C4 MSM with Female Partners

Facilitator Guide

MSM with Female Partners

Pehchan Training Curriculum
MSM, Transgender and Hijra Community Systems Strengthening
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.
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About this Module

This module is designed to help training participants: 1) understand the issues of men who have sex with men (MSM) who also have sex with female partners; 2) become familiar with how gender impacts health; 3) learn basic sexual anatomy and differences between male and female; and 4) learn basic strategies to reach out to MSM with female partners and provide appropriate support and linkages to services. In the Pehchan programme, this module is used to familiarise CBO staff on the specific needs of MSM with female partners.

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; Urmi 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 Prabughate, ICRW; Nagendra Prasad, Ashodaya Samithi; Revathi, Consultant; Rex, KHPT; Amitava Sarkar, SAATHII; Dr. Maninder Setia, Consultant; Chetan Sharma, SAFRG; Suneeta Singh, Amaltas; Prabhakar Sinha, Heroes Project; Sreeram, Ashodaya Samithi; Suresh, KHPT; Sanjanthi 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 Achrya, 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 Hariyot 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, Yadendra (Rahul) Singh, Simran Shaikh, Yashwinder Singh, Rohit Sarkar, Chaitanya Bhatt, Nenthuk Vunghoikhim, 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 pehčan.
Module Acknowledgments: MSM with Female Partners

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 Authors**
Sylvester Merchant, Lakshya Trust; Yadavendra Singh and Harjyot Khosa, India HIV/AIDS Alliance

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

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

**References**
About the MSM with Female Partners Module

<table>
<thead>
<tr>
<th>No.</th>
<th>C4</th>
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<tbody>
<tr>
<td>Name</td>
<td>MSM with Female Partners</td>
</tr>
<tr>
<td>Pehchan Trainees</td>
<td>• Counsellors • Peer Educators (PEs) • Outreach Workers (ORWs)</td>
</tr>
<tr>
<td>Pehchan CBO Type</td>
<td>Pre-TI, Ti Plus</td>
</tr>
<tr>
<td>Training Objectives</td>
<td>By the end of this module, participants will: • Understand the needs of MSM with female partners, especially their sexual and reproductive health (SRH) needs; • Understand the importance of non-judgmental attitudes and confidentiality when dealing with MSM who have female partners; • Gain knowledge on male and female sexual and reproductive anatomy and its role in reproduction; and • Understand the programmatic approaches to reach out to MSM with female partners</td>
</tr>
<tr>
<td>Total Duration</td>
<td>One day. A day’s training typically covers 8 hours.</td>
</tr>
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</table>

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
1. Audio-video clip ‘Male reproductive system’.
2. Audio-video clip ‘Fertilisation and the reproductive system’.

Annexures
1. Annexure 1 on ‘Gender and Health Implications for Female Partners of MSM’.
2. Annexure 2 on ‘Male and Female Reproductive Anatomy’.
3. Annexure 3 on ‘Case Studies’.
# Activity Index

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity Name</th>
<th>Time</th>
<th>Material(^1)</th>
<th>Audio-visual Resources</th>
<th>Take-home material</th>
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<tbody>
<tr>
<td>1</td>
<td>Introduction to MSM with Female Partners Module</td>
<td>15 minutes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Understanding MSM with Female Partners</td>
<td>1 hour</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
<tr>
<td>3</td>
<td>Gender and Health Implications for Female Partners of MSM</td>
<td>1 hour 30 minutes</td>
<td>Annexure 1 on ‘Gender and health implications for female partners of MSM’</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Sexual and Reproductive Anatomy and Physiology</td>
<td>1 hour 30 minutes</td>
<td>Annexure 2 on ‘Male and female reproductive anatomy’</td>
<td>1. Audio-video clip ‘Male reproductive system’ 2. Audio-video clip ‘Fertilisation and the reproductive system’</td>
<td>Annexure 4 on ‘Fact sheets on sexual and reproductive health and rights’</td>
</tr>
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<td>5</td>
<td>Reaching out to MSM with Female Partners</td>
<td>2 hours</td>
<td>Annexure 3 on ‘Case studies’</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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1 Overhead projector, laptop, sound system and whiteboard should be provided at every training.
Activity 1: Introduction to MSM with Female Partners Module

<table>
<thead>
<tr>
<th>Time</th>
<th>15 minutes</th>
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</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, participants will:</td>
</tr>
<tr>
<td>• Be able to articulate the objectives of this training module.</td>
<td></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

Welcome the participants, and ask them to share their thoughts on, or experiences of, MSM who have female sexual partners. Ask them if they have heard queries from MSM about their female partners and the problems thereof?

Write down the responses from the participants on a flip-chart. This will help you to refer to these points during the course of the day. Some of the key words that are relevant to this module are family pressure, aspirations for a child, emotional attachment to female partners, etc.

Ask participants to voice their expectations from this module and list these on the board.

Map their expectations with the objectives of the module, and tell them which of their expectations would be met in the day's training. It is also important to explain why some expectations are beyond the scope of this module.

Note: Female partners of MSM refer not only to spouses but also to girlfriends and any other sexual or non-sexual partners including sex-workers. While the primary concern with sexual relationships are health risks, including the transmission of HIV and other sexually-transmitted diseases (STDs), one also needs to consider the social and psychological aspects of such relationships. In fact, many MSM people are often married but not sexually involved with their spouses, and their spouses are not aware of their alternate sexual lives.

Note to Facilitator

In reaching out to the MTH community, Pehchan Programme works with some MSM who have female partners and offers psychosocial support and friendly services to help address some of their distinct needs.

During discussions, please ensure that the participants understand that Pehchan’s focus is on the MTH community. Complementing this mandate, addressing the needs of MSM and their female partners represents a key strategy of the programme to increase its responsiveness and impact.
Activity 2: Understanding MSM with Female Partners

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
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<tbody>
<tr>
<td><strong>Learning Outcomes</strong></td>
<td>By the end of this activity, the participants will learn:</td>
</tr>
<tr>
<td></td>
<td>• About the different kinds of female partners MSM have, and some of the common issues faced by MSM with female partners; and</td>
</tr>
<tr>
<td></td>
<td>• The importance of being non-judgmental while dealing with issues of MSM with female partners.</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**

Divide participants into two groups. Ask the groups to answer the following questions and list their responses on separate flip-charts.

- Who are the female partners of MSM? (For Group 1)
- Why do you think MSM have female partners? (For Group 2)

Lead a discussion among participants to help them understand why MSM have female partner(s). Ensure that the discussion covers the following points:

- The reasons vary from one individual to another.
- It is important to note that MSMs, irrespective of their sexuality and the number of partners they have, may care deeply about their female partners. Some of them may be bisexual and have a healthy sexual relationship with their female partners.
- They may have familial obligations – parents, siblings and children.
- Emphasise the importance of being non-judgmental about MSM who have female partners.

Use the following statements to elicit the opinions of participants.

- An MSM who has a wife and a boyfriend is cheating on the boyfriend.
- An MSM cannot have both a wife and a boyfriend — he should choose one or the other.
- Does an MSM have the right to make his female partner unhappy?
- Kothis cannot be bisexual.
- If you are a transgender (male to female) married to a woman, you cannot keep your wife happy.
- How can hijras be married?
- MSM people have no right to marry.
After encouraging a healthy debate on these issues point out judgmental attitudes/views that may be expressed, and remind participants (especially counsellors) that regardless of their own personal views, they must have a non-judgmental attitude when dealing with clients.

Bring out different opinions by letting participants debate these issues, and gently point out where they are making value judgments about another’s behaviour and thoughts.

Note to Facilitator

As the participants have already undergone a training session on sexuality and gender, you may quickly revisit the concepts of gender and sex and their social constructs and implications on the following:

- Health and well-being.
- Access to and understanding of information about health-related issues, including sexual and reproductive health.
- Experience of illness.
- Attitudes toward maintaining own health and that of family members.
Activity 3: Gender and Health Implications for Female Partners of MSM

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour 30 minutes</th>
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</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, participants will:</td>
</tr>
<tr>
<td></td>
<td>• Know how gender differences influence health and health-seeking behaviour.</td>
</tr>
<tr>
<td>Materials</td>
<td>Annexure 1 on “Gender and Health Implications for Female Partners of MSM”.</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
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</tbody>
</table>

Methodology

The Gender and Health Case Study

Divide the participants into three to four groups, preferably homogenous groups comprising participants from a particular state or district.

Distribute copies of the Annexure 1 on “Gender and health implications for female partners of MSM”, chart papers and markers to each group, and give participants 15 minutes to discuss the case and answer the questions accompanying the case study.

Ask each group to present its findings to the larger group. During the presentation and the discussion that follows, ensure that the following points are covered.

• The regional differences in status of women, with particular reference to female sexual partners of MSM.
• Lack of access to accurate health information for both MSM and their female partners.
• Limited migration and mobility for women, as compared with opportunities for men.
• Subordination of women in patriarchal family and social systems.
• Usage of protection when having multiple sexual partners.
• The lack of family support systems for MSM and for women in general.
Case Study: Urmila and Ashok

Urmila is married with two children and stays in a village with her in-laws. She works in the fields. Her husband, Ashok, works in the city and sends money every month to his mother. Urmila is completely dependent on her mother-in-law for any monetary requirement.

Sometime ago, her father-in-law became ill, and had to be admitted to the nearest hospital, which was 25 km away. It was Urmila’s responsibility to attend to her father-in-law.

Due to the nature of his work, Ashok visits his family only twice a year. There is an NGO in the area where Ashok’s works and it organises a health camp regularly. Ashok cares deeply for his wife, but he cannot deny the fact that he prefers emotional and sexual relationships with men. While Urmila is in a monogamous relationship with her husband, Ashok has a number of male partners.

Recently, Urmila developed a chronic fever, and the family insisted she consults a traditional healer, who gives her local medication, her fever has not subsided. Her father-in-law, the head of the family, refuses to let her go to the city for treatment.

Questions

1. What are some of the health risks that Ashok and Urmila face? As Ashok is an MSM, does his behaviour create any additional risks for Urmila? Could Urmila’s fever be a symptom of a sexually-transmitted infection (STI)?

2. Is Urmila's position in the family and social structure having an impact on her access to treatment?

3. How can you relate this case with the communities and regions you work in?
Activity 4: Sexual and Reproductive Anatomy and Physiology

Time | 1 hour 30 minutes
--- | ---
Learning Outcomes | By the end of this activity, the participants will:
  - Understand the sexual and reproductive systems of males and females, and their role in sexual pleasure and reproduction;
  - Understand how pregnancies happen, and the different contraceptives available to prevent pregnancy;
  - Understand how STIs and Reproductive Tract Infections (RTI) are transmitted from one partner to another through sexual contact, and how they can be prevented; and
  - Identify the sexual and reproductive health (SRH) needs of female partners of MSM.

Materials | Annexure 2 on ‘Male and Female Reproductive Anatomy’. One per group.
Take-home Material | Annexure 4 on ‘Fact Sheets on Sexual and Reproductive Health and Rights’.

Methodology

Show the videos and tell participants that a quiz would be taken at the end of the screening of the video to understand how much they have learned.

After the video ends, divide the participants into two groups, Group A and Group B. Give Group A the hand-out depicting the male reproductive system anatomy and Group B the hand-out depicting the female reproductive anatomy.

Next, ask a participant from Group A to come up to the whiteboard and draw the female reproductive system. The rest of Group A should help their team member. The representative also needs to explain what each part’s function is.

Explain to them that the terms used in the videos were medical terms, and that they may translate the name into local language for the benefit of the other participants.

Group B should then judge whether the drawing matches the hand-out given to them.

Repeat the exercise with Group B and the male reproductive system.

Use the activity to discuss the following:
  - Parts of male and female sexual and reproductive anatomy that are associated with pleasure;
  - Menstruation and pregnancy;
  - Role of condoms and other contraceptives in preventing pregnancy;
  - High-risk sexual behaviour (including anal sex) and how STIs and RTIs can be transmitted to female partners; and
  - SRH services for female partners.

Conclude by giving each participant a copy of the Annexure on ‘Fact sheets on sexual and reproductive health and rights’
Activity 5: Reaching out to MSM with Female Partners

<table>
<thead>
<tr>
<th>Time</th>
<th>2 hours</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>• Explore strategies to help MSM and their partners with their psycho-social issues, without disclosure of marital status and/or sexuality; and</td>
</tr>
<tr>
<td></td>
<td>• Understand Pehchan’s programmatic strategies of reaching out to MSM with female partners.</td>
</tr>
<tr>
<td>Materials</td>
<td>Annexure 3 on ‘Case Studies’.</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

Divide the participants into three groups. Distribute Annexure 3 ‘Case studies’ to each group.

Participants in all the three groups need to review the case studies and prepare a presentation for rest of the participants on their suggested outcomes. After 30 minutes, have each group present its findings to the larger group. For the ensuing discussion, ensure that the following points are covered.

- Participants should be aware of their own attitudes towards MSM who have sexual relations with women, and ensure that their own personal feelings and attitudes do not colour their interactions with these individuals.
- Remind participants that disclosing marital status or sexuality is not required. Whether or not to disclose is an individual’s choice, and participants should understand that their role is only to:
  - Help an individual weigh the pros and cons of disclosure; and
  - Support the individual in dealing with the consequences of his decision regarding disclosure.

Tip

When participants are sharing their findings in the larger group, identify volunteers who are more confident and vocal to enact the roles in the case study being discussed.

As participants warm up to the role-playing, encourage the less vocal/shy participants to play some of the roles.
Case Studies

Case Study 1
Refer to the Case Study of Urmila and Ashok discussed above. In the study, it is mentioned that Ashok cares deeply about his wife.

Questions
- Should Ashok’s caring extend to helping her access proper healthcare facilities?
- If yes, then what are the options available to them? If not, why?

If the participants feel that Ashok should help his wife access proper healthcare, you can remind them that Friendly Services are an integral part of Pehchan, and help them make a list of the available facilities that are available to the couple.

If the participants feel that Ashok should not get involved in his wife’s health problems, explore the reasons for their opinions and reflect on any prejudicial or judgmental attitudes that they may voice.

( Needless to say, your feedback should be in a non-judgmental manner!). Discuss with them why it is important for Ashok to care about his wife’s health.

Case Study 2
One of Ashok’s partners is Ravi, an effeminate male who is also married. His wife hears some gossip about his sexuality in their neighbourhood. She gets very disturbed. One day she confronts Ravi about his sexuality, which he strongly denies. After this incident, Ravi decides to visit the counsellor.

Questions
- List all the possible dilemmas that Ravi could be facing.
- What are the possible solutions that Ravi could come up with while discussing his problems with the counsellor?
- If Ravi is willing to bring his wife to the drop-in-centre (DIC), how should the counsellor handle the wife’s questions (and distress) without endangering Ravi’s right to confidentiality?

Remind participants of the pillars of counselling (covered in Module C3 on Mental Health), and tell them that as Ravi is their client, his best interests need to be primary. Therefore, confidentiality is of utmost importance. He should not be negatively judged because he misguided his wife about his sexuality.

When exploring strategies, they should encourage Ravi to come up with his own solutions, as each person’s situation is unique and externally imposed solutions, while appearing ideal, may not necessarily be the best for Ravi. They should however help Ravi weigh the pros and cons of each strategy.
Case Study 3
Srikanth recently got married and is very happy in his marriage. He likes his wife a lot. After one month of his marriage he comes to know that one of his ex-boyfriends tested positive for HIV. Though he is very worried, he is very scared to get himself tested. He stopped having sex with his wife because he did not want to infect her. His wife, however, wants a child, and doesn’t understand why Srikanth is avoiding her. This situation leads to tension in their lives. Srikanth approached a CBO for counselling.

Questions
- What are the arguments that the counsellor could make to persuade Srikanth to go for HIV testing?
- If he does agree to get tested, and turns out negative, how should he take care of himself, his wife, and other partners from infection?
- If he does turn out positive, should he disclose his HIV status to his wife?
- How can he do so without talking about his sexuality?
- How can Srikanth be persuaded to get his wife tested for HIV?
- What options can they explore regarding having children?

Case Study 4
Naushad is a Peer Educator (PE) in a TI Plus organisation. He is very happy to know that his CBO will address the issues of MSM with female partners. During one of the support-group sessions, there were a lot of questions from the community as to why his CBO is trying to reach the female partners: is the CBO trying to disclose their sexuality to their female partners? Many were reluctant to reveal their marital status to the group, and few had revealed their sexual behaviour with men to their female partners.

Questions
- Can you identify a few reasons why some members of the community are nervous about reaching out to female partners?
- What strategies can be developed to address these concerns?
- What services can a CBO provide to the MSM with female partners?
- What services can a CBO provide to the female partners of MSM?

Note: One of the strategies that could be applied is the design of a targeted intervention (TI) where, rather than only visit houses of MSM, the ORWs and PEs visit each house in the target area. For instance, if an ORW/PE finds out from an MSM that he wants his wife/female partner to become aware of HIV and why it is important to get tested, the ORW/PE could design his/her intervention to reduce suspicion.

While there is no foolproof strategy to reach out to the female partners of MSM, some organisations have tried this method and have been successful.
Annexure 1: Gender and Health Implication for Female Partners of MSM

Case Study: Urmila and Ashok

Urmila is married with two children and stays in a village with her in-laws. She works in the fields. Her husband, Ashok, works in the city and sends money every month to his mother. Urmila is completely dependent on her mother-in-law for any monetary requirement.

Sometime ago, her father-in-law took ill, and had to be admitted to the nearest hospital 25 km away. It was Urmila’s responsibility to attend to her father-in-law.

Due to the nature of his work, Ashok visits his family only twice a year. There is an NGO in the area where Ashok works and it organises a health camp regularly. Ashok cares deeply for his wife but he cannot deny the fact that he prefers emotional and sexual relationships with men. While Urmila is in a monogamous relationship with her husband, Ashok has a number of male partners.

Recently, Urmila developed a chronic fever, and the family insisted she visit a traditional healer. In spite of the ‘medicines’ the healer gave her, her fever has not subsided. Her father-in-law, the head of the family, refuses to let her go to the city for treatment.

Questions

- What are some of the health risks that Ashok and Urmila face?
- How Urmila’s social condition had an impact on her access to treatment?
- As an MSM, does Ashok’s behaviour create any additional risks for Urmila?
- How does gender affect decisions about work? What does this mean for gender differences in access to economic barriers?
- Describe the power-structure in Ashok’s family and community. How does this structure impact the health of male and female characters in this case?
- How can you relate this case with the communities and regions you work with?
Annexure 2: Male and Female Reproductive Anatomy

Female Reproductive System

Female Genitalia
Male Reproductive System
Annexure 3: Case Studies – MSM with Female Partners

Case Study 1

Refer to the Case Study of Urmila and Ashok. In the study, it is mentioned that Ashok cares deeply about his wife.

Questions

• Should Ashok’s caring extend to helping her access proper healthcare facilities?
  • If yes, then what are the options available to them? If not, why not?

Case Study 2

One of Ashok’s partners is Ravi, an effeminate male who is also married. His wife hears some gossip about his sexuality in their neighbourhood. She gets very disturbed. One day she confronts Ravi about his sexuality, which he strongly denies. After this incident, Ravi decides to visit the counsellor.

Questions

• List all the possible dilemmas that Ravi could be facing.
  • What are the possible solutions that Ravi could come up with while discussing his problems with the counsellor?
  • If Ravi is willing to bring his wife to the drop-in-centre (DIC), how should the counsellor handle the wife’s questions (and distress) without endangering Ravi’s right to confidentiality?
Case Study 3

Srikanth recently got married and is very happy in his marriage. He likes his wife a lot. After one month of his marriage he comes to know that one of his ex-boyfriends has tested positive for HIV. Although very worried, he is also very scared to get himself tested. He has stopped having sex with his wife because he does not want to infect her. His wife however, wants a child, and doesn’t understand why Srikanth is avoiding her. This situation leads to tension in their lives. Srikanth approached a CBO for counselling.

Questions

- What arguments could the counsellor use to persuade Srikanth to go for HIV testing?
- If he does agree to get tested, and turns out negative, how should he take care of himself, his wife, and other partners from infection?
- If he does turn out positive, should he disclose his HIV status to his wife?
- How can he do so without talking about his sexuality?
- Should the client lie to his female partner if he thinks that is the only way to expose her to testing and treatment for HIV?
- What options can they explore regarding having children?

Case Study 4

Naushad is a Peer Educator (PE) in a TI Plus organisation. He is very happy to know that his CBO will address the issues of MSM with female partners.

During one of the support group sessions, there were a lot of questions from the community as to why his CBO was trying to reach female partners. Many wanted to know whether the CBO was trying to disclose their sexuality to their female partner.

Many were reluctant to reveal their marital status to the group, and few had revealed their sexual behaviour with men to their female partners.

Questions

- Can you identify some of the reasons as to why some of the community could be nervous about reaching out to female partners?
- What strategies can be developed to address these concerns?
- What services can a CBO provide to the MSM with female partners?
- What services can a CBO provide to the female partners of MSM?
# Pehchan Training Curriculum

**MSM, Transgender and Hijra Community Systems Strengthening**

<table>
<thead>
<tr>
<th>Module</th>
<th>Content</th>
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</thead>
<tbody>
<tr>
<td><strong>CG</strong></td>
<td>Curriculum Guide</td>
</tr>
</tbody>
</table>
| **A**  | Organisational Development  
|        | Leadership and Governance  
|        | Resource Mobilisation and Financial Management |
| **B**  | Basics of HIV Prevention and Outreach Planning (Pre-TI) |
| **C**  | Identity, Gender and Sexuality  
|        | Family Support  
|        | Mental Health  
|        | MSM with Female Partners  
|        | Transgender and Hijra Communities |
| **D**  | Human and Legal Rights  
|        | Trauma and Violence  
|        | Positive Living  
|        | Community Friendly Services  
|        | Community Preparedness for Sustainability  
|        | Life Skills Education |