

RECLAIMING SRHR *of* WOMEN *and* GIRLS *with* DISABILITIES

A TRAINING OF TRAINERS (ToT) MANUAL ON DISABILITY RIGHTS,
GENDER, AND SRHR

arrow
asian-pacific resource & research
centre for women



WDDF



RECLAIMING SRHR OF WOMEN AND GIRLS WITH DISABILITIES

This work is licensed under the Creative Commons Attribution-Non-Commercial 4.0 International License. To view a copy of this license, visit <http://creativecommons.org/licenses/by-nc/4.0/>.

Any part of the text of the publication may be photocopied, reproduced, stored in a retrieval system, or transmitted in any form by any means, or adapted and translated to meet local needs, for non-commercial and non-profit purposes. However, the copyright for images used remains with respective copyright holders. All forms of copies, reproductions, adaptations, and translations through mechanical, electrical, or electronic means should acknowledge ARROW as the source. A copy of the reproduction, adaptation, and/or translation should be sent to ARROW. In cases of commercial usage, ARROW must be contacted for permission at arrow@arrow.org.my.

ISBN: 978-967-0339-53-5

ASIAN-PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN (ARROW)

1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

Telephone: (603) 2273 9913/9914/9915

Fax: (603) 2273 9916

Email: arrow@arrow.org.my

Website: arrow.org.my

Facebook: facebook.com/ARROW.Women

Instagram: [arrow_women](https://www.instagram.com/arrow_women)

Twitter: [@ARROW_Women](https://twitter.com/ARROW_Women)

YouTube: youtube.com/user/ARROWWomen

LinkedIn: linkedin.com/company/arrowwomen

PRODUCTION TEAM

Author: *Shreshtha Das*

Overall Supervision: *Sivananthi Thanenthiran and Sai Jyothirmai Racherla*

External Reviewers: *Abdullah Anbar Anan Titir, Ashrafunnahar Misti,*

Hezzy Smith, Md. Rejaul Karim Siddiquee, Nidhi Goyal; Shirin Akther,

Pramada Menon, Pratima Gurung, and Shirin Akther

Internal Reviewers: *Biplabi Shrestha, Momota Hena, and Nawmi Naz Chowdhury*

Project Coordinators: *Biplabi Shrestha, Momota Hena, and Nawmi Naz Chowdhury*

Copy Editor: *Stefanie Peters*

Graphic Design: *Nicolette Mallari*



RECLAIMING SRHR *of* **WOMEN** *and* **GIRLS** *with* **DISABILITIES**



It is time for parents to teach young people early on that in diversity there is beauty and there is strength.

Maya Angelou



**A TRAINING OF TRAINERS (ToT) MANUAL
ON DISABILITY RIGHTS, GENDER, AND SRHR**

Shreshtha Das

contents

6 ACKNOWLEDGEMENTS

8 ABBREVIATIONS

8 KEY TERMINOLOGIES

10 INTRODUCTION

10 Background

11 Who is the Manual For?

11 How to Use the Manual

- 11 > Approach
 - 12 > Structure
 - 12 > Tips for Facilitators
 - 12 > Preparing for Training
 - 14 > Facilitators Role
-

16 MODULE 1. INTRODUCTION

16 Activity 1.1: Common Ground (Participant Introductions)

16 Activity 1.2: Talking About Sexuality

17 Activity 1.3: Expectations and Ground Rules

18 Activity 1.4: Logistics and Reasonable Accommodations

Handouts for Module 1 (Pages 19-21)

24 MODULE 2. DISABILITY BASICS

24 Activity 2.1: Different Disabilities

25 Activity 2.2: Models of Disability

25 Activity 2.3: Framework of Disability Rights

Handouts for Module 2 (Pages 27-34)

36 MODULE 3. BODY IMAGE AND SELF ESTEEM

36 Activity 3.1: Ableism, Productivity and Human Worth

38 Activity 3.2: Strengthening Self-Esteem

38 Activity 3.3: Body Image

42 MODULE 4. GENDER, SEX AND SEXUALITY

CHAPTER 1: SOCIAL CONSTRUCTION OF GENDER AND SEX

41 Activity 4.1: Understanding Gender

44 Activity 4.2: Sex Characteristics and Gender Identity

CHAPTER 2: SEXUALITY

47 Activity 4.3: Sexuality Alphabet Soup

48 Activity 4.4: Myth Busting on Sexuality

48 Activity 4.5: Genderbread Person

50 Activity 4.6: Short Film

CHAPTER 3: POWER, PRIVILEGE AND INTERSECTIONALITY

51 Activity 4.7: Pebbles and Petals

52 Activity 4.8: Intersectionality

Handouts for Module 4 (Pages 55-62)

64 MODULE 5. GETTING TO KNOW OUR BODIES

CHAPTER 1: SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY

64 Activity 5.1: Body Mapping

66 Activity 5.2: Anatomy and Physiology

CHAPTER 2: CHANGES THROUGH THE AGES

67 Activity 5.3: Changes throughout the Life Cycle

CHAPTER 3: MENSTRUATION AND ITS MANAGEMENT

68 Activity 5.4: The Menstruation Process

69 Activity 5.5: Menstruation Management

69 Activity 5.6: Menstrual Myth Busting

Handouts for Module 5 (Pages 71-88)

90 MODULE 6: DESIRES, PLEASURE AND SEXUALITY

- 90 **Activity 6.1:** Pleasure Story
91 **Activity 6.2:** Desire, Pleasure and Love
92 **Activity 6.3:** Resisting Pressure

Handouts for Module 6 (Pages 95-96)

98 MODULE 7: SEXUAL AND REPRODUCTIVE HEALTH**CHAPTER 1: REPRODUCTIVE AUTONOMY**

- 98 **Activity 7.1:** Conception, Contraception and Pregnancy
101 **Activity 7.2:** Parenting and Adoption
103 **Activity 7.3:** Myths and Facts on Abortion

CHAPTER 2: STI, RTI, HIV AND AIDS

- 105 **Activity 7.4:** Quiz on STI, RTI, HIV and AIDS
106 **Activity 7.5:** Demonstration of Barrier Method

Handouts for Module 7 (Pages 108-128)

130 MODULE 8: ABUSE AND VIOLENCE

- 130 **Activity 8.1:** Mapping Abuse and Violence
131 **Activity 8.2:** Sexual Abuse and Humanitarian Crisis
132 **Activity 8.3:** Access to Justice

Handouts for Module 8 (Pages 134-142)

144 MODULE 9: SRHR ADVOCACY

- 144 **Activity 9.1:** Laws and Policies on SRHR
146 **Activity 9.2:** Developing an Advocacy Strategy

Handouts for Module 9 (148-159)

160 EVALUATION AND FEEDBACK

162 ENDNOTES

164 REFERENCES

165 APPENDIX A: SAMPLE NEEDS ASSESSMENT TOOL

168 TRAINER'S NOTE SHEET

acknowledgements

The manual is developed as part of ARROW's initiative, 'Defending SRHR of Women and Girls with Disabilities'. ARROW acknowledges experts from multiple disciplines whose contributions made Reclaiming SRHR of Women and Girls with Disabilities possible.

Shreshtha Das, the author of the manual, for developing the resource that is comprehensive in content and participatory in methodologies. ARROW also acknowledges *Shreshtha's* efforts in ensuring the process that is consultative and for incorporating the inputs received through the consultations and reviews.

Abdullah Anbar Anan Titir; Ashrafunnahar Misti; Hezzy Smith; Md. Rejaul Karim Siddiquee; Nidhi Goyal; Pramada Menon; Pratima Gurung; and Shirin Akther for their invaluable time and for providing technical guidance through an in-depth review of the whole or certain parts of the manual. This is in addition to their review as part of the consultations listed below.

All the experts who attended regional consultation/s organized by ARROW on 22 and 23 July, 2020. The consultations helped shape the manual both in terms of the content and methodologies. The experts are, in alphabetic order: *Abdullah Anbar Anan Titir (BLAST)/Bangladesh; Abha Khetrupal/India; Adv. Shakir Khondokar/Bangladesh; Abia Akram (National Forum of Women with Disabilities)/Pakistan; Ashrafunnahar Misti (WDDF)/Bangladesh; Dr. Sabina Rashid (BRAC James P Grant School of Public Health)/Bangladesh; Kamrun Nahar (Naripokkho)/Bangladesh; Laxmi Nepal (Blind Women Association)/Nepal; Md. Rejaul Karim Siddiquee/Bangladesh; Mohua Paul (Access Bangladesh Foundation)/Bangladesh; Nandini Rao/India; Nazrana Yasmin Hira (Manusher Jonno Foundation)/Bangladesh; Nidhi Goyal (Rising*

Flame)/India; Niluka Gunawardena/Sri Lanka; Prabha Nagaraja (TARSHI)/India; Pramada Menon/India; Pratima Gurung (National Indigenous Disabled Women Association)/Nepal; Rama Dhakal (NFDN)/Nepal; Shampa Sengupta (Sruti Disability Rights Centre)/India; Shirin Akther (WDDF)/Bangladesh; Smruti Behera, Ishani Cordeiro, and Swarnalata Mahilkar (CREA), India; Taposhi Rabaya (BLAST)/Bangladesh; and Yumna Ikram (Disability Visual Impairment Organization Inclusive Destiny)/Pakistan.

Surbhi Taneja and Manisha Sharma for providing sign interpretations during the above-mentioned consultations.

Kiran Nayak, Mamatha, Pratima Gurung, Shalini Abeysinghe, and Sowbhagya for sharing and allowing their stories to be added as case studies in the Manual. *Neha Kamat and Kavitha Srinivasan* for facilitating translation from Kannada to English.

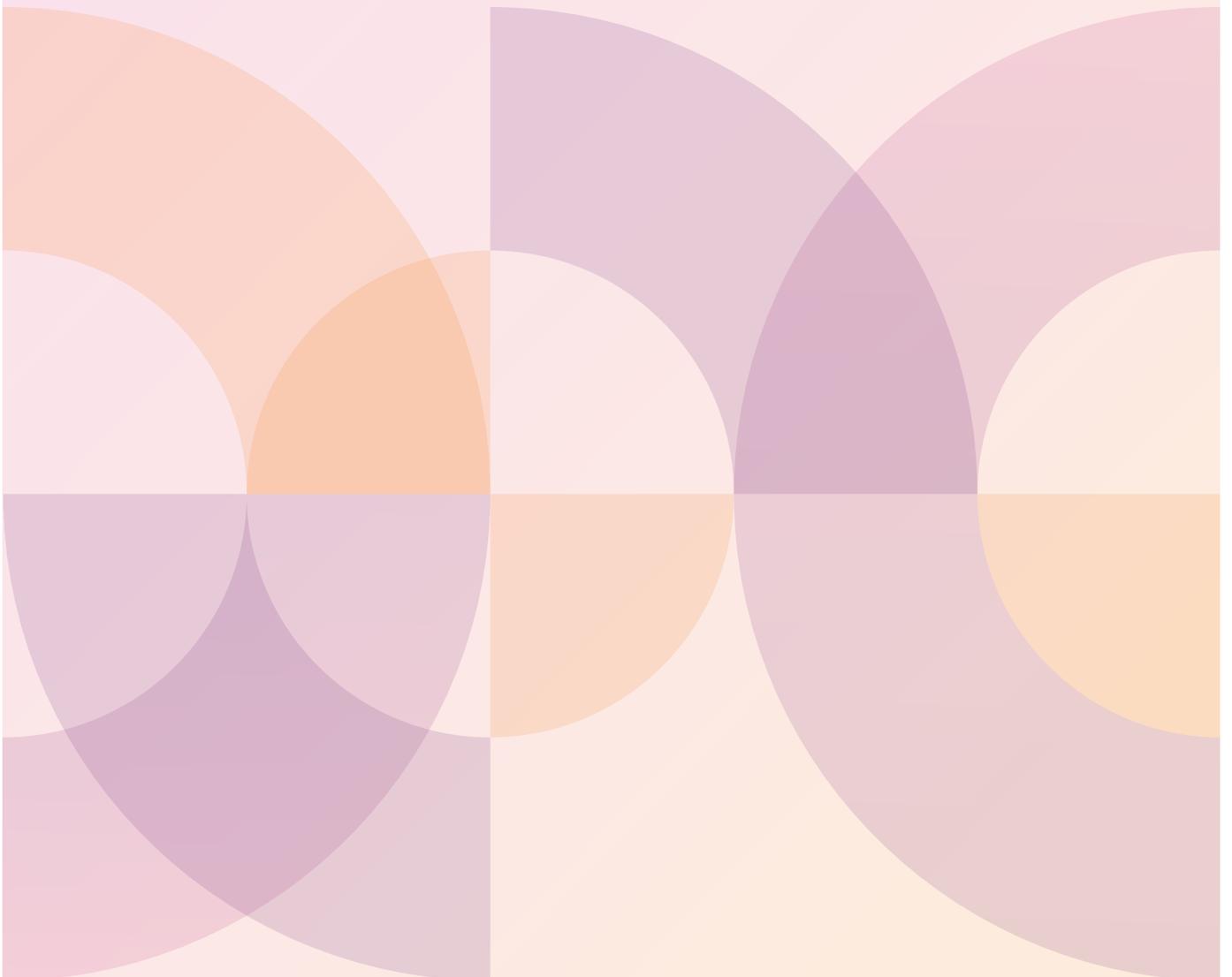
Women with Disabilities Foundations (WDDF), ARROW's partners in Bangladesh, for the work that they do with women and girls with disabilities, and for an extensive sharing of their experience and knowledge on the ground and at the national level in the process of the development of the manual. WDDF's work with women and girls with disabilities in the country has hugely inspired this initiative including the development of the manual.

CREA, Anjali Mental Health Rights Organisation, Point of View, Equals Centre for Promotion of Social Justice and Sruti Disability Rights Centre for allowing the use of the Needs Assessment Tool jointly developed by them in this Manual.

UN Trust Fund and UN Women for supporting this crucial initiative in Bangladesh and in the Region. For further credit, refer to the following information in the back cover as well.

INTRODUCTION

to the Training Manual



abbreviations

- AIDS:** Acquired Immune Deficiency Syndrome
- ARROW:** The Asian-Pacific Resource & Research Centre for Women
- ART:** Anti-Retroviral Therapy
- CEDAW:** Convention on the Elimination of All Forms of Discrimination against Women
- CRPD:** Convention on the Rights of Persons with Disabilities
- DPO:** Disabled People's Organization
- HIV:** Human Immunodeficiency Virus
- OHCHR:** Office of the High Commissioner for Human Rights
- RPPDA:** Rights and Protection of Persons with Disabilities Act, 2013
- RTI:** Reproductive Tract Infection
- SRH:** Sexual and Reproductive Health
- SRHR:** Sexual and Reproductive Health and Rights
- STI:** Sexually Transmitted Infection
- UNAIDS:** The Joint United Nations Programme on HIV/AIDS
- WHO:** World Health Organization

key terminologies

ACCESSIBILITY

It requires ensuring access for persons with disabilities “to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas”, on an equal basis with others. (*Article 9, CRPD*)

For the purposes of this Manual, accessibility also refers to provision of information, facilities and services in native language, and to have access free from discrimination, prejudice and bias.

ACCESS TO JUSTICE FOR PERSONS WITH DISABILITIES:

Access to Justice includes the “provision of procedural and age-appropriate accommodations, in order to facilitate the effective role of persons with disabilities as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.” (*Article 13, CRPD*)

CONSENT:

The understanding of consent shall include the concept of “free, prior and informed consent” as put forth by indigenous groups, which requires the right of self-determination, consultation and participation in decision making to be respected.

DISABILITY:

The CRPD defines disability as an ‘evolving concept’ that “results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others”. (*Preamble to the CRPD*)

DISABILITY JUSTICE:

Disability justice recognises that while a rights based model is important in principle, these rights cannot be accessed by many owing to many intersectional barriers. It therefore, “pushes forward the disability movement beyond a single issue discourse centred on rights to promote an intersectional movement led by those most impacted by ableism and historical systemic oppression”.¹

DISCRIMINATION:

Discrimination occurs when distinctions, exclusions or restrictions affect the recognition of, and ability to enjoy and exercise human rights and fundamental freedoms on an equal basis with others, in all spheres of life.

INTERSECTIONALITY:

It is a term coined by black feminist scholar and activist, Kimberlé Crenshaw, to denote a lens for seeing the way in which various forms of inequality often operate together and exacerbate each other. It involves understanding that the discrimination faced by persons who face “intersecting” forms of oppression (for example on grounds of race and gender) cannot be captured wholly by looking at just one dimension of those experiences separately (either race or gender).²

LEGAL CAPACITY:

It refers to a traditional legal construct used to determine which members of society may undertake actions that carry consequences under law, such as entering into contracts, owning property, or consenting to health care. However, this right of legal capacity is often denied to many women and girls with disabilities through discriminatory laws, allowing for decisions to be made on their behalf. The denial of legal capacity gives rise to numerous other violations of fundamental rights for women and girls with disabilities, including their right to marry and start a family; make autonomous and voluntary decisions about their sexual and reproductive health; give or withhold consent to intimate relationships; seek accountability for various forms of abuse through the justice system; and participate in all other daily aspects of civil, political, cultural, economic, and social life.³

REASONABLE ACCOMMODATION:

Refers to necessary and appropriate modification and adjustments where needed in a particular case, so as to ensure to persons with disabilities the enjoyment or exercise of all human rights and fundamental freedoms, on an equal basis with others. (*Article 2 CRPD*).

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR):

Sexual and reproductive health and rights include four interlinked concepts that cover both the health aspects of sexuality and human reproduction, and the right to make informed choices related to sexuality and reproduction. These rights include the freedom to: choose one’s partner, marry or not; have children or not, and if yes, then to decide on the number, spacing, and timing of children; the right to be free from coercion and violence; and the right to attain the highest standards of sexual and reproductive health.

WOMEN AND GIRLS WITH DISABILITIES:

Women and girls with disabilities are not a homogenous group. They include, but are not limited to: “indigenous women; refugee, migrant, asylum seeker and internally displaced women; women in detention (hospitals, residential institutions, juvenile or correctional facilities and prisons); women living in poverty; [rural women;] women from different ethnic, religious and racial backgrounds; women with multiple disabilities and high levels of support [needs]; women with albinism; and lesbian, bi-sexual, transgender women, and intersex persons. The diversity of women with disabilities also includes all types of impairments which is understood as physical, psychosocial, intellectual or sensory conditions which may or may not come with functional limitations.”⁴

“Disability is mutable and ever-evolving. Disability is both apparent and nonapparent. Disability is pain, struggle, brilliance, abundance, and joy. Disability is sociopolitical, cultural, and biological. Being visible and claiming a disabled identity brings risks as much as it brings pride.”

Alice Wong, Disability Visibility: First-Person Stories from the Twenty-first Century

introduction

background

It is estimated that there are one billion people with disabilities in the world today (almost 15% of the population) and women with disabilities account for one fifth of the female population.⁵ Despite these large numbers, the needs and concerns of women and girls with disabilities are neglected and overlooked, and they face marginalisation, discrimination and violence in all aspects of life.

Not only do women and girls with disabilities experience similar forms of gender-based violence as their non-disabled peers, they face heightened vulnerability to violence and unique forms of violence owing to the intersecting discrimination on account of gender and disability.⁶ For example, women and girls with disabilities are at three times greater risk of rape, twice as likely to be survivors of domestic violence and other forms of gender-based violence and are likely to experience abuse over a longer period and with more severe injuries than women without disabilities.⁷

Violence against women and girls with disabilities is further compounded by a number of factors. This includes inaccessible justice systems and socio-economic status of women and girls with disabilities, which in most cases leads to dependency on the abuser and makes it difficult to report abuse. Women and girls with disabilities are unable to report violence in many instances for fear of not being believed, not being considered as credible witnesses, and physical and communication barriers at every level from police stations to medical examinations as well as trial processes. Moreover, systemic discrimination and oppression stemming from other forms of social exclusion such as race, ethnicity, caste, class, religion, rural/urban status, indigeneity, sexual and gender identity and orientation further exacerbate and impact violence experienced by women and girls with disabilities and heighten the barriers in accessing justice.

Yet, women and girls, especially in the South Asian context, continue to lack access to SRH information and health and legal services that are necessary to minimise risks of gender-based violence, and response mechanisms to gender-based violence seldom address SRHR. This gap is further exacerbated for women and girls with disabilities whose SRHR needs and concerns are repeatedly disregarded. This is often premised on harmful assumptions that construe women

and girls with disabilities to be non-sexual or hypersexual (depending on the nature of disability). Women and girls with disabilities are infantilised, invisibilised and robbed of agency to make decisions about their own bodies, sexuality, and lives, including through practices such as forced sterilisation, forced abortion and forced institutionalisation.

In reality, persons with disabilities have a wide range of desires and sexuality⁸ and need access to SRH information and services just like their non-disabled peers. Sexuality is as intrinsic a part of their lives and they have a right to access information around sexuality and their bodies; have positive and loving relationship with their bodies; have pleasurable and consensual sexual experiences and relationships; have a right to choose one's partner; have a right to decide whether to have children or not, if yes, then to decide on the number, spacing, and timing of children; avoid infections and diseases; and live a life free from discrimination, violence and abuse. When those needs and rights are not met, they are exposed to unintended pregnancies, sexually transmitted infections, gender-based violence and sexual abuse, child marriage and other harmful practices that hamper their quality of life.⁹

Despite this urgent need for SRHR information and disability and culturally sensitive services, women and girls with disabilities face innumerable barriers in accessing SRHR information and SRH services. First, they continue to be rendered invisible in provision of SRHR information and delivery of services. Second, they face many barriers in accessing health care, including negative, hostile and biased attitudes of health care providers, physical barriers in terms of inaccessible buildings and equipment, and lack of affordable services and public transportation. Many intersecting forms of marginalisation, further exacerbate the difficulty in accessing SRHR information and services. Lack of accessible and culturally sensitive information on SRHR has meant that women and girls with disabilities lack the skills, tools and information to protect themselves from abuse, violence and infections and seek pleasurable SRH outcomes.

Women and girls with disability have the right to decide about their bodies and sexuality and this is a critical component of addressing gender-based violence. This Manual, therefore, aims to equip women and girls with disabilities with necessary SRHR information and knowledge to make informed choices free from coercion, violence, discrimination and abuse. The Manual contains detailed Modules on gender, sexuality, disability, rights and their interlinkages in the context of addressing violence against women and girls with disabilities. Through this, it seeks to provide accessible information and knowledge on SRHR to women and girls with disabilities

with the aim of building their capacities and that of other stakeholders such as journalists, service providers, community leaders etc., to understand and address sexual and gender-based violence more holistically using a feminist and intersectional approach.

who is the manual for?

The ultimate aim of the Manual is to ensure knowledge on SRHR of women and girls with disabilities aids in upholding their SRHR in the context of addressing sexual and gender based violence against them and can be used by different stakeholders to that end.

The Manual is particularly aimed at training of trainers who can use the Manual to gain necessary knowledge, information and skills that enable them to conduct capacity building training primarily with women and girls with disabilities, but also with disability advocates, DPOs, and other relevant stakeholders such as journalists, lawyers and other service providers in Bangladesh. The exercises and methodologies detailed in the Manual can be used and adapted by community groups to create a learning environment whereby knowledge and information on SRHR can percolate down to women and girls with disabilities in their communities. For ease of understanding and to keep the learning participatory and interactive, the Manual uses exercises and methodologies that place minimal reliance on knowledge of reading and writing and can, therefore, be used in resource poor settings.

The Training Manual is initially being planned for use by DPOs in Bangladesh but is expected to be expanded in its usage and applicability to countries in the South-Asia sub-region where the context is similar.

It is crucial to recognise that women and girls with disabilities are not a homogenous group and there is a lot of diversity based on other factors such as ethnicity, caste, religion, location, nature of disability, gender and sexual identity and orientation and sex characteristics etc. While the Manual is built with a strong intersectional lens, it may need to be adapted to the context of different groups of women and girls with disabilities as necessary.

Importantly, the Manual is limited in its scope and is primarily meant for conducting SRHR trainings with women and girls with physical disabilities, which includes those with visual disability, speech and/or hearing disability, those with locomotor disability, dexterity issues, reduced stamina etc.

This is based on the recognition that a ‘one size fits all’ approach does not work given the diversity of needs and realities of persons with disabilities, and the content and methodology in the Manual may not holistically address and accommodate the SRH realities of neurodiverse persons, persons with psychosocial disability, and persons with intellectual disabilities. Trainers who are well experienced in working with different disabilities may, however, adapt the modules and exercises for persons with other disabilities as deemed suitable.

how to use the manual

APPROACH:

The Manual promotes a participatory learning approach, which is not top-down and recognises the valuable contribution that each participant makes in ensuring that the training is holistic. The trainer, therefore, acts as a facilitator to create a space for critical reflection on and engagement with attitudes, perceptions, existing knowledge around SRHR. The Manual draws on different participatory and experiential learning methodologies such as the follows:

- 1. Warm Up/Ice-Breakers/Energizers:** These are quick, easy and fun activities that can be used at the start of training for building comfort and familiarity among participants and during the training to break monotony, lift energies and for some respite after particularly difficult sessions.
- 2. Working in Pairs:** This technique allows participants to discuss their opinions in pairs before sharing with the larger group and can ensure everyone is able to participate in the discussion.
- 3. Small Group Work/Discussion:** This enables participants to appreciate different experiences and views on the same topic; to learn from each other; and sharpens teamwork/ collaboration skills.
- 4. Games and Art and Crafts:** Games and art & craft offer a fun and alternate way of communicating information and triggering discussion.
- 5. Case Studies:** This draws on situations and scenarios, often drawn from real life, which can be used as a basis of creating discussion and deliberation within the group.
- 6. Role Play/Theatre/Drama:** Role play involves providing a theme, objects, story to participants around which they can create a story.
- 7. Audios, Videos and Pictorial Aids:** This can be used to introduce and illustrate a concept, bring in diverse perspectives and ensure easy breaking down of concepts.

8. **Plenary:** This is an open space for all participants to share thoughts, ideas, experiences and suggestions on a given topic.
9. **Debates:** It allows participants to present differing viewpoints on the same issue.
10. **Myth-Busting:** Myth-busting is an important tool for clearing misconceptions and encouraging participants to dig deeper around commonly held knowledge, attitudes, perceptions and beliefs.

STRUCTURE:

The Manual is divided into nine Modules. Modules 1 to 3 lay the foundation on which SRHR training with women and girls with disabilities needs to be built. Modules 4-8 explore various areas of sexuality and SRH and Module 9 provides tools and resources for advocacy on SRHR issues.

Each Module is divided into segments comprising of various activities that look at different aspects of the Module with the aim of making it more holistic. Additional resources are provided at the end of each Module for further information and reading. The description of each activity details the following:

- Objective
- Materials needed for the session
- Time
- Process (Steps for carrying out the activity/discussion)
- Key Messaging for the session
- Notes for the Facilitator (if any)
- Handouts (if any)

Ideally, the Manual should be used as a whole as Modules and concepts build on each other progressively. Such a training session involving all the Modules should be planned over five to six days. However, based on a Needs Assessment (please see below), trainers may choose to select particular modules that meet the learning needs of the group. Tailor-made design of the training sessions can also be made to ensure the training is age appropriate and culturally sensitive.

TIPS FOR FACILITATOR:

The key to a meaningful and effective training session is preparation, preparation and more preparation! This section highlights some useful tips that facilitators could keep in mind while using the Manual.

PREPARING FOR TRAINING:

Training sessions should ideally have between 20-25 participants. Some other tips are as follows:

1. **Risk Analysis:** Prior to the training conduct a detailed assessment of legal and political scenarios to gauge the topics that can be covered, terminologies that can/cannot be used and methodologies that can be employed, keeping in mind safety of everyone involved. Facilitators can adjust the Modules and the exercises based on their assessment.
2. **Entry and Exit Point:** Given the taboo and stigma around sexuality and SRHR, conducting training on these issues can be quite difficult. It is best to start with organizations and groups where there is an established relationship between the facilitator and the organizers. In order to negotiate restrictive circumstances, sexuality and SRHR training can be administered within the broader framework of 'women's health', 'body literacy', 'reproductive health', 'self-expression', 'violence training', 'gender diversity training' and 'human rights training' etc.

Facilitators should ensure that the concepts are introduced responsibly so as to not overwhelm the participants. Ideally, training should be a part of broader engagement with the community, so that the participants feel comforted and supported in taking forward and implementing the perspectives gained.

Facilitators should also be conscious to ensure a follow up mechanism for further queries to be addressed, as the training may trigger many questions for participants who are introduced to a lot of the information for the first time.

3. **Know your participants:** It is good practice to conduct a Needs Assessment¹⁰ prior to the training. This can be a combination of informal research about the organization's work; nature of past trainings (if any); group specifications in terms of age, ethnic, socio-cultural and economic background; nature of disability; and understanding on different SRHR topics etc. This can be complemented with a formal needs assessment/focussed group discussion to understand perceptions and current access to information on SRHR. It is important to always assess what the group is ready for before commencing training and to know their context.

For first time facilitators, it is best to start with a group of participants with a similar disability.

- 4. Knowledge of topics:** Prior to the training, go through the entire manual and read up where necessary to ensure you have strong grasp of the topics being covered.

The website [Link] <https://sexualityanddisability.org/> is a good place to get more clarity on the topics covered in the Manual, in the South Asian context. You can also browse through the Health Handbook for Women with Disabilities,¹¹ which is available online for free.

- 5. Flexible Budgeting:** When planning the training budget, have a portion of funds that is flexible to ensure reasonable accommodation needs of participants are met.
- 6. Accessible Venue:** As far as possible, training should be conducted in venues that participants are already familiar with as this helps to build a sense of comfort and security. The venue should also be chosen keeping in mind the ease with which participants can reach the venue.

Ensure that all parts of the training venue are accessible including training rooms, toilets, refreshment and leisure areas. It is a good practice to personally visit the training space to ensure accessibility measures are in place.

- 7. Structuring Sessions:** Session plans should be made keeping sufficient time for sign language interpretations to take place.

The facilitator should also be flexible and dynamic, to ensure that training objectives and participants needs and concerns are balanced and managed.

- 8. Materials:** Prior to the training ensure the materials and handouts needed for the different activities are in place. The handouts must be in accessible format and language, for example in Braille and/or DAISY format or with large font, as necessary. Based on the literacy levels of the group, plan the session in a way that there is enough time to read out and discuss the material in the handouts, if needed.

All videos being used must be accompanied by simultaneous sign language interpretation (for persons with hearing difficulties) and scene descriptions (for persons with visual disability) as needed (depending on the nature of disability within the group).

- 9. Resource Persons:** As far as possible, sign language interpreters and other resource persons should be local and familiar with the context of the group. This not only ensures familiarity with the discussions during the sessions, but also creates a support structure for participants to access the resource persons beyond the trainings.

Sign language interpreters, in particular, should be someone who is known, in order to ensure that information is not filtered, distorted or lost in the process of translation.

The facilitator must meet with all resource persons prior to the training sessions and go over session plans and material to ensure clarity of training objectives and outcomes.

- 10. Language:** In many instances the language will have to be adapted to the local context and dialects to ensure that the message is conveyed. However, it is important to balance accessible language and terminologies along with ensuring a rights based and non-stigmatising language is used in the sessions.

In terms of sign language, many words may not be available in sign language. It is important to meet with the interpreter beforehand and understand the gaps. The gaps can then be filled by evolving signs collectively with the group.

- 11. Caregivers:** The facilitator must decide if the carer can participate in the sessions. While the presence of a caregiver is important for the participant, most often caregivers are family members whose presence may limit the openness with which participants interact in the sessions. The facilitator must have a plan in place to work with the participant, the caregiver and the institution to successfully negotiate this.

- 12. Addressing Queries:** It is good practice to have a box where participants can raise queries anonymously, as they may feel uncomfortable speaking about some topics openly. The exact placement of this box must be informed to the participants and must remain the same throughout the duration of the training.

Depending on the nature of disability and literacy levels of the group, instead of having a queries box, participants can also be encouraged to record their queries and share it with the facilitator. A specific number can also be designated for queries where participants can text their queries anonymously. This would work well for participants who are technologically proficient, and particularly those who have a visual disability and are screen reader users.

- 13. Photos and Recording of Sessions:** Prior consent from the participants needs to be taken if the training is being recorded, or if pictures are being taken. No pictures of the role plays should be taken and/or shared as they can be taken out of context.

FACILITATOR'S ROLE:

In conducting the sessions, the facilitators are expected to:

- Be comfortable in talking about sexuality
- Be respectful of other's views
- Have some prior understanding of disability and accessibility needs
- Be non-judgmental
- Be flexible to adapt activities and schedule based on discussions, needs and queries of the group
- Have willingness to learn
- Invest in building a fun and creative learning space

FIGURE 1: DOS and DON'TS FOR FACILITATORS

DO

- ✓ Be patient.
- ✓ Show that s/he is a learner too.
- ✓ Build on participants' experience.
- ✓ Be sensitive to what's happening in the group.
- ✓ Deal with issues raised in the group.
- ✓ Encourage participation.
- ✓ Use simple language.
- ✓ Keep the group on the topic.
- ✓ Be a good listener.
- ✓ Be aware of all the members of the group.
- ✓ Keep eye contact with group members.
- ✓ Be enthusiastic.
- ✓ Plan the sessions in advance.
- ✓ Be empathetic.
- ✓ Have a sense of humor.
- ✓ Act responsibly.

DON'T

- ✗ Dominate the group.
- ✗ Intimidate people.
- ✗ Take sides.
- ✗ Jump to conclusions.
- ✗ Be prejudiced.
- ✗ See her/himself as the expert.
- ✗ Put participants on the spot.
- ✗ Create a long dialogue with one participant.
- ✗ Lose her/his temper with a participant.
- ✗ Be biased.
- ✗ Facilitate discussion if s/he is uncomfortable with the topic.
- ✗ Criticise a participant's personal beliefs.
- ✗ Allow participants to dominate the discussion or intimidate each other.

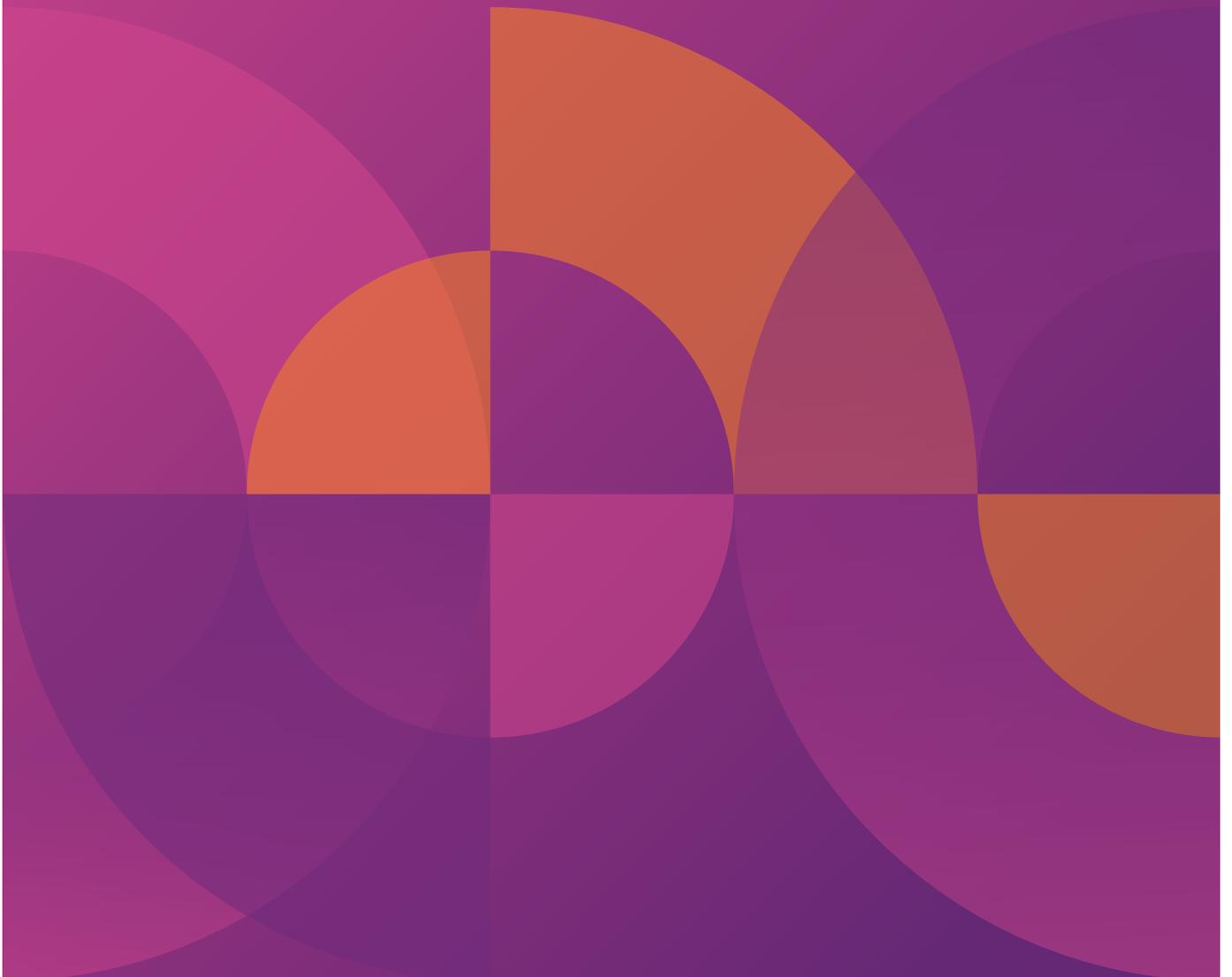
Source: PATH and African Youth Alliance (2004) *Life Planning Skills: A Curriculum For Young People In Africa, Tanzania Version*.

“A Disability Justice framework understands that all bodies are unique and essential, that all bodies have strengths and needs that must be met.”

*Leah Lakshmi Piepzna-Samarasinha
Care Work: Dreaming Disability Justice*

module 1

introduction



module 1

introduction

MODULE OBJECTIVES

1. To enable the participants to get to know each other and to build comfort in talking about gender, sexuality and SRHR.
2. To arrive at consensus on objectives of the training and how participants can contribute to ensuring that the objectives are met.

ACTIVITIES

Activity 1.1: Common Ground (Participant Introductions) > 30 Minutes

Activity 1.2: Talking about Sexuality > 60 Minutes

Activity 1.3: Expectations and Ground Rules > 30 Minutes

Activity 1.4: Logistics and Reasonable Accommodations > 20 Minutes

HANDOUTS

Activity 1.1: Common Ground (Participant Introductions)
> None

Activity 1.2:

- a. Facilitator Handout 1.1: Disability, Sexuality and SRHR – Case Studies
- b. Facilitator Handout 1.2: Core Values

Activity 1.3: Expectations and Ground Rules

> Facilitator Handout 1.3: Signs For Ground Rules

Activity 1.4: Logistics and Reasonable Accommodations
> None

ACTIVITY 1.1: COMMON GROUND (PARTICIPANT INTRODUCTIONS)

Objective:

To enable the group to know each other better, and build comfort and trust among the group.

Time:

30 Minutes

Materials Needed:

None

Process:

1. Ask the participants to divide themselves into pairs. Encourage the participants to pair up with somebody they do not already know.
2. Let the participants know that they have 10 minutes to first introduce themselves and then to find as many things common between them that they can. The participants should try to find common things that are unique, such as favourite actor, favourite flavour of ice cream, a place they would really like to visit, their favourite body part, attributes they value in a partner, ideal date, etc.
3. At the end of 10 minutes, ask the pair to introduce each other to the group and some of the unique things they found in common.

ACTIVITY 1.2: TALKING ABOUT SEXUALITY

Objective:

To build comfort around discussing sexuality and SRHR issues.

Time:

60 Minutes

Materials Needed:

- Facilitator Handout 1.1. and 1.2
- Flip chart
- Markers

Process:

1. Ask the participants about the type of trainings they have attended before. Note down the participant responses.
Note for facilitator: Usually trainings with persons with disabilities centre on skill building, employment, accessibility and education. This step will also give you a sense of current levels of comfort, understanding and knowledge among the participants on SRHR.
2. Read out the case studies in Facilitator Handout 1.1.
3. Divide the participants in groups of four and ask them to discuss the following:
 - a. How did they feel hearing these stories? Did it feel uncomfortable?
 - b. What are the barriers they face in talking about sexuality and SRHR?
 - c. Are these conversations important? And if so, why? The groups have 15 minutes to discuss these questions.

4. One person from each group should report back on the discussion.
5. Play the following set of four very short videos, which provide an overview of SRHR:
 - a. RedOrange Media and Communications (2018). *Decoding SRHR Sexual Health Bengali*. Available at: [Link] <https://www.youtube.com/watch?v=zTelznp4cXo>. Accessed on 17 July 2020.
 - b. RedOrange Media and Communications (2018). *Decoding SRHR Sexual Rights Bangla*. Available at: [Link] <https://www.youtube.com/watch?v=fHyXHJpL9fU>. Accessed on 17 July 2020.
 - c. RedOrange Media and Communications (2018). *Decoding SRHR Reproductive Health Bengali*. Available at: [Link] <https://www.youtube.com/watch?v=GbSfRumPLWw>. Accessed on 17 July 2020.
 - d. RedOrange Media and Communications (2018). *Decoding SRHR Reproductive Rights Bengali*. Available at: [Link] <https://www.youtube.com/watch?v=5l0BnGcr78>. Accessed on 17 July 2020.

For an introductory video on SRHR in English, see Action Canada for Sexual Health and Rights (2019). What is SRHR? Available at: [Link] <https://www.youtube.com/watch?v=jsnusOoT2-o>.

6. Discuss the core values that underline a human rights based approach to working on sexuality, as developed by TARSHI (Talking About Reproductive and Sexual Health Issues).¹² These are detailed in Facilitator Handout 1.2. The five core values are:
 - a. Choice
 - b. Dignity
 - c. Diversity
 - d. Equality
 - e. Respect

Key Messaging:

SRHR issues are often given less importance as other issues such as accessibility, access to education and employment are seen as more pressing issues. Societal and cultural taboos further add to creating an inhospitable environment for discussion on these topics. However, sexuality and SRHR are equally important facets of people's lives as issues of employment, education etc. and can impact a person's overall quality of life. Lack of access to accurate information can

breed misinformation, stigma and fear and make it difficult to access healthcare and support. It is, therefore, essential that participants understand and appreciate the need to have a safe space to discuss these issues.

ACTIVITY 1.3: EXPECTATIONS AND GROUND RULES

Objective:

To discuss participants' expectations from the training and develop ground rules to enable smooth functioning of the sessions.

Time:

30 Minutes

Materials Needed:

- Flip chart
- Markers
- Optional: Print out of signs in Facilitator Handout 1.3

Process:

1. Divide the participants into smaller groups of four-five persons each.
2. Instruct the participants that each group must come up with five expectations and five ground rules each for the training sessions that are arrived at jointly. The groups have 15 minutes for this.
3. Each group must report back on the expectations and ground rules their group came up with. All of these must be noted by the facilitator.
4. From the expectations that participants have highlighted, address what will and will not be addressed in the training. Detail the topics and concepts that will be covered through the training.
5. Read out each of the ground rules and allow participants to express if they have reservations with it. Once the whole group agrees to it, write down the rules on the flip chart. Read out the final list of rules that the group has agreed upon. The flip chart containing the final set of rules should be pinned to a corner throughout the sessions.

Variation: If the group has overall low levels of reading and writing skills, signs for ground rules can be used instead. Some of the signs for the important ground rules are provided in Facilitator Handout 1.3. After sharing the images in the Handout, the meaning of each of the signs can be discussed with the group for consensus. However, this will not work with a group of persons with visual disability and the earlier process detailed will be a better alternative.

MODULE 1 FACILITATOR HANDOUT 1.1

DISABILITY, SEXUALITY AND SRHR – CASE STUDIES

(Activity 1.2: Talking about Sexuality)

(The following case studies are extracted from: Saad Adnan Khan and Farhana Alam (2017) *Untold Desires*. Dhaka, Bangladesh: BRAC James P Grant School of Public Health, BRAC University.)

CASE STUDY 1

“Twenty-one year old Neetu has post-polio syndrome. She can’t walk at all and has to crawl on all fours from one place to another. Neither her house, nor the area she lives in, is wheelchair friendly. Regardless of these limitations, she has an active life and does most of the household chores.

Five years back Neetu had a relationship with her maternal cousin and became pregnant from that relationship. She bore the child believing that the cousin will marry her. However, he left her eventually. Neetu gave birth to the child but her mother got rid of the child, with assistance of a midwife. Neetu always carried a baby doll after that incident, pretending that it was her child.

Neetu wants to have a relationship and get married. However, her mother doesn’t want her to get into any relationship, as she thinks that her husband will leave after impregnating her, which will be an extra burden for Neetu’s parents. Her mother’s decision of not letting her get married has made Neetu frustrated. She wants to be with a man now.

Neetu mentions her present lover, who is a married man. He wants to marry Neetu, as his wife cannot bear children. Neetu says that she will do anything to be with the man. She however says that she doesn’t know if she loves him or not, or that whether it is about having someone physically available to fulfil her urges once in a while. Neetu thinks that she is very beautiful. She blames God for making her disabled, and giving her such beauty at the same time.”¹³

CASE STUDY 2

“Twenty-six year old Sonia had a car accident in 2008. She was with her elder sister and brother. She couldn’t feel anything as she lay on the ground. After getting seven months of treatment and therapy, she could barely sit. She realised that she will never be the person she used to be. The transition from being able-bodied to being disabled was traumatic and difficult for Sonia.

Sonia never wanted to get married as she thought that that would make her life more complicated. But her parents convinced her. Sonia however had one condition. She wanted to marry someone who would want to marry her after knowing about her disability. She eventually fell in love and married her physiotherapist at CRP. Due to the length of the treatment, Sonia and her physiotherapist became good friends, and ended up marrying each other.

While talking about married life, Sonia said that it’s a blessing for her that she is married to her physiotherapist, as he knows about her disability more than anybody else, which helps their relationship a lot. She says that it is a misconception about people with spinal cord injury being asexual, and not wanting any sexual interaction. Sonia mentions that the partner should be positive and supportive when it comes to having sex. While talking about pregnancy she said that she has mixed feelings about wanting to be a mother. She is scared of complications and for the fact that there isn’t enough medical support available in Bangladesh for pregnant women with spinal cord injury.”¹⁴

MODULE 1_FACILITATOR HANDOUT 1.2

CORE VALUES

(Activity 1.2: Talking about Sexuality)

(The following core values are extracted from: Talking About Reproductive and Sexual Health Issues (TARSHI) (2006) Basics and Beyond: A Manual for Trainers; Integrating Sexuality, Sexual and Reproductive Health and Rights. New Delhi: TARSHI.)

“CHOICE:

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

DIGNITY:

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

DIVERSITY:

Involves acceptance of the fact that [all individuals] express their sexuality in diverse ways and that there is a range of sexual behaviour, identities (homosexual, bisexual, transgender, intersex), and relationships.

EQUALITY:

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

RESPECT:

[Everyone is] entitled to respect and consideration regardless of their sexual choices or identities. For example, it is important to respect sex workers’ choice of profession and give them the consideration they deserve when they access health services.”¹⁵

MODULE 1 FACILITATOR HANDOUT 1.3

SIGNS FOR GROUND RULES

(Activity 1.3: Expectations and Ground Rules)

FIGURE 2: CONFIDENTIALITY



FIGURE 3: NON-JUDGEMENTAL



FIGURE 4: OPENNESS



FIGURE 5: RESPECT



FIGURE 6: ONE AT A TIME

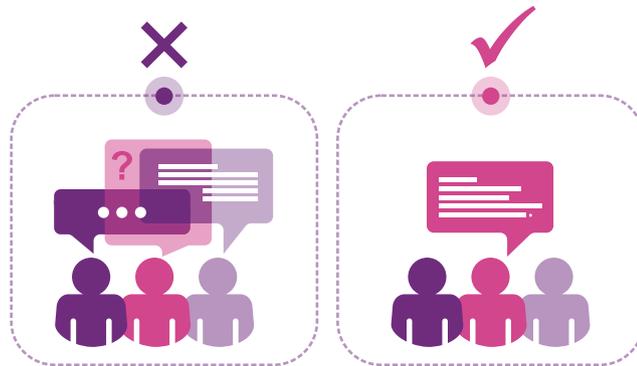


FIGURE 7: TIMING



FIGURE 8: RIGHT TO PASS

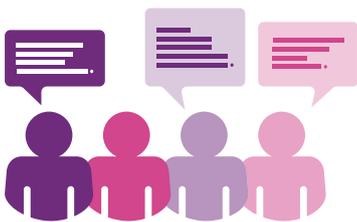


FIGURE 9: "I" STATEMENTS

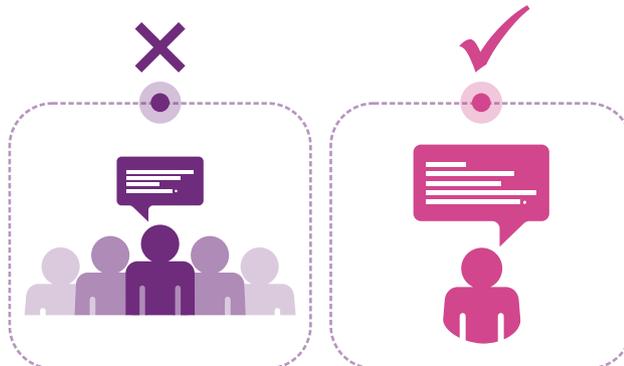
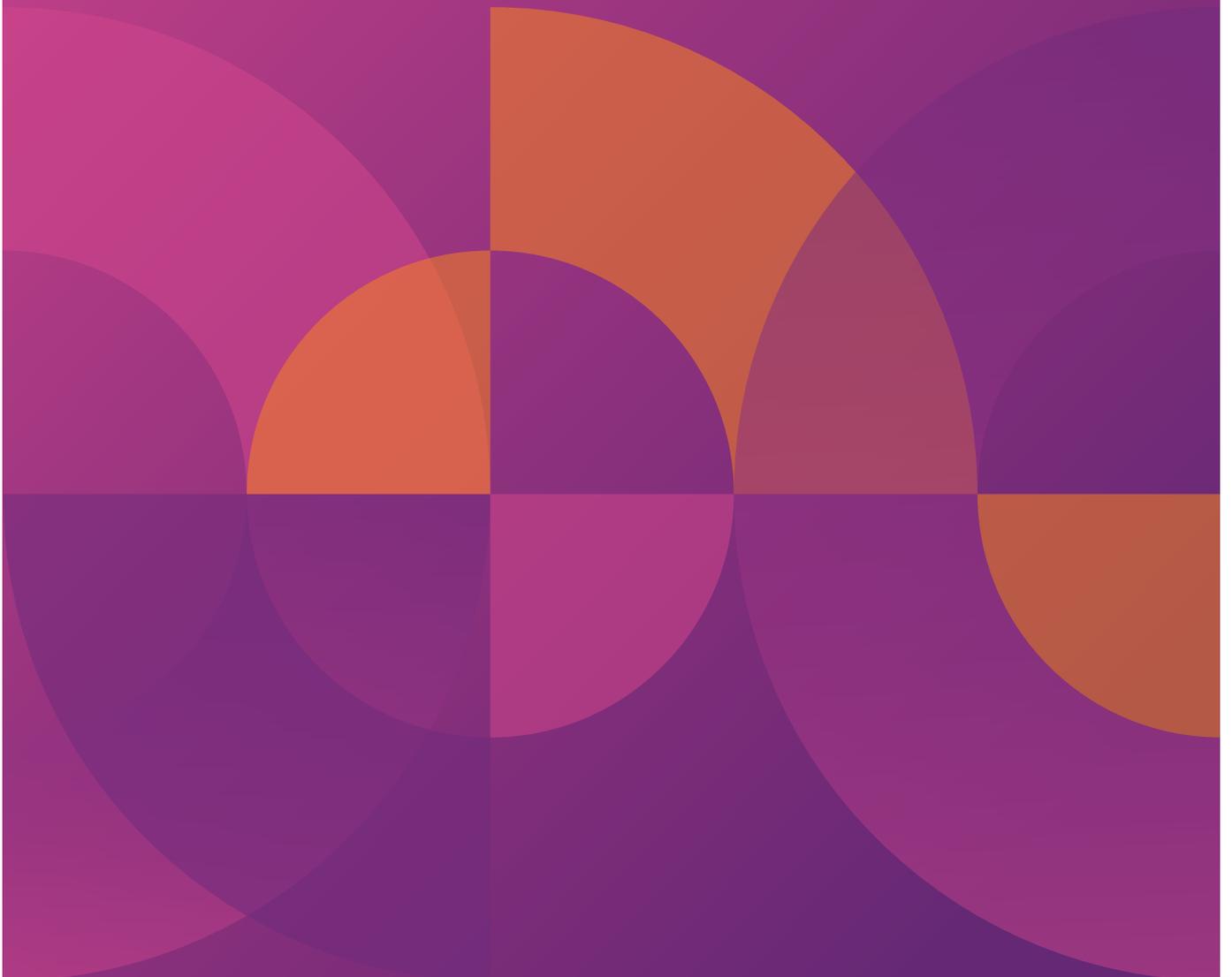


FIGURE 10: NO PHONES





module 2
disability basics



module 2

disability basics

MODULE OBJECTIVES

1. To develop a common understanding of disability.
2. To create awareness on legal safeguards available to persons with disabilities.

ACTIVITIES

Activity 2.1: Different Disabilities > 20 Minutes

Activity 2.2: Models of Disability > 40 Minutes

Activity 2.3: Framework of Disability Rights > 60 Minutes

HANDOUTS

Activity 2.1: Different Disabilities

- > Facilitator Handout 2.1: Understanding Disability

Activity 2.2: Models of Disability

- > Participant Handout 2.1: Models of Disability

Activity 2.3: Framework of Disability Rights

- a. Facilitator Handout 2.2: Case Studies on Rights of Persons With Disabilities
- b. Participant Handout 2.2: Case Studies on Rights of Persons With Disabilities
- c. Participant Handout 2.3: Important Rights under CRPD and RPPDA

ACTIVITY 2.1: DIFFERENT DISABILITIES

Objective:

To enable a broader and more inclusive understanding of disability.

Time:

20 Minutes

Materials Needed:

- Flip chart
- Marker
- Facilitator Handout 2.1

Process:

1. Ask the participants what they understand by the term disability. Note down key phrases.
2. Ask the participants to list different disabilities they have come across or know of.
Variation: Participants can also be asked to draw a person with disability. This would work best for participants with hearing and speech disability.
3. If the disabilities that are being mentioned are limited to physical disabilities, encourage the participants to think of disabilities that are not immediately apparent.
4. Conclude by sharing the definition of persons with disabilities as provided in the CRPD and explain that persons with disabilities includes a diverse range of persons. Since, the CRPD is also an evolving document, it is constantly being reinterpreted to account for changes in the understanding of disability.

Debrief:

1. Are persons with disabilities, whose disabilities are not immediately apparent, accounted for in our understanding of disability, in our work and in our advocacy?
2. Is it important to build cross-disability conversations and movement? If so, why?
3. What are some examples of cross-disability initiatives that participants have come across?

Key Messaging:

1. CRPD defines a person with disability as follows:
“Persons with disabilities include those who have long – term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” (*Article 1, CRPD*)
The illustrations in Facilitator Handout 2.1. can be used to convey the key points from the definition.
2. There are various types of disabilities, some of which are less apparent than others. A person can have more than one disability as well.

ACTIVITY 2.2: MODELS OF DISABILITY

Objective:

To understand the different lenses with which disability is viewed and its impact on stigma and discrimination against persons with disabilities.

Time:

40 Minutes

Materials Needed:

- Flip chart
- Markers
- Participant Handout 2.1

Process:

1. Ask participants to share some of the common statements they have come across around disability. For example, “must have committed a sin in past life”, “oh! The poor thing”, “You should get medical treatment” etc. They should draw on all spheres for the statements – family, community, society, media, government, as well as DPOs.
2. Note down the statements and phrases that the participants share.
3. Segregate the statements under different disability models – religious/moral model, charity model, medical model, social model, and rights based model.
4. Provide the participants with Participant Handout 2.1 which explains the different models. Explain each of the different models of disability.
 - a. Religious/Moral Model: Disability is a result of punishment or because of sin(s) committed by the person with disability.
 - b. Charity Model: Persons with disability are regarded with pity and need to be helped out of the goodness of one’s heart.
 - c. Medical Model: It places primacy on the impairment and the focus lies on ‘curing’ or ‘treating’ the impairment.
 - d. Social Model: The focus is on the barriers that inhibit full and effective participation and is concerned with removing these barriers.
 - e. Rights-Based Model: It builds on the social model to recognise equal opportunities and full participation as a matter of rights and places responsibility on States to ensure these rights are realised.

Debrief:

For each model, ask the participants:

- a. Is this a good model? If not, what are the problems with it?
- b. Does this model perpetuate stigma and discrimination or does it support full and effective inclusion?

Key Messaging:

The moral/religious model, the charity model and the medical model continue to be the primary lens through which our societies view disability. However, these models view disability as an individual problem, stigmatise persons with disabilities and allow others to make decisions on behalf of persons with disabilities. The other models of disability build on each other and focus on the environment that acts as a barrier and disables people instead of viewing it as the problem of an individual.

Note for the Facilitator:

Most discussion on the models stop with the rights based model. However, disability jurisprudence is increasingly moving towards the concept of disability justice. Disability justice recognises that while a rights based model is important in principle, these rights cannot be accessed by many owing to many intersectional barriers. It therefore, “pushes forward the disability movement beyond a single issue discourse centred on rights to promote an intersectional movement led by those most impacted by ableism and historical systemic oppression”¹⁶.

Therefore, ask participants to think about

- Barriers that make access to rights difficult – poverty, prejudice and bias based on caste, class, ethnicity, gender, location, rural/urban status etc. and the need for addressing these.
- Can rights be achieved without addressing these intersectional issues?

ACTIVITY 2.3: FRAMEWORK OF DISABILITY RIGHTS

Objective:

To understand international and national rights mechanisms around disability.

Time:

60 Minutes

Materials Needed:

- Facilitator Handout 2.2
- Participant Handout 2.2. and 2.3

Process:

1. Divide the participants into five groups. Each group gets a case study.
2. Based on the case study, ask the participants to discuss the following in their groups:
 - a. What right, if any, is being violated?
 - b. In their opinion, what should the respective right entail?
 - c. What are the mechanisms in place to protect this right?
 The groups have 20 minutes to discuss the case study.

3. Ask the groups to share their case study and their responses to the three questions with the larger group.
4. Check with the larger group if they agree with the group's responses.
5. After introducing the CRPD and RPPDA, discuss the corresponding rights from the case studies in the CRPD. Refer Facilitator Handout 2.2. for this.

Debrief:

1. Are participants aware of any existing international and national framework that enumerates and protects the rights of persons with disabilities?
2. How can we ensure that the rights of persons with disabilities are being protected?

Key Messages:

1. Introduce the Convention on the Rights of Persons with Disabilities and the Rights and Protection of Persons with Disabilities Act, 2013.

Convention on the Rights of Persons with Disabilities (adopted in 2006): *It is an agreement entered into by countries, under which rights of persons with disabilities are recognised and a corresponding obligation imposed on States to protect and promote these rights.*

Why is it relevant? Bangladesh ratified CRPD in 2007 and the government, therefore, has to report to the CRPD Committee on the progress in meeting its obligations to protect the rights.

The Rights and Protection of Persons with Disabilities Act (RPPDA), *was passed in the year 2013. It includes a wide of variety of disabilities in its ambit including hearing disability, speech disability, visual disability, autism, Down's syndrome, psychosocial disability, intellectual disability etc. It provides a list of rights that each person with disabilities shall have and creates a monitoring mechanism to ensure the rights are enjoyed in practice.*

2. Individuals can ensure government accountability under CRPD and the RPPDA.

CRPD: *Every four years, each country must submit a progress report on how far the rights under CRPD have been met. Along with the government, disabled people's organizations and networks can submit alternative (or 'shadow') reports on their assessment of government actions and initiatives to uphold rights of persons with disabilities. Based on these, the CRPD Committee provides*

recommendations to the government on further steps to be taken. For example, Bangladesh has so far only submitted one progress report and its first review was completed in 2019. Many networks, coalitions and organizations submitted their alternative reports for the committee's consideration.

Second, because Bangladesh has also ratified the CRPD's Optional Protocol, after exhausting all national mechanisms, a person can file a complaint with the committee under the Individual Complaint mechanism.

RPPDA: *An individual can file a complaint with the district committee for violation of any of the rights mentioned. The committee has the power to provide compensation to the individual, in case of any discrimination. A person can also file a case in the court if a right mentioned under the Act is violated.*

Note for the Facilitator:

For country contexts other than Bangladesh, explore in advance the respective country's position and progress on CRPD.

Resources for Further Reading:

1. OHCHR (2012). *The Convention on the Rights of Persons with Disabilities – Training Guide*, Professional Training Series No. 19.
2. Sins Invalid (2017). 'Skin, Tooth, and Bone – The Basis of Movement is Our People: A Disability Justice Primer', *Reproductive Health Matters*, 25(50), pp.149-150.
3. Mia Mingus (2011). 'Changing the Framework: Disability Justice', *Leaving Evidence*. Available at: [Link] <https://leavingevidence.wordpress.com/2011/02/12/changing-the-framework-disability-justice/>. Accessed on 2 August 2020.
4. Special Rapporteur on the Rights of Persons with Disabilities (2017). *Sexual and reproductive health and rights of girls and young women with disabilities*, A/72/133.
5. Women with Disabilities Developmental Foundation (WDDF), Asia-Pacific Development Center on Disability (APCD) and South Asian Disability Forum (SADF), *Persons with Disabilities Rights and Protection Act in Bangladesh: User Friendly Booklet*. Available at: [Link] <http://www.ilo.ch/dyn/natlex/docs/ELECTRONIC/95795/118013/F51789448/BGD95795%20Booklet.pdf>. Accessed on 25th July 2020.
6. Resources on RPPDA (2013). Available at: [Link] <https://disabilitybangladesh.org/resources>.

MODULE 2 FACILITATOR HANDOUT 2.1

UNDERSTANDING DISABILITY

(Activity 2.1: Types of Disabilities)

FIGURE 11: DIAGRAM EXPLAINING HOW DISABILITY WORKS

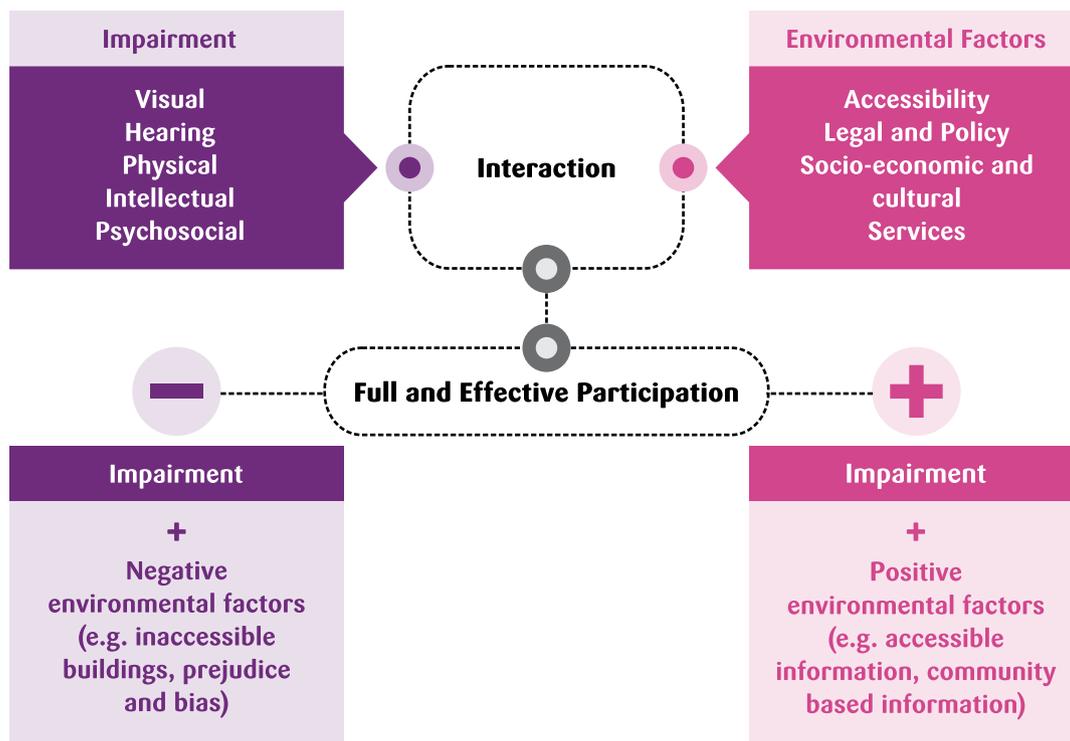


FIGURE 12: DIAGRAM LISTING DIFFERENT ENVIRONMENTAL FACTORS THAT DISABLE PEOPLE

Accessibility of Environment (Physical and Informational)	Legal/Policy	Socio-economic	Services
<ul style="list-style-type: none"> > Hilly/flat > Lack of accessibility > Partial accessibility > High levels of accessibility 	<ul style="list-style-type: none"> > Charity approach > Anti-discrimination > Supportive > Measures (quotas...) > Good enforcement > Poor enforcement 	<ul style="list-style-type: none"> > Rural/city/big city > Rich/poor > Strong negative attitudes and prejudice > Positive awareness > Open to change/closed > Pro-poor 	<ul style="list-style-type: none"> > Inclusive school/not inclusive > Inclusive healthcare/not inclusive > Inclusive youth centres/not inclusive > Inclusive livelihood support/not inclusive > Technical aids > Community-based services > Social support services > Public/private > Affordable

Source: Adapted from OHCHR Training Package on the Convention on the Rights of Persons with Disabilities, Module 1: What is Disability?

MODULE 2 PARTICIPANT HANDOUT 2.1 Page 1

MODELS OF DISABILITY	
<p>MORAL APPROACH</p> <p>FIGURE 13</p>	<p>How this approach sees disability:</p> <ul style="list-style-type: none"> • Persons with disabilities are suffering because of their/their parent's sins. • Persons with disabilities are being punished. • Persons with disabilities are opportunities for families to redeem themselves. <p>How this approach proposes to treat disability:</p> <ul style="list-style-type: none"> • They can be cured through patience and penance. • Subjected to religious and mystic rituals to 'rid' people of disability. <p>Who is the duty bearer on disability issues:</p> <ul style="list-style-type: none"> • Families, the individual themselves, religious, spiritual and faith leaders.
<p>CHARITY APPROACH</p> <p>FIGURE 14</p>	<p>How this approach sees disability:</p> <ul style="list-style-type: none"> • Persons with disabilities are in a tragic situation • Persons with disabilities cannot take care of themselves • Persons with disabilities inspire compassion • Persons with disabilities are objects of benevolence <p>How this approach proposes to treat disability:</p> <ul style="list-style-type: none"> • They need our help, sympathy, charity... • Collect and give money to provide for persons with disabilities. • The quality of the 'care' is less important <p>Who is the duty bearer on disability issues:</p> <ul style="list-style-type: none"> • Benevolent persons, charity houses, homes, foundations, religious institutions¹⁷
<p>MEDICAL APPROACH</p> <p>FIGURE 15</p>	<p>How this approach sees disability:</p> <ul style="list-style-type: none"> • Persons with disabilities need to be cured • Persons with disabilities play the passive role of patients • Persons with disabilities are considered abnormal • Persons with disabilities are unable to live independently <p>How this approach proposes to treat disability:</p> <ul style="list-style-type: none"> • Persons with disabilities need as much rehabilitation as possible to reach the best extent of normality, in order to access rights and participate in society <p>Who is the duty bearer on disability issues:</p> <ul style="list-style-type: none"> • Doctors and health authorities¹⁸
<p>SOCIAL APPROACH</p> <p>FIGURE 16</p>	<p>How this approach sees disability:</p> <ul style="list-style-type: none"> • Disability is the result of a wrong way of organising society: thus, persons with disabilities face bias and barriers that prevent their equal participation. • Disability is not an individual problem and mainly lies in the social environment that can be limiting or empowering depending on many factors. • Persons with disabilities can and should participate in society. <p>How this approach proposes to treat disability:</p> <ul style="list-style-type: none"> • Eliminate environmental barriers that constrain the participation of persons with disabilities, including attitudinal barriers • Enable the participation of persons with disabilities in public policymaking • Make all public services and polices accessible and inclusive • Ensure accessibility <p>Who is the duty bearer on disability issues:</p> <ul style="list-style-type: none"> • State, all ministries, society¹⁹

MODULE 2 PARTICIPANT HANDOUT 2.1 Page 2

MODELS OF DISABILITY

RIGHTS-BASED MODEL

FIGURE 17

We, persons with and without disabilities, are part of the same society and we have the same rights and obligations.



How this approach sees disability:

- Ensures full and equal enjoyment of all human rights to persons with disabilities, and promotes respect for their inherent dignity
- Focuses on equal opportunities, non-discrimination on the basis of disability and participation in society
- Requires authorities to ensure rights and not restrict them
- Views persons with disabilities as rights-holders

How this approach proposes to treat disability:

- Enforce laws to ensure full inclusion in all social aspects (school, family, community, work, ...)
- Apply policies to raise awareness
- Respect equal recognition before the law
- Regulate the private sector

Who is the duty bearer on disability issues:

- State, all ministries, society²⁰

DISABILITY JUSTICE

How this approach sees disability:

- As interconnected with other forms of oppression.
- Challenges assumptions about ability and lovingly embraces all kinds of bodies.
- Reinforces that people's worth has nothing to do with their ability to perform as productive members.

How this approach proposes to treat disability:

- As an issue that must be covered by all movements and vice versa.
- Must be led by those most impacted by ableism and systemic oppression.
- Celebrates different bodies and abilities.

Who is the duty bearer on disability issues:

- Systems, institutions and all movements.

FIGURE 18



Collection of illustrations representing the concept of 'disability justice'. Source: Barnard Center for Research on Women.

Source: Sins Invalid, (2017) 'Skin, Tooth, and Bone – The Basis of Movement is Our People: A Disability Justice Primer', *Reproductive Health Matters*, 25(50), pp.149-150.

MODULE 2_FACILITATOR HANDOUT 2.2_Page 1

CASE STUDIES ON RIGHTS OF PERSONS WITH DISABILITIES

(Activity 2.3: Framework of Disability Rights)

CASE STUDY 1:

Rabiul, a boy with intellectual disability lived with his mother at Chatgaon slum area of Chattogram division. Rabiul's mother, Fatima, a domestic worker, restrained him with chains in their room every morning before going to work. On the morning of 11 August 2018, Fatima had gone to work, restraining him with chains as per usual. Unfortunately, on that day there was a fire in the slum and their house caught on fire. All slum habitants went out of the slum in panic as soon as possible, but Rabiul couldn't escape as he was restrained with steel chains. As a result he burned to death.²¹

Discussion: The above situation violates Rabiul's right to liberty and security (*Article 14 of CRPD*) which states no person with disability shall be deprived of their rights, except in accordance with law. Despite Constitutional provisions (Art. 32 and 33 of the Constitution) that enshrine this right, there are no initiatives to protect the liberty and security of persons with disabilities.

CASE STUDY 2

Salima was born in a small district on the outskirts of Khulna. She is the eldest of her siblings. When she was 13 years old she met with a traffic accident and her spine was damaged. Her life changed completely, she could barely walk and was not able to go to school anymore, as it was too far away. She was unable to continue her studies because the school had no toilet and with the bladder problem resulting from the accident it became impossible for her to continue. Even when she joined an open school, it was still very difficult for her as classes and exams were conducted on the third floor of the building, and she had to be carried by her father.²²

Discussion: In this scenario, Salima's Right to Education (*Article 24 of the CRPD*) is violated. Article 24 requires that persons with disabilities have access to inclusive education at par with members of the community they live in. It requires governments to ensure that there are reasonable accommodations in place. Governments also have an obligation to ensure that support is available within the general education system, to ensure effective inclusion. By not having in place accessible toilets and having the exams and classes on third floor, Salima's right to education is being violated.

CASE STUDY 3:

Mehran was born with a visual disability. She was forced to quit her studies and had to look for a job to support her family. However, she found it impossible to find any work. There were no skills training available in her village, everybody in the village was self-employed and hence there was nobody she could work with. While the government had reservations in place for disabled people, in reality there were no recruitment policies in place and no jobs were available for her.²³

Discussion: This violates obligations under Right to Work and Employment (*Article 27*) of the CRPD. It requires governments to go beyond reservations to enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training, which was not available in this case. It also requires governments to promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assist in finding, obtaining, maintaining and returning to employment. It requires that persons with disabilities are employed in the public sector and opportunities for their employment are promoted in the private sector through measures and policies such as reservations, incentives etc. Governments must also promote self-employment. Reasonable accommodations must be ensured in each case.

MODULE 2_FACILITATOR HANDOUT 2.2_Page 2

CASE STUDIES ON RIGHTS OF PERSONS WITH DISABILITIES

(Activity 2.3: Framework of Disability Rights)

CASE STUDY 4:

Naksha is a woman with visual disability who is married to a non-disabled man. Her father gave her contraceptive pills under the pretext of giving her pills to ensure a happy and satisfying married life. While she was taking these pills, she continued to try to conceive a child. A year later when her husband noticed her having the pill, he took the pills to the chemist to have them examined. Only then did they realise that Naksha was being given contraceptive pills without her consent under false pretences.²⁴

Discussion: Naksha's father's actions violate her Right to respect for Home and Family (*Article 23*) which requires governments to take steps to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others. Under this right, governments must ensure that persons with disability can decide freely and responsibly on the number and spacing of their children. They should have access to age-appropriate information, reproductive and family planning education, and the means necessary to enable them to exercise these rights. Most importantly, given the widespread practice of forced sterilisation of women with disabilities, it requires state governments to ensure that women with disabilities are not sterilised against their will.

CASE STUDY 5:

Lamiya, a 14-year-old girl with intellectual disabilities, was raped and impregnated by her neighbour. Her father is a day labourer, earning a meagre salary. As a first resort, her parents approached the local village arbitration system where they were coerced to withdraw the case. Her parents did not want to go to the courts and were not aware of any other mechanism available to them. When they tried to file a case, the police was uncooperative and delayed in registering a report. With the help of local DPOs, finally a case was registered. Her parents are worried of further discrimination in the court, especially when Lamiya has to give her testimony, as she has speech impairments.²⁵

Discussion: This situation violates Lamiya's right to Freedom from exploitation, violence and abuse (*Article 16*). Countries have an obligation to prevent abuse and they should make sure there is proper support, information and training on how to see abuse and how to report it. They also need to ensure that disabled people who have been abused get the help and support they need to keep them safe and help them recover from the abuse. It also violates the Right to Access Justice (*Article 13*) which requires effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants. This provision also calls upon governments to provide necessary training to law enforcement officials.

However, in the case of Bangladesh it is seen that there is lack of appropriate information about laws, government and non-government legal aid services and it is not available in an accessible format. Further, law enforcement institutions, i.e. police stations, court premises, counselling centres and legal aid centres have no infrastructural and informational accessibility for women and girls with disabilities. Lastly, law enforcement officials do not have training on how to handle cases of persons with disability, especially women and girls with disabilities. All of these act as barriers in the enjoyment of a life free from exploitation, violence and abuse.

MODULE 2 PARTICIPANT HANDOUT 2.2

CASE STUDIES ON RIGHTS OF PERSONS WITH DISABILITIES

(Activity 2.3: Framework of Disability Rights)

CASE STUDY 1:

Rabiul, a boy with intellectual disability lived with his mother at Chatgaon slum area of Chattogram division. Rabiul's mother, Fatima, a domestic worker, restrained him with chains in their room every morning before going to work. On the morning of 11 August 2018, Fatima had gone to work, restraining him with chains as per usual. Unfortunately, on that day there was a fire in the slum and their house caught on fire. All slum habitants went out of the slum in panic as soon as possible, but Rabiul couldn't escape as he was restrained with steel chains. As a result he burned to death.²⁶

CASE STUDY 2

Salima was born in small district on the outskirts of Khulna. She is the eldest of her siblings. When she was 13 years old she met with a traffic accident and her spine was damaged. Her life changed completely, she could barely walk and was not able to go to school anymore, as it was too far away. She was unable to continue her studies because the school had no toilet and with the bladder problem resulting from the accident it became impossible for her to continue. Even when she joined an open school, it was still very difficult for her as classes and exams were conducted on the third floor of the building, and she had to be carried by her father.²⁷

CASE STUDY 3:

Mehran was born with a visual disability. She was forced to quit her studies and had to look for a job to support her family. However, she found it impossible to find any work. There was no skills training available in her village, everybody in the village was self-employed and hence there was nobody she could work with. While the government had reservations in place for disabled people, in reality there were no recruitment policies in place and no jobs were available for her.²⁸

CASE STUDY 4:

Naksha is a woman with visual disability who is married to a non-disabled man. Her father gave her contraceptive pills under the pretext of giving her pills to ensure a happy and satisfying married life. While she was taking these pills, she continued to try to conceive a child. A year later when her husband noticed her having the pill, he took the pills to the chemist to have them examined. Only then did they realise that Naksha was being given contraceptive pill without her consent under false pretences.²⁹

CASE STUDY 5:

Lamiya, a 14-year-old girl with intellectual disabilities, was raped and impregnated by her neighbour. Her father is a day labourer, earning a meagre salary. As a first resort, her parents approached the local village arbitration system where they were coerced to withdraw the case. Her parents did not want to go to the courts and were not aware of any other mechanism available to them. When they tried to file a case, the police was uncooperative and delayed in registering a report. With the help of local DPOs finally a case was registered. Her parents are worried of further discrimination in the court, especially when Lamiya has to give her testimony, as she has speech impairments.³⁰

MODULE 2 PARTICIPANT HANDOUT 2.3_Page 1

IMPORTANT RIGHTS UNDER CRPD AND RPPDA

(Activity 2.3: Framework of Disability Rights)

1. CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)

The Convention is a legally binding instrument which once ratified by a country, imposes responsibility on the government to ensure that all laws, policies, and programmes comply with its provisions. Bangladesh ratified the CRPD in 2007.

Some important articles for CRPD that relate to sexuality and SRHR:

- **Article 6:** Recognises that women and girls with disabilities are treated unfairly in lots of different ways and requires countries to make sure that women and girls with disabilities have full, free and equal lives. General Comment 3 (2016) specifically recognises the intersectional and multiple barriers faced by women and girls with disabilities with respect to equal access to education, access to economic opportunities, access to social interaction, access to justice and equal recognition before the law, the ability to participate politically, and the ability to exercise control over their own lives across a range of contexts (for example: with regard to healthcare, including sexual and reproductive health and decision about where and with whom they wish to live).
- **Article 9:** It calls for accessibility to be ensured, including access to medical facilities and information.
- **Article 16:** Requires states parties to take measures to protect persons with disabilities from violence and abuse, including gender-based violence and abuse.
- **Article 22:** Asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information.
- **Article 23:** Requires countries to eliminate discrimination against persons with disabilities in all matters relating to “marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life”. Importantly, it recognises the rights of persons with disabilities to decide freely on the number and spacing of children, have access to age-appropriate reproductive and family planning information and the means necessary to enforce this. Therefore, it safeguards against forced abortion and contraceptives. It also protects the right to retain fertility, and is an important check against forced sterilisation.
- **Article 25:** Requires that countries ensure equal access to health services for persons with disabilities, with specific mention of SRH and population-based public health programmes. Health care must be provided on the basis of free informed consent. It also mandates that the same range, quality and standard of free or affordable health care and programmes must be provided to persons with disabilities as provided to other persons, including in the area of sexual and reproductive health.

SRHR can also be read into many other Articles of CRPD.

MODULE 2 PARTICIPANT HANDOUT 2.3 Page 2

IMPORTANT RIGHTS UNDER CRPD AND RPPDA

2. RIGHTS AND PROTECTIONS OF PERSONS WITH DISABILITIES ACT, 2013

প্রতিবন্ধী ব্যক্তির অধিকারসমূহ

[প্রতিবন্ধী ব্যক্তির অধিকার ও সুরক্ষা আইন, ২০১৩
এর ১৬ ধারার আলোকে]










প্রতিবন্ধী ব্যক্তির আইনের আশ্রয় লাভে প্রতিবন্ধকতা সৃষ্টি করা দণ্ডনীয় অপরাধ

প্রতিবন্ধী ব্যক্তিকে উত্তরাধিকারসূত্রে প্রাপ্য সম্পত্তি বন্টনের ক্ষেত্রে প্রাপ্য হিস্যা থেকে বঞ্চিত করা দণ্ডনীয় অপরাধ

প্রতিবন্ধী ব্যক্তির সম্পদ আত্মসাৎ করা দণ্ডনীয় অপরাধ

এ সকল অপরাধে অভিযুক্ত ব্যক্তির ৩ বছর পর্যন্ত কারাদণ্ড হতে পারে



- ★ পূর্ণমাত্রায় বেঁচে থাকা এবং বিকশিত হওয়া।
- ★ সর্বক্ষেত্রে সমান আইনী স্বীকৃতি ও বিচারগম্যতা।
- ★ উত্তরাধিকার প্রাপ্তি।
- ★ স্বাধীন অভিব্যক্তি ও মত প্রকাশ এবং তথ্যপ্রাপ্তি।
- ★ মাতা-পিতা, বৈধ বা আইনগত অভিভাবক, সন্তান বা পরিবারের সাথে সমাজে বসবাস, বৈবাহিক সম্পর্ক স্থাপন ও পরিবার গঠন।
- ★ প্রবেশগম্যতা।
- ★ সামাজিক, অর্থনৈতিক ও রাষ্ট্রীয় ক্ষেত্রে পূর্ণ ও কার্যকরভাবে অংশগ্রহণ।
- ★ শিক্ষার সকল স্তরে একীভূত বা সমন্বিত শিক্ষায় অংশগ্রহণ।
- ★ সরকারি-বেসরকারি প্রতিষ্ঠানে কর্মে নিযুক্তি।
- ★ কর্মজীবনে প্রতিবন্ধিতার শিক্ষার ব্যক্তি কর্মে নিয়োজিত থাকার, অন্যথায় পুনর্বাসন বা ক্ষতিপূরণপ্রাপ্তি।
- ★ নিপীড়ন থেকে সুরক্ষা এবং নিরাপদ ও স্বাস্থ্যকর পরিবেশের সুবিধাপ্রাপ্তি।
- ★ প্রাপ্যতা সাপেক্ষে, সর্বাধিক মানের স্বাস্থ্য সেবা প্রাপ্তি।
- ★ শিক্ষা ও কর্মক্ষেত্রে যুক্তিসাপেক্ষ ব্যবস্থায়ন বা রিজনেবল একোমোডেশন প্রাপ্তি।
- ★ সমাজজীবনের সকল ক্ষেত্রে একীভূত হবার লক্ষ্যে সহায়কসেবা ও পুনর্বাসন সুবিধাপ্রাপ্তি।
- ★ পরিবার থেকে বিচ্ছিন্ন হলে বা আবাসন ও ভরণ-পোষণের সংস্থান না হলে নিরাপদ আবাসন ও পুনর্বাসন।
- ★ সংস্কৃতি, বিনোদন, পর্যটন, অবকাশ ও ক্রীড়া কর্মকাণ্ডে অংশগ্রহণ।
- ★ শ্রবণ ও বাকপ্রতিবন্ধী ব্যক্তির নিজ ইচ্ছা অনুযায়ী বাংলা ইশারা ভাষাকে প্রথম ভাষা হিসাবে গ্রহণ।
- ★ ব্যক্তিগত তথ্যের গোপনীয়তা।
- ★ স্ব-সহায়ক সংগঠন ও কল্যাণমূলক সংঘ বা সমিতি গঠন ও পরিচালনা।
- ★ জাতীয় পরিচয়পত্র প্রাপ্তি, ভোটার তালিকায় অন্তর্ভুক্তি, ভোট প্রদান এবং নির্বাচনে অংশগ্রহণ।
- ★ সরকার কর্তৃক সরকারি গেজেট বা প্রজ্ঞাপন দ্বারা নির্ধারিত অন্য কোন অধিকার।





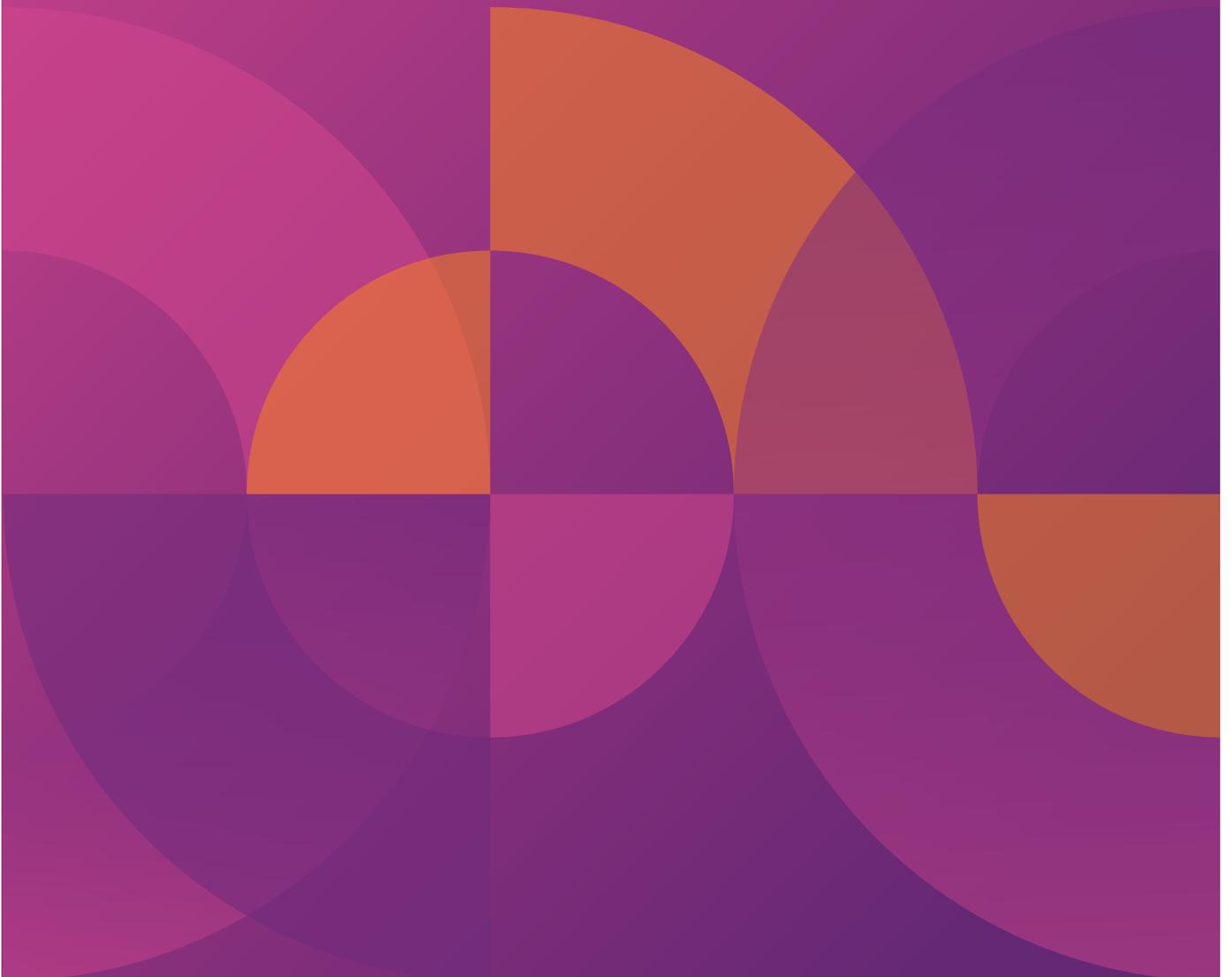


FIGURE 19: POSTER ON RIGHTS AND PROTECTIONS OF PERSONS WITH DISABILITIES ACT, 2013

The poster is available at the following link: <https://disabilitybangladesh.org/resources/poster>.
Accessed on 9 August 2020).

module 3

body image and
self-esteem



module 3

body image and self esteem

MODULE OBJECTIVES

1. To enable participants to challenge ableist^{*31} ideas of bodies and ability.
2. To deepen appreciation for and recognise the value of human diversity.

ACTIVITIES

Activity 3.1: Ableism, Productivity and Human Worth

> 60 Minutes

Activity 3.2: Strengthening Self-Esteem > 40 Minutes

Activity 3.3: Body Image > 40 Minutes

ACTIVITY 3.1: ABLEISM, PRODUCTIVITY AND HUMAN WORTH

Objective:

To understand how systems of ableism link human worth to productivity and productive capacities.

Time:

60 Minutes

Materials Needed:

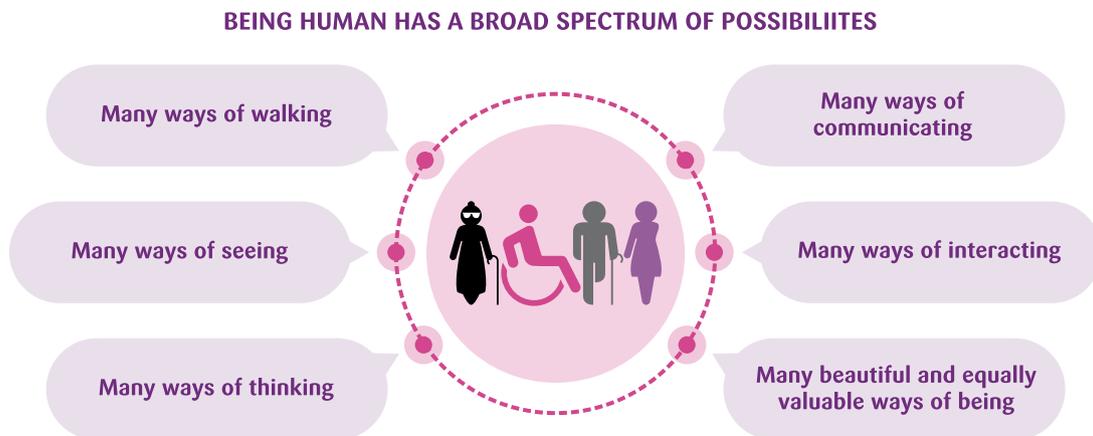
- Facilitator Notes

Process:

1. Read out the following situation to the group:
Five people decided to travel together by boat from village X to village Y. The journey would take them 10 days and so they stocked the boat with food and water supply to last them for their journey. To manage the food and water supply, they appointed one person, Khairat, as the person who would be responsible for managing the supply. However, on day seven, Khairat informed the others that they had enough supplies only for four people for the remaining three days and, therefore, one person would have to forego having food and water even though they may not survive without it. This is what we know of the five passengers:
 - a. Nayeem is an engineer working with a reputed company in Dhaka. He works long hours every day and felt he really deserved a break. He had gone for small vacation to a tiger sanctuary in village X and was returning home to his wife and children in village Y.

- b. Utpala is one of four daughters in a family of construction workers. She contracted polio when she was 10 years old and was forced to drop out of school. The part of the boat where the food is served is not accessible to her and someone has to bring the food to her and assist her with eating. She is going to village Y to meet her cousins.
 - c. Khairat runs a business dealing with rice processing in village Y, which supplies rice to the village. Khairat had gone to village X to meet some clients and source raw materials for the business. Khairat must return to village Y to ensure that the business operates smoothly and rice processing happens on time.
 - d. Shammi is a labourer in Khairat's business. She had gone to village X to attend her brother's wedding and was returning back to village Y to resume working at the rice processing factory. Shammi has diabetes.
 - e. Masum is a 72 year old women who lives in a home for elders in village X. She has no living family. She goes to village Y every year to attend the annual fair where she is able to find her favourite food dish. She is on her way to attending the annual fair.
2. Ask the participants who think Khairat should forego food and water to assemble in one part of the room. Give clear directions where. This is Group 1. One by one name the different passengers and the person who think they should be the one to forego food and water should assemble in a different corner of the room. There should be five groups each supporting why one passenger should forego food and water.
 3. In the first round, each participant has to pick someone to forego food and water. There must be enough participants in each group. In the case there are no participants for one group, request some of the participants to move to that group as the exercise requires discussion on why each person should or should not go hungry.

* *Structuring of societal values and behaviours that place attributes of non-disabled people as the norm and as a result devalue and discriminate against disabled people. These norms are deeply shaped by racism, capitalism, sexism, settler-colonialism etc.*

FIGURE 20: PERSONS WITH DISABILITIES ARE PART OF HUMAN DIVERSITY

Source: Adapted from OHCHR Training Package on the Convention on the Rights of Persons with Disabilities, Module 1: What is Disability?

4. Ask the first group why they think the person should be the one to go hungry. One by one, ask each group to explain their reasons for their choice of who should forego water and food.
5. Once all the groups have explained their rationale, ask the participants if there is another way to distribute the food so that nobody goes hungry. If participants suggest that the food should be divided equally, remind them that nutrition needs of all the passengers are not the same. In that case, how should the distribution be? Should we prioritise those who need it the most?
6. Lastly, if none of the participants have pointed it so far, remind them that at the start of the journey they had packed enough supplies for 10 days for all people. In that case, should we not hold Khairat accountable for how the supplies were rationed by him such that did not last for the intended period?
7. Share with the participants that the situation they were presented with, is similar to how most governments handled Covid-19 response. In light of limited facilities for care, medicine and ventilators, government responses prioritised those who are seen as most 'productive' in contributing to the society and decided to prioritise them in their protection strategies, at the cost of persons with disabilities and others who are seen as less 'productive', for example, the elderly. Instead of accepting this without any questions, just like in our simulation, it is important to raise questions on government handling and imagine alternate ways of responding to the crisis.

Debrief:

1. What are the attributes that participants valued in deciding who should have access to food and water?
2. What assumptions did they take for granted? Are these assumptions fair?
3. What role does productivity play in how human life is valued by our society?

Key Messaging:

1. Productivity is a key feature around which our society is organized and which determines the worth of a person. Productivity is concerned with the efficiency with which outputs (which have monetary value) can be produced. Most societies are interested in investing the least amount of resources and getting maximum output. In this ordering of things, you are only as valuable as the monetarily valuable outputs you generate. Those who need reasonable accommodations and other investments in building their capacities, or those who do not fit this "productive" understanding, such as persons with disabilities, are valued less in this scheme of things.
2. Owing to this emphasis on productivity, we are constantly bombarded with the messaging of disabled lives and bodies as being less valuable. This constant negative messaging from media, governments, societies and families is bound to negatively impact the self-esteem of persons with disabilities and also affect their relationship with their bodies. Persons with disabilities may begin to attach negative emotions with their bodies and themselves, for not fitting within these impossible standards.

3. In reality, persons with disabilities are transforming our world into a more democratic, diverse, flexible, empathetic, creative place that benefits both disabled and non-disabled people alike. For example, consider how the importance of caregiving and interdependence championed by persons with disabilities, challenges the emphasis on self-reliance and normalises the need for support, something we all need at one time or another in our life. Similarly accessibility features such as having captioning services for audio and videos and having text-to-speech software and vice versa, benefits both disabled and non-disabled people.

ACTIVITY 3.2: STRENGTHENING SELF-ESTEEM

Objective:

To enable participants to discover their own unique strengths and qualities.

Time:

40 Minutes

Materials Needed:

None

Process:

1. Ask the participants to pair up.
2. In each pair one person plays the role of a journalist who is interviewing the other person for a story which will be published in a magazine. The participant conducting the interview, can use the following prompts:
 - a. Describe an event in your life you are most proud of.
 - b. Were there any barriers you had to overcome?
 - c. Describe a situation where your experiences as a person with disability helped you to arrive at a creative solution at home/in the community/at your work place that nobody else thought of.
 - d. You have a huge fan following. What according to you are your qualities and attributes that they admire the most?
 - e. Our readers would love to have a glimpse of the person behind the persona. What is an activity you really enjoy doing? Any place you would like to visit? A person you have a secret liking for?
 - f. Finally, what are some of your goals for the next year? What strengths of yours make you confident about achieving them?

The interviewer has 15 minutes to conduct the interview.
3. Once this is completed, switch roles and the person being interviewed before will now conduct the interview with the above prompts.

Additional suggested activity: You can also share this piece with the participants which is written by disabled feminist, activist and comedian, Nidhi Goyal, on being a part of a community of love, friendship and care as a blind woman – Nidhi Goyal (2018) *As a blind woman, I belong to a community of friendship, love and care*, Skin Stories. Available at: [Link] <https://medium.com/skin-stories/as-a-blind-woman-i-belong-to-a-community-of-friendship-love-and-care-5aa82bd28570>. Accessed on 10 August 2020.

Debrief:

1. Did participants discover something about themselves they had not thought of before?

Key Messages:

1. Stigma against disability and gender means that women and girls with disabilities regularly receive negative messaging about their bodies, abilities and worth from different spheres. This negatively impacts their self-esteem. There is a need to address the negative impact of socio-cultural messaging and highlight the contribution of women and girls with disabilities and the value that they can and do add to our society.
2. Low self-esteem can have a negative impact on how women and girls with disabilities negotiate SRHR decisions. For example, they may hide their disabilities from sexual partners for fear of rejection or may be willing to have unprotected sex because they value the need to be loved more than their own safety.

ACTIVITY 3.3: BODY IMAGE

Objective:

To counter negative messaging around beauty and disabled bodies and build positive body image.

Time:

40 Minutes

Materials Needed:

None

Room Arrangement:

The participants should preferably be seated in one big circle.

Process:

1. Share the instructions for the activity with the group – a person will name a body part and the person to their left must say something nice about that body part of their own. For example, X says neck. The person to the left of X, for example Y, should say “something I love about my neck is ____” (for example, the sensations I feel when somebody caresses it.) Y will now name a body part, say cheeks. The person to the left of Y will now have to say something nice about their own cheeks.
2. Continue till everybody in the circle has had a chance. Encourage the participants that as far as possible they must not name the same body part. Remind them that is a safe space so they should also include breast, genitals and other body parts we do not usually speak about.

Debrief:

1. How did the participants feel?
2. What makes appreciation of ourselves and our bodies difficult?
3. How often do we appreciate ourselves and our bodies?

Key Messaging:

We are constantly faced with notions of what is beautiful and who is beautiful, that are shaped by ideas of (dis)ability, race, ethnicity, colour, size etc. However, all our bodies are different, diverse and beautiful and we do not need external validation to find beauty in ourselves.

Notes for the Facilitator:

1. Having sessions on body and self-esteem before moving to other areas of SRHR is quite important as a lot of the negative messaging around bodies that do not fit the notions of ideal beauty in a society (very often thin, able-bodied, fair) are internalised and affect a person’s sense of self. This can have wide ranging impact on SRHR decisions of women and girls with disabilities, including negotiations in relationships (for example, accepting an abusive partner because of the belief that nobody else would want to be with them); how they understand and deal with violence (for example, not reporting sexual violence because they worry nobody will believe a woman with disability), sexual pleasure (for example, not exploring pleasure which we can derive from different parts of our body) etc.
2. This activity can be discomforting and triggering for some participants. Even as you encourage participation, reiterate the ground rule that participants have a right to pass and can choose to skip their turn. This should be explained at the beginning of the activity.

Resources for Further Reading:

1. Nidhi Goyal, *As a blind woman, I belong to a community of friendship, love and care*, Skin Stories (2018). Available at: [Link] <https://medium.com/skin-stories/as-a-blind-woman-i-belong-to-a-community-of-friendship-love-and-care-5aa82bd28570>. Accessed on 10 August 2020.
2. Srinidhi Raghavan, *In a world that often interprets ‘care’ as ‘burden’, interdependence should be valued beyond disabled community*, Firstpost (2020). Available at: [Link] <https://www.firstpost.com/living/in-a-world-that-often-interprets-care-as-burden-interdependence-should-be-valued-beyond-the-disabled-community-8376271.html>. Accessed on 18 August 2020.
3. Reshma Valliapan (2018). *Why I call myself a schizophrenist*, Skin Stories. Available at: [Link] <https://medium.com/skin-stories/why-i-call-myself-a-schizophrenist-8f8bo29422cf>. Accessed on 10 August 2020.
4. Mia Mingus (2009). *On Claiming My Movement: Disability and Reproductive Justice*, *Leaving Evidence*. Available at: [Link] <https://leavingevidence.wordpress.com/2009/12/02/on-claiming-my-movement-disability-and-reproductive-justice/>. Accessed on 14 August 2020.
5. Mia Mingus (2017). *Access Intimacy, Interdependence and Disability Justice*, *Leaving Evidence*. Available at: [Link] <https://leavingevidence.wordpress.com/2011/05/05/access-intimacy-the-missing-link/>. Accessed on 14 August 2020.
6. Vilissa Thompson (2016). *The Unicorn Effect: Finding Self-Love and Acceptance as a Disabled Black Woman*. Available at: [Link] <https://colorwebmag.com/2016/07/14/unicorn-effect-finding-self-love-acceptance-disabled-black-woman/>
7. Leah Lakshmi Piepzna-Samarasinha (2018). *Care Work: Dreaming Disability Justice*. Vancouver: Arsenal Pulp Press.
8. Alice Wong (ed.) (2020), *Disability Visibility: First Person Stories from the Twenty-First Century*, Vintage Books. See also: [Link] <https://disabilityvisibilityproject.com/>
9. Gillian Giles (2017). *Loving My Body For What It Is And Not For What It Produces*, *The Body is Not an Apology*. Available at: [Link] <https://thebodyisnotanapology.com/magazine/you-are-more-than-what-you-do-dismantling-ideas-of-productivity-in-life-purpose/>. Accessed on 15 August 2020.
10. Positive You Project by Leah Jones. [Link] <http://www.positiveyouwithleah.com/>. Accessed on 15 August 2020.

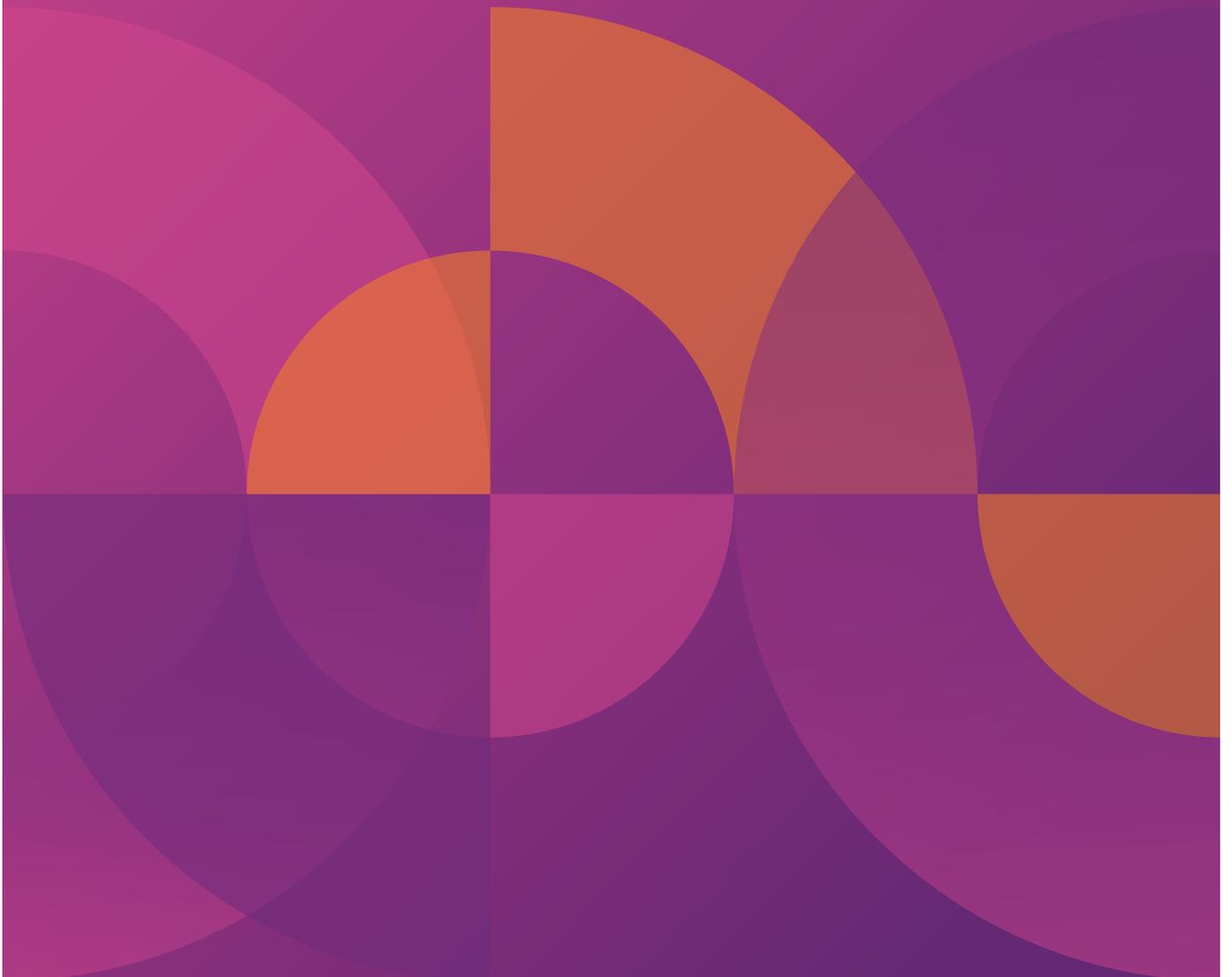
FUTURE IS ACCESSIBLE



ipsita

module 4

gender, sex and
sexuality



module 4

gender, sex and sexuality

MODULE OBJECTIVES

1. To understand the concepts of gender, sex and sexuality and how they are societally constructed and assigned.
2. To understand the difference between sexual acts and sexuality, and gender and sex.
3. To understand diversity in gender identity and expression, sexual identity and behaviour, and sex characteristics.
4. To appreciate intersectionality and the impact of multiple forms of marginalisation on the lives of persons with disabilities and develop a commitment to intersectional work.

ACTIVITIES

CHAPTER 1: SOCIAL CONSTRUCTION OF GENDER AND SEX

Activity 4.1: Understanding Gender > 60 Minutes

Activity 4.2: Sex characteristics and Gender Identity > 60 Minutes

CHAPTER 2: SEXUALITY

Activity 4.3: Sexuality Alphabet Soup > 30 Minutes

Activity 4.4: Myth Busting on Sexuality > 45 Minutes

Activity 4.5: Genderbread Person > 45 Minutes

Activity 4.6: Short Film > 30 Minutes

CHAPTER 3: POWER, PRIVILEGE AND INTERSECTIONALITY

Activity 4.7: Pebbles and Petals > 60 Minutes

Activity 4.8: Intersectionality > 60 Minutes

HANDOUTS

Activity 4.1: Understanding Gender > None

Activity 4.2: Sex characteristics and Gender Identity and Expression

> Participant Handout 4.1: Glossary of Terms- Gender, Sex and Sexuality

Activity 4.3: Sexuality Alphabet Soup > None

Activity 4.4: Myth Busting on Sexuality

> Facilitator Handout 4.1: Myths about Sexuality

Activity 4.5: Genderbread Person

> Facilitator Handout 4.2: Genderbread Person

Activity 4.6: Short Film > None

Activity 4.7: Pebbles and Petals

> Facilitator Handout 4.3: Statements for Pebbles and Petals

Activity 4.8: Intersectionality

> Participant Handout 4.2: Narratives of Intersectionality

CHAPTER 1: SOCIAL CONSTRUCTION OF GENDER AND SEX

ACTIVITY 4.1.: UNDERSTANDING GENDER

Objective:

To understand how gender is socially and culturally constructed and that individuals display a wide range of gender roles and expressions.

Time:

60 Minutes

Materials Needed:

- Flip chart
- Markers
- See variation for other materials that might be needed

Process:

1. Put up a flip chart and on one side write 'Man' and on the other write 'Woman'. Under each heading, invite responses from the participants on the following:
 - **Appearance** (hair, dressing, build, voice and manner of speaking)
 - **Behaviour/Personality Traits** (For example: aggressive, sensitive, strong, weak, chatty/gossip, dominant, active, passive, keeps to themselves (stoic), caring, independent, self-confident, measured, approachable, etc.)
 - **Expectations** (For example: looking after children; earning money; household chores – cooking, cleaning, washing; going to the bank; grocery shopping; maintaining finances; better at maths; better at mentoring)
 - **Activities** (choice of hobbies, sports and games; leisure activities – reading newspaper, watching TV shows; learning mechanical skills; learning stitching, cooking etc.)

- **Occupation** (For example: teacher, nurse, doctor, engineer, domestic help, pilot, flight service crew, police, judges, accountant, stay-at-home parent, caregiver)

Variation: You can carry visual representations of the above as cut outs from magazines and newspapers. You can also use clips from TV advertisements, movies and other videos. Unless you are using audio cues with lyrics, such as popular songs, this variation will not work with persons with visual disabilities.

The activity can also be done in groups, and each small group can be asked to create a picture, a sculpture, a role play or use their bodies to depict the characteristics (image theatre) – for example, an action for strong, aggressive, caring, style of walking, working as a doctor, nurse etc.) and the other teams can guess the characteristic being depicted. The format involving sculptures and role play can also be used with participants with visual disability, by allowing perception of sculptures and shapes created using the body, by touch.

2. Read out the final list under each heading.
3. Next, interchange the headings – instead of ‘Man’ replace it with ‘Woman’, keeping the descriptions the same, and vice versa for the ‘Woman’ heading. Discuss if each of the roles mentioned under the ‘Man’ category earlier can be performed by a ‘Woman’ and vice versa. Encourage debates and discussions among participants on why/why not.

Debrief:

1. Are there variations among men in meeting the criteria on the list? For example, do all men look and sound the same; are all men equally aggressive?
2. Are there variations among women in meeting the criteria on the list? For example, do all women look and sound the same; are they all “natural care givers”?
3. Is this understanding of attributes, expectations, occupation, among others, socially governed? For example how do we decide who can have long hair or short hair; who needs to grow facial hair and who needs to remove it; the assignment of domestic chores within the household?
4. Are both set of roles valued equally? For example, is being aggressive and sensitive valued equally? Are the different occupations valued equally? Is there a difference in how attributes, occupations, activities etc. are valued based on who performs it? What happens when one set of roles are valued more, can it lead to discrimination?

5. What are some of the participant experiences around gender roles? Does having a disability impact expectations of gender roles? Can we think how our other identities shape our experience of gender?
6. Have participants come across people who refer to themselves with other terms beyond just ‘man’ and ‘woman’?
7. Was it uncomfortable to reverse the roles? If so, why?
8. Is there a problem with forcing people to strictly stick to these gender roles?

Key Messaging:

1. Ideas around characteristics, behaviour, appearance, aspirations and expectations of men and women (together called ‘gender roles’) are socially determined and there is nothing natural about them. These ideas are shaped by local cultures and change over time. From a young age these rules of gender roles are learned through different institutions such as the family, community, media, peers, schools, religion and other social institutions. They impact all aspects of a person’s life from how we understand and value ourselves, how we interact with others, to our expectations and aspirations from life etc.
2. However, our experiences of gender roles are not uniform. Other aspects of our identity such as class, religion, caste, ethnicity, race, geographical location, (dis)ability, among others, deeply shape our experiences of gender roles.
3. There are range of possible ways in which men and women exhibit gender roles and they are vastly different from each other. There is no one way to be a man or a woman. We must therefore aspire for flexible gender roles versus having rigid roles and expectations.
4. While we often hear of gender in the binary terms of ‘man’ and ‘woman’, gender is fluid and exists on a spectrum and range of gender identifications are possible. This is explored in greater detail in the following activity.
5. These prescriptions and ideas of gender roles are not harmless. There is often a hierarchy between the values that are attached to different characteristics. Invariably those attached with masculine attitudes and behaviours (qualities thought to be typical of a ‘man’) are more valued than those with feminine attitudes and behaviours (qualities thought to be typical of a ‘woman’). For example, being aggressive is valued more and sensitivity is denigrated, which is reflected in statements such as “be a man” “don’t cry like a girl” “don’t throw like a girl” “sissy”, being used to shame people.

Further, depending on who performs a particular occupation, behaviour, activity etc., there is vast disparity. For example, when women take on dominant traits in leadership they are valued poorly, while the same is considered an asset for men; the same household chore of cooking which is often exclusively performed by women go unrecognised, but are valued when performed in the market by chefs who are men; the same sports played by men and women received different patronage and attention, etc.

6. Rigid rules of gender and forcing people to conform to these rules have severe consequences as they limit people from reaching their full potential and expressing themselves fully. For example, limiting aspirations and expectations of what women can do, often results in lower education of girls as the investment in education is not expected to turn into profitable employment opportunities. Ideas such as men are aggressive and women are passive, can encourage and normalise violence. Similarly, ideas about caring capacities of women and girls, results in unequal distribution of care responsibilities because of which women and girls are forced to drop out of schools, their health is affected and they are unable to pursue gainful employment. The hierarchy of gender roles and their rigid enforcement breed discrimination, violence and abuse.

Notes for the Facilitator:

1. The session is likely to bring discomfort to many participants as it questions and challenges deep-rooted assumptions around gender which is often taken for granted. Ensure that a respectful learning space is created where participants have the opportunity to unlearn values, norms and behaviours of gender which are well entrenched. Be patient and respectful while pushing participants to challenge gendered assumptions.
2. Be ready for resistance in inverting gender roles and have responses ready. Encourage participants to think deeper on why/why not these roles need to be rigid and the consequences if they are forced on people.
3. One way to ease the understanding of gender, its hierarchy and discrimination that follows is to draw parallels from other forms of social exclusion participants may be familiar with. For example, you can invite participants to reflect on how norms around ability are created, how values are attached to them and the discrimination faced by people if they do not conform to these rigid norms.
4. The facilitators themselves must be committed to challenging their own assumptions around gender and build their knowledge around gender, sex and sexuality to confidently respond to participant queries.

5. Provide ample time for participants to engage with and reflect on the concepts that are being introduced.

ACTIVITY 4.2: SEX CHARACTERISTICS AND GENDER IDENTITY

Objective:

To understand how gender is assigned based on sex characteristics, the different possibilities of gender identity, and the discrimination faced by those who do not confirm to gender assigned based on sex characteristics.

Time:

60 Minutes

Materials Needed:

- Chart papers,
- Colourful markers
- Participant Handout 4.1

Process:

1. Invite eight volunteers for a small role play.
2. Brief the volunteers on the activity: Tell them that they are playing the role of actors who are being cast for a new movie. They are each being given a script which they must pretend has detailed descriptions of how the characters are expected to act, speak, dress, groom, behave and conduct themselves. In pairs, the volunteers have to act out the following scenarios. They must use dialogues that help to convey the scene and convince the directors (the audience) to go with their suggestion.

Scenario 1: Both the actors look at their own scripts and each other's. They are each very happy and content with how their characters have been detailed and have no problems playing their character as scripted.

Scenario 2: Both the actors look at their own scripts and each other's. They feel very strongly that they connect better with the other's script and want to exchange their characters. This would help them to be more authentic in their roles.

Scenario 3: Both the actors look at their own scripts and each other's and compare their scripts. They like some parts of how their character has been scripted and some parts of how the other's character has been scripted. They suggest that it might be better to mix some of the details to create more robust characters.

Scenario 4: Both the actors look at their own scripts and each other's and compare their scripts. They feel the way the characters have been detailed are completely wrong and would not fit the role in the movie and the movie would be a flop. They suggest that an entirely new characterisation might be needed for the movie to be a hit.

3. Explain to the larger group that they are the directors of a movie and they have created a script for our actors that describe in great detail how their characters are expected to act, speak, dress, groom, behave and conduct themselves in their roles. They will be witnessing four different responses by the actors to the script they have provided. In each case the actors will make some suggestions to them and they must decide if they are okay with the actor's suggestions.
4. Invite the volunteers to enact the four scenarios one by one. Solicit the group's opinion on the suggestions after each scenario.
5. Explain to the group the concept of sex and assignment of gender: When a person is born, doctors usually adopt only two ways of classifying them. This classification is based primarily on their external genitalia and the chromosomes, called sex characteristics. Usually, if a baby has a penis, the doctors assign them as 'male' and if the baby has a vulva, they are assigned as 'female'. This is called the sex of person, which is a medical determination based on physical factors, including hormones, chromosomes, and genitalia.
6. Based on the sex assigned to the person, society attaches the gender of 'man' and a 'woman' – a person with male genitalia is assigned the gender of man and a person with female genitalia is assigned the gender of a 'woman'.
7. Remind the participants that as we saw in the previous activity, gender guides all aspects of a person's life – appearance, behaviour, aspirations, expectations and life choices, and are given by the society to a person. Therefore, they are quite like the scripts we handed to our actors which detailed how they are expected to act, speak, dress, groom, behave and conduct themselves.
8. Ask the group if, just like in the scenarios the volunteers acted out, is it then possible that different people have different reaction to their gender scripts which society gives them – some might happily accept it; some may identify better with the gender assigned to the other; some may adopt some parts of the roles that was assigned to them and some parts of the other's; and others may altogether reject the script and want to chart their own path in how to act, speak, dress, groom, behave and conduct themselves, which is not already charted out for them by somebody else? If not, why?
9. Finally, play the following video on narratives of *hijras* in Bangladesh: Gender Spectrum (2017) Understanding Gender: Narratives of *Hijras* in Bangladesh. [Link] <https://www.youtube.com/watch?v=IspDHFvpa6o>. Accessed on 4 September 2020.

Variation: Instead of doing the above activity, you can also introduce an arrow between the labels 'man' and 'woman' in the previous activity, to indicate the range of gender identities that are possible; introduce the idea of gender identity and transgender identity and sex determination and intersex variations. In this case, you can cover the key messages from this activity in the previous activity.

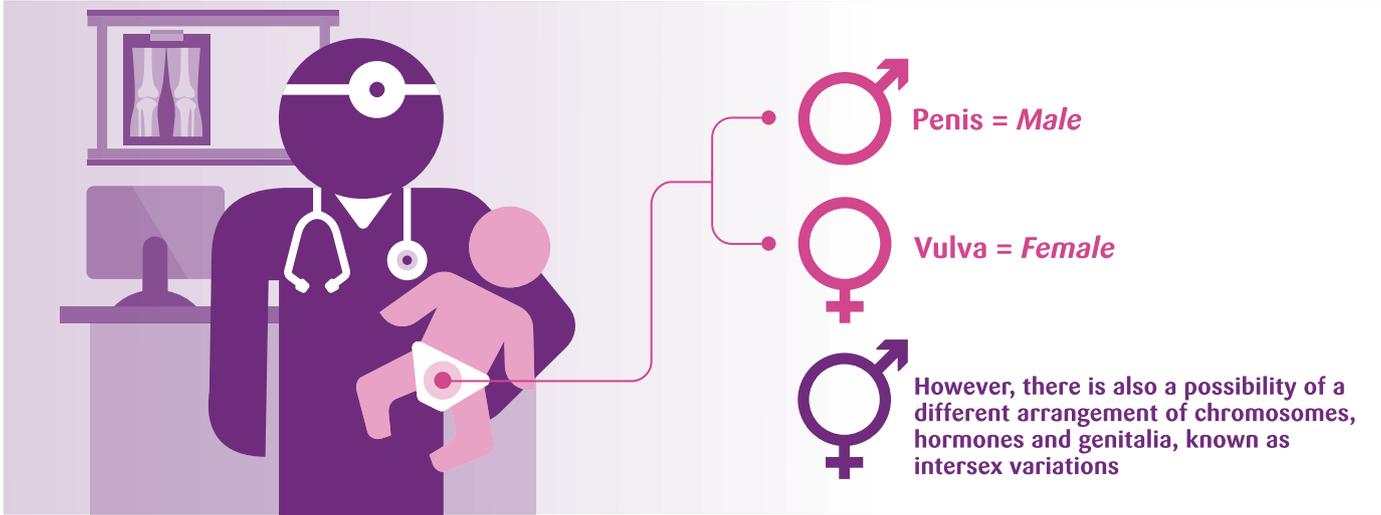
Debrief:

1. Is there any basis for assigning gender to a person based on physical characteristics, in other words, what does our genitalia have to do with how we express, behave and conduct ourselves?
2. If it is just a social creation, can we not imagine alternate ways of being? Why are people interested in maintaining status quo?
3. Was it challenging to imagine different possibilities through which people can express their gender identity?
4. In reality, what happens when people try to challenge gender assigned to them?
5. How can we support people who wish to express their gender identities differently than what was assigned to them?

Key Messages:

1. While many use the term 'biological sex', sex is also assigned by doctors. Looking at a baby's chromosomes, hormones and external genitalia, doctors make a determination to assign male and female respectively. However, not every person's chromosomes, hormones and external genitalia fit neatly in the typical understanding of 'male' and 'female'. There are many people who are born with intersex variations, their chromosomes could be different, the external genitalia might have a vagina without opening, have both ovarian and testicular tissues etc. This is a naturally occurring variation and not a medical problem. However, doctors often operate on babies with these intersex variations to make their genitalia closer to typical male or female genitalia, without permission. This is yet another example where a medical model is used against people, without their permission, to make them fit dominant ideas of sex characteristics. You can draw parallels with this to what happens with many persons with disabilities, on whom medical interventions are done to bring them closer to dominant ideas of physical, intellectual and mental ability.

FIGURE 21: INFOGRAPHIC REPRESENTATION OF ASSIGNMENT OF SEX BY DOCTORS



Adapted from pictorial representation of assignment of sex by doctors. Source: AMAZE Org.³²

2. Assigning gender based on sex characteristics is a social process. From an early age we receive messages on how to act, behave, dress and communicate, from different institutions. This leads many of us to follow the gender roles and expressions that are assigned to us and for various reasons, we may be okay with it. However, forcing people to conform to socially-dictated gender roles and expressions, can leave deep emotional and psychological scars on people and limit them from living their full lives. It is important to remember that these ideas are learned, and therefore can also be unlearned, a commitment we must share.
3. In terms of gender, people can have a range of gender identity and expressions. While gender identity refers to a person's internal, deeply held sense of their gender (as a man, woman, neither or both, and a range of other possibilities), expression refers to its outward manifestation (how we dress, hair, make up, voice, body language etc.). For illustrations on some of the range of gender identities and sexual identities possible, refer to the Participant Handout 4.1. on Glossary of Terms and discuss the different terms with participants.
4. This distinction between gender identity and expression is important. A person who was assigned female at birth may express herself through clothes and mannerisms that are typically considered masculine, and identify as a woman. In a different scenario a person assigned female at birth may start feeling and identifying as a man, irrespective of how they outwardly express themselves. What matters is how a person feels about their gender and chooses to identify themselves. The difference between gender identity and expression will be explored further in the genderbread activity.
5. The range of ways people choose to identify and express themselves can be confusing as the idea that having a penis = man and having a vulva = woman, is deeply-rooted and often taken for granted. However, at a very basic level, what is important is that we have an open mind; be committed to learning more; treat individuals with dignity and respect; and ensure their right to self-determination, safety, equality and non-discrimination is upheld.
6. Those who challenge gender assigned to them on the basis of sex characteristics, for example the *hijra* community from the video, often face discrimination, violence and abuse from their families, community, religious, social and public institutions. The bias, discrimination and lack of understanding makes it impossible to access SRH services or seek redressal for violence. They are excluded from the society and public life and forced to live in poverty.

Notes for the Facilitator:

1. In reality, gender identity is much more complex than the metaphor of a script. The metaphor and activity provide an opening to understand and appreciate how people may not wish to identify with gender assigned to them.
2. A lot of gender expressions are visual and persons with visual disability often use the nature of voice to determine the gender of a person. There needs to be some engagement on the aspect of quality of voice (heavy set or mild) as a determinant of gender as they may not be able to receive other visual cues from a person's appearance.

Before showing the video on narratives of *hijras* in Bangladesh, explain who *hijras* are and that while their voice may sound similar to what one attributes to a man, they do not identify as men. While audio cues are important, it is important to respect the gender of the person they expressly identify as.

3. Most of the notes from the previous activity are applicable here. These are likely to be new and challenging concepts, hence, ensure a respectful learning space is created.
4. Invite gender diverse people as speakers for the session, as hearing from a person's lived experience can enrich the session much more.

CHAPTER 2: SEXUALITY

ACTIVITY 4.3: SEXUALITY ALPHABET SOUP

Objective:

To gauge participant perceptions, attitudes and knowledge towards sexuality and to build a common understanding of sexuality among participants.

Time:

30 Minutes

Materials Needed:

None

Room Arrangement:

Suggested – one big circle

Process:

1. Share with the participants that they will be playing a game on sexuality.
2. Proceeding with letters of the alphabet (in local language), they must come up with one word that comes to their mind related to the word 'sexuality'. For example, 'a for affection', 'b for beautiful', 'c for consent' etc.

Variation: Instead of using the alphabet, you can also ask participants to share the first word that comes to their mind, without taking too much time to think.
3. Start with one person and proceed clockwise. Encourage participants to think of words that might be missing – related to pleasure, words that we do not talk about openly, what they might have heard from others etc.
4. Note down the answers.
5. Discuss with the participants how each of the words can be categorised into the following categories. The same word can also be put under multiple categories:
 - a. Body parts
 - b. Sexual acts
 - c. Thoughts, fantasies and desires
 - d. Beliefs
 - e. Attitudes

- f. Expression
- g. Roles
- h. Attraction

Debrief:

1. Did any of the words surprise you or challenge your perception of sexuality?
2. Is talking about sexuality important?
3. What role does sexuality play in different aspects of our lives – at home, in public places, in the workplace, in media depictions?
4. How do different institutions, social, political and legal, impact sexuality?

Key Messages:

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

Note: This is only a working definition as it is difficult to define the concept of sexuality. This definition just captures some of the concepts that are important for the understanding of sexuality.
2. Sexuality goes much beyond sexual acts. Sexual acts are only a part of sexuality. As the working definition illustrates, it comprises of access to information around sexuality, access to sexual health, knowledge about our bodies and reproduction, sexual and reproductive health, our outer expressions through how we dress, behave and act, how society and community reacts to this, pleasure and relationships, choice of sexual and romantic partners, and also violence and abuse.
3. Each person expresses and experiences sexuality differently. For example, in terms of choice of romantic and sexual partners, a person may be attracted to a person of the same gender, a different gender, many genders, or none.
4. Sexuality is an intrinsic part of human life. Talking about it openly ensures that people can have a good quality of life. It is also crucial for understanding sexual attraction, our bodies and how we feel about it and perceive it, how we experience our gender roles, what constitutes a healthy relationship, how to communicate with our intimate partners, and how to protect ourselves from sexual

infections and unwanted pregnancies. Talking about sexuality helps people by ensuring access to necessary information and support, clarifying misconceptions, helping people make informed choices and avoid stigma and discrimination on the basis of how we express our sexuality.

- Sexuality is shaped by various factors, including our different identities and social, legal and political institutions. All of these factors may make it difficult for a person to express and experience sexuality, attach taboos, create legal sanctions on how we can express and exercise sexuality, discourage some forms of sexuality, or influence how we view and understand our own sexuality. For example, criminalisation of some sexual orientations may make it difficult for a person to express their sexuality. Similarly, misconceptions and myths around disability may prevent women and girls with disabilities from experiencing sexual pleasure. Harmful myths around promiscuity associated with sexuality of certain groups can impede access to services and normalise violence.

Notes for the Facilitator:

- Note the kind of words that are being used – are there too many words that depict a negative aspect such as violence and abuse; are people also mentioning positive aspects of sexuality such as pleasure and fun; are certain words missing especially those which people shy away from (masturbation, orgasm, sex etc.).
- Participants might feel shy and uncomfortable in talking about sexuality and may hesitate with the words for the exercise. Encourage participants to engage by drawing attention to why we need to talk about sexuality. Reiterate ground rules on safe space and respect.

ACTIVITY 4.4: MYTH BUSTING ON SEXUALITY

Objective:

To challenge misconceptions around sexuality, especially gendered assumptions and myths relating to persons with disability.

Time:

45 Minutes

Materials Needed:

- Facilitator Handout 4.1

Process:

- Share with participants that you will be reading out different statements around sexuality one by one. The participants must share their thoughts on whether they think the statement is true and why/why not.

- Read out the following statements:
 - Men have a higher sex drive than women.
 - Masturbation (sexually pleasuring oneself) is bad for health.
 - A person with disability is not attractive or desirable.
 - A homosexual man wants to have sex with every man.
 - A woman going out late at night or her manner of clothing is inviting sexual harassment.
 - Persons with disabilities do not need information on sexuality.
 - Hijras* do not have or have incomplete sexual organs.
 - Sex must be spontaneous.

For more myths around sexuality of persons with disabilities, you can also refer to the Mythbusting section of the sexualityanddisability.org website. Available at: [Link] <https://sexualityanddisability.org/having-sex/mythbusting/>. Accessed on 23 October 2020.

Debrief:

- What are some of the other myths and stereotypes you have come across?
- What are the problems with such myths?

Key Messages:

Myths and misconceptions about sexuality perpetuate stigma, discrimination and violence. They make it difficult for a person to receive correct information on sexuality and SRHR, access SRH services and access justice for violence against them.

ACTIVITY 4.5: GENDERBREAD PERSON

(Activity instructions adapted from process guidance by the Safe Zone Project)

Objective:

To bring together the different concepts related to gender and sexuality, explain how they differ from each other and also fit together.

Time:

45 Minutes

Materials Needed:

- Flipchart
- Marker
- Tactile model of the genderbread person with the heart marked out (from clay/mixture of flour and water);
- Facilitator Handout 4.2

Process:

1. Draw the genderbread person on the flip chart (without the labels)/handout a tactile model of the genderbread person, and use the following steps to go over the activity.
2. Explain to the participants that the genderbread person is a diagram that helps us understand gender and sexuality, and the parts that make up both. The activity will involve marking out areas for gender identity, expression, sex and attraction and invite participants to identify the concepts being marked one by one.
3. Start with the head, and ask participants what aspect of gender and sexuality is being referred to. Explain that this is about 'Gender Identity'. Gender identity is who we, in our heads, know ourselves to be, based on what we understand to be the options for gender, and how much we align (or don't align) with one of those options. Gender identity is our psychological sense of gender.
4. Next, moving to the heart, ask participants what aspect is being referred to. Explain this is about 'Attraction.' Attraction is the different ways we feel pulled to other people, often categorised based on our gender and the gender of those we feel drawn to. This categorisation is referred to as sexual orientation.
5. Next move to the bottom, between the legs. The concept being referred to is 'Sex'. Sex, referring to anatomical sex, refers to the physical makeup of our bodies, and specifically all the body parts we have named as sex characteristics – both the primary traits we are born with, and the secondary ones that we might develop later in life (such as breasts and testicles).
6. Point to the entire external part of the genderbread person next. This is about 'Expression'. Gender expression is all the different ways we present ourselves through our actions, our clothing, and our demeanour, and the gendered ways those presentations are socially interpreted.
7. Check with the participants if they have any questions about those terms, or their definitions, and draw on discussions from the previous activities.
8. Next, share with the participants that we are going to look at how these concepts play out in our lives. As discussed during the activity on 'Understanding Gender' and the one on 'Sex characteristics and gender identity and expression', there is a huge diversity in how we live out gender roles and in our sex characteristics. Through a continuum, we can understand where we would place ourselves and others in these different aspects.
9. Start with gender identity and draw two arrows as in the Handout. Next to the top arrow write 'woman' and next to the bottom arrow write 'man'. With gender identity, people often think of social roles, gender norms, and personality traits, and the expectations linked to them.

Reiterate what was discussed in the activity on 'Understanding Gender'.

Add the word -ness (woman-ness and man-ness) to both of these, which reflect that people's feeling of their gender lies on different points of the continuum. Different points on these lines indicate all the varying degrees of potential 'Woman-ness' and/or 'Man-ness' with which someone might identify. For example, some may feel they completely identify with the gender 'woman', and they would be a 100% on the first arrow and 0% on the second arrow. Some may identify somewhere in between on both.

10. Next, move to gender expression and draw two arrows as in the Handout. Next to the top arrow write 'feminine' and next to the bottom arrow write 'masculine'. With gender expression, people often think of hair styles, grooming, make-up, clothing, nonverbal mannerisms, and other things we see on the outside. Again, link up to discussion in the 'Understanding Gender' Activity. Repeat the process of adding -ness to both and explain what that means (varying degrees). For example, a person may like to adopt some degree of femininity in their expressions but maybe not a 100%.
11. Next, move to anatomical sex and repeat the process with two arrows and male and female next to them. With anatomical sex, the first things that people think of are genitals and reproductive organs, but lots of things make up what we call sex, including body hair, hip to shoulder ratio, chromosomes, pitch of voice, and more. Draw on discussion from the 'Sex Characteristics and Gender Identity' activity.

On the top line, write 'Female-ness,' and on the bottom line write 'Male-ness', because here we are depicting the varying degrees someone might embody these sexual characteristics and traits.

12. Check if participants have any questions about these scales, or the words we are using to label them.
13. Next, move to the attraction section. People experience attraction (or don't) in a lot of different ways. Two common ways people describe the attraction they may or may not be experiencing is as 'sexual' and 'romantic'. You can think of sexual attraction as the drive to engage in physically intimate behavior like touching, kissing, or intercourse, and romantic attraction as the drive to engage in socially intimate behavior like flirting, dating, and marriage.

Some people experience both, some only one, and some neither. And within those experiences of attraction, we often focus on the gender of others that we are attracted to.

14. Check if participants have any questions about these scales, or the words used using to label them.
15. Ask the participants to take a moment to consider where they fit in these continuums. How much woman-ness do you identify with? How much man-ness? Maybe neither? How much femininity and/or masculinity do you express? A lot of both? A lot of one and not a lot of the other? How much female-ness or male-ness do you see yourself embodying?
16. Share with the participants that we are socialised to oversimplify all of this, and to think that once we know one thing about someone, we can fill in the rest of their blanks. For example, if we learn someone is a woman, we have a picture in our mind of what that person looks like and who she is attracted to. We might assume she expresses gender in feminine ways, was assigned female at birth and embodies female-ness, and is exclusively attracted to men. This image is simple, however, it is not true or complicated enough for many, if not most, of us. Many of us exist in different degrees on the continuum, and may keep moving through them in ways that break assumptions and norms.
17. Remind the participants, once again that “Identity ≠ Expression ≠ Sex,” and “Gender ≠ Sexual Orientation.”

Variation: When doing the exercise with participants with visual disability instead of using arrows, use the idea of a spectrum with two extremes and detail out what this extreme could look like. Explain how many of us lie somewhere in between these two extremes.

Notes for the Facilitator:

1. Try to bring in how much our ideas of attraction, desire, being masculine or feminine or neither is derived from the society we live in, norms set by it, and social structures such as patriarchy, class, caste, race, ethnicity, geographical location etc.
2. Go through the exercise thoroughly and be confident about carrying it out before conducting the exercise with the group. You can watch the following video to get an idea of how to conduct the activity: Wel Jong Niet Hetero (2018). *Genderbread Cookie*. Available at: [Link] <https://www.youtube.com/watch?v=-cdeGFNP6Q>. Accessed on 24 September 2020.
3. Draw on discussions and agreements from the previous activities and explain that this activity just brings it all together.

ACTIVITY 4.6: SHORT FILM

Objective:

To challenge our perceptions about gender roles, types of families and gender expression and imagine different possibilities.

Time:

45 Minutes

Materials Needed:

- Video of short film Miss Man.

Process:

1. Play the following film: Tathagata Ghosh (2019). *Miss Man*. Available at: [Link] <https://www.youtube.com/watch?v=WbSBHji3dJs>. Accessed on 25 August 2020.
2. Pause at 1:00 minute and ask the participants what they think is being depicted in the film. Likely response will be two families with children, husband going to work, mother tending to household chores like cooking.
3. Now play the rest of the film

Debrief:

1. Did the movie challenge notions of family and gender roles? Was it difficult to imagine families and gender expressions and identities coming together like this?
2. Other thoughts on the film.

Key Messages:

1. People have a right to express their gender, sexuality and have diverse sexual and gender identities and have them respected, without fear of discrimination and violence. In doing so we can create diverse ways of being and living our lives.
2. Our notions of families are quite limited – it usually comprises of a man and a woman. The gender identity matches their sex and gender assigned at birth. But different kinds of families can and do exist.

Note for the Facilitator:

The film is made rich by the visual depictions. For participants with visual disability, pause periodically and describe the scene as it is shown.

CHAPTER 3: POWER, PRIVILEGE AND INTERSECTIONALITY

ACTIVITY 4.7: PEBBLES AND PETALS

Objective:

To challenge the idea of persons with disabilities as a homogenous group with similar life experiences and to understand the idea of privilege.

Time:

60 Minutes

Materials Needed:

- Pebbles and petals
- Sheets of paper
- Facilitator Handout 4.3

Room Arrangement:

Suggested – one big circle

Process:

1. Share with the participants that we will be doing an activity which gives us an initial understanding of how different circumstances that we are born with and sometimes acquire (such as being married or not married), can create different positions of power and privilege.
2. Through this exercise we are drawing a journey of our lives through pebbles and petals. The facilitator will be sharing different statements with the participants. If the statement applies to a participant, place a petal on your life journey path, if it does not place a pebble instead.
3. Distribute sufficient number of pebbles and petal to each participant.
4. Read out the statements in Facilitator Handout 4.3. Request the participants to interpret the statement by themselves and take an action accordingly. Pause between statements to give participants a moment to understand the statement and reflect on it.
5. At the end of the exercise, ask participants to take a moment to check-in on how they are feeling and reflect on the exercise.

Debrief:

1. How did the activity feel? Are these factors people have considered before?
2. What were some factors influencing your privilege that you have never thought of before?
3. What statements made you think most?
4. What are some other ways in which our multiple identities play out to create situations of power and privilege in different situations?

Key Messages:

1. Power contains with it the ability to control and influence – actions and choices of another person, direction of one's own life, resources, course of events, narratives etc. It is not unidimensional, it is relational. Power is both exerted against us and we exert power over others as well in different situations. Power is often exercised in ways that is not immediately visible.
2. Often, some aspects of our identities which marginalise us stand out to us more than others and we do not notice privileges from our other identities because they are so ingrained in our culture. This is usually tied up with our socio-political identities. Hence, while some aspects of identities may marginalise us and create barriers for us, others bestow privileges and power on us. For example, consider the situation of a person with disability who does not belong to an indigenous community vis-a-vis a person with disability who belongs to an indigenous community.
3. Privileges can be understood as the benefits and advantages that people have which they may not realise, think about or notice because they never have to experience the oppressive side of things. *“Those who have these privileges often believe they are earned or that everyone could have access to these privileges if only they worked to earn them. However, this is not the case. Privileges are unearned and they are granted to people based on their different identities whether they want those privileges or not, and regardless of their stated intent.”*³³ As a starting point, it is important to acknowledge one's privileges.

Note for the Facilitator:

Ensure a self-reflective and learning space and encourage participants to dig deeper while contemplating these ideas.

“You may not control all the events that happen to you, but you can decide not to be reduced by them.”

– Maya Angelou

ACTIVITY 4.8: INTERSECTIONALITY**Objective:**

To understand how other identities intersect with disability; and to understand how intersectionality can become a practice.

Time:

60 Minutes

Materials Needed:

- Participant Handout 4.2

Room Arrangement:

Suggested – one big circle

Process:

1. Ask the participants to list the different factors that create and perpetuate inequality, discrimination and oppression in the context of Bangladesh. This should include (dis)ability, class, caste, ethnicity, religion, gender identity and expression, sexual orientation, sex characteristics, education, relationship status, rural/urban domicile, migrant status, refugee status, among others. Note these down.
2. Share with the participants that you will be reading out different statements and the list of identities that participants have shared one by one. After you read out the statement and an identity, if they think it applies to them, they can indicate with an agreed upon sign. For example, for participants with visual disability it can be a clap; for participants with hearing disability the indication can be through show of hands; for participants with physical disability it can be either of the above or squeezing a toy or any other sign depending on their motor abilities.
3. Read out the following statements and after each statement, read out the list of identities one by one. Pause after each, allowing participants to indicate their response.
 - a. *“The part of my identity that I am most aware of on a daily basis is _____.”*
 - b. *The part of my identity that I am the least aware of on a daily basis is _____.*
 - c. *The part of my identity that was most emphasised or important in my family growing up was _____.*
 - d. *The part of my identity that garners me the most privilege is _____.*
 - e. *The part of my identity that I believe is the most misunderstood by others is _____.*
 - f. *The part of my identity that I feel is difficult to discuss with others who identify differently is _____.*
 - g. *The part of my identity that makes me feel discriminated against is _____.*
 - h. *The part of my identity that I wish I knew more about is _____.”*
(*This part of the activity is adapted from the activity “Identity Signs” in ARROW’s ‘E-Module on InterSEXuality: A Facilitator’s Guide’*)³⁴
4. For example, after the first statement is read out, start with the first identity on the list, say religion. Pause and those who think their religious identity is the most important identity they identify with on a daily basis, must respond using the agreed sign (clap, show of hands etc.). Move to the next identity and similarly allow people to respond.
5. If there are very few responses to some identities, have a discussion on why that is the case. How do our processes of socialisation and activism perpetuate homogeneity?
6. Introduce the idea of intersectionality: While we may stress on sameness based on one aspect of our identity, it is important to recognise that a person has many other parts to their identity which come together and interact with each other to create unique life experiences and challenges and exacerbate discrimination. Intersectionality involves recognising that a person suffers systemic discrimination on account of various aspects of their identity, but also face unique barriers because of how these parts of our identity come together (intersect). For example, as a woman with disability, a person faces discrimination on account of gender (for example, domestic violence) and also on account of disability (for example, lack of accessible public transportation). But there are also some unique challenges on account of being a woman AND a person with disability. For example, a woman with disability may not be considered as a suitable wife by a man with disability because of an assumption that she will not be able to perform the gendered roles of a wife because of her disability.

Often women with disabilities end up being excluded both from mainstream feminist and disability spaces. Even when they are included, one aspect of their identity is focussed and not the whole of their being which is constituted by both these parts together. However, as the activity demonstrates, even women with disability are not a homogenous group and other aspects of our identity significantly shape our life experiences.

Optional: You can also use this infographic developed by Miriam Dobson. Available at: [Link] <https://miriamdobson.com/2013/04/24/intersectionality-a-fun-guide/>. Accessed on 16 October 2020.

FIGURE 22:
INFOGRAPHIC EXPLAINING INTERSECTIONALITY



Image Credit: Miriam Dobson

- Distribute copies of Participant Handout 4.2 and allow time for participants to go through the stories shared. Share with them that these are real life stories of persons with disabilities, where they highlight what living at the intersection of different forms of oppression, along with being a person with disability, has meant for them. Allot 30 minutes for this.
- In a plenary, discuss different ways in which participants can adopt an intersectional approach into their lives and work.

Debrief:

- Were there parts of the activity that were new to you/ surprised you?
- What are some of your reflections from the activity?
- How do you think this concept is relevant to different aspects of your life?

Key Messages:

- Intersectionality involves an understanding of how our sexual orientation, gender identity and expression, sex characteristics, ethnicity, economic status, caste, religion, migrant status, national origin, among other aspects of one's identity, create situations of privilege and marginalisation.

The stories of intersectionality demonstrate how as persons with disabilities we share some common barriers, but others are unique owing to a culmination of other aspects of our identity and life situations.

- It is important that we acknowledge diversity and challenges stemming from other aspects of one's identity, even as we stress on the sameness of barriers encountered on the basis of some aspects of our identity. For example, recognising that as persons with disabilities we share a common barrier of disabling environments, but we have other identities on account of our sexual orientation and identity, gender and gender identity, age, caste, ethnicity, refugee status, class, location etc. Requiring people to forego other aspects of their identity by focussing solely on our similarities further marginalises them, as different aspects of ourselves are not separable from each other- they exist together and need to be acknowledged and addressed as such.

3. This understanding of intersectionality also needs to be reflected in our work. Some ways in which we can do this is as follows:
- Recognise that there are multiple voices within a movement and that there is no singular way of experiencing an issue. These various voices and perspectives need to be considered in order to make real, lasting, and equitable change.
 - Respect people's experiences and voices and centre the voices of those most affected by the issue, respect their goals for their communities, and step aside and allow them to serve as spokespeople for their own causes.
 - Being truly intersectional requires us to understand the impact of our work and advocacy on others – how is our approach linked to other issues, is our approach benefitting those more marginalised among us or undermining their efforts. For example, in advocating for accessible health services for women with disabilities, if we only look at physical accessibility, we fail to account for language accessibility for indigenous women with disabilities and the attitudinal bias and prejudice that persons with disabilities face within the health system on account of sexual orientation and identity, gender identity, ethnicity, caste, HIV status etc.
 - For truly transformative change, it is important we look beyond our single issue and collaborate and work with other movements fighting against discrimination and inequality and envision a joint agenda for change.

“There are many, many different kinds of intersectional exclusions—not just black women but other women of color. Not just people of color, but people with disabilities. Immigrants. LGBTQ people. Indigenous people.”

– Kimberle Williams Crenshaw

Note for the Facilitator:

The concepts by themselves maybe difficult to grasp for people, use abundant illustrations and examples to demonstrate how these concepts translate into reality.

Resources for Further Reading:

1. Videos by Amaze.Org on YouTube. Available at: [Link to video] https://www.youtube.com/channel/UCXQZTtGgsy6QHH2fg-OJ_eA. Accessed on 27 July 2020.
2. Andrea Conrnwall and Susie Jolly, (2006). 'Introduction: Sexuality Matters', *Institute of Development Studies Bulletin*, 37(5).
3. Jane Maxwell, Julia Watts Belser, Darlena David (2007). *A Health Handbook for Women with Disabilities*, Berkely, California: Hesperian, pp. 13-156 (Chapter 7: Sexuality).
4. Sam Killerman (2015). *Breaking through the Binary: Gender Explained Using Continuums*, It's Pronounced Metrosexual. Available at: [Link] <https://www.itspronouncedmetrosexual.com/2011/11/breaking-through-the-binary-gender-explained-using-continuums/>. Accessed on 2 August 2020.
5. Solidarity Foundation, *What if it is neither? A report on the historic seminar on intersex persons' issues in India* (2018).
6. International Disability Alliance, Indigenous People with Disabilities Global Network and UN Women, *Fact Sheet: Indigenous Women with Disabilities*. Available at: [Link] <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/fact-sheet-on-indigenous-women-with-disabilities-en.pdf?la=en&vs=5640>. Accessed on 3 August 2020.
7. Movement Advancement Project, Centre for American Progress, National Centre for Lesbian Rights and National LGBTQ Task Force, *LGBT People with Disabilities*. Available at: [Link] <https://www.lgbtmap.org/file/LGBT-People-With-Disabilities.pdf>. Accessed on 3 August 2020.
8. Jayna Kothari, Almas Shaikh, Aj Agrawal (2020). *The Intersection of Disability and Caste: A Policy Paper*, Bangalore: Centre for Law & Policy Research.
9. The Center for Gender Sexuality and HIV/AIDS (CGSH) (2010). *Sexuality and Power*. Dhaka, Bangladesh: James P Grant School of Public Health, BRAC University. Available at: [Link to PDF] <https://assets.publishing.service.gov.uk/media/57a08b10ed915d622c000a9f/Sexuality-and-Power.pdf>. Accessed on 6 august 2020.
10. Farhana Alam et.al (2017). *Let's Debunk the Misconceptions*. Dhaka, Bangladesh: BRAC James P Grant School of Public Health, BRAC University.
11. Maria Melinda Ando (2019). *InterSEXionality: A Facilitator's Guide*. Kuala Lumpur, Malaysia: ARROW.

MODULE 4 PARTICIPANT HANDOUT 4.1

GLOSSARY OF TERMS – GENDER, SEX AND SEXUALITY

(Activity 4.2: Sex Characteristics and Gender Identity)

(The terms listed here are only indicative and not exhaustive as different people choose to identify themselves in different ways. Many of the terms used here are based on a global referent and different regions have their own unique identities and terminologies.)

ASEXUAL: A person who experiences sexual attraction on a spectrum characterised by low levels of sexual attraction or no sexual attraction. A person who does not experience sexual attraction can still experience romantic attraction, as physical attraction and emotional attraction are separate aspects of a person's identity.

BISEXUAL: A person who is sexually and romantically attracted towards people of the same as well as other genders, or towards people regardless of their gender. Some people may use bisexual and pansexual interchangeably.

CISGENDER: A person whose sex assigned at birth and gender identity correspond. (e.g., someone who was assigned male at birth, raised as a boy and identifies as a man).

GAY: Usually, a man who is primarily sexually and romantically attracted to men.

GENDER NON-CONFORMING (GNC): "Adjective for people who do not subscribe to societal expectations of typical gender expressions or roles. The term is more commonly used to refer to gender expression (how one behaves, acts, and presents themselves to others) as opposed to gender identity (one's internal sense of self)."³⁵

HETEROSEXUAL/STRAIGHT: A person who experiences sexual and romantic attraction to people of a gender other than their own.

HIJRA: Usually, refers to persons who were assigned male at birth and "reject their masculine identity and identify either as women, or "not-men", or "in-between man and woman" or "neither man nor woman".³⁶ The community is defined by induction into the community by an elder known as "guru", along with their own rituals and customary practices.

INTERSEX: It refers to a wide range of natural variations in the body that do not neatly fit into dominant definitions of male or female. Intersex variations may include, but are not limited to, variations in chromosome compositions, hormone concentrations, and external and internal sex characteristics.

QUEER: An umbrella term that is used by people who do not conform to dominant perceptions and expectations of gender and/or gender expression and/or sexuality.

LESBIAN: Usually, a woman who is primarily sexually and romantically attracted to women.

NON-BINARY: "A gender identity and experience that embraces a full universe of expressions and ways of being that resonate for an individual, moving beyond the male/female gender binary."³⁷

PANSEXUAL: People who have romantic and sexual desire for people of all genders and sexes.

TRANSGENDER: Transgender, or trans, refers to a person whose internal sense of gender is different from the sex that was assigned to them at birth. In order to feel more aligned with their sense of gender identity, they may choose to undergo medication and/or surgery. Some may opt for surgeries, some may opt for hormone therapy, while others may opt for both. However, changing one's body is not necessary to identify as transgender, what matters is how one feels and identifies themselves.

TRANSGENDER MAN/TRANS MAN: A person who was assigned female at birth, but identifies as a man.

TRANS WOMEN: A person who was assigned male at birth but identifies as a woman. Members of the *hijra* community may or may not identify as transwomen, as *hijra* is a unique identity of its own.

For further reading see: LGBTQIA Resource Center at UC Davis, *Glossary*. Available at: [Link] <https://lgbtqia.ucdavis.edu/educated/glossary>. Accessed on 16 October 2020; and Safezone Project, *LGBTQ+ Vocabulary: Glossary of Terms*. Available at: [Link] <https://thesafezoneproject.com/resources/vocabulary/>. Accessed on 16 October 2020.

MODULE 4 FACILITATOR HANDOUT 4.1

MYTHS ABOUT SEXUALITY

(Activity 4.4: Myth Busting on Sexuality)

A. Men have a higher sex drive than women. Sex drive and gender are not related. The taboo and stigma around women's sexuality often inhibit them from speaking about and expressing desires as openly as men. Every person experiences fluctuations in their sex drive, irrespective of gender. This depends on various factors including mental health and the effect of certain medications. Statements such as these are often used to justify non-consensual violent behaviour. It also further stigmatises women from speaking about sexual pleasure more openly.

B. Pleasuring oneself (masturbation) is bad for health. Masturbation is absolutely healthy and safe as long as the person feels good about it. It is common and quite normal, irrespective of gender and can be a source of pleasure. However, there are appropriate places and times for masturbation and one's pleasure cannot cause another discomfort. For example, a person masturbating in front of you without your consent is not appropriate and amounts to sexual violence.

C. A person with disability is not attractive or desirable. We have all been exposed to the message that sex is for 'beautiful' people. This poses many powerful questions for a person with a disability who may not be considered 'beautiful' according to the rigid, false ideals of beauty that exist in society. Attraction, above all else, is a connection between two people. What attracts people and what people find 'beautiful' is unique, and fantasies, desires and attractions exist outside the rigid and false idea of 'beauty' that we often come across.³⁸

D. A homosexual man wants to have sex with every man. Notions about promiscuity of homosexual men are quite common. For homosexual men, as for heterosexual people, wanting to establish a sexual relationship depends on many factors including attraction and a feeling of comfort. Desiring a person of the same gender does not in any way increase the sexual drive of a person or affect the factors that lead us to establishing a sexual relationship in the first place. Myths such as these, along with skewed media representations, enable stigma and discrimination to be perpetuated against certain groups.

However, this is also gendered since we do not hear similar myths about homosexual women. This is primarily on account of two reasons, one is that homosexual women are under-represented in public discourse and the second relates to myths about female sexuality and low sex drive as discussed above.

E. A woman going out late at night or her manner of clothing is inviting sexual harassment. Abuse, violence and harassment faced by women have nothing to do with their behaviour or clothing. Instead, it is more a question of power and sense of entitlement stemming from a gender hierarchy. Blaming a person for their own harassment and violence further aggravates the deep emotional and psychological trauma in the aftermath of a violent, abusive or harassing situation. These myths also become an important tool of controlling and dictating women's sexuality.

F. Persons with disabilities do not need information on sexuality. This stems from the false assumption that persons with disabilities are not sexual. Persons with disabilities, like their non-disabled peers, have a right to information on sexuality which allows them to understand their own bodies and development, how to exercise autonomy over reproductive and sexual choices, look after their health, choose and engage with romantic and/or sexual partners and how to seek support in the event of violence.

G. Hijras do not have or have incomplete sexual organs. *"Majority of those who identify as hijras in Bangladesh are male bodied and born with (complete) male sexual organs. However, psychologically they think of themselves as women. Bangladeshi society has several mythical ideas about hijras. It is thought by some people that hijra do not have sexual organs; or that they have a small hole instead of sexual organs; or that their organ is incomplete/disformed. Some hijras choose to get rid of their male sex organ because of shame or guilty feelings."*³⁹

Instead of focussing on their self-determined gender identity, a culturally embedded obsession over sexual organs of *hijras*, perpetuates discrimination and violence. For example, it results in abuse by health professionals touching their sexual organs unnecessarily. In another instance, the government of Bangladesh conducted medical scrutiny of sex organs of *hijras* who were appointed to a position reserved for transgender individuals, but used that to declare them as fully male irrespective of their gender identity.

H. Sex must be spontaneous. The idea that sex can happen without thinking, planning or communicating before and during sexual activity is unrealistic, especially for a person with a disability who may require additional assistance when preparing for sex. While popular media may tell us otherwise, in reality sex is a process of communication that takes forethought. Having a pleasurable sexual experience depends on clear communication and can sometimes involve planning ahead.⁴⁰

MODULE 4_ FACILITATOR HANDOUT 4.2

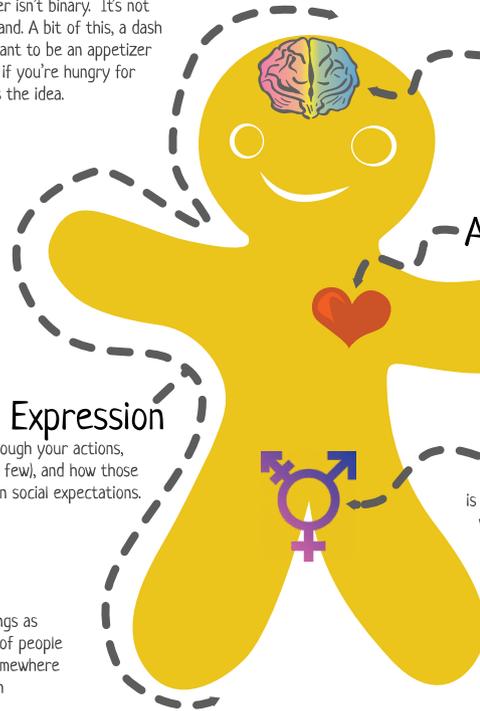
THE GENDERBREAD PERSON

(Activity 4.5: Genderbread Person)

The Genderbread Person

by its pronounced **METROsexual**.com

Gender is one of those things everyone thinks they understand, but most people don't. Gender isn't binary. It's not either/or. In many cases it's both/and. A bit of this, a dash of that. This tasty little guide is meant to be an appetizer for gender understanding. It's okay if you're hungry for more after reading it. In fact, that's the idea.



Identity

is how you, in your head, experience and define your gender; based on how much you align (or don't align) with what you understand the options for gender to be.

Attraction

is how you find yourself feeling drawn (or not drawn) to some other people, in sexual, romantic, and/or other ways (often categorized within gender).

Expression

is how you present gender (through your actions, clothing, and demeanor; to name a few), and how those presentations are viewed based on social expectations.

Sex

is the physical traits you're born with or develop that we think of as "sex characteristics," as well as the sex you are assigned at birth.

We can think about all these things as existing on continuums, where a lot of people might see themselves as existing somewhere between 0 and 100 on each

⊘ means a lack of what's on the right side



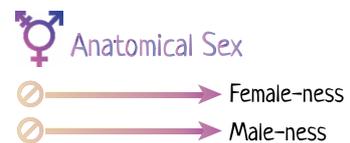
personality traits, jobs, hobbies, likes, dislikes, roles, expectations

common GENDER IDENTITY things



style, grooming, clothing, mannerisms, affect, appearance, hair, make-up

common GENDER EXPRESSION things



body hair, chest, hips, shoulders, hormones, penis, vulva, chromosomes, voice pitch

common ANATOMICAL SEX things

Identity ≠ Expression ≠ Sex
Gender ≠ Sexual Orientation



Typically based solely on external genitalia present at birth (ignoring internal anatomy, biology, and change throughout life), Sex Assigned At Birth (SAAB) is key for distinguishing between the terms "cisgender" (when SAAB aligns with gender identity) and "transgender" (when it doesn't).



MODULE 4_ FACILITATOR HANDOUT 4.3

STATEMENTS FOR PEBBLES AND PETALS

(Activity 4.7: Pebbles and Petals)

1. One or both of my parents have received education up to a college degree.
2. My choice of partner is not criminalised and religious leaders will not issue –s sanctioning violence against me and my partner for our sexual and/or romantic preferences.
3. I have attended school with people I feel were like myself, and did not face any discrimination or stigma.
4. I have never been made fun of or bullied by my friends, family and people in my community.
5. I have never had to worry about moving around with the fear of sexual assault.
6. I am able to show affection for my romantic partner in public without fear of discrimination, ridicule or violence.
7. I can express my gender identity, which is different from the sex I was assigned at birth, in public without fear of discrimination, ridicule and violence.
8. I have never been forced to flee my homeland and move to an unknown place.
9. I have had the opportunity to learn about the culture, tradition and practices of my ancestors and these are regularly reflected in popular culture.
10. I have never had to skip a meal or go hungry because there was not enough money to buy food.
11. My accessibility needs are accounted for in the design of public facilities such as roads and transportation facilities.
12. The law does not place restrictions on my ability to own property, consent to treatment and make decisions about myself based on their assumption of my mental capacity.
13. My merit and progress in life are not constantly questioned and seen through a lens of charity.
14. I am able to access sexual and reproductive services without any discrimination.
15. My identities are reflected in the media and portrayed positively.
16. I have never been refused entry into a public place based on my caste and ethnicity.
17. I have savings.
18. People do not try to invalidate my sense of gender.
19. My parents have always told me I can be whatever I want to be.
20. I have never been refused entry into a person's house or told I cannot share their utensils.
21. I have not had to live my life under the constant shadow of guns and under the complete authority and control of state military.
22. I am able to practice my religion, without fear of discrimination and violence.
23. I am able to express my opinions, beliefs and thoughts without fear of violence from the state.
24. My family owns land.
25. The land owned by my family and community have not been snatched away arbitrarily.
26. I have role models I could identify with growing up.
27. I have been able to take my own decisions about getting married.
28. I have been able to take my own decisions about having children.
29. I do not feel the impact of climate change on a day-to-day basis.
30. I have never had to feel ashamed or been made to feel ashamed for wanting sexual pleasure, or finding information about sex.

MODULE 4 PARTICIPANT HANDOUT 4.2 Page 1

NARRATIVES OF INTERSECTIONALITY

(Activity 4.8: Intersectionality)

1. PRATIMA'S STORY

Chair, National Indigenous Disabled Women Association Nepal (NIDWAN)

Pratima is an indigenous woman with disability belonging to the Gurung indigenous community in Nepal. She acquired her disability through an accident at the age of seven. While Pratima has long been an active member of the indigenous women's movement, she faced many hurdles and rejection when she tried to join the disability movement. Within the mainstream disability movement, she was chided for asserting her indigenous identity and accused of being racially divisive for bringing up the issues of indigeneity/ethnicity. She realised that there was no space or an enabling environment to assert her indigenous identity within the disability movement and a forced homogeneity was being pushed on her. But, Pratima clearly asserts that her indigenous identity is her foremost identity and her indigenous, disability, and gender identities reinforce and impact each other in several ways which are sometimes visible but most often invisible.

Pratima proudly claims her identity as an indigenous woman with disability and asserts that these identities are not divisible. Unfortunately, each movement has sought to address one aspect of her identity and not as a whole. As a result she is often left out of all three movements – the disability movement, the women's movement and the indigenous people's movement.

Pratima points out that the indigenous identity is a very distinctive identity. Indigenous people have historically faced stigma, exclusion, indirect and structural discrimination. Indigenous people embrace their identity as a collective identity with collective rights. Therefore, a disability rights perspective that looks at individual rights only, will not serve

the indigenous community who are fighting for individual and collective rights together. Pratima also points out the multiple marginalisation that indigenous women with disabilities face.

For example, an indigenous women with disabilities, dressed in the traditional attire, had gone to the local office to get a disability card. However, the officer refused to issue the card asking her to return in “proper clothes” and asking her to “speak in a proper way” for a card to be issued. Similarly, she highlights the problems with narrow definition of accessibility – even if information is made available keeping in mind disability specific needs, it will still remain inaccessible for indigenous persons with disabilities unless the information is available in the native/local language. Therefore, the intercultural aspect has to be integrated in disability accessible forms and formats. Moreover, not only do indigenous women with disabilities face greater sexual violence and many barriers in accessing justice, these forms of public humiliation relating to one's attire, accent, physical features and inability to partake in one's culture and tradition, she asserts, is violence in itself. There are many forms of discrimination and violence that indigenous women with disabilities distinctly face both in public and private spheres which have not been a part of public discussion. Most often their issues remain mixed or diluted within the different movements for women's rights, disability rights and indigenous rights.

Pratima says that as indigenous women with disabilities, their voices have always been repressed and discriminated against and, therefore, through their advocacy they are creating a new framework and discourse and defining their own narratives and reclaiming spaces as indigenous women with disabilities.

(As shared with the author. Printed with permission from Pratima Gurung.)

MODULE 4 PARTICIPANT HANDOUT 4.2 Page 2

NARRATIVES OF INTERSECTIONALITY

(Activity 4.8: Intersectionality)

2. SOWBHAGYA'S STORY

Convenor of the DPO, Karnataka Vikalachetanara Sangatane

As a young child, Sowbhagya contracted polio which resulted in limited mobility. Because of her disability she was treated differently, including by her siblings, and as a result she was very withdrawn. It was only when she turned nine that her mother started carrying her to school. At school, Sowbhagya was made to sit separately at the back of the class. The students and teachers discriminated against her and did not allow her to participate in class activities saying "education is of no use to somebody like her". As a result of this constant discrimination, she was forced to drop out of school after Class 9. Soon after, she was pressured into getting married.

When Sowbhagya was six months into her second pregnancy, she found out that she had tested positive for HIV. She sought counselling at the government hospital, but they refused to provide her with medical care and treatment. Sowbhagya wanted an abortion fearing that she would pass on the infection, but was refused an abortion because she was six months pregnant. She, therefore, had to get an unsafe abortion. While her first son tested negative for HIV, her husband tested positive.

Sowbhagya was regularly abused by her husband. After he passed away, she moved back with her family, but her husband's family continued to harass her, including disclosing her HIV status to everyone in their village and publicly blaming her for her husband's death.

Owing to the medication that Sowbhagya has to take both for her HIV treatment and for her disability, she experiences seasonal changes in her body which are difficult to manage. She is repeatedly ostracised by society, who have said many hurtful things to her such as "You have a disability, no husband and are HIV positive, how will you live? Why are you alive?"

However, on meeting other supportive people from local DPOs and NGOs, she feels she is able to live life on her own terms. She is now a convenor of a local DPO, where she provides counselling to other people.

She is very proud that she has been able to successfully educate her son. When he was about 15 years old, she shared her HIV status with him. Her son assured her that her HIV status does not in any way impact how he sees her and has been a pillar of support in fighting the discrimination and bias she faces.

(As shared with the author. Translated from Kannada by Neha Kamat. Printed with permission from Sowbhagya.)

3. MAMATHA'S STORY:

Board member of the DPO, Karnataka Vikalachetanara Sangatane

Mamatha was born into a very poor Dalit family and was one of five siblings, comprising four girls and one boy. Her father passed away at a young age. Because of her disability, she was mistreated and isolated by her family and was accused of bringing bad luck to her family. She was told that nobody would marry her and that she would always remain a burden.

Her mother was the primary earner and worked as a sweeper. None of the five children went to school and they relied on food discarded by other families for their survival. Like Mamatha's family, due to a highly entrenched caste system, generations of Dalit families have been excluded and discriminated against in access to education and employment, and forced to live in poverty.

When Mamatha got married, she faced severe abuse from her husband. She feels that her husband only married her because she receives a disability allowance, which he took from her and used it for drinking. She was forced to move back with her mother and brother, in whose hands she faced regular abuse.

Mamatha feels that people never showed her much respect and that people rarely talked to her nicely. Once she started living by herself, the discrimination she faced on account of her caste identity became more apparent to her. She realised that she was being put down for not having received education. Stemming from deep rooted caste discrimination, people also refused to let her enter into their homes and stood far away from her while talking to her.

MODULE 4 PARTICIPANT HANDOUT 4.2 Page 3

NARRATIVES OF INTERSECTIONALITY

(Activity 4.8: Intersectionality)

After meeting the founder of the local DPO and the other members of the DPO, Mamatha feels that she has derived a lot of courage and hope to live. She now lives by herself and is a board member of the DPO, where she provides counselling and legal support to other persons with disability who are facing abuse.

(As shared with the author. Translated from Kannada by Neha Kamat. Printed with permission from Mamatha)

4. KIRAN'S STORY:

Founder, Karnataka Vikalchetanara Sangatane

Kiran is a transman (female to male), Adivasi, and a person with disability. Although Kiran was assigned as female at birth and raised as a girl, Kiran did not identify as a girl. He identifies as a man. Kiran was born into a family of poor farmers belonging to an Adivasi community and contracted polio when he was three years old, which restricted mobility in his lower limbs. While his other siblings attended school, Kiran was confined to his house till he was nine years old. Although Kiran was being raised as a girl, he felt like a boy from within.

One day, a teacher came to his house and advocated with his parents to send Kiran to school. He offered to carry Kiran and bring him back and also help with the classes. He also suggested that Kiran change his name (Badri), which reflected his Adivasi background, as that would invite discrimination at the school. Since Kiran felt like a boy, he gave Kiran a more masculine name – Ushakiran. With the teacher's help, Kiran was able to attend school, but did not have any friends as he could not share with anybody that he felt like a boy within and was being forced to dress in a skirt.

When Kiran reached Class X, he moved to a hostel under the disability quota to pursue further education. However, the hostel was for women and he felt deeply uncomfortable there as he felt and behaved like a man. Kiran took the decision to leave the hostel and using his wheelchair, travelled 20 km each way to study.

While Kiran was at the hostel, he made his first friend Saritha, with whom he was finally able to share how he truly felt about his gender. Kiran fell in love with Saritha's sister Kavya, whom he married in 2008. However, their relationship was not easy and they faced a lot of abuse and violent attacks and were asked insensitive questions such as "how will you have babies", "how can you have sex", etc. They were eventually forced to leave their village and move to a new place, where they did not even know the local language.

In 2008, when Kiran was having an operation on his leg because of polio, a local organization came forward to help him learn the local language and equip him with computer skills. Since then, Kiran has received multiple fellowships to build his work that supports transgender persons with disabilities and other marginalised persons with disabilities who face abuse. Kiran is the founder of multiple organizations, including KVS which was founded in 2012 to support and advocate for rights of marginalised persons with disabilities such as Dalit persons with disabilities, transmen with disabilities and those with multiple disabilities.

Kiran finds that there is no single platform that addresses all his identities – as a person with disability, a transman and as a person belonging to the Adivasi community. He gives one instance of this – availing benefits. When he avails benefits under the transgender law, they forget that he is also disabled and Adivasi. Similarly, when he avails benefit under the disability law, they do not address that he is transgender and Adivasi. As a result Kiran is not sure under which law he should apply for benefits and ends up losing in all three categories.

(As shared with the author. Translated from Kannada by Neha Kammat. Printed with permission from Kiran Nayak)

MODULE 4 PARTICIPANT HANDOUT 4.2 Page 4

NARRATIVES OF INTERSECTIONALITY

(Activity 4.8: Intersectionality)

5. SHALINI'S STORY

Educator and Disability Rights Activist, Sri Lanka

Shalini Abeysinghe is a woman with multiple disabilities from Colombo, Sri Lanka. Shalini was born with a congenital limb deficiency. Growing up, she did not feel 'different' to others in her younger years. It is only after attending nursery school that she started to realise that she might not be like other 'normal children' based on the differential treatment that she received from her teachers. Shalini was asked to work at a table separate from other children and was not allowed to play with her classmates during recess. Similar experiences of segregation in primary school led to Shalini feeling isolated and estranged from her peers. She also experienced bullying and social ostracism during this time. In hindsight, the shift in self-perception due to societal reactions indicate the socio-cultural nature of the disability experience. Predominant world views including the belief that disability is a karmic punishment were also often expressed by strangers to Shalini as a young child which led to her internalising a sense of 'badness' and 'unworthiness' over time.

During her adolescent years, Shalini came to the realisation that she may not be heterosexual and that she was attracted to both girls and boys. Given the deep stigma and enduring criminalisation of same-sex desire and relations in Sri Lanka, Shalini struggled with coming to terms with her sexuality. Those close to her said that she was already ostracised due to her visible disability and that it was foolish and unwise of her to become even more oppressed by leading a 'homosexual life'. The notion that non-heterosexuality is a stigmatised lifestyle choice underlies such beliefs. While her disability was perceived as something beyond her control, her queerness was perceived as a deviant choice. While Shalini's family was empowering and supportive during her childhood as she navigated her disability and societal reactions, her 'abnormal' sexuality led to significant tension and estrangement. Queerness was deemed as a shame and unbearable loss of face for the family which would undermine her sisters' marriage prospects and the dignity and social standing of her

family. This has compelled Shalini to hide her sexuality and pass as 'straight' in order to maintain the peace. Homosexuality is also viewed as a karmic punishment in Sri Lanka, affirming the deviance of someone with a disability. On the other hand, disability is often equated with undesirability and asexuality. Hence Shalini has been subjected to very little pressure or expectations when it comes to getting married and leading a heterosexual family life unlike her sisters who faced significant pressure to get married. There is less of an imperative to meet gendered expectations and maintain family honour as a woman with disabilities. In that sense, disability acted as a shield for Shalini who could pursue her sexuality given the deviance/invalidity accorded to sexuality of persons with disabilities to begin with.

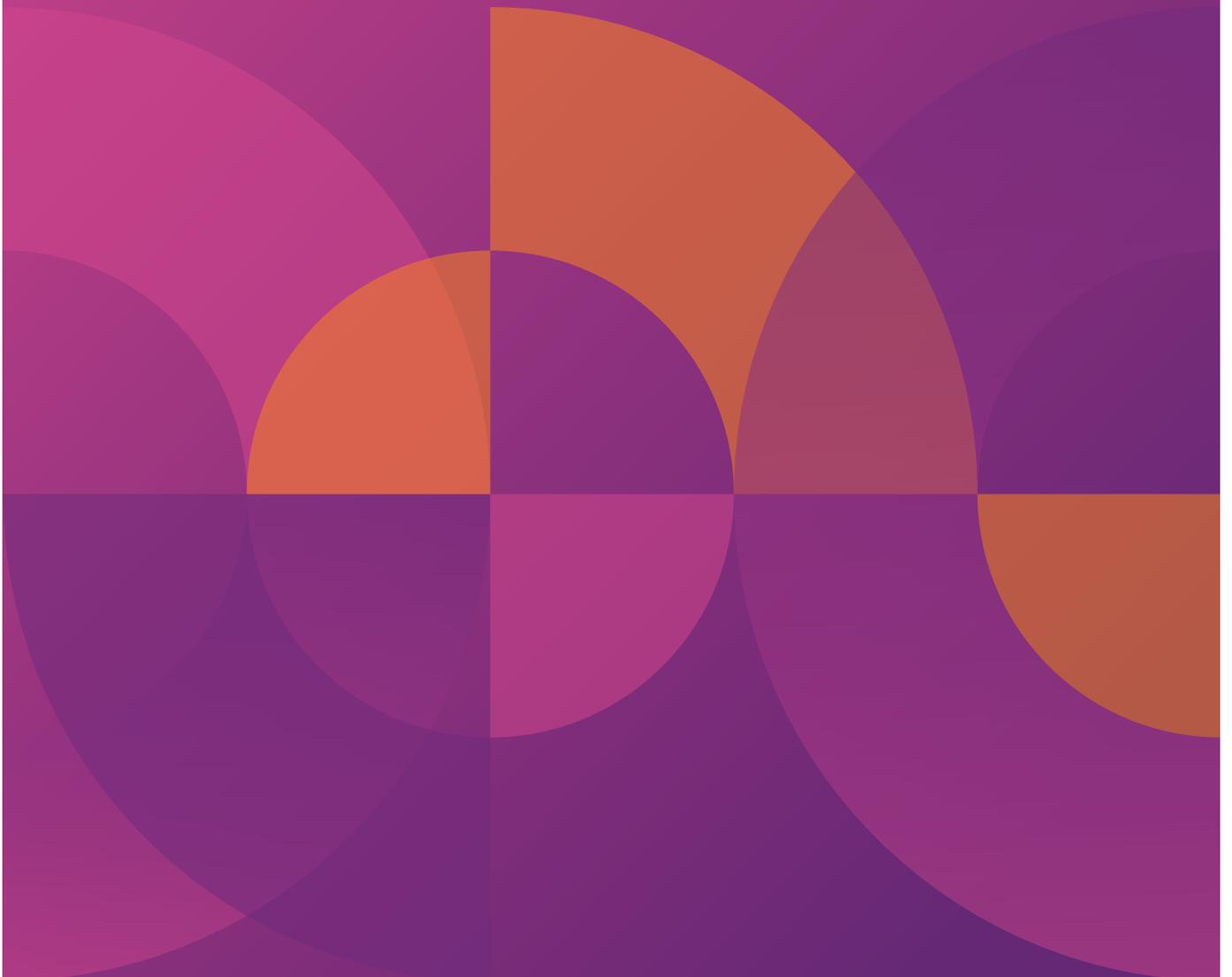
Shalini acquired a long-term psychosocial disability during young adulthood. Like her sexuality, her psychosocial disability was seen as a source of shame and stigma and every effort was made to ensure that others would not know that she was on 'psychiatric medication'. In terms of impairment effects, Shalini found the limitations and disruptions arising from her psychosocial disabilities to be far more grave than those associated with her congenital limb loss or long-term pain. She also realised that it was socially more acceptable to have a physical disability than a psychosocial disability. The intersectionality of differing impairments and identities leads to heightened complexities. Shalini is aware that her majority ethnicity and privileged socio-economic status lessened the impact of her stigmatised identities of disability and non-heterosexuality.

Shalini went on to become a teacher and understood the paramount importance of teacher training and sensitisation given her experiences of early childhood education. Her life experience has led to an understanding of the diversity and complexity that disability entails.

(As shared with the author. Printed with permission from Shalini Abeysinghe)

module 5

getting to know
our bodies



module 5

getting to know our bodies

MODULE OBJECTIVES

1. To develop anatomical and physiological understanding of our bodies and to understand the changes taking place throughout the life cycle.
2. To develop an understanding of our bodies, enabling us to exercise choice, consent and autonomy over our sexuality and sexual and reproductive health.
3. To cultivate awareness of our bodies, allowing us to identify pleasurable versus uncomfortable/coercive/abusive experiences linked to our bodies.

ACTIVITIES

CHAPTER 1: SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY

Activity 5.1: Body Mapping > 60 Minutes

Activity 5.2: Anatomy and Physiology > 30-60 Minutes

CHAPTER 2: CHANGES THROUGH THE AGES

Activity 5.3: Changes Throughout the Lifecycle > 30 Minutes

CHAPTER 3: MENSTRUATION AND ITS MANAGEMENT

Activity 5.4: The Menstruation Process > 30 Minutes

Activity 5.5: Menstrual Management > 30 Minutes

Activity 5.6: Menstrual Myth Busting > 40 Minutes

HANDOUTS

Activity 5.1: Body Mapping > None

Activity 5.2: Anatomy and Physiology

- a. Facilitator Handout 5.1: Diagrams of Typical Female Sexual and Reproductive Anatomy
- b. Facilitator Handout 5.2: Diagrams of Typical Male Sexual and Reproductive Anatomy
- c. Participant Handout 5.1: Diagrams of Typical Female Sexual and Reproductive Anatomy
- d. Participant Handout 5.2: Diagrams of Typical Male Sexual and Reproductive Anatomy

Activity 5.3.: Changes throughout the Life Cycle

- > Facilitator Handout 5.3: Changes Throughout The Life Cycle

Activity 5.4: The Menstruation Process

- a. Facilitator Handout 5.4: Menstruation Process
- b. Participant Handout 5.3: Menstruation Cycle

Activity 5.5: Menstrual Management

- a. Participant Handout 5.4: Menstrual Products And Their Management

Activity 5.6: Menstrual Myth Busting

- a. Facilitator Handout 5.5: Case Studies on Menstrual Taboo
 - b. Participant Handout 5.5: Case Studies on Menstrual Taboo
-

CHAPTER 1: SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY

ACTIVITY 5.1: BODY MAPPING

Objective:

To know our own body and its link to sexuality; and challenge notions of shame associated with certain body parts.

Time:

60 Minutes

Materials Needed:

- Long sheets of paper
- Colourful markers

Process:

The activity can be done in three variations depending on the nature of disability of the participants:

Variation 1 (*This variation will not work for participants with visual disability and for wheelchair users*):

1. Divide the participants into smaller groups of four to five people each.
2. In each small group, the participants must decide on one person whose outline will be drawn. The person will lie down on the long sheet of paper and others will trace the person's outline with the colourful markers.
3. Once the outline is complete, the group must label all the different parts of the body. Encourage them to label as many parts as they can. If they are not aware of other terms besides the slang that is used for some body parts, they can label with those words. However, the facilitator must make a note of any slang words used and have a conversation at the end of the exercise.

4. As they label each part, ask the group to discuss the emotions (if any) such as pleasure and/or pain and/or shame, which they attach with it. Encourage them to take time to think how different body parts can be a source of pleasure, pain or shame.
5. The facilitator must walk around the room, and encourage participants to talk about those body parts which are often missed, such as the breasts, the genitalia, and the clitoris.

Variation 2 (*This variation will not work for participants with visual disability, unless the body outline can be felt by tactile touch*):

1. Divide the group into smaller groups of four to five people each.
2. Provide each group with an outline of a body shape. Ensure that each of the outline is different from the others and different types of bodies are depicted.
3. Follow steps 3-5 in Variation 1.

Variation 3 (*For participants with visual disability*):

1. Ask the participants to stand/sit in a circle and share that we will be journeying through each part of our body. Participants should be requested to close their eyes and follow the voice of the facilitator.
2. Share with the participants that as you call out the name of each body part, participants should follow by touching/ drawing attention to that specific body part and taking a moment to think of pleasure and/or pain and/or shame associated with the body part. Make sure all parts of the body from head to toe are covered, including breasts, genitalia, clitoris etc.
3. Participants might be hesitant in touching their body parts and it is important to remind them that it is a safe space and that they are on their own and not being observed by anyone.

Debrief:

1. How did the groups choose the participant whose body outline will be drawn? Was the choice influenced by cultural beauty ideals such as being thin and not having a physical impairment? (For Variation 1 only)
2. How did the person whose outline was being drawn and the person who was drawing the outline feel? Were they uncomfortable? If so, can they think of why? (For Variation 1 only)
3. Was it difficult to name certain body parts rather than others?
4. Were they able to imagine and associate with their bodies in ways they might not have thought of earlier?

Key Messages:

1. Shame attached to certain parts of our bodies is socially learned and gendered. In our culture, from adolescence, women's breasts are sexualised and we begin to attach shame to it. However, this is not the case for boys and men. Shame being attached to parts of our body also varies from culture to culture and changes over time, which indicates the social nature of it.
2. Connotations of shame and taboo are attached to openly talking about certain body parts including the genitals and the breasts. We are also taught to think that massaging our genitals is a shameful act. This can become a hindrance to living satisfactory sex lives, accessing necessary healthcare and knowing our bodies fully, which can help in identifying if something is wrong.
3. Shame is also intrinsically linked to body image. With popular media and society creating false and rigid ideas of beautiful bodies and shaming those who do not fit in this narrow understanding, we can begin to attach shame to our body. Link back to Module 3 on body image and self-esteem and relate it to experiences of pleasure.
4. There are various dimensions to sexual pleasure, yet, sexual pleasure is often framed in the context of penis-vaginal penetration. This can be traced to a focus of sexual pleasure solely on male sexual pleasure, and hence the focus on the penis. We can experience sexual pleasure in many ways and through different parts of our body. It can be experienced both with a partner and by ourselves. The clitoris, for example, is an organ whose only function is to provide pleasure when stimulated and this can be done on our own. Moreover, for persons with disabilities who do not experience sensations below the waist, it is important to explore different ways in which sexual pleasure can be experienced through the upper part of the body.
5. The same parts of our body can invite different feelings at different times. For example, the parts of our body which provide pleasurable sensations when touched, can also bring feelings of shame and pain if touched without consent. Our pleasure, therefore, is significantly linked to consent and respect.
6. It is important to be aware of our bodies and understand them well, so we can communicate with others about forms of touch/action(s) we like/dislike with regard to different parts of our body. Developing a positive relationship with our sexual organs is an important step in accepting and integrating sexuality in our lives.

Notes for the Facilitator:

1. There are many socio-cultural taboos around the body which makes discussion, or even mention of body parts like breasts and genitals difficult. At the beginning of the session, share with the participants that the session pertains to the body and may bring discomfort because many of these taboos are internalised by us. However, remind them that this is a safe space and understanding our bodies is key to our experiences of sexuality.
2. Reiterate to participants that the session is an opportunity to explore our bodies in a safe space and to think about different ways and points in our bodies for experiencing sexual pleasure.
3. Participants may use informal language to talk about many of the body parts. The facilitator must be vigilant in ensuring that the language used treads a balance between not becoming too formal and at the same time does not use slang which can have derogatory references. If such slang words which are used in a derogatory context are used, do not immediately correct the participant or accost them. Make a mental note of the words and open up the discussion for participants to reflect on the use of these words and why they might be problematic at the end of the session.
4. Many of the body parts may not have equivalent signs. Discuss with the sign language interpreter beforehand about this and come up with respectful signs collectively.
5. The discussions may surface traumatic associations/ episodes for participants. Have a plan ready to address this.

ACTIVITY 5.2: ANATOMY AND PHYSIOLOGY

Objective:

To develop anatomical and physiological understanding of typical male and female internal and external sexual and reproductive organs.

Time:

30-60 Minutes

Materials Needed:

- Tactile models/images of cross section of inner male and female genitalia
- Cross section of outer male and female genitalia
- Facilitator Handout 5.1 and 5.2
- If you are using images, you can use Participant Handout 5.1, 5.2, 5.3 and 5.4 (Tactile models will be needed for participants with visual disability)

Process:

1. Share with the participants about the objective of the session and that tactile models will be used, as necessary. Reiterate about safe space and challenging socio-cultural taboos that may cause discomfort in this exercise.
2. Ask the participants to go over the models/images and identify the body part and their function.
3. Add to what is being discussed to ensure that points mentioned in Facilitator Handout 5.1 and 5.2 are covered.
4. Reiterate that the body parts discussed can be both reproductive and sexual organs and sexual pleasure can be experienced beyond these body parts as well.

Debrief:

1. How did you feel during the process? Was it uncomfortable?
2. Were there some parts of your body you heard about for the first time? Were you surprised to hear about the function of certain organs?
3. Why do you think it is important to know about our body?
4. In what ways do you think this session was helpful in unpacking sexuality and sexual and reproductive health?
5. Would you now be comfortable exploring these different parts of yourself on your own?

Key Messaging:

1. Every individual has a right to proper information about their bodies which allows one to make informed sexual and reproductive choices.
2. Information about our bodies and physiology is also important to counter myths and misinformation. The absence of proper information may cause fear and worry and prevent us from seeking appropriate sexual and reproductive health care.
3. Each person is different and so are their body parts. They can be of different shapes and sizes.
4. Connect back to the Module on Gender, Sex and Sexuality. Remind the participants that anatomy does not determine gender and a person can identify as a man, woman, transgender, non-binary etc. irrespective of their anatomical parts.
5. Highlight that the anatomical models and images used are of an average female and male bodied person. However, as discussed in Module 4, there are persons with intersex variations, who may have a different combination of anatomical parts, for example have a large clitoris or not have a vaginal opening or the scrotum formed in a way that it looks closer to a labia.

Notes for the Facilitator:

1. If you are unable to purchase readymade tactile models, these can be made using several household goods, such as using flour and water/clay,⁴¹ using cloth,⁴² and using thermocol.⁴³
 2. Have multiple models and five to six volunteers for the session. To conduct this session with persons with visual disability, each participant would have to go over the tactile models by touch. With one facilitator using one set of four tactile models, this could take a very long time. The process can be completed faster with each volunteer working with a small number of participants.
 3. For persons with visual disability, with their consent, you can place your hands on top of their fingers and guide them through each part of the tactile model.
 4. Ensure that you are well prepared for the session, as participants are likely to have been introduced to many body parts for the first time and they may have many questions. You can also opt to have a specialised doctor/gynaecologist, who is sex positive, for this session. If you are engaging a specialist, please do go over the session plan with them in advance and clarify the objectives of the training and the session.
 5. Using tactile models may cause arousal in participants. Have a plan in place to sensitively tackle this.
2. Write out the following statements on different post-it notes.
 - a. Hair begins to appear especially around the genitals and under the armpits.
 - b. Breasts start to grow in size.
 - c. Voice deepens.
 - d. You begin to experience sexual curiosity and attraction for the first time.
 - e. You can find a discharge (wetness) on your underwear.
 - f. Regular ovulation and menstruation happen cyclically.
 - g. Experience of cramps and breast tenderness along with mood issues, including anger, anxiety and depression.
 - h. Sudden feelings of hot flashes (feeling very hot and sweaty).
 - i. Irregular menstrual cycle over a long duration followed by a year without menstruating.
 - j. Ovaries no longer produce eggs and makes lesser amount of the hormones oestrogen and progesterone.
 3. Ask the participants to discuss among themselves where in the continuum each statement on a post-it note would fit and place the notes along the continuum accordingly. Some of the statements may be appropriate for multiple places on the timeline and participants can note down those statements.
 4. Once all the post-it notes have been placed, check if they are in a proper order.
 5. Discuss the notes and share with the participants about the changes in the body at the time of puberty, onset of menstruation and the end of menstruation marked by the onset of menopause. Refer to Facilitator Handout 5.3. Menstruation will be discussed in greater detail in the next activity.
 6. In light of the information shared, ask the participants if the notes are properly placed and if they would like to make changes.

CHAPTER 2: CHANGES THROUGH THE AGES**ACTIVITY 5.3:
CHANGES THROUGHOUT THE LIFE CYCLE****Objective:**

To enable participants to understand changes in the body throughout the life cycle.

Time:

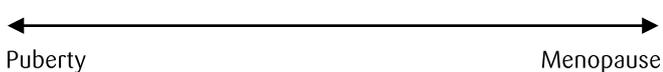
30 Minutes

Materials Needed:

- Charts
- Markers
- Tape
- Different coloured post-it notes
- Facilitator Handout 5.3

Process:

1. Draw a two sided arrow across a wide sheet of paper. On one end, write puberty and on the other end, menopause. This will be used to depict a continuum of changes in the body associated with different age groups.



Variation: For participants with visual disability and for groups which have low reading skills, read out each of the sentence and ask them to think of average age (closer to puberty, between puberty and menopause, or closer to menopause) when these changes are experienced. Discuss the response to each statement and provide clarifications from Facilitator Handout 5.3. as necessary.

Debrief:

1. Did everyone agree on where the statement should be placed in the continuum? Did participant experiences match the group assessment of the placement of the change in the continuum? What were some of the differences?

2. What were some of the fears and concerns they faced at the onset of puberty? What could have helped to address them?
3. Were there people in the family, community, health care workers they could approach to understand what was happening? If any of the participants did approach someone to discuss their worries, what was their reaction?
4. What are some of the barriers that prevent open conversations on these issues?

Key Messaging:

1. Since sexuality is often a topic of taboo in our society, we often do not receive necessary information to understand and cope with bodily changes throughout the ages. This can create a lot of fear and misinformation about unexpected changes in the body. It also precludes us from getting necessary SRH support needed at different stages.
2. Everyone's experiences of bodily changes are different. Puberty is often a difficult experience for many, and messaging that seeks to shame people for difference in pace of bodily changes (for example, delayed breast development, growth of bodily hair, size of penis and breasts), can further add to the fear and upheaval a person is experiencing.
3. For a person who was assigned female at birth but identifies as a boy, puberty can be an especially anxious period as the changes that their body is going through may not necessarily align with their sense of gender.
4. Women with disabilities often do not receive information about menopause even though it has serious implications for their health. Knowledge of changes accompanying menopause and its impact on health allows women with disabilities to plan how the impact needs to be managed.

CHAPTER 3: MENSTRUATION AND ITS MANAGEMENT

Notes for the Facilitator:

1. The activities and concepts in this chapter need to be adapted in accordance with the age group of the participants.
2. For an adult age group, many menstruation management practices may already be in place. Check with the group about concepts that they are unclear about and what they would like more information on.
3. Myths around menstruation may be prevalent irrespective of age. Therefore, Activity 5.6 can be conducted with participants of an older age group as well.
4. Encourage participants to share their own menstrual knowledge and practices.

ACTIVITY 5.4: THE MENSTRUATION PROCESS

Objective:

Enable participants to better understand the process of menstruation.

Time:

30 Minutes

Materials Needed:

- Cross section of internal female sexual and reproductive anatomy
- Thermocol balls/beads
- Facilitator Handout 5.4 and Participant Handout 5.3

Process:

1. Explain the process of menstruation using Facilitator Handout 5.4 and Participant Handout 5.3. Use tactile models with thermocol balls/beads as eggs, when working with persons with visual disability.
2. Play the following video, which explains menstruation and highlights how menstruation can be managed. The video has both audio (in Bengali) and uses images and illustrations and can be used for participants with different disabilities.

Video: RedOrange Media and Communications (2018) *SNV Animation MHM Fine*. Available at: [Link] https://www.youtube.com/watch?v=AoT-dgQ4Bo&list=PLXgzjvso6cBu_r1jScPuAdi-cMKoDMWsd&index=4.

You can use this video for a younger audience: RedOrange Media and Communications (2018) *Ritur Din Ratri*. Available at: [Link] https://www.youtube.com/watch?v=NL7MAfjzXGo&list=PLXgzjvso6cBu_r1jScPuAdi-cMKoDMWsd&index=5.

Debrief:

1. What are the words used in local language for menstruation? Are some of them problematic?
2. What were some new aspects about menstruation that the participants learnt from the video?
3. Is information and knowledge of menstruation necessary for women and girls with disabilities? If yes, why?
4. Are there other methods/practices of managing menstrual pain that they follow?

Key Messaging:

1. Menstruation is a biological process that happens as a result of the uterine lining shedding itself when there is no fertilised egg for it to nurture. Therefore, attitudes and myths towards menstruation are societally constructed and need to be challenged.
2. The onset of menstruation can be a particularly difficult time for girls with disabilities, as it increases concerns about sexual vulnerability and pregnancy. This is often the time that parents and caregivers forcefully sterilise girls with disabilities (a process that renders them incapable of reproduction) supposedly as a way to 'protect' them from sexual violence and pregnancy. However, this is a harmful practice which robs women and girls with disability the chance to make their own reproductive choices and violates their right to life and family. It also does not prevent sexual violence in any manner.
3. All those who menstruate may not identify as women. Link the discussion back to the session on gender and sex characteristics. Owing to having female sex characteristics and organs, a person may undergo menstruation but their gender identity (sense of how they see themselves) may not be that of a woman.

**ACTIVITY 5.5:
MENSTRUATION MANAGEMENT****Objective:**

Enable better understanding of menstrual products, their usage as per different disabilities and tips for better hygiene.

Time:

30 Minutes

Materials Needed:

- Tactile models of menstrual products mentioned/images of using different menstrual products
- Participant Handout 5.4

Process:

1. Ask the participants to list the different menstrual products they are aware of.
2. Give the participants copies of Participant Handout 5.4. and give them 15 minutes to go through it.

Variation:

1. For participants with visual disability, discuss each of the menstrual products mentioned in the Handout and allow them to feel the menstrual product. Go over how the menstrual product must be used and if possible, do a demonstration of using a sanitary pad/cloth, as needed.
2. For participants with low reading skills, the facilitator must read out the information conveyed in the Handouts.

Debrief:

1. What are some of the difficulties that participants face in managing their menstrual cycles?
2. What are some of the steps that can be taken to minimise the barriers? If accessible toilets, lack of clean water etc. are mentioned note these points for using in the advocacy session later.

Key Messaging:

Menstruation can be managed using the right menstrual products, depending on nature of disability and socio-economic conditions such as availability of water, accessible toilets etc. People should not hesitate to seek support with managing menstruation, as there is nothing shameful about the process.

**ACTIVITY 5.6:
MENSTRUAL MYTH BUSTING****Objective:**

To differentiate between myths and facts around menstruation and build collective capacities to respond to menstruation taboos.

Time:

40 Minutes

Materials Needed:

- Facilitator Handout 5.5

Process:

1. Divide the participants into five groups.
2. Each group should be assigned a case study.
3. They have 15 minutes to discuss each case study and must discuss the following points with respect to the case study:
 - a. Have you come across/heard of similar situations in your family/community?
 - b. Discuss your views on the situation described in the case study.
 - c. How can it be addressed?
4. At the end of 15 minutes each group must share their case study and discussion with the larger group.

Debrief:

1. What are some of the cultural taboos around menstruation within our communities?
2. What are the possible reasons for such taboos and how can we counter them?

Key Messaging:

Menstruation is a biological process that is mired in different socio-cultural practices, taboos and myths in different communities. Taboos and myths around menstruation are key ways in which social control is exercised over bodies of women and girls by restricting mobility, access to services and food and controlling their fertility. These taboos and myths are dangerous and if left unchecked are a source of violence and discrimination in a person's life. Further, they prevent a person from getting support and proper health care for fear of backlash from the family and community.

Resources for Further Reading:

1. Abha Khetarpal, (2020), *Manual on Sexual and Reproductive Health & Rights of Women with Disabilities*.
2. Jane Maxwell, Julia Watts Belser, Darlena David (2007). *A Health Handbook for Women with Disabilities*, Berkely, California: Hesperian.
3. Talking About Reproductive and Sexual Health Issues (TARSHI) (2006). *Basics and Beyond: A Manual for Trainers; Integrating Sexuality, Sexual and Reproductive Health and Rights*. New Delhi: TARSHI, pp. 125-148 (Module 2, Chapter 1: Sexual and Reproductive Anatomy and Physiology).
4. Institute for Reproductive Health of Georgetown University and Family Health International (2003). *My Changing Body: Fertility Awareness for Young People*.
5. WaterAid and Sanitation and Hygiene Applied Research for Equity, *Menstrual hygiene matters: A Training Guide for Practitioners*. Available at: https://washmatters.wateraid.org/sites/g/files/jkxooof256/files/MHM%20training%20guide_o.pdf. Accessed on: 18 August 2020.

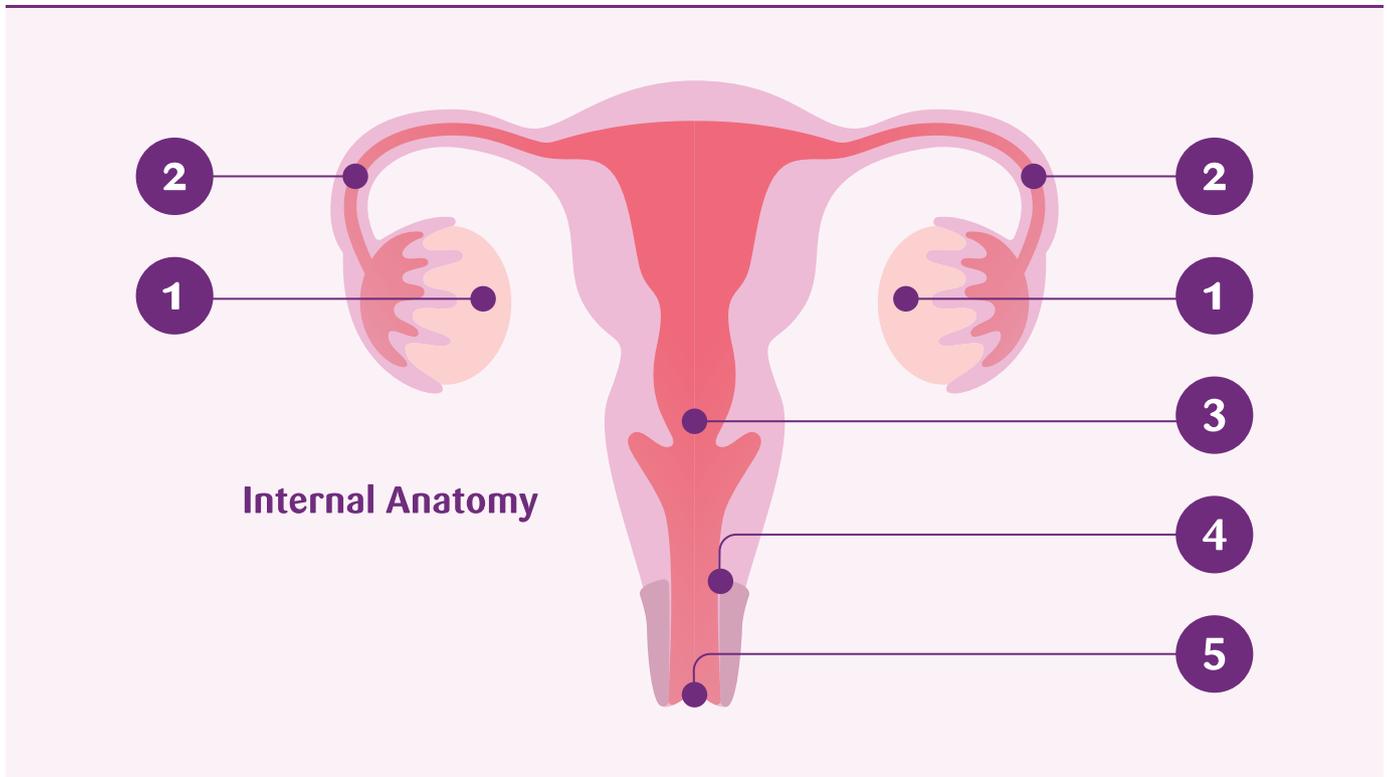


Original artwork: Ipsita.

MODULE 5_FACILITATOR HANDOUT 5.1_Page 1

DIAGRAMS OF TYPICAL FEMALE SEXUAL AND REPRODUCTIVE ANATOMY

(Activity 5.2: Anatomy and Physiology)

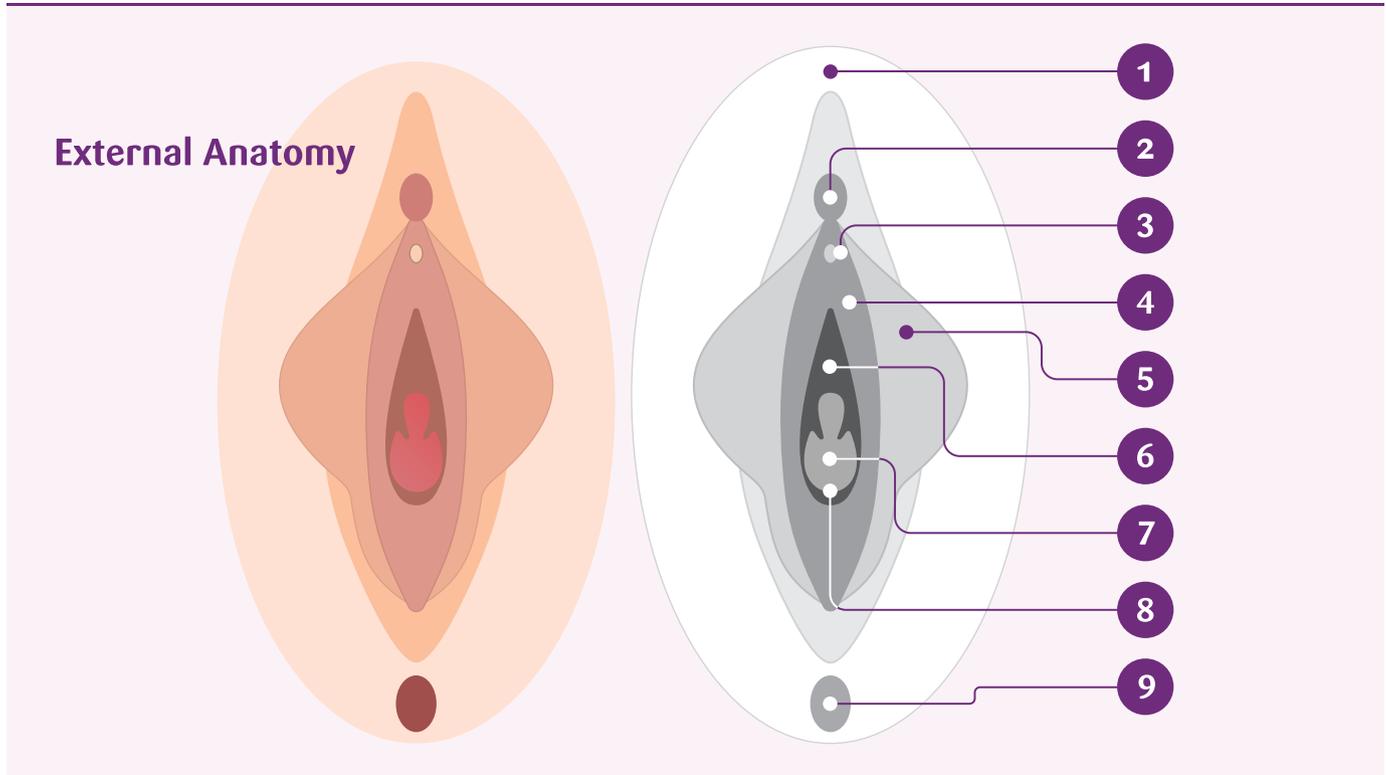


- 1. OVARIES:** Ovaries are walnut sized organs which can be found on either side of the uterus, right below the fallopian tubes. Ovaries are responsible for producing eggs and also produce oestrogen and progesterone.
- 2. FALLOPIAN TUBES:** Fallopian tubes are narrow tubes that connect the ovaries to the uterus and carry the eggs released by the ovaries to the uterus. Conception, the process of fertilisation of an egg by a sperm, takes place in the fallopian tubes.
- 3. UTERUS:** The uterus is a pear shaped hollow organ. The uterus has a thick lining. In case an egg is not fertilised the uterus sheds this lining every month during menstruation. If the egg is fertilised, it attaches itself to the wall of the uterus and develops into a foetus. The uterus expands during pregnancy.
- 4. CERVIX:** The cervix is the lower part of the uterus that connects it to the vagina. The cervix allows for the passage of sperm into the uterus and for menstrual blood to exit the uterus.
- 5. VAGINA:** The vagina is a canal that joins the cervix to the outer genitalia. It produces fluids that keep the vagina lubricated, clean and prevents infection. It stretches and lubricates itself to aid sexual activity. It allows the foetus to pass during delivery. It is a sexual and reproductive organ. The first few inches of the vaginal passage has nerve endings that give pleasure during sexual stimulation.

MODULE 5_FACILITATOR HANDOUT 5.1_Page 2

DIAGRAMS OF TYPICAL FEMALE SEXUAL AND REPRODUCTIVE ANATOMY

(Activity 5.2: Anatomy and Physiology)

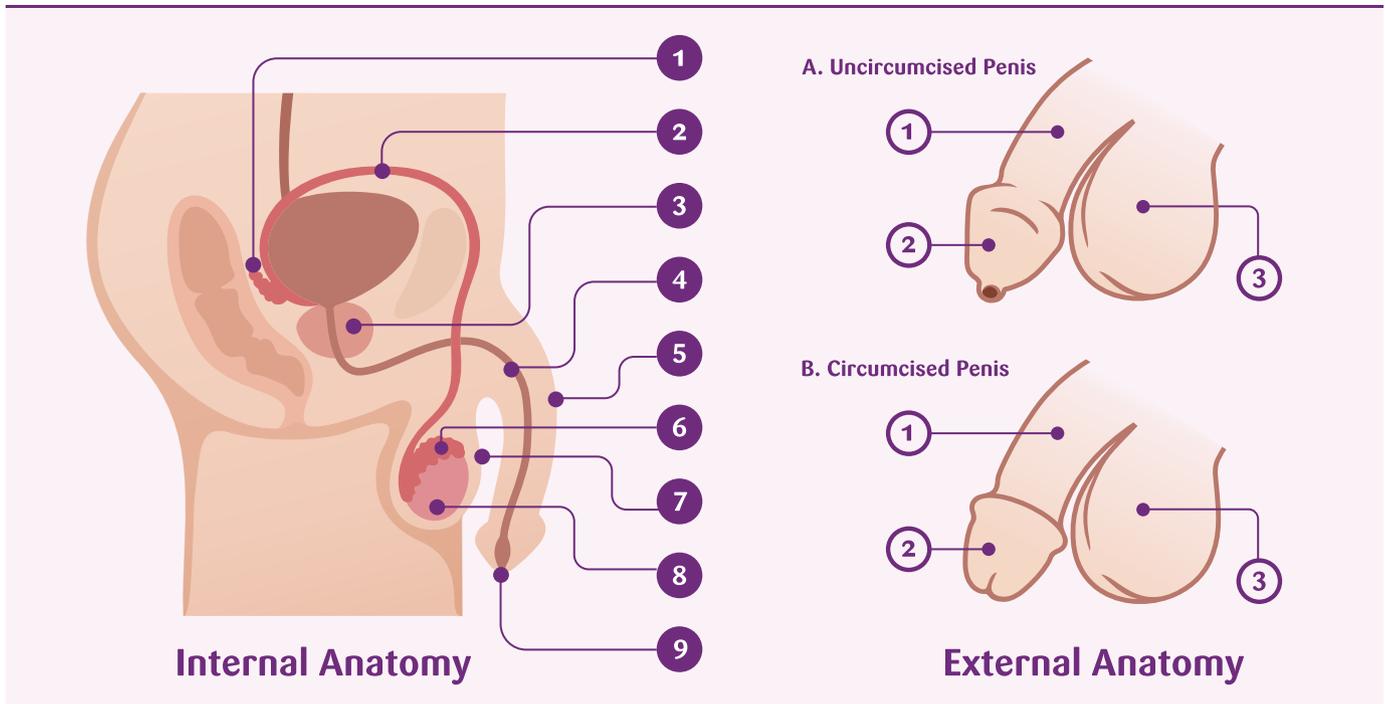


- 1. MONS PUBIS:** Mons Pubis or the vaginal mound is where the pubic hair grows. Once aroused, it can be quite a sensitive area.
- 2. CLITORIS:** At the top of the labia majora is a small pink nub called the clitoris. It is covered by folds of skin called the clitoral hood. An average clitoris has about 8,000 nerve endings and can provide immense pleasure when stimulated. Each person may require different types of stimulation of the clitoris for pleasure. Its only function is to provide sexual pleasure.
- 3. URETHRA:** It is the opening through which urine passes out of the body. It can be a source of pleasure when stimulated while others find it painful when stimulated.
- 4. LABIA MINORA:** The inner lips that cover the vaginal opening and the clitoris. It can be darker than the outer lips and wrinkly. The inner lips are of different sizes for different people.
- 5. LABIA MAJORA:** The outer lips (folds of skin) of the vulva that cover the inner lips and other parts of the vulva. Pubic hair grows here for many people.
- 6. VAGINAL OPENING:** It is the opening to the vaginal canal. The skin at vaginal opening is quite sensitive and can allow a person to experience stimulation.
- 7. HYMEN:** Some people have a hymen, which is a thin delicate piece of tissue that covers or surrounds the vaginal opening. In many cultures the presence of a hymen is associated with virginity. However, this is not true as the hymen is delicate enough to be ruptured during exercise, masturbation or any physical activity without involving penetration by a penis.
- 8. BARTHOLIN GLANDS:** They are small glands located on the vaginal lips around the vaginal opening. They make small amounts of fluid to lubricate the vaginal lips.
- 9. ANUS:** The opening through which faeces leaves the body. It can also be a site of sexual pleasure for many.

MODULE 5_FACILITATOR HANDOUT 5.2

DIAGRAMS OF TYPICAL MALE SEXUAL AND REPRODUCTIVE ANATOMY

(Activity 5.2: Anatomy and Physiology)

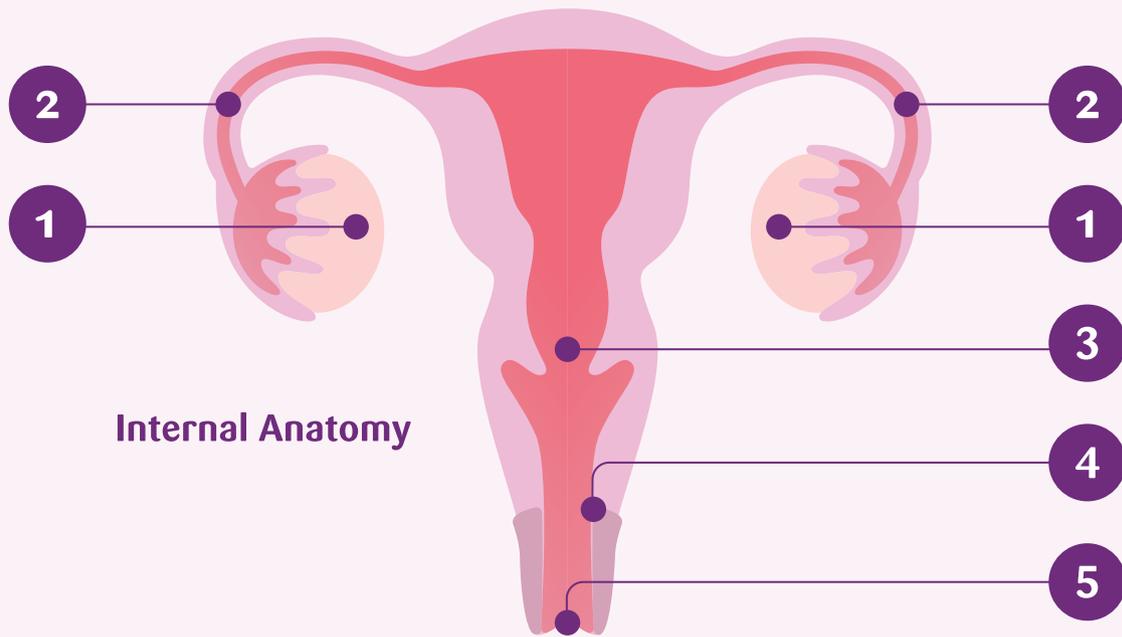


1. **SEMINAL VESICLES:** Sacs that are attached to the vas deference near the base of the bladder. They secrete a fluid, which is a part of the semen, and which allows the sperm to move.
 2. **VAS DEFERENS:** Vas Deferens is a long muscular tube that carries mature sperm from the epididymis to the urethra.
 3. **PROSTATE:** It is a walnut sized gland located under the bladder. It secretes fluids that are a part of the semen that comes out and also nourishes the sperm. Stimulation of the prostate gland can be a source of pleasure for some.
 4. **URETHRA:** Urethra carries urine from the bladder to outside the body. However, in males it also enables semen to be ejected when the person reaches orgasm. With the penis being erect during arousal, the urethra blocks the urine, allowing only semen to be ejaculated during orgasm.
 5. **PENIS:** It is the primary male sexual organ. It has three parts: the base, the body or the shaft and the glans (the cone-shaped part at the end of the penis. The glans also has many nerve endings that can be stimulated for sexual pleasure. The penis is made up of sponge-like tissues that allow it to become erect when sexually aroused.
 6. **EPIDIDYMIS:** It is a long coiled tube that can be found at the back of each testicle. It stores the sperm, allows it to mature and moves it to the vas deferens during sexual arousal.
 7. **SCROTUM:** It is a loose pouch-like sac of skin that hangs behind and below the penis. The scrotum holds the testes. It has muscles on its wall which allow it to contract and relax, especially during sexual arousal.
 8. **TESTES (TESTICLES):** The testes are oval shaped organs that are placed inside the scrotum. Most males have 2 testicles. They are responsible for making testosterone, the primary male sex hormone and produce sperms.
 9. **URETHRAL OPENING:** It is the opening at the tip of the penis from which the semen or urine leave the body.
-
- IN BOTH UNCIRCUMCISED and CIRCUMCISED PENIS:**
1. **SHAFT**
 3. **SCROTUM**
- A. UNCIRCUMCISED PENIS:**
2. **PREPUCE:** Foreskin that protects the head of the penis.
- B. CIRCUMCISED PENIS:**
2. Glans of the penis.

MODULE 5 PARTICIPANT HANDOUT 5.1 Page 1

DIAGRAMS OF TYPICAL FEMALE SEXUAL AND REPRODUCTIVE ANATOMY

(Activity 5.2: Anatomy and Physiology)

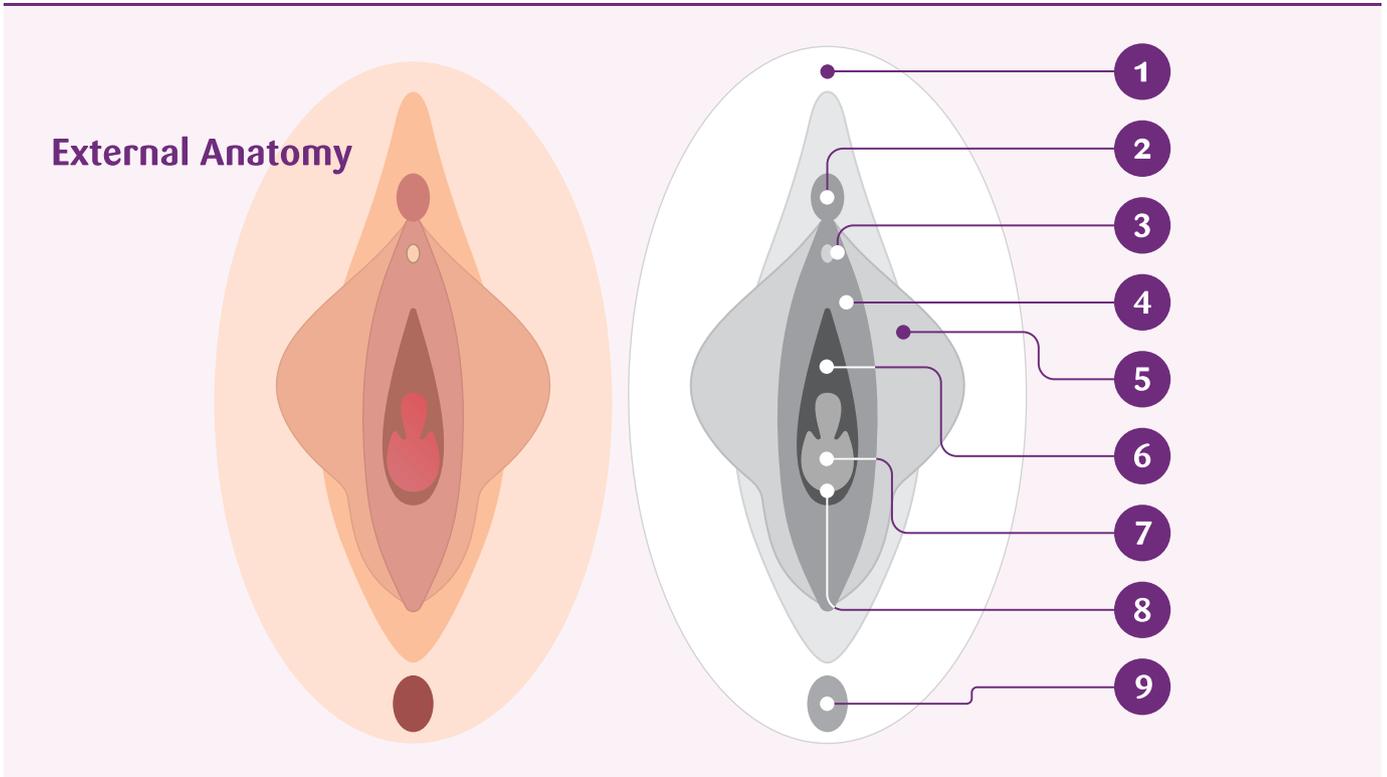


- 1.
- 2.
- 3.
- 4.
- 5.

MODULE 5 PARTICIPANT HANDOUT 5.1 Page 2

DIAGRAMS OF TYPICAL FEMALE SEXUAL AND REPRODUCTIVE ANATOMY

(Activity 5.2: Anatomy and Physiology)

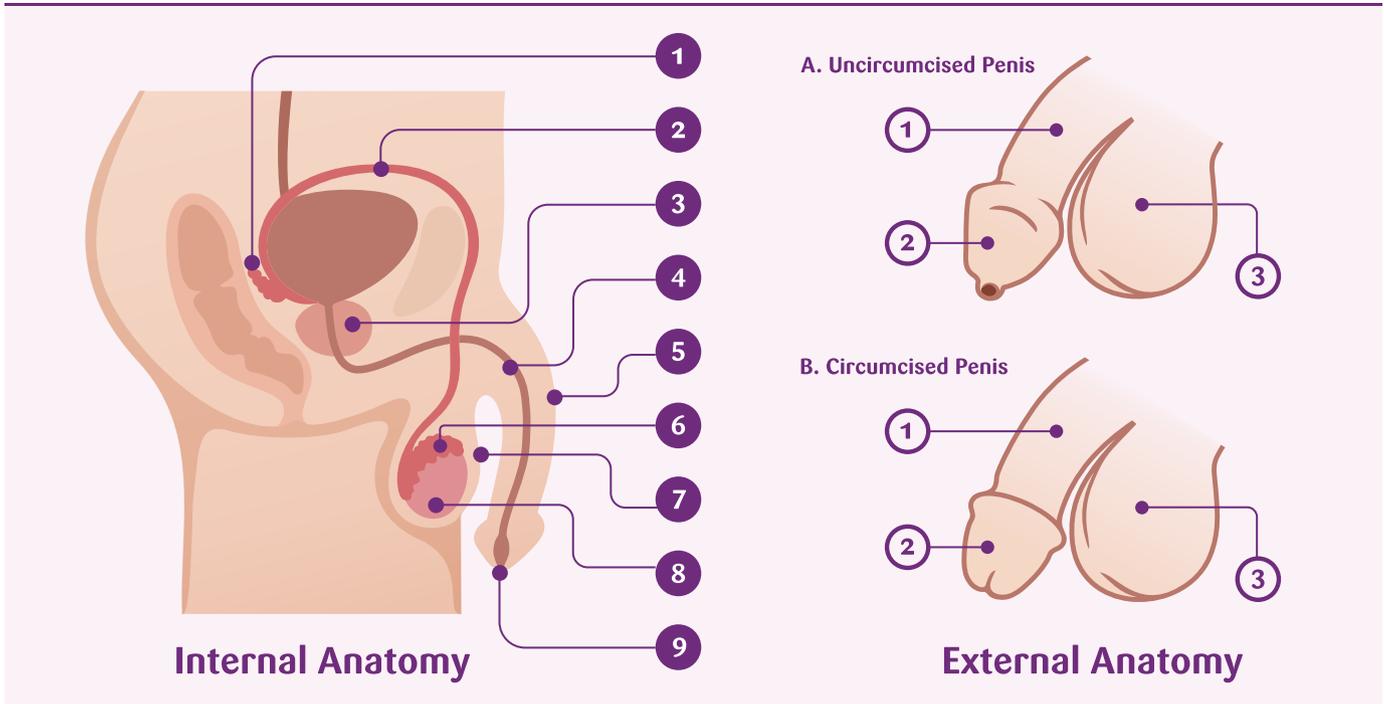


- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

MODULE 5 PARTICIPANT HANDOUT 5.2

DIAGRAMS OF TYPICAL MALE SEXUAL AND REPRODUCTIVE ANATOMY

(Activity 5.2: Anatomy and Physiology)



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

Uncircumcised Penis:

- 1.
- 2.
- 3.

Circumcised Penis:

- 1.
- 2.
- 3.

MODULE 5_FACILITATOR HANDOUT 5.3_Page 1

CHANGES THROUGHOUT THE LIFE CYCLE

(Activity 5.3: Changes throughout the Life Cycle)

PUBERTY: Puberty is a time when the body of young person begins to change – they grow taller, genitals begin developing, and body hair appears on the genitals and under the armpits. The body starts producing more of the hormones oestrogen, progesterone and testosterone, which are responsible for many of the changes that we see. Typically, young people reach puberty around the ages of 10-14. However, many may start later or earlier.

Typically female bodies produce more oestrogen and progesterone. Some of the changes in the body that can be observed as a result are:

1. Breasts begin to grow as they become ready for lactation in the event of pregnancy. The breasts may grow at different speeds, one breast may grow faster than the other and everyone's development is different, there is nothing to worry about.
2. Wetness (discharge) starts to come out of your vagina, as the ovaries start producing eggs.
3. The skin may become oily and pimples and spots may develop.
4. The body sweats more and the sweat may smell different.
5. Voice starts to change.
6. Hips may become rounder.
7. The ovaries start producing eggs.

Typically male bodies produce more testosterone. Some of the changes in male bodies are as follows:

1. Hair begins to appear around and on the genitals, on the chest, under the arm and on the face.
2. Voice become deeper.
3. Penis and testicles start to grow and the testicles start producing sperms.
4. Shoulders and chest begin to broaden.
5. The skin may become oily and pimples and spots may develop.
6. The body sweats more and the sweat may smell different.

Puberty can be a stressful time for young adults as it is accompanied by many emotional and sexual feelings and societal expectations. You may experience being more conscious about your body, worried about self-identity, experiencing feelings of anger and depression. It is also usually associated with the start of developing sexual curiosity and having more sexual thoughts and urges.

However, it is important to remember that these are average experiences of puberty and each individual may experience puberty quite differently and it can be a stressful time for young adults. It is, therefore, important that there are safe spaces for them to get proper information and have their questions answered without judgement.

The following statements from the exercise, reflect changes in the body during puberty:

- a. Hair begins to appear especially around the genitals and under the armpits.
- b. Breasts start to grow in size.
- c. Voice deepens.
- d. You begin to experience sexual curiosity and attraction for the first time. (However, some people may experience this much later in life and some may not experience it at all.)
- e. You can find a discharge (wetness) on your underwear.

MENSTRUATION begins around the same time that a person attends puberty and ends with menopause, for most. The following statements from the exercise would therefore fit in the middle between puberty and menopause. Share with the participants that we will discuss menstruation in detail in the next chapter.

- f. Regular ovulation and menstruation happen cyclically.
- g. Experience of cramps and breast tenderness along with mood issues, including anger, anxiety and depression.

MODULE 5_ FACILITATOR HANDOUT 5.3_Page 2

CHANGES THROUGHOUT THE LIFE CYCLE

(Activity 5.3: Changes throughout the Life Cycle)

MENOPAUSE: Menopause refers to the stage at which monthly bleeding ends. The body makes less of the hormones oestrogen and progesterone and the ovaries stop making eggs. After experiencing unexceptionally irregular periods over a while (you may bleed more often, or not bleed for a while and then bleed again), menstruation stops over a period of one to two years. Usually, menopause takes place around late forties and early fifties, but for some it may happen as early as 35 or much later.

Menopause may be accompanied by some of the following experiences:

1. You may experience sudden bouts of feeling hot and sweaty ('hot flashes').
2. There can be sudden changes in moods and feelings.
3. The vagina may become smaller and less wet.
4. You may experience disturbed sleep.
5. Calcium deficiency.

As the body produces less oestrogen and progesterone, post-menopause can be a difficult period, especially for women with disabilities. For example, women with locomotor disabilities might be more prone to osteoporosis and cardiovascular diseases. Those with multiple sclerosis (MS) may find hot flashes more difficult to manage because of sensitivity to fluctuations in temperature. Menopause is also associated with problems of eyes like Macular Degeneration and Glaucoma, and can be a cause of worry for persons with visual impairments. It is, therefore, important to schedule regular visits and undergo regular screenings by health care professionals. Some of the medications to handle post-menopause complications can also interfere with medications to manage some ailments.⁴⁴

The following statements from the exercise reflect changes during menopause:

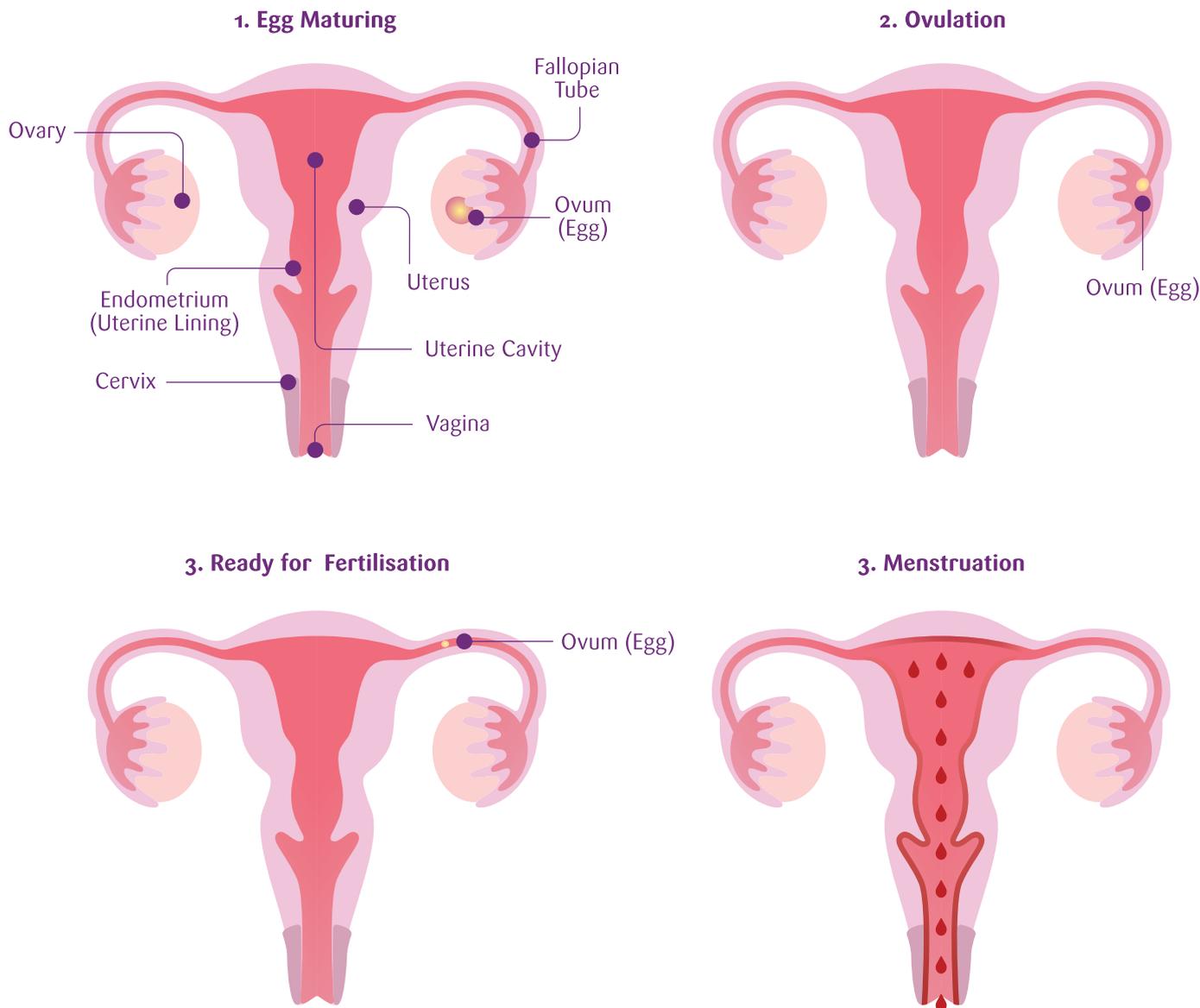
- h. Sudden feelings of hot flashes (feeling very hot and sweaty).
- i. Irregular menstrual cycle over a long duration followed by a year without menstruating.
- j. Ovaries no longer produce eggs and makes lesser amount of the hormones oestrogen and progesterone.

MODULE 5_FACILITATOR HANDOUT 5.4_Page 1

MENSTRUATION PROCESS - HOW YOUR MENSTRUAL CYCLE WORKS

(Activity 5.4.: The Menstruation Process)

FIGURE 24: Diagram of Menstrual Cycle



MODULE 5_FACILITATOR HANDOUT 5.4_Page 2

MENSTRUATION PROCESS – HOW YOUR MENSTRUAL CYCLE WORKS

(Activity 5.4: The Menstruation Process)

THE MENSTRUAL CYCLE:

FOLLICULAR PHASE: Around the sixth day from the start of menstruation, oestrogen levels begin to rise as an egg prepares to be released. At the same time progesterone causes the uterine lining to thicken.

OVULATION: The egg is released from the ovary. The ovulation phase is often accompanied by a white discharge, which may be experienced as a feeling of wetness/secretions on the underpants. Secretions are a normal part of the menstrual cycle and nothing to be worried about. Different people have different levels of secretion and some may not have any secretion at all. However, if the secretions change colour (yellowish in colour) or emit a strong smell, it may be a sign of infection, requiring a visit to healthcare professionals.

LUTEAL PHASE: The uterus prepares for a possible pregnancy, in the event that the egg is fertilised by a sperm and the lining of the uterus thickens in preparation.

MENSTRUAL PHASE: If the egg is not fertilised (which is most often the case), the lining of the uterus is no longer needed. This lining breaks down into a fluid and leaves the vagina as menstrual blood. This lasts between three to seven days and different people have different amounts of bleeding. The cycle starts again.

Persons with visual disabilities may have trouble identifying their menstruation phase initially as they may be unable to see the blood. However, over time by tracking their cycle and bodily changes before menstruation starts, they will be able to sense their timing. If there is staining, it is nothing to be ashamed or feel worried about. They can seek support from someone they trust to check if there is any blood on their clothing.

Before menstruation starts, a person may experience a range of physical, emotional and mental changes. The breasts may become sensitive, tender and swollen. There may be bloating, headache, body ache, cramps etc. many people may experience changes in mood including, anger, anxiety, depression, fatigue, irritability etc.

Menstruation can also be accompanied by cramps, which can range from a dull pain to painful contractions in the uterine region. Menstrual pain can be managed through different ways:

1. Placing a hot water bag on the belly.
2. Taking a hot bath.
3. Exercising.
4. Sipping hot liquids, such as tea.
5. Taking pain management medications, as needed.

The menstrual cycle/interval between bleeding can be anywhere between 21 and more than 35 days, and 28 days is the usual average. The gap in between months can also fluctuate slightly.

However, visiting a gynaecologist is recommended in the following situations:

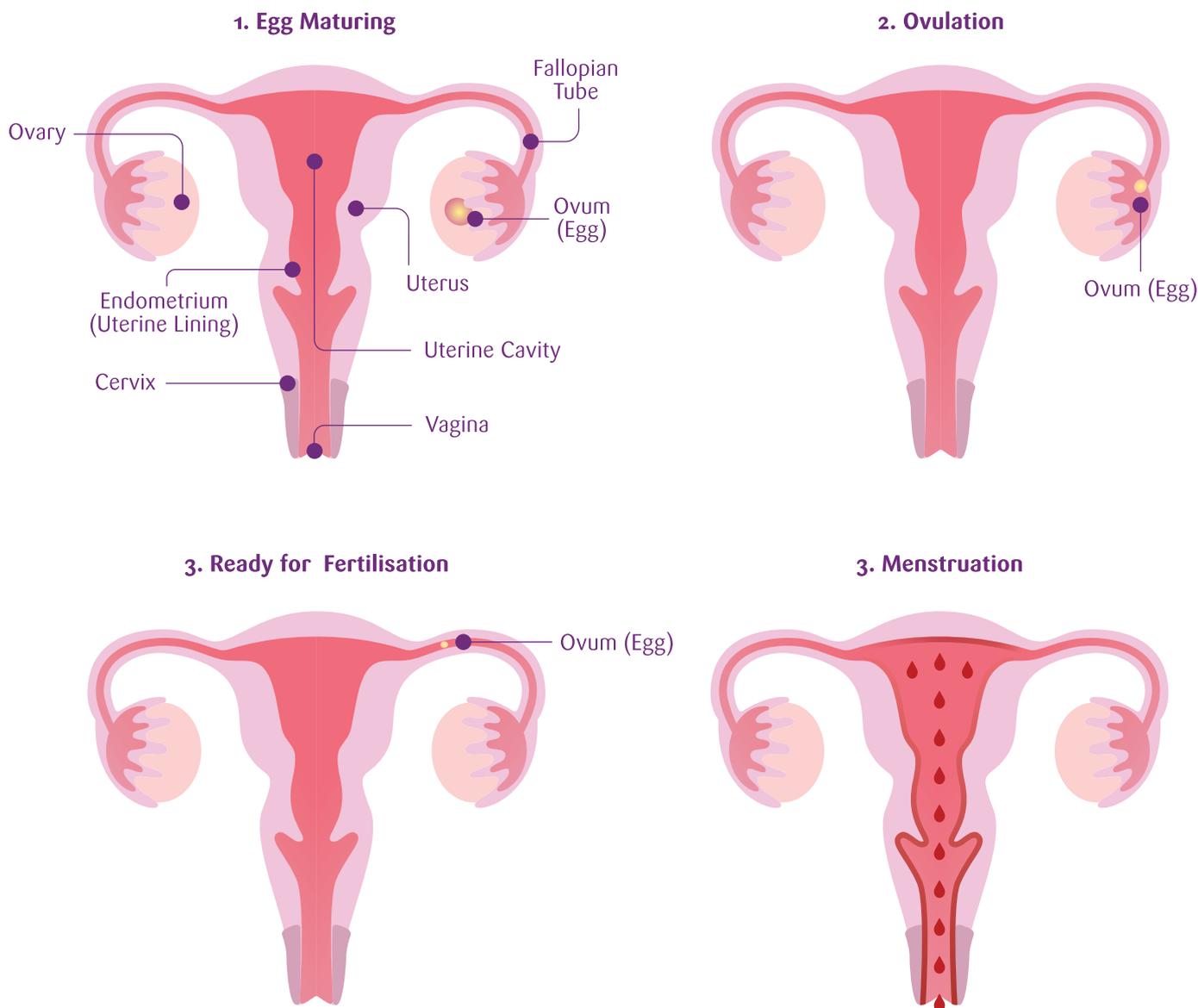
1. If bleeding lasts for more than seven days.
2. There is bleeding/spotting in between two menstrual phases.
3. Absence of bleeding for three to six months.
4. Erratic cycles and irregular intervals.
5. Unmanageable pain in lower back, abdomen, and legs during menstruation.
6. Blood loss is more than 80ml.

MODULE 5 PARTICIPANT HANDOUT 5.3_Page 1

MENSTRUATION PROCESS - HOW YOUR MENSTRUAL CYCLE WORKS

(Activity 5.4: The Menstruation Process)

FIGURE 25: Diagram Explaining the Menstruation Process

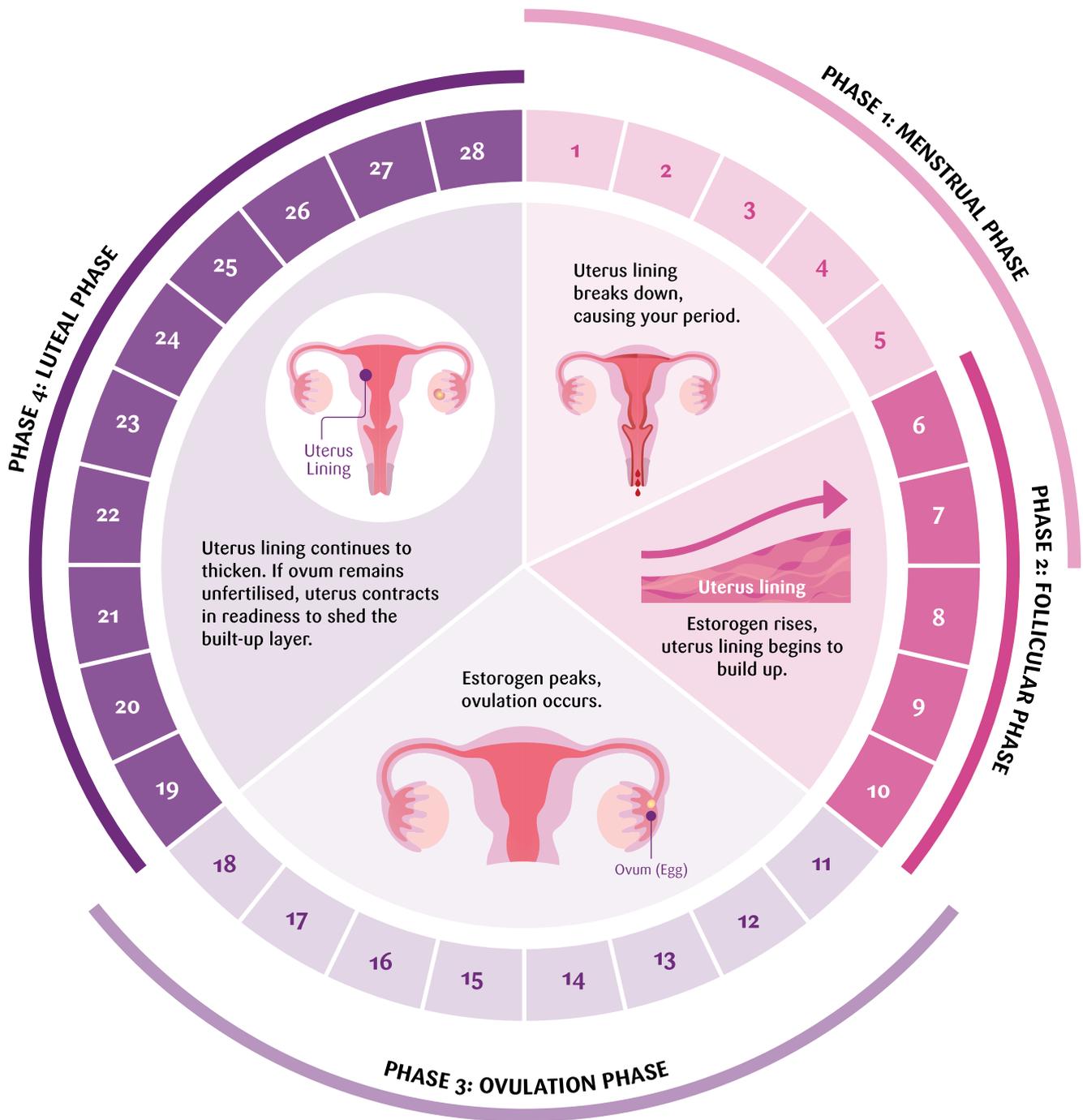


MODULE 5 PARTICIPANT HANDOUT 5.3_Page 2

MENSTRUATION PROCESS – HOW YOUR MENSTRUAL CYCLE WORKS

(Activity 5.4: The Menstruation Process)

FIGURE 26: Different parts of a 28-day Menstrual Cycle



Source: Adapted from lovelibra.com.au

MODULE 5 PARTICIPANT HANDOUT 5.4 Page 1

MENSTRUAL PRODUCTS AND THEIR MANAGEMENT

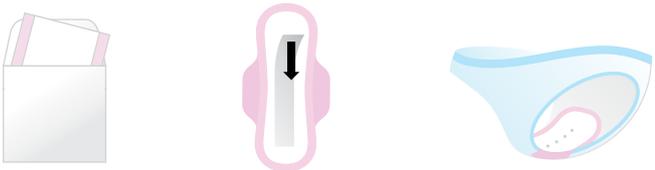
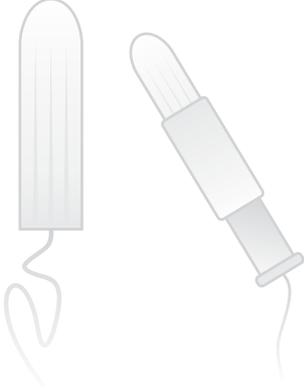
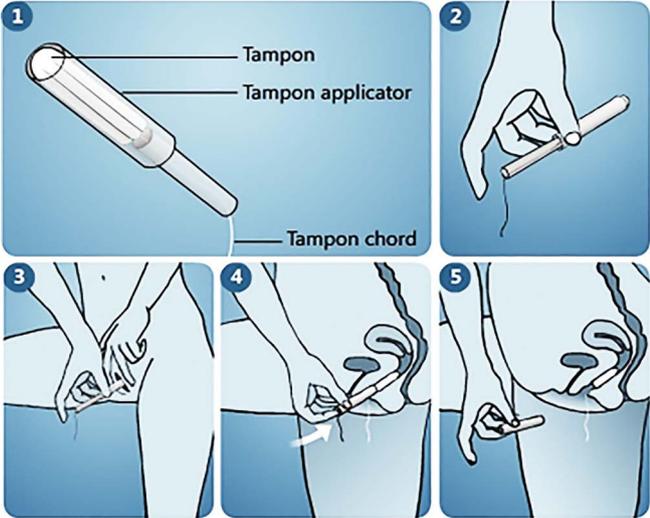
(Activity 5.5: Menstrual Management)

OPTION	USAGE
<p>FIGURE 27 Natural Materials (e.g. mud, cow dung, leaves)</p>  <p><i>Image source: WaterAid. The Global Face of Menstruation.</i></p>	<p>While these products are easily available, there is a high risk of contamination from them and it can be quite uncomfortable to use.</p>
<p>FIGURE 28 Cloth Rags</p>  <p><i>Image source: WaterAid. The Global Face of Menstruation.</i></p>	<p>They must be washed thoroughly and hung in a sunny place to dry. Due to cultural belief and stigma which makes it difficult to dry in open places or in the absence of access to a sunlit place to dry, an iron can be used or it can be placed on a basket/coins next to the fireplace. The lack of proper washing and drying can cause reproductive and urinary tract infections. Used cloth rags must be stored in a plastic bag until they can be washed.</p>
<p>FIGURE 29 Cloth Sanitary Pad</p>  <p><i>Image source: WaterAid. The Global Face of Menstruation.</i></p>	<p>FIGURE 30 How to Use a Reusable Sanitary Pad</p>  <p>Cleaning reusable sanitary pads</p> <ol style="list-style-type: none"> 1 Soak in cold water 2 Wash 3 Sun dry <p><i>Image source: Menstrupedia.</i></p>

MODULE 5 PARTICIPANT HANDOUT 5.4_Page 2

MENSTRUAL PRODUCTS AND THEIR MANAGEMENT

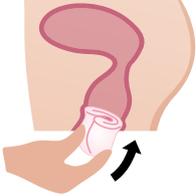
(Activity 5.5: Menstrual Management)

OPTION	USAGE
<p>FIGURE 31 Commercial Disposable Sanitary Pads</p> 	<p>FIGURE 32 How to Use and Dispose a Sanitary Pad <i>Source: Adapted from Pee Safe infographic.</i></p> <p>Directions for Use</p>  <ol style="list-style-type: none"> 1. Take the pad out of the bag. 2. Remove the release sheet. 3. Fix the pad onto the underwear. <p>How to Dispose</p>  <ol style="list-style-type: none"> 1. Roll the used the pad and seal it with the release sheet. 2. Place the rolled pad into the disposable bag. 3. Safely dispose in a dustbin.
<p>FIGURE 33 Tampon</p> 	<p>FIGURE 34 How to Use a Tampon <i>Source: Menstrupedia</i></p>  <p>They must be disposed of by wrapping them and throwing in the dustbin and should not be flushed or thrown into the river.</p>

MODULE 5 PARTICIPANT HANDOUT 5.4_Page 3

MENSTRUAL PRODUCTS AND THEIR MANAGEMENT

(Activity 5.5: Menstrual Management)

OPTION	USAGE
<p data-bbox="260 710 414 774">FIGURE 35 Menstrual Cup</p> 	<p data-bbox="970 455 1082 480">FIGURE 36</p> <p data-bbox="831 491 1219 517">How to Use a Menstrual Cup Tampon</p> <p data-bbox="847 523 1203 549">Source: Adapted from iCare Menstrual Cup.</p> <div style="display: flex; justify-content: space-between;"> <div data-bbox="587 576 778 644"> <p>1. WASH - Wash your hand and cup well with warm water</p>  </div> <div data-bbox="815 576 1086 693"> <p>2. FOLD & HOLD - Press the sides of the cup together, then fold it in half again. Hold the folded sides firmly between your thumb and forefinger.</p>  </div> <div data-bbox="1123 576 1501 715"> <p>3. INSERT - Relax, gently separate the labia with your free hand and then push the curved edge of the folded cup into the vaginal opening. Cup retains 5-15-28 ml. of menstrual blood. Depending on the flow, empty the cup 2-5 times daily.</p>  </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div data-bbox="587 959 871 1119"> <p>4. REMOVE - Wash your hands well with warm water and soap. Pull gently on the stem until you can reach the base of the cup. Pinch the base of the cup to release the seal and continue to pull down to remove.</p>  </div> <div data-bbox="1134 959 1493 1027"> <p>5. EMPTY - Simply empty the contents in the toilet, wash it well with warm water and re-insert/store safely till next cycle.</p>  </div> </div> <p data-bbox="592 1229 1481 1332">The menstrual cup must be boiled before each use. It must be washed with soap and water before reinserting, which may not be easily accessible in many places. It is also not easily available.</p>

Some things to keep in mind while using different products:

1. Wash hands before and after using the product.
2. All products must be changed every four to six hours (may vary depending on flow) to avoid a leak and to prevent reproductive tract infection. If sanitary pads are not changed often they may emit a bad odour as the iron in the blood is exposed to oxygen in the air.
3. Wash the genital area thoroughly after passing urine, faeces and in between changing the product. While washing, wash from front to the back (vulva to anus) to avoid any infections.
2. A person who does not have sensation around the vulva region/below the waist, may not know if the product is properly placed. In such cases period-proof underwear, such as the ones lined with plastic, can be a good alternative to prevent leaks.
3. Inserting a tampon/menstrual cup may increase the spasticity of a persons who have involuntary jerky muscular contractions.
4. Persons with visual disability may have trouble using menstrual cups, as they may not be sure if the cup is full or not. There might also be worries about staining.

Using different menstrual options as a person with disability:⁴⁵

1. A person who has lack of strength in hands may have trouble getting their pants down, transferring to the toilet, placing the pad or standing. They may also have difficulty opening the packages of sanitary pads and tampons and may end up bending the tampons.

Do not hesitate to seek help from a family member/carer/ someone you trust. There is nothing shameful about menstruation and everyone should have the support to manage it in way that respects their bodily integrity.

MODULE 5_ FACILITATOR HANDOUT 5.5_Page 1

CASE STUDIES ON MENSTRUAL TABOO

(Activity 5.6: Menstrual Myth Busting)

CASE STUDY 1

“Rafia Khatun, an 11 year old girl, who has not started menstruating, thinks menstruation is a curse. Her family members have not shared any information about it with her. She knows about menstruation from a book she once borrowed, from one of her cousins. The story of Eve eating the forbidden fruit and then getting her period intrigues her. Rafia then comes to the conclusion that women get menstruation as a form of punishment.”⁴⁶

FACT:

Menstruation is a biological process that occurs as a result of the shedding of uterine wall when there is no egg to be fertilised and nourished. However, such myths about menstruation are quite common and require awareness and information about menstruation from an early age.

CASE STUDY 2

Kalpna is 25 years old, has a hearing and speech disability and works on her small family farm. Every month when she gets her period she has to wake up at 5am and walk to the canal on the outskirts of her village to take a bath as she has been told that taking a bath at the village pond will kill the fishes in the pond. She is also not allowed near the cows when she is menstruating as it is widely believed that cows will give less milk or they might die if a menstruating person comes near them.

FACT:

Menstruation is often associated with being ‘impure’ and several taboos such as the ones mentioned here flow from that. There is nothing ‘impure’ about the blood as it is a natural process of the body shedding tissues that are no longer needed. It is like any other secretion from the body. There is a need for greater awareness and capacity building with communities to explain the biological process of menstruation to counter these socio-cultural taboos.

CASE STUDY 3

Sultana is a person with intellectual and locomotor disability. When she turned 12 years old and had her first period, her parents decided that it would be best to sterilise her as managing periods would be quite challenging and opens up possibilities of sexual abuse. Sultana was not consulted with on this decision.

FACT:

This violates Sultana’s right to control her own fertility. Hysterectomy and sterilisation is often forced on women and girls with disability due to fears of menstrual management, exposure to violence and pregnancy. However, what is needed in this situation is to have access to information, resources and training with the person, their caregivers (including family members), and health care professionals about the different options available and collectively coming up with a menstrual management plan. Forced sterilisation and hysterectomy are prohibited under the provision of right to family in CRPD and the RPPDA, 2013.

Exposure to sexual violence and sterilisation are not linked, and sterilisation will not protect a person from sexual abuse and violence. In fact, forced sterilisation is itself a form of reproductive violence by taking away a person’s choice to control their reproductive decisions. Countering sexual violence requires access to information and support in reporting and litigating against sexual violence.

MODULE 5_FACILITATOR HANDOUT 5.5_Page 2

CASE STUDIES ON MENSTRUAL TABOO

(Activity 5.6: Menstrual Myth Busting)

CASE STUDY 4

Sneha's daughter, Reena, started menstruating when she was 13 years old. Reena sometimes experiences painful cramps during menstruation. Sneha was told by her mother that you must only lie down during menstruation and not do any exercise. She now gives the same advice to her daughter.

FACT:

Encouraging someone who is menstruating to not engage in physical activities is a common myth. While a person may require some amount of rest during menstruation, being physically active and doing some exercise is helpful to relieve menstrual cramps.

CASE STUDY 5

Rokaya Begum loves eating fish. However, every month when she is menstruating, she is told to not eat certain foods, such as meat, eggs, fish and leafy vegetables at this time since they are believed to increase her "polluted state". She is also told that she must not have sexual intercourse while she is menstruating as she is "polluted".

FACT:

With the loss of blood and fatigue that accompanies menstruation, such taboos around eating habits prevents people from getting necessary nutrients and may cause further fatigue, loss of energy and malnutrition. Menstruation does not prevent somebody from eating anything and in fact, eating meat, eggs, fish and leafy vegetables during menstruation should be encouraged as they provide nutrition. Many people may feel uncomfortable having sex while they are menstruating. However, this is a question of personal choice and negotiation between partners, and there is no problem in having sex during menstruation and no risk of infections. In fact, having sex during menstruation can sometimes help in relieving menstrual cramps.

CASE STUDY 6

Every month when Asmi is menstruating, she is told to isolate herself from the rest of her family and stay in a separate hut outside the family home. The hut barely fits one person and lacks any basic infrastructure. She asked her parents why she has to do this and was told that while she is menstruating she is "impure" and must therefore not come in contact with any male members, enter the family home or participate in religious activities.

FACT:

This is a common practice which stems from the belief that menstrual blood is "impure" and contaminates anybody who comes in touch with it. This is especially prevalent in Nepal, and the practice is referred to as "chaupadi". However, as noted earlier there is nothing impure about menstrual blood and it is a biological process. Such practices endanger the life of women and girls and being banished to these huts has resulted in deaths due to exposure to the cold, smoke inhalation or attacks by animals.

MODULE 5 PARTICIPANT HANDOUT 5.5

CASE STUDIES ON MENSTRUAL TABOO

(Activity 5.6: Menstrual Myth Busting)

CASE STUDY 1

“Rafia Khatun, an 11 year old girl, who has not started menstruating, thinks menstruation is a curse. Her family members have not shared any information about it with her. She knows about menstruation from a book she once borrowed, from one of her cousins. The story of Eve eating the forbidden fruit and then getting her period intrigues her. Rafia then comes to the conclusion that women get menstruation as a form of punishment.”⁴⁷

CASE STUDY 2

Kalpana is 25 years old, has a hearing and speech disability and works on her small family farm. Every month when she gets her period she has to wake up at 5am and walk to the canal on the outskirts of her village to take a bath as she has been told that taking a bath at the village pond will kill the fishes in the pond. She is also not allowed near the cows when she is menstruating as it is widely believed that cows will give less milk or they might die if a menstruating person comes near them.

CASE STUDY 3

Sultana is a person with intellectual and locomotor disability. When she turned 12 years old and had her first period, her parents decided that it would be best to sterilise her as managing periods would be quite challenging and opens up possibilities of sexual abuse. Sultana was not consulted with on this decision.

CASE STUDY 4

Sneha’s daughter, Reena, started menstruating when she was 13 years old. Reena sometimes experiences painful cramps during menstruation. Sneha was told by her mother that you must only lie down during menstruation and not do any exercise. She now gives the same advice to her daughter.

CASE STUDY 5

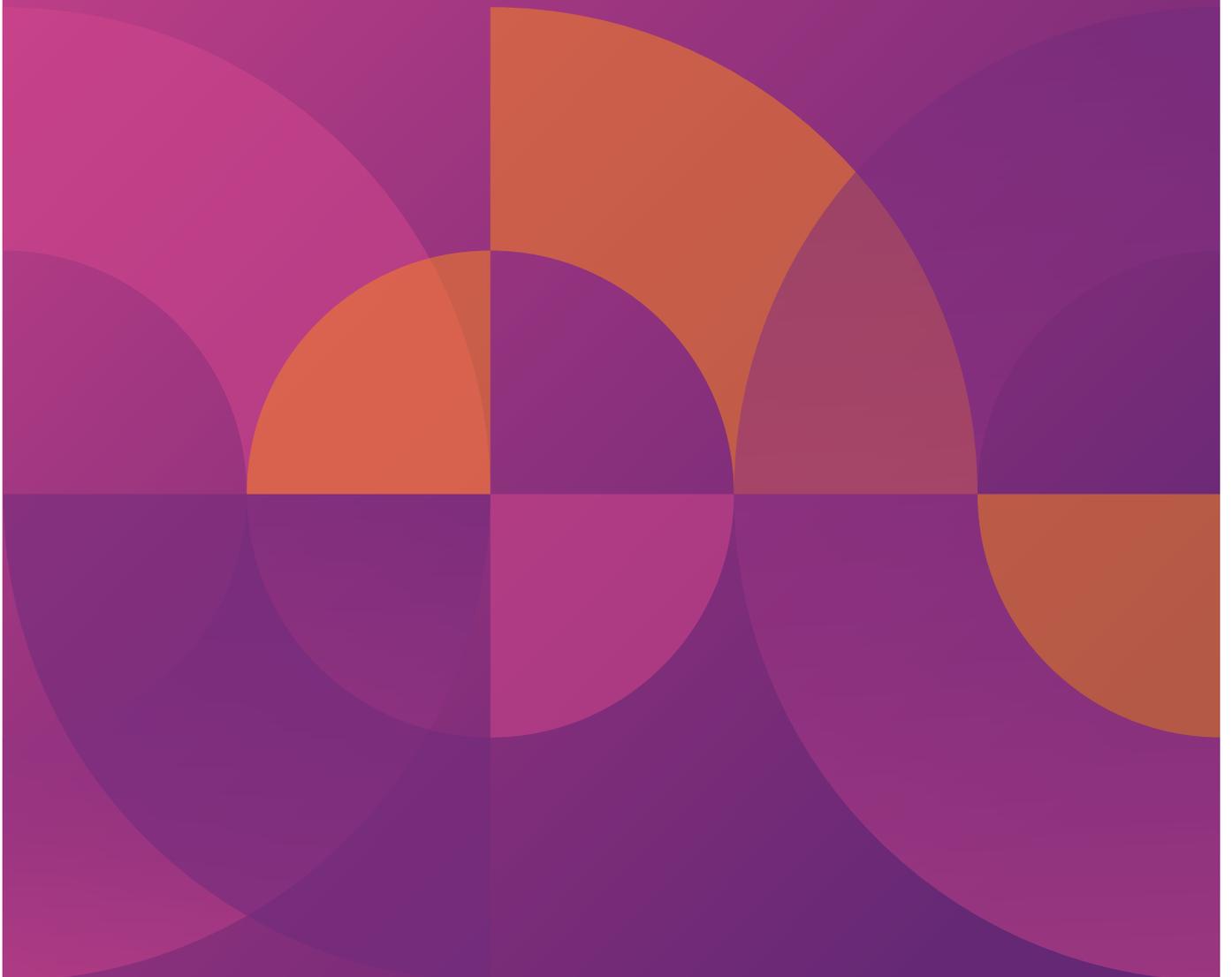
Rokaya Begum loves eating fish. However, every month when she is menstruating, she is told to not eat certain foods, such as meat, eggs, fish and leafy vegetables at this time since they are believed to increase her “polluted state”. She is also told that she must not have sexual intercourse while she is menstruating as she is “polluted”.

CASE STUDY 6

Every month when Asmi is menstruating, she is told to isolate herself from the rest of her family and stay in a separate hut outside the family home. The hut barely fits one person and lacks any basic infrastructure. She asked her parents why she has to do this and was told that while she is menstruating she is “impure” and must therefore not come in contact with any male members, enter the family home or participate in religious activities.

module 6

desire, pleasure
and sexuality



module 6

desires, pleasure and sexuality

MODULE OBJECTIVES

1. To build comfort in talking about desires and pleasure in the context of sexuality.
2. To understand how ideas of consent, choice, trust, and agency relate to pleasure, especially in the context of sexual and/or romantic relationships.
3. To build skills in negotiation and communication to ensure pleasure and safety within relationships.

ACTIVITIES

Activity 6.1: Pleasure Story > 60 Minutes

Activity 6.2: Desire, Pleasure and Love > 60 Minutes

Activity 6.3: Resisting Pressure > 40 Minutes

HANDOUTS

Activity 6.1: Pleasure Story > None

Activity 6.2: Desire, Pleasure and Love

> Facilitator Handout 6.1: Desires, Pleasure And Love

Activity 6.3: Resisting Pressure > None

Variation: You can introduce a bag with different objects: condom or other contraceptive, bottle cap, make up products, clothing pieces, phones, kitchen item, food item, accessories, bus ticket, music CD, toy car, nature item: (leaf, flower, stick, rock) etc. The participants can pick a few objects from the bag which they must include in their story. (Source: Program for Appropriate Technology in Health (PATH) (2002) Games For Adolescent Reproductive Health: A Handbook.)

Debrief:

1. Is sexual pleasure more important to men than it is to women?
2. Should sexual activity be limited for the purpose of procreation within marriage?
3. Is peno-vaginal sexual intercourse the only way to experience sexual pleasure between a man and woman?
4. Is there an age limit for experiencing pleasure?

Key Messages:

1. Pleasure is part of our sexual rights, and has an impact on our wellbeing and quality of life. Awareness of one's desires and what is pleasurable also helps to identify and navigate that which is uncomfortable and/or coercive.
2. Desires and pleasure are personal and different for different people. Everyone should have avenues to explore their desires and pleasure and express their sexuality, as long as it does not infringe the right of another.
3. There are many reasons a person may want to engage in sex: for intimacy, pleasure, to fulfil other emotional needs, for money and for procreation as well. Each person has a right to do that consensually with their partners, without infringing another's right, and we should refrain from exercising moral judgment on people's choices. A focus on sex just for procreation within marriage, can limit the possibilities of sexual pleasure for many people.
4. Sexual pleasure can be explored by oneself (for example, through masturbation), or with a consensual partner, and can encompass a wide range of activities, including touching, hugging, kissing, fondling etc.
5. People have a right to experience sexual pleasure across ages.

ACTIVITY 6.1: PLEASURE STORY

Objective:

To build comfort in exploring ideas around pleasure and sexuality.

Time:

60 Minutes

Materials Needed:

None (See variation for other materials that might be needed)

Process:

1. Divide the participants into four groups.
2. Each group must create a small role play exploring the theme of 'pleasure and sexuality'. The theme is open to interpretations by the participants, but must explore contexts within the ambit of sexuality.
3. The groups will have 30 minutes to prepare the role play, after which they will present their role play to the group.

Notes for Facilitator:

1. Through the stories, participants may focus on pleasure in a heterosexual setting, not include transgender people etc. Encourage participants to think of stories outside a heterosexual setting as everyone has a right to pleasurable experiences without stigma and discrimination.
2. You can also suggest some story lines to give participants an idea of how the stories can be created.
3. Depending on the group and your context, you can also use the Erotica Writers Activity from the Manual, *InterSEXionality: A Facilitator's Guide*,⁴⁸ by ARROW. Depending on the disability, the activity can be done orally and through sign language instead of a written format.

ACTIVITY 6.2: DESIRE, PLEASURE AND LOVE

Objective:

To explore how different persons with disabilities negotiate pleasure and sexuality; and to challenge myths around sexuality of persons with disabilities.

Time:

60 Minutes

Materials Needed:

- Facilitator Handout 6.1

Process:

1. Tell the participants that you will be sharing stories by different persons with disabilities about their experiences with sexuality, romance, finding a partner, and challenging notions about disability in the process.
2. Read out the stories in Handout 6.2. Most of the stories are from the publication, 'Untold Desires'⁴⁹ (Shahririk Protibondhider Na Bola Kotha), a collection of photo narratives published by The Centre of Excellence for Gender, Sexual and Reproductive Health and Rights, BRAC James P Grant School of Public Health, BRAC University.

About the publication: The book presents narratives of physically disabled people between the ages of 20-40, and their perceptions around love, romance, intimacy and sexuality. The narratives explore how disabilities of the participants intersect and influence with their experiences and understandings around sexuality, desire and romance.

Note: The publication is both in Bangla and English.

3. After the stories have been read out, invite discussion on some of the following themes that emerge from the stories:
 - How does (dis)ability affect our preferences for partners – preference for partners with the same

disability, other disabilities, non-disabled? What factors influence these choices (For example: fear of being pitied, worry that a non-disabled person will not attend understand experiences of disability, need for support, etc.)?

- How are people creating their own unique experiences of sexuality, romance and pleasure? (For example: taking on a married man as a lover; fighting ideas of gender and love as a transman; using different parts of the body to find alternate ways of pleasure; experiencing pleasure outside marriage; fantasies as a site of pleasure).
 - In these stories how are persons with disabilities actively exercising choice and challenging the misplaced idea we often come across – that as a person with disability, you should accept anyone who shows interest? (For example: defining and communicating what is pleasurable; being clear about their expectations; insistence on respect not pity or charity; and finding pleasure in one's own self).
 - What are the different things people value and are looking for in partners?
 - How are people negotiating other people's view of their sexuality with their own needs? (For example: Neetu's lover wants to marry her because his wife cannot have children. She is also not sure if their relationship is about love or having someone physically available to fulfil her urges).
 - Do gendered ideas and expectation play any role in these stories?
4. In pairs, ask the participants to discuss qualities they would look for in a partner and some essentials in a relationship (such as having opinions, ideas and choices respected; being able to ask for what they need; fun; being able to protect sexual health; being able to say no without feeling guilty; feeling safe in the relationship and not being abused physically or emotionally; being able to make decisions and change your mind; having your right over your body, boundaries and privacy respected; shared values)

Debrief:

1. What were some of the other things that stood out in the stories?
2. How have participants' experiences been similar or different?
3. Are the experiences of men with disabilities different from women with disabilities? If so, how?
4. How can we balance pleasure and safety when using digital forms of communication?

Key Messages:

1. Different people experience romance, love, intimacy and pleasure in different ways both within marriages and outside of them, through single or multiple partners, with partners of different genders and sex, through different sexual activities, with or without partners, through fantasies etc. A person should have the right to set their boundaries, decide on what is pleasurable and have them respected without fear of stigma, discrimination or violence.
2. A person's disability is not a reason for them to not experience pleasure, romance and intimacy in ways they desire and choose and to have unfair expectations of compromise pinned on them.
3. Gender often plays an important role in our experiences of sexuality. For example a man with disability may have sexual and romantic encounters with a woman with disability, but, refuse to marry her based on his ideas of roles and duties of a wife which he perceives women with disabilities cannot fulfil.

Notes for facilitator:

1. Ensure that in discussing the case studies the ground rules of respect, non-judgment, confidentiality and listening to each other are maintained as some topics may invite strong and heated opinions.
2. Often conversations around sexuality and SRHR focus on abuse and violence instead of pleasure. However, pleasure, consent and abuse are closely related. Awareness of what is pleasurable, our bodies and our boundaries, focusing on choice, agency and consent can help us identify uncomfortable/abusive situations.

**ACTIVITY 6.3:
RESISTING PRESSURE****Objective:**

To build confidence in being able to communicate about desires and pleasure and to negotiate pleasure within sexual and/or romantic relationships and encounters.

Time:

40 Minutes

Materials Needed:

None

Process:

1. Explain the rules of the game.
 - a. The participants will gather at the centre of the room and split themselves into groups of four.
 - b. Each participant must think of a sound/movement. (This will depend on nature of disability – for persons with visual disability use a sound; for persons with hearing disability use a movement; and for persons with physical disabilities, depending on the nature of disability if movement is difficult, use sound)
 - c. With a cue from the facilitator, they can begin making the sound/movement. Their goal is to convince others in their small group to adapt to their sound/movement. At the same time everyone must try to retain their sound/movement, unless they feel like adapting to somebody else's.
 - d. The members in each small group will have five minutes to convince the others in their smaller group to adopt their sound/movement.
 - e. With the next cue from the facilitator, they must move out into the larger group and convince as many people to adopt their sound/movement.
2. Once the rules of the game have been explained, ask the participants to gather at the centre and think of their sound/movement.
3. Give the first cue. Participants must start making their sound/movement and convince others in the smaller group to adapt their sound and movement. The smaller groups might be convinced to adopt one sound from amongst the members or after a while it may emerge that they are not able to arrive at one common sound.
4. After five minutes, give the second cue. Now the smaller groups can move out to the larger groups, convincing as many people to adopt their sound/movement.
5. Allow this to continue for 10-12 minutes.
6. Once the activity has concluded, come back to a big circle and ask the participants the following questions:
 - a. How did you choose your sound/movement?
 - b. What convinced you to adopt somebody else's sound/movement?
 - c. What helped you retain your sound/movement?
 - d. At any point did you feel you no longer wanted to continue the sound/movement you were making? If yes, what did you do?
7. Encourage the participants to think of the game as our everyday lives and how we face pressures and negotiate in relationships.
 - For example, one of the methods that participants employ in convincing others to adopt their sound/movement is by being too loud and overpowering. Yet, people have developed many strategies to retain their own sound/movement. One helpful strategy could be to think of why you chose a particular sound/movement, what it means to you and if you are willing to change that.

In the context of relationships, similarly, we may feel pressurised into doing something because our partners are being loud and overpowering through arguments, threats, name-calling etc. For instance, this can include coercion to engage in sexual acts we do not feel comfortable with, not using protection, requesting you to share photos you are not comfortable with etc. In these instances, thinking about what matters to us and why that's important can help us push back against the pressure and stick to our choices and positions. Just like our strategies in retaining our sound/movement we have the ability and can develop strategies to not be pressured into doing something we do not wish to.

- A person may also adapt another person's sound/movement because it appeals to them. Once they move out of the smaller group, they may drop this sound/movement and adapt another person's sound/movement from the larger group that appeals to them, or go back to their original sound/movement.

Similarly, in the context of relationships we may move from our original position and try new things because it appeals to us, but it does not bind us forever. For example, being in a relationship with a person does not mean you cannot end it. Just as people could take on a different sound when they moved to a larger group, we have a right to change our minds and move on to. In another instance, we may consent to trying something new romantically or sexually with our partners, for example performing oral sex. However, just like a sound/movement adapted once can be changed/dropped, agreeing to try oral sex once does not mean we cannot change our minds at any point.

- Lastly, we can think of all the different sounds/movements that we see/hear from the larger group as messaging we receive from our friends, families, societies, communities and culture about sexuality. There are different messages and each one is trying to convince us they are right. This can be overwhelming. However, even within this cacophony of messages, just like having our own sound/movement, we have a right to understand and establish our own ideas, values, perceptions and views on pleasure and sexuality.

Optional Variation: Instead of the activity described above, you can also address this topic through role plays. Participants can enlist some of the situations where they feel pressurised in relation to their sexual decision making. Select three situations for the role play. One person can act as the person exerting pressure and one by one participants can try different tactics to negotiate and resist against the pressure being exerted. This will allow a safe space to practice different tactics.

Debrief:

1. What are some situations where people are likely to face pressure in the context of sexual and/or romantic relationships and encounters?
2. What are some strategies that can be used to deal with them?
3. If you consent to something once can you change your mind? Would this apply to sexual relationship between a married couple?

Key Messages:

1. Everyone has a right to make decision about their bodies, pleasure, boundaries, values, and sexual health and to have them respected.
2. There are different strategies that can be employed if you are being pressured:
 - some situations may allow for negotiations – arriving at a solution that both are happy with;
 - delaying it to later time – for example when you want to talk to a friend/trusted person, obtain more information or need to push the conversation to a time and space where you feel physically and emotionally safe;
 - reaching out to friend/family member/organization/legal help/healthcare professional for support
 - refusing to comply; and
 - leaving the situation or the relationship.
3. Sexual consent must be constantly and repeatedly established and not assumed. People may consent to something initially and realise they no longer find it pleasurable, in which case they have a right to withdraw consent. Consent cannot be based on deceit or wrongful information.

Note: The explanation of consent using tea, can be a simple way to initiate conversations on consent, albeit slightly simplistic. For Bangla version of this see: Orodho Foundation (2019), Tea – A Tale of Consent, Consent explained Using Tea. Available at: [Link]: <https://www.youtube.com/watch?v=MCYLtgk7n2l>. Accessed on 5 September 2020.

However, it is important to understand this is a way to start the conversation, consent is quite complex and deeply embedded within systems of power, privilege and socialization, and the video does not cover many areas.

Notes for the Facilitator:

1. You can observe how the game is to be played with the help of the following video: Tony Cealy (2017) *Rio Carnival Exercise*. Available at: [Link] <https://www.youtube.com/watch?v=Qh5iONo8FXE>. Accessed on 5 September 2020.
2. People may have difficulty connecting the exercise with relationships and sexuality. You can build connections by using concrete examples such as the ones suggested above.
3. In reality, negotiations are far tougher than in the context of a game and depend on numerous factors. Acknowledge this and reiterate that the purpose of the game is to encourage us to build strategies and skills to negotiate sexual pleasure in a safe and fun way.

Resources for Further Reading:

1. Sexuality and Disability. [Link] <https://sexualityanddisability.org/>.
2. Skin Stories. [Link] <https://medium.com/skin-stories>.
3. Saad Adnan Khan and Farhana Alam (2017). *Untold Desires*. Dhaka, Bangladesh: BRAC James P Grant School of Public Health, BRAC University.
4. Hannah Witton (2018), *Disability, Sex, Relationships and Dating Roundtable*. Available at: [Link to video] <https://www.youtube.com/watch?v=AvGNiwR57il>. Accessed on 2 September 2020.
5. Cassandra Loeser, Barbara Pini, Vicki Crowley, (2018). ‘Disability and sexuality: Desires and pleasures’, *Sexualities*, 21(3), pp. 255-270.

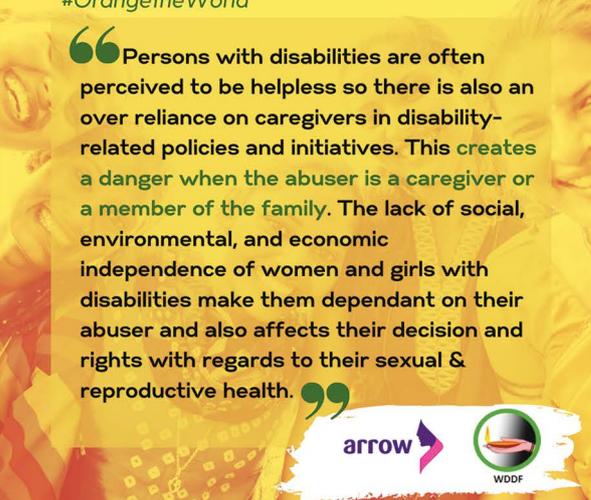
16 Days of Activism #OrangetheWorld 7th December 2020

“When women & girls with disabilities try to take legal action against sexual & gender-based violence perpetrated against them, they face threats, including death threats, and such threats extends to their families and the witnesses. In the absence of appropriate and adequate care & support for survivors of violence, their families and the witnesses, it is difficult for women and girls to navigate the criminal justice system to bring the perpetrators of crime to justice.”




16 Days of Activism #OrangetheWorld 8th December 2020

“Persons with disabilities are often perceived to be helpless so there is also an over reliance on caregivers in disability-related policies and initiatives. This creates a danger when the abuser is a caregiver or a member of the family. The lack of social, environmental, and economic independence of women and girls with disabilities make them dependant on their abuser and also affects their decision and rights with regards to their sexual & reproductive health.”




16 Days of Activism #OrangetheWorld 9th December 2020

For prevention of sexual and gender-based violence for women & girls with disabilities, & to ensure better access to justice, the following key barriers ought to be addressed:

- 1) Legal Barriers
- 2) Attitudinal Barriers
- 3) Information, knowledge & communication-related barriers
- 4) Physical Barriers
- 5) Economic Barriers
- 6) Barriers caused by delay in justice




MODULE 6 _FACILITATOR HANDOUT 6.1_Page 1

DESIRES, PLEASURE AND LOVE

(Activity 6.2: Desire, Pleasure and Love)

1. NEETU'S STORY

“Twenty-one year old Neetu has post-polio syndrome. She can't walk at all and has to crawl on all fours from one place to another. Neither her house, nor the area she lives in, is wheelchair friendly. Regardless of these limitations, she has an active life and does most of the household chores.

Five years back Neetu had a relationship with her maternal cousin and became pregnant from that relationship. She bore the child believing that the cousin will marry her. However, he left her eventually. Neetu gave birth to the child but her mother got rid of the child, with assistance of a midwife. Neetu always carried a baby doll after that incident, pretending that it was her child.

Neetu wants to have a relationship and get married. However, her mother doesn't want her to get into any relationship, as she thinks that her husband will leave after impregnating her, which will be extra burden for Neetu's parents. Her mother's decision of not letting her get married has made Neetu frustrated. She wants to be with a man now.

Neetu mentions about her present lover, who is a married man. He wants to marry Neetu, as his wife cannot bear children. Neetu says that she will do anything to be with the man. She however says that she doesn't know if she loves him or not, or that whether it is about having someone physically available to fulfil her urges once in a while. Neetu thinks that she is very beautiful. She blames God for making her disabled, and giving her such beauty at the same time.”⁵⁰

2. HOSNA'S STORY

“Twenty-three year old Hosna has spinal cord injury. She fell down from the stairs on the day she came back to Dhaka from her village after Eid holidays in 2011. She was admitted to the Centre for the Rehabilitation of the Paralysed for almost a month. The lower half of her body was completely paralysed. Doctors informed her that she will have to use a wheelchair for the rest of her life. She couldn't feel when she had to urinate or pass stool. She wouldn't know if she had menstruated or not. It was difficult for her to adapt to the whole process mentally. She says that people around her changed rapidly. Her boyfriend who she was dating for three years, decided to break up with her. She was heartbroken and felt lonely.

Disability has completely changed Hosna's life, but it didn't change her dreams about life and desires. Hosna is a very romantic person, and is in search for a partner who will understand romance through her lens. Even though Hosna doesn't have any feeling from waist below, she doesn't want to limit her possibilities when it comes to sex and sexuality. She wants to explore alternate ways of having pleasure. Her upper body is extra sensitive, as Hosna describes, and she thinks that her other senses in her upper body are much more enhanced now, which she believes will act as an advantage for her in terms of experiencing pleasure.

For a life partner, Hosna will prefer an able-bodied man. She doesn't want to be with a disabled man as she thinks that that will make things more difficult for her. She wants to be with someone who can support her, and whom she can depend on. She thinks that a disabled man might be dependent on her, and she doesn't want that. She thinks that a wheelchair bound man can get an able-bodied woman quite easily in Bangladesh. However, given the patriarchal nature of Bangladeshi society, it is an ambitious expectation for a disabled women to want to be with an able-bodied man.

Hosna doubts if she will ever find a partner who will be willing to shape their relationship according to her needs. She however notes optimistically that there's no harm in wishing and that one should always have a plan B for every situation. If she doesn't find anyone to be with, according to her plan B, she will be on her own and she is perfectly okay with that.”⁵¹

3. SHUKLA'S STORY

“Thirty-year old Shukla has post-polio syndrome. She works with disabled children. Shukla is open to romance, but doesn't want to get married. She says that she doesn't trust men. She prefers having casual romance and doesn't want to commit, as she is not sure about how a man would treat her after he marries her. Shukla thinks that a man can never fully embrace a disabled women to be his partner. They would feel ashamed to be seen in public with a wife who cannot walk properly, according to Shukla.

She also mentioned that she lost interest from marriage, when she saw how able-bodied women were treated in marriage. She thinks it is impractical that a disabled woman will ever be

MODULE 6 _ FACILITATOR HANDOUT 6.1 _ Page 2

DESIRES, PLEASURE AND LOVE

(Activity 6.2: Desire, Pleasure and Love)

in a relationship that is solely based on love and feelings, and not how she looks, or is capable of doing. Women are seen as machines to produce babies. Men leave their wife for other women, and Shukla doesn't want such drama or complication in her life.

She wants respect in every relationship and doesn't want to be pitied. She knows a man whom she connected with over social media. They have been having romantic conversations over the phone for the past two years, but have never met each other. Shukla likes to hold the pillow when she talks to this man over the phone. She does not support the idea of having sexual relationship before marriage even though she feels that the main objective of being in a relationship is to have pleasure, and that does not always have to be sexual intercourse. Talking to someone, having romantic conversation and fantasising can also be pleasurable, says Shukla. She fantasises a lot about her boyfriend. The fact that they have never seen each other, makes her fantasies more exciting to her.”⁵²

4. SONIA'S STORY

“Twenty-six year old Sonia had a car accident in 2008. She was with her elder sister and brother. She couldn't feel anything as she lay on the ground. People rushed to rescue them. It was then when they tried to pull her out of the car that Sonia realised she had broken her back bone. Her spine was more than 80% damaged. She didn't quite understand what would the implication be or how this was going to shape her life. Doctors reset her backbone with the help of a plate. They were hopeful after the surgery. Sonia received further treatment at the Centre for the Rehabilitation of the Paralysed (CRP).

After seven months of treatment and therapy, she could barely sit. She realised that she will never be the person she used to be. The transition from being able-bodied to being disabled was traumatic and difficult for Sonia.

Sonia never wanted to get married as she thought that that would make her life more complicated. But her parents convinced her. She however had one condition. She wanted to marry someone who would want to marry her after knowing about her disability. She eventually fell in love and married her physiotherapist at CRP. Due to the length of the treatment, they became good friends, and ended up marrying each other.

While talking about married life, Sonia said that it's a blessing for her that she is married to her physiotherapist, as he knows about her disability more than anybody else, which helps their relationship a lot. She says that it is a misconception about people with spinal cord injury being asexual, and not wanting any sexual interactions. Sonia mentions that the partner should be positive and supportive when it comes to having sex.

While talking about pregnancy, she said that she has mixed feelings about wanting to be a mother. She is scared of complications and for the fact that there aren't enough medical support available in Bangladesh for pregnant women with spinal cord injury.”⁵³

5. KIRAN AND KAVYA'S STORY⁵⁴

Kiran is a 32 year disabled Transgender activist and the founder of Karnataka Viklchetna Sangathan.

Kiran: I am a female to male transgender. We are a total of four siblings. In my family, I am the only one disabled and only one having developed the feelings of a boy. People used to bully me in school. I completed my education till the 10th standard. In school, I met Kavya who I later married.

Kavya: We decided to get married in 2008.

Kiran: We took time to decide whether we should get married because we were afraid of its acceptance.

Kavya: After my marriage my family didn't contact me for five years.

Kiran: People used to ask us for uncomfortable questions and abuse me as well. They would ask “How would you have sex?” “How will you produce children?” “How would you lead your life?” I could answer only few and Kavya answered the ones I could not.

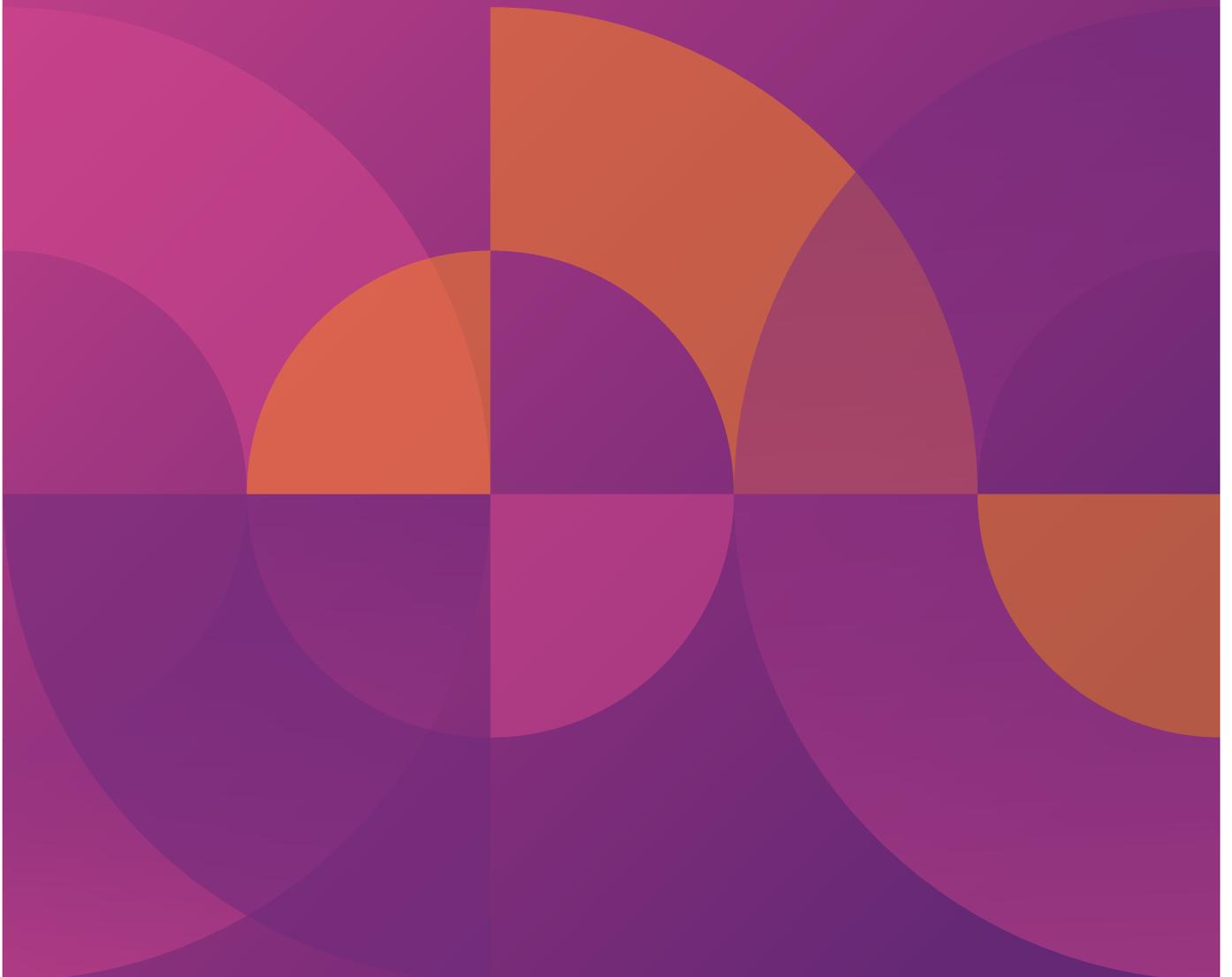
Kavya: Everyone takes Kiran as a disabled person, but he is just physically disabled, not mentally.

Kiran: Anybody else in my place would be depressed and wanting to commit suicide. We suffered too much. But I thought why should we commit suicide? Let us live and show the world what we can offer. We started the Karnataka Viklchetna Sangathan (KVS) focussing on accessibility issues for the disabled and concerns related to sexuality.

Kavya: I feel so proud that I am Kiran's wife.

module 7

sexual and
reproductive health



module 7

sexual and reproductive health

MODULE OBJECTIVES

1. To provide information to participants on various aspects of sexual and reproductive health such as pregnancy, parenting, abortion (menstrual regulation),*⁵⁵ so as to enable them to better exercise choice and agency in dealing with them.
2. To initiate discussion on attitudes and beliefs on these issues; and challenge misconceptions that breed stigma and discrimination.
3. To develop safer sex practices.

ACTIVITIES

CHAPTER 1: REPRODUCTIVE AUTONOMY

Activity 7.1: Conception, Contraception and Pregnancy

> 60 Minutes

Activity 7.2: Parenting and Adoption > 60 Minutes

Activity 7.3: Myths and Facts on Abortion > 45 Minutes

CHAPTER 2: STI, RTI, HIV AND AIDS

Activity 7.4: Quiz on STI, RTI, HIV and AIDS > 45 Minutes

Activity 7.5: Demonstration of Barrier Methods

> 20-45 Minutes

HANDOUTS

Activity 7.1: Conception, Contraception and Pregnancy

> Participant Handout 7.1: Contraceptive Choices

Activity 7.2: Parenting and Adoption > None

Activity 7.3: Myths and Facts on Abortion

> Facilitator Handout 7.1: Myths and Facts on Abortion

Activity 7.4: Quiz on STI, RTI, HIV and AIDS >

a. Facilitator Handout 7.2: Quiz on STI, RTI, HIV & AIDS

b. Participant Handout 7.2: STI, RTI, HIV & AIDS

c. Participant Handout 7.3: Information on STIs and RTIs

Activity 7.5: Demonstration of Barrier Methods

> Participant Handout 7.4: Using Condoms and Dental Dams

CHAPTER 1: REPRODUCTIVE AUTONOMY

Activity 7.1: CONCEPTION, CONTRACEPTION AND PREGNANCY

Objective:

To understand the process of conception and factors affecting decision making regarding pregnancy; and to understand types of contraception and their interaction with different disabilities.

Time:

60 Minutes

Materials Needed:

- Flip charts
- Markers
- Participant Handout 7.1

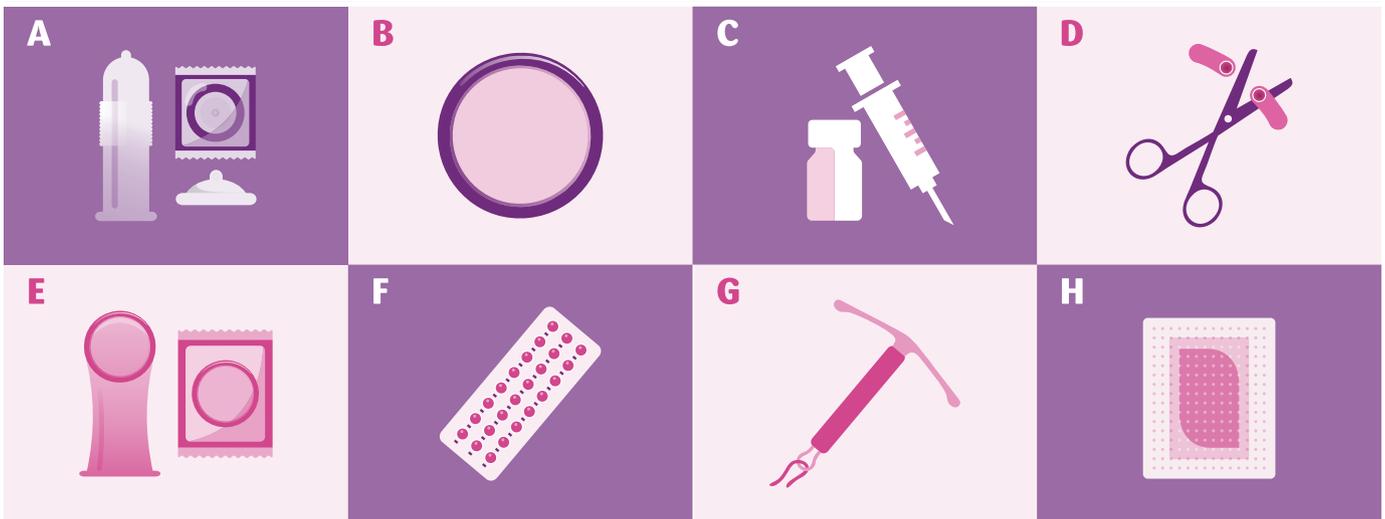
Process:

1. Divide the participants into three groups. Each group will work with one topic each: conception, contraception and next steps.
2. The first group working on conception must be given the following sentences in a jumbled order and through group work they must put it in correct order.
 - The ejaculated sperm travels from the cervix to the uterus.
 - The mature egg leaves the ovary and enters the fallopian tube.
 - The ovary releases an egg (ovulation).
 - There is ejaculated sperm in the vagina.
 - The egg is fertilised.
 - The fertilised egg attaches itself to the uterine wall.
 - The sperm meets the egg in the fallopian tube.
3. Group 2 working on contraception should try to identify as many methods of contraception they can from Figure 37.

Variation: For persons with visual disability, tactile models of the contraceptive would be the most preferred option. However, if tactile models are difficult to access/make, you can ask the participants to list all the different forms of contraception they have heard of.

* In the context of Bangladesh, the term 'menstrual regulation' is used to denote the range of procedures that are usually covered under abortion services. The term abortion per se is not used. While abortion is deemed illegal (except to save the life of the mother), menstrual regulation is legally permissible. Refer to Activity 7.3 for more details.

FIGURE 37: CONTRACEPTIVE METHODS



4. Group 3 will answer the following question: If there is successful conception and you get pregnant, what next – what are the factors to be considered in deciding whether to go ahead with the pregnancy?
5. Each group will have 15 minutes for the discussion.
6. Group 1 must present first. The correct order is as follows:
 - The ovary releases an egg (ovulation).
 - The mature egg leaves the ovary and enters the fallopian tube.
 - There is ejaculated sperm in the vagina.
 - The ejaculated sperm travels from the cervix to the uterus.
 - The sperm meets the egg in the fallopian tube.
 - The egg is fertilised.
 - The fertilised egg attaches itself to the uterine wall.

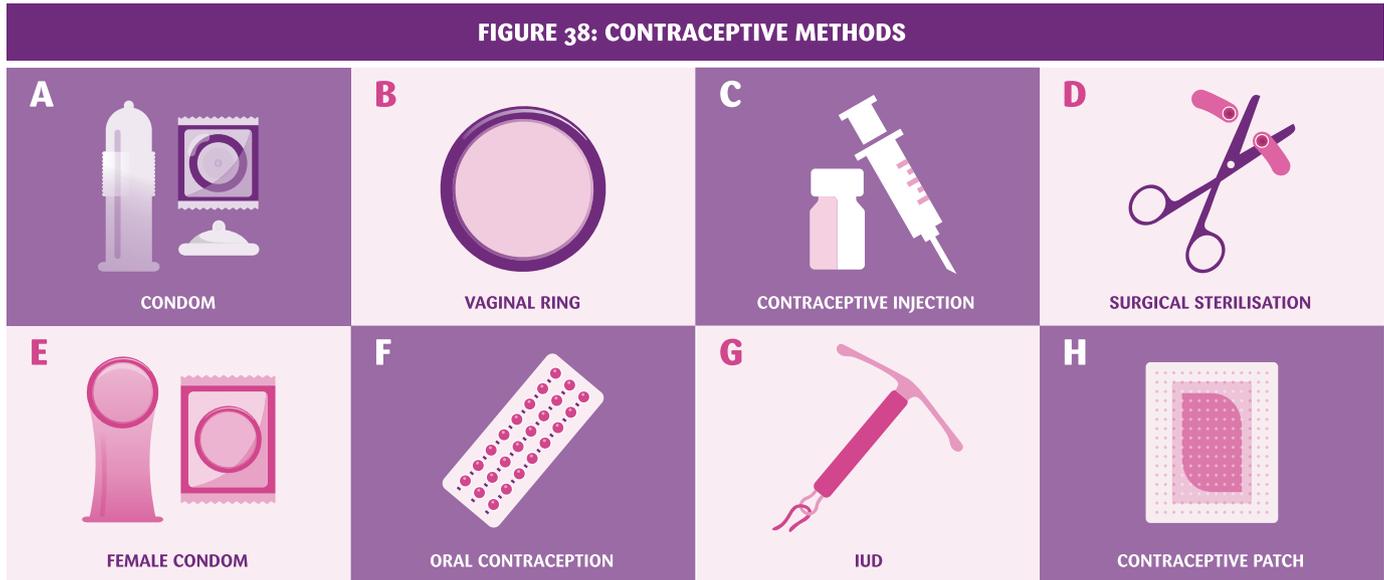
Explain the process of conception: Every month, the ovaries produce eggs and some eggs become mature. Around the same time, hormones cause the uterus to develop a lining, getting the body ready for pregnancy. The mature egg leaves the ovary and travels through the fallopian tube. A matured egg stays in the fallopian tube for 24 hours. If in case sperm enters the vagina through ejaculation, the sperm can swim from the cervix, through the uterus and into the fallopian tube, where it can stay up to six days in search of an egg. If a sperm meets an egg and joins together, it is called fertilisation. The fertilised egg breaks into cells and together moves towards the uterus. In the uterus, it might be able to attach itself to the uterine wall. This process is called implantation. Pregnancy starts with implantation.

The sperm, which is a part of the semen produced by the testicles, may enter the vagina through different sources. One of the foremost ways is through unprotected penetration by the penis. In some cases, even without penetration, the sperm may enter the vagina if there is ejaculation around the vagina. Sperm can also enter the vagina, if a person chooses to do an artificial insemination, in which sperm are introduced into the uterus through a medical procedure without sexual intercourse.

Variation: You can play the following video from Planned Parenthood to explain the process side-by-side. Planned Parenthood (2015). *How Do You Get Pregnant*. Available at: [Link] <https://www.youtube.com/watch?v=no4NPtZl4QQ>. Accessed on 18 August 2020.

For persons with visual disabilities, explain the process using tactile models and describe that the sperm has a 'tail' of sorts that allows it to move forward once it enters the vagina.

7. Group 2 should present next. The correct answers are in Figure 38.



8. Ask the participants to go through Participant Handout 7.1 and look at the different contraception options available.

Addition: You can also use this video on contraception to introduce the topic. RedOrange Media and Communications (2018) *Animation Contraceptive*. Available at: [Link to video] https://youtu.be/D_oBuPhZHxc. Accessed on 8 August 2020.

9. Group 3 will present last to explain their discussions around what are the next steps to be taken by a person if they become pregnant. Some factors to be considered are as follows:
 - Choice to become pregnant (include discussion around pressure to become pregnant or not become pregnant; pregnancy resulting from contraceptive failure; and pregnancy resulting from an act of rape, among other factors)
 - Desire for a child
 - Availability of support system
 - Financial support
 - Impact on health, if any

While these factors are important to consider, many other facets of a person’s life significantly influences decisions around pregnancy. With due consideration to these factors, the person may decide to go ahead with the pregnancy or to undergo ‘menstrual regulation’ (as abortion is known in Bangladesh). Both these options are discussed in detail in the following activities.

Debrief:

1. How do social, cultural and religious ideas impact information and attitudes around conception, contraception and pregnancy? For example, how does society view pregnancy in women with disabilities, pregnancy outside of marriage, and pregnancy in a non-heterosexual context?
2. What are the taboos around contraception?
3. Are contraceptive choices available to women with disabilities? If not, what are the barriers?

Key Messages:

1. Pregnancy is a personal choice and all persons, irrespective of marriage, sexual orientation, gender identity and disability, have a right to decide if they want children, when they want children and how many.
2. However, women with disabilities are often denied this right to control their reproductive choices. Women with disabilities are often forcefully sterilised or forced to abort because of misconceptions about their parenting abilities. Women with disabilities have a right to control their fertility and parent a child just as much as their non-disabled peers.
3. Women with disabilities are also often considered as non-sexual and left out of information on reproductive autonomy. However, Article 23 of the CRPD states that persons with disabilities have the right to “*decide freely and responsibly on the number and spacing of their children, and to have access to age-appropriate information, reproductive and family planning education.*”

- The burden of pregnancy often falls upon women. However, this does not mean that contraception is the primary responsibility of women and the responsibility ought to be shared by both partners. Partners, must therefore, provide persons with disabilities with necessary support in using appropriate contraception.

Notes for the Facilitator:

- The topic can be quite sensitive given different cultural contexts, and people may experience discomfort, express strong opinions, or rely on moralising.
- Ensure that you have control over the discussion and draw the discussion back to emphasise on the right to make reproductive choices for which information is key. Use the ground rules to reiterate that this is a safe space and learning must be encouraged, but with respect.
- Prior to the session, acquaint yourself with local mechanisms and healthcare facilities from where contraception options can be availed.

ACTIVITY 7.2: PARENTING AND ADOPTION

Objective:

To understand different ways of parenting as a person with disability and dispel myths around parenting as a person with disability.

Time:

60 Minutes

Materials Needed:

None

Process:

This activity involves discussing four case studies with the participants.

Case Study 1:

Ruksana, who has a psychosocial disability and spinal bifida, took a pregnancy test, which showed that she is pregnant. She then visited a health care professional to confirm the test results. Ruksana is now sure she is pregnant and wants to continue with the pregnancy. She is not sure of how to plan her pregnancy. What advice would you give her?

Key Messages: (These messages are only indicative. Have a discussion on barriers to accessing good maternal health information and services and discuss strategies based on context, location and experiences of the participants.)

- You can start the discussion by showing this video by RedOrange Media and Communications on Pregnancy: RedOrange Media and Communications (2018). *Animation Pregnancy*. Available at: [Link to video] https://www.youtube.com/watch?v=4kJH_1Elzbl. Accessed on 8 August 2020.
- As far as possible, ensure that nutritional needs of the pregnant woman are met.
- Reach out to local collectives, women health workers and health centres to know more about government schemes for maternal health which you can access.
- Speak to supportive friends, family members, community members, disability and women's rights collectives and organizations to learn from their experiences of child birth.
- Talk to the family about sharing childcare responsibilities.
- Certain types of disabilities may create complications during pregnancy and labour and therefore it is important to discuss options to manage these complications. For example persons with a high-level of spinal cord injury (T6 and above) are at increased risk of sudden high blood pressure (autonomic dysreflexia). Those who have neurological conditions, such as multiple sclerosis, spinal cord injury, spinal bifida and cerebral palsy, may experience increased spasticity. Persons with physical disabilities are also at greater risk of blood clots, urinary tract infections, falls from impaired balance as the centre of gravity changes, impact on bowel movements, and may need a different wheelchair due to weight gain.
- It is therefore important to have a birthing plan to manage the pregnancy. This involves:⁵⁶
 - Identifying a primary health care service where you can visit regularly for pre-natal care and whom you trust. If you are encountering negative attitudes by health care workers about being pregnant as a person with disability, be assertive and remind them that you have the right to make family planning decisions just as much as a non-disabled person and this is a legally protected right.
 - Getting regular pre-natal and ante-natal check-ups. A supportive friend/partner/family member/ someone you trust can accompany you and support in discussing possible complications and how to manage them, effect of current medications on pregnancy and how to manage labour (for example, women with spinal cord injuries or musculoskeletal disabilities (e.g., spina bifida, osteogenesis imperfecta, cerebral palsy) will have to plan ahead before receiving anaesthesia).

Case Study 2:

Hiran, who has blindness, is very excited and happy that she is pregnant. However, her family is pressuring her to have an abortion because they are worried that the child may be born with a disability as well. Hiran is also worried because her sister-in-law, Hakima, gave birth to a female child and is regularly blamed by the family for the sex of the child and is mistreated. What advice would you give her?

Key Messages:

1. Women with disabilities have a right to become mothers and cannot be forced to abort their pregnancy. Yet, forced abortion and sterilisation are quite common in the case of women and girls with disabilities. Forced abortion is often based on harmful misconception that women with disabilities are not good mothers as well as the societal worth that is attached to a person with disability.
 2. It is not necessarily true that women with disabilities will give birth to children with disabilities. In fact, most disabilities are not passed from mother to child, but some such as spinal muscular atrophy and muscular dystrophy (diseases of the muscles and nerves), may pass from the mother to child.
 3. Children with disabilities can enjoy a full life and if Hiran, on assessing her ability to support a child, even if the child is born with a disability, would like to go ahead with the pregnancy, fears about the child having a disability should not be used to force her to abort.
 4. The sex of the child is not determined by the mother, but by the father. Usually, one half of the male sperm will produce a male child and the other half a female child. The sex of the child depends on the sperm that attaches to the egg.
 5. Cultures, values and traditions that denigrate a female child must be challenged and changed.
2. Women with disabilities may require support in some tasks, this does not diminish their role as mothers. They are still the ones making decisions and raising the child.
 3. Some other factors have been noted by parents with disabilities, as unique strengths. However, this research has been done with parents with disabilities in a different context and the realities may or may not be the same in the South Asia context depending on various factors, including socio-economic class.
 - In many cases, there is a possibility of more equitable distribution of care responsibilities – studies indicate that partners of women with disabilities tend to take on more equal responsibilities in childcare than partners of non-disabled women, yet they do not perceive that they have more childcare responsibilities than fathers or other partners of non-disabled women.⁵⁷
 - A Twitter chat on parenting with disabilities, among disabled parents, noted the following statements:
 - *“My strength comes from recognising my own limits. I see so many able-bodied parents who ignore theirs.”*
 - *“My kindergartener has learned so much about empathy. He has a deep understanding that everyone brings different strength.”*
 - *“It has made my kids more adaptive and flexible. Skills gonna serve them well in life.”*
 - *“Also sharing a disability with my children, I’ve been able to expose them to positivity about their disability.”*
 - *“My kids know their mom is not invincible and we are a team. We have to work together to keep our home functioning.”⁵⁸*

Case Study 3:

Sujata has a physical disability (spinal cord injury) and after some unsuccessful attempts, she is finally pregnant. Although she constantly receives negative messaging which says women with disabilities cannot be good mothers, she is fully confident of her abilities as a mother. What can be some of the responses to this harmful misconception that women with disabilities cannot be good mothers?

Key messages:

1. Women with disabilities are like any other mothers, who can also make mistakes in raising a child. A disability does not make a woman more susceptible to bad parenting choices and decisions, it has no impact.

Case Study 4:

Raktima has a hearing disability and is worried about taking care of her new born baby’s needs. What are some suggestions you can give Raktima for how she can manage the care needed by a new born?

Key Messages:

Some suggestions are as follows:⁵⁹

- **Comforting the baby:** Babies usually makes a lot of noise when they are hungry or not feeling well. So if you do not hear well, it is best for you to stay close to your baby as much as possible so you can see when your baby needs attention. Raktima can use sign language even if her baby can hear. In this way you are establishing a form of communication with your child for life.
- **Sleeping with the baby:** At night, sleep with the baby close to you so that you can feel the baby move. This might also alleviate some of your anxiety. If you cannot hear well, their movements can indicate to you when they need to be changed or fed.

Case Study 5:

Shammi has cerebral palsy and she, along with her partner want to adopt a child. She has come to you for advice.

Key Messages:

- Women with disabilities often experience discrimination and biased attitudes while trying to adopt a child and their fitness as mothers is often questioned.
- Women with disabilities should be able to adopt children, just as any other non-disabled person.
- Different forms of families, with single mothers, with sexual and gender diverse parents, are possible and should not have to face barriers in adoption.
- Adoption, however, depends on the country's laws and are usually determined by religious codes. For example, adoption in Bangladesh is controlled by Islamic law which does not allow for adoption, and only guardianship till age of majority is allowed. A person wishing to become a guardian must apply to the family courts and it is the discretion of the court to allow guardianship. However, a child through guardianship will have no right of inheritance. Under the Hindu law governing adoptions of Hindus in Bangladesh, adoption is allowed. However, only a Hindu male of "sound mind" can adopt, and the child must be of the same caste and only a son can be adopted. Hindu women cannot adopt on their own.⁶⁰

Key Messages:

1. Have a discussion on challenges faced by women with psychosocial disabilities, those who are neurodiverse and those with intellectual disabilities. Are the challenges similar or further heightened? Discuss the concept of legal capacity (see key terminologies), how laws restrict it and the impact it has on parenting decisions.
2. Those who do not identify as women, but have a uterus, can also become pregnant. Link the discussion back to the session on gender and sex characteristics. A person may have a uterus, but their gender identity (sense of how they see themselves) may not be that of a woman. Therefore, transmen and non-binary persons can also become pregnant.

**ACTIVITY 7.3:
MYTHS AND FACTS ON ABORTION****Objective:**

To understand the options available for menstrual regulation and to clarify myths around abortions.

Time:

45 Minutes

Materials Needed:

- Facilitator Handout 7.1

Process:

1. Share with the participants that you will be reading out different statements on menstrual regulation and the participants must share if they think the statement is true/false and their reasons.
2. The following statements are to be shared:
 - a. Statement 1: Any procedure to terminate pregnancy is illegal in Bangladesh.
 - b. Statement 2: I can terminate a pregnancy on my own by consuming readily available remedies at home, taking scalding baths or performing some rituals.
 - c. Statement 3: Having an abortion or menstrual regulation procedure does not affect your fertility.
 - d. Statement 4: People who resort to these procedures are irresponsible.
 - e. Statement 5: If these procedures are strictly prohibited by law, menstrual regulation/abortion will end.
3. For each statement, allow participants to share both sides, those who think the statement is false as well as those who think it is true, before the facilitator adds their input. This will ensure debate and co-learning among participants. Refer Facilitator Handout 7.1 for further details.

Debrief:

1. Why is menstrual regulation considered as taboo? What impact do such taboos have?
2. How is menstrual regulation linked to sexuality and reproductive rights?
3. Who should have the final say in deciding whether to undergo a menstrual regulation procedure or not?
4. Do only women need menstrual regulation/abortion services?

Key Messages:

1. A person's right to life and health is well protected, and this involves the right to make choices about their bodies and this needs to be respected.
2. While there are strong views about abortion by a married, non-disabled person, in the case of women with disabilities, there is often coercion to undergo abortion. This is based on misplaced ideas of the child being born with a disability, or a woman with disability not being a good mother. However, as we have discussed earlier, these are simply not true. Women with disabilities have a right to control their reproductive choices and should not be forced or coerced into an abortion.
3. While there are socio-cultural and religious messaging that frowns upon menstrual regulation, the choice and right of every person must be recognised and it is important to remember that banning menstrual regulation/abortions does not prevent them from taking place, it just pushes people into unsafe abortions with detrimental health consequences.
4. Pregnancy in the South Asian context is often a social phenomenon where different members of the family get involved. However, since it is the mother who will have to bear the health risks, undergo pregnancy and bear responsibility for raising the child, they should have the right to decide about their pregnancy. This is particularly important for women with disabilities who might be coerced by their families and/or partners to terminate pregnancy.
5. Reiterate the difference between a person's reproductive and sexual organs and their self-identified gender. A person may identify as transman and have a uterus, and therefore need access to menstrual regulation/abortion services. Unfortunately, the needs of these groups are often not considered, which makes access to services difficult for them and violates the rights of everyone to have access to appropriate health services.⁶¹

Notes for the Facilitator:

1. Strictly use the term menstrual regulation instead of abortion, as abortion is illegal in Bangladesh.
2. Prior to the session, acquaint yourself with laws and facts around menstrual regulation/abortion in Bangladesh.
3. As in the case of the session on contraception, people may have strong opinions, discomfort and moral value judgments on the issue. Reiterate that it is a legal procedure and people have a right to information. Draw attention to the ground rules of respect, confidentiality, no judgment and listening to one another.
4. There is a possibility that some participants may have undergone abortion. Handle the topic sensitively and ensure no value judgments are being made in the discussions.

Resources for Further Reading:

1. The website of Sexuality and Disability. Available at: [Link] www.sexualityanddisability.org.
2. Abha Khetarpal (2020). *Manual on Sexual and Reproductive Health & Rights of Women with Disabilities*.
3. Jane Maxwell, Julia Watts Belser, Darlena David (2007). *A Health Handbook for Women with Disabilities*, Berkeley, California: Hesperian, pp. 185-208 (Chapter 9: Family Planning).
4. The Empowered Fe Fes, *Take Charge!: A Reproductive Health Guide for Women with Disabilities*. Available at: [Link] <http://awrcsasa.ca/wp-content/uploads/2017/02/Take-Charge-Reproductive-Health-Guide.pdf>. Accessed on 21 August 2020.
5. Amba Gauri (2018). *What to expect when you're expecting (and happen to live with mental health issues)*, Skin Stories. Available at: [Link] <https://medium.com/skin-stories/what-to-expect-when-youre-expecting-and-happen-to-live-with-mental-health-issues-b8b19b2014d4>. Accessed on 20 August 2020.
6. CREA, *The Nairobi Principles on Abortion, Pre Natal Testing and Disability*. Available at: [Link] <https://nairobiprinciples.creaworld.org/>. Accessed on 21 August 2020.
7. Amba Salelkar (2017). *The dilemma when a pregnant woman seeks to abort a foetus with a detected disability*, The Scroll.
8. Shikha Aleya (2019). *Interview: Jeeja Ghosh*, In Plainspeak. Available at: [Link] <https://www.tarshi.net/inplainspeak/interview-jeeja-ghosh/>. Accessed on 20 August 2020.
9. Sharon Mazel, *Physical Disability During Pregnancy, what to expect*, 3 June 2019. Available at: [Link] <https://www.whattoexpect.com/pregnancy/pregnancy-health/physical-disability-during-pregnancy/>.
10. Rachel Mayes, Gwynnyth Llewellyn & David Mcconnell, (2006). 'Misconception: The Experience of Pregnancy for Women with Intellectual Disabilities', *Scandinavian Journal of Disability Research*, 8(23), p. 120-131.
11. Resources by the National Research Centre for Parents with Disabilities, The Heller School for Social Policy and Management, Brandeis University. Available at: [Link] <https://heller.brandeis.edu/parents-with-disabilities/>. Accessed on 20 August 2020.
12. Resources by Centre for Research on Women with Disabilities, Baylor College of Medicine. Available at: [Link] <https://www.bcm.edu/research/labs-and-centers/research-centers/center-for-research-on-women-with-disabilities>. Accessed on 20 August 2020.
13. Disabled Parenting Project. Available at: [Link] <http://www.disabledparenting.com/>. Accessed on 20 August 2020.
14. 'Through the Looking Glass' (Support Group for Families with Disabilities). Available at: [Link] <https://www.lookingglass.org/>. Accessed on 20 August 2020.

CHAPTER 2: STI, RTI, HIV AND AIDS

Activity 7.4: QUIZ ON STI, RTI, HIV AND AIDS

Objective:

To learn how STIs are transmitted and how that can be prevented; identify signs and symptoms of different STIs; and differentiate between myths and facts on STIs.

Time:

90 Minutes

Materials Needed:

- Flipchart
- Marker
- Four squeeze toys
- A small prize
- Facilitator Handout 7.2
- Participant Handout 7.2 and 7.3

Room Arrangement:

Chairs around four tables

Process:

1. Ask the participants if they have heard the term STI, RTI, HIV & AIDS. Ask them to share what they know.
2. Introduce the topics and cover the information provided in Participant Handout 7.2.
3. Give all the participants a copy of Participant Handout 7.2. and 7.3. and give 20-30 minutes to go over the information.
4. Share that the participants will be playing a game of quiz and explain how it is to be played.
 - a. The participants will be divided into four teams. Ask each team to give themselves a name.
 - b. Note down the names on a flipchart for scoring.
 - c. The quiz will comprise of two rounds of seven questions each. The first round is a question & answer session to gauge how much information from the Handouts has been understood by the participants. Round 2 will consist of true or false questions, which participants will have to answer based on external knowledge and information.
 - d. In Round 1, each correct answer gets 20 points. In case the team that goes first gives the wrong answer, another team can guess the answer for 10 points. In Round 2, there will be no passing and each correct answer will earn 20 points.
 - e. Once the question is completed, if a team thinks that they know the answer, they should press the squeeze toy (or raise their hands for participants with hearing disability, or any other form of signing agreed by participants). The team that indicates first, will first get the chance to answer.
 - f. The teams may refer to the Handouts.
 - g. The winner will receive a prize (indicate what).
5. Use Facilitator Handout 7.2 for the Quiz

Debrief:

1. What are the common things that you have heard about STI, RTI, HIV & AIDS? Do some of these messages cause stigma and discrimination against certain groups?
2. Is information on STIs, RTIs, HIV & AIDS important for persons with disabilities?
3. What are the barriers in accessing testing for STIs, RTIs, HIV and AIDS for persons with disabilities?
4. How is access to SRH services further impeded for persons with disabilities based on rural/urban status, ethnicity, caste, belonging to Adivasi communities, gender and sexual identity and orientation, and as refugees?

Key Messages:

1. STIs including HIV & AIDS continue to affect millions of people across the world and yet the issue is treated with fear, discomfort, indifference, and stigma. This makes it difficult for people to access knowledge, and necessary care and treatment.
2. Anyone can catch an infection. It is important to refrain from moral judgment and not perpetuate stigma and discrimination against certain groups, which further increases their vulnerability. Infection spreads on account of many reasons such as lack of information, lack of access to condoms, difficulty in negotiating condom usage, stigma by health care professionals, sexual violence etc.
3. It is an erroneous belief that women with disabilities do not need information on STIs including HIV & AIDS. This is based on the misconception that women and girls with disabilities are non-sexual and have no vulnerability to STIs. In fact, many studies have suggested that women with disabilities are in fact at a higher risk of contracting infection. These misconceptions prevent women and girls with disabilities from accessing information, receiving care and may aggravate the infection, causing life threatening situations.
4. Knowledge of STIs is important to reduce risk of transmission, prevent aggravated problems from the infection being untreated and also reduce risk of stigma and discrimination.
5. Intersecting identities such as rural/urban status, ethnicity, caste, gender identity, sexual orientation and becoming a refugee further impedes access to SRH information and services. For example, lack of awareness on how to interact with gender and sexually diverse people and stigma by health care professionals make it impossible to access health care services. Similarly, indigenous

groups are faced with lack of culturally sensitive and accessible SRH information and services, discrimination and bias by health care professionals, high costs and limited transport facilities.

Notes for the Facilitator:

1. Encourage participants to share existing knowledge and beliefs and correct misconceptions.
2. Update yourself on important local information on HIV & AIDS, including availability and cost of treatment, spread, and local organizations working on the issue.
3. The session must be conducted in an open and non-judgmental manner. Avoid painting certain groups as high risk, which increases stigma and discrimination. Focus instead on factors that increase vulnerability, how to avoid transmission and getting the necessary care.
4. Where possible, invite persons living with HIV as guest speakers, use real life stories and video aids.

Activity 7.5: DEMONSTRATION OF BARRIER METHOD

Objective:

To enable participants to know the right way of using condoms (male and female) and dental dam.

Time:

20-45 minutes, depending on format

Materials Needed:

- Banana/cucumber
- Condoms/balloons/fingers of surgical gloves
- Participant Handout 7.4

Room Arrangement:

Chairs around four tables

Process:

1. Explain to the participants that knowing the right way of using condoms and dental dams is key to ensuring good sexual and reproductive health, as they help in preventing transmission of most STIs.

Dental dams are latex/polyurethane sheets which can be used for oral sex involving the vagina and anus. It acts as a barrier to help prevent sexually transmitted infections passing from one person to another. While condoms are useful in sexual activity involving a penis, dental dams can be used for sexual activities involving oral sex. Dental dams can be cut out of condoms, as demonstrated in Participant Handout 7.4. If this is not available you can use plastic wrap such as cling film.

2. Explain the process by which the activity will be conducted.
3. You can use the images in Participant Handout 7.4. to explain how different barrier methods can be effectively used. Male and female condoms are effective in case of vaginal and anal sex, while a dental dam is effective for oral sex. You can also conduct a demonstration of using each of the barrier methods.
4. Share some important information about the usage:
 - Check for the expiry date. This is difficult for persons with visual disability as this information on packages is not provided in accessible formats. You can request help from a trusted friend/family member/partner.
 - They must be stored in a cool-dry place, as exposure to heat can spoil them.
 - Do not use oil-based lubricants, such as Vaseline, as this can damage the condom.
 - Condoms fit all size of penises and the lack of proper size of condom cannot be used as an excuse to not use a condom.
 - Check for tears in the condom/dental dam, while removing it. Tears will allow fluids to be exchanged and is therefore not an effective protection.
 - Condoms and dental dams cannot be used more than once.
 - Using condoms and dental dams does not prevent people from enjoying sensations during sex and cannot be a reason for a partner refusing to use them.

Variation (for persons with visual disability): For persons with visual disability, it is best to do a condom demonstration where each participant has a chance to understand how it is used and how to dispose it. Using real condoms may be difficult due to lack of availability, and/or cultural taboos. In such cases, you can use balloons and cut out fingers of surgical gloves for the demonstration. If you are using these instead of condoms, tell the participants that condoms are lubricated and feel wet to the touch.

In case a female condom is not available, describe how it looks and go through the steps of putting it on.

This should be followed by a demonstration of how a dental dam can be cut out from a condom.

Debrief:

1. How was the activity? Did the participants feel uncomfortable?
2. Do the participants feel confident about using condoms and dental dams?
3. How will you negotiate with a partner to use a condom or dental dam?

Key Messages:

1. While this can be a culturally sensitive topic, knowing how to use these barrier methods correctly allows women with disabilities to take their sexual and reproductive decisions in their hands and is key to ensuring good sexual and reproductive health, including preventing transmission of STIs.
2. Female condoms are often not widely available in the South Asia region. However, it is good for participants to know how to use it. Knowing how to use male condoms can enable participants to ensure that their partners use them correctly.
3. Latex condoms may not be viable for some persons with disabilities and polyurethane condoms may work better. Dexterity issues may also mean that support may be needed from the partner to open the package, wear the product and remove and dispose it properly. This must be communicated effectively between partners.
4. Dental dams may not be widely available. Explain the procedure of making a dental dam from a condom.

Note for the Facilitator:

Share with the participants beforehand about what the activity entails. Many participants may feel discomforted to touch condoms or participate in the activity. Reiterate that information on using these barrier methods is key to ensuring people are able to exercise their sexual and reproductive health rights. Also reiterate about the training space being a safe space. If despite that some participants do not wish to participate, do not force them. They can opt to listen to the instructions being shared or step out.

Resources for Further Reading:

1. Website of UNAIDS. Available at: [Link] <https://www.unaids.org/en>. Accessed on 22 August 2020.
2. Website of Ashar Alo Society, Peer Support Group of Persons with HIV and AIDS. Available at: [Link] <https://asharalo.org.bd/>. Accessed on 22 August 2020.
3. Jane Maxwell, Julia Watts Belser, Darlena David (2007). *A Health Handbook for Women with Disabilities*. Berkely, California: Hesperian, pp. 157-184 (Chapter 8: Sexual Health: Preventing Sexually Transmitted Infections including HIV/AIDS).
4. UNAIDS (2017). *Disability and HIV*.
5. OHCHR, WHO and UNAIDS (2009). *Disability and HIV Policy Brief*.
6. International HIV/AIDS Alliance (2010). *Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide*.



MODULE 7 PARTICIPANT HANDOUT 7.1 Page 1

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

Talking About Reproductive and Sexual Health Issues (TARSHI) (2006) *Basics and Beyond: A Manual for Trainers; Integrating Sexuality, Sexual and Reproductive Health and Rights*. New Delhi: TARSHI. Updated and inputs added from Abha Khetarpal (2020) *Manual on Sexual and Reproductive Health & Rights of Women with Disabilities*; and Jane Maxwell, Julia Watts Belser, Darlena David (2007). *A Health Handbook for Women with Disabilities*. Berkeley, California: Hesperian, pp. 185-208 (Chapter 9: Family Planning).

TABLE 1: BARRIER METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Cervical Cup and Diaphragm</p>  <p>They act as a physical barrier to block the cervix and prevent sperm from reaching the egg and to hold chemical spermicide to kill sperm.</p>	<p>When used correctly with spermicide, 92-96% effective at preventing pregnancy</p>	<ul style="list-style-type: none"> > Reusable after washing with soap and water. > Can be inserted six hours prior to intercourse and left in up to 48 hours for multiple acts of intercourse if more spermicide is added. > Does not interrupt intercourse. > Can be discontinued at any time. > Does not affect fertility. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Some people may have allergic reactions to spermicides/ the latex. > May be difficult for some people to insert. > Needs a health care provider to fit the cap (they come in different sizes). > If a person is at higher risk of HIV infection using spermicides that contain Nonoxydol-9 may increase the likelihood of transmission. 	<ul style="list-style-type: none"> > Before using check for holes, tears or cracks. > Apply spermicide to the cervical cap, and then insert it into the vagina and place the cap onto the cervix so the cervix is completely covered and the cap fits snugly. > Leave the cervical cap in place for at least eight hours after sex.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Should not be used if you are using other vaginal medications, like treatments for yeast infection, or during a menstrual period. The cap should be replaced every year. The cap needs to be refitted if a person has had a child vaginally, gains or loses more than 3 kgs, or had an abortion or a miscarriage, as these can affect the way the cap fits. > May not be suitable if you have limited hand movement, cannot reach your vagina, cannot open your legs very wide or get muscle spasms in your upper legs. 				
<p>Female Condom</p>  <p>A polyurethane pouch that has a flexible ring at both ends. It is approximately three inches wide and seven inches long.</p>	<p>79- 95%</p>	<ul style="list-style-type: none"> > Reduces the risk of STI and HIV transmission. > Can be used by those with latex allergies. > Can be inserted up to eight hours prior to intercourse. > Can increase pleasure for both partners because the rim of the outer ring stimulates the clitoris and testes during sex. > Does not affect fertility. 	<ul style="list-style-type: none"> > Can be expensive. > Not easily available. > It may be difficult to insert. 	<ul style="list-style-type: none"> > Add lubricant. > Insert the closed end of the condom deep into the vagina to cover the cervix. The open end stays outside the vagina to partially cover the labia. > After sex, remove the condom by twisting the outer ring and pulling it out gently to avoid spilling any semen.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Do not use the male and female condom together. Recommendations for the female condom indicate a single usage for each condom. > May not be suitable if you have limited hand movement, cannot reach your vagina, cannot open your legs very wide or get muscle spasms in your upper legs. 				

MODULE 7 PARTICIPANT HANDOUT 7.1 Page 2

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 1: BARRIER METHODS

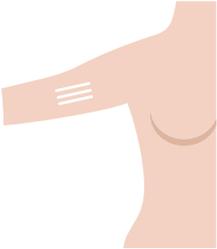
FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Male Condom</p>  <p>A sheath of latex or plastic that is worn on the penis. Comes rolled up in a wrapper.</p>	98%	<ul style="list-style-type: none"> > Reduces the risk of STI and HIV transmission. > Usually inexpensive and easily accessible. > Available in various textures, flavours, sizes, colours and brands. > Does not affect fertility. 	<ul style="list-style-type: none"> > May break or rip if used incorrectly. > Can disrupt spontaneity during sex. > If stored incorrectly (in warm/moist conditions) the condom can begin to disintegrate. > Some people may have allergic reactions to the latex. 	<ul style="list-style-type: none"> > Put the condom on after the penis is erect. > Squeeze the air out of the closed end of the condom and place it on the head of the penis. Hold it in place and unroll it completely on to the penis. Let go of the tip when unrolled. > After sex, the man should withdraw before the penis goes soft in order to avoid spillage of semen.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Necessary to check expiry date and whether electronically tested. > Latex condoms should not be used with oil-based lubricants (like lotion or oil). Using water-based lubricants with the condom can reduce condom failure (such as breakage). > Do not use a male and female condom together, and use the condom only once. > If you're sensitive to latex, you can use polyurethane or polyisoprene condoms instead. > For those who have limited hand movement, putting on a condom may require additional support. 				
<p>Intra-Uterine Device (IUD)</p>  <p>A small, flexible device (sometimes T-shaped) inserted into the uterus. There are two types of IUDs - non-hormonal (also known as a Copper T) and hormonal. An IUD works at preventing fertilisation by altering the uterine environment. A hormonal IUD also contains progestin that thickens cervical mucous making it more difficult for sperm to enter the uterus to fertilise an egg.</p>	92-99%	<ul style="list-style-type: none"> > The non-hormonal IUD can be left in place for up to 10 years. The hormonal IUD can be kept in place for up to five years. > Does not interrupt intercourse. > The progestin in the hormonal IUD can help relieve menstrual cramps and bleeding. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > In the first few months after insertion, a person may experience cramps or backaches. > It can increase menstrual bleeding, cramping or spotting between menstrual periods. > Needs to be inserted by a health care provider in clean hygienic surroundings. > Increased risk for pelvic inflammatory disease (PID) in the first 20 days after insertion. 	<ul style="list-style-type: none"> > A health care provider will insert the IUD. > Variants are available for different durations – three, five, seven or even ten years.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > If any side effects are experienced within the first month after insertion, contact a health care provider. > Make sure the IUD is in place regularly by checking the two small strings that hang down from the IUD into the upper vagina. > Fertility can return a month after an IUD is removed. > It should be recommended to women who have less sensation in the lower body only after careful evaluation. With a decreased level of sensation they may not feel the symptoms of complications. 				

MODULE 7 PARTICIPANT HANDOUT 7.1 Page 3

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 1: BARRIER METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Combined Oral Contraceptive Pills (COCS)</p>  <p>Contain the hormones of oestrogen and progestin. The combination of these two hormones primarily work to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.</p>	<p>92-99%</p>	<ul style="list-style-type: none"> > Easy to administer. > There are many types of COCs to choose from. > Reduces menstrual flow for some women. > Can decrease the risk of some diseases such as PID, some cancers, or benign breast disease. > Does not interrupt intercourse. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Must be taken every day at the same time and requires a regular supply. 	<ul style="list-style-type: none"> > Take one pill every day for 21-25 days depending on the type of COC. > A doctor/health care provider can help determine which COC is best for each woman and when to start the pills. > Must be taken daily at the same time.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Should not be used if you have blood clots, have migraine headaches or are over 35 years and smoke. > Once COCs are stopped, regular fertility levels will return in approximately three months. It may take a month or two for periods to become regular after stopping. COCs can be used by women who are breastfeeding, after six months of regular breastfeeding. > The effectiveness of hormonal contraceptives depends on medications already being used. Oestrogen content in the pills may not be suitable for persons with reduced mobility. > Some physical disabilities also affect bone density, such as cerebral palsy, anorexia, and congenital conditions where osteoporosis (low bone density) is a concern. Contraceptives that contain progesterone impact bone density, and may not be suitable for some. 				
<p>Implants</p>  <p>Small, plastic tubal implants that are inserted under the skin of a woman's arm. These implants slowly release hormones that primarily work to thicken cervical mucous to prevent sperm from entering the uterus and prevent ovulation.</p>	<p>99%</p>	<ul style="list-style-type: none"> > Lasts for 3-5 years. > Does not interrupt intercourse. 	<ul style="list-style-type: none"> > Can cause temporary side effects such as nausea and breakthrough bleeding which usually last the first three months. > Does not reduce risk of STI and HIV transmission. > Some severe side effects have been reported. > Can cause weight gain, irregular bleeding, and lower abdominal pain. > Can be visible through the skin. 	<ul style="list-style-type: none"> > A health care provider will insert the implant under the skin in minor surgery. > The implants are inserted within the first seven days of a menstrual cycle.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > A good option for those who cannot take oestrogen based contraceptives (mobility issues), but not suitable if likely to have bone density issues because of the progesterone. > Suitable for those who may not be able to take oral pills every day. 				

MODULE 7 PARTICIPANT HANDOUT 7.1_Page 4

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 1: BARRIER METHODS

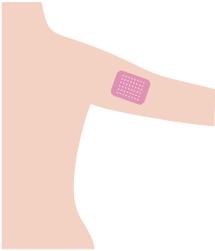
FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Injectables</p>  <p>An intramuscular injection contains progestin and is given every 12 weeks. The shot slowly releases the hormone into the body. This primarily works to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.</p>	97-99%	<ul style="list-style-type: none"> > For some injectables, protection against pregnancy can last for three months. > Does not interrupt intercourse. > Decreased risk for some cancers. > Decrease in menstrual flow and in menstrual cramps. Can be used for women who are breastfeeding. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV. > A health care provider must administer the shot. > Possible side effects include weight gain, irregular bleeding, breast tenderness, headaches, mood swings, loss of bone density that can increase the risk for osteoporosis. 	<ul style="list-style-type: none"> > A health care provider will administer the shot in the arm or buttocks.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > It can take up to one year for fertility to return. Some women may stop having their period or have large gaps in between menstrual cycles when on an injectable. > A good option for those cannot take oestrogen based contraceptives (mobility issues), but not suitable if you are likely to have bone density issues because of the progesterone. > Suitable for those who may forget to take oral pills every day. 				
<p>Mini Pill</p>  <p>A progestin only pill. It primarily works to thicken the mucous around the cervix to prevent sperm from entering the uterus. Also prevents ovulation.</p>	87-99%	<ul style="list-style-type: none"> > Easy to administer. > Does not interrupt intercourse. > Can be used by those who cannot take oestrogen. > Those who are breastfeeding can use the mini-pill. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Must be taken at the same time every day. > You may have irregular periods or spotting in between periods. 	<ul style="list-style-type: none"> > Take one pill every day at the same time.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Should not be used by those who have certain conditions or diseases such as liver disease or breast cancer. > Fertility will return immediately or within a few months after discontinuing the mini-pill. > Should not be used by those with bone density issues. 				

MODULE 7 PARTICIPANT HANDOUT 7.1 Page 5

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 1: BARRIER METHODS

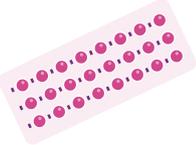
FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Patch</p>  <p>A small adhesive patch. It contains oestrogen and progestin which are gradually released into the blood and primarily work to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.</p>	<p>99%</p>	<ul style="list-style-type: none"> > Does not interrupt intercourse. > Can reduce menstrual flow for some women. > Can decrease the risk of some conditions and diseases such as PID, some cancers, or benign breast disease. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Visible on the skin. > Can cause possible skin irritations and temporary side effects such as nausea and spotting in between periods that usually last for the first three months of use. 	<ul style="list-style-type: none"> > Each patch lasts for one week. You change the patch every week for three weeks, then have a week off without a patch. > The patch can be worn on the lower, upper torso or arms, abdomen, buttocks.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Those who have blood clots, are breast-feeding, have migraine headaches or women over 35 years who smoke should not use the patch. Efficacy is also lower if you weigh over 90 kilograms. > Can cause complications for those with mobility issues because of the Oestrogen and progesterone can affect those with bone density issues. > Women with upper arm amputation need to take implantation on their leg. Heavy bleeding can cause hygiene issues in women with mobility impairment. Anticonvulsant medicines would not act properly if these implants are done. > Most effective when used in conjunction with other barrier methods, but used on its own, it is better than no contraception method. 				
<p>Spermicides</p>  <p>Pessaries, foams, creams, gels, suppositories, or tablets that are placed in the vagina. They contain chemicals that kill sperm.</p>	<p>71-82%</p>	<ul style="list-style-type: none"> > Available in many forms. > Can be left in for 6-8 hours. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > May weaken latex condoms making them less effective. > Can have an unpleasant taste or smell. > If a woman is at higher risk of HIV infection using spermicides that contain nonoxydol-9 may increase the likelihood of transmission. 	<ul style="list-style-type: none"> > Put the spermicide deep into the vagina. > Must be inserted 10-15 minutes prior to intercourse. > Leave it in place for 6-8 hours after having sex. > Do not douche (spray water or other solutions, such as vinegar, baking soda, or douching solutions into the vagina) after insertion.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Most effective when used in conjunction with other barrier methods, but used on its own, it is better than no contraception method. 				

MODULE 7 PARTICIPANT HANDOUT 7.1 Page 6

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 1: BARRIER METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Vaginal Ring</p>  <p>A soft, plastic, flexible ring that goes into the vagina. The ring slowly releases oestrogen and progestin hormones into the body that primarily work to prevent ovulation and thicken cervical mucous to prevent sperm from entering the uterus.</p>	<p>92-99%</p>	<ul style="list-style-type: none"> > Does not interrupt intercourse. > Can reduce menstrual flow for some women. > Decreases the risk of some conditions and diseases such as PID, some cancers, or benign breast disease. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Some side effects can include, irregular bleeding, breast tenderness, headaches, nausea, and weight gain. > It may be difficult to insert. 	<ul style="list-style-type: none"> > You leave it in for 21 days, then remove it and have a seven-day ring-free break. You're protected against pregnancy during these seven days. > New ring is inserted after seven days.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > The ring should not be removed during sexual intercourse. > Those who have blood clots, are breastfeeding, have migraine headaches or are over 35 years and smoke should not use the vaginal ring. > May not be suitable if you have limited hand movement, cannot reach your vagina, cannot open your legs very wide or get muscle spasms in your upper legs. 				
<p>Emergency Contraceptive Pills</p>  <p>Also known as the 'morning-after pill'. ECPs are higher dosages of the hormones found in regular oral contraceptive pills. They can be taken up to 3-5 days after unprotected sex or contraceptive failure to prevent pregnancy. EC works to prevent fertilisation, inhibit ovulation or alter the uterine lining preventing implantation of an egg.</p>	<ul style="list-style-type: none"> > Up to 94% effective if taken within 24 hours. > It is up to 79% effective if taken within five days. 	<ul style="list-style-type: none"> > Easy to use. > The side effects are short-term. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > ECPs can only be used up to five days after unprotected sex or contraceptive failure. > Some side effects are nausea, or vomiting, breast tenderness, late or early onset of the next period with heavier or lighter flow. 	<ul style="list-style-type: none"> > Take ECPs as soon as possible after unprotected sex/contraceptive failure. > A copper bearing IUD can also be used as an emergency contraceptive.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > This is not a long term contraceptive option and should be used for emergency only. > ECPs do not cause an abortion and should not be confused with the abortion pill. If you are already pregnant when you take EC, it will not interrupt the pregnancy. > If EC is taken mistakenly during a pregnancy, it will not harm the foetus. > Taking EC will not harm your ability to become pregnant in the future. 				

MODULE 7 PARTICIPANT HANDOUT 7.1 Page 7

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 2: NON-HORMONAL /NON-CHEMICAL METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Abstinence</p>  <p><i>Defined as either choosing to abstain from any sexual activity, or refraining from any penetrative sexual acts (such as anal or vaginal sex), while participating in other sexual acts (such as oral sex).</i></p>	<p>100% if abstaining from any sexual activity.</p>	<ul style="list-style-type: none"> > Nothing to purchase. > Can be discontinued at any time. > Reduces the risk of STI and HIV transmission. 	<ul style="list-style-type: none"> > Potential to transmit some STIs, such as syphilis if there is skin to skin contact during sexual activity other than intercourse. 	<ul style="list-style-type: none"> > Can include periodic abstinence, in which an individual refrains from sexual activity from time to time (such as during ovulation), or constant abstinence in which an individual refrains from sexual activity at all times.
<p>OTHER INFORMATION: Requires the cooperation of both partners, which may not be possible at all times.</p>				
<p>Basal Body Temperature</p>  <p><i>A fertility awareness method (FAM), where a woman takes her body temperature each morning to determine the fertile phase in her menstrual cycle. During the fertile period, pregnancy can be prevented by voluntarily avoiding sex or using other forms of contraception.</i></p>	<p>With other FAMs 75-99%</p>	<ul style="list-style-type: none"> > Nothing to purchase. > Can help in better understanding reproductive physiology. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Takes time to learn the fertile phase and requires a commitment to checking every day. 	<ul style="list-style-type: none"> > Record temperature with a thermometer as soon as you wake up. > A temperature rise indicates that ovulation has occurred. The fertile period lasts for three consecutive days after this increase in temperature.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Women are advised to not eat, drink, or smoke before taking their temperature. > May be difficult to use this method during times of stress, illness or lack of sleep because these factors can affect body temperatures. 				

MODULE 7 PARTICIPANT HANDOUT 7.1 Page 8

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 2: NON-HORMONAL /NON-CHEMICAL METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Calendar (Rhythm) Method</p>  <p>A fertility awareness method (FAM), this requires recording and calculating the number of days in the menstrual cycle to determine the fertile phase in the cycle. During the fertile period, pregnancy can be prevented by voluntarily avoiding sexual intercourse or using another contraceptive method.</p>	<p>With other FAMs 75-99%</p>	<ul style="list-style-type: none"> > Nothing to purchase. > Can help in better understanding reproductive physiology. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Takes time to learn the fertile phase and requires a commitment to recording the menstrual cycle each month. 	<ul style="list-style-type: none"> > Keep a written record of each menstrual cycle, counting from the first day of one menstrual period up to, but not including, the first day of the next. > Keep records of six cycles. > To find the start of the fertile days take the shortest cycle recorded and subtract 18. > To find the end of the fertile phase, take the longest cycle recorded and subtract 11.
<p>OTHER INFORMATION: This method may be difficult to use for someone with irregular periods.</p>				
<p>Coitus Interruptus</p> <p>Withdrawal method in which the penis is completely removed from the vagina before ejaculation.</p>		<ul style="list-style-type: none"> > Nothing to purchase. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Can be highly ineffective at preventing pregnancy because pre-ejaculatory fluid secreted from the penis after erection also contains sperm that can enter the vagina during penetration. > Can interfere with sex and make partners worry about withdrawing 'in time'. 	<ul style="list-style-type: none"> > Before ejaculating, the penis needs to be removed from the vagina. > Your partner must be able to anticipate and control their ejaculation.
<p>OTHER INFORMATION: Requires cooperation from both partners.</p>				

MODULE 7 PARTICIPANT HANDOUT 7.1 Page 9

CONTRACEPTIVE CHOICES

(Activity 7.1: Conception, Contraception and Pregnancy)

TABLE 3: PERMANENT METHODS

FORM OF CONTRACEPTION AND DESCRIPTION	EFFICACY	ADVANTAGES	DISADVANTAGES	USAGE
<p>Tubectomy or Tubal Ligation</p>  <p><i>A surgical procedure that blocks the fallopian tubes. The procedure prevents an egg from travelling from the ovary to the uterus and sperm from reaching the egg to fertilise it.</i></p>	Nearly 100%.	<ul style="list-style-type: none"> > Does not interrupt intercourse. 	<ul style="list-style-type: none"> > Permanently prevents pregnancy. > Does not reduce risk of STI and HIV transmission. > Can be emotionally difficult for women who see it as an inability to have more children. > Complications such as infection can occur from the surgery. > Reversal is difficult and requires a highly skilled medical practitioner. 	<ul style="list-style-type: none"> > There are surgical and non-surgical options. > In the surgical procedure the fallopian tubes are cut, sewn or tied. > In a non-surgical procedure small metal implants are inserted into the fallopian tubes.
<p>OTHER INFORMATION:</p> <ul style="list-style-type: none"> > Over time scar tissues grows over these implants and blocks the fallopian tubes. > The patient can leave soon after these procedures are completed. > Does not affect menstrual periods, ability to have an orgasm, and nor does it cause menopause. > Must be conducted with the consent of the person. Often women and girls with disabilities are forced into these procedures. 				
<p>Vasectomy</p> <p><i>A surgical procedure that seals the vas deferens preventing sperm from getting into semen. After a vasectomy, a man still produces semen but there is no sperm it.</i></p>	Nearly 100% effective at preventing pregnancy.	<ul style="list-style-type: none"> > Does not interrupt intercourse. > Permanently prevents pregnancy. > Complications are rare. > Takes around 15-30 ejaculations after the operation to clear out the sperm already in the vas deferens – during this time an alternative contraception should be used. > Does not affect ability to have an erection, ejaculation, or the ability to have an orgasm. 	<ul style="list-style-type: none"> > Does not reduce risk of STI and HIV transmission. > Can be emotionally difficult. > Reversal surgeries are not highly successful. 	<ul style="list-style-type: none"> > A health care provider will cut and seal the two vas deferens. > Can be done by the standard method or the no-scalpel technique (non- invasive). > The patient can leave soon after the procedure is completed.

MODULE 7_ FACILITATOR HANDOUT 7.1

MYTHS AND FACTS ON ABORTION

(Activity 7.3: Myths and Facts on Abortion)

STATEMENT 1: Any procedure to terminate pregnancy is illegal in Bangladesh.

FALSE. While induced abortion, except to save a woman's life, is prohibited under the Penal Code, menstrual regulation has been part of Bangladesh's national family planning programme since 1979. Menstrual regulation refers to the use of medicines or medical procedures to regulate the menstrual cycle when menstruation is absent for a short duration, in short it allows for pregnancy to be terminated within a specified time period.

STATEMENT 2: I can terminate a pregnancy on my own by consuming readily available remedies at home, taking scalding baths or performing some rituals.

FALSE. Trying to self-abort can have serious repercussions on your health, life, and ability to become pregnant in the future. It can also be fatal in some cases.

In Bangladesh, two forms of menstrual regulation are allowed and it is best to avail these services at a health care clinic. The first is medical menstrual regulation through the use of mifepristone and misoprostol pills. The first medication that is taken is mifepristone which blocks the hormones needed for the pregnancy and detaches the fertilised egg from the uterine wall. The second medication, misoprostol, is taken within 24-48 hours of the first medicine and it causes the body to expel the fertilised egg and the lining that had developed to support it. It is non-invasive and reliable. This form of medical menstrual regulation is allowed up to nine weeks from the last date of menstruation in Bangladesh.

The second option is through a procedure which is called "manual vacuum aspiration", where a small tube is inserted into the uterus, and through gentle suction, it removes the contents and the lining of uterus. It involves the use of anaesthesia to perform the procedure. The procedure itself takes about 10 minutes. In Bangladesh, this form of menstrual regulation procedure is allowed up to 10-12 weeks from the last date of menstruation.

Since the pills involve regulation of hormones and the procedure involves use of anaesthesia, it is best for women with disabilities to discuss complications and its management with the healthcare professional.

STATEMENT 3: Having an abortion or menstrual regulation procedure does not affect your fertility.

TRUE. Abortion/menstrual regulation, when performed under the supervision of healthcare professionals, has no impact on a person's ability to reproduce in the future. In fact, a person can get pregnant immediately after undergoing menstrual regulation procedure. There is no statistical data to back claims that fertility is affected, or that it causes breast cancer and other diseases. This is a myth.

STATEMENT 4: People who resort to these procedures are irresponsible.

FALSE. There are many reasons why a person may choose to undergo menstrual regulation. It could be because they do not want children; they became pregnant as a result of failed contraceptive; the timing of the pregnancy is not right; socio-economic factors, such as financial support and non-availability of support system; age; health concerns etc. The reasons are innumerable. Each person should have the right to decide if and when they want to have a child and should be allowed to make that decision for themselves based on their assessment.

STATEMENT 5: If these procedures are strictly prohibited by law, menstrual regulation/abortion will end.

FALSE. When menstrual regulation is criminalised, it forces women to undergo unsafe abortions which can seriously impact their health, cause infections and diseases, affect future fertility and may even result in death. In Bangladesh, an estimated 384,000 women suffered complications from clandestine abortion in 2014.⁶² Unsafe and clandestine abortion affects rural poor women the most, as they are not able to get fertility-based care for complications from unsafe abortions. Unsafe abortions also contribute to maternal mortality.

MODULE 7 PARTICIPANT HANDOUT 7.2 Page 1

STI, RTI, HIV AND AIDS

(Activity 7.4: Quiz on STI, RTI, HIV and AIDS)

STI (Sexually Transmitted Infections)

Sexually Transmitted Infections are infections that are usually transmitted through sexual activity involving vaginal sex, anal sex and oral sex. They are quite common. Many people do not show any symptoms. They are easy to test for and are treatable. However, if they are left untreated, they can cause serious health complications. Refer Participant Handout 7.3. for details about different STIs.

RTI (Reproductive Tract Infections)

Reproductive Tract Infections are infections of the reproductive tract. While some RTIs are sexually transmitted, others are not. RTIs consist of three types: those that are sexually transmitted (such as Gonorrhoea, chlamydia, syphilis, trichomoniasis, genital herpes, genital warts, HIV); endogenous, caused by microorganisms present in the vaginal tract (yeast infections and bacterial vaginosis); and iatrogenic, provoked by medical procedures or following examination or intervention during pregnancy, childbirth, or in family planning (e.g., IUD insertion) and gynaecology settings. Infection may be pushed through the cervix into the upper genital tract and cause serious infection of the uterus, fallopian tubes and other pelvic organs.

HIV and AIDS

HIV (Human Immunodeficiency Virus) is a type of virus that attacks the cells of the immune system that help the body to fight infection. Through the use of antiretroviral therapy, ART, (a combination of medicines), the virus can be prevented from multiplying and affecting the body's capacity to fight diseases. While HIV is often transmitted through sexual contact, it can be transmitted through other routes as well. If left untreated, it may progress to the stage of AIDS (Acquired Immunodeficiency Syndrome). At this later stage, the body loses its ability to fight infections, making a person more vulnerable to other infections and diseases. However, this progression to AIDS can be prevented through ART.

While, there is no cure for HIV and AIDS, ART is an effective treatment. ART uses a combination of medicines that prevents the virus from multiplying, and therefore reduces the viral load. Regular use of ART throughout a person's life can keep the viral load suppressed allowing the person's immune system to function, and ensuring they can continue to live their lives as usual. ART, by suppressing virus load, also prevents further transmission.

1. Transmission

HIV is found in certain bodily fluids of people living with HIV, including blood, semen, vaginal fluids, rectal fluids and breastmilk. It can be transmitted in the following ways:

- Unprotected vaginal or anal sex, and, in very rare cases, through oral sex with a person living with HIV;
- Blood transfusion of contaminated blood;
- Sharing of needles, syringes, other injecting equipment, surgical equipment or other sharp instruments such as blades and scissors; and
- From a mother living with HIV to the child during pregnancy, childbirth or breastfeeding.

However, if the person is using ART and their virus load is suppressed and not detectable, their chances of transmitting HIV is significantly reduced.

2. Prevention

The following are effective ways to prevent infection:

- a. Taking PrEP (pre-exposure prophylaxis). PrEP is an HIV prevention method in which people who do not have HIV take medicines daily to reduce their risk of getting HIV in case they are exposed to the virus. PrEP can stop HIV from taking hold and spreading throughout your body.
- b. Taking PEP (post-exposure prophylaxis) within 72 hours. It is a short course of HIV medicines that must be taken within 72 hours of possible exposure to HIV in order to prevent the virus from taking hold in your body. It is taken daily, usually for a period of four weeks. It is not meant for regular use. After an incident of sexual abuse, discuss the need for this medicine with health care professionals.
- c. Using condoms and dental dams. Condoms and dental dams are highly effective at preventing HIV infection, if used in the right way every time you have sex.
- d. Using clean and sterilised needles. Ensure that needles and syringes are not shared and are sterilised before each use.
- e. Vigilance during blood transfusion. Ensure that blood at the time of transfusion has been analysed for possibility of carrying HIV.

MODULE 7 PARTICIPANT HANDOUT 7.2 Page 2

STI, RTI, HIV AND AIDS

(Activity 7.4: Quiz on STI, RTI, HIV and AIDS)

- f. Regular STI testing. If you are sexually active, it is best to get tested at least twice a year. Having other STIs increases the risk of contracting HIV through the presence of sores, through which HIV can enter the body. STIs can also have long-term health consequences.
- g. Encourage the partner living with HIV to stay on ART. If you do not have HIV and have a partner living with HIV, regular use of ART can reduce the risk of transmission significantly.

3. Testing

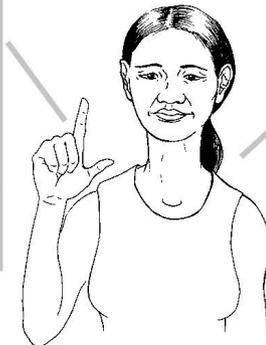
It is important to get tested for STIs, including HIV, regularly as many of the infections do not have any symptoms. While getting tested, follow the 5Cs rule: consent, confidentiality, counselling, correct results and connection with treatment and other services.

Ensuring confidentiality can be difficult for women with disabilities, especially if they have difficulty communicating and need a support person.

FIGURE 39: CONFIDENTIALITY IN STI TESTING.

Because I am deaf, I often have trouble with privacy, especially when I use an interpreter to speak with a health worker.

The interpreter who works at the clinic I go to knows that whatever the health worker and I talk about is confidential and private. She will never tell anyone—not even another health worker—what we have talked about.



If I take my own interpreter with me, I remind her ahead of time that whatever I talk about with the health worker is private. I try to make sure the interpreter understands that the test results are private. I ask her not to tell anyone else—not even my family—without my permission.

Source: Jane Maxwell, Julia Watts Belser, Darlena David (2007), *A Health Handbook for Women with Disabilities*, Berkeley, California: Hesperian.

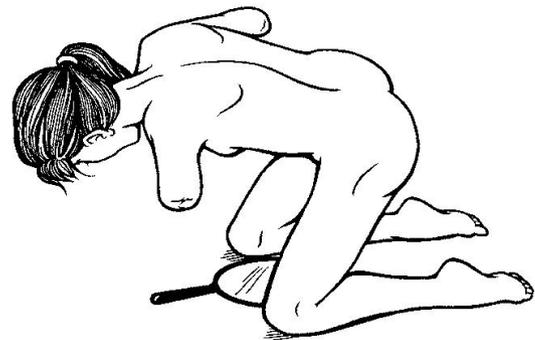
CHECKING FOR STIs

(The information provided below is an extract from Jane Maxwell, Julia Watts Belser, Darlena David (2007). A Health Handbook for Women with Disabilities. Berkeley, California: Hesperian)

“If you are blind: When you wash your genitals, use your fingers to feel for any unusual discharge, lumps or soreness. Do this once a week. If you do it every day, it will be difficult for you to notice any changes.

If you have little or no hand control: If you are unable to use your fingers to feel your genitals for any changes, try to use a mirror to look for them instead. If you cannot hold the mirror, put it on the floor and crouch over it.

FIGURE 40: A PERSON WITH LIMITED UPPER LIMB MOBILITY CHECKING FOR STIs USING A MIRROR



Source: Hesperian, *A handbook for Women with Disabilities*.

MODULE 7 PARTICIPANT HANDOUT 7.2 Page 3

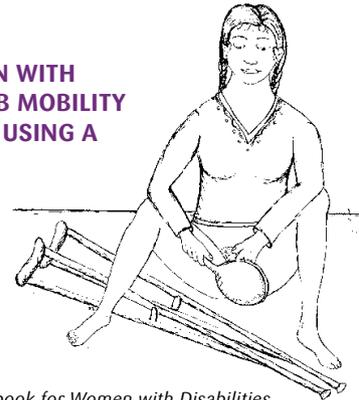
STI, RTI, HIV AND AIDS

(Activity 7.4: Quiz on STI, RTI, HIV and AIDS)

If you have a spinal cord injury: If you can feel and look at your genitals, do this once a week while you bathe. If you are unable to do this yourself, ask someone you trust to help you. You will probably not be able to feel if there is any pain in your belly or itching in your genitals. But if you have an STI and it does not get treated early, you may get dysreflexia. This is dangerous.

If you have limited or no movement in your legs: If possible, find a position in which you can either feel your genitals with your fingers while you wash, or use a mirror to look at them. If necessary, ask someone you trust to hold your legs steady.⁶³

FIGURE 41: A PERSON WITH LIMITED LOWER LIMB MOBILITY CHECKING FOR STIS USING A MIRROR



Source: Hesperian, A handbook for Women with Disabilities.



Fight against the conditions that lead to the spread of disease and not against the people who are infected. Discrimination is an obstacle to care. It may stop people from learning how to prevent the spread of infection.

Remember:
Information and care is key, and not stigma and discrimination.

Source: Hesperian, A handbook for Women with Disabilities.

MODULE 7 PARTICIPANT HANDOUT 7.3 Page 1

INFORMATION ON STIs AND RTIs

(Activity 7.4: Quiz on STI, RTI, HIV and AIDS)

TABLE 4: TYPES OF STIs AND RTIs

TYPE OF INFECTION	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION
Chlamydia	<p>Primarily through fluids (semen, pre-ejaculate and vaginal fluids) during vaginal sex, anal sex and oral sex.</p> <p>May also pass from pregnant woman who has chlamydia to the child at the time of birth.</p>	<p>Usually no symptoms. If there are symptoms it is usually in the form of burning sensation during urination, abnormal discharge from the penis or vagina. For females it can also cause abnormal bleeding during menstruation or during sexual intercourse. In case of rectal infection, it can cause rectal pain and bleeding.</p>	Antibiotics	Use of male/female condom or dental dam during vaginal, anal and oral sex.
	<p>COMPLICATIONS FROM NOT TREATING: Can cause pelvic inflammatory disease, pelvic pain, affect ability to get pregnant and may also cause pregnancy to occur outside the uterus.</p>			
Gonorrhoea	<p>Primarily through fluids (semen, pre-ejaculate and vaginal fluids) during vaginal sex, anal sex and oral sex.</p> <p>May also pass from pregnant woman who has gonorrhoea to the child at the time of birth.</p>	<p>Usually no noticeable symptoms for females. If there are symptoms, it may include discharge or burning during urination or ejaculation, pain in the lower abdomen or back, pain during intercourse, discharge from the vagina, bleeding between menstrual periods, nausea, or fever.</p>	Antibiotics	Use of male/female condom or dental dam during vaginal, anal and oral sex.
	<p>COMPLICATIONS FROM NOT TREATING: Can cause pelvic inflammatory disease, scar tissues on fallopian tube, pelvic pain, affect ability to get pregnant and may also cause pregnancy to occur outside the uterus.</p>			
Syphilis	<p>Direct contact with a syphilis sore during vaginal, anal, or oral sex.</p> <p>Can also spread from infected mother to foetus.</p>	<p>Primary stage: Sore where the infection entered your body, including vulva, vagina, anus, penis, scrotum, and sometime your lips or mouth.</p> <p>Secondary stage: rashes on the palms of your hands, soles of your feet, or other parts of your body. You may also have a slight fever, feel tired, have a sore throat, swollen glands, headache, and muscle aches.</p>	Antibiotics	Use of male/female condom or dental dam during vaginal, anal and oral sex. Avoid sexual intercourse till sores are treated and healed.
	<p>COMPLICATIONS FROM NOT TREATING: If left untreated it can spread to the brain, the nervous system and the eye.</p>			

MODULE 7 PARTICIPANT HANDOUT 7.3 Page 2

INFORMATION ON STIs AND RTIs

(Activity 7.4: Quiz on STI, RTI, HIV and AIDS)

TABLE 4: TYPES OF STIs AND STIs

TYPE OF INFECTION	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION
Genital Herpes	<p>Skin-to-skin contact with infected areas, often during vaginal, oral and anal sex, and kissing.</p> <p>Transmission is possible even without an outbreak of sores. Can be transmitted from mother to new born during childbirth.</p>	<p>Often no noticeable symptoms. May cause one or more sores, blisters, pimples, bumps, or a rash around mouth, genitals or anus, and itching, pain or burning or discomfort because of sores. If caused by HSV-2 strain, it can cause swollen glands, fever, chills, ache and tiredness.</p>	<p>No cure but medications can reduce the frequency and duration of outbreaks.</p>	<p>Avoid sexual intercourse during an outbreak. Use of male/female condom or dental dam during vaginal, anal and oral sex.</p>
	<p>COMPLICATIONS FROM NOT TREATING: People with low immunity may suffer infections of various organs including kidneys, eyes, brain etc.</p>			
HPV (Human Papilloma Virus) and Genital Warts caused by some strains of HPV)	<p>Most common form of STI. Skin-to-skin contact during anal, vaginal and oral sex. Genital touching.</p> <p>Can be transmitted from mother to new born during childbirth.</p>	<p>Most feel no symptoms and are absolutely fine. If genital warts is caused by specific strains of HPV, there may be fleshy, soft bumps that sometimes resemble miniature cauliflower on genitals and anus.</p>	<p>No cure but preventable. Warts can be removed using creams and surgery, or laser treatment.</p>	<p>Vaccines for certain strains of HPV that cause cervical cancer.</p> <p>Regular check-ups including pap smears, which can detect abnormal changes in the cervix.</p> <p>Use of male/ female condom or dental dam during vaginal, anal and oral sex.</p>
	<p>COMPLICATIONS FROM NOT TREATING: Certain strains of HPV are considered risk factors for cervical cancer.</p>			
HIV and AIDS	Refer to Participant Handout 7.2.			
Trichomoniasis	<p>Vaginal sex through semen, pre-cum and vaginal fluids.</p>	<p>Trichomoniasis can cause symptoms in people of any gender. But it is most likely to cause vaginitis and symptoms include: Green, yellow, grey, frothy, and/or bad-smelling vaginal discharge, blood in vaginal discharge, itching and irritation in and around vagina, genital swelling, pain during intercourse.</p>	<p>Antibiotics</p>	<p>Since vaginitis is most common form, use of male/ female condom or dental dam during sexual activity involving the vagina.</p>
	<p>COMPLICATIONS FROM NOT TREATING: On rare occasions, leads to pelvic inflammatory disease in females.</p>			

MODULE 7 PARTICIPANT HANDOUT 7.3 Page 3

INFORMATION ON STIs AND RTIs

(Activity 7.4: Quiz on STI, RTI, HIV and AIDS)

TABLE 4: TYPES OF STIs AND STIs

TYPE OF INFECTION	TRANSMISSION	SYMPTOMS	TREATMENT	PREVENTION
Hepatitis- B	Contact with semen, vaginal fluids, and blood, including through anal, vaginal and oral sex, blood on scissors and blades, and sharing needles and syringes. Can also spread from infected mother to foetus.	No noticeable symptoms, but, when symptoms appear, they include: tiredness, abdominal pain, loss of appetite, nausea and vomiting, joint pain, headache, fever, chills, dark-coloured urine, pale, clay-coloured bowel movements, jaundice (yellowing of eyes and skin)	No cure but easily preventable.	Vaccination for Hepatitis-B and use of male/female condom or dental dam during vaginal, anal and oral sex.
	COMPLICATIONS FROM NOT TREATING: Chronic hepatitis, liver cancer.			
Scabies (caused by mites) and Pubic Lice (Crabs)	Skin-to-skin contact (usually prolonged sexual contact). In rare cases, through infected person's clothes, towels, and bedding.	Genital itching, miniscule lice in the genital area, crab eggs (small, oval, yellow, white or pearly), and dark or bluish spots from bites.	Over the counter shampoo, creams and foams for lice. Wash all linen, clothing and towels.	Every person in close contact should be treated.
	COMPLICATIONS FROM NOT TREATING: In rare cases can cause bacterial infection due to itching.			
Bacterial Vaginosis	A RTI caused by an imbalance or overgrowth of certain bacteria in the vagina that disrupts the normal bacterial balance. Not passed from person to person, but more common among sexually active people.	No symptoms for many. If symptomatic, possibility of a thin white or grey vaginal discharge and strong odour, especially after sex; pain, itching, or burning in the vagina; burning when urinating; itching around the outside of the vagina.	Antibiotics and vaginal cream	Avoid scented soaps and douching (washing or rinsing out the vagina by forcing water or other mixtures of fluids into the vaginal cavity); using a condom may lower risk because of the effect semen can have on bacteria in the vagina; keep the vulva dry and clean.
	COMPLICATIONS FROM NOT TREATING: Increased risk for other reproductive tract problems such as pelvic inflammatory disease (PID); if a woman is pregnant, it has been associated with premature labour; increases susceptibility to HIV and other STIs.			

MODULE 7_FACILITATOR HANDOUT 7.2_Page 1

QUIZ ON STI, RTI, HIV AND AIDS

(Activity 7.4: Quiz on STI, RTI, HIV AND AIDS)

ROUND 1:

1. **What is the primary treatment for HIV and how does it help? (10 points for partial answer)**

ANSWER: ART (Antiretroviral therapy). It prevents the virus from multiplying and thereby slowing down the progression of the virus, and allowing the immune system to function normally. It reduces the viral load allowing a person to live a full life and prevents further transmission.

2. **This STI causes fleshy, soft bumps that sometimes resemble miniature cauliflower on genitals and anus. Which STI are we talking about?**

ANSWER: Genitals Warts, a form of infection caused by the Human Papilloma Virus.

3. **How can you prevent transmission of HPV (Human Papilloma Virus)?**

ANSWER: Taking vaccines for certain strains of HPV that cause cervical cancer.

- Undergoing regular check-ups including pap smears, which can detect abnormal changes in the cervix.
- Using male, female condoms and/or dental dam during vaginal, anal and oral sex.

4. **List three ways to prevent exposure to HIV?**

ANSWER: Any three of the following:

1. If you are HIV-negative taking PrEP prior to exposure.
2. Taking PEP within 72 hours of exposure.
3. Ensuring needles and syringes are not shared and are sterilised before each use.
4. Ensuring blood at the time of transfusion has undergone HIV analysis.
5. Using male/female condoms or dental dam during vaginal, anal and oral sex.
6. Regular STI testing.
7. Encouraging your partner living with HIV to stay on ART.

5. **How is pubic lice transmitted?**

ANSWER: Primarily through skin-to-skin contact, usually prolonged sexual contact. In very rare cases, through an infected person's clothes, towels, and bedding.

6. **What are the symptoms of syphilis?**

ANSWER: Primary stage: Sores where the infection entered your body, including vulva, vagina, anus, penis, scrotum, and sometimes your lips or mouth. Secondary stage: rashes on the palms of your hands, soles of your feet, or other parts of your body. You may also have a slight fever, feel tired, have a sore throat, swollen glands, headache, and muscle aches. *(Half points if symptoms of only one stage are mentioned)*

7. **How can Hepatitis B be prevented?**

ANSWER: Taking vaccination for Hepatitis-B and using male, female condoms and/or dental dam during vaginal, anal and oral sex.

MODULE 7_FACILITATOR HANDOUT 7.2_Page 2

QUIZ ON STI, RTI, HIV AND AIDS

(Activity 7.4: Quiz on STI, RTI, HIV AND AIDS)

ROUND 2:

True/False (20 points for correct answer + correct explanation)

1. **Only people who have lots of sexual partners and no morals get STIs.**

ANSWER: FALSE. STIs are very common and a person can be infected for multiple reasons such as lack of information and awareness; lack of availability of condoms; stigma against certain sexual practices that prevent people from accessing sexual health needs; difficulty in negotiating safer sex; through sexual abuse; blood transfusion; medical negligence etc. Anyone can contract STIs, irrespective of whether they have one or multiple sex partners, who they are having sexual intercourse with (sexual orientation), gender identity, married or not. These myths only create stigma and discrimination against certain groups as being primary carriers and transmitters of STI, which makes their access to sexual health needs and care very difficult.

2. **You cannot get STIs (including HIV) from touching, hugging, shaking hands, sharing toilets, sharing dishes and glasses with an infected person.**

ANSWER: TRUE. You cannot get HIV or other STIs from such casual contact. Myths about the spread of HIV and other STIs through such casual forms of contact provide breeding ground for discrimination against an infected person. In fact, HIV cannot be transmitted even through saliva, it can only be transmitted through an open sore in the mouth during kissing.

3. **Disabled people need information about STIs and HIV & AIDS.**

ANSWER: TRUE. Disabled people are often excluded from information on STI and HIV & AIDS as they are assumed to be non-sexual. Even when symptoms are reported, healthcare practitioners do not consider STIs as a possible cause, which can have long term impact on persons with disabilities. There are many factors that increase the risk of persons with disabilities to contract STI and HIV: social marginalisation leading to exclusion from spaces of education and awareness on these themes;

lack of accessible information; need for blood transfusion after serious injuries; inability to negotiate barrier usage during sex; and higher risk of sexual violence.

4. **Urinating after sexual activity guarantees protection from STIs.**

ANSWER: FALSE. Only the usage of barrier methods such as male/female condoms and dental dam acts as an effective barrier, along with taking vaccination for particular STIs and getting regular check-ups.

5. **Having sex with a woman with disability cures HIV and AIDS.**

ANSWER: FALSE. This is a very dangerous myth in many cultures, where it is believed that having sex with a virgin can cure HIV and AIDS. Since, women with disabilities are assumed to be non-sexual, people may believe that having sex with a woman with disability can cure HIV & AIDS. In many instances, women and girls with disabilities are raped as a result of this myth.

6. **STIs cannot be treated at home.**

ANSWER: TRUE. STIs cannot be treated at home and using home remedies can further aggravate the symptoms and prevent the person from getting immediate treatment, resulting in dangerous complications. You need to visit a health care professional and get proper medications to treat STIs.

7. **Testing positive for HIV is a death sentence.**

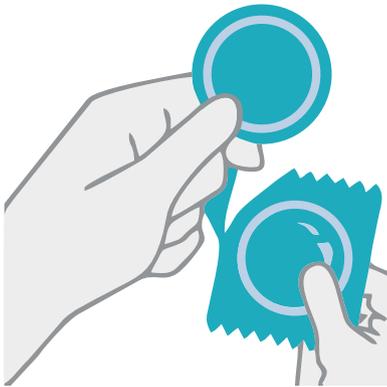
ANSWER: FALSE. While earlier contracting HIV led to a subsequent progression to AIDS which reduced the ability of the body to fight diseases, this is no longer the case. With advances in science, the antiretroviral therapy, when taken regularly and throughout a person's life, can stop progression to AIDS and allow a person to live their lives as usual.

MODULE 7 PARTICIPANT HANDOUT 7.4 Page 1

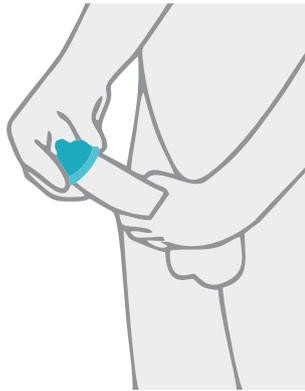
USING CONDOMS AND DENTAL DAMS

Source: Centers for Disease Control and Prevention (CDC).
Available at: [Link] <https://www.cdc.gov/condomeffectiveness/male-condom-use.html>.

HOW TO PUT ON AND TAKE OFF A MALE CONDOM



Carefully open and remove condom from wrapper.



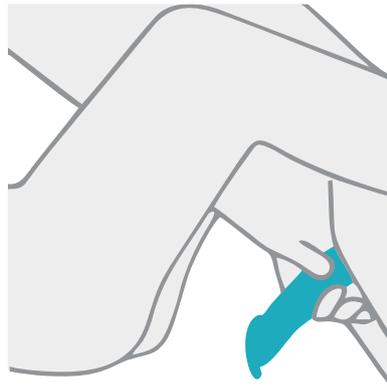
Unroll condom all the way down the penis.



Pinch air out of the tip of the condom



Place condom on the head of the erect, hard penis. If uncircumcised, pull back the foreskin first.



After sex but before pulling out, hold the condom at the base. Then pull out, while holding the condom in place.



Carefully remove the condom and throw it in the trash.

MODULE 7 PARTICIPANT HANDOUT 7.4 Page 2

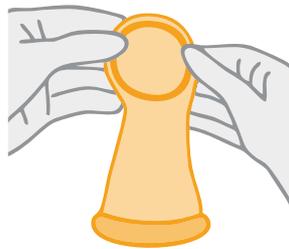
USING CONDOMS AND DENTAL DAMS

Source: Centers for Disease Control and Prevention (CDC).
Available at: [Link] <https://www.cdc.gov/condomeffectiveness/Female-condom-use.html>.

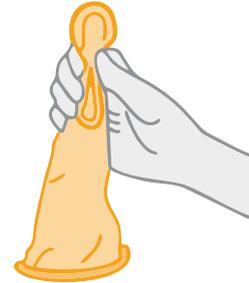
HOW TO INSERT AND REMOVE A FEMALE CONDOM



Carefully open and remove female condom from package to prevent tearing.



The thick, inner ring with closed end is used for placing in the vagina and holds condom in place. The thin, outer ring remains outside of body, covering vaginal opening.



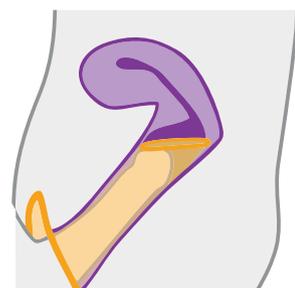
Find a comfortable position. While holding outside of condom at closed end, squeeze sides of inner ring together with your thumb and forefinger and insert into vagina. It is similar to inserting a tampon.



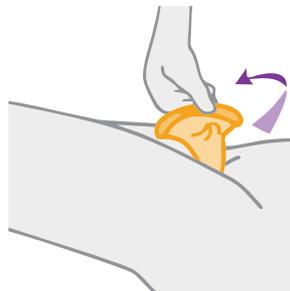
Using your finger, push inner ring as far up as it will go until it rests against cervix. The condom will expand naturally and you may not feel it.



Be sure condom is not twisted. The thin, outer ring should remain outside the vagina.



Guide partner's penis into opening of female condom. Stop intercourse if you feel penis slip between condom and walls of vagina or if outer ring is pushed into vagina.



To remove, gently twist outer ring and pull female condom out of the vagina.



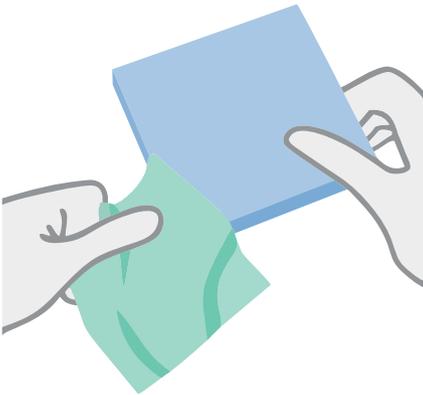
Throw away female condom in trash after using it one time. Do not reuse.

MODULE 7 PARTICIPANT HANDOUT 7.4 Page 3

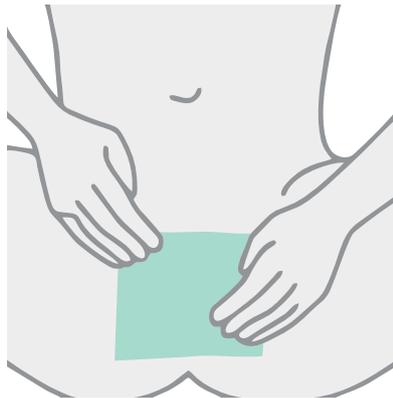
USING CONDOMS AND DENTAL DAMS

Source: Centers for Disease Control and Prevention (CDC).
Available at: [Link] <https://www.cdc.gov/condomeffectiveness/Female-condom-use.html>.

HOW TO USE A DENTAL DAM



Carefully open dental dam and remove from package.



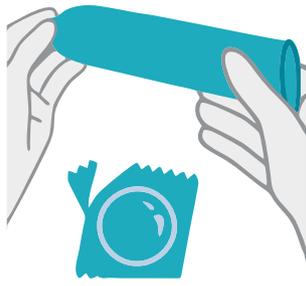
Place dental dam flat to cover vaginal opening or anus.



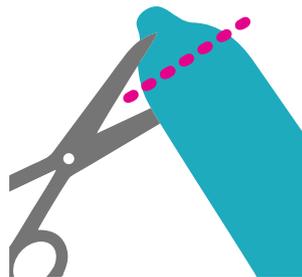
Throw away used dental dam in trash.

HOW TO MAKE A DENTAL DAM FROM A CONDOM*

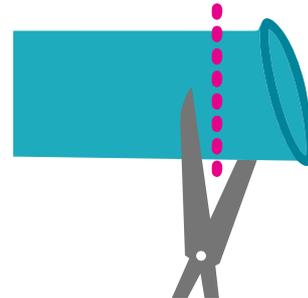
*Make sure the condom is made of latex or polyurethane.



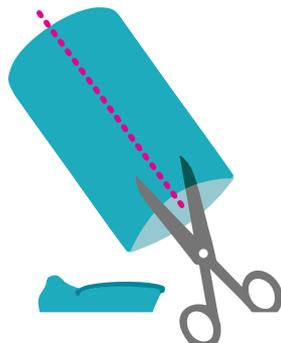
Carefully open package, remove condom, and unroll.



Cut off tip of condom.



Cut off bottom of condom.

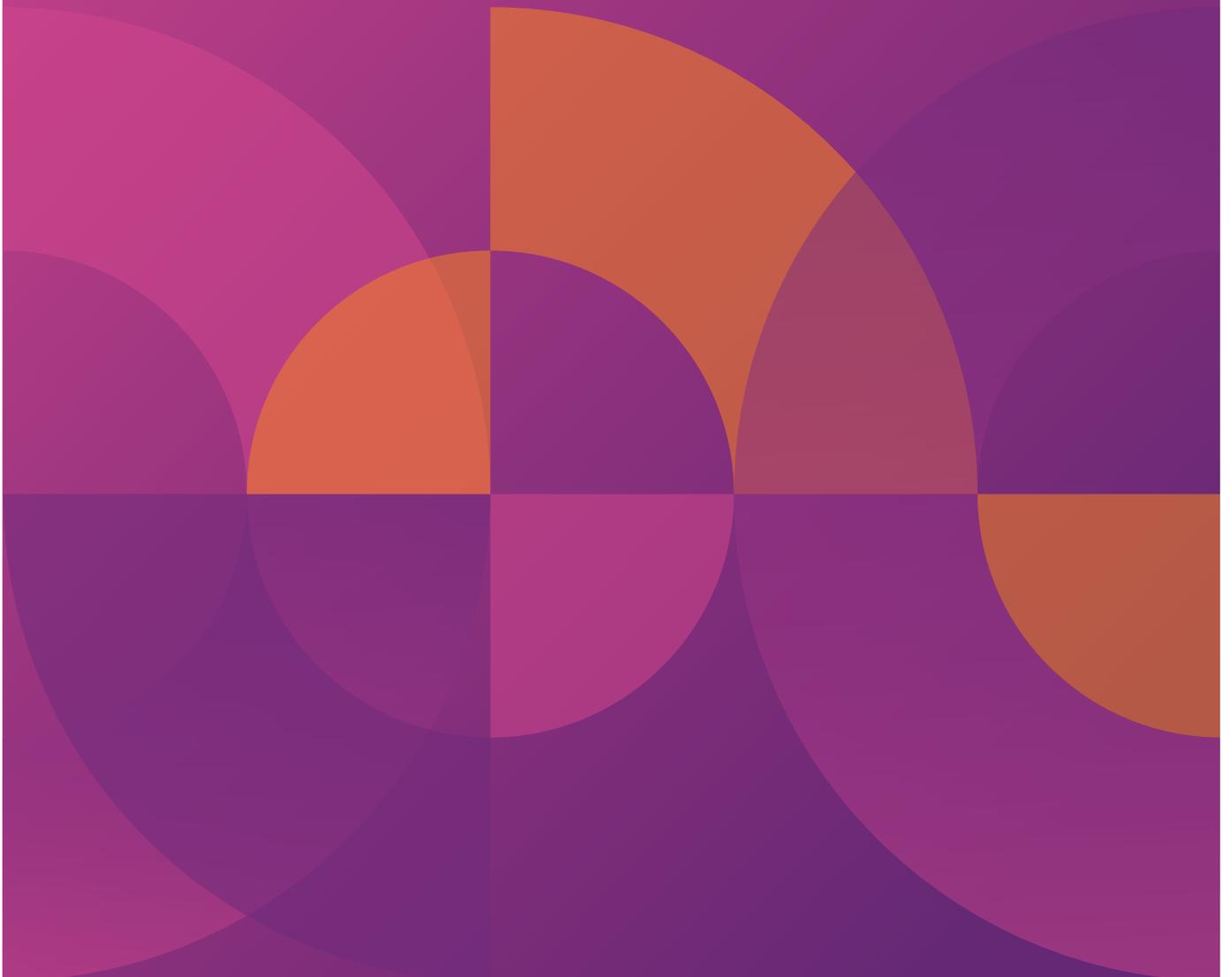


Cut down one side of condom.



Lay flat to cover vaginal opening or anus.

module 8
abuse and violence



module 8

abuse and violence

MODULE OBJECTIVES

1. To build understanding on: different forms of abuse and violence, some of which are unique to women with disabilities; spheres in which abuse and violence may occur; factors which increase vulnerability; and the barriers in accessing justice.
2. To build understanding on how intersecting forms of social exclusion can increase vulnerability and barriers in accessing justice.
3. To recognise the impact of conflict, displacement, disaster, emergencies and health crisis on abuse and violence faced by women and girls with disabilities.
4. To equip women and girls with disabilities on steps to be taken in the event of abuse and violence.

ACTIVITIES

Activity 8.1: Mapping Abuse and Violence > 90 Minutes

Activity 8.2: Sexual Abuse and Humanitarian Crisis

> 45 Minutes

Activity 8.3: Access to Justice > 60 Minutes

HANDOUTS

Activity 8.1: Mapping Abuse and Violence

> Facilitator Handout 8.1: Mapping Abuse and Violence

Activity 8.2.: Sexual Abuse and Humanitarian Crisis

> Facilitator Handout 8.2: Case Studies for Sexual Abuse during situations of Humanitarian Crisis

Activity 8.3: Access to Justice

- a. Participant Handout 8.1: Responding to Sexual Violence
- b. Facilitator Handout 8.3: Case Studies on Access to Justice
- c. Participant Handout 8.2: Case Studies on Access to Justice
- d. Participant Handout 8.3: Organizations and networks working on Gender-Based Violence in Bangladesh

Activity 8.1.:

MAPPING ABUSE AND VIOLENCE

Objective:

To help identify various forms of abuse and violence, spheres in which they may occur and factors that increase vulnerability.

Time:

90 Minutes

Materials Needed:

- Facilitator Handout 8.1

Process:

1. In a plenary, discuss the following with the participants:
 - a. What are the types of abuse and violence that women and girls with disabilities face? (If participants offer instances of only direct violence, encourage them to think of forms of violence which cannot be seen, 'indirect violence')
 - b. What are the spheres in which violence occurs? (Family, community, health systems etc.)
 - c. What are some factors that heighten vulnerability of women and girls with disabilities?
2. After participants have been invited to share their views, ensure that points mentioned in Facilitator Handout 8.1 are covered.
3. Divide participants into four groups. Ask them to develop a small role play (of five minutes), keeping in mind the earlier discussions. They must incorporate diverse situations in which violence may occur. The groups have 20 minutes to prepare the role play.
4. Ask each group to present their role play and have a discussion on the nature of violence and specific vulnerabilities depicted in the role play.

Debrief:

1. Have participants come across similar instances within their lives?
2. How do other intersecting forms of social exclusion heighten vulnerability and increase marginalisation?
3. How do violence and abuse relate to SRHR?

Key Messages:

1. Women and girls with disabilities not only face violence on account of gender, but also unique forms of abuse and violence that are disability and gender based. However, many factors such as myth of non-sexuality/hyper sexuality, stigma and discrimination against disability, make it difficult to address these forms of violence.
2. Women and girls with disabilities are not a homogenous group and their vulnerability to violence is heightened on account of other forms of social exclusion depending on age, location, nature of disability, ethnicity, caste, sexual and gender diversity, religion and class, among others. For example, indigenous women with disabilities are more vulnerable to sexual abuse and trafficking and may be forcefully sterilised as a form of cultural dominance and control—to dispose them from the land and exercise military control. Access to education and information may be more difficult and information may not be provided in native language. Marginalised groups among women and girls with disabilities also suffer from bias, stigma and discrimination on account of various facets of their identity which may make access to care and justice even more difficult. For example, transgender persons with disability, women and girls with intellectual disability and indigenous women with disability often face stigma as being perceived as hypersexual and are likely to be poorly treated by the police when reporting abuse.
3. Violence and abuse violate the right of a person to bodily integrity and the right to make sexual and reproductive health choices that are based on free, prior and informed consent.

Notes for the Facilitator:

1. Indirect forms of violence may be difficult to grasp as a form of violence. Provide examples and solicit opinions from participants about how the situation could be considered as abusive and violent.
2. Be mindful that the participants may have undergone many of the forms of violence being discussed in the session. Have in place a mechanism for trauma management and referrals.
3. If an instance of violence is being shared by a participant ensure that they feel they are being heard and believed, and their experiences are respected.

Resources for Further Reading:

1. Special Rapporteur on violence against women, its causes and consequences (2012). *Report of the Special Rapporteur on violence against women, its causes and consequences (A/67/227)*.
2. The International Network of Women with Disabilities (2011). *Violence Against Women with Disabilities*, Centre for Women Policy Studies.
3. Stephanie Ortoleva and Hope Lewis (2012). *Forgotten Sisters – A Report on Violence against Women with Disabilities: An Overview of Its Nature, Scope, Causes and Consequences*. Available at: [Link to PDF Document] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2133332. Accessed on 3 September 2020.
4. Pacific Disability Forum (2014). *Toolkit on Eliminating Violence Against Women and Girls with Disabilities in Fiji*.
5. Jane Maxwell, Julia Watts Belser, Darlena David (2007). *A Health Handbook for Women with Disabilities*, Berkely, California: Hesperian, pp. 287-312 (Chapter 14: Abuse, Violence and Self Defense).

**Activity 8.2:
SEXUAL ABUSE AND HUMANITARIAN CRISIS****Objective:**

To build an understanding of abuse and violence against women and girls with disabilities in the context of humanitarian crisis, which includes conflicts, disasters and outbreak of infectious diseases.

Time:

45 Minutes

Materials Needed:

- Facilitator Handout 8.2

Process:

1. Explain to the participants that you will be sharing three case studies with them to understand forms of violence against women and girls with disabilities during emergencies and crisis. Given the context of Covid-19 and other conflicts and emergencies that are recurrent in the region, it becomes important to understand heightened vulnerabilities to violence and abuse of women and girls with disabilities during these emergencies and crisis.
2. Share the case studies from Facilitator Handout 8.2.

Debrief:

1. What are some of the forms of violence that women and girls with disabilities face during situations of conflict, displacement, emergencies and health crisis?
2. What are the factors that heighten their vulnerability to abuse and violence during conflict, displacement, emergencies and health crisis?
3. What are some possible suggestions to reduce vulnerability to abuse and violence?

Key Messages:

1. Women and girls with disabilities face both direct and indirect violence in the aftermath of conflict, displacement, emergencies and health crisis. Direct forms of violence include domestic violence (as evident in the Covid-19 case study). In situations of displacement in the aftermath of conflict and emergencies, they are also faced with sexual violence and abuse, increased risk of trafficking, and forced and early child marriage. In terms of indirect violence, some of the forms of violence include lack of accessible information; lack of access to SRH services (sanitary products, contraceptives, accessible toilets in camps); impaired mobility (lack of public transportation, lack of proper roads, remote location); lack of attention to mobility aid and communication devices and being neglected in planning and decision making.
2. Many factors, such as the following, may heighten the vulnerability of women and girls with disabilities to abuse and violence:
 - Lack of accessible information – in terms of sign language, easy to read information, information not reaching remote locations and not being made available in native languages for indigenous people.
 - Poverty: Increased poverty during the Covid-19 crisis and in situations of conflict and displacement significantly increase vulnerability to abuse and violence. The lack of income or basic supplies may place greater power in the hands of service providers or community members, and increase vulnerability for abuse especially in terms of sexual favours in return for access to relief material. It could also increase the risk of abuse and exploitation perpetrated by partners, and reduce the ability of women and girls with disabilities to leave violent relationships due to their dependence on others.
 - Reduced mobility, on account of lack of public transport, inaccessible healthcare centres and inability to attend peer support groups in poorly planned camps.

- Dependence: Women and girls with disabilities would have to depend on others for access to relief material, day-to-day resources, using toilets and mobility within camps, which increases risk of abuse and violence.
- Loss of family and community support: For example, the isolation caused by Covid-19 lockdowns and displacement lead to breakdown of existing systems of support that create heightened vulnerabilities.
- Family stress: Increased stress on the family may result in frustration being vented out against women and girls with disabilities.

3. Some ways to mitigate vulnerabilities faced by women and girls with disabilities during emergencies and crisis include provision of accessible information, including in native languages; including women and girls with disabilities, especially marginalised women and girls with disabilities, in disaster-management planning, designing of relief camps and in handling health emergencies such as Covid-19.

Resources for Further Reading:

1. Brigitte Rohwerder, (2017). *Women and girls with disabilities in conflict and crises*, Brighton: Institute of Development Studies.
2. Women's Refugee Commission (2015). *"I See That It Is Possible": Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*.
3. Women's Refugee Commission (2014). *"It doesn't matter if you are disabled. You are talented" The intersection of sexual and reproductive health and disability for Bhutanese refugees in Damak, Nepal*.

Activity 8.3: ACCESS TO JUSTICE**Objective:**

To provide practical guidance on steps to be taken in case of abuse and violence, especially sexual violence; and to identify barriers in accessing justice and develop collective strategies to address barriers.

Time:

60 Minutes

Materials Needed:

- Participant Handout 8.1
- Facilitator Handout 8.3
- Participant Handout 8.2
- Participant Handout 8.3

Process:

1. Divide the participants into four small groups.
2. In groups, ask the participants to go through Participant Handout 8.1. Groups may allocate 15-20 minutes for this.
3. Next, in small groups, participants should discuss the case studies in Participant Handout 8.2, and discuss the barrier in access to justice that women and girls with disabilities are faced with.
4. Distribute copies of Participant Handout 8.3. which has details of organizations participants can reach out to for support when faced with gender-based violence and abuse. Many of these organizations work on accessibility and can support with providing accessibility services required at different stages of reporting, litigating, and accessing other support services.

Debrief:

1. What are some other barriers that women and girls with disabilities face in accessing justice?
2. How are barriers in access to justice heightened for marginalised women and girls with disabilities?
3. What are some ways in which the different barriers can be reduced?

Key Messages:

1. Some of the different barriers are as follows:⁶⁴
 - Institutional Barriers: Very few legal interventions look at specific needs of persons with disabilities in filing cases or in taking forward legal proceedings. For example, provisions for reasonable accommodations, such as sign language interpreters, special educators, and access to information in native language, are not in place at police stations and in courts. Even where provisions exist, implementation is lax.
 - Infrastructural Barriers: Many court buildings, offices of lawyers and other legal service providers including government legal aid offices, One-Stop Crisis Centres, Victim Support Centres as well as police stations are not physically accessible for people with disabilities; and transport systems allowing access to police stations and courts are not yet accessible for people with disabilities. Further, hospitals services for testing, including DNA testing, are not accessible.
 - Attitudinal Barriers: The attitude of officials and other actors within the justice system is not disability sensitive. Similarly, even within local mediation systems, negative attitudes towards persons with disabilities persists.

- Lack of Coordination: There is lack of coordination among relevant actors within the justice system, such as police stations, hospitals, crisis centres and other staff working on the ground.
 - Lack of Information and Awareness: There is lack of awareness among women with disabilities, particularly for women with disabilities living in rural areas, and indigenous women with disabilities, regarding existing legal provisions, legal aid services as well as lack of information on how to navigate the justice system.
 - Rural Power Structures: Rural power structures influence access to justice of people with disabilities. For example, dominant groups in local areas have influence over community level mediations and create barriers in accessing justice.
2. In addition, marginalised women and girls with disabilities may encounter further barriers in the form of biased attitude of police officers and judiciary based on their caste, ethnicity, gender identity, particular forms of disability (such as psychosocial disability and intellectual disability), which draw on very harmful misconceptions of sexual promiscuity. These groups are also more likely to face violence from police officials when trying to report violence and in a large number of cases, their reports of violence are not registered by police.

Notes for Facilitator:

1. Make a list of credible local organizations that can provide different forms of support including psychological assistance, health care, and assistance with filing cases.
2. Invite speakers from local DPOs who can share good practices on reducing/overcoming barriers in access to justice and highlight some strategies that can be used by women and girls with disabilities.

Resources for Further Reading:

1. Handicap International and Bangladesh Legal Aid and Services Trust (BLAST) (2015). *Good Practice Report on Access to Justice for People with Disabilities in Bangladesh*.
2. Human Rights Watch (2018). *Invisible Victims of Sexual Violence: Access to Justice for Women and Girls with Disabilities in India*.

MODULE 8_FACILITATOR HANDOUT 8.1_Page 1

MAPPING ABUSE AND VIOLENCE

(Activity 8.1: Mapping Abuse and Violence)

Evidence suggests that women and girls with disabilities are much more likely to face abuse and violence than non-disabled women and girls.

FORMS OF VIOLENCE

1. Direct Forms of violence: Not only do women and girls with disabilities face forms of violence that non-disabled women and girls face, such as sexual violence and rape, sexual harassment, dowry violence and death, domestic violence, acid violence and trafficking, there are some forms of violence unique to women and girls with disabilities:

- a. Psychosocial and Emotional Abuse**, including:
 - Insulting – Name calling and telling them they are a burden, and ridiculing their disability in front of others.
 - Neglect – Refusing to help with assistance and medicine; leaving people without care for hours such that they soil themselves; not helping with accessing toilets, clothes, changing soiled sheets; leaving a person naked; not providing food etc.
 - Isolation – Hiding women and girls with disabilities at home; and keeping them locked up at home.
 - Abandonment – families and intimate partners abandon women and girls with disabilities for many reasons including if they think they need too much care, are a financial burden or acquire a disability later in life.
 - Removing children from the care of women with disabilities.
- b. Physical Violence**, including:
 - Beating, slapping, and handling someone roughly.
 - Breaking or hiding their assistive devices, such as crutches and hearing aid.
 - Forcing them to be naked during physical exams, and using intrusive devices without warning.
 - Chaining and restraining women and girls with disabilities.
 - Withholding medicines, mobility aid, communication devices etc. and putting them out of reach.
- c. Sexual violence**, including:
 - Touching any part of your body, especially breasts and genitals without permission.
 - Forcing you to have sex in exchange for care.
 - Forced sterilisation and abortion.

- Being forced to look at pornography or posing for pornographic pictures.
- Being forced to hear or watch someone having sex.
- d. Financial abuse**, including
 - Withholding money needed to buy medicines, mobility aid, and communication devices.
 - Denying access to and control over financial resources.

2. Indirect violence

- a. Socio-cultural violence:** myths about being possessed by evil spirits; disability as a result of punishment or sin, exclusion from community activities etc.
- b. Structural violence:** form of violence wherein social structures or social institutions harm people by preventing them from meeting their basic needs. This includes:
 - Inaccessible public spaces and information, inaccessible healthcare and sanitation facilities, and inaccessible courts and victim support centres. This can be on account of both physical inaccessibility and lack of information in native language.
 - Stigma and discrimination built into institutions such as police, healthcare, and justice system.
 - Lack of opportunities in education and employment.
 - Lack of meaningful participation in decision making.

SPHERES IN WHICH VIOLENCE MAY OCCUR:

- 1. Family and intimate partners:** Name calling; denying access to and control over financial resources; force feeding medicines; forced sterilisation; isolation; neglect by leaving women and girls with disabilities unattended for hours in uncomfortable situations; forcefully committing them to institutions; sexual violence; controlling SRH decision; not providing necessary nutrition; beating; slapping; and withholding access to medicines, mobility aid and communication devices etc.
- 2. Caregivers:** Neglect by leaving women and girls with disabilities unattended for hours in uncomfortable situations; withholding access to medicines, mobility aid and communication devices; forcing them to have sex in exchange of care; name calling etc. In many instances family and partners are often the caregivers.

MODULE 8 _FACILITATOR HANDOUT 8.1_Page 2

MAPPING ABUSE AND VIOLENCE

(Activity 8.1: Mapping Abuse and Violence)

3. **Community:** Exclusion from community events and programmes; –s by religious leaders; discrimination, name calling, rough handling on streets, in public transport, and other public services.
 4. **Institutions:** Chaining and restraining women and girls with disabilities; leaving them naked and denying access to clothes; forcing medicines; neglect by leaving them unattended for hours in uncomfortable situations; forced sex with workers, caretakers, or other residents; being beaten, slapped, or hurt; no activity for work or pleasure and always being bored; forced sterilisation or abortions; being locked in a room alone; ice baths or cold showers as punishment; forced medication; having to undress or be naked in front of other people; and watching other people be abused or hurt.
 5. **Workplace:** Unwelcome touching; sexually suggestive comments and jokes; expectations of quid pro quo; hiding mobility aid and communication equipment; bias, stigma and discrimination; derogatory language; and lack of representation in sexual harassment policies and committees.
 6. **Healthcare systems:** Performing testing and procedures without free, prior and informed consent; lack of culturally sensitive forms of treatment; lack of accessible infrastructure and information; bias, stigma and discrimination in access to healthcare; rough handling; forced sterilisation and abortion; forced medication; lack of accessible SRH services; and derogatory language.
 7. **Justice System:** Lack of accessible infrastructure at police stations and courts; lack of information on rights and laws; lack of reasonable accommodation such as sign language interpreter, special educator, being accompanied by a person you trust; bias, stigma and discrimination; not believing women and girls with disabilities; and derogatory language.
 8. **State Actors:** Sexual abuse by military, police and other public officials; sexual favours in return for care; bias, stigma and discrimination; and derogatory language.
 9. **Systemic Violence:** Invisibilising persons with disabilities and their concerns and needs, including through lack of proper mechanisms to ensure effective participation in decision making spaces.
- FACTORS THAT HEIGHTEN VULNERABILITY:**
1. Lack of access to sexuality education and SRHR information.
 2. Myths of non-sexuality or hyper sexuality.
 3. Stigma and discrimination which leads to negative attitudes and increased vulnerability, reduces access to services and care and makes redressal of abuse and violence difficult.
 4. Isolation at home leads to lack of social participation, resulting in reduced access to information and support network.
 5. Dependence on abuser, making it difficult to report.
 6. Barriers to resistance and escape as there is less information on how to protect oneself from abuse and violence.
 7. Perceived credibility where women and girls with disabilities reporting violence are often not believed.
 8. Lack of financial resources which stems from lack of access to education and employment opportunities.
 9. Low self-esteem and body image issues owing to media representations which may cause them to devalue their bodies and themselves.

MODULE 8 FACILITATOR HANDOUT 8.2 Page 1

CASE STUDIES FOR SEXUAL ABUSE DURING SITUATIONS OF HUMANITARIAN CRISIS

(Activity 8.2: Sexual Abuse during situations of Humanitarian Crisis)

CASE STUDY 1: SITUATION IN ROHINGYA REFUGEE CAMPS

Use the following videos: (ensure necessary accommodation for accessibility, including sign language)

1. Human Rights Watch (2018). *Bangladesh: Poor Conditions for Rohingya Refugees with Disabilities (Accessible)*. Available at: [Link] <https://www.youtube.com/watch?v=YonbaOvmqIM>. Accessed on 8 September 2020.
2. AS BD News (2017). *Rape of Rohingya women is two-fold: Once in Myanmar army Come to Bangladesh once again*. Available at: [Link] https://www.youtube.com/watch?v=IFwqxQ_buqo. Accessed on 8 September 2020.
3. C Voice (2018). *Sexual assault in Rohingya Camp*. Available at: [Link] <https://www.youtube.com/watch?v=9st2joqyX9M>. Accessed on 8 September 2020.

Further Resources:

1. Raisa Imran Chowdhury and Mahbuba Nasree (2020). 'Humanitarian Response for Improving Quality of Life of Persons with Disabilities: A study on Rohingya Camps of Cox's Bazar, Bangladesh', *Journal of Human Rights and Peace Studies*, 6(1), pp. 60-68.
2. Inter-Sector Coordination Group (2018). *Interconnectedness of Gender, Age and Disability Issues in Rohingya Refugee Response*, Gender in Humanitarian Action Brief No. 4.
3. International Rescue Committee (2020). *The Shadow Pandemic: Gender-Based Violence among Rohingya refugees in Cox's Bazar*.

CASE STUDY 2: NEPAL EARTHQUAKE: RELIEF AND REHABILITATION

Share the following experiences of women and girls with disabilities in the aftermath of the earthquake in 2015 in Nepal.

Accessing Relief:

A person with moderate disability: *"disabled person like me who can easily walk and go anywhere could get access to all the information, but those who need assistance to move and deaf persons could not get information easily. And because of this situation, lots of apaangata [PwDs] did not get relief support after the earthquake."* (UNDP, 2016)

Leader of an organization of disabled people: *"A single and 52 year-old Tamang [indigenous community in Nepal] woman who acquired her disability during the earthquake in Nuwakot was unable to receive relief goods during the early relief goods distribution. This was due to the simple fact that she did not understand the Nepali language. She understands and speaks only her native Tamang language, and there were no translators/interpreters in the relief team who could translate for her. After the disaster, we cannot call or contact other members of the community since most of them live far away. There were no records of received relief goods and recovery assistance. While some of them who have access received the relief goods repeatedly, others who do not have connections with organizations and leaders did not receive any. Relief operations were under much pressure because people were in desperate need at that time. However, relief efforts remained inaccessible to many people."* (Gurung, 2016-17)

Situation in Relief Camps:

Mother of an indigenous woman with physical disability: *"I went back along with my family to our own shelter due to our daughter's disability. Her condition and care were not possible in public places where we were sharing our shelter with others. Doing some activities would be more public to others in the same tent and there might be activities that are unsafe for our whole family in the future so we decided to return. Despite the risk, our trauma and fear of aftershocks, we returned to our own shelter and took care of her; because the temporary shelter was unsafe for her."* (Gurung, 2016-17)

MODULE 8 FACILITATOR HANDOUT 8.2 Page 2

CASE STUDIES FOR SEXUAL ABUSE DURING SITUATIONS OF HUMANITARIAN CRISIS

(Activity 8.2: Sexual Abuse during situations of Humanitarian Crisis)

Resources:

1. Pratima Gurung (2016-2017). *Life at the Margins: The Challenges of Indigenous Women with Disabilities*, Asian Indigenous Women's Network.
2. UNDP (2016). *Disaster, Disability, & Difference A Study of the Challenges Faced by Persons with Disabilities in Post-Earthquake Nepal*.
3. Kay Standing, Sara Parker & Sapana Bista, (2016). 'Grassroots responses to violence against women and girls in post-earthquake Nepal: lessons from the field', *Gender & Development*, 24(2), pp. 187-204.

CASE STUDY 3: EXPERIENCES OF HANDLING OF COVID-19 IN INDIA

(Extracted from: International Disability Alliance (2020) *Covid 19 in Rajasthan (India): What are Women with Disabilities' Main Challenges?*). Available at: [Link] <https://www.internationaldisabilityalliance.org/covid19-india-women>. (Accessed on 9 September 2020)

Zainab is a Muslim woman in her early 40s who has a physical disability and faces restrictions in using her hands. She is married and has children. Zainab and her family have a grocery store in their home. She is used to handling the store but due to Covid-19, she is only allowed to have it open from 7am to 11am, reducing her income.

Barriers to sexual and reproductive health and rights are also aggravated during the pandemic and Zainab, therefore, faces difficulties in accessing feminine hygiene products, including sanitary pads. Zainab finds that that in many families, men are those who usually leave the house so women are shy to ask them to get sanitary pads.

Zainab relies on the newspaper and WhatsApp groups to obtain information but she confirms that "none of this information is accessible, those who are blind might be able to access it in some way or another but what happens with those who don't have phones, deaf people or those who can't read?" she asks.

"Whatever freedom we had before, this is completely gone due to COVID-19", says Zainab referring to women having to stay at home. She says that most of her time is dedicated to the male members of the house and she barely has time for herself. Household chores have increased, keeping her very busy. She has no help from other family members: "Even my daughter complains about having to help me, she gets irritated and has fights with my son", she says. She admits that fights have increased and so has the abusive behaviour of her husband. "The verbal abuse keeps happening and I feel suffocated, I'm dying for the lockdown to be over to leave the house, before, husbands would be out most of the time but now we're stuck at home 24/7", she says.

Resources:

1. Rising Flame and Sightsavers (2020) *Women with Disabilities during the Covid Crisis in India*.
2. Minority Rights Group International (2020), *Statement on the Impact of the Global COVID-19 Pandemic on Persons with Disabilities from Minority, Indigenous and other Marginalised Communities*. Available at: [Link] <https://minorityrights.org/2020/04/27/statement-covid-19-pandemic-on-persons-with-disabilities-from-minority-indigenous-communities/>. Accessed on 9 September 2020).

MODULE 8 PARTICIPANT HANDOUT 8.1 Page 1

RESPONDING TO SEXUAL VIOLENCE

Handout adapted from Human Rights Watch et, al. (2015) *What to do if someone hurts you or does bad things to you: Information About Gender-Based Violence for People with Disabilities.*

WHAT TO DO IF SOMEONE HURTS YOU OR DOES BAD THINGS TO YOU

IT IS IMPORTANT TO GET HELP IF SOMEONE COMMITS AN ACT OF ABUSE AND VIOLENCE AGAINST YOU



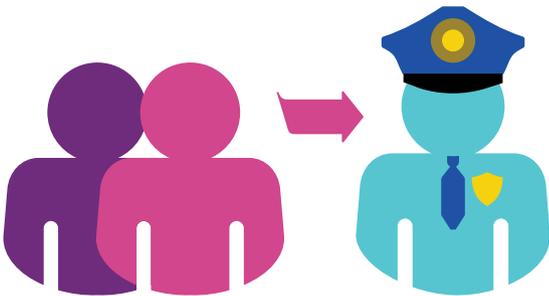
You can tell:

Someone you trust like a friend, someone in your family, a teacher or a nurse.



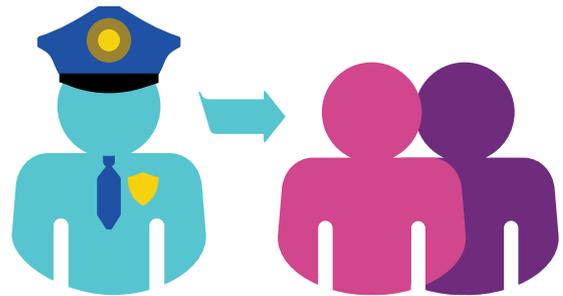
You can tell:

The police. Someone you trust can speak up for you if you find this hard.



You can take someone you trust with you when you go to the police.

There may be special policemen and women to help with problems like this.



The police should:

- Treat you in a respectful way
- Talk to you about what happened
- Make sure you are safe
- Help you get medical care if you need it
- Find out what happened, make a report of your complaint and conduct due investigation.



The person who hurt you may go to court.



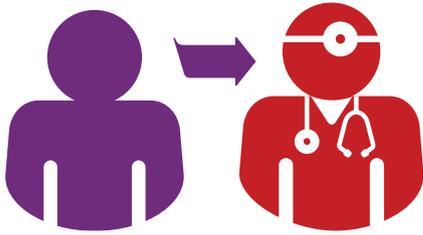
You can get help to keep safe if this happens. For example, the court can keep the person who hurt you far away from you. They can help you find a safe place to stay.

MODULE 8 PARTICIPANT HANDOUT 8.1 Page 2

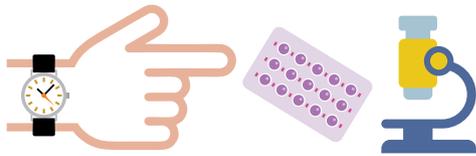
RESPONDING TO SEXUAL VIOLENCE

WHAT TO DO IF SOMEONE HURTS YOU OR DOES BAD THINGS TO YOU

YOUR HEALTH



It is very important to see a doctor or nurse, and get physical and psychosocial health support, if someone has hurt you or forced you to do something sexual.



You need to do this very quickly. You may need medicine or tests very quickly.



They may need to check your body to see if you are hurt. They may need to see your private parts if someone has forced you to do something sexual. But they have to ask you if it is **OK** first.

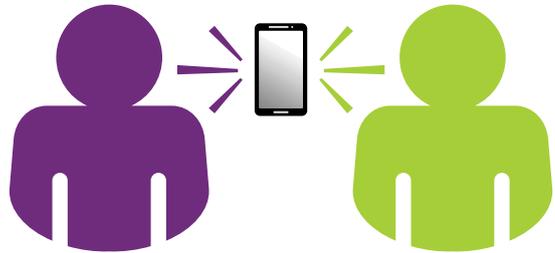
3 Days • To take medicine (PeP – Post Exposure Prophylaxis) to prevent HIV infection.

5 Days • To take medicine to prevent pregnancy.

OTHER HELP

Here are other things you can do:

Phone a helpline



These are numbers you can call for free. You can get help or advice. You can talk to them in private.

Approach people who help children



If you are a girl or boy under 18 years old, you can ask for help from people who help children.

Approach an organisation



Get help from groups (DPOs and legal organizations) in your area. For example, there may be groups near you that help women and children in danger, or people with disabilities.

MODULE 8 _ FACILITATOR HANDOUT 8.3

CASE STUDIES ON ACCESS TO JUSTICE

(Case Studies 1-5 are extracts from: Human Rights Watch (2018) *Invisible Victims of Sexual Violence Access to Justice for Women and Girls with Disabilities in India*)

CASE STUDY 1:

“Nafisa, a woman with difficulties in hearing and speaking, was 19 when she was raped while attending a tailoring class. She said that at the time of the incident, she did not go to the police because she did not know that sexual violence was a criminal offense. She says “One day, my teacher was finishing some work on the sewing machine in the veranda and asked me to wait inside the house. I was alone inside and that was when her brother forced himself on me. I did not know that if someone raped me, I could go to the police.”⁶⁵

Primary Barrier: Lack of access to information on sexual violence.

CASE STUDY 2:

“Pooja, an 11-year-old girl with an intellectual disability, was taken to the police station [...] by her father after she was allegedly raped by a neighbour. The police brought in a sign language interpreter to assist the interviewee, but Pooja cannot speak due to a neurological condition; she is not deaf and has no knowledge of sign language.”⁶⁶

Primary Barrier: Lack of understanding of reasonable accommodation.

CASE STUDY 3:

“Susmita, a woman with a psychosocial disability, [...] was sedated and gang raped by four men who lived in the building next door. However, according to her, the police refused to believe her or register her case on account of her disability. Susmita said: “I approached the police. The police asked me very nasty things like how it felt for me. I mean—I told them I was totally unconscious, so how would I know? The police said things like: “She’s mental, why should I pay attention to her?” “She’s a gone case, why should I listen?””⁶⁷

Primary Barrier: Stigma and discrimination against women and girls with disabilities, especially women with psychosocial disabilities.

CASE STUDY 4:

“[...] Maneka, a 15-year-old girl with intellectual and physical disabilities, [was taken] to the hospital [after being raped]. However, once there, neither Maneka nor her mother, Soumya,

received information on the examinations that took place. Soumya said: “They took Maneka in for the examination all alone—she was scared. No one explained to me what tests they were doing.”⁶⁸

Primary Barriers: Attitude of health care professionals; lack of coordination; and lack of accessible information and reasonable accommodation.

CASE STUDY 5:

“Meera, a 38-year-old woman with cerebral palsy leading to developmental delays, regressed from a communication level of an 11-year old to a three-year old after she was raped. Meera testified in court, with the assistance of a special educator. The magistrate, however, refused to accept her testimony on the grounds that she did not use adult language. Her mother, Anjali, described the day that Meera testified:

“Meera has given her statement in court and the psychologist interpreted it. The psychologist asked her, ‘What did the bad man do?’ And she said, sobbing, with tears running down her face, ‘The bad man put his sussu’ [child term for penis]—and she pointed down. She couldn’t stop crying and the judge said—‘I will not accept that word.’ My daughter has barely managed to recover the communication of a 3-year-old. Even earlier she would not have known the anatomy of a man.” The interpreter, a psychologist who knows Meera well, explained that it is a perfectly acceptable childlike word.”⁶⁹

Primary Barriers: Attitude of court officials; lack of reasonable accommodations; lack of access to SRHR information; and stigma and discrimination.

CASE STUDY 6:

One day when Hla Ching Marma, a 20 year old indigenous women with disability, was home alone, a person who was working on the nearby road entered her house and raped her. This was witnessed by a local person. While he was trying to escape, he was nabbed by the locals and taken to the local counsel head. When he was taken to the police, the case was settled through the payment of compensation of Tk. 40,000. No further official action was taken.⁷⁰

Primary Barriers: Rural power structures where dominant groups in local areas have influence over community-level mediation; socio-economic vulnerability; limited access to those who can help in accessing justice; fear of discrimination by police and court owing to stigma attached to indigenous identity, by which indigenous women are perceived as “sexually open”; lack of access to information about laws and legal procedures in native language.

MODULE 8 PARTICIPANT HANDOUT 8.2

CASE STUDIES ON ACCESS TO JUSTICE

(Case Studies 1-5 are extracts from: Human Rights Watch (2018) *Invisible Victims of Sexual Violence Access to Justice for Women and Girls with Disabilities in India*)

CASE STUDY 1:

“Nafisa, a woman with difficulties in hearing and speaking, was 19 when she was raped while attending a tailoring class. She said that at the time of the incident, she did not go to the police because she did not know that sexual violence was a criminal offense. She says “One day, my teacher was finishing some work on the sewing machine in the veranda and asked me to wait inside the house. I was alone inside and that was when her brother forced himself on me. I did not know that if someone raped me, I could go to the police.”⁷¹

CASE STUDY 2:

“Pooja, an 11-year-old girl with an intellectual disability, was taken to the police station [...] by her father after she was allegedly raped by a neighbour. The police brought in a sign language interpreter to assist the interviewee, but Pooja cannot speak due to a neurological condition; she is not deaf and has no knowledge of sign language.”⁷²

CASE STUDY 3:

“Susmita, a woman with a psychosocial disability, [...] was sedated and gang raped by four men who lived in the building next door. However, according to her, the police refused to believe her or register her case on account of her disability. Susmita said: “I approached the police. The police asked me very nasty things like how it felt for me. I mean—I told them I was totally unconscious, so how would I know? The police said things like: “She’s mental, why should I pay attention to her?” “She’s a gone case, why should I listen?”⁷³

CASE STUDY 4:

“[...] Maneka, a 15-year-old girl with intellectual and physical disabilities, [was taken] to the hospital [after being raped]. However, once there, neither Maneka nor her mother, Soumya, received information on the examinations that took place. Soumya said: “They took Maneka in for the examination all alone—she was scared. No one explained to me what tests they were doing.”⁷⁴

CASE STUDY 5:

“Meera, a 38-year-old woman with cerebral palsy leading to developmental delays, regressed from a communication level of an 11-year old to a three-year old after she was raped. Meera testified in court, with the assistance of a special educator. The magistrate, however, refused to accept her testimony on the grounds that she did not use adult language. Her mother, Anjali, described the day that Meera testified:

“Meera has given her statement in court and the psychologist interpreted it. The psychologist asked her, ‘What did the bad man do?’ And she said, sobbing, with tears running down her face, ‘The bad man put his *sussu*’ [child term for penis]—and she pointed down. She couldn’t stop crying and the judge said—‘I will not accept that word.’ My daughter has barely managed to recover the communication of a 3-year-old. Even earlier she would not have known the anatomy of a man.” The interpreter, a psychologist who knows Meera well, explained that it is a perfectly acceptable childlike word.”⁷⁵

CASE STUDY 6:

One day when Hla Ching Marma, a 20 year old indigenous woman with disability, was home alone, a person who was working on the nearby road entered her house and raped her. This was witnessed by a local person. While he was trying to escape, he was nabbed by the locals and taken to the local counsel head. When he was taken to the police, the case was settled through the payment of compensation of Tk. 40,000. No further official action was taken.⁷⁶

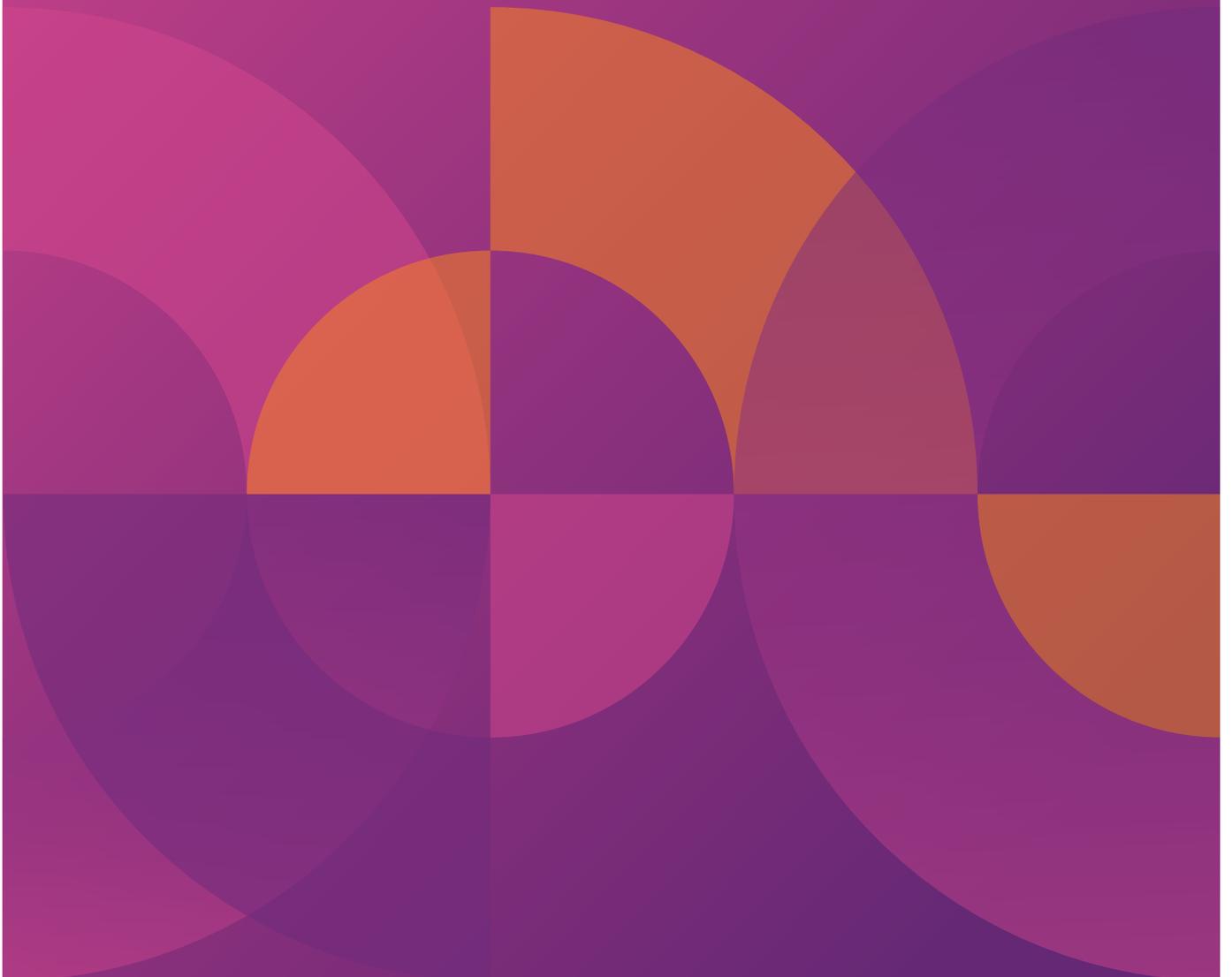
MODULE 8 PARTICIPANT HANDOUT 8.3

ORGANIZATIONS AND NETWORKS WORKING ON GENDER-BASED VIOLENCE IN BANGLADESH

(Activity 8.3: Access to Justice)

1. **ACCESS BANGLADESH FOUNDATION** – Works for grassroots persons with disabilities, including girls and women with disabilities. They implement their projects through DPOs and work on policy advocacy.
2. **ADD INTERNATIONAL, BANGLADESH** – Organization working on access to justice for persons with disabilities, as well as violence and discrimination towards persons with disabilities.
3. **AIN O SHALISH KENDRA (ASK)** – Human rights-based legal aid organization.
4. **BANGLADESH LEGAL AID AND SERVICES TRUST (BLAST)** – Human rights-based legal aid organization.
5. **BANGLADESH MAHILA PARISHAD (BMP)** – The oldest women’s human rights organization working towards the advancement of women’s rights in Bangladesh since 1970.
6. **BANGLADESH NATIONAL WOMEN’S LAWYERS ASSOCIATION (BNWLA)** – A platform for women lawyers across the country to enhance their professional capacities and skills to fight against all forms of violence.
7. **BANGLADESH SOCIETY FOR THE CHANGE AND ADVOCACY NEXUS (B-SCAN)** – An organization working with people with disabilities, that focuses on policy advocacy. They run a newspaper that focuses on news concerning persons with disabilities.
8. **CENTRE FOR THE REHABILITATION OF THE PARALYSED (CRP)** – CRP works to promote an environment where all girls and boys, and women and men with disabilities have equal access to health, rehabilitation, education, employment, the physical environment, and information.
9. **KAPAEENG FOUNDATION** – An organization that works on the rights of indigenous people in Bangladesh.
10. **MANUSHER JONNO FOUNDATION (MJF)** – Provides funding and capacity building support to organizations working on critical issues related to human rights (including disability rights) and governance.
11. **NAGORIK UDYOG** – Organization promoting social and gender justice, equality and rule of law with accountable, transparent and responsive institutions by mobilising community people through building their own self-sustaining agency that can help realise their rights and entitlements, with special focus on women, workers, socially excluded, underprivileged and minority communities.
12. **NARIPOKKHO** – Working on women’s rights and feminist movement especially around SRHR.
13. **NIJERA KORI** – Nijera Kori is a grassroots organization focused on establishing the fundamental rights of people to create a society free from oppression and deprivation.
14. **SOCIETY OF THE DEAF AND SIGN LANGUAGE USERS (SDSL)** – Works on building capacity on sign language interpretation.
15. **STEPS TOWARDS DEVELOPMENT (STEPS)** – Working to support women’s rights movement with activities on promoting gender equality.
16. **TURNING POINT FOUNDATION** – An organization of and for persons with disabilities. They are implementing a project on the reproductive health of women and girls with disabilities.

module 9
srhr advocacy



module 9

srhr advocacy

MODULE OBJECTIVES

1. To provide participants with tools and strategies for advocacy on SRHR.
2. To develop skills for practical application of rights-based advocacy.

ACTIVITIES

Activity 9.1: Laws and Policies on SRHR > 60 Minutes

Activity 9.2: Developing an Advocacy Strategy
> 120 Minutes

HANDOUTS

Activity 9.1: Laws and Policies on SRHR

- a. Facilitator Handout 9.1: Case studies on SRHR in Bangladesh
- b. Participant Handout 9.1: Case studies on SRHR in Bangladesh
- c. Participant Handout 9.2: Laws and Policies on SRHR in Bangladesh

Activity 9.2: Developing an Advocacy Strategy

- a. Participant Handout 9.3: Considerations for Developing an Advocacy Strategy
- b. Participant Handout 9.4: Problem Tree Analysis
- c. Participant Handout 9.5: The Nine Questions
- d. Participant Handout 9.6: Presenting the Advocacy Plan
- e. Participant Handout 9.7: Coalitions, Networks and Organizations working on Disability Rights

Activity 9.1.:

LAWS AND POLICIES ON SRHR

Objective:

To develop skills in legal advocacy and acquaint participants with provisions on SRHR under various human rights mechanisms.

Time:

60 Minutes

Materials Needed:

- Facilitator Handout 9.1
- Participant Handout 9.1. and 9.2

Process:

1. Ask participants to share what they understand from the term 'advocacy'.
2. Share the following features of advocacy:
 - a. "Advocacy includes a collection of strategies that can be used to achieve specific outcomes related to social, economic, political, cultural, legal, and civil change. For example, advocacy can be used to:
 - Advance rights through seeking to eliminate harmful and discriminatory laws and policies;
 - Mobilise towards the enactment of progressive, rights-based laws and policies;
 - Hold governments accountable to their human rights obligations as duty-bearers;
 - Create enabling environments for the realisation of rights.

Advocacy strategies focus on holding duty-bearers accountable for their obligations and empowering rights-holders to claim their rights as a means of catalysing systemic change." (Source: Action Canada for Sexual Health and Rights, Unpacking advocacy in the context of sexual and reproductive health and rights, 2019).

- b. Advocacy includes both public policy and addressing socio-cultural beliefs, attitudes and behaviours that make realisation of rights difficult. Therefore, advocacy can also involve changing public opinion.
- c. Advocacy efforts can be directed at multiple stakeholders – government departments, health officials, law enforcement officials such as police, judiciary, religious heads, local governance bodies, companies etc.
- d. Some examples of SRHR advocacy:
 - Strategic litigation – For example in the absence of specific sexual harassment laws in Bangladesh, the Bangladesh National Women Lawyers Association, filed a writ petition before the Supreme Court of Bangladesh to pass guidelines on protection of women at workplace and educational institutions.⁷⁷

- Mobilisation for upholding rights of women with disabilities – For example, Women with Disabilities Development Foundation (WDDF) partners with other women with disabilities’ organizations to recognise the rights and improve lives of women with disabilities in Bangladesh. Recognising the role that police and legal officers can play in hindering access to justice for women with disabilities, some of their efforts have included training police and the legal system about issues faced by women with disabilities, ensuring reports of violence are recorded, monitoring compliance of UNCRPD and submitting reports on status of compliance.
 - SRHR advocacy can also include building capacities of health care professionals to ensure health services and SRH information are accessible.
3. A key component of advocacy, therefore, is knowledge of laws and policies on SRHR at international, regional and national level, against which accountability can be ensured. Explain to the participants that in this activity, we will look at some of the laws and policies on SRHR.
 4. Divide the participants into four groups and give each group a copy of Participant Handout 9.1.
 5. In each of the case studies, the groups must identify if there is a corresponding legal right for the violation that is detailed in the case study. The groups have 30 minutes to discuss the case studies.
 6. Discuss each of the case studies and applicable law for each.
 7. Ask participants to go through Participant Handout 9.2.

Debrief:

1. Were participants aware of some of the laws discussed in the activity?
2. What are some of the gaps in national laws and policies with regard to rights of women and girls with disabilities?
3. How does knowledge of legal rights help in advancing sexual and reproductive health?
4. What are the barriers in the exercise of rights by persons with disabilities?

Key Messages:

1. Awareness of legal rights is crucial to hold duty-holders accountable, ensure availability of appropriate and accessible services and can be a key tool for redressal of violence and discrimination faced by marginalised people, including persons with disabilities.

2. In the context of Bangladesh, there are limited mechanisms to litigate violations of sexual and reproductive health. The Rights and Protection of Persons with Disabilities Act, 2013 provides only for the right to marriage and having a family but fails to holistically address sexual and reproductive health of women and girls with disabilities, including on questions of accessibility, information provision, education, employment, health care and access to justice. The laws on gender-based violence applies to everyone, which includes women and girls with disabilities. However, they do not account for specific concerns of women and girls with disabilities, such as unique forms of violence faced by them, accessibility needs in reporting and accessing justice, and other forms of support required by women and girls with disabilities.
3. Due to factors such as social marginalisation, low literacy level and lack of accessible information, there is very little awareness on SRHR applicable to women and girls with disabilities in Bangladesh.
4. There is poor implementation of laws and policies in practice and attitudinal barriers make it difficult to access justice and receive relief/compensation for violations of sexual and reproductive health rights of women and girls with disabilities.

Notes for the Facilitator:

1. The participants may have difficulty in understanding the importance of international mechanisms, as it may seem far removed. Stress on the importance of international mechanisms, especially for marginalised groups, as it can create pressure on governments to uphold their obligations. This can be further explained through some successes, such as the process of shadow reporting under CRPD, by which grassroots organizations were able to shed light on violations against persons with disabilities, and obtain suitable recommendations from the Committee to which they can hold the government accountable. Similarly, provisions under CEDAW have been used by courts in Bangladesh to direct governments to enact guidelines to fulfil their obligations, as was observed in the case of the court laying down guidelines on sexual harassment. Recommendations by the CEDAW Committee have also been used to hold forced veiling as a form of discrimination and delineate it as gender-based violence.
2. Many participants may have experiences of filing cases or being a part of different advocacy efforts. Encourage them to share their experiences of doing rights-based advocacy.

**Activity 9.2:
DEVELOPING AN ADVOCACY STRATEGY**

Objective:

To provide tools for SRHR advocacy and develop practical knowledge in building SRHR advocacy strategies.

Time:

120 Minutes

Materials Needed:

- Participant Handouts 9.3, 9.4, 9.5, 9.6, and 9.7

Process:

1. Share Participant Handout 9.3 which details considerations involved in developing an advocacy strategy and have a discussion on the points highlighted.
2. Explain to the participants that in this activity they will be using advocacy tools to develop an advocacy strategy on an SRHR theme of their choice. You can use some of the areas of concerns that may have come up during the course of the training – sensitising police officials, working with health professionals, working with community leaders,

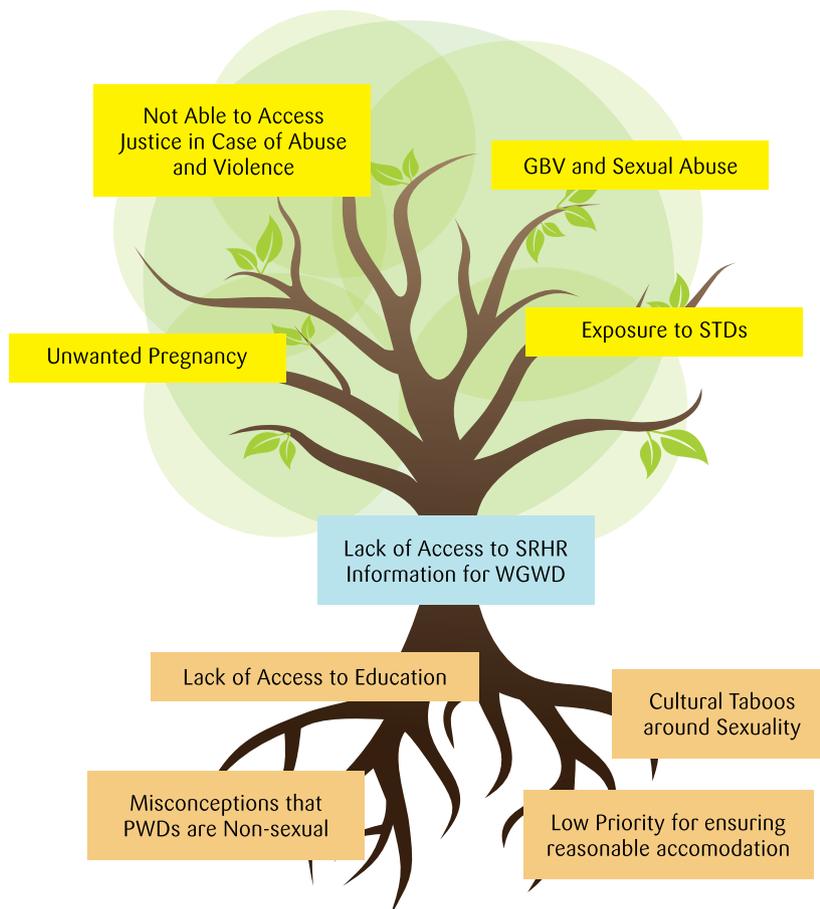
accessible SRHR information etc. Participants can pick any theme from the Modules covered in the training.

3. Divide the participants into three groups.
4. Each group must pick an issue they would like to address. In identifying an issue, the groups can use Participant Handout 9.4, the problem tree, to identify the problem and its root causes, so that advocacy efforts can be focused. Explain that the trunk of the tree represents the problem being discussed, the roots represent the causes (which give rise to and sustain the problem) and the branches symbolise the consequences/effects arising from the problem. The problem tree tool helps to identify the root causes behind a problem, which ensures that advocacy efforts are aimed at targeting the causes, instead of the symptoms.

Participants can use post-it notes on the problem tree: They can first identify the problem they want to address, and then add post-it notes for causes and consequences. They should allocate 10 minutes to this.

FIGURE 43: SAMPLE PROBLEM TREE

Looking at the Issue of Lack of Access to SRH Information for Women and Girls with Disabilities



Variation: For groups comprising of persons with visual disability and those with low reading and writing skills, the activity can be discussed orally.

5. Once they have identified the problem in their smaller groups, participants must use Handout 9.5 to further sharpen the analysis. Groups should allocate 40 minutes to this.
6. Finally, the participants must put together their strategy into a short presentation format using Handout 9.6. Groups should allocate 20 minutes to this.
7. Overall the groups have 70 minutes for the activity.
8. At the end of 70 minutes, each group must present their final advocacy strategy in 5-10 minutes each. Presentation of key points should be as per Handout 9.6.
9. Distribute copies of Participant Handout 9.7. The Handout provides a list of coalitions, networks and organizations that are working on disability rights at the national, regional and international level. Participants may consider an outreach to these organizations, coalitions and networks as a part of their advocacy efforts.

Debrief:

1. Did the activity help boost confidence in participants' ability to carry out advocacy around SRHR issues?
2. Which tools were helpful and what other support would be needed for building an effective advocacy strategy?

Key Messages:

1. All of us have the capacity to be catalysts for change and ensure that our rights are realised. These tools help us to gauge what we need, build on what we have and advocate for change effectively.
2. Start with smaller and concrete goals and changes, leading up to larger goals that are often more structural.
3. People have a right to make decisions about issues that affect them. In developing advocacy efforts, active participation and decision making capacity of all impacted groups, especially the most marginalised, must be recognised and ensured.

Notes for the Facilitator:

1. If participants face difficulty in answering the questions in the Handout, provide concrete examples.
2. For this session, you can also invite a guest speaker to share about their advocacy efforts on SRHR, enabling participants to visualise the activity more concretely and gain practical knowledge of how strategies are put into action.

Resources for Further Reading:

1. Website of Bangladesh Legal Aid and Services Trust (BLAST). Available at: [Link] <https://www.blast.org.bd/>. Accessed on 13 September 2020.
2. Website of Ain-O-Salish Kandra, Legal Aid & Human Rights Organization. Available at: [Link] <http://www.askbd.org/ask/>. Accessed on 13 September 2020.
3. Website of BRAC University, Human Rights and Legal Aid Services. Available at: [Link] <http://www.brac.net/program/human-rights-and-legal-aid-services/>. Accessed on 13 September 2020.
4. Naripokkho and ARROW (2017). *Country Profile on Universal Access to Sexual and Reproductive Rights: Bangladesh*.
5. National Grassroots and Disabilities Organization (NGDO), National Council for Women with Disabilities (NCDW), Bangladesh Legal Aid and Services Trust (BLAST) (2015). *Current status of Rights of Persons with Disabilities in Bangladesh: Legal and Grassroots Perspectives*.
6. Abdullah Titir (2019). *From Recognition to Realizing Rights*. Dhaka: Bangladesh Legal Aid and Services Trust (BLAST).
7. Abdul Aziz and Sameena Azhar, (2020). 'Social Exclusion and Official Recognition of Hijra in Bangladesh', *Journal of Women and Gender*, 9(1), p. 3-19.
8. Amy Lynne Locklear and Sunila Abeysekera (2012). *Reclaiming and Redefining Rights, Guidance Series: Analysing Sexual and Reproductive Health and Rights under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*, ARROW.
9. Sonke Gender Justice and MenEngage Africa (2019). *SRHR Advocacy Toolkit for Young People*.
10. ARROW (2010). *Making a Difference: Improving Women's Sexual and Reproductive Health and Rights in South Asia – A Resource Book for Advocates*.

MODULE 9_FACILITATOR HANDOUT 9.1_Page 1

CASE STUDIES ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN BANGLADESH

(Activity 9.1: Laws and Policies on SRHR)

CASE STUDY 1

Hena Akther, a 14 year old girl, was alleged to have an extra marital affair with a married cousin by the cousin's wife. However, media reports of the incident alleged that she was actually sexually assaulted by the married cousin. The cousin's wife complained to the local *shalish* (traditional dispute resolution processes, often involving religious leaders) that she had seen Hena speaking to her husband near their home. The *shalish* ruled that Hena and the man should each be flogged 100 times. Halfway through the beatings, she collapsed and became unconscious and had to be taken to hospital, where she died a week later.⁷⁸

Discussion: Extra judicial penalties (including –s) by the local *shalish*, are a form of cruel, inhuman, and degrading treatment or punishment. In the past some of these penalties have included whipping, lashing, publicly humiliating women and girls by forcibly cutting their hair or blackening their faces, ostracising women, girls, and their families, and imposing fines.

In the case of *Bangladesh Legal Aid and Services Trust and others vs Bangladesh and others*, the High Court division of Supreme Court of Bangladesh held that the imposition of all sorts of extrajudicial punishments in the name of ‘–’ illegal. Further, it held that any person involved, present or assisting in any conviction or execution of extrajudicial punishment shall be liable to punishment under the Penal Code, 1860. The Supreme Court of Bangladesh has also held that no punishment, including physical violence and/or mental torture in any form can be imposed or inflicted on anybody in pursuance of –. The court further held that –s can be issued only by “properly educated persons” and clarified that even where issued, they are not binding and cannot be enforced.

Due to inaccessibility of legal systems, combined with other socio-economic factors, persons with disabilities are often forced to rely on *shalish* systems. For example, a study by DPOs revealed that in 61% of the cases, the dispute between a persons with disabilities (facing violence, exploitation or torture) and the perpetrators was settled through a *shalish*.⁷⁹

CASE STUDY 2

“Sriya married Farid in 2010 in accordance with Muslim personal law. In the marriage registration documents, the dowry amount was fixed at Tk. 70,000 (seventy thousand). At the time of marriage, Sriya's father gave Tk. 20,000 (twenty thousand taka) and furniture as a gift to the couple. However, Farid became very violent towards Sriya after their marriage, and started to demand payments of dowry from her and became violent when she failed to meet his demands. Ultimately when he demanded Tk. 25,000 (twenty five thousand) and Sriya could not pay, Farid threw her out of his house.”⁸⁰

Discussion: This is in violation of the Dowry Prohibition Act, 2018. According to the Act, any person demanding or giving dowry will have to face imprisonment, which will not be less than one year's jail term, or maximum Tk 50,000 as fine or both.

The marriage of a woman with disability in exchange for a huge dowry is reportedly quite common.⁸¹

CASE STUDY 3

“Kameela married Kamrul, a businessman in 1991 under Muslim personal law. In 2005, Kameela found out that Kamrul had an extra marital affair with an office employee. They then started living separately within the same house. During this time, Kamrul did not provide her with maintenance regularly and also subjected her to physical and mental violence. On 6 January 2012, Kamrul suddenly became violent and threatened Kameela, demanding she get out of the house despite the fact that the sales deed of the flat was executed and registered jointly in both Kameela and Kamrul's name.”⁸²

Discussion: This is in violation of the Domestic Violence (Prevention and Protection) Act, 2010. As per the act, domestic violence includes physical abuse, psychological abuse, sexual abuse or economic abuse by any person of that family with whom victim is, or has been, in family relationship. In particular, Section 10 of the Act states that the victim shall have every right to reside in the shared residence due to family relationship. The court can also pass orders restraining the person against whom the complaint has been filed from visiting, residing in the shared residence

MODULE 9_FACILITATOR HANDOUT 9.1_Page 2

CASE STUDIES ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN BANGLADESH

(Activity 9.1: Laws and Policies on SRHR)

where the victim resides and from changing ownership of shared property. The court can also pass protection orders restraining the person from committing, aiding and abetting further acts of domestic violence.

CASE STUDY 4

Pinki is a 32 year old *hijra* who wanted a medical referral from a doctor in the hospital. However, Pinki found that discrimination made it impossible for *hijras* to seek medical care. Pinki found that when trying to visit doctors they are often informed that the doctors are not present. Therefore, they often have no choice but to take care of their medical issues themselves, even if they are in critical medical need. *Hijras* have noted that when they visit hospitals, people often stare at them in hospital waiting rooms, resulting in feelings of embarrassment and humiliation.⁸⁴

Discussion: In 2013 the Bangladeshi cabinet endorsed a policy allowing *hijras* to self-identify as ‘third gender’ on all government forms, including passports and national identification cards. In January 2014, the Ministry of Social Welfare published a gazette notification stating that the *Hijra* community “shall be recognised as the ‘Hijra sex/gender’ (‘Hijra *linggo*’). However, this recognition expressly refers to ‘Hijra’. It does not deal with other communities and individuals who have non-normative gender and sexual expressions, and do not conform to the gender assigned to them at birth (*transgender women and men*), but do not belong to the *Hijra* culture.”

The Fundamental Principles of State Policy set out in the Bangladesh Constitution mandate the state to provide the basic necessities for all citizens, including medical care. Since this applies to all citizens, *Hijra*, transgender and other gender non-conforming communities, are automatically covered by it. However, in practice, discrimination in access to healthcare continues to exist. Access to healthcare must be provided in a way that ensures that the *hijra* community does not experience discrimination. This requires sensitisation trainings to be mandated for health care workers.⁸⁵

CASE STUDY 5

Golapi is 18 years old and works in a garment manufacturing factory. During many instances, her supervisor touched her shoulder and back, tried to touch her breasts and even commented on her figure and appearance and made remarks about wanting “to have her”. One day when Golapi was on night shift duty, she was called by the supervisor into a room where the manager was also present. Both the supervisor and the manager tried to rape her. Golapi started screaming and cried for help, but the manager attempted to stifle her scream by trying to choke her with his shirt. As a result of this she started bleeding from her mouth. She was taken to the hospital in an almost unconscious condition.⁸⁶

Discussion: In *Bangladesh National Women Lawyer’s Association v. Government of Bangladesh & Others*, the High Court Division of the Supreme Court laid down guidelines on sexual harassment to be followed at all workplaces and educational institutions. The guidelines provide a wide definition of sexual harassment to include, unwelcome sexually determined behaviour, attempts or efforts to establish physical relation having sexual implication by abuse of powers, sexually coloured language, demand or request for sexual favours, insults and jokes having sexual implications etc. It requires governments to initiate public awareness and provides for the setting up of a compliant mechanism, including a complaint committee with majority women members.

MODULE 9 PARTICIPANT HANDOUT 9.1

CASE STUDIES ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN BANGLADESH

(Activity 9.1: Laws and Policies on SRHR)

CASE STUDY 1

Hena Akther, a 14 year old girl, was alleged to have an extra marital affair with a married cousin by the cousin's wife. However, media reports of the incident alleged that she was actually sexually assaulted by the married cousin. The cousin's wife complained to the local *shalish* (traditional dispute resolution processes, often involving religious leaders) that she had seen Hena speaking to her husband near their home. The *shalish* ruled that Hena and the man should each be flogged 100 times. Halfway through the beatings, she collapsed and became unconscious and had to be taken to hospital, where she died a week later.⁸⁷

CASE STUDY 2

*"Sriya married Farid in 2010 in accordance with Muslim personal law. In the marriage registration documents, the dowry amount was fixed at Tk. 70,000 (seventy thousand). At the time of marriage, Sriya's father gave Tk 20,000 (twenty thousand taka) and furniture as a gift to the couple. However, Farid became very violent towards Sriya after their marriage, and started to demand payments of dowry from her and became violent when she failed to meet his demands. Ultimately when he demanded Tk 25,000 (twenty five thousand) and Sriya could not pay, Farid threw her out of his house."*⁸⁸

CASE STUDY 3

*"Kameela married Kamrul, a businessman in 1991 under Muslim personal law. In 2005, Kameela found out that Kamrul had an extra marital affair with an office employee. They then started living separately within the same house. During this time, Kamrul did not provide her with maintenance regularly and also subjected her to physical and mental violence. On 6 January 2012, Kamrul suddenly became violent and threatened Kameela, demanding she get out of the house despite the fact that the sales deed of the flat was executed and registered jointly in both Kameela and Kamrul's name."*⁸⁹

CASE STUDY 4

Pinki is a 32 year old *hijra* who wanted a medical referral from a doctor in the hospital. However, Pinki found that discrimination made it impossible for *hijras* to seek medical care. Pinki found that when trying to visit doctors they are often informed that the doctors are not present. Therefore, they often have no choice but to take care of their medical issues themselves, even if they are in critical medical need. Others have noted that when they visit hospitals, people often stare at them in hospital waiting rooms, resulting in feelings of embarrassment and humiliation.⁹⁰

CASE STUDY 5

Golapi is 18 years old and works in a garment manufacturing factory. During many instances, her supervisor touched her shoulder and back, tried to touch her breasts and even commented on her figure and appearance and made remarks about wanting "to have her". One day when Golapi was on night shift duty, she was called by the supervisor into a room where the manager was also present. Both the supervisor and the manager tried to rape her. Golapi started screaming and cried for help, but the manager attempted to stifle her scream by trying to choke her with his shirt. As a result of this she started bleeding from her mouth. She was taken to the hospital in an almost unconscious condition.⁹¹

MODULE 9 PARTICIPANT HANDOUT 9.2 Page 1

LAWS AND POLICIES ON SRHR IN BANGLADESH

(Activity 9.1: Laws and Policies on SRHR)

1. CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (See Participant Handout 2.3 under Module 2)

2. CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)

The United Nations' Convention on the Elimination of all forms of Discrimination against Women (CEDAW) sets out a comprehensive set of rights for women in civil, political, economic, social and cultural fields. Like CRPD, it is an international human rights treaty which creates obligations on states that ratify it. The Government of Bangladesh ratified the CEDAW in 1984. As part of the obligations of member states ratifying the Convention, the governments are obliged to submit a periodic report to the Committee on the Elimination of all forms of Discrimination Against Women (CEDAW Committee).

Why is it important?

- Once a state ratifies the Convention, they are obliged to take a variety of steps to protect and promote women's human rights, which includes taking appropriate actions to bring about equality between women and men in all areas, taking action to eliminate discrimination against women in the areas of employment, education, health, economic and social life, marriage, and family life, and modify social and cultural norms, values, and practices based on stereotypes.
- The government has to report to the CEDAW Committee on progress made in terms of implementing the CEDAW every four years (after the first report within one year). Civil society and NGOs prepare their own reports, called alternate or "shadow" reports, to indicate how successfully the government has met its obligations. The Committee reviews all these documents to ask the government questions and provides recommendations for greater compliance. Therefore, this provides a critical space for NGOs to draw attention to the gaps and challenges being faced.

- Obligations under CEDAW can be used to pressure governments to enact laws and policies to eliminate discrimination against women. Courts in Bangladesh have relied on CEDAW to direct the government to take action on issues such as sexual harassment and to protect women from forced veiling.

Key provisions relevant to SRHR:

1. **Article 12:** Women have equal rights to a health care access including sexual health, family planning services and pre and post-natal care.
2. **Article 14:** Upholds the right of rural women to have access to adequate health care facilities, including information, counselling and services in family planning.
3. **Article 16:** Requires governments to take measures to eliminate discrimination against women in all matters relating to marriage and family relations, including rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights. It also requires governments to take action against child marriage.

Many other rights mentioned in CEDAW are interconnected with SRHR as well.

3. CONSTITUTION OF BANGLADESH

Article 28 provides that no citizen shall be discriminated on the grounds of religion, race, caste, sex or place of birth. It also ensures that women have equal right as men in public life and also provides for special provisions for the advancement of 'backward sections', including women. Article 27 ensures the right of all citizens to be treated equally before the law and everyone is entitled to equal protection of law (non-discrimination).

MODULE 9 PARTICIPANT HANDOUT 9.2 Page 2

LAWS AND POLICIES ON SRHR IN BANGLADESH

(Activity 9.1: Laws and Policies on SRHR)

4. KEY POLICIES AND LAWS ON SRHR

<p>National Population Policy, 2012</p>	<p>An important objective of the policy is to ensure the availability of family planning methods to eligible couples. It seeks to achieve this by: providing easy access to reproductive health services including family planning methods; building awareness among the poor and adolescents on family planning, reproductive health, reproductive tract infections and HIV/AIDS; and prioritising counseling services. It requires framing of policies and programmes to advance this.</p>
<p>National Health Policy, 2011</p>	<p>Aims to ensure primary and emergency health care services for all on the basis of rights and dignity.</p>
<p>National Policy for Women's Advancement 2011</p>	<p>Has a section on 'Special Programme for Disabled Women', which requires that right of recognition and the right to live with honour and dignity be upheld. It seeks to ensure that women with disability are part of mainstream society and can participate equally in all aspects of life.</p> <p>It also requires the government to make the framework, facilities and services accessible to all, so that women with disabilities are not deprived of any kind of rights, facilities and services set up under the Policy.</p>
<p>National Strategy for Adolescent Health 2017-2030</p>	<p>It recognises that adolescents with disabilities are more vulnerable in terms of having access to education, information on health, SRHR, and are more susceptible to higher incidence of violence, including sexual violence. It also recognises the importance of addressing disability as a cross-cutting issue.</p> <p>Its strategy objectives include promotion of age appropriate comprehensive sexuality education.</p>
<p>4th National Strategic Plan For HIV and AIDS Response</p>	<p>The plan seeks to minimise the spread of HIV and minimise the impact of AIDS on the individual, family, community, and society through enhanced prevention linked with testing, treatment, care and support.</p> <p>It also seeks to ensure quality and coverage in the delivery of services and seeks to eliminate stigma and discrimination.</p>
<p>The Child Marriage Restraint Act, 2017</p>	<p>The Act states that the minimum age of marriage is 18 for women and 21 for men. It further provides for punishment and a fine for anyone who performs, conducts or directs any child marriage.</p> <p>It also contains a 'special circumstances' clause which allows child marriage under special circumstances, where the marriage is in '<i>the best interests of the child</i>', at the directions of the court and with consent of the parents or guardian of the child. This clause is potentially very problematic for girls with disabilities and can be a grave violation of SRHR.</p> <p>Parents/guardians of girls with disabilities might think that they would not be able to find a suitable groom for their child when she grows up because of her disability and the stigma attached with that, and find it "in the best interests" of their girl to be married off even as a minor to any potential suitors, presumably as a way to ensure lifelong security for her.</p> <p>Forced and early marriage is a common phenomenon for women and girls with disabilities, and the existence of such a clause, in a law that is meant to restrain child marriage in the first place, exposes children to vulnerable situations where their consent, agency and right to bodily integrity are not respected.</p>
<p>The Family Court Ordinance, 1985</p>	<p>Deals with causes of marriage, divorce, and the maintenance, guardianship, and custody of children.</p>

MODULE 9 PARTICIPANT HANDOUT 9.2_Page 3

LAWS AND POLICIES ON SRHR IN BANGLADESH

(Activity 9.1: Laws and Policies on SRHR)

<p>The Prevention of Oppression Against Women and Children Act 2000</p>	<p>Contains punishments for rape, acid attacks, sexual assault, and dowry death, among others.</p> <p>However, in this Act, rape is defined as vaginal penetration only by the penis, where the burden of proof lies on the complainant.</p>
<p>Dowry Prohibition Act, 2018</p>	<p>Prohibits and penalises giving and taking of dowry with a punishment of maximum five years' imprisonment, which will not be less than one year's jail term or maximum Tk 50,000 as fine or both.</p>
<p>Domestic Violence (Prevention and Protection) Act 2010 and Domestic Violence (Prevention and Protection) Rules 2013</p>	<p>Domestic violence includes physical abuse, psychological abuse, sexual abuse or economic abuse by any other person of that family with whom victim is, or has been, in family relationship. Provides for protection orders, temporary maintenance to survivors of domestic violence, right to remain in a shared household, residence orders including prohibition from changing ownership of shared property, claims for compensation and child custody.</p> <p>Provides duties of police officers, medical service providers, shelter homes and other service providers. The Rules state that service providers must provide necessary cooperation to women with disabilities.</p>
<p>Acid Crime Prevention Act 2002 and Acid Crime Control Act, 2002</p>	<p>Acid Crime Prevention Act provides for penalties for acid attack, creates a special court procedure for acid attack cases; and the Acid Control Act regulates and monitors the use, sale, purchase, storage, transportation, import, and export of acid in Bangladesh, and also makes provisions for treatment, rehabilitation and legal assistance for survivors of acid attacks.</p>
<p>Judgment of the High Court Division of the Supreme Court of Bangladesh in Naripokkho and others vs. Bangladesh and others [Writ Petition No. 5541 of 2015]</p>	<p>The Supreme Court of Bangladesh issued 18 directives on the prosecution of rape cases. These directives are guidelines meant to be followed by police officers, Victim Support Centres and forensics teams when responding to survivors of sexual violence and through the complaints/investigation/trial processes. One of these directives is about ensuring that interpretation services are provided where necessary, particularly for women or girls with disabilities who have been subjected to rape or sexual assault.</p> <p>However, despite these directives, implementation is poor and interpretation services are not available at police stations.</p>
<p>Menstrual Regulation</p>	<p>While abortion is illegal except to save the life of a woman, medical menstrual regulation (MR) is allowed up to nine weeks from the last date of menstruation and menstrual regulation involving vacuum suction is allowed within 10 weeks of pregnancy when conducted by paramedics and 12 weeks of pregnancy by medical doctors.</p>
<p>Section 377 of Penal Code of 1860</p>	<p>Criminalises same-sex sexual activity, whether in public or private. However, this is in contradiction with anti-discrimination clause and the right to equality before the law guaranteed by the Constitution of Bangladesh.</p>
<p>Gender Identity</p>	<p>In January 2014, the Ministry of Social Welfare published a gazette notification stating that the Hijra community “shall be recognised as the ‘Hijra sex/gender’ (‘Hijra linggo’)”. However, this recognition expressly refers to ‘Hijra’. It does not deal with other communities and individuals who have non-normative gender and sexual expressions, and do not conform to the gender assigned to them at birth (transgender women and men), but do not belong to the <i>Hijra</i> culture.⁹²</p>

MODULE 9 PARTICIPANT HANDOUT 9.3

CONSIDERATIONS FOR DEVELOPING AN ADVOCACY STRATEGY

(Activity 9.2: Developing an Advocacy Strategy)

(Adapted from: ARROW (2010), Making a Difference: Improving Women's Sexual and Reproductive Health and Rights in South Asia – A Resource Book for Advocates.

1. **DEFINING AN ADVOCACY ISSUE:** In general an advocacy issue should be linked to a clear policy/programme solution and should be easily communicable to as many people as possible. Some important questions to keep in mind are as follows:
 - Is there evidence available on the issue? If not, how can evidence be built? Building evidence allows us to understand what is going wrong, who is directly affected, and the seriousness of the problem.

In building evidence, keep in mind those who are most impacted by the issue and ensure their meaningful participation and representation in the process of building evidence.

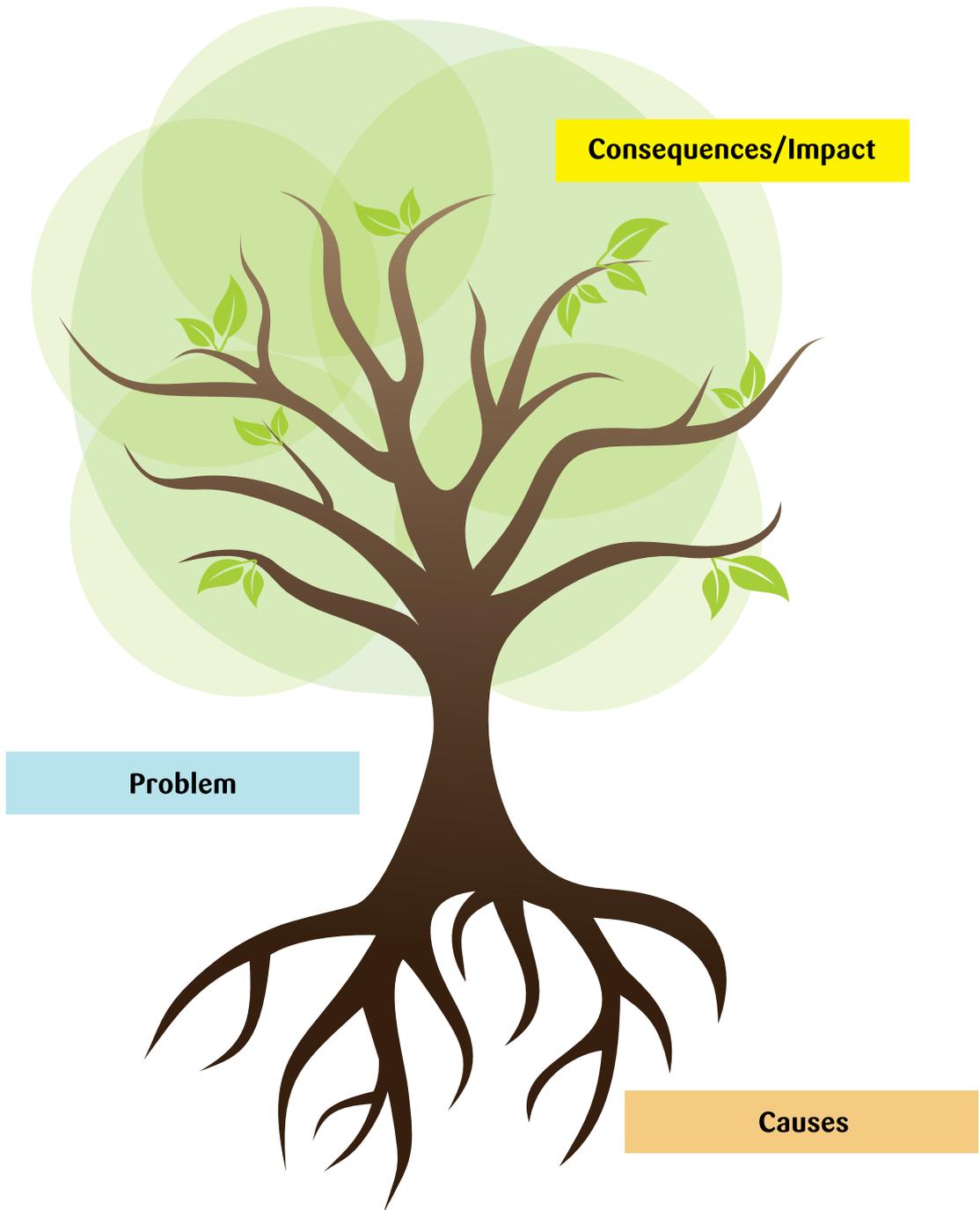
 - Based on the evidence on the issue, what are the existing gaps that need to be addressed?
 - Is it a 'content' problem – for example there is no law or policy to address a specific issue or existing laws and policies are not sufficient/harmful? Or is it a 'process' issue – a problem of implementation?
2. **POSITIONALITY VIS-À-VIS THE ISSUES**
Some Questions to Keep in Mind:
 - How are you affected by the issue?
 - Are you speaking on behalf of another group? What are your assumptions and motivations in doing so? In doing so, are you reinforcing power and hierarchy in some way?
 - How is the issue being framed – are those who are most marginalised and affected included and do they have the ability to represent themselves?
 - How are you building an intersectional approach into your advocacy lens and strategy?
3. **MAPPING STAKEHOLDERS:** List all possible actors who could have anything to do with the issue from micro to macro level. Segregate the stakeholders on the following basis:
 - 'Allies' – those who will support you on the issue
 - 'Threats' – those who will oppose you on the issue
 - Those who do not have a clear position on the issue/ are not presently engaging on the issue
4. **DEVELOPING AN ADVOCACY STRATEGY:** Advocacy strategies are usually focussed on building alliances with allies, neutralising/countering the impact of threats, and convincing those who are undecided/not engaged in your favour. Some of the considerations to be kept in mind are as follows:
 - Is your advocacy effort reactive (for example reacting to a legislation/policy being passed) or proactive (often sustained long-term advocacy)? Analyse the situation to see the kind of strategy required. This will guide the form of action and evaluation of strategy.
 - Do you want to 'engage with' or 'confront'? This will usually depend on the nature of the stakeholder.
 - Do you want to engage in advocacy by participating within the system (for example by attending consultations set up the government), outside the system (through protests and campaigns), or use a mix of both?

MODULE 9 PARTICIPANT HANDOUT 9.4

PROBLEM TREE ANALYSIS

(Activity 9.2: Developing an Advocacy Strategy)

FIGURE 44: PROBLEM TREE TEMPLATE



MODULE 9 PARTICIPANT HANDOUT 9.5

THE NINE QUESTIONS

(Activity 9.2: Developing an Advocacy Strategy)

The following tool of “Nine Questions of Advocacy” has been developed by the Advocacy Institute.⁹³ The questions and parts of the explanation developed by them, have been extracted in this Handout.

1. **WHAT DO WE WANT? (GOALS)**
(Short term and long-term goals)
2. **WHO CAN GIVE IT TO US? (AUDIENCES; KEY PLAYERS; OR POWER-HOLDERS)**
(Who are the people and institutions that you need to approach – legislators, law enforcement, healthcare, international bodies, religious bodies, local governance, public, media etc.)
3. **WHAT DO THEY NEED TO HEAR? (MESSAGES)**
(Advocacy messages will have two basic components: an appeal to what is right and an appeal to the audience’s self-interest.)
4. **WHO DO THEY NEED TO HEAR IT FROM? (MESSENGERS)**
(The same message has a very different impact depending on who communicates it – In some cases, these messengers are “experts” whose credibility is largely technical, while sometimes it needs to be those who can speak from personal experience. What do we need to do to equip these messengers, both in terms of information and to increase their comfort level as advocates?)
5. **HOW CAN WE GET THEM TO HEAR IT? (DELIVERY)**
(Tactics to deliver the message – lobbying, capacity building, arts campaigns, theatre, etc.)
6. **WHAT DO WE HAVE? (RESOURCES)**
(This includes past advocacy work that is related, legislations and policies, reports and data, alliances already in place, staff and other people’s capacity, information and political intelligence. Build on what you have got.)
7. **WHAT DO WE NEED TO DEVELOP? (GAPS)**
(This includes looking at alliances that need to be built, need for data, and capacities such as outreach, media, and research, which are crucial to any effort.)
8. **HOW DO WE BEGIN? (FIRST STEPS)**
(What would be an effective way to begin to move the strategy forward?)
9. **HOW DO WE TELL IF IT’S WORKING? (EVALUATION)**
(Strategy needs to be evaluated by revisiting each of the questions above (i.e., are we aiming at the right audiences; are we reaching them, etc.) It is important to be able to make mid-course corrections and to discard those elements of a strategy that don’t work once they are actually put into practice.)

MODULE 9 PARTICIPANT HANDOUT 9.6

PRESENTING THE ADVOCACY PLAN

(Activity 9.2.: Developing an Advocacy Strategy)

FIGURE 44: TEMPLATE FOR PRESENTATION OF ADVOCACY PLAN

What is the issue?

What are your long term and short term goals?

Who is your target group?

What resources do you have/need?

What challenges do you expect?

How will you achieve your goals? (Planned activities)

MODULE 9 PARTICIPANT HANDOUT 9.7 Page 1

COALITIONS, NETWORKS AND ORGANIZATIONS WORKING ON DISABILITY RIGHTS

(Activity 9.2: Developing an Advocacy Strategy)

NATIONAL LEVEL:

1. National Grassroots Disabilities Organisation (NGDO), Bangladesh – NGDO is a national level network of grassroots DPOs working to promote the rights and inclusion of people with disabilities in Bangladesh.
2. National Council of Disabled Women (NCDW) – National Council of Disabled Women (NCDW) is national-level network organization of 111 grassroots groups of women and girls with disabilities (DPOs) across 23 districts in Bangladesh.
3. Human Rights Forum, Bangladesh – Human Rights Forum Bangladesh (HRFB) is a coalition of 20 human rights and development organizations working for the promotion and protection of human rights in the country. Started in 2007, the Forum was initially titled Human Rights Forum on Universal Periodic Review (HR-UPR Forum) since its main objective was to collectively prepare the Stakeholders Report to submit under the Universal Periodic Review process of the UN Human Rights Council. Later in 2012, the Forum was transformed into the Human Rights Forum Bangladesh (HRFB), expanding its remit to a more comprehensive range of human rights issues going beyond the task of reporting under UN human rights mechanisms.
4. Citizen's Initiatives on CEDAW, Bangladesh (CIC-BD) – CIC-BD is a platform of 56 non-government women and human rights organizations working for the full ratification and implementation of CEDAW Convention in Bangladesh since 2007.
5. Citizen's Platform for SDGs – Being encouraged by the two features of the 2030 Agenda for Sustainable Development Goals (SDGs) i.e. transformative and inclusive and remaining committed to implementing 2030 Agenda, a group of individuals have taken an initiative to set up the Citizen's Platform for SDGs, Bangladesh with the objective to contribute to the delivery of the SDGs and enhance accountability in its implementation process.

The Platform was formally launched on 18 June 2016. Apart from the Core Group of individual members, the Platform also include 104 organizations from across the country working on SDGs as Partners. The overall guidance is provided by an Advisory Group, who are eminent citizens of the country. The Secretariat of the Platform is being hosted by the Centre for Policy Dialogue (CPD).
6. National Human Rights Commission, Bangladesh – NHRC was established by the National Human Rights Commission Act, 2009 after the original ordinance lapsed. Then it was reconstituted in 2009 as a national advocacy institution for human rights promotion and protection. It is committed to the accomplishment of human rights in a broader sense, including dignity, worth and freedom of every human being, as enshrined in the Constitution of the People's Republic of Bangladesh and different international human rights conventions and treaties to which Bangladesh is a signatory.

MODULE 9 PARTICIPANT HANDOUT 9.7_Page 2**COALITIONS, NETWORKS AND ORGANIZATIONS WORKING ON DISABILITY RIGHTS****(Activity 9.2: Developing an Advocacy Strategy)****REGIONAL LEVEL:**

1. Asia Pacific Forum on National Human Rights Institutions (Link to the website: <https://www.asiapacificforum.net/human-rights/people-disabilities/>)
2. Various regional forums and dialogues led by UNESCAP (Link to the website: www.unescap.org)
3. Commonwealth Human Rights Initiative (Link to the website: www.humanrightsinitiative.org)
4. Advocacy in regional and international spaces led by regional rights-based NGOs and networks such as:
 - Asian Indigenous Women's Network [IAWN] (Link to IAWN's website: <https://www.asianindigenouswomen.org/>)
 - Asia Pacific Forum on Women, Law and Development [APWLD] (Link to APWLD's website: <https://apwld.org/>)
 - CREA (Link to CREA's website: <https://creaworld.org/>)
 - International Women's Rights Action Watch Asia Pacific [IWRAP Asia Pacific] (Link to IWRAP Asia Pacific's website: <https://www.iwrap-ap.org/>)
 - The Asian-Pacific Resource & Research Centre for Women [ARROW] (Link to ARROW's website: <https://arrow.org.my/>)
5. South Asia Reproductive Justice and Accountability Initiative (SARJAI) (Link to the website: <http://www.reproductiverights.org/initiatives/sarjai>)
6. Transforming Communities for Inclusion Asia-Pacific [TCI Asia-Pacific] (Link to TCI Asia Pacific's website: <https://www.tci-asia.org/>)

INTERNATIONAL LEVEL:

1. Advocacy efforts led by donors and international orgs such as:
 - International Disability Alliance [IDA] (Link to IDA's website: <https://www.internationaldisabilityalliance.org/>);
 - Action on Disability and Development International [ADD International] (Link to ADD International's website: <https://www.add.org.uk>);
 - Handicap International (Link to Handicap International's website: <https://hi.org/en/index>); and
 - Disability Rights Fund [DRF] (Link to DRF's website: <https://disabilityrightsfund.org/>).
2. The UN Stakeholder Group of Persons with Disabilities for Sustainable Development (Link to the website: <https://sustainabledevelopment.un.org/majorgroups/personswithdisabilities>).
3. Special Rapporteur on the rights of persons with disabilities (Link to the website: <https://www.ohchr.org/en/issues/disability/srdisabilities/pages/srdisabilitiesindex.aspx>).
4. Disability rights based projects in academic institutions such as the Harvard Law School Project on Disability (Link to the website: <https://hpod.law.harvard.edu/about/mission>).
5. International SRHR based organizations such as the Centre for Reproductive Rights (CRR) (Link to CRR's website: <https://beta.reproductiverights.org/>); and Sexual Rights Initiative (SRI) (Link to SRI's website: <https://sexualrightsinitiative.com/about-us>).
6. Pro-bono legal networks (grassroots level), such as Namati (Link to Namati's website: <https://namati.org>)
7. Indigenous Persons with Disabilities Global Network (Link to website: <https://www.internationaldisabilityalliance.org/ipwgn>).

evaluation and feedback

This section provides a sample questionnaire that can be used at the end of the training sessions to collect feedback. This may be complemented with daily evaluations, including on the content and methodology of the Modules; structuring of the sessions; logistical arrangements, among others.

The evaluation can be formal/informal or a mix of both depending on the objectives of evaluation. Further, depending on the literacy levels of the group, you can also introduce images for rating through emoticons. This will, however, not work with participants with visual disability.

TRAINING QUESTIONNAIRE

Name:

Age: Gender you identify with:

How would you rate your overall experience of the training sessions: (pick one)

- a. Beyond my expectations
- b. Largely met expectations
- c. Somewhat met my expectations
- d. Below my expectations

How would you rate the daily schedule of the sessions? (pick one)

- a. Too long
- b. Just right
- c. Too short

How would you rate the duration of the training sessions? (pick one)

- a. Too long
- b. Just right
- c. Too short

CONTENT AND METHODOLOGY

Rate the different aspects of the Modules based on the following scale:

1. Poor 2. Fair 3. Good 4. Very Good 5. Excellent

	Topics Covered	Exercises	Handouts	Trainer
Module 1: Introduction				
Module 2: Disability Basics				
Module 3: Body Image and Self Esteem				
Module 4: Gender, Sex and Sexuality				
Module 5: Getting to know our bodies				
Module 6: Pleasure and Sexuality				
Module 7: Sexual and Reproductive Health and Rights				
Module 8: Abuse and Violence				
Module 9: SRHR Advocacy				

Are there some topics you wish were included? (If yes, can you explain further)

TRAINING QUESTIONNAIRE

Which Module did you find the most impactful and why?

Which Module did you find the least impactful and why?

LOGISTICAL ARRANGEMENTS

Rate your experience with different logistical arrangements:

1. Poor 2. Fair 3. Good 4. Very Good 5. Excellent

	Rating	Comments (If any)
Information about the workshop and troubleshooting		
Venue		
Accommodation and Food		
Accessibility (sign language interpretation, accessibility of materials, accessibility of language)		
Reasonable Accommodation Requirements (if you had raised any)		

Are there any specific areas of improvement you would like to highlight?

OVERALL

What were some of the strong points of the training sessions?

What were some of the weak points of the training sessions?

What were some of your key learnings?

Were there aspects of the training that left an impact on you/forced you to rethink? If yes, could you explain how?

Do you have any other suggestions/feedback for the organizers?

endnotes

MODULE 1

1. Sins Invalid (2017) 'Skin, Tooth, and Bone – The Basis of Movement is Our People: A Disability Justice Primer', *Reproductive Health Matters*, 25(50), pp. 149-150.
2. Kimberle Crenshaw (1991) 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color', *Stanford Law Review*, 43(6), pp. 1241-1299.
3. Women Enabled International, *Legal Capacity of Women and Girls with Disabilities*. Available at: [Link to PDF document] <https://www.womenenabled.org/pdfs/Women%20Enabled%20International%20-%20Legal%20Capacity%20of%20Women%20and%20Girls%20with%20Disabilities%20-%20English.pdf?pdf=GBVEnglish> (Accessed on 5 September 2020).
4. UN Committee on the Rights of Persons with Disabilities (CRPD) (2016) *General comment No. 3 (2016), Article 6: Women and girls with disabilities*, CRPD/C/GC/3.
5. World Health Organization (WHO) and World Bank (2011) *World Report on Disability*. Geneva: WHO, p. xi.
6. Report of the Secretary-General (2017) *Situation of women and girls with disabilities and the Status of the Convention on the Rights of Persons with Disabilities and the Optional Protocol thereto*, A/72/227.
7. Stephanie Ortoleva and Hope Lewis (2012) *Forgotten Sisters – A Report on Violence against Women with Disabilities: An Overview of Its Nature, Scope, Causes and Consequences*. Available at: [Link to PDF Document] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2133332. (Accessed on 3 September 2020).
8. See for instance: ARROW (2017) *ARROW for Change – Women with Disabilities: Disabled, Sexual, Reproductive*, 23(3); *Reproductive Health Matters* (2017) *Disability and sexuality: claiming sexual and reproductive rights*, 25(50); CREA (2018) *Women, Disabled, Queer: Working Together for our Sexuality and Rights*; TARSHI (2018) *Sexuality and Disability in the Indian context*. New Delhi: TARSHI.
9. Special Rapporteur on the Rights of Persons with Disabilities (2017) *Sexual and reproductive health and rights of girls and young women with disabilities*, A/72/133. New York: UN.
10. For a sample Needs Assessment Tool on SRHR training with disability rights organizations, refer to Appendix A. The tool was jointly developed by CREA, Anjali Mental Health Rights Organization, Point of View, Equals Centre for Promotion of Social Justice and Sruti Disability Rights Centre.
11. Jane Maxwell, Julia Watts Belser & Darlena David (2007) *Health Handbook for Women with Disabilities*. Berkeley, California: Hesperian.
12. Talking About Reproductive and Sexual Health Issues (TARSHI) (2006) *Basics and Beyond: A Manual for Trainers; Integrating Sexuality, Sexual and Reproductive Health and Rights*. New Delhi: TARSHI.
13. Saad Adnan Khan and Farhana Alam (2017) *Untold Desires*. Dhaka, Bangladesh: BRAC James P Grant School of Public Health, BRAC University, p. 27.
14. Ibid, p.71.
15. Talking About Reproductive and Sexual Health Issues (TARSHI) (2006) *Basics and Beyond: A Manual for Trainers; Integrating Sexuality, Sexual and Reproductive Health and Rights*. New Delhi: TARSHI, p.52.
16. Sins Invalid (2017), 'Skin, Tooth and Bone - The Basis of Movement is Our People: A Disability Justice Primer', *Reproductive Health Matters*, 25(50), pp.149-150.

MODULE 2

17. OHCHR, *Training Package on the Convention on the Rights of Persons with Disabilities – Module 1: What is Disability?*
18. Ibid.
19. Ibid.
20. Ibid.
21. Disabled Peoples' Organizations, Community Based Organizations and Non-Government Organizations in Bangladesh working for the rights of People with Disabilities (2019) *Alternative Report on the Status of Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh*. Available at: [Link] <https://www.blast.org.bd/content/report/Alternative-Report-NGDO-2019.pdf> (Accessed on 5 July 2020).
22. Adapted from case study in Indumathi Rao, *Equity to women with disabilities in India* (A strategy paper prepared for the National Commission for Women, India). Available at: [Link] <http://standingindia.com/wp-content/uploads/2017/01/7667871Equity-to-women-with-disabilities-in-India2012-october.pdf> (Accessed on 10 August 2020).
23. Ibid.
24. Women with Disabilities India Network (2019) *Alternate Report towards Article 6*. Submitted to the Committee on the Rights of Persons with Disabilities.
25. Disabled Peoples' Organizations, Community Based Organizations and Non-Government Organizations in Bangladesh working for the rights of People with Disabilities (2019) *Alternative Report on the Status of Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh*. Available at: [Link] <https://www.blast.org.bd/content/report/Alternative-Report-NGDO-2019.pdf> (Accessed on 5 July 2020).
26. Disabled Peoples' Organizations, Community Based Organizations and Non-Government Organizations in Bangladesh working for the rights of People with Disabilities (2019) *Alternative Report on the Status of Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh*. Available at: [Link] <https://www.blast.org.bd/content/report/Alternative-Report-NGDO-2019.pdf> (Accessed on 5 July 2020).
27. Adapted from case study in Indumathi Rao, *Equity to women with disabilities in India* (A strategy paper prepared for the National Commission for Women, India). Available at: [Link] <http://standingindia.com/wp-content/uploads/2017/01/7667871Equity-to-women-with-disabilities-in-India2012-october.pdf>. Accessed on 10 August 2020.
28. Ibid.
29. Women with Disabilities India Network (2019) *Alternate Report towards Article 6*. Submitted to the Committee on the Rights of Persons with Disabilities.
30. Disabled Peoples' Organizations, Community Based Organizations and Non-Government Organizations in Bangladesh working for the rights of People with Disabilities (2019) *Alternative Report on the Status of Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh*. Available at: [Link] <https://www.blast.org.bd/content/report/Alternative-Report-NGDO-2019.pdf> (Accessed on 5 July 2020).

MODULE 3

31. Structuring of societal values and behaviours that place attributes of non-disabled people as the norm and as a result devalue and discriminate against disabled people. These norms are deeply shaped by racism, capitalism, sexism, settler-colonialism etc.

MODULE 4

32. AMAZE Org (2019) *Sex Assigned at Birth and Gender Identity: What Is The Difference?* Available at: [Link] <https://www.youtube.com/watch?v=Y19kYh6k7ls> (Accessed on 27 July 2020).
33. Vanderbilt University, *Handout on Privilege and Oppression*. Available at: [Link to word doc] <https://www.vanderbilt.edu/oacs/wp-content/uploads/sites/140/Understanding-Privilege-and-Oppression-Handout.doc>. (Accessed on 14 October 2020).
34. Maria Melinda Ando (2019) *InterSEXuality: A Facilitator's Guide*. Kuala Lumpur, Malaysia: ARROW.
35. LGBTQIA Resource Center at UC Davis, *Glossary*. Available at: [Link] <https://lgbtqia.ucdavis.edu/educated/glossary> (Accessed on 16 October 2020).
36. National Legal Services Authority v. Union of India (2014) 5 SCC 438.
37. LGBTQIA Resource Center at UC Davis, *Glossary*. Available at: [Link] <https://lgbtqia.ucdavis.edu/educated/glossary> (Accessed on 16 October 2020).
38. Independence Australia, *Myth Busting: Disability and Sex*. Available at: [Link] <https://www.independenceaustralia.com.au/health-articles/health-disabilities-and-sex/>. (Accessed on 8 August 2020).
39. Farhana Alam et.al (2017) *Let's Debunk the Misconceptions*. Dhaka, Bangladesh: BRAC James P Grant School of Public Health, BRAC University.
40. Independence Australia, *Myth Busting: Disability and Sex*. Available at: [Link] <https://www.independenceaustralia.com.au/health-articles/health-disabilities-and-sex/>. (Accessed on 8 August 2020).

MODULE 5

41. For a video tutorial on making a uterus model from flour and water, see the video at this link: <https://www.youtube.com/watch?v=a8e3f1SFV1U&t=63s> (Accessed on 30 July 2020).
42. For a video tutorial on making a uterus model from cloth, see the video at this link: <https://www.youtube.com/watch?v=hajfherzwXM> (Accessed on 30 July 2020).
43. For a video tutorial on making a uterus model from thermocol, see the video at this link: <https://www.youtube.com/watch?v=2cDUoOJdg8M&t=114s> (Accessed on 30 July 2020).
44. Abha Khetarpal (2020) *Manual on Sexual and Reproductive Health & Rights of Women with Disabilities*.
45. Abha Khetarpal (2020) *Manual on Sexual and Reproductive Health & Rights of Women with Disabilities*.
46. Afsana Aziz Nitol (2017) *Myths and misconceptions regarding menstruation in rural areas*, The Daily Star. Available at: <https://www.thedailystar.net/star-youth/myths-and-misconceptions-regarding-menstruation-rural-areas-1472059> (Accessed on 28 August 2020).
47. Afsana Aziz Nitol (2017) *Myths and misconceptions regarding menstruation in rural areas*, The Daily Star. Available at: <https://www.thedailystar.net/star-youth/myths-and-misconceptions-regarding-menstruation-rural-areas-1472059> (Accessed on 28 August 2020).

MODULE 6

48. Maria Melinda Ando (2019) *InterSEXuality: A Facilitator's Guide*. Kuala Lumpur, Malaysia: ARROW.
49. Saad Adnan Khan and Farhana Alam (2017) *Untold Desires*. Dhaka, Bangladesh: BRAC James P Grant School of Public Health, BRAC University.
50. Saad Adnan Khan and Farhana Alam (2017) *Untold Desires*. Dhaka, Bangladesh: BRAC James P Grant School of Public Health, BRAC University, p.27.
51. Ibid, p.40.
52. Ibid, p. 50.
53. Ibid, p.71.
54. Transcript of video: Batra healthcare (2018) *Kiran Nayak, started KVS organization for transgenders*. Available at: [Link] <https://www.youtube.com/watch?v=MF1XkzvEko> (Accessed on 6 August 2020).

MODULE 7

55. In the context of Bangladesh, the term 'menstrual regulation' is used to denote the range of procedures that are usually covered under abortion services. The term abortion per se is not used. While abortion is deemed illegal (except to save the life of the mother), menstrual regulation is legally permissible. Refer to Activity 7.3 for more details.
56. Center for Research on Women with Disabilities, Baylor College of Medicine, *Pregnancy and Delivery*. Available at: [Link] www.shorturl.at/gosLR (Accessed on 20 August 2020). See also: Abha Khetarpal (2020) *Manual on Sexual and Reproductive Health & Rights of Women with Disabilities*.
57. Center for Research on Women with Disabilities, Baylor College of Medicine, *Parenting*. Available at: [Link] <https://www.bcm.edu/research/labs-and-centers/research-centers/center-for-research-on-women-with-disabilities/a-to-z-directory/parenting> (Accessed on: 20 August 2020).
58. National Research Centre for Parents with Disabilities, *Strengths and Benefits of Parenting with a Disability*. Available at: [Link] <https://heller.brandeis.edu/parents-with-disabilities/pdfs/twitter-strengths-benefits-1.pdf> (Accessed on 27 August 2020).
59. SexualityandDisability.org, *Caring for your baby*. Available at: [Link] <https://sexualityanddisability.org/having-children/caring-for-your-baby/> (Accessed on 28 August 2020). For further information on managing care responsibilities of a new born with other disabilities, see: Jane Maxwell, Julia Watts Belser, Darlena David (2007) *A Health Handbook for Women with Disabilities*. Berkeley, California: Hesperian, pp. 253-276 (Chapter 12: Caring for your Baby).
60. Omar Khan Joy (2010) *Adoption of a child and its formalities*, The Daily Star. Available at: <http://archive.thedailystar.net/law/2010/12/03/advocate.htm> (Accessed on 20 August 2020).
61. For further reading see: Alana Vagianos (2020) *Women Aren't The Only People Who Get Abortions*, Huffpost. Available at: [Link] www.shorturl.at/quP26 (Accessed on: 21 August 2020).
62. Guttmacher Institute (2017) *Fact Sheet: Menstrual Regulation and Unsafe Abortion in Bangladesh*. Available at: [Link to PDF] <https://www.guttmacher.org/sites/default/files/factsheet/menstrual-regulation-unsafe-abortion-bangladesh.pdf> (Accessed on 22 August 2020).
63. Jane Maxwell, Julia Watts Belser, Darlena David (2007) *A Health Handbook for Women with Disabilities*. Berkeley, California: Hesperian, p. 159.

MODULE 8

64. Handicap International and Bangladesh Legal Aid and Services Trust (BLAST) (2015) *Good Practice Report on Access to Justice for People with Disabilities in Bangladesh*.
65. Human Rights Watch (2018) *Invisible Victims of Sexual Violence Access to Justice for Women and Girls with Disabilities in India*, pp. 29-30.
66. Ibid, pp. 6-7.
67. Ibid, p.34.
68. Ibid, p.43.
69. Ibid, p.46-47.
70. Chittagong Hill Tracts Commission (2014) *Marginalisation and Impunity: Violence against women and girls in the Chittagong Hill Tracts*.
71. Human Rights Watch (2018) *Invisible Victims of Sexual Violence Access to Justice for Women and Girls with Disabilities in India*, pp. 29-30.
72. Ibid, pp. 6-7.
73. Ibid, p.34.
74. Ibid, p.43.
75. Ibid, p.46-47.
76. Chittagong Hill Tracts Commission (2014) *Marginalisation and Impunity: Violence against women and girls in the Chittagong Hill Tracts*.

MODULE 9

77. Bangladesh National Women Lawyer's Association v. Government of Bangladesh & Others, Writ Petition No. 5916 of 2008.
78. Human Rights Watch (2011) *Bangladesh: Protect Women Against '–' Violence*. Available at: [Link] <https://www.hrw.org/news/2011/07/06/bangladesh-protect-women-against-–-violence> (Accessed on 10 September 2020).
79. Disabled Peoples' Organizations, Community Based Organizations and Non-Government Organizations in Bangladesh working for the rights of People with Disabilities (2019) *Alternative Report on the Status of Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh*. Available at: [Link] <https://www.blast.org.bd/content/report/Alternative-Report-NGDO-2019.pdf> (Accessed on 5 July 2020).
80. BLAST, *Success Stories – Case Study (2011): Domestic Violence Perpetrator Demanding Dowry Brought to Justice through Litigation*, (Reg. No: 15/247/2011). Available at: [Link] <https://www.blast.org.bd/success/369> (Accessed on 12 September 2020).
81. Disabled Peoples' Organizations, Community Based Organizations and Non-Government Organizations in Bangladesh working for the rights of People with Disabilities (2019) *Alternative Report on the Status of Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh*. Available at: [Link] <https://www.blast.org.bd/content/report/Alternative-Report-NGDO-2019.pdf> (Accessed on 5 July 2020).
82. BLAST, *Success Stories – Case Study (2012): Domestic Violence Act 2010 Litigation* (Reg. No: 19/2012). Available at: [Link] <https://www.blast.org.bd/success/369> (Accessed on 12 September 2020).
83. Abdul Aziz and Sameena Azhar (2020) 'Social Exclusion and Official Recognition of Hijra in Bangladesh', *Journal of Women and Gender*, 9(1), p. 3-19.
84. Jeopardy-Community-Toolkit.pdf.
84. Abdullah Titir (2019) *From Recognition to Realizing Rights*. Dhaka: Bangladesh Legal Aid and Services Trust (BLAST), p.1.
85. Ibid, p.4.
86. Bangladesh National Women Lawyer's Association v. Government of Bangladesh & Others, Writ Petition No. 5916 of 2008.
87. Human Rights Watch (2011) *Bangladesh: Protect Women Against '–' Violence*. Available at: [Link] <https://www.hrw.org/news/2011/07/06/bangladesh-protect-women-against-–-violence> (Accessed on 10 September 2020).
88. BLAST, *Success Stories – Case Study (2011): Domestic Violence Perpetrator Demanding Dowry Brought to Justice through Litigation*, (Reg. No: 15/247/2011). Available at: [Link] <https://www.blast.org.bd/success/369> (Accessed on 12 September 2020).
89. BLAST, *Success Stories – Case Study (2012): Domestic Violence Act 2010 Litigation* (Reg. No: 19/2012). Available at: [Link] <https://www.blast.org.bd/success/369> (Accessed on 12 September 2020).
90. Abdul Aziz and Sameena Azhar (2020) 'Social Exclusion and Official Recognition of Hijra in Bangladesh', *Journal of Women and Gender*, 9(1), p. 3-19.
91. Bangladesh National Women Lawyer's Association v. Government of Bangladesh & Others, Writ Petition No. 5916 of 2008.
92. Abdullah Titir (2019) *From Recognition to Realizing Rights*. Dhaka: Bangladesh Legal Aid and Services Trust (BLAST), p.1.
93. Advocacy Institute (2002) *"Nine Questions" A Strategy Planning Tool For Advocacy Campaigns*. Available at: [Link] <https://www.ndi.org/sites/default/files/Handout%201%20-%20Nine%20Advocacy%20Questions.pdf> (Accessed on 10 September 2020).

references

Other toolkits on different aspects of SRHR and disability

1. Curriculum by Training in Sexual Education for People with Disabilities (TRASE). Available at: <https://www.traseproject.com/curriculum>.
2. Pacific Disability Forum (2014) *Toolkit on Eliminating Violence Against Women and Girls with Disabilities in Fiji*. Available at: [Link to PDF] <https://www.rccr-resilience-southeastasia.org/document/toolkit-on-eliminating-violence-against-women-and-girls-with-disabilities-in-fiji/>.
3. Women With Disabilities Australia (WWDA) (2016) 'Human Rights Toolkit for Women and Girls with Disability'. Hobart, Tasmania: WWDA. 1st Edition. Available at: [Link to PDF] https://assets-global.website-files.com/5ea654fbfc3264738bbe2618/5ea654fbfc326460cdeb2ffa_WWDA-Human-Rights-Toolkit-Final-Reduced%20Filesize.pdf.
4. Women Enabled International (2017) *accountABILITY Toolkit*. It is a guide to using U.N. Human Rights Mechanisms to Advance the Rights of Women and Girls with Disabilities. Available at: [Link] <https://womenenabled.org/atk.html>.
5. Women's Refugee Commission, *"I See That It Is Possible": Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*, 2015. Available at: [Link to PDF] <https://s33660.pcdn.co/wp-content/uploads/2020/04/Disability-Inclusion-in-GBV-English.pdf>.
6. Channthey Heng et.al., (2013) *Challenging Discrimination Against Women with Disabilities: A Community Toolkit*, Banteay Srei, CDPO, CBM Australia, IWDA and Monash University. Available at: [Link to PDF] <https://www.iwda.org.au/assets/files/Triple->
7. Life Support Productions (2019) *You, Your Body, Growing Up, Relationships and Sex*. It is a comprehensive sex education resource for children and young people with learning disabilities. The full resource is paid, but lesson plans can be accessed for free. Available at: [Link] <https://lifesupportproductions.co.uk/online-resources/>.
8. Arc of Maryland, *Personal SPACE Lesson Plans*. The lesson plans are a part of gender violence prevention program for women with developmental disabilities. Available at: [Link to PDF] http://www.ncdsv.org/images/Arc_PersonalSpace-AViolencePreventionProgramForWomen.pdf.
9. King Country Public Health, *F.L.A.S.H.: Family Life and Sexual Health, Lesson Plans for Special Education*. Available at: [Link] <https://www.kingcounty.gov/depts/health/locations/family-planning/education/FLASH/special-education.aspx>.
10. DiAnn L. Baxley and Anna L. Zendell, *Sexuality Across the Life Span*. This is an instructional guide for educators of individuals with developmental disabilities. Available at: [Link] <http://www.fddc.org/sites/default/files/file/publications/Sexuality%20Guide-Educators-English.pdf>.

Further resources on each topic is available at the end of the chapter/Module.

APPENDIX A: Sample Needs Assessment Tool

This tool was jointly developed by CREA, Anjali Mental Health Rights Organization, Point of View, Equals Centre for Promotion of Social Justice and Sruti Disability Rights Centre.

NEEDS ASSESSMENT QUESTIONNAIRE

City:

Interviewee:

Date:

ORGANIZATIONAL INFORMATION

1. Name of the organization:
2. Address:
3. Contact number:
4. Email id:
5. Your organization specifically works for persons with: (Please tick your answer)
 a. Visual impairment
 b. Hearing impairment
 c. Loco motor disability
 d. Intellectual disability
 e. Multiple disabilities
 f. Others then please specify
6. Focus area/or area of specialisation (like technology, employment etc):
7. Do you have a women's department/cell in your organization?
8. Could you please give us the approximate number and demographics (like age, socio economic strata etc.) of the disabled women associated with your organization?
9. How many women are there working in your organization?
10. Can you share any reports, publications, training material that the organization has prepared or uses regularly?

TRAINING COMPOSITION

11. Mention three to seven words or phrases that you would use to define the following:
- Disability:
 - Gender:
 - Sexuality:
12. Do you think talking about sexuality and reproductive health and rights are important for PWD? (Please tick the option and explain why)
- Not at all
 - A little bit
 - Important
 - Very important
- Why?
13. In your opinion, does sexuality play a role in a person's – (Yes/No, Please Explain)
- Personal/domestic life: Yes/No
 - Work life: Yes/No
 - Social/community life: Yes/No
 - Does not play a role at all: Yes/No
14. In the past have you conducted trainings in any of the following areas? (Please tick if you have)
- Understanding body, body image, self esteem
 - Menstruation and puberty education
 - Sex education and reproductive system
 - Sexual desires, sexual orientation and sexual pleasure
 - Socialising, dating, marriage
 - Parenting and adoption
 - Sexual harassment at work, on streets and with caregivers
 - Domestic violence and sexual assault
 - Child sex abuse
 - Abortion rights, sexually transmitted infections and HIV
15. Have these trainings been conducted:
- exclusively with women
 - A mixed group?
16. Can you share some examples of challenges, dilemmas, problems or questions that you have faced while conducting the above mentioned trainings?
17. Please rate the following areas on the scale of 1 to 5, according to it being an important training content for your organization. (1 – not important at all / 2 – a little important but secondary / 3 – important / 4 – very important)
- Understanding body, body image, self esteem
 - Menstruation and puberty education
 - Sex education and reproductive system
 - Sexual desires, sexual orientation and sexual pleasure
 - Socialising, dating, marriage
 - Parenting and adoption
 - Sexual harassment at work, on streets and with caregivers

- _____h. Domestic violence and sexual assault
- _____i. Child sex abuse
- _____j. Abortion rights, sexually transmitted diseases and HIV
- _____k. Institutional Violence

Additional comment:

18. Out of the above areas please list up to three areas that are linked to your focus and work (for example if you work for employment, you will have a direct link to sexual harassment at work).
- a.:
 - b.:
 - c.:

19. What are your expectations out of the training program on sexual and reproductive health and rights?

TRAINING LOGISTICS:

20. What language will be preferable for trainings?
21. Please list the specific accessibility needs to keep in mind during the training (more pictorial representation, tactile material, shorter session durations etc.)
22. What would be your preferred length of training?
- a. Half day
 - b. Full day
22. Do you have any preferred/regular venue for the trainings?
23. Do you have any trainers/facilitators/special educators who can be nominated to work with us to plan the training? If yes, who and their contact.



ipsita

ISBN 978-967-0339-53-5



9 789670 339535 >



ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Established in 1993, it envisions an equal, just, and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

Asian-Pacific Resource & Research Centre for Women (ARROW)

1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

- Telephone** (603) 2273 9913/9914/9915
- Fax** (603) 2273 9916
- E-mail** arrow@arrow.org.my
- Web** www.arrow.org.my
- Facebook** facebook.com/ARROW.Women
- Instagram** [arrow_women](https://www.instagram.com/arrow_women)
- Twitter** [@ARROW_Women](https://twitter.com/ARROW_Women)
- Youtube** youtube.com/user/ARROWWomen
- LinkedIn** linkedin.com/company/arrowwomen



This publication is produced with funding from the UN Trust Fund to End Violence Against Women. However, the views expressed, and content included does not imply official endorsement or acceptance by the United Nations.