM.

Transgender
Sometimes shortened to ‘TG’, the word ‘transgender’ is used to describe those who transgress social gender norms. It is often used as an umbrella term to mean those who defy binary gender constructions and those who break or blur culturally prevalent or stereotypical gender roles.

TG persons often live, for all or part of their lives, in a gender role opposite to the one they were assigned at birth. In contemporary usage, TG has become an umbrella term used to describe a wide range of identities and experiences, including but not limited to pre-operative, post-operative and non-operative transsexual people, and male or female cross-dressers (sometimes referred to as ‘transvestites’, ‘drag queens’ or ‘drag king’). A male-to-female TG is referred to as ‘a transgender woman’ and a female-to-male TG is referred to as ‘a transgender man’.

Transsexual
These are people whose gender identity is that of the opposite biological sex. There are male-to-female and female-to-male transsexuals. A transsexual may or may not have had sex reassignment surgery and thus could be ‘pre-operative’ transsexual, ‘post-operative’ transsexual and ‘non-operative’ transsexual. (A male-to-female transsexual person is referred to as ‘a transsexual woman’ and a female-to-male transsexual person is referred to as ‘a transsexual man’).

Intersex
The term ‘intersex’ refers to individuals who possess variations in sex characteristics including chromosomes, gonads, and/or ambiguous genitals that do not allow them to be distinctly identified as female/male sex binary.

Kothi
Traditionally, in India, a kothi is defined as a male who displays feminine characteristics, such as physical mannerisms. Kothis are often considered receptive in anal/oral intercourse with men; however, kothis may also penetrate other men and are often referred to as dhoru kothis. In addition, kothis may get married to women and may be behaviourally bisexual. These married effeminate men are sometimes referred to as pav-bata-wali-kothis.

Kothis are a heterogeneous group and a single definition or identity does not describe the heterogeneity in this group. The meanings attached to kothi-identity vary according to region, language, age-group, socio-economic status, educational status, degree of involvement in the kothi community, and even from one kothi-identified person to another.

For example, in Manipur, as mentioned above, the term used for them is ‘B-MSM’ or the receptive (not penetrative) partner. Men identified as kothis 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. They may not otherwise publicly cross-dress and also may not let their birth families know that they cross-dress. It has been argued that the kothi-identified men may want to differentiate themselves from hijras. Further, they may not want to place themselves under the hijra or TG umbrella.

Gay
The term ‘gay’ is typically used to describe people attracted to people of the same sex, often in the context of a social, cultural or political identity. In India, this term often reveals a person’s social class, education, or media exposure. Some self-identified kothis may also identify themselves as gay due to their association with organisations working with HIV prevention.
**Panthi/Ghadiya/Giriya**

These are terms used by kothis to describe ‘masculine’-looking men who are usually considered to be ‘real men’ who penetrate. These men may not self-identify themselves as anything other than heterosexual, although there are some who know the term *kothis* use to describe them and may call themselves *panthis*.

Some *kothis* have steady *panthis* who are referred to as partners, boyfriends or *mard* (meaning a macho man in Hindi). These are also referred to as ‘A-MSM’ in Manipur. Though they are usually the penetrative partners, they may get penetrated in certain situations.

A *panthi* may not identify with the *kothi* culture and may consider himself a heterosexual who ‘just has sex with other men’. *Kothis* may not encourage *panthis* to have some sort of homosexual identity. Though apparently reflecting the ‘top’/‘bottom’ dichotomy seen in western gay culture, *kothi* and *panthi* identities are not exactly congruent since a gay-identified man may call himself a ‘top’, a ‘bottom’, or ‘versatile’ based on his sexual behaviour.

**Double-Decker**

This term is used in India for individuals who get penetrated as well as penetrate. They might not be effeminate, and some *kothis* call themselves double-deckers if they have ever been a penetrative partner in the past. Often this term is used as a label rather than a self-claimed identity.

**Bisexual**

This term describes men (i) who are behaviourally bisexual but may not have any identity associated with their bisexuality; or (ii) who self-identify as bisexual men. Specific sexual behavior, such as penetrative or penetrated, does not necessarily form a part of this identity. For example, if a man is bisexual it means that he has sex with men and women. However, it may not be instantly clear as to what sort of sexual role he plays while having sex with other men.

**Men who are vulnerable due to their occupation/profession**

This group includes multiple categories of men who may be ‘situational’ homosexuals or engage in sex for economic reasons. In India, this group includes *maalish-waalas* or masseurs, vocational groups like male film extras, room boys, beer-parlour boys, or truck cleaner boys. These may be temporary situations that may change with passage of time.

**Hijras/Kinnars**

Hijras is derived from Urdu and suggests the idea of ‘leaving one’s tribe’. Hijras have a distinct socio-cultural identity. They are different from male-to-female TGs. They are biological males who have feminine gender identity, wear women’s attire and play a feminine gender role, but they are also part of a unique history and sub-culture on the Indian subcontinent.

There are two categories of hijras. These categories are named to indicate what they signify. *Akwa* hijras are ones who are not castrated and therefore may also have penetrative sex with men or women. *Nirwan* hijras are ones who are ritually castrated. Sometimes, they may also undergo a surgical procedure for emasculation or removal of the penis.

Many of them do not live with their biological families. Hijra communities are organised into seven major clans, called *gharanas*, and each *gharana* is owned by a key person called a *Nayak*, a senior hijra. Under each *nayak* are many *gurus* (masters or teachers), and under each *guru* there are many *chelas* (disciples).
A person can be a *chela* of a particular *guru* and also be a *guru* for some other persons (i.e., have their own *chelas*). In India, the term *kinnar* is used to describe hijras and is seen as a more respectable and formal term. A number of terms are used across the country. In Tamil Nadu, the equivalent term is *thirunangai* (respected women), *aravanni*. In Punjabi the term *khusra* is used. In Gujarati, they are called *Vyandhal*.

In South India, male devotees in female clothing are known as *jogappa*. Hindu temple hijras are often referred to as *jogtas*. The term ‘eunuch’ was once commonly used to describe hijras in English, now experts have sought to include them under the umbrella term of transgenders.

Overall, male-to-female transgenders and hijras are a separate group socially, culturally, and behaviourally from MSM. Thus, HIV prevention programmes and activities should be specific for this group, and they should not be grouped together with the other MSM sub-populations.

The preceding is by no means an exhaustive list of all identities. Each local area may use multiple other names or have other groups that could be added to this list. Also, identity categories are fluid, and there can be movements across these various groups.

You can show a diagram developed by the Humsafar Trust (CBO in India) called the MSM circle which captures many of the different identities described above and reflecting the context of Mumbai where Humsafar is based. Use only if you think that it is necessary and will help clarify these issues and not confuse the participants.
Activity 4: Understanding Gender and Sexual Identity Formation

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, participants will:</td>
</tr>
<tr>
<td></td>
<td>• Understand the formation of sexual and gender identity; and</td>
</tr>
<tr>
<td></td>
<td>• Understand the challenges that people face in coming to terms with their identity, especially when the identity does not clearly align with societal norms.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Part I

Read out the following case study to the participants.

Case Study

Pummy is in his early thirties. He grew up in a small town where his father worked as a construction labourer. He is the only son and is also the youngest one in the family; he has five sisters. Pummy had a relatively happy childhood with lot of affection from his parents and sisters.

‘As I was the youngest and the only son I was pampered a lot,’ says Pummi. ‘My parents and all my sisters loved me a lot. I never did any household work. Literally, I was a spoilt kid. When I was a child, sometimes my sisters would dress me up as a girl. I liked it a lot. I used to admire myself standing in front of the mirror. Due to the nature of his work, my father would mostly be away from the home. My mother was a very dominating women and a strict disciplinarian. But she was very lenient with me and also she never scolded my sisters for dressing me up as a girl. As I grew up, my sisters stopped dressing me as a girl. I found it very odd. When I requested them to do so, they either ignored me or scolded me for being effeminate. After all, I was a grown up boy.’

Pummy got married at the young age of 19. He had already had a couple of sexual relationships with other men by then. As these relationships were clandestine, they never became a matter of concern for Pummy, who always thought that once he was married to a woman he would assume a normal married life. He was very happy to get married. However, he did not understand the meaning and importance of getting married.

By the time he was 23, Pummy was a father of two children – a girl and a boy. As his father was not keeping well, Pummy shifted to Delhi with his family to look for a job.

Pummy says, ‘I came to Delhi. I simply loved the energy of the city but at the same time its vastness scared me. Soon I got a job as a salesman. I was living happily with my family. Sometimes when I was alone at home I used to wear my wife’s clothes. Once I had to catch a bus from ISBT (the Inter-state Bus Terminus...
in Delhi). When I reached there it was late in the evening. I was waiting for the bus when I noticed a group of effeminate boys chatting with each other very happily. I wanted to approach them but was very nervous. I took the bus and came back home. I could not sleep the whole night.

Pummy started going to ISBT daily after that. For months, he just went there to sit in a tea stall and observe the group. Then one day he gathered the courage and approached the group. He introduced himself as ‘Raman’ as he was still scared to reveal his true name. ‘He is a kothi,’ said one guy. ‘Her real name must be Ramona,’ said another guy. Everyone laughed. Pummy was confused. He did not understand the word kothi. Pummy excused himself and came back home.

Using the case study as a backdrop, lead the discussion on identity, acceptance, and disclosure.

Ask the participants how and when they heard the words hijra (if they are hijras), kothis (if they are kothis), TGs (if they are TGs), and gay (if they are gay).

Ask whether the participants felt any confusion, shame and guilt when they realised they were a hijra or a gay or a kothi or a TG. For example, it is very common for sexual minorities to say, ‘we often wondered why God made us like this’. This is an expression of the emotional difficulties that people face due to their identities.

Ask the participants what they think are the difficulties that Pummy will face. Remind them that Pummy is married now. What sort of confusion will he face? What can he do now? Will he feel confused, alone and isolated because of his desires?

At this stage, provide them with relevant, additional information.

Given below is some additional information on the various stages of identity formation (homosexual), (Troiden, 1989)

**Stage 1**
The first stage is sensitisation, usually occurring before puberty. Here the individual might believe that s/he is heterosexual, and it is only in some respects (such as mannerisms, choice of clothes, or sexual preferences, etc.) that she/he is ‘different’ from other people of her/his own sex.

**Stage 2**
The next stage is that of identity confusion. This may occur during the adolescent period when these young people start experiencing homosexual desires and feelings. Inadequate knowledge about sexuality, and experiencing desires and feelings which are new to them, may lead to identity confusion and turmoil.

**Note to Facilitator**
There are several models of identity formation. While it is not advisable to present these to participants, reading about them will give you a broad base of perspectives to base your session on.

Cass proposed the Sexual Identity Formation Model which comprises the following stages (Palmer and Stuckey, 2008):

- Pre-stage: the individual has a heterosexual identity.
- Identity confusion: questioning same-sex gender affinity.
- Identity comparison: there is some sort of acceptance about the new identity but there may still be some 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 heterosexuals.
- Identity synthesis: gradually the individual starts accepting the whole identity and comes to term with the heterosexuals as well.

There are various other models as well, such as the Inclusive Model (awareness, exploration, deepening, commitment, internalisation, and synthesis). (Rowland and Rose, 2008)
Stage 3
The third stage is that of identity assumption when 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’. They might not be comfortable with their identity and might still be feeling isolated, alone and depressed, but at that point of time they know their identity.

Stage 4
The last stage is that of commitment. Here the individual is comfortable with the homosexual identity and lives life accordingly.

Remind participants that these models are all theoretical and are not definitive, i.e. a person can undergo doubts several times before she/he is sure of her/his identity. It can be a long process for a person to become comfortable with his/her identity in a stable way.

Summarise the key learnings of the session which ORWs, counsellors and Advocacy Officers need to be sensitive to when working with persons of the MTH community.

- Sexual identity, gender identity, and behaviour are complex.
- Identity and behaviours are fluid and are a matter of individual choice. All individuals with the same identity may not necessarily have the same behaviour.
- Individuals may self-identify the way they want to; however, they should practice safe sex practices irrespective of their identities.
- Remember that nearly all who are born as biological males and have now taken different identities are vulnerable to HIV and other STIs; for example, a panthi, giriya, may be masculine looking but that does not mean that the person is not vulnerable.
- Use the appropriate gender term as self-identified by the individuals while addressing them.
- Advocacy Officers need to know that:
  - Their work in the field relies on their understanding various identity groups existing in the immediate community, their specific behaviour practices, and to ensure responsiveness of ORW messages and expectations of specific groups.
  - They must try to assess any possible uneasiness with messages given to various groups.
  - They should act as a medium to bring these issues to the notice of the counsellor.
  - They must try to figure out any identity politics on-site and adapt the prevention messages to be responsive to the local context.
Activity 5: Stigma, Discrimination and Homophobia

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Understand the concepts of homophobia and transphobia;</td>
</tr>
<tr>
<td></td>
<td>• Understand how identities that counter societal norms can engender stigma and discrimination; and</td>
</tr>
<tr>
<td></td>
<td>• Be able to articulate strategies for dealing with stigma and discrimination.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Part I: Introducing ‘Stigma’

Start this session with a game. The idea behind the game (described below) is to demonstrate the stereotypical notions people have about the behaviour of people labelled with sexual and gender identities outside the mainstream.

Divide the participants into five groups and name the groups Mr. India (Men), Ms. India (Women), Mr. TG India, Ms. TG India, and Ms. Hijra India.

Ask all the groups to stand on one side of the room. Play some lively music and ask one or two members of each group (one member at a time) to walk their way to the other end of the room (or a designated area). Tell them that as they walk across their room, they should behave in a manner that they think is representative of their group (mannerisms of men if they are from group Mr. India Men and so on).

Ask the participants whether the representatives portrayed their roles properly.

If participants voice an opinion, for instance, that Mr. India Men was not manly enough, point out that our concept of an ideal male is a result of social conditioning. Also point out that when we or others are not able to live up to such ‘ideal’ standards created by social conditioning, it leads to both self and social stigmatisation.

Continue with the discussion on stigma in which you describe stigma as the process by which individuals with devalued physical attributes, behavioural patterns, or medical conditions experience prejudice, discrimination, stereotyping, and exclusion (Dovidio, Major J and Crocker, 2000). In simple words, stigma is the severe disapproval of a person on the grounds of characteristics that distinguish them from other members of a society.

Stigmatised individuals experience or anticipate negative reactions due to the existing social norms or due to their own awareness of how they violate social norms (Goffman, 1963). We find multilayered, and different types of, stigma in lesbian/gay/bisexual and TG settings. For example, there may be stigma because of their sexuality and sexual orientation, their expression in society, and their sexual behaviours and infections associated with it. If someone has HIV, then there is an additional stigma of the HIV infection.
(Note: Remind participants that some of these types will be discussed later during the training).

After defining stigma and describing its various types, move on to explaining ‘homophobia’. Start by defining homophobia as the fear and hatred of homosexuality (The Oxford Dictionary, 2010).

Part II
Dealing with Stigma and Discrimination

Divide the participants in two groups. Give one case study (given below) to each of the group and ask the groups to study present a synopsis of their case study to rest of the participants along with the answers for the below questions. Use the below mentioned points to debrief the participants on both the case studies.

Pointers for debriefing Case Studies:

Ask participants the following questions:

- Where in the story does the character face stigma?
- Is there any self-stigmatisation?
- Does the stigma experienced by the protagonist result in any discrimination?
- What sort of challenges – psychological, social or other – does the protagonist face because of stigma and discrimination?

Brainstorm as to what the counsellors, ORWS and peer educators (PEs) can do to strategise and counter stigmatisation and discrimination. Once all the responses are elicited and discussed, proceed to explaining the following:

- Types of homophobia;
- Internalised homophobia/transphobia;
- Heterophobia; and
- Internalised stigma of all forms for homosexuals/transsexuals/TGs.

Initiate a discussion on issues of transphobia, prejudged notions, medical issues, and gender violence. Explain that transphobia can manifest in the following ways:

- Prejudices about the roles and place of TGs in society.
- Using pronouns not confirming to the gender expression.
- Forcing them to choose male or female in forms that need to be filled.
- Medical admissions in male wards.
- Heckling on streets.
- Unnecessary and unfounded fear of TGs on streets.
- Gender violence in extreme cases.
- People not being comfortable with the fact that they were born as men and live as women.
- Discouraging them from sex reassignment procedures.

Summarise the key learnings of the session for the participants:

- Homophobia and transphobia are shown by members of the general population and in a few instances by a few lesbian/gay/bisexual/TG community members. One has to deal with issues of homophobia at various levels – personal, social, political, communal, religious, and legal. Often, addressing these issues with support from the MTH community, along with the support from sensitive non-community members, helps in dealing with homophobia at various levels.
• Addressing ‘internalised homophobia’ and stigma is essential for success of any program that works for the MTH community. If an ORW or a PE sees that any of their clients are confused or depressed because of internal and external homophobia/transphobia, then they should strongly encourage or convince the clients to come to the drop-in centre (DIC) and speak to the counsellor. During sessions, counsellors should first address internalised homophobia before dealing with external homophobia. Before addressing cases of homophobia, the counsellor needs to be clear about the source and level of homophobia the client is experiencing – whether it is personal, social, political, and so on – and assist the client in devising appropriate strategies.

• Excessive labelling of homophobia or heterophobia is not very helpful. One has to be careful in labelling any wrong doing or injustice as homophobia.

Advocacy Officers need to:

• Understand the issues of structural homophobia (example: in medical settings, legal settings, etc.); and

• Sensitise individuals in these structural settings in order to address homophobia at these levels.

Case Study 1

Anshul studies in a college in Mumbai. He travels everyday in train with a group of friends from college and has also made friends with others he has met in the train. He meets with the non-college friends outside of college campus once in a while and is good friends with them too.

Anshul has always felt attracted to boys in his class and college. Though he does not know any other men who have similar yearnings, he is aware of the term ‘homosexual’ and ‘gay’ and has read about it in some newspaper articles. He has tried to find other people like him but has not been successful so far.

Sidhaant is one of his friends and Anshul really likes him, but he is not sure if Sidhaant is gay or not. So he tries to take it easy and does not approach Sidhaant with anything. Nevertheless they are very good friends and meet often in a tea shop close to their house/ They love tea and call these meetings their ‘masala time.’ Anshul values the friendship and decides not to pursue his feelings any further with Sidhaant.

One day, when Anshul and other guys were travelling back from college in the train, they meet Sidhaant. It is a very busy time of the day and the train is crowded. Suddenly one well-dressed and groomed young man accuses Anshul of making physical contact in an inappropriate way and shouts at him for ‘behaving like a homosexual.’ Anshul is stunned and does not how to react to the outburst. His friends tell him not to worry and forget about the incident. The moment passes and they all get down at their respective stations.

However, Anshul is bothered by this incident. He worries that he has some problem that others do not have. He wonders why the passenger yelled only at him. Did he figure that Anshul was gay? Do others know about him? Do they talk about him behind his back? He is not sure about these answers but wonders if there is something wrong with the way he talks or walks or holds books or the way he dresses; he somehow concludes that there is something ‘wrong’ with him.

He decides to discuss this with Sidhaant. He hopes that Sidhaant will understand him. So they meet for one of their ‘masala times.’ He reminds Sidhaant about the incident and tells him that because of the whole episode he was depressed.
and could not focus. He adds that ‘Sidhaant, I want to let you know that I do like men. I mean, I always fantasise about them.’ On hearing this, Sidhaant responds nicely and says it is OK, he understands it. Anshul is happy that he was able to talk with someone and feels good about it.

However, Anshul notices after this conversation that Sidhaant’s attitude towards him has changed. They have not had a ‘masala time’ in about four weeks. Nor does he see him that often. Anshul has a feeling that because of the disclosure about his sexual orientation, Sidhaant ignores him and hardly responds to his calls. Once when they spoke, Sidhaant was indifferent on the phone and said that he had been busy with work and studies.

Case Study 2

Sushant is a high school (10th grade) student. He goes to school regularly, is studious, and always scores well in all exams. Often on the way to the school, he and his friends see a group of hijras at the traffic signal, clapping loudly and asking for money from all the car and rickshaw passengers who stop at that signal. Once in a while they also see some people making fun of them, jeering at them, making rude gestures, or heckling them.

Sushant sees this one day and tells his friends that it is not nice to behave that way. ‘Let them live as they want to,’ he says.

Friend 1: What are you saying! Do you think this is normal, dressing up like a woman and all that? I don’t like this, and I don’t think what they are doing is right.

Friend 2: I agree with him. This is not normal. Why don’t you and I behave like them? They just want to create a nuisance in society.

Sushant: I don’t think so. I think they are born that way. I think they are called hermaphrodites. I don’t think they have ‘proper’ male or female organs.

Friend 1: How do you know all this?

Sushant: I read it in a book. It was some sort of a medical magazine. They did talk about this group of men called transgenders. You know, interestingly, some are men and want to become women!

Friend 2: Really? They are there just to harass normal people. When we were small, we were asked to stay away from them as they were notorious for abducting young boys and making them look and behave like them. I was always very afraid of them.

Friend 1: What else did the magazine write about them?

Sushant: They had interviewed some doctor who dealt with people like these, and many of them frequented his clinic for sex-change operations.

Friend 2: So does he do these operations?

Sushant: No yaar, he said he discourages people from getting it done. He says that it is not the right thing to do, and this behaviour can be rectified by hormones and other therapies.

Friend 1: See I told you, this is not right.

Sushant: But then there was this other doctor who said that it is fine as long as they take proper precautions and medications.

Friend 2: I don’t know. I don’t agree with you that it is alright to be a transgender.
Background Information

(Kantor, 1998)

Types of Homophobia

- Medical
- Religious
- Socio-cultural
- Criminal
- Political
- Biological

Medical

Homosexuality has been, for many years, considered a mental illness that could be treated or even cured. Though the perception has changed significantly over the years, there are physicians who still believe that homosexuality is not ‘normal’. They use different forms of therapies (aversion therapy, psychotherapy, hormonal therapy) which they claim can cure the condition.

Another commonly presented argument is that gay men waste ‘nature’s gift,’ the opportunity to procreate. Some also believe that anus is not suited to penetrative sex. Another point often made is that anal sex often leads to sexually transmitted infections, including HIV.

Counter arguments are: heterosexual sex is also not always for procreation and many times sex between a man and a woman is recreational; anal sex is pleasurable, and the use of lubricants can facilitate anal sex just as they are often used in case of inadequate lubrication during vaginal sex; peno-vaginal sex also can transmit infections and diseases, including HIV.

Religious

Many religions call homosexuality a sin, an act against the ‘wish of God.’ Some believe that HIV/AIDS is the result of that ‘sin.’ Issues of religion and homosexuality are sensitive and have to be dealt with carefully. For those who would like to maintain both religious as well as sexual identities and feel that they may be going against their religion, it helps to introduce them to groups and religious scholars who are known for their soft and sympathetic stand on homosexuality.

Socio-cultural

Society accepts heterosexuality as the norm. Individuals grow up seeing heterosexual couples (male and female) and accept it as the model for sexual and emotional relationships. This becomes part of the conditioning that most people go through in their early years.

Family expectations and societal expectation about our individual roles also play a significant part in shaping attitudes. For example, most men in India are expected to get married to a woman by a particular age and anything that goes against this norm is not seen as acceptable. As a result, many gay men in the country get married under pressure from their families.
Criminal
Sexual relationships between consenting adults of the same sex have long been the target of both social and legal sanctions. Though such relationships are increasingly gaining social acceptance as society is gradually becoming more tolerant, certain jurisdictions have retained statutory prohibitions on homosexuality despite advocacy and criticism from groups and individuals who believe that the laws are obsolete and should be removed.

The arguments opposing decriminalisation revolve around concerns about ‘negative’ aspects of homosexuality, STDs, and paedophilia and claim that decriminalisation will result in increased frequency of homosexuality and will destroy the sanctity of the ‘family.’

People favouring decriminalisation counter by arguing that sexual orientation develops due to multiple factors, including genetics, and it is unlikely that an increase in the incidence of homosexuality will occur as a consequence of decriminalisation. Anti-sodomy laws compel many gay men and women to conceal their sexuality and marry for appearance’s sake. Decriminalisation may actually help to remove some of the stigma and have a positive influence on relationships between homosexuals and their families, thereby promoting greater acceptance of homosexuals by their families.

What is Internalised Homophobia?
This is defined as a negative feeling towards oneself because of homosexuality. However, the term has given way to the term ‘internalised stigma’ as many believe that negative attitudes are not the same as having fear or phobia. Many see this phenomenon as an inevitable consequence for children who are exposed to heterosexist norms. Research has shown that most gay men and lesbians adopt negative attitudes towards (their) homosexuality early in their developmental histories.

These negative attitudes result in repression of one’s own homosexual desires and encourage a clash between a person’s religious or social beliefs and his sexual and emotional desires. This could result in clinical depression, denial and suicidal thoughts. Such a situation may cause extreme repression of homosexual desires.

In addition to internalised stigma, some gay men may also disapprove of other MSM who do not confirm to their identity or social structure. For example, a gay-identified man may have issues identifying himself with ‘kothi’ men.

What is Transphobia
Transphobia refers to a range of negative attitudes and feelings towards transsexualism, transgenderism, and transsexual or transgender people.

Transphobia can manifest as physical violence, verbal abuse, social marginalization and neglect. Many TG people also experience homophobia from people who associate their gender identity with homosexuality.
Activity 6: Psychological Issues Related to Identity, Gender and Sexuality

<table>
<thead>
<tr>
<th>Time</th>
<th>45 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning Outcomes</strong></td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Know the various psychological issues that can arise in connection with one’s identity, gender, and sexuality; and</td>
</tr>
<tr>
<td></td>
<td>• Be able to identify the situations where a person has to be referred to specialist care.</td>
</tr>
<tr>
<td><strong>Materials</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Audio-visual Support</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Take Home Material</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Methodology**

Use a question and answer format to discuss the various psycho-social issues faced by the members of MTH community. Use the discussion that ensues to allow participants to discuss and share experiences from the field.

**Is homosexuality normal? Am I the only one?**

Medically, homosexuality is no longer considered a disease or abnormality. Globally, various surveys have provided information on the prevalence of same-sex sexual behaviours across cultures and communities.

Though various theories were proposed to explain homosexuality (genetic, hormonal, and psychoanalytic, etc) and ‘treat’ it medically, it is now widely accepted that homosexuality is not a disease.

**What about Transsexualism?**

The term ‘transsexualism’ refers to individuals who have a cross-gender desire and identification. They are not comfortable in the sex of their birth and may like to identify themselves with the opposite gender. This is differentiated from ‘transvestitism,’ which is the practice of cross-dressing or wearing clothing traditionally associated with the opposite sex or gender.

When transsexualism causes distress in an individual, it can be diagnosed under ‘Gender Identity Disorder (GID).’ GID can be caused by genetic factors and prenatal exposure to hormones, as well as other psychological and behavioral reasons. It is generally required that the treating physician figures out whether: (i) the GID is temporary (sub-clinical), frequent/periodic, or constant; and (ii) the benefits to the individual from medical and surgical therapies.

Such a person might consider medical and surgical options for sex reassignment procedures. Hormonal therapy include medical castration (suppression of indigenous hormones) and later the addition of hormones of the opposite sex. Surgical procedures include removal of testes and scrotum, removal of penis, vaginal space creation (vaginoplasty), urethra creation, creation of clitoris, labia, and vulva. Other procedures may include breast augmentation and voice box surgeries. For women, the surgeries may include removal of ovaries and uterus and creation of the penis and scrotum.
What about penis size? Do I have a small one?

Generally speaking, many men may come to the counselor or other project staff with concerns about penis size. They may say that they have a small penis and would like to enhance its length. Some authors have shown that homosexual men may place particular importance on size. This may be associated with greater self-esteem. It may also play a role in sexual positioning.

However, it is often found that though they may be within the average range, many men often underestimate the size of their penis relative to other men and think that they are undersized. Further, size typically does not impact function. Educating the individual about penis size is important; staff should try to tell them, unless it is really very small (which can happen with some medical conditions), most fall within a normal range.

An important issue for HIV prevention is the role of penis size in condom use. There may be condom slippage, condom tightness, and poor use of condoms due to penis size. Thus, a range of condom sizes may be required for optimal HIV prevention.

Myths about ‘semen loss’ and ‘masturbation’

Many individuals are concerned about semen loss. It is often referred to as ‘Dhat Syndrome’ (the word ‘Dhat’ referring to semen). There are wrongly-held beliefs that a lot of blood is required to create one drop of semen, and therefore, with the loss of semen, men may lose vigour. This may also be accompanied by other symptoms such as pain, tiredness, mental health issues, and excessive worries. There are other fears about masturbation, such that it is bad or abnormal, will lead to sexual weakness in future, may alter the penis permanently, and cause mental problems. On the contrary, masturbation is safe, pleasurable and healthy.

It is important to assert that semen is a body fluid and is produced normally by body without causing damage. Semen ejaculated by masturbation or by a sexual act with another person is replaced as needed. A third route is that of nocturnal emissions. Semen is sometimes ejaculated during sleep, referred to as ‘wet dreams’. One should not worry too much about these – the semen will be replenished soon.

Premature ejaculation

It is defined as persistent or recurrent ejaculation with minimal stimulation before, or on, or shortly after penetration and before the person wishes it. (The American Psychiatric Association, 2000) Premature ejaculation simply means early ejaculation, when a male is unable to control or delay ejaculation. It can cause distress for both the person and his partner and can be treated often with the help of a physician.

Erectile dysfunction

This is the inability to achieve or maintain an erection sufficient for sexual performance. It can occur due to various reasons: ageing, anxiety, stress, relationship issues, depression, obesity, smoking, cardiovascular problems, and hormonal problems, to name a few. There are multiple therapies available, and treatment will include detailed history-taking, psychological and psychiatric evaluation, and therapies, including lifestyle changes as well as cognitive, behavioural, medical, and surgical interventions. Any treatment needs to be undertaken under the guidance of a physician. If erectile problems impede daily functioning, an individual may also require mental health counseling.
Activity 7: Wrap-up

**Time** | **30 minutes**
---|---
**Learning Outcomes** | The participants will summarise:
- The various concepts they have learnt throughout the training session.
**Materials** | N/A
**Audio-visual Support** | N/A
**Take-home Material** | Annexure 1 on ‘Notes on Identity, Gender and Sexuality’.

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

- What are some of the characteristics of identity? (Remind them that identities are fluid and can change over time).
- What are the various things that ORWs, counsellors, and Advocacy Officers should remember about the concept of identity?
- What is sex?
- What is gender?
- What is sexual orientation?
- What is sexual identity and gender identity?
- What are the four steps towards identity formation?
- What are the points that ORWs, counsellors and Advocacy Officers should remember when dealing with identity formation?
- What is stigma?
- When does it result in discrimination?
- What is homophobia (the various models of homophobia)?
- What is transphobia?
- What is internalised homophobia and transphobia?
- What should ORWs, PEs and counselors remember when they find their clients suffering from and dealing with stigma and discrimination?

End the day’s training emphasising that there is diversity in our identities, sexualities, sexual identities, gender identities, and orientations, and that this diversity needs to be celebrated and encouraged and not stigmatised.
Annexure 1: Notes on Identity, Gender and Sexuality

For Outreach Workers and Counsellors

1. Identity is never constant; it changes with factors such as time, roles, social milieu, geographic location, and phase in life to name a few.
2. Identity is a matter of choice. Sometimes, however, it may be ‘forced’ and the person then internalises over a period of time.
3. While dealing with outreach clients try to understand more about their identity—how they would like to identify themselves. Even if they seem to be MSM, there may be other identities that they would want to be identified with.
4. Identity is often not linear; each individual may have multiple identities. An interaction of these identities may lead to complex life situations, and this should be borne in mind.
5. Recognise that although there is one main identity assumed by a person at any given point, it may clash with other roles and responsibilities of the person. Understanding the predominant identity will help ORWs to understand various issues related to the individual on the field; for example a man may be more concerned about being a son than about 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.
6. Identity and behaviours are fluid and are a matter of individual choice. Do not try to impose your identity on the individual while dealing with them in the field.
7. All individuals with the same identity may not necessarily display the same behaviour.
8. Individuals may self-identify the way they want to; however, they should practice safe sex practices irrespective of their identities.
9. Remember that nearly all who are born as a biological male and have now taken different identities are vulnerable to HIV and other STIs; for example, a panthi, giriya, may be masculine looking and muscular; however that does not mean that the person is not vulnerable.

For Advocacy Officers

1. The role of the Advocacy Officer is to understand the work of ORWs, and the problems they face while dealing with subjects on site.
2. The role is to mediate and facilitate, between the counsellors and outreach subjects, negotiation skills related to understanding one’s identity, the interactions with different identities, and the most pressing issues related to it. (By this we mean that even though the NGO might be working on issues such as HIV and STI prevention for MTH, if the MSM has a child who is facing discrimination then the NGO has to realise that the pressing issue for the person is the child’s welfare and education, because the person is also a father. The Advocacy Officer will have to explore the possibilities of crisis management regarding that issue.)
Notes
Pehchan Training Curriculum
MSM, Transgender and Hijra
Community Systems Strengthening

**CG**
CG Curriculum Guide

**module A**
- A1 Organisational Development
- A2 Leadership and Governance
- A3 Resource Mobilisation and Financial Management

**module B**
- B Basics of HIV Prevention and Outreach Planning (Pre-TI)

**module C**
- C1 Identity, Gender and Sexuality
- C2 Family Support
- C3 Mental Health
- C4 MSM with Female Partners
- C5 Transgender and Hijra Communities

**module D**
- D1 Human and Legal Rights
- D2 Trauma and Violence
- D3 Positive Living
- D4 Community Friendly Services
- D5 Community Preparedness for Sustainability
- D6 Life Skills Education

© 2013 India HIV/AIDS Alliance